LEICESTER CITY
HEALTH AND WELLBEING BOARD

Date: THURSDAY, 29 JUNE 2023

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

NOTE:

This meeting will be webcast live at the following link:-

http://www.leicester.public-i.tv

An archive copy of the webcast will normally be available on the Council's website within 48 hours of the meeting taking place at the following link:-

http://www.leicester.public-i.tv/core/portal/webcasts

MEMBERS OF THE BOARD

Councillors:

Councillor Sarah Russell, Deputy City Mayor, Social Care, Health, and Community Safety (Chair)

Councillor Adam Clarke, Deputy City Mayor, Climate, Economy, and Culture

Councillor Elly Cutkelvin, Deputy City Mayor, Housing and Neighbourhoods

Councillor Vi Dempster, Assistant City Mayor, Education, Libraries, and Community Centres

1 Vacancy

City Council Officers:

Martin Samuels, Strategic Director of Social Care and Education

Ivan Browne, Director Public Health

Dr Katherine Packham, Public Health Consultant

1 Vacancy

NHS Representatives:

Andy Williams, 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

David Sissling, Independent Chair, Leicester, Leicestershire and Rutland Integrated Care System

Oliver Newbould, Director of Strategic Transformation, NHS England * NHS Improvement – Midlands

Richard Mitchell, Chief Executive, University Hospitals of Leicester NHS Trust

Jean Knight, Deputy Chief Executive, Leicestershire Partnership NHS Trust

Healthwatch / Other Representatives:

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

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

Barney Thorne, Mental Health Partnership Manager, Leicestershire Police

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

Kevin Liles, Chief Executive, Voluntary Action Leicester

Kevin Routledge, Strategic Sports Alliance Group

Sue Tilly, Head of the Leicester and Leicestershire Enterprise Partnership

1 Vacancy

STANDING INVITEES: (Non-Voting Board Members)

Cathy Ellis – Chair of Leicestershire Partnership NHS Trust

Professor Andrew Fry – College Director of Research, Leicester University

Susannah Ashton, Divisional Manager for Leicester, Leicester and Rutland, East Midlands Ambulance NHS Trust

John MacDonald, Chair of University Hospitals of Leicester NHS Trust

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

Information for members of the public

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You have the right to attend formal meetings such as full Council, committee meetings, City Mayor & Executive Public Briefing and Scrutiny Commissions and see copies of agendas and minutes. On occasion however, meetings may, for reasons set out in law, need to consider some items in private.

Dates of meetings and copies of public agendas and minutes are available on the Council's website at www.cabinet.leicester.gov.uk, from the Council's Customer Service Centre or by contacting us using the details below.

Making meetings accessible to all

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If you intend to film or make an audio recording of a meeting you are asked to notify the relevant Democratic Support Officer in advance of the meeting to ensure that participants can be notified in advance and consideration given to practicalities such as allocating appropriate space in the public gallery etc.

The aim of the Regulations and of the Council's policy is to encourage public interest and engagement so in recording or reporting on proceedings members of the public are asked:

- ✓ 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 Jacob Mann**, Democratic Support on (0116) 454 5843 or email jacob.mann@leicester.gov.uk** or call in at City Hall, 115 Charles Street, Leicester, LE1 1FZ.

For Press Enquiries - please phone the **Communications Unit on 0116 454 4151**

PUBLIC SESSION

AGENDA

FIRE/EMERGENCY EVACUATION

If the emergency alarm sounds, you must evacuate the building immediately by the nearest available fire exit and proceed to area outside the Ramada Encore Hotel on Charles Street as directed by Democratic Services staff. Further instructions will then be given.

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. MEMBERSHIP OF THE BOARD

To note the membership of the Board for 2023/24, approved by Annual Council on 18 May 2023:

City Councillors (5 places)

- Councillor Sarah Russell, Deputy City Mayor, Social Care, Health, and Community Safety (Chair)
- Councillor Adam Clarke, Deputy City Mayor, Climate, Economy, and Culture
- Councillor Elly Cutkelvin, Deputy City Mayor, Housing and Neighbourhoods
- Councillor Vi Dempster, Assistant City Mayor, Education, Libraries, and Community Centres
- 1 Vacancy

Council Officers (4 places)

- Martin Samuels, Strategic Director of Social Care and Education
- Ivan Browne, Director of Public Health
- Dr Katherine Packham, Public Health Consultant
- 1 Vacancy to be nominated by the Chief Operating Officer

NHS Representatives (7 places)

- Andy Williams, 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
- David Sissling, Independent Chair, Leicester, Leicestershire and Rutland Integrated Care System
- Oliver Newbould, Director of Strategic Transformation, NHS England * NHS Improvement – Midlands
- Richard Mitchell, Chief Executive, University Hospitals of Leicester NHS Trust
- Jean Knight, Deputy Chief Executive, Leicestershire Partnership NHS Trust

Healthwatch / Other Representatives (8 places)

- Harsha Kotecha, Chair, Healthwatch Advisory Board, Leicester and Leicestershire
- Rupert Matthews, Police and Crime Commissioner, Leicester, Leicestershire and Rutland
- Barney Thorne, Mental Health Partnership Manager, Leicestershire Police
- Benjamin Bee, Area Manager Community Risk, Leicestershire Fire and Rescue Service
- Kevin Liles, Chief Executive, Voluntary Action Leicester
- Kevin Routledge, Strategic Sports Alliance Group
- Sue Tilly, Head of the Leicester and Leicestershire Enterprise Partnership
- 1 Vacancy

STANDING INVITEE: (Not A Council Appointed Voting Board Member – Invited by the Chair of the Board. and no set number of places)

- Professor Bertha Ochieng – Integrated Health and Social Care, De Montfort University
- Professor Andrew Fry – College Director of Research, Leicester University
- Susannah Ashton, Divisional Manager for Leicester, Leicester and Rutland, East Midlands Ambulance NHS Trust
- Cathy Ellis – Chair of Leicestershire Partnership NHS Trust
- John MacDonald, Chair of University Hospitals of Leicester NHS Trust

4. TERMS OF REFERENCE

Appendix A (Pages 1 - 6)

To note the Board's Terms of Reference approved by Full Council on 18 May 2023.

5. MINUTES OF THE PREVIOUS MEETING **Appendix B (Pages 7 - 18)**

The Minutes of the previous meeting of the Board held on 16 March 2023 are attached and the Board is asked to confirm them as a correct record.

6. LEICESTER CHILDREN'S HEALTH AND WELLBEING SURVEY 2021/22 **Appendix B (Pages 19 - 160)**

Gurjeet Rajania (Public Health Intelligence Analyst, Leicester City Council) and Rob Howard (Consultant in Public Health, Leicester City Council) will present a summary of the key findings from the recent Children and Young People's Health and Wellbeing Survey.

7. LLR CHILD DEATH OVERVIEW PANEL ANNUAL REPORT FOR 2021-2022 **Appendix C (Pages 161 - 216)**

Rob Howard (Consultant in Public Health, Leicester City Council) and Dr Suzanna Armitage (Consultant Community Paediatrician and Designated Doctor for Child Death, Leicestershire Partnership Trust) will outline the work of the Child Death Overview Panel (CDOP) and present the findings of the CDOP annual report.

8. 0-19 HEALTHY CHILD PROGRAMME **Appendix D (Pages 217 - 226)**

Clare Mills (Children's Commissioner, Leicester City Council) and Catherine Yeomanson (Family Service Manager, Leicestershire Partnership Trust) will present on the work the 0-19 Healthy Child Programme is delivering to address children's health and wellbeing in the city.

9. MATERNAL MORTALITY IN ETHNIC MINORITY GROUPS **Appendix E (Pages 227 - 238)**

Rob Howard (Consultant in Public Health, Leicester City Council) and Dr Ruw Abeyratne (Director of Health Equality and Inclusion – University Hospitals of Leicester NHS Trust) will present an update on work which has been taking place – and future plans - to address the health inequities experienced by Black and Asian women in terms of access to, and experience of, maternity services, and the significant differences in maternal mortality between white British women and BAME women.

10. COLORECTAL CANCER 1 YEAR SURVIVAL RATES **Appendix F (Pages 239 - 260)**

Julia Emery (Consultant in Public Health, NHS England) and Dr Pawan Randev (Cancer Lead, LLR ICB) will present on a programme of work which has taken place to address the poor one-year survival rate for colorectal cancer which is experienced in Leicester, and to highlight the importance of retaining focus on

this following a period of 12 months intensive work across the system to address the issue.

11. LEICESTER'S JOINT HEALTH, CARE AND WELLBEING STRATEGY DELIVERY PLAN QUARTERLY UPDATE **Appendix G (Pages 261 - 268)**

Amy Endacott (Public Health Programme Manager, Leicester City Council) will present a highlight report summarising key progress during February – May 2023 against the six priorities (and associated actions/activity) outlined within the Joint Health, Care and Wellbeing Strategy which form the focus of a delivery action plan.

12. BETTER CARE FUND END OF YEAR APPROVAL **Appendix H (Pages 269 - 286)**

The Chair will ask the Board to provide formal approval of the Better Care Fund end of year submission to NHS England, noting that the associated reports have been circulated for review in advance of the meeting.

13. QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair to invite questions from members of the public.

14. DATES OF FUTURE MEETINGS

To note that meetings have been arranged for the following dates in 2023/2024 which were submitted to the Annual Council in May 2023. Please add these dates to your diaries. Diary appointments will be sent to Board Members.

Thursday 21 September 2023 – 9.30am
Thursday 23 November 2023 – 9.30am
Thursday 18 January 2024 – 9.30am
Thursday 22 February 2024 – 9.30am
Thursday 18 April 2024 – 9.30am

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.

15. ANY OTHER URGENT BUSINESS

Appendix A

Leicester City Health and Wellbeing Board

Terms of Reference

Approved at Annual Council on 18 May 2023

Introduction

In line with the Health and Social Care Act 2012, the Health & Wellbeing Board is established as a Committee of Leicester City Council.

The Health & Wellbeing Board operated in shadow form since August 2011. In April 2013, the Board became a formally constituted Committee of the Council with statutory functions and met for the first time on 11 April 2013.

1 Aim

To achieve better health, wellbeing and social care outcomes for Leicester City's population and a better quality of care for patients and other people using health and social services.

2 Objectives

2.1 To provide strong local leadership for the improvement of the health and wellbeing of Leicester's population and work to reduce health inequalities.

2.2 To lead on improving the strategic coordination of commissioning across NHS, adult social care, children's services and public health services.

2.3 To maximise opportunities for joint working and integration of services using existing opportunities and processes and prevent duplication or omission.

2.4 To provide a key forum for public accountability of NHS, Public Health, Adult Social Care and Children's Services and other commissioned services that the Health & Wellbeing Board agrees are directly related to health and wellbeing.

3 Responsibilities

3.1 Working jointly, to identify current and future health and wellbeing needs across Leicester City through revising the Joint Strategic Needs Assessment (JSNA) as and when required. Preparing the JSNA is a statutory duty of Leicester City Council and Leicester, Leicestershire and Rutland (LLR) Integrated Care Board (ICB).

3.2 Develop and agree the priorities for improving the health and wellbeing of the people of Leicester and tackling health inequalities.

3.3 Prepare and publish a Joint Local Health and Wellbeing Strategy (JLHWS) that is evidence based through the work of the Joint Strategic Needs Assessment (JSNA) and supported by all stakeholders. This will set out strategic objectives, ambitions for achievement and how we will be jointly held to account for delivery. Preparing the JLHWS is a statutory duty of Leicester City Council and LLR Integrated Care Board.

3.4 Save in relation to agreeing the JSNA, JLHWS and any other function delegated to it from time to time, the Board will discharge its responsibilities by means of recommendation to the relevant partner organisations, who will act in accordance with their respective powers and duties.

3.5 Ensure that all commissioners of services relevant to health and wellbeing take appropriate account of the findings of the Joint Strategic Needs Assessment and demonstrate strategic alignment between the JLHWS and each organisation's commissioning plans.

3.6 Ensure that all commissioners of services relevant to health and wellbeing demonstrate how the JLHWS has been implemented in their commissioning decisions.

3.7 To monitor, evaluate and annually report on the LLR Integrated Care Board's contribution to the delivery of the JLHWS at the request of NHS England as part of its annual performance assessment.

3.8 Review performance against key outcome indicators and be collectively accountable for outcomes and targets specific to performance frameworks within the NHS, Local Authority and Public Health.

3.9 Ensure that the work of the Board is aligned with policy developments both locally and nationally.

3.10 Provide an annual report from the Health and Wellbeing Board to the Leicester City Council Executive and to the Board of LLR Integrated Care Board to ensure that the Board is publicly accountable for delivery.

3.11 Oversee progress against the Health and Wellbeing Strategy and other supporting plans and ensure action is taken to improve outcomes.

3.12 The Board will not exercise scrutiny duties around health and adult social care directly. This will remain the role of the relevant Scrutiny Commissions of Leicester City Council. Decisions taken and work progressed by the Health & Wellbeing Board will be subject to scrutiny by relevant Scrutiny Commissions of Leicester City Council.

3.13 The Board will need to be satisfied that all commissioning plans demonstrate compliance with the Equality Act 2010, improving health and social care services for groups within the population with protected characteristics and reducing health inequalities.

3.14 The Board will agree Better Care Fund submissions and have strategic oversight of the delivery of agreed programmes.

4 Membership

Members:

Up to five Elected Members of Leicester City Council (5)

- The Executive Lead Member for Health (1)
- Four Elected Members nominated by the City Mayor (4)

Up to seven representatives of the NHS (7)

- The Chief Executive and two other representatives from the LLR Integrated Care Board (3)
- The Director of Strategic Transformation – NHS England & NHS Improvement – Midlands (1)
- The Independent Chair of the Integrated Care System (1)
- The Chief Executive of University Hospitals NHS Trust (1)
- The Chief Executive of Leicestershire Partnership NHS Trust (1)

Up to four Officers of Leicester City Council (4)

- The Strategic Director of Social Care and Education (Leicester City Council) (1)
- The Director of Public Health (Leicester City Council) (1)
- A Public Health Consultant leading on improving cross organisational initiatives and communication and developing links with the between system, place and neighbourhood within the Integrated Care System. (1)
- One Officer nominated by the Chief Operating Officer (1)

Up to eight further representatives including Healthwatch Leicester/Other Representatives (8)

- One representative of the Local Healthwatch organisation for Leicester City (1)
- Leicester City Local Policing Directorate, Leicestershire Police (1)
- The Leicester, Leicestershire and Rutland Police and Crime Commissioner (1)
- Chief Fire and Rescue Officer, Leicestershire Fire & Rescue Service (1)
- Two other people that the local authority thinks appropriate, after consultation with the Health and Wellbeing Board (2)
- A representative of the city's sports community (1)
- A representative of the private sector/business/employers (1)

5 Quorum & Chair

5.1 For a meeting to take place there must be at least six members of the Board present and at least one representative from each of the membership sections:

- Leicester City Council (Elected Member)
- LLR Integrated Care Board or NHS England & NHS Improvement - Midlands
- One senior officer Board Member from Leicester City Council
- Local Healthwatch/Other Representatives

5.2 Where a meeting is inquorate those members in attendance may meet informally but any decisions shall require appropriate ratification at the next quorate meeting of the Board.

5.3 Where any member of the Board proposes to send a substitute to a meeting, that substitute's name shall be properly nominated by the relevant 'parent' person/body and submitted to the Chair in advance of the meeting. The substitute shall abide by the Code of Conduct.

5.4 The City Council has nominated the Executive Lead for Health to Chair the Board. Where the Executive Lead for Health is unable to chair the meeting, then one of the other Elected Members shall chair (noting that at least one Elected Member must be present in order for the meeting to be declared quorate).

6 Voting

6.1 The City Council at its meeting on 29 May 2014 resolved to disapply Section 13(1A) of the Local Government and Housing Act 1989 such that the four local authority officers on the Board will not exercise voting rights.

6.2 Any representatives of bodies asked to attend meetings of the Board as 'Standing Invitees' by the Board shall not have a vote.

6.3 All other members will have an equal vote.

6.4 Decision-making will be achieved through consensus reached amongst those members present. Where a vote is required decisions will be reached through a majority vote of voting members; where votes are equal the chair will have a second and casting vote.

7 Code of conduct and member responsibilities

All voting members are required to comply with Leicester City Council's Code of Conduct, including each submitting a Register of Interest.

In addition, all members of the Board will commit to the following roles, responsibilities and expectations:

7.1 Commit to attending the majority of meetings.

7.2 Uphold and support Board decisions and be prepared to follow though actions and decisions obtaining the necessary financial approval from their organisation for the Board proposals and declaring any conflict of interest.

7.3 Be prepared to represent the Board at stakeholder events and support the agreed consensus view of the Board when speaking on behalf of the Board to other parties. Champion the work of the Board in their wider networks and in community engagement activities.

7.4 To participate in Board discussion to reflect views of their partner organisations, being sufficiently briefed to be able to make recommendations about future policy developments and service delivery.

7.5 To ensure that are communication mechanisms in place within the partner organisations to enable information about the priorities and recommendation of the Board to be effectively disseminated.

8 Agenda and Meetings

8.1 Administration support will be provided by Leicester City Council.

8.2 There will be standing items on each agenda to include:

- Declarations of Interest
- Minutes of the Previous Meeting
- Matters Arising
- Updates from each of the working subgroups of the Health & Wellbeing Board.

8.3 Meetings will be held a minimum of four times a year and the Board will meet in public and comply with the Access to Information procedures as outlined in Part 4b of the Council's Constitution.

Version 9.8 May 2023

Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: THURSDAY, 16 MARCH 2023 at 9:30 am

Present:

Councillor Dempster (Chair)	–	Assistant City Mayor, Health, Leicester City Council.
Ivan Browne	–	Director of Public Health, Leicester City Council.
Harsha Kotecha	–	Chair, Healthwatch Advisory Board, Leicester and Leicestershire.
Kevan Liles	–	Chief Executive, Voluntary Action Leicester.
Rani Mahal	–	Leicestershire and Rutland Police and Crime Deputy Commissioner.
Richard Mitchell	–	Chief Executive, University Hospitals of Leicester NHS Trust.
Dr Katherine Packham	–	Public Health Consultant, Leicester City Council.
Sara Prema		Chief Strategy Officer, Leicester, Leicestershire and Rutland Integrated Care Board
Mark Powell	–	Deputy Chief Executive, Leicestershire Partnership NHS Trust.
Kevin Routledge	–	Strategic Sports Alliance Group.
Martin Samuels	–	Strategic Director Social Care and Education, Leicester City Council.
Councillor Piara Singh Clair	–	Deputy City Mayor, Culture, Leisure and Sport, Leicester City Council.
David Sissling	–	Independent Chair of the Integrated Care System for Leicester, Leicestershire and Rutland.

Barney Thorne	–	Mental Health Partnership Manager, Local Policing Directorate, Leicestershire Police.
Councillor Sarah Russell	–	Deputy City Mayor, Social Care and Anti-Poverty, Leicester City Council.
Rachna Vyas	–	Chief Operating Officer, Leicester, Leicester, Leicestershire and Rutland Integrated Care Board.

Standing Invitees

Cathy Ellis	–	Chair of Leicestershire Partnership NHS Trust.

In Attendance

Graham Carey	–	Democratic Services, Leicester City Council.

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96. APOLOGIES FOR ABSENCE

Apologies for Absence were received from:-

Susannah Ashton	East Midlands Ambulance Service, Divisional Director.
Ben Bee	Area Manager Community Risk, Leicestershire Fire and Rescue Service.
Professor Andrew Fry	College Director of Research, Leicester University
Rupert Matthews	Leicester, Leicestershire and Rutland Police and Crime Commissioner.
John MacDonald	Chair of University Hospitals of Leicester NHS Trust.
Oliver Newbould	Director of Strategic Transformation, NHS England and NHS Improvement.
Professor Bertha Ochieng	Integrated Health and Social Care, De Montfort University.
Dr Avi Prasad	Place Board Clinical Lead, LLR Integrated Care Board.
Sue Tilley	Head of Leicester, Leicestershire Enterprise Partnership.

Andy Williams Chief Executive, LLR Integrated Care Board.

97. DECLARATIONS OF INTEREST

Members were asked to declare any interests they may have in the business to be discussed at the meeting. No such declarations were received.

98. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

The Minutes of the previous meeting of the Board held on 26 January 2023 be confirmed as a correct record.

99. CHAIR'S INTRODUCTION

The Chair reported on a visit earlier in the week to the A&E department at Leicester Royal Infirmary and thanked the Chief Executive and Senior Offciers for their help and assistance. She had met the operations team and was impressed by the focus on the flow of patients and their safety as they were processed through the department. Although the unit had the look of a portacabin on the outside, once inside in the unit it was like any other ward in the hospital. Although some patients were moved to other parts of the hospital late at night, that was due entirely to their clinical and care needs and was undertaken when it was considered to be in their best interests. It was pleasing to see the whole system was working well together with the ambulance service and others involved in the patients care.

100. JAMILA'S LEGACY

Rehana Sidat (Founder/CEO -Jamila's Legacy) gave a presentation on the work and remit of the local non-profit organisation, Jamila's Legacy, which supported and educated communities and organisations in mental health and wellbeing.

During the presentation it was noted that:-

- Jamila's Legacy was a non-profit organisation that offered advice, advocacy, support, a listening service, self-care activities and training to individuals interested in maintaining their own mental health well-being and supporting others.
- Jamila's Legacy had been bringing people together to increase mental health awareness and deepen understanding since 2015.
- It had been working at a community and grassroots level, engaging with ethnic minority communities, and had developed an understanding of their needs, barriers and challenges. It was good that schools were talking about mental health but it was not enough. During a recent presentation most people when asked talked about mental illness and not mental health. Mental health was not just about diagnosis it was also about being mentally well and healthy as well

- Stigma and shame around mental health still existed and in some
- ethnic minority communities there could be additional barriers and challenges to opening up or seeking help due to family and community expectations and/or some cultural norms and beliefs.
- In the City there were higher levels of poor mental health than the national average reported in 2018. Locally people were on the CAMHS waiting for 18 months to 2 years or were waiting a year for an appointment with a counsellor.
- The number of people with long-term mental health problems was significantly higher than the average across England.
- Mental health disorders in children and young people were also higher than England's average.
- Greater energy was needed to be put into prevention, rather than waiting until people reach crisis point. Education was provided so people could take control and know what they needed to do
- The project's vision was to normalise mental health conversations and create a society where people with mental health problems were accepted, valued and felt they belonged.
- The mission was to educate, build confidence and empower people with mental health problems so that they were well informed of their rights and choices, were able to maintain their own mental wellbeing and become confident self-advocates.
- The project had been set up with nothing and no building etc but had support and knowledge. Cafes and the University gave free space and cafés gave free drinks to people who came. Volunteers received no payments or travel expenses, and they offered support and help for nothing. The project collaborated with public, voluntary and business sector organisations. The Women's Mental Health Wellbeing project funded by the national lottery, the Mental Wellbeing offer was provided by John Lewis and men from ethnic minority groups were encouraged to come forward in safe environment because of the cultural stigma on mental health.
- The project had supported 1,200 people last year but there was infrastructure to support the small number of people involved. There also used to be a lot of support groups for parents but they were not there any more.

Members of the Board commented that:-

- Physical and mental health were both equally important.

- Cathy thanks and well done – how many people do you help in build resilience do you have resilience support

- It was a powerful example of what communities could do for themselves and the presentation was both encouraging for the support provided and concerning on the impact upon those providing support. The Council's financial system would not allow a small payment to a single organisation, and it was felt that the structures and management needed

to change to help in these instances.

- Social care had looked at the ethnicity of people who accessed the service and it was immediately clear that the people in the system did not reflect the composition of the community. The difference started at the point people approached the service but once people were engaged with the service the proportions remain static. It was considered that the communities were not hard to reach groups, but the system needed to change on how it responded to these groups.

- Attending a memorial event at Crown Hills had been incredibly powerful for the help it had given to people who had lost a great deal in the in the pandemic. These organisations had resonance in the community and they had links to groups the Council did not have. It was felt that there was a need to create an associate network involving UHL, LPT and public health to support projects such as this where there was fragile structures at the top and where they were doing very good work.

- The project was a great example of making a difference and it does it on its own. There were challenges to relate to this and other small organisations and initiatives would come out the new strategy and then hopefully there would be a structure of support for them. The was a need to consider providing small amounts of funds at a greater risk for a good cause and to think about how a to build network of people to trust and people know where to go.

The Chair thanked everyone for their contributions and supported an holistic approach to physical and emotional health. The Chair supported the idea of an associate network and asked officers and Board members to look at that and start to think what it could look like and share information with the Board. Offciers were asked to look at school nursing as it currently focus on secondary schools and the project worked with primary schools and these should be joined up involving Heath for Care and Healthy Teams and suggested that LPT looked at the school nursing provision. The issue of providing finances to a small organisation for a small payment should be reviewed to see how the Council could engage with such organisations and provide them a resource.

RESOLVED:- That Rehana be thanked for her very useful and provoking presentation highlighting the work and achievements of the project and Board Members consider the issues raised in the meeting and by the Chair above.

101. CELEBRATING SUCCESSES, INNOVATION, AND CASE STUDIES OVER THE WINTER PERIOD

Rachna Vyas (Chief Operating Officer, NHS Leicester, Leicestershire and Rutland) and colleagues gave a presentation on some of the key initiatives which have been developed and delivered during the winter months to manage the increasing pressure on services.

The LLR health and care community has been working in partnership to plan for and deliver services through a difficult period of seasonal pressures and at a time of unprecedented industrial action across the public sector.

Whilst demand had stabilised through the start of Q4 23/24, all parts of the system remained busy in terms of both acuity and demand. This trend spanned primary care, NHS111, Clinical Navigation Hub, home visiting, urgent care services, acute services and social care services. Despite pressures, the LLR system has continued to deliver innovative services, grounded in true partnership; the presentation highlighted some of the key services delivered over the winter period. Colleagues from across health and care service, represented on the LLR Winter Board, would present these highlights, along with plans for further developments in 2023/2024.

During the presentation it was noted that:-

- The Winter Plan focused on 20 key activities which were outline in the presentation.
- The Urgent Care Response was the only system in the country that looked at falls, made sure that people hade food at home, why falls occurred and what services patients could link into. It was an holistic approach and a person centre approach. It was intended to grow and develop it this year and embed it within the system.
- The Urgent community response service for Leicester City had a 100% response rate within 2 hours, with the vast majority of people kept safely in their place of residence, using a holistic checklist of care.
- Patients could access these services through any health and care professional.
- This model had been used to develop the UCR model for LLR and formed the basis of the national specification.
- About 100 patients per week being supported in their place of residence through a ‘virtual ward’. There was very positive patient feedback, with pathways live for cardiac and respiratory illness. There was further development of pathways to support frailty and intermediate care and an opportunity to work with LA monitoring services such as pendant alarm services etc.
- The LLR unscheduled care hub was a team represented by all services including social care, ambulance, UHL and LPT. It took 30-40 patients off ambulance lists every day as it assessed and supported patients in their own place of residence. It was being rolled out across the country because of its success. Nobody was denied a service, if they didn’t want this service they would be admitted to hospital. 10 of the patients were mental health. There was also the nurse and paramedic in triage car available to use.

- Initiatives in place to support discharges from UHL included a partnership approach between the Council and health to assess how best to get patients the right care at the right time, based on local insights and knowledge. Sometimes reasons for delayed discharges could be the patient did not have a fridge, heating or food etc and whilst this was not a health responsibility it affected the patient's discharge if it was felt their home environment was an unsafe environment, especially where the patient was elderly. Staff worked on these issues to address them and minimise delays in discharges.
- There had been the launch of 'Inspire to care' programme across the City, with a focus on recruiting new staff into care careers, retaining current staff and ensuring that new colleagues have a known career pathway across health and care.
- The was recent evidence that hoarding and other housing related factors were impacting on ability to discharge patients from mental health wards in LPT.
- There was an opportunity to expand the Housing Enablement Team (HET) to cover MH Services Older People inpatients wards.
- Up to 25 patients were supported with early discharge - housing cases could have complex circumstances and resulted in long delays in discharges, impacting further on physical and mental health.
- It was acknowledged that it was extraordinarily difficult in every area of health and care at the moment with a mix of demand, COVID/Flu, staff absence, capacity plus impact of industrial action.
- The system had managed the ambulance service industrial action with a critical incident called at Leicester Hospitals as a partnership but it recognised that the surges in activity were causing a poorer patient experience across the pathway, with long waits across the pathway. Staff were also under increasing pressure.
- Staff were continually strengthening the winter plan and would apply learning from what we know had worked through difficult periods throughout the year.
- It was clear that the partnerships across health and care had held firm and these case studies demonstrated the art of the possible when services continually worked together.

The Chair thanked officers for the presentation and asked board members to take away the messages and reflect upon them. Partnership working had been undertaken for some years and it had grown, developed and strengthened. – It had been increased during covid and some people though it had been done because it was expedient to do it and had not recognised that it was already in place. It was important that all partners reflected upon change management messaging to reflect these partnerships had been in place for some time and

were continually being developed as they were being driven by the need to be clinical safe and in partnership with individual residents. All partners needed to issue their own messaging on how change was being managed but not in a way that minimised issues but focused on improvements being achieved so that people understood how the changes gave better services.

RESOLVED:- Officers were thanked for the presentation and Board members were asked to consider the comments made by the Chair above.

102. COST OF LIVING IMT/FUEL POVERTY AND HEALTH

Ivan Browne (Director of Public Health, Leicester City Council) and Rob Howard (Consultant in Public Health, Leicester City Council) gave a presentation on the whole council approach which has been taken to tackle the cost-of-living crisis, the key elements of activity being undertaken, and outline the Fuel Poverty Programme.

Leicester City Council (LCC) had adopted an incident management team (IMT) approach to tackling the cost-of-living crisis. The presentation looked briefly at key elements of activity being undertaken, and outlined the Fuel Poverty Programme. The Council had taken a whole council approach to the crisis, aligning with its Anti-Poverty strategy, coordinating activity across the authority, and ensuring that people were able to easily access support. Cells across the authority had been addressing cost-of-living issues, providing support to citizens through a variety of workstreams, and highlighting broader issues within the core IMT meetings.

The Council also worked closely with key external partners and community groups to provide wider support coverage and engagement. Horizon scanning within cells allowed upcoming issues to be recognised and where necessary addressed by IMT. Current upcoming issues included a likely increase in Council Tax, pressure on Commissioned Services, and pressure on Advice Services. The cost of living support offer continued to evolve, and remains accessible and robust.

The Council were working in partnership with National Energy Action (NEA) and had introduced a Fuel Poverty Programme. The impacts of fuel poverty on health were widely recognised, and Leicester had relatively high levels of fuel poverty. The Fuel Poverty Programme aimed to tackle the issues at hand through three workstreams; an advice service, training, and education.

The Advice service has been soft launched within the Council's Housing Division. And a further rollout of the service would be coming soon.

The Training workstream would extend the reach of the programme by embedding energy advice and qualifications into front line services and communities. The Education workstream would raise awareness of energy efficiency at home and at school, initially targeting children in years 5-11

through tailored sessions delivered within schools.

The presentation set out factors and initiatives on all issues involved.

The asked Board members who were part of large organisations to give thought on how the message out. There was a need to work with large employers' workforce to get this message out.

It was suggested that based upon the experience of the Anti-Poverty Strategy organisations should train members of staff to be energy advisors. The discharge of people to cold home was a massive issue and could be used as a catalyst of conversation for fuel poverty. It was known that many people were turning off appliance to save fuel and many were now living in cold houses, and this could result in many people being see by all areas of the system as a result. Many organisations such as the Police had staff who could be entering cold premises and could provide much needed information for possible interventions.

RESOLVED:- Officers were thanked for the presentation and Board members were asked to progress the issues raised to develop the partnership response.

103. BUILDING CAPACITY FOR CARE OUTSIDE OF HOSPITAL

Jagjit Singh-Bains (Head of Independent Living, Leicester City Council) and Beverley White (Adult Social Care Lead Commissioner, Leicester City Council) gave a presentation on:-

- Integrated Crisis Response Service support to the Unscheduled Care Coordination Hub (with a focus on case studies and impact).
- Commissioning support to the independent sector – covering the new night care offer and payments to enable provider decision making capacity at weekends.

During the presentation it was noted that:-

- Carers Retention Grant Scheme could be used for carers who had to take time off work and travel from another area and had to incur other costs. Small grants could be paid for travel and microwaves etc.
- Other schemes available were Night time care at home, staffing of out of hours in the independent sector supported through back office support from the local authority and a hardship fund.
- The impacts of support were
    - 40% reduction in numbers of staff leavers
    - Increased capacity - 21% increase in number of additional hours
    - 0 providers requiring emergency response due to workforce issues

    - 0 providers handing back packages
    - Reduction in staff absence levels
    - Reduction in hospital admissions
    - Reduction in awaiting care from 43 to 12, and presently 0
    - Positive feedback from workers
- The Reablement Service was the main service provider for the majority of hospital discharges with a same/next day discharge (8am to 10pm x 7 days).
- Reablement also helped to bridge packages that were ready for discharge, but the domiciliary care provider was unable to start immediately.
- The Integrated Crisis Response Service (ICRS) operated 24-7 with a 2-hour response and had a key focus on hospital avoidance.
- The impact of the reablement service had been:-
    - Reablement supported 75% of all hospital discharges
    - Over 1,142 people had been supported over the last 12 months
    - Up to 60% required no ongoing support
    - Up to 90% continued to live at home 91 days later
    - ICRS core activity remained at 90% hospital avoidance
    - Over 5,500 people were supported over the last 12 months
    - Up to 82% required no ongoing support
    - Over 1,500 fallers were supported with only 8% being conveyed into hospital

The Chair was pleased that the CQC rated the service as outstanding. When the discharge money became available many health services bought additional care home beds butt the City did not and looked at what it should be spent on to achieve best results.

The Board members commented that:-

- There was a good agenda of partnership working and it may be useful to look at what the key ingredients were and re focus on good quality leadership, money and rigorous evaluation.
- Indicating that the national system did not provide the best solution for the City and having its own solution was applauded. Listening to the views of front-line staff to achieve best outcomes was to be commended.
- The level of trust and confidence between partners in Leicester was high

and it made a huge difference.

- One reason that relationship was felt to be good was because it had been built over a long period of time and staff had stayed in post to provide continuity and trust had grown as a result.

RESOLVED:- Officers were thanked for the informative and helpful presentation and it was suggested that the Integrated Care Board should consider the key elements of the partnership and how it could be refocused as suggested by the Board members' comments.

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

Martin Samuels (Strategic Director for Social Care & Education, Leicester City Council) presented a report on the formation of the Children & Young People's Collaborative involving the senior leaders for children's services from the LLR. The group had identified a number of key priorities for shared work in this area to ensure the needs of children and young people in the City were given equitable focus as the needs of adults in relation to their health and wellbeing needs.

It was noted that:-

- Demand in services for children and young people across LLR had increased significantly especially in families affected by the pandemic. Financial distress and mental health in 17- 23 year olds had worsened.
- Early intervention was being successful in preventing families having to access the health system and they had been provided with support elsewhere in education services. Post Covid there had been a 10% increase in EHCP and mental health impacts upon the system, education and home etc.
- The Director of Public Health and the Strategic Director of Social Care and Education were representative on that Collaborative group and would report back to the Board when necessary.
- It was felt that when people made presentations to the Board they should consider issues relating to children and young people in their presentation.
- There were good links at officer level in the services taking part.
- It was of concern that in a question in the trusted adult survey showed that 50% of those having poor mental issues had no trusted adult to support them.
- Although there were increasing demands the different organisations involved had limited resources, staff and funds but partnership working

had shown the system were doing good things.

RESOLVED:- Officers were thanked for the report and asked to report back to the Board as necessary on issues arising out of the Children & Young People's Collaborative and a further update be provided in 6 months' time.

105. ICB 5 YEAR FORWARD PLAN

Sarah Prema (Chief Strategy Officer, Leicester, Leicestershire and Rutland Integrated Care Board) submitted a report and presentation outlining the direction of travel for the ICB Five Year Forward Plan.

RESOLVED:- That the contents of the report and the presentation be noted and that if Board members had any further comments to make, these be discussed with Sarah Prema after the meeting.

106. QUESTIONS FROM MEMBERS OF THE PUBLIC

No questions from members of the public had been received.

107. DATES OF FUTURE MEETINGS

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

Thursday 29 June 2023 – 9.30am
Thursday 21 September 2023 – 9.30 am
Thursday 18 January 2024 – 9.30am
Thursday 18 April 2024 – 9.30 am

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

108. ANY OTHER URGENT BUSINESS

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

109. STATEMENT OF THANKS

The Chair stated that this would be the last meeting she would be the Chair and she thanked everyone on the Board that had contributed to its work and had developed the Board's partnership approach to making progress to improve Health and Wellbeing.

110. CLOSE OF MEETING

The Chair declared the meeting closed at 12.01pm.

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	Leicester Children's Health and Wellbeing Survey 2021/22
Presented to the Health and Wellbeing Board by:	Gurjeet Rajania and Rob Howard
Author:	Gurjeet Rajania

EXECUTIVE SUMMARY:

Leicester City Council commissioned the School Health Education Unit (SHEU) to undertake a high-quality survey of 10-15-year olds (years 6, 8, and 10) who attend schools in Leicester. The survey was carried out during the 2021/22 academic year across the autumn and spring terms.

The survey covers health and wellbeing topics such as diet, physical activity, emotional wellbeing, bullying, relationships and sexual health, and the use of alcohol, tobacco and drugs. The survey also provides a unique opportunity to better understand the impact COVID-19 has had upon children and young people in the city. New questions have featured in this survey including questions about topics such as sleep, period poverty, and sexual harassment.

Insight from the survey is used to help plan children's services across Leicester, including public health services such as school nursing, children's social services, and local NHS children's services.

Survey results have been used to create:

- School-level health report for each participating school (circulated summer 2022)
- School Health Profiles 2022 (circulated autumn 2022)
- Leicester Children's Health and Wellbeing Survey report 2021/22 (published spring 2023)

Overall, the survey paints a picture of children and young people who are positive about life and their prospects. Most, for example, like where they live and are positive about their school. They feel safe in their neighbourhood, school and home. Most children report good mental health, two-thirds say they learn from their mistakes, and most children have a trusted adult they can talk to when worried about something. Leicester children and young people are unlikely to have tried alcohol, smoking or drugs. Children recall being told how to stay safe while online. This is important given that seven out of ten children have a social media account.

The survey also identifies challenges involving some children and young people. One in five children reveal they care for family members after school, many children struggle to achieve the recommended level of physical activity, and about a third of children had nothing to eat for breakfast. Some children struggle with their emotional wellbeing, one in ten children report they have no adult to talk to when worried, and these children find it more difficult when something goes wrong.

Results have been broken down by different groups and this identifies that some groups of children are more likely to experience health and wellbeing issues. For example Leicester girls are significantly more likely to have caring responsibilities, older children are more likely to make poorer health and wellbeing choices, and there are also health and wellbeing issues more closely linked to some ethnic groups.

Data from the survey reveals that amongst the most vulnerable are those children with a poor emotional wellbeing score. The survey reports that one in ten Leicester children have poor emotional wellbeing and these children tend to report the poorest health and wellbeing outcomes.

Full report is available on Leicester City Council website: Leicester health and wellbeing surveys

Data will be made available on the Leicester Open Data Platform: Home — Leicester Open Data

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- Receive and review the Leicester wide overall report.
- Support the dissemination of results and data.
- Consider the results and findings when commissioning/reviewing services for children and young people in Leicester.

Leicester Children's Health and Wellbeing Survey

Appendix C

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

Division of Public Health

Leicester City Council

Introduction

The School Health Education Unit (SHEU) were commissioned by Leicester City Council to undertake a school based survey of Leicester school pupils aged 10 to 15.

All primary, junior, secondary and special schools in Leicester were invited to participate. Children from 26 primaries, 9 secondary schools and 2 special schools completed the survey.

The majority of surveys were completed online in schools during the Autumn and Spring terms in the 2021/22 academic year. Over 3,000 Leicester school pupils completed the survey and responses were collated by SHEU.

The survey sample was weighted against the known school aged population using the Leicester School Census (Spring 2022) to ensure survey responses were representative of the Leicester school population.

Each participating school received a bespoke school level report detailing key health and wellbeing issues for their school.

Contents

Our presentation today…

- A day in the life of Leicester children - Headlines
- Leicester children and their environment - Headlines
- Emotional wellbeing of Leicester children
- Conclusions

A day in the life of Leicester children…

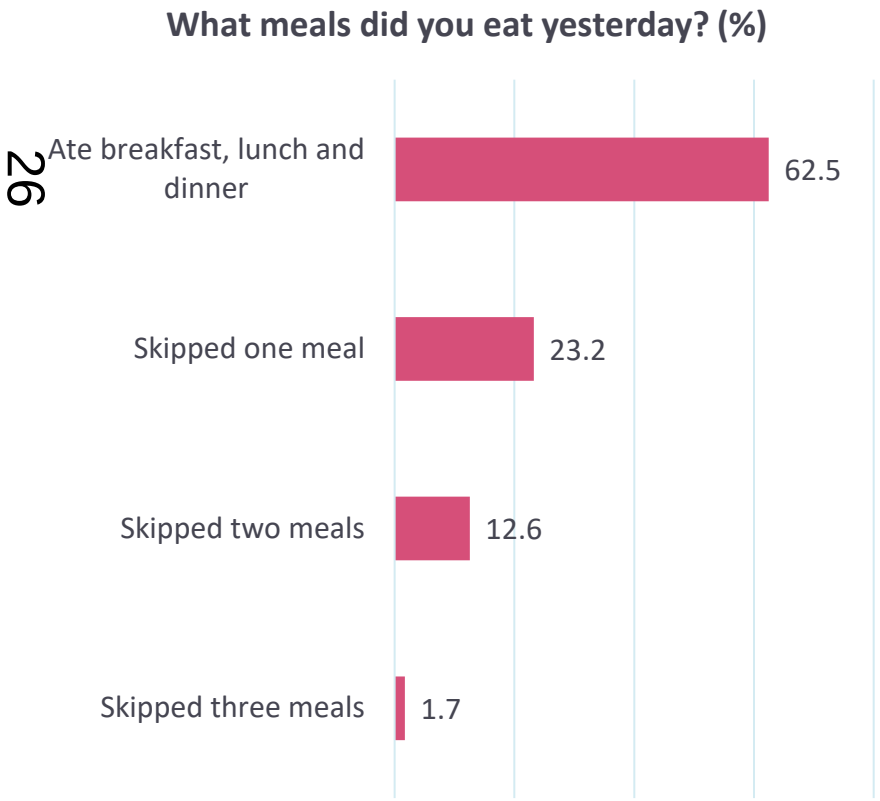
- **Healthy eating:** Three out of five children had breakfast, lunch and dinner the day before the survey. About two in five (37.5%) children skipped at least one meal.
- **Breakfast:** Nearly one in three children (31%) had nothing to eat for breakfast on the day of the survey.
- **Fruit and Veg:** Four out of five children (81%) are not eating the recommended 5 or more portions of fruit and vegetables a day, with only one in five (19%) children stating they have five or more portions.
- **Physical activity:** About half of children have completed at least 30 minutes of physical activity.

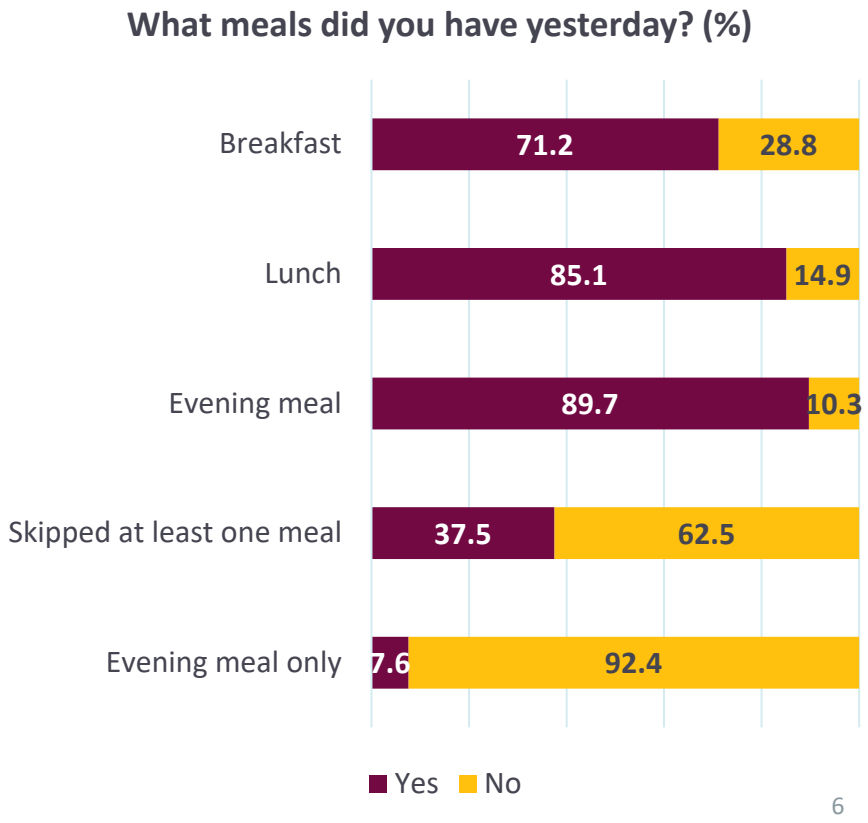
- **Leisure activities – Screen time:** The most popular after school activities include screen time activities such as watching tv, playing screen based games, and texting on a phone. Over a quarter (27.1%) of 10-15 year olds spent five or more hours yesterday looking at a screen.
- **Leisure activities:** Children are also involved in a range of activities including doing homework, listening to music, sports, reading, pet care, and caring for family.
- **Sleep:** Many children (39%) are sleeping late (11pm or later) and are at risk of not getting enough sleep.
- **Active travel:** About six out of ten children (59%) actively travel to school by walking, scooting or cycling.
- **Sanitary products:** About two in five secondary aged females could not access sanitary products all of the time.

Three out of five children had breakfast, lunch and dinner the day before the survey. About two in five (37.5%) children skipped at least one meal. The most common meal to skip was breakfast (29%), followed by lunch (15%), and then evening meal (10%).

22. What meals did you have yesterday?

There is a minority of children (8%) who only had an evening meal the day before the survey. About a quarter (23%) of children skipped one meal, just over one in ten (13%) skipped two meals, and a small minority stated they skipped all meals (2%).

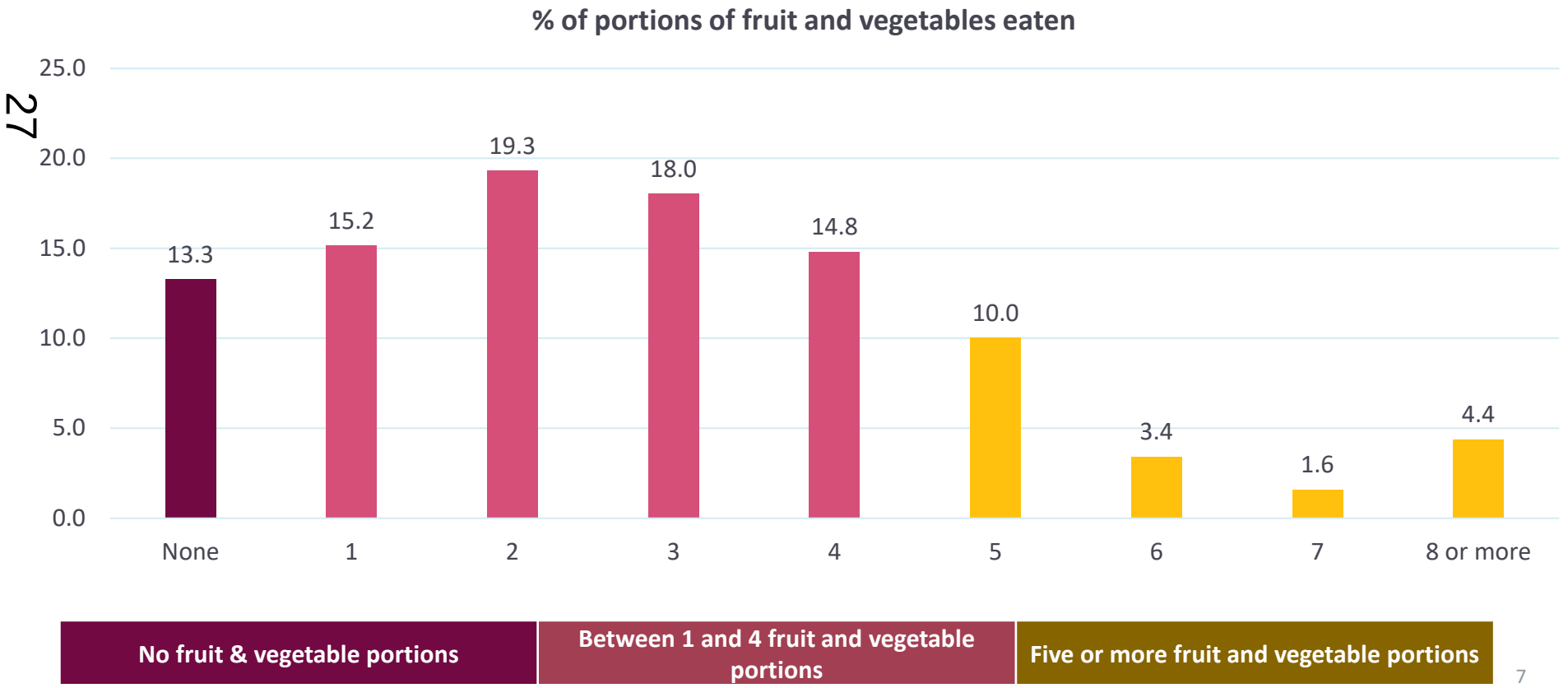




One in five (19%) children are eating the recommended 5 or more portions of fruit and vegetables a day, four out of five children (81%) are not.

28. How many portions of fruit and vegetables did you eat yesterday?

Over one in ten (13%) children had no fruit and vegetable portions the day before the survey. A further two thirds (67%) of children had between 1 and 4 portions.



The most popular after school activities include screen time activities such as watching tv, playing screen based games, and texting on a phone. However, children are involved in a range of activities including doing homework, listening to music, sports, reading, pet care, and caring for family. Younger children are significantly more likely to read for pleasure compared to older children.

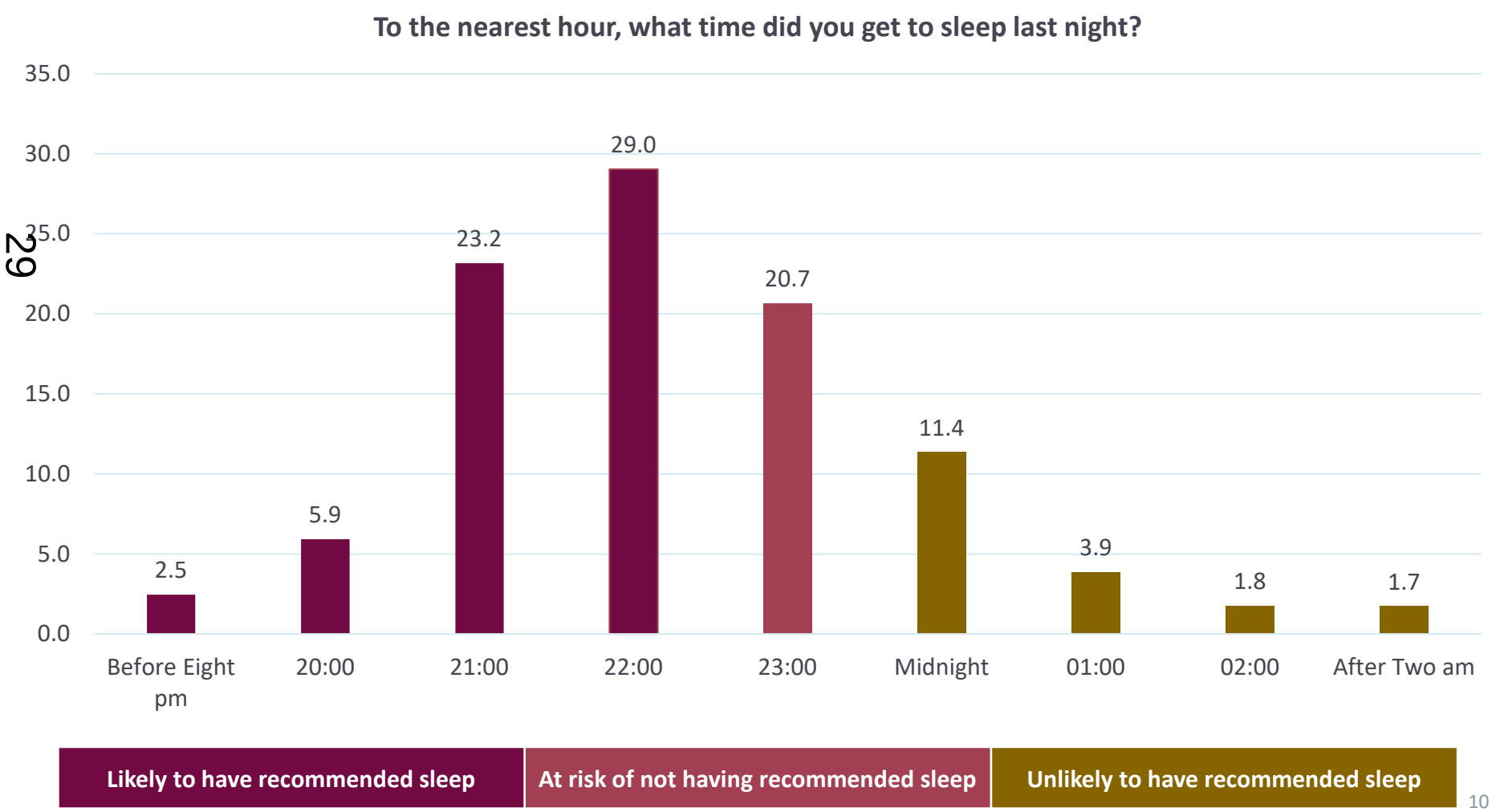
36. Did you spend any time doing any of these things after school yesterday?

Leisure Activity	All	10-11 year olds	12-13 year olds	14-15 year olds
Watching TV/film (live, online, catch-up)	76.0	83.3	71.0	72.7
Playing games on a phone, computer, tablet or console (e.g. Xbox, DS, etc.)	67.0	73.5	67.1	59.9
Talking/texting on the 'phone	59.5	47.1	62.5	70.5
Listened to music	49.2	47.4	48.5	51.9
Doing homework	47.1	48.3	51.6	41.6
Sport/physical activity	40.3	47.7	42.6	29.8
Read a book for pleasure	32.6	50.7	25.7	19.3
Talking/messaging online e.g. Facebook, Twitter	26.7	18.5	28.0	34.5
Met with friends	26.1	24.3	25.8	28.3
Cared for pets	25.7	29.3	27.5	19.9
Used a computer for school work	24.2	22.5	26.7	23.9
Cared for family members (babysitting, minding grandparents, etc.)	19.3	23.0	16.6	17.9
Helping and volunteering outside the home	8.2	12.9	7.3	3.8
Played a musical instrument	7.8	10.6	8.0	4.7
Extra lessons/tutoring	6.8	8.6	5.2	6.3
Other	6.2	5.9	6.9	5.8
None of these	0.5	0.3	0.7	0.6

Significantly Higher than Leicester | Similar | Significantly Lower than Leicester

The NHS recommends that children require 9 to 13 hours sleep. Children will be waking by at least 8 to attend school. Therefore to have the minimum recommended amount of sleep children should be asleep by 11pm. Many children (39%) are sleeping late (11pm or later) and are at risk of not getting enough sleep.

38. To the nearest hour, what time did you get to sleep last night?

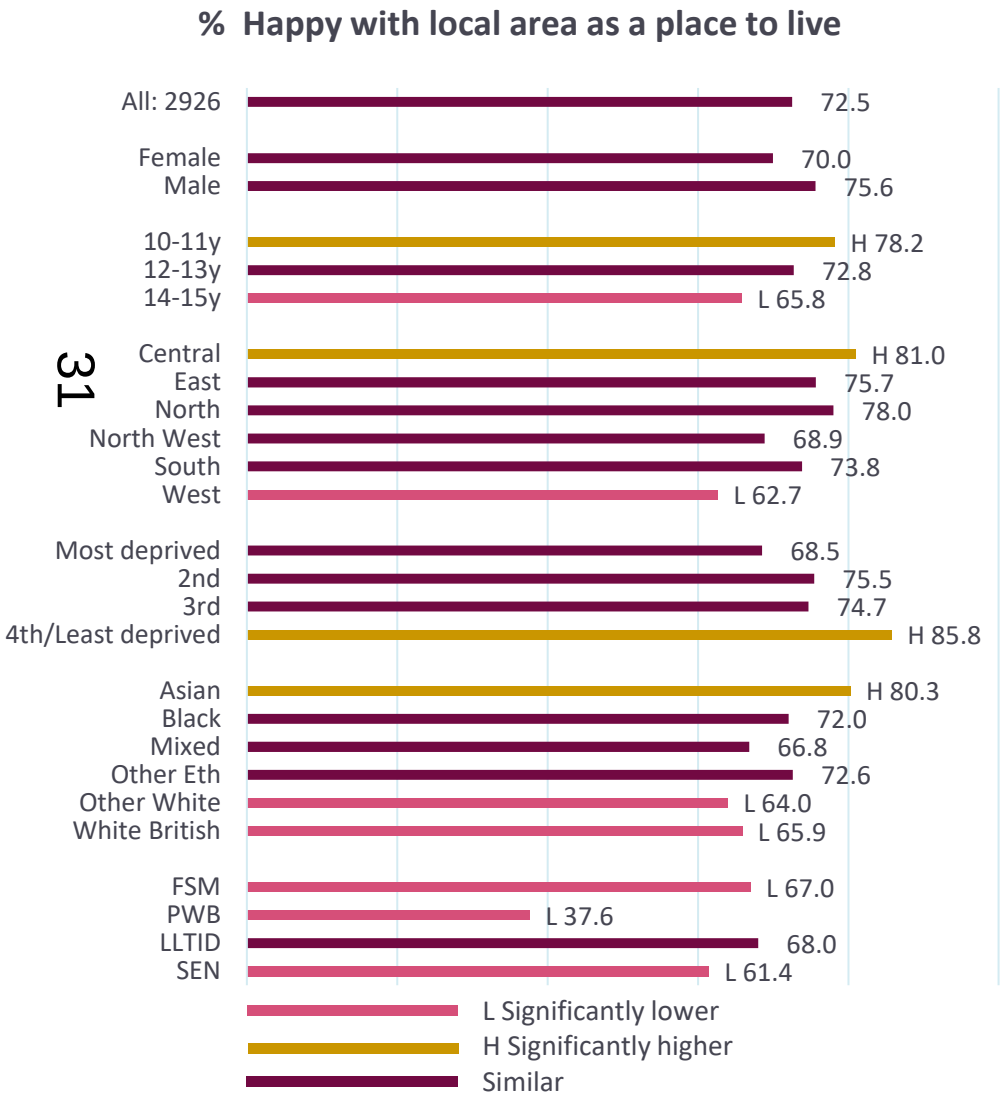


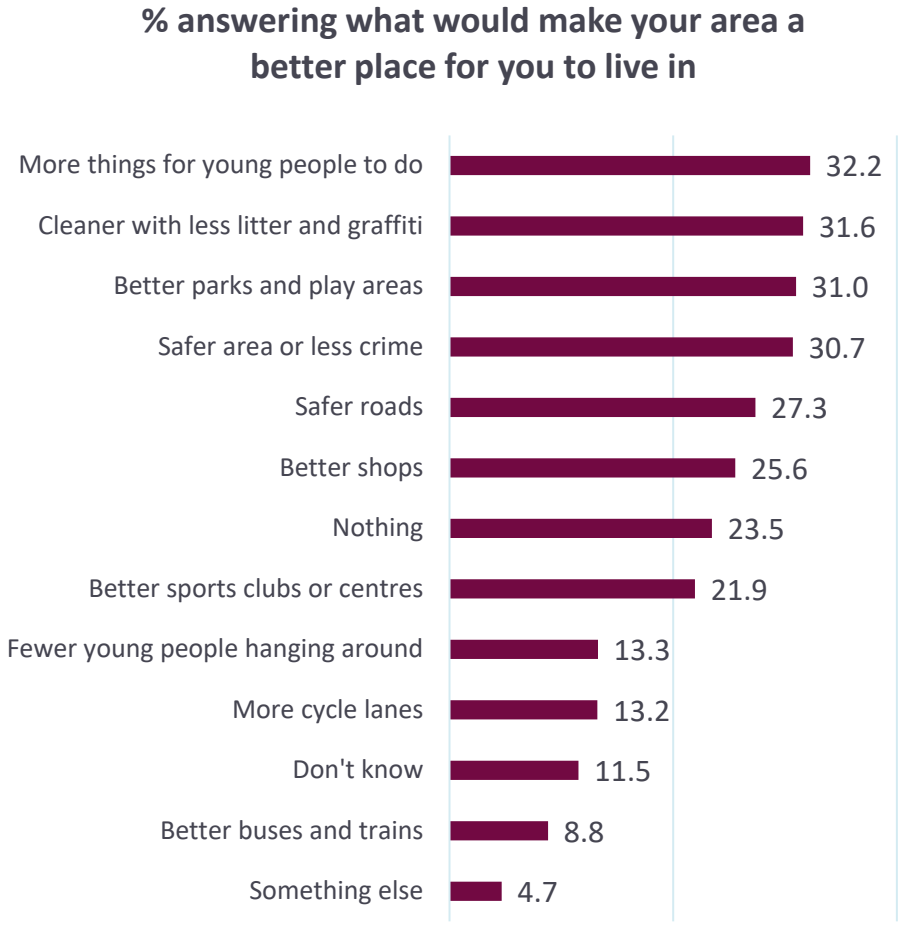
Leicester children, their environment and experiences…

- **Local area:** Around seven in ten children (73%) reported being happy with their local area. Children largely felt safe in their local area (95%), and felt safest travelling to and from school, at school, and at home.
- **Home living:** The majority of Leicester children live with their mum or dad. Over a quarter of Leicester children also live with adult siblings. One in ten live with grandparents.
- **Internet access:** 99% of children have access to the internet at home.
- **Smoking:** Around a third of children reported that their parents/carers smoke. Children who have parent/carers who smoke are more likely to have tried smoking.
- **Drugs:** Around one in ten secondary aged children reported that they have been offered drugs.
- **Bullying:** Almost one quarter of children (24%) reported that they had been bullied in the last twelve months.
- **Services:** About half or more of Leicester children have visited their dentist, doctor, pharmacy, optician, and COVID-19 test centre in the last 12 months.

Around 7 in 10 children (73%) reported being happy with their local area, however there are differences by group. Children reported that more things for young people to do, a cleaner local area with less litter and graffiti, and better parks and play areas would improve their area.

66. Overall, how happy or unhappy are you with your local area as a place to live? 67. What would make your area a better place for you to live in?

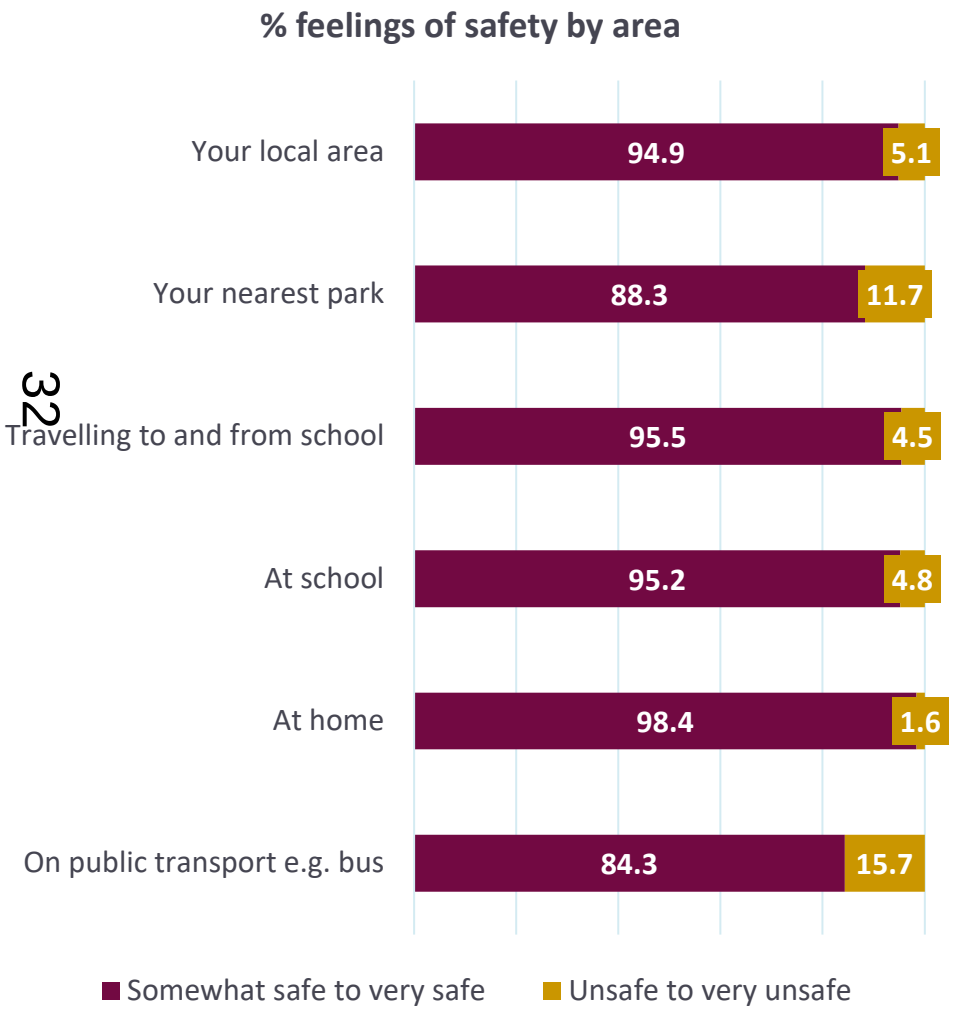


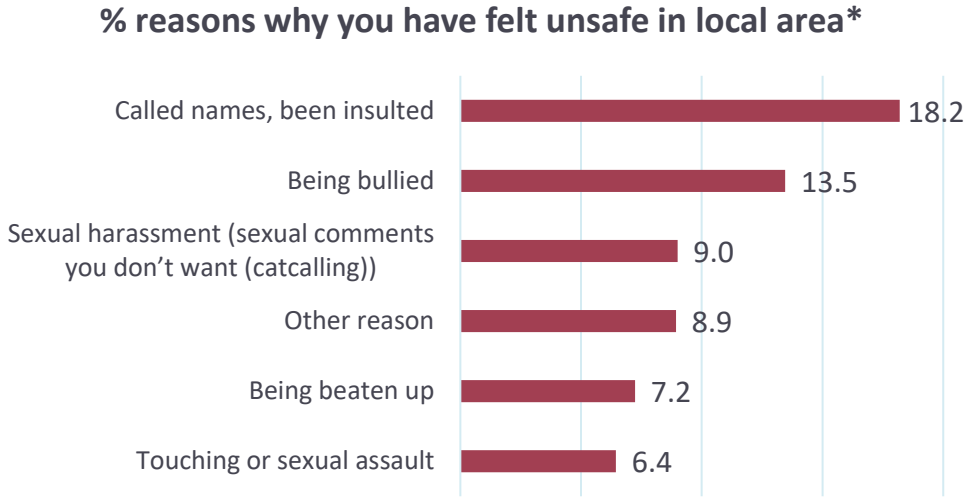


Deprivation Quintiles: *Most deprived (Living in 20% most deprived areas nationally and 4th/Least deprived (living in the 40% least deprived areas nationally)*
Additional groups: *FSM- Free School Meals, PWB – Poor Wellbeing, LLTID – Long term limiting illness or disability, SEN Special Educational Need*

Children largely felt safe in their local area (95%), and felt safest travelling to and from school, at school, and at home. Children felt least safe on public transport and in their nearest park, with over 1 in 10 children reporting they feel unsafe in these areas.

68. How safe do you feel in these places? 69. Why have you felt unsafe in your local area?





***Note:** Only Secondary aged children were asked to respond to this follow up question*

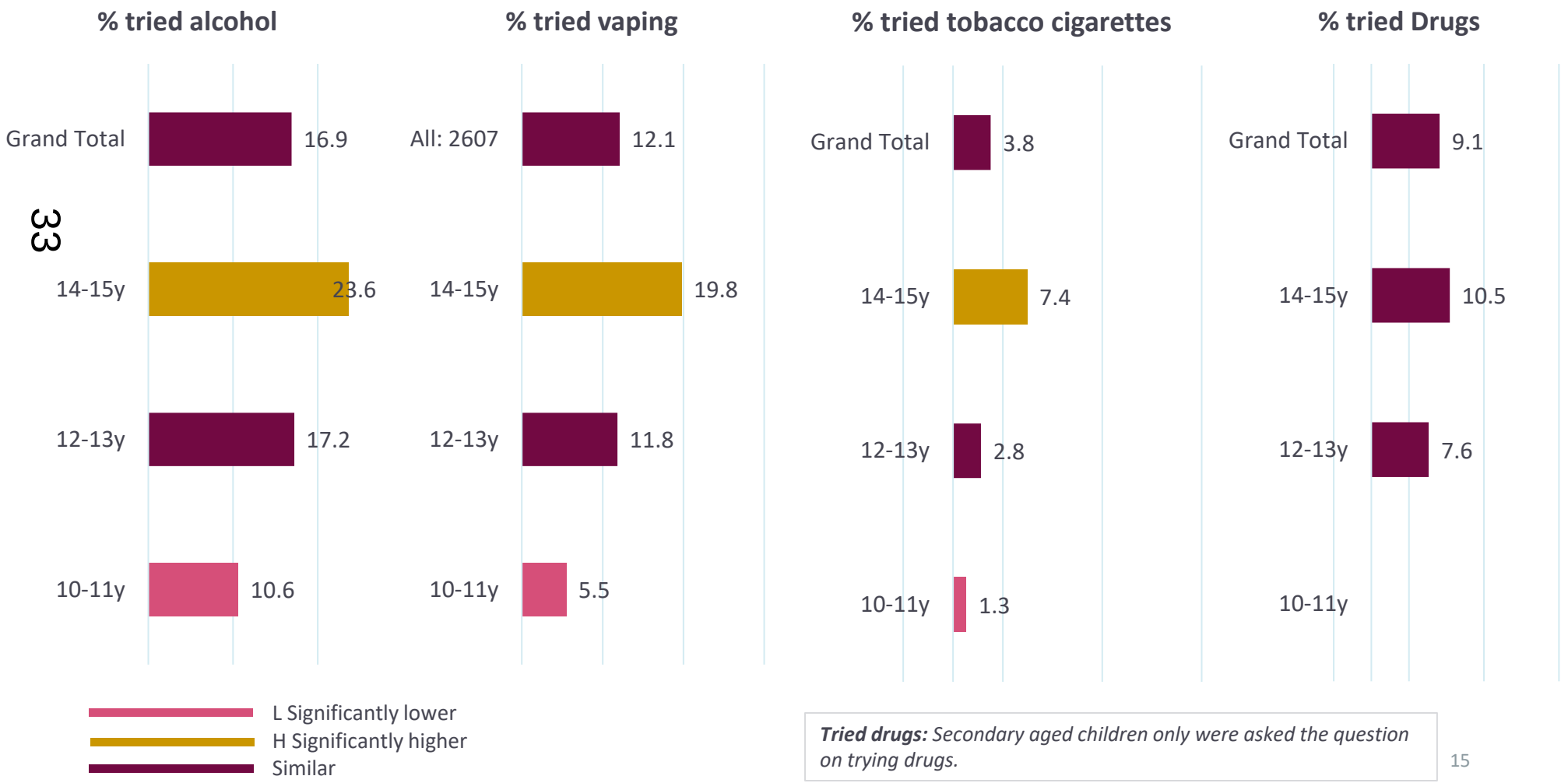
The main reasons for secondary aged children feeling unsafe in their local area include being called names and/or being insulted, and being bullied.

About one in ten (9%) children report experiencing sexual harassment and unwanted sexual comments. For females it was 17% who experienced sexual harassment.

Physical assault, inappropriate touching and/or sexual assault were the least common reasons.

Children and young people were asked if they had tried alcohol, tobacco, vaping and drugs. Older children were more likely to have experimented with alcohol, tobacco, vaping or drugs compared to younger children.

55, 59 & 61 Have you tried any of the following? (Alcohol, E-cigarettes, Tobacco Cigarettes, Drugs) - by age group



Tried drugs: *Secondary aged children only were asked the question on trying drugs.*

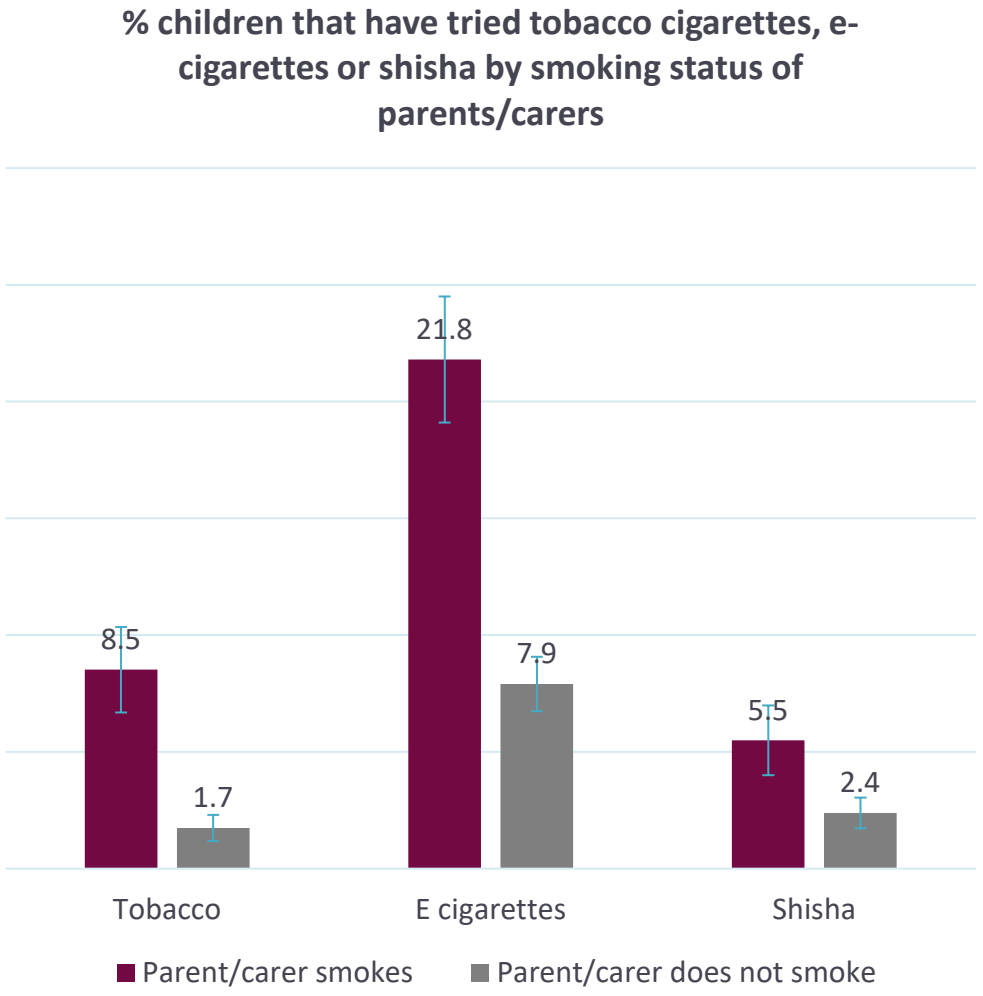
The smoking status of a parent/carer has a strong influence on whether children have tried smoking/vaping. Children who have parent/carers who smoke are more likely to have tried tobacco cigarettes, e-cigarettes or shisha.

58 and 59. Have you tried any of the following? (Tobacco cigarettes, shisha waterpipe, e-cigarettes) - by smoking status of parents/carers

The proportion of children reporting that they have tried tobacco cigarettes, e-cigarettes or shisha was significantly higher in those whose parents/carers smoke than those whose parents/carers do not smoke.

Over one in five (22%) children with parents/carers who smoke have tried e-cigarettes (vaping).

Nearly one in ten (9%) children with parents/carers who smoke have tried tobacco cigarettes, and around one in twenty (6%) have tried shisha.



Emotional wellbeing of Leicester children…

- **Worries:** It is normal for children to worry, four out of five children worry about at least one issue quite a lot. The biggest worries include school work, health of a family member (physical and mental) and the way they look. About one in five children worry about having enough money or enough to eat.

- **Mental wellbeing:** One in ten Leicester children have a poor mental wellbeing score.

35

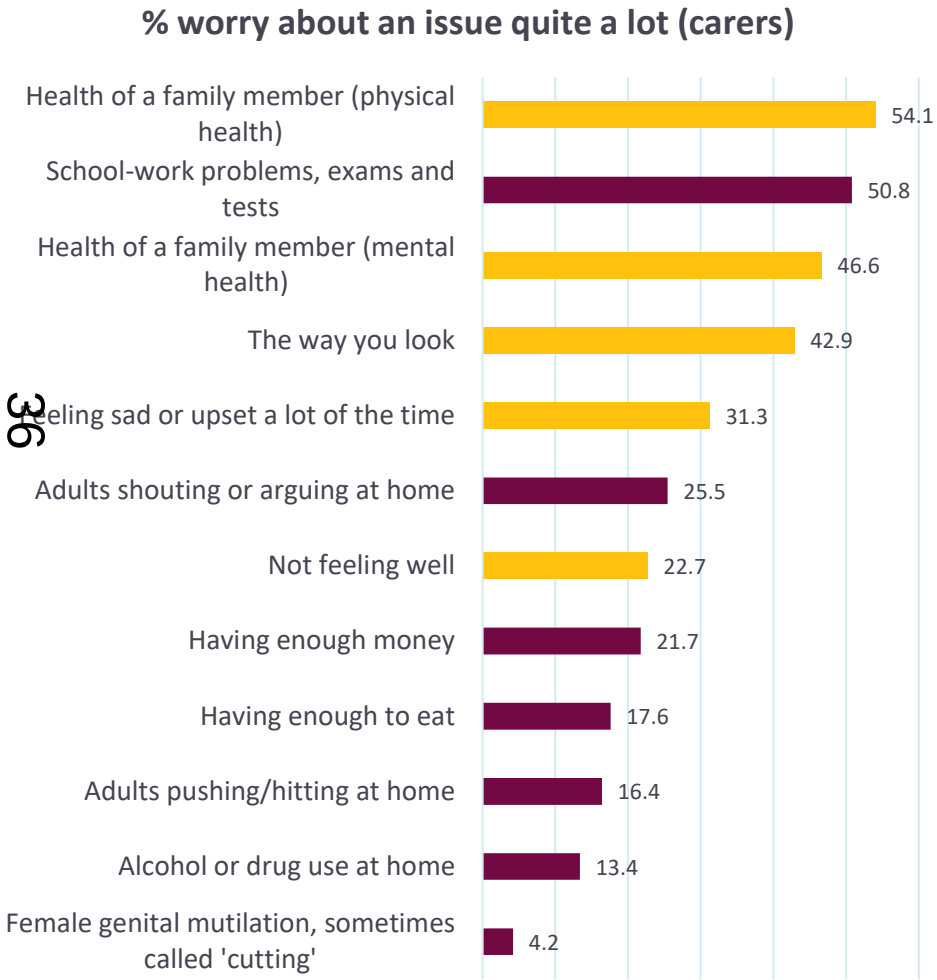
- **Adult confidant:** One in ten (10.1%) Leicester children do not have a trusted adult confidant.

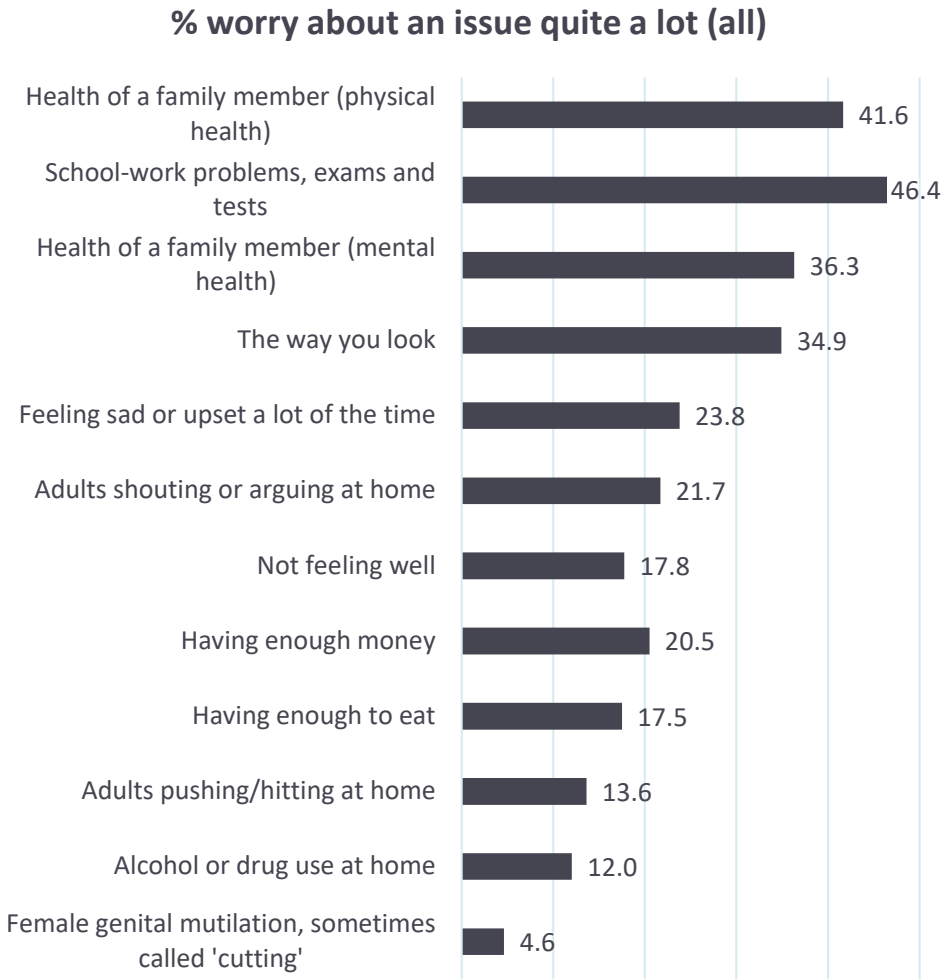
- **Resilience:** Children with no adult confidant find it more difficult to deal with issues when something goes wrong and show signs of poorer resilience.

- **Reaction to worries:** A minority of children sometimes react to worries and stress by drinking alcohol or smoking cigarettes. A larger 15% of secondary aged children will react by cutting or harming themselves.

It is normal for children to worry, four out of five children worry about at least one issue quite a lot. The biggest worries include school work, health of a family member (physical and mental) and the way they look. About one in five children worry about having enough money or enough to eat.

50-52. How much do you worry about the issues listed below? Young carer comparison

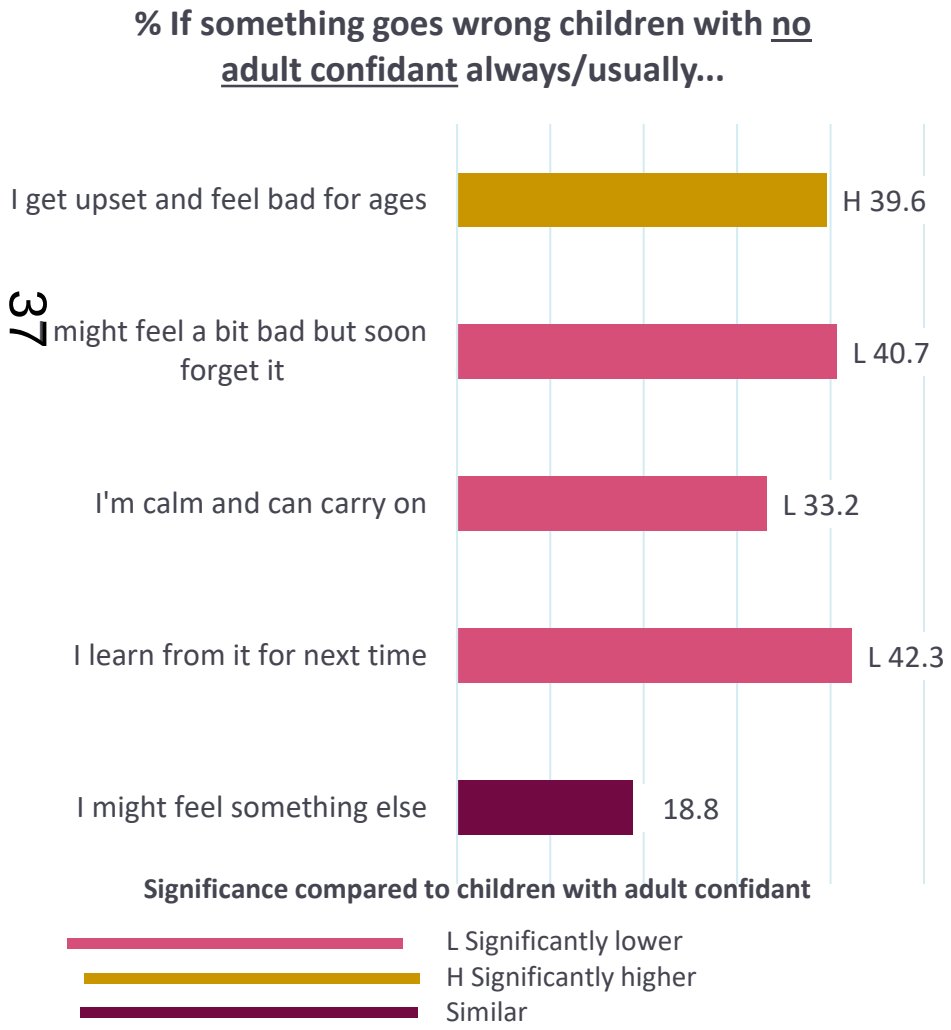


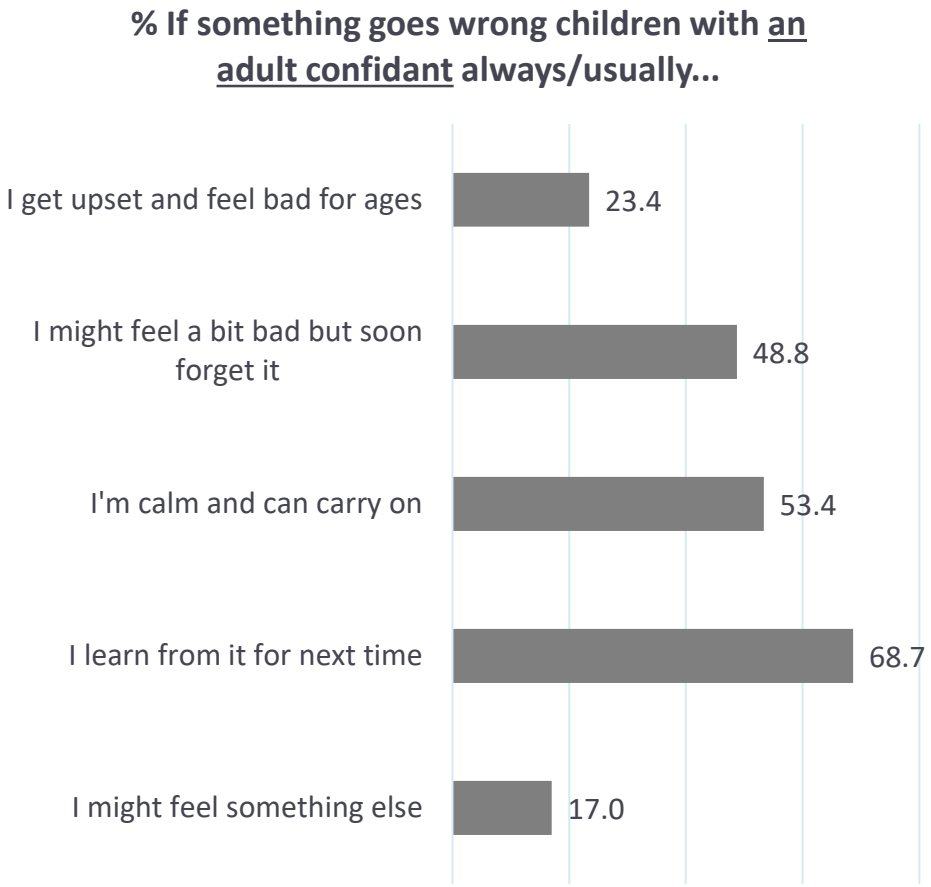


Significance: L Significantly lower H Significantly higher Similar

Children with no adult confidant (10%) find it more difficult to deal with issues when something goes wrong and show signs of poorer resilience.

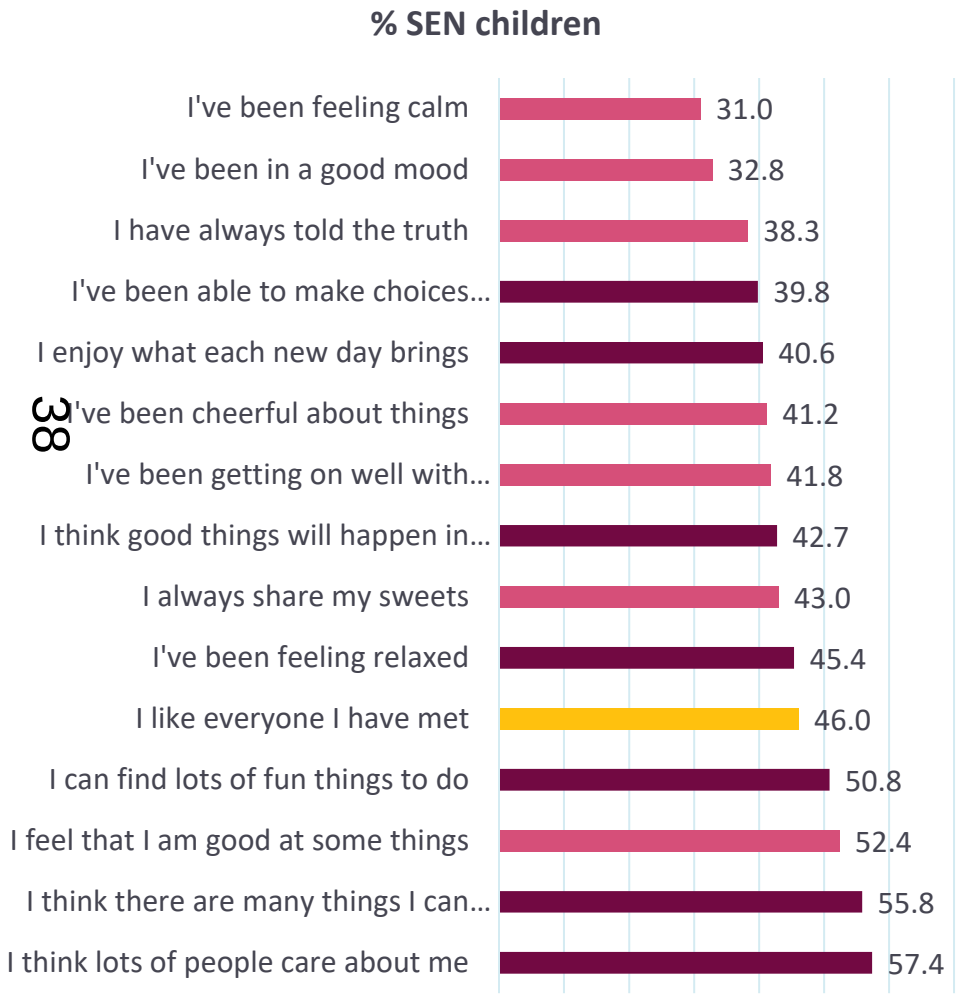
48. If something goes wrong... (resilience) & 49. do you know an adult you trust?

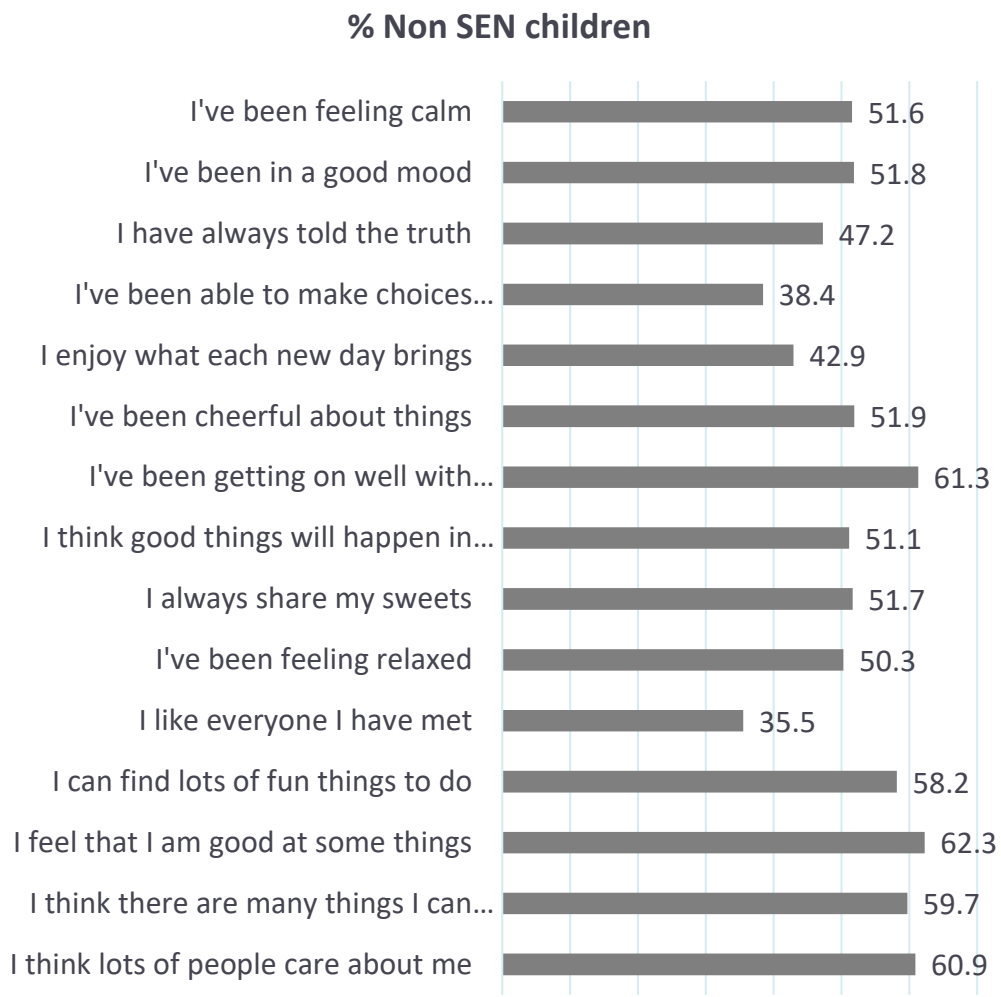




Children with special educational need are significantly less likely to always/most of the time… enjoy what new days bring, feel calm, be cheerful about things, be in a good mood, and get on well with people compared to children with no long term illness or disability.

47. The Stirling Children's Wellbeing Scale. SEN statement breakdown.



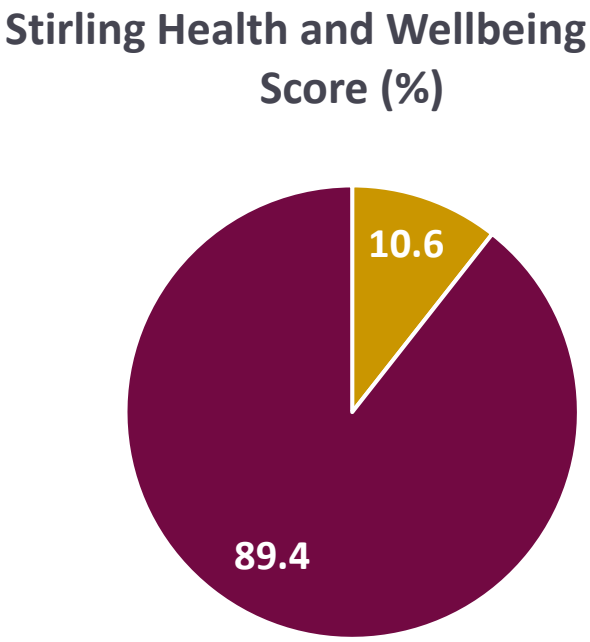


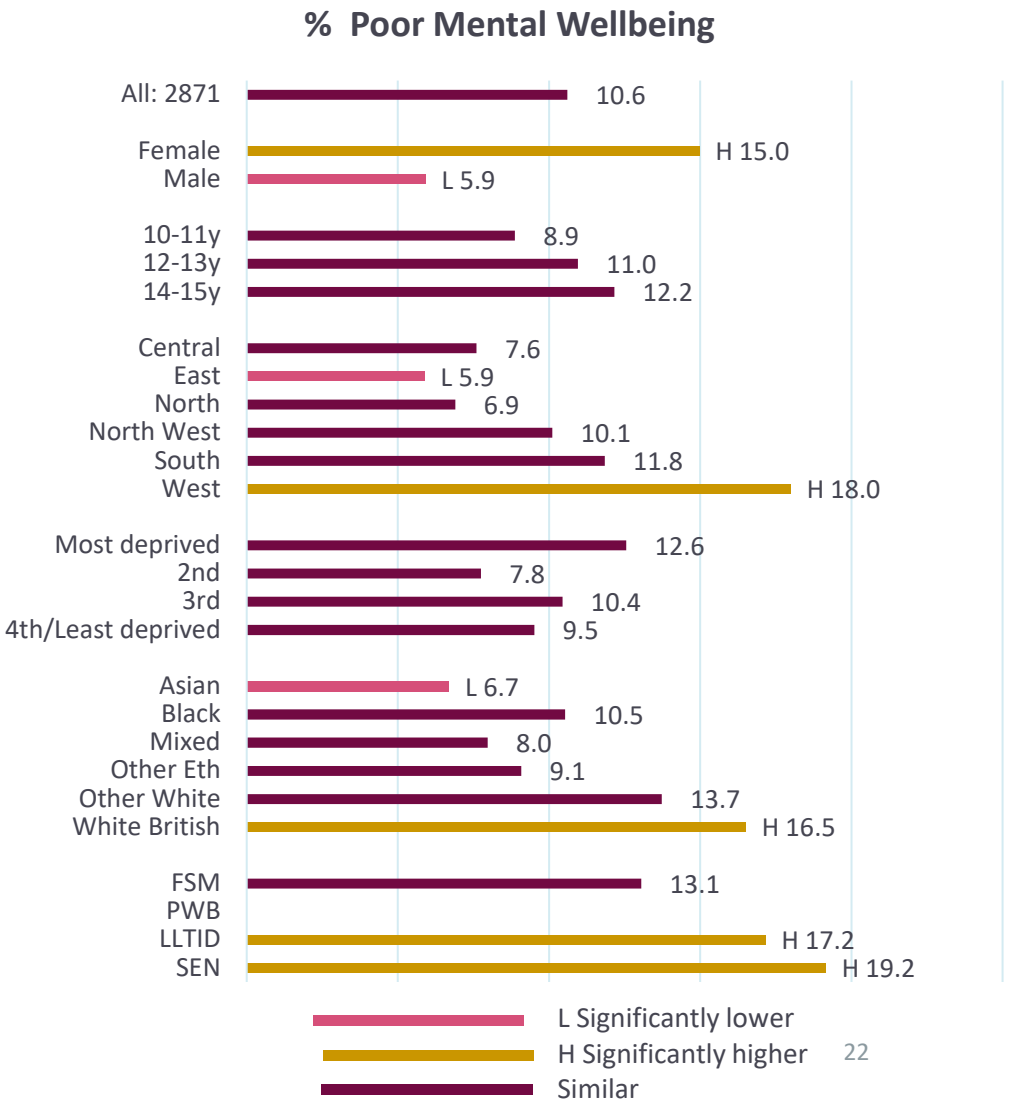
Significantly higher than non SEN children

Significantly lower than non SEN children

One in ten Leicester children have a poor mental wellbeing score. Girls are more likely to have a poor wellbeing score. Children with a disability or long term illness and children with special education needs also report higher poor mental wellbeing scores.

47. The Stirling Children's Wellbeing Scale. Scoring indicates poor mental wellbeing





Deprivation Quintiles: *Most deprived (Living in 20% most deprived areas nationally and 4th/Least deprived (living in the 40% least deprived areas nationally)*
Additional groups: *FSM- Free School Meals*
PWB – Poor Wellbeing
LLTID – Long term limiting illness or disability
SEN Special Educational Need

Summary table: Risk factors by demographics and other groups

% of children	Caring for family members	Nothing to eat for breakfast	No fruit and vegetable portions	Less active (under 30 mins a day)	Five or more hours of Screen time	Going to sleep at midnight or later	Poor Resilience	No trusted adult	Worry about having enough to eat	Parent carer smokes	Bullied in the last 12 months
All:	**19.3**	**31.3**	**13.3**	**47.9**	**27.1**	**18.7**	**28.0**	**10.1**	**17.5**	**30.2**	**24.4**
Female	23.5	33.4	12.4	53.4	26.6	19.5	35.9	10.8	14.6	29.3	26.3
Male	15.7	29.2	14.0	43.0	26.9	17.8	20.3	9.1	20.0	31.1	22.2
10-11 years	23.0	22.1	9.2	47.9	16.5	7.4	31.6	6.2	25.0	28.2	32.2
12-13 years	16.6	34.5	13.0	42.8	29.7	20.4	26.0	10.5	15.1	31.5	23.9
14-15 years	17.9	39.1	18.2	52.5	36.4	29.0	26.1	14.3	11.3	31.4	16.0
Asian British	18.6	27.0	10.8	50.0	16.0	14.7	26.4	9.6	15.7	14.1	17.7
Black British	18.2	35.7	17.7	48.2	30.8	14.8	28.9	14.0	17.5	19.2	23.8
Mixed Heritage	19.1	34.4	13.9	49.6	29.4	22.2	26.8	11.9	18.3	32.1	21.7
Other Ethnicity	19.3	30.8	10.5	46.4	23.3	17.8	19.5	14.4	23.9	17.6	19.1
Other White	17.9	29.5	13.8	50.7	41.5	30.6	30.4	10.0	17.0	58.7	30.8
White British	20.4	37.3	15.2	40.9	40.1	23.0	31.9	8.1	15.8	54.1	33.9
Free Sch Meals	20.7	33.7	13.1	47.1	34.7	24.0	31.0	10.4	19.6	42.7	29.6
Poor wellbeing	21.6	52.7	28.2	55.8	50.3	38.7	55.3	32.9	20.3	51.2	46.7
Long term ill	21.3	34.2	13.4	46.5	37.2	24.2	29.5	13.8	17.6	41.7	32.3
SEN	20.6	31.7	18.3	50.8	35.6	26.8	39.6	11.5	32.2	45.8	37.5

Significantly higher | No significant differences | Significantly lower

And finally…

- Children's aspirations
- Reflections on changes since 2016/17
- Conclusions
- Next steps

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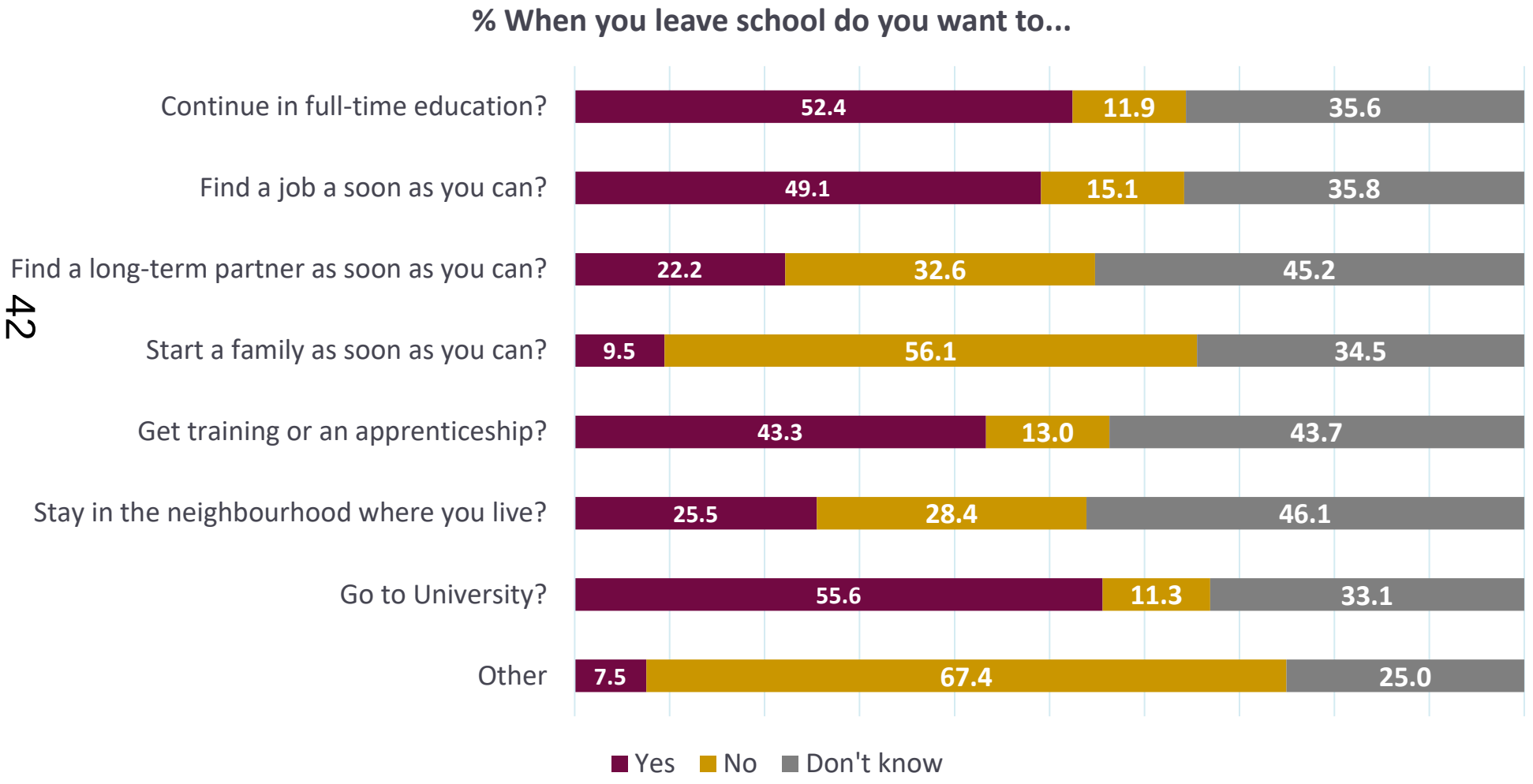
About half of children (52%) would like to continue in full time education after leaving school, and a similar proportion of children would like to go to university (56%). About half of children would like to find a job as soon as they can (49%), and about four in ten children would like an apprenticeship (43%).

80. When you leave school, do you want to…?



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Note: *Only Secondary aged children were asked to respond to this question*

Conclusions

- Overall, the survey paints a picture of children and young people who are positive about life and their prospects, but there are challenges and some Leicester children report significant health and wellbeing issues.

- About one in five children worry about having enough to eat, and for children with a SEN it is closer to one in three.

- Following the pandemic there has been a significant increase in the proportion of children who have caring/babysitting responsibilities (19%).

- Excessive screen time (27%) and poor sleeping habits (39%) is an issue for many children.

- Children with no adult confidant in their lives (10%) showed signs of poorer resilience compared to those with a trusted adult.

- Children with a poor mental wellbeing score (10%) report poor health and wellbeing and are amongst the most vulnerable group of children. Half of these children have reported self harm.

Making use of the results…

- Support the dissemination of results and data.
- Consider the results and findings when commissioning/ reviewing services for children and young people in Leicester.
- To inform targeted provision of services.

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- This is a unique set of data and many local authorities will not have access to this level of data for this age group. Data from past health and wellbeing surveys have been used in a variety of successful funding bids.
- Get in touch – there is a wealth of data that can be further interrogated.

Leicester Child Health and Wellbeing Survey 2021/22

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

Leicester health and wellbeing surveys

Completed by Leicester City Council, Division of Public Health and the School Health Education Unit

Authors: Amy Chamberlain, Gurjeet Rajania & Hannah Stammers

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Leicester Children's Health and Wellbeing Survey

Appendix C

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

Division of Public Health

Leicester City Council

Introduction

The School Health Education Unit (SHEU) were commissioned by Leicester City Council to undertake a school based survey of Leicester school pupils aged 10 to 15.

All primary, junior, secondary and special schools in Leicester were invited to participate. Children from 26 primaries, 9 secondary schools and 2 special schools completed the survey.

The majority of surveys were completed online in schools during the Autumn and Spring terms in the 2021/22 academic year. Over 3,000 Leicester school pupils completed the survey and responses were collated by SHEU.

The survey sample was weighted against the known school aged population using the Leicester School Census (Spring 2022) to ensure survey responses were representative of the Leicester school population.

Each participating school received a bespoke school level report detailing key health and wellbeing issues for their school.

Methods

Questionnaire design: Primary, secondary and special school questionnaires were designed by SHEU and Leicester City Council Public Health professionals. Local school leaders were also consulted on the themes of the survey. There are some differences in the questionnaires to allow for age appropriate questions. There is a core of questions that were included in each questionnaire.

Quality assurance: Documents were offered to all participating schools to explain the administration of the survey to children. Each supervising teacher was asked to provide feedback about the conduct of the sessions. Most of these feedback sheets raised no concerns or made only positive comments.

Consent: Consent was sought from schools, parents and pupils. Schools informed parents/carers about the survey. SHEU provided relevant materials to support this. Pupils were advised that they could opt out or not complete all of the questions. The following analysis reports the number of children who completed each question.

Participation: Classes in school years 6 (primary), 8 and 10 (secondary) were selected to participate in the survey. Schools were instructed to select mixed ability groups to ensure a cross section of the school and that school level results would better represent the whole school.

Sample Analysis

Demographic and geographic data was collected to allow for detailed analysis of the survey.

The responses have been weighted against the Leicester School Census (spring 22) to ensure the sample is representative.

Comparisons show that the sample is similar to the known population for age, gender, geography, ethnicity, and deprivation/free school meals.

The self reporting of special educational need has led to some under reporting. Data suggests some pupils have not disclosed SEN status or are not aware.

Group	Sub-group	Number weighted	Percentage (%)	School Census (%)
All		3276	100%	
Sex	Female	1479	45%	49%
	Male	1713	52%	51%
Age	10-11 year olds	1239	38%	36%
	12-13 year olds	1001	31%	33%
	14-15 year olds	1036	32%	32%
Broad area*	Central	520	20%	17%
	East	392	15%	16%
	North	522	20%	20%
	North West	436	16%	14%
	South	275	10%	9%
	West	512	19%	17%
Deprivation quintiles*	Most deprived	1085	41%	42%
	2	984	38%	33%
	3	383	15%	14%
	4/Least deprived	163	6%	11%
Broad ethnicity	Asian	1258	41%	47%
	Black	348	11%	10%
	Mixed	272	9%	7%
	Other	172	6%	5%
	Other White	248	8%	8%
	White British	783	25%	23%
Other groups	Free School Meals (FSM)	777	24%	27%
	Poor wellbeing (PWB)	304	11%	-
	Long term illness or Disability (LLTID)	530	16%	-
	Special Education Need (SEN)	236	7%	17%

Broad area and deprivation is dependent on a valid postcode being provided. 80% of respondents provided a valid postcode.

Contents

Key findings…

Overall, the survey paints a picture of children and young people who are positive about life and their prospects. Most, for example, like where they live and are positive about their school. They feel safe in their neighbourhood, school and home. Most children report good mental health, two-thirds say they learn from their mistakes, and most children have a trusted adult they can talk to when worried about something. Leicester children and young people are unlikely to have tried alcohol, smoking or drugs. Children recall being told how to stay safe while online. This is important given that seven out of ten children have a social media account.

The survey also identifies challenges involving some children and young people. One in five children reveal they care for family members after school, many children struggle to achieve the recommended level of physical activity, and about a third of children had nothing to eat for breakfast. Some children struggle with their emotional wellbeing, one in ten children report they have no adult to talk to when worried, and these children find it more difficult when something goes wrong.

Results have been broken down by different groups and this identifies that some groups of children are more likely to experience health and wellbeing issues. For example Leicester girls are significantly more likely to have caring responsibilities, older children are more likely to make poorer health and wellbeing choices, and there are also health and wellbeing issues more closely linked to some ethnic groups.

Key findings by topic…

Pupil backgrounds and poverty…

Children come from a range of backgrounds. About half are from an Indian or White British background, and the remainder are from a range of diverse communities.

The survey reveals half of children speak another language (not English) and about one in five children always or mostly spoke another language at home.

One in five children cared for family members after school.

About one in five children had worries about having enough to eat.

Physical activity…

Three out of four children enjoy physical education.

About half of children are completing less than half an hour of physical activity a day, and one in ten are completing less than half an hour across the entire week.

Six out of ten children's main method of travel to school is walking or cycling, three out of ten travel by car and about one in ten will use bus/public transport.

One in three children report that they have never been to a leisure centre.

Healthy eating and oral health…

Three out of five children ate breakfast, lunch and dinner the day before the survey.

Two in five skipped at least one meal, the most common meal to skip was breakfast.

About one in five children ate five or more fruit and veg portions, one in ten children had no fruit and veg portions the day before the survey.

About one in ten children have a takeaway meal more than once a week.

Two thirds of children have been to the dentist in the last 12 months.

Internet use, leisure and sleep…

99% of children have access to the internet. Four out of five children access the internet via a mobile phone.

About a quarter of children spent five or more hours looking at a screen the day before the survey.

The most popular after school activities include screen time activities, followed by listening to music, completing homework, and sport/physical activity.

Many children (two out of five) are sleeping late (11pm or later) and are at risk of not getting enough sleep. One in five are sleeping at midnight or later the day before the survey.

Emotional wellbeing…

Three quarters of Leicester children report a medium to high wellbeing score indicative of good mental health.

Two out of three children state that they learn from their mistakes.

About one in ten children report signs of poor mental wellbeing.

Children reporting a long term illness are more likely to report poor mental wellbeing.

One in ten children state they have no trusted adult to talk to and these children show signs of poorer resilience.

Alcohol, smoking and drugs…

Trying alcohol, smoking or drugs is uncommon for Leicester children.

Trying alcohol increases with age and a quarter of older children (14-15 year olds) have tried alcohol.

Some children are exposed to smoking at home. About a third of parents/carers smoke, and a smaller proportion are exposed to smoking at home and in the car.

Around one in ten children have tried vaping/e-cigarettes. A smaller proportion of children have tried tobacco cigarettes or shisha.

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Health, relationships & sexual health..

Seven out of ten children agree that they feel healthy most of the time and one in ten disagree that they feel healthy. The remainder are unsure.

Most children agreed with positive health statements, such as ‘if I take care of myself I will stay healthy’.

About two in five female secondary aged children were not able to access sanitary products all of the time when on their period.

One in twenty 14 to 15 year old children report they have had sexual intercourse.

Bullying and safety…

Three out of four children are happy with their local area.

95% of children feel safe in their local area, home, and school.

Almost one quarter of children reported that they had been bullied in the last twelve months.

Of children bullied almost half thought that they had been picked on because of the way they look.

The majority of children recall being told how to stay safe while online. This is important given that seven out of ten children have a social media account.

Key findings by population group…

Sex…

Girls (24%) are significantly more likely to have caring responsibilities compared to boys (16%).

Half (53%) of girls complete less than 30 minutes of physical activity a day compared 43% of boys.

Girls (42%) are significantly more likely to have skipped a meal compared to boys (33%).

One in five boys (22%) drink energy drinks regularly compared to 13% of girls.

Over a third (36%) of girls report poorer resilience compared to 20% of boys, and girls are also significantly more likely to self harm, with 20% of girls and 10% of boys reacting to worries by sometimes cutting or hurting themselves.

Girls (17%) are significantly more likely to experience sexual harassment compared to 2% of boys.

Two in five (37%) girls could not access sanitary products all of the time.

Age…

Older children (14-15 year olds) tended to have higher likelihood of poor health and wellbeing choices such as sleeping late (29%), excessive screen time (36%), poorer diet (18%), no breakfast (39%) and skipping meals (49%), and more likely to try smoking (7%), alcohol (24%), and have been offered drugs (14%).

Younger children (10-11 year olds) tended to make more positive health and wellbeing choices. They were less likely to have excessive screen time (17%) or sleep late (7%).

Broad area…

Children living in the West of the city reported higher rates of excessive screen time (38%), lack of sleep (25%), and poorer resilience (36%). They are also more likely to have a parent/carer who smokes (45%) and to have been bullied in the last 12 months (33%).

Children in the North of the city were significantly more likely to be less physical active (59%) and to have never been to a leisure centre (51%).

There are significant differences in walking/cycling to school with those in Central (70%), South (71%) and West (69%) more likely to actively travel compared to those in the East (27%).

Ethnicity…

Children from a White British (54%) and Other White (59%) backgrounds are significantly more likely to have parents/carers who smoke, and in turn be more likely to try smoking.

White British children are significantly more likely to have had no breakfast (37%), have excessive screen time (40%), and experienced bullying in the last 12 months (34%).

Children from Other White groups are also significantly more likely to have excessive screen time (42%) and go to sleep late (31%). They are also more likely to be vaccine hesitant with 59% stating they are not likely to have a COVID-19 vaccination.

Asian British children are more likely to be less physically active and 42% have never been to a leisure centre. They are also more likely to travel to school by car (39%).

Children from Other White (24%) and Other (23%) ethnic groups are find speaking, reading and writing English not easy.

Additional groups…

Free School Meals: Children in receipt of free school meals are significantly more likely to have excessive screen time (35%), go to sleep late (24%). These children are also significantly more likely to have a parent/carer who smokes (43%).

Special Educational Needs: Children who self-reported a special educational need are significantly more likely to consume energy drinks regularly (31%), have excessive screen time (36%), go to sleep late (27%), and have poorer resilience (40%). They are also more likely to have a parent/carer who smokes (46%) and have experienced bullying (38%).

Long term illness or disability: Children with a long term illness or disability are significantly more likely to have excessive screen time (37%) and go to sleep late (24%). These children are also more likely to have a parent/carer who smokes (42%) and have experienced bullying (32%).

Poor wellbeing: Children who had a poor mental wellbeing score were significantly more likely to report poorer health and wellbeing across a range of issues. This group of children are particularly vulnerable and report amongst the highest rates for a number of issues.

Changes since the 2016/17 survey

There are some questions where we can compare results with the 2016/17 survey

Significant increase since 2016/17…

There has been a significant increase in the percentage of children caring for family members from 17% to 19%.

Children showing signs of poor resilience has increased. The percentage of children who get upset and feel bad for ages increased from 23% to 28%.

Children are spending more time looking at screens. The percentage of children looking at a screen for five or more hours increased from 22% to 27%.

The proportion of children who report they have never visited a dentist increased from 4% to 9%.

Significant decrease since 2016/17…

Use of tobacco cigarettes has fallen significantly amongst 14 to 15 year old children from 13% to 7%.

Trying Shisha has also fallen significantly amongst 14 to 15 year olds from 26% to 7%.

There has been a fall in the proportion of children having a take-away meal more than once a week from 23% to 13%.

There has been a significant decrease in the percentage of children who eat five or more fruit and vegetable portions a day from 23% to 19%.

Note: Further detail can be found in the direction of travel table and throughout the report.

Direction of travel table for Leicester Child Health and Wellbeing Survey 2016/17 to 2021/22

Theme	Percentage of children	2016/17	2021/22	Direction of travel	Significance to 2016/17
Pupil backgrounds	Limiting long term condition	13.7	16.2	Increase	No significant difference
Pupil backgrounds	Looking after (caring for) family members	16.5	19.3	Increase	Significantly higher
Deprivation	Worry about having enough to eat	18.7	17.5	Decrease	No significant difference
Deprivation	Worry about having enough money	23.5	20.5	Decrease	Significantly lower
Healthy Eating	Nothing to eat or drink for breakfast	16.3	17.2	Increase	No significant difference
Healthy Eating	Five a day/5+ portions of fruit and veg	22.7	19.4	Decrease	Significantly lower
Healthy Eating	Water consumption rarely or never	5.0	4.6	Decrease	No significant difference
Healthy Eating	Energy drinks more than once a week	20.0	17.9	Decrease	No significant difference
Healthy Eating	Home cooked meals – more than once a week	92.7	92.1	Decrease	No significant difference
Healthy Eating	Take away meals – more than once a week	23.0	13.2	Decrease	Significantly lower
Screen time	Screen time: Five hours or more	22.1	27.1	Increase	Significantly higher
Oral Health	Never been to a dentist	4.3	8.5	Increase	Significantly higher
Oral Health	Brushing teeth less than twice a day	15.6	18.7	Increase	Significantly higher
Emotional Wellbeing	Poor Resilience: I get upset and feel bad for ages	22.9	28.0	Increase	Significantly higher
Emotional Wellbeing	No Trusted adults	9.6	10.1	Increase	No significant difference
Emotional Wellbeing	Sometimes have self harmed	16.7	14.6	Decrease	No significant difference
Emotional Wellbeing	Never like to talk about feelings	32.8	43.6	Increase	Significantly higher
Smoking/Vaping	Parents/carer smoke	32.8	30.2	Decrease	No significant difference
Smoking/Vaping	Smoke in car	9.5	10.0	Increase	No significant difference
Smoking/Vaping	Tried tobacco cigarettes –14-15 year olds	12.6	7.4	Decrease	Significantly lower
Smoking/Vaping	Tried shisha –14-15 year olds	26.4	7.0	Decrease	Significantly lower
Smoking/Vaping	Tried E-Cigarettes –14-15 year olds	21.0	19.8	Decrease	No significant difference
Bullying	Bullied in the last 12 months – All	22.5	24.4	Increase	No significant difference
Bullying	Mean and unkind to someone because you wanted to upset them	14.8	15.1	Increase	No significant difference
Online safety	E-safety - know where to get help? - 12-13 year olds	82.5	79.0	Decrease	No significant difference
Online safety	E-safety - know where to get help? - 14-15 year olds	75.7	75.6	Decrease	No significant difference

Significantly higher | No significant differences | Significantly lower

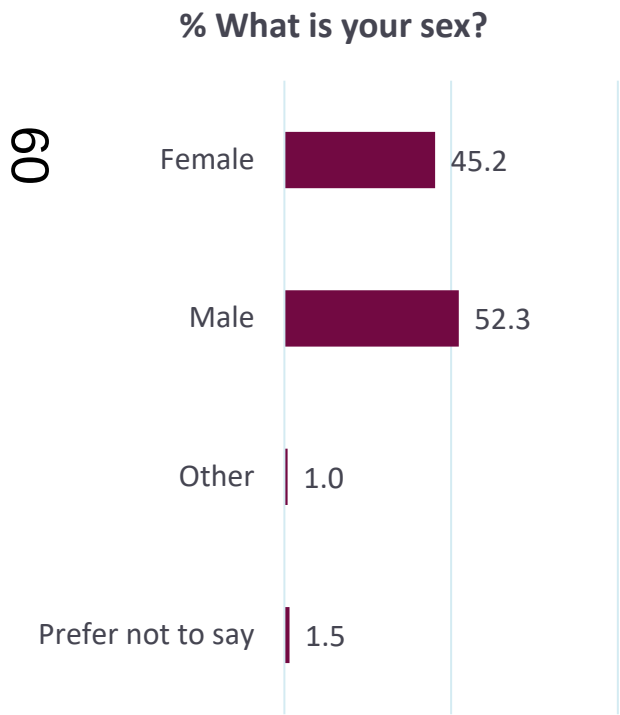
Pupil backgrounds

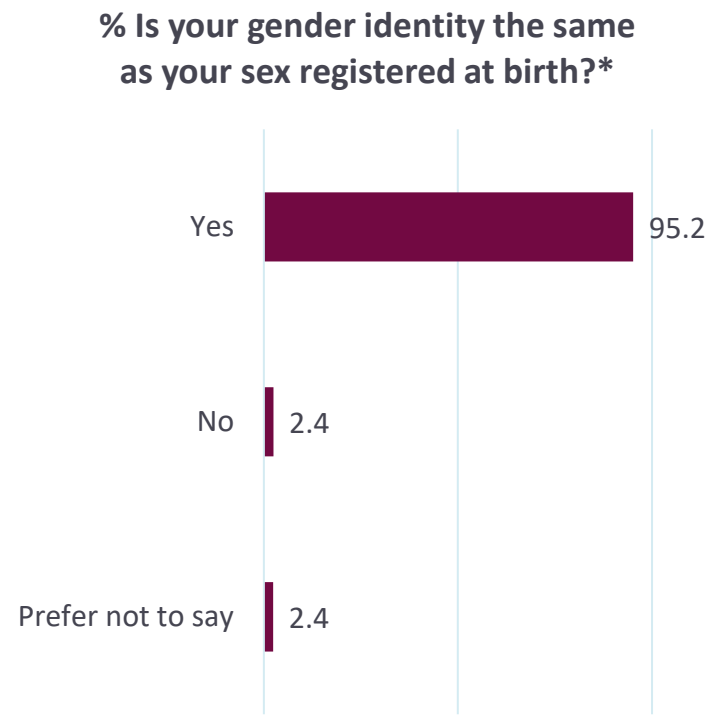
- Over 3,000 10 to 15 year old children participated in the Leicester Children's Health and Wellbeing survey.
- There are responses from a diverse range of communities. About half of the pupils are from an Indian or White British background, and the remainder are from a range of communities reflecting the residents of Leicester.
- One in fifty described that their sex is not the same as assigned at birth. One in twenty described they are lesbian, gay or bisexual.
- Data indicates that 6 in a classroom of 30 care for family members, and girls are significantly more likely to have caring responsibilities. Most of these young carers care for someone they live with, and some state that nobody outside of the family know they are a carer.

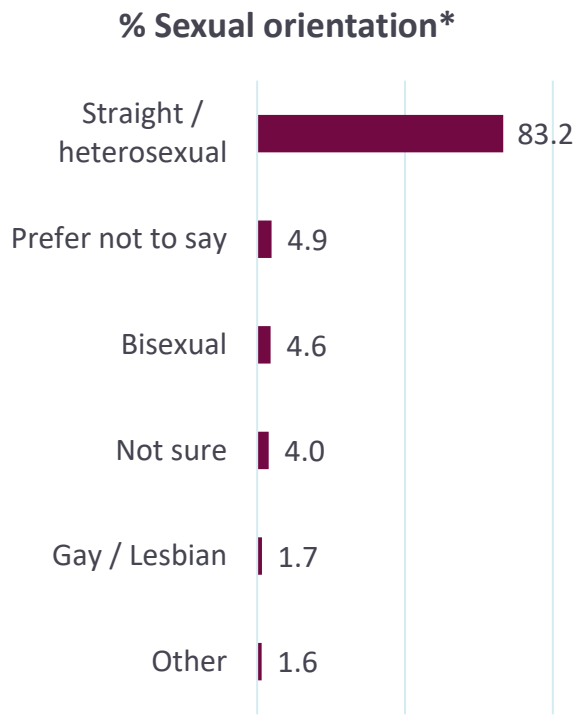
There are slightly more male (52%) respondents compared to female (45%) respondents in this survey. The majority describe their gender as the same assigned at birth.

Sex, gender identity, and sexual orientation

About one in fifty (2%) state their gender identity is not the same as their sex registered at birth. Over four in five (83%) describe their sexuality as straight/heterosexual, about 6% state they are lesbian, gay or bisexual, and the remaining 10% prefer not to say or are unsure.





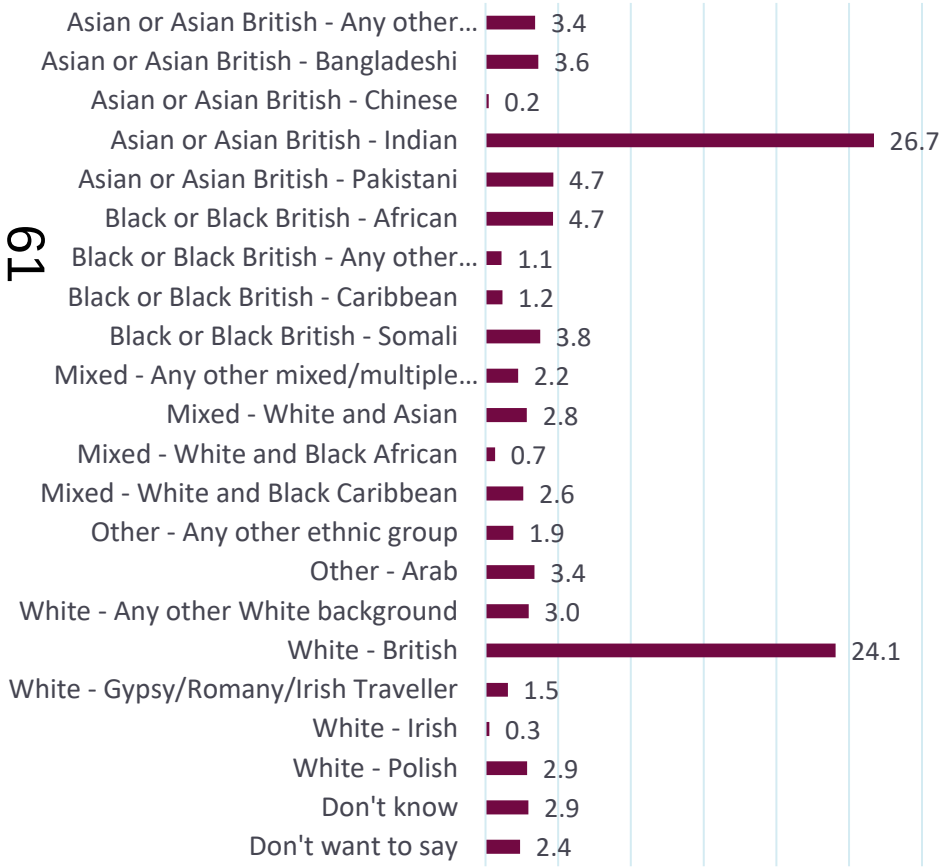


***Note:** *Only secondary aged children were asked this question.*

The survey includes responses from a diverse range of ethnic backgrounds, the two largest ethnic groups participating in the survey include Asian Indian and White British. Asian, White Other and Other ethnicity groups are more likely to speak a language other than English, and speak it at home.

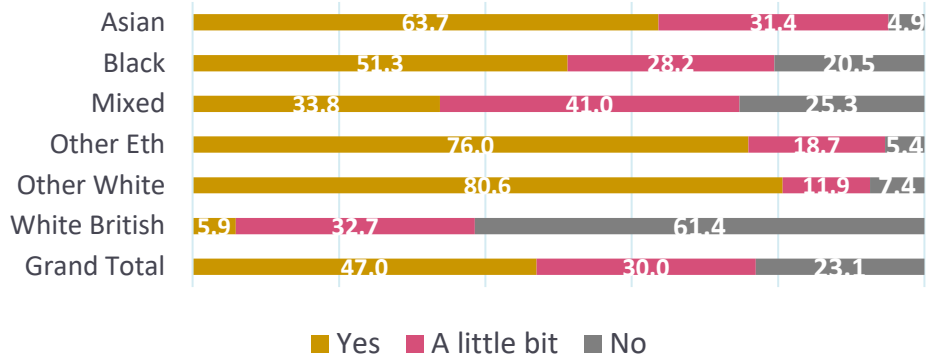
Ethnic background and language spoken

% Ethnic group*

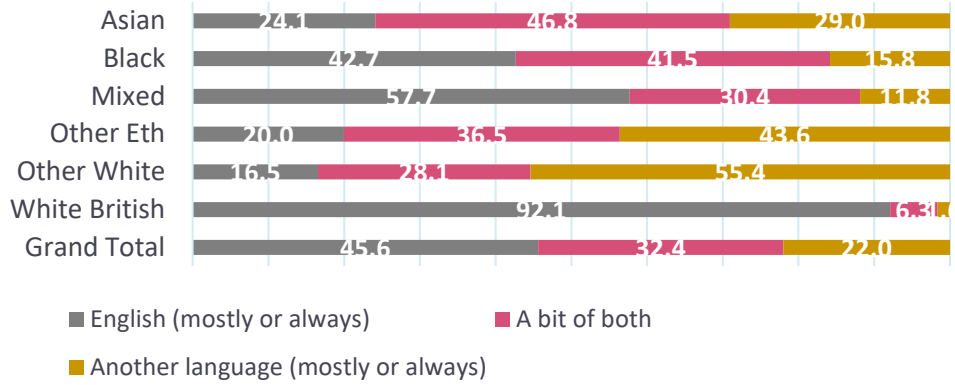


**Ethnic group sorted by broad ethnic group Asian, Black, Mixed Heritage, Other Ethnicity, White*

% Speaking a language other than English by ethnicity



% Language spoken at home by ethnicity

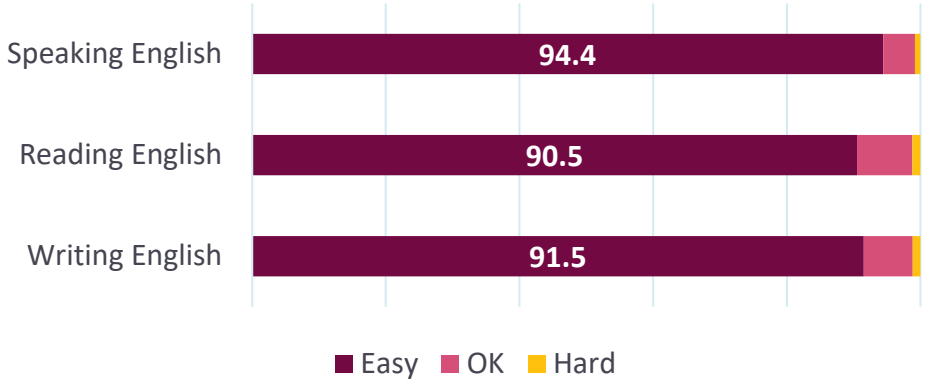


Most children find it easy to speak, read or write English, but there are some who find it more challenging. Groups significantly more likely to experience English language issues include those from Other White and Other Ethnicity and also children with a special educational need.

7. Proficiency in reading, speaking and writing English

About one in seven (14%) of children have an issue with at least one of speaking, reading, or writing English. Some groups are significantly more likely to have an issue with English including those with a poor mental wellbeing, and special education need.

Speaking, reading, and writing English



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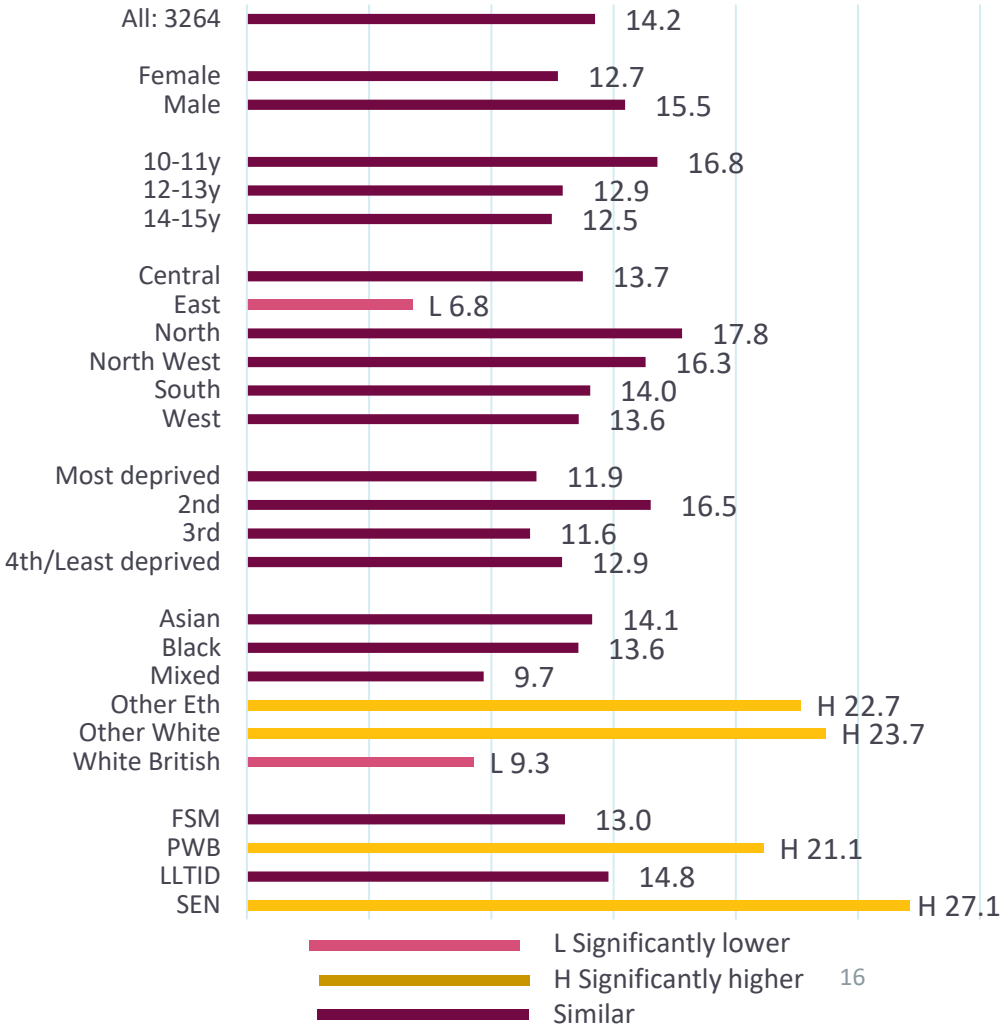
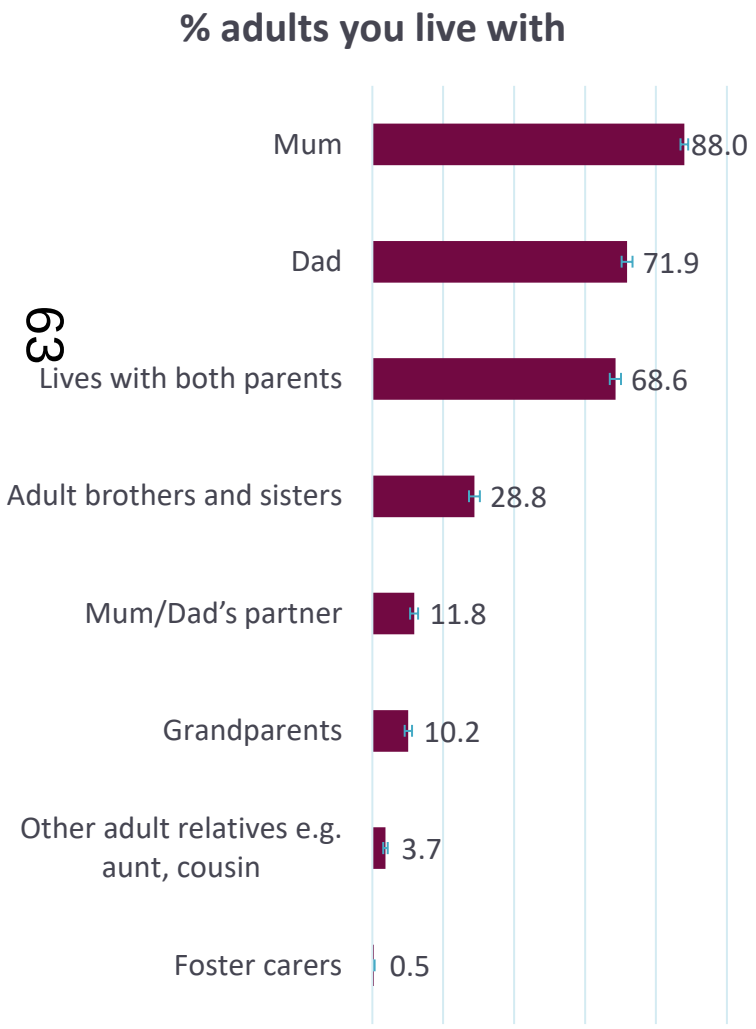
Additional groups: *FSM- Free School Meals*
PWB – Poor Wellbeing
LLTID – Long term limiting illness or disability
SEN Special Educational Need

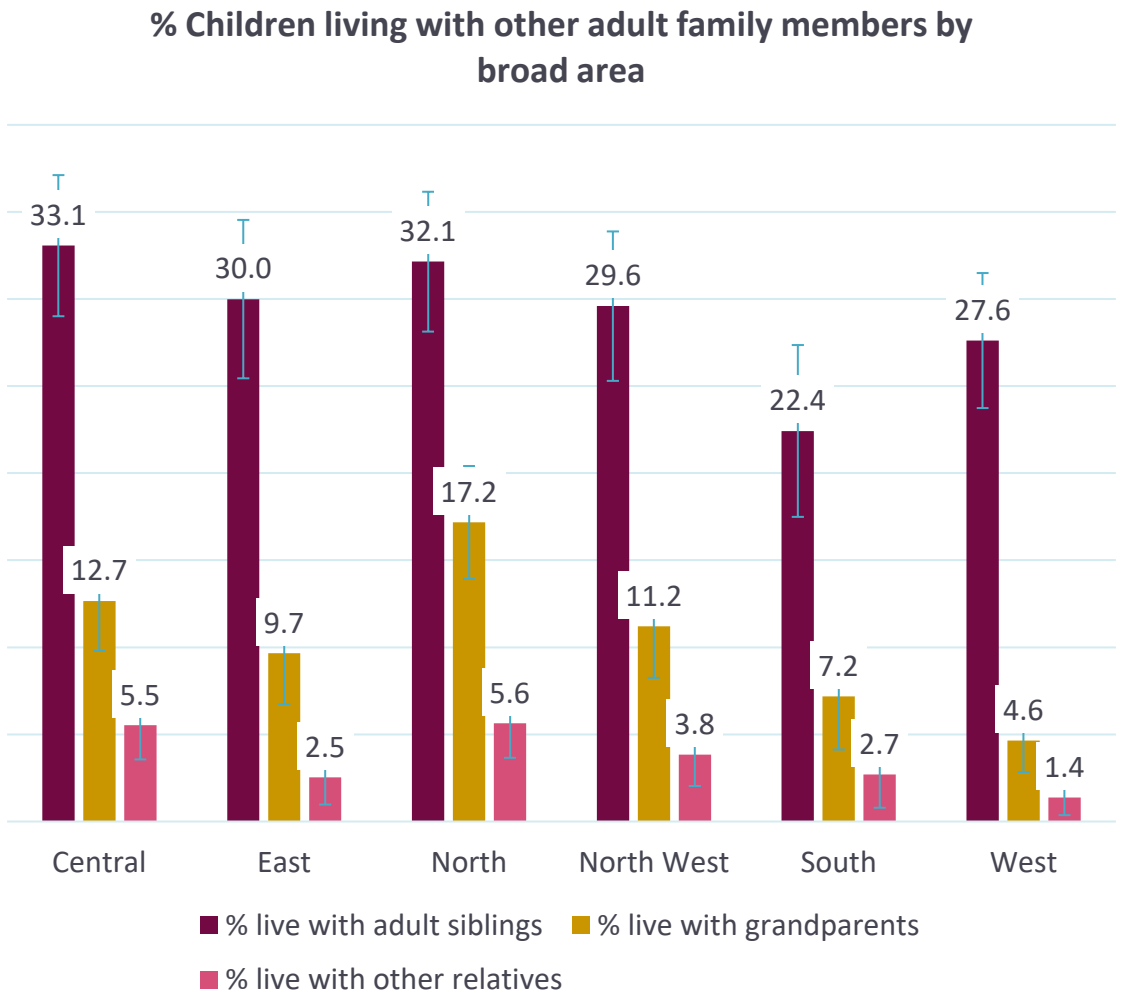
% who find English not easy



The majority of Leicester children live with mum or dad. Over a quarter of Leicester children also live with adult siblings. One in ten live with grandparents and for Asian children it is closer to one in six children living with a grandparent. Analysis by broad area shows that the Central, North and North West report higher proportions of children living with adult relatives.

8. Which adults do you live with? Including adult family members breakdown by broad area.





About a quarter (24%) of Leicester pupils reported that they currently have free school meals. A further 10% have had free school meals but not any more and about 7% were not sure if they had free school meals.

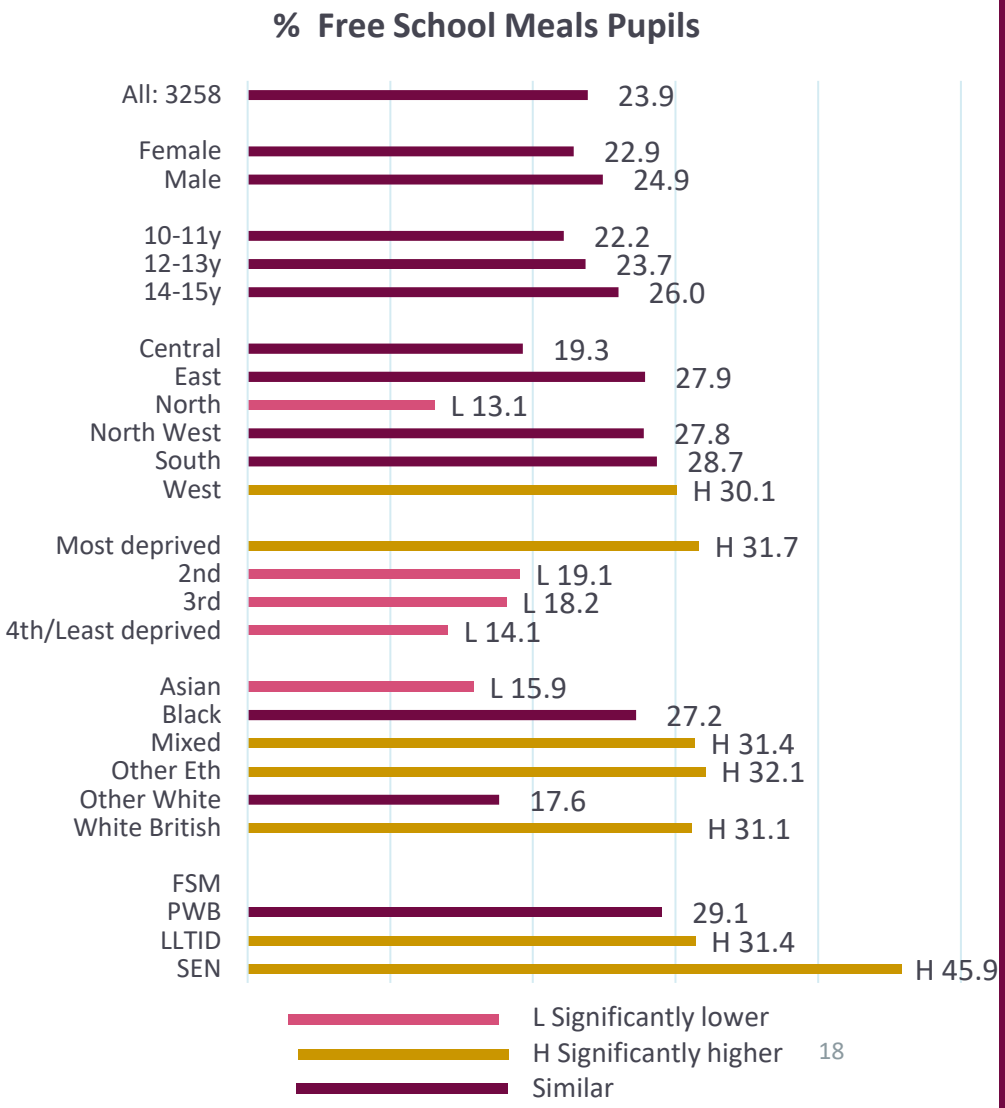
20. Have you ever had free school meals, or vouchers for free meals?

Children living in the West of the city are significantly more likely to be in receipt of free school meals, and children in the North are significantly less likely to have free school meals.

Children living in the most deprived areas of the city are more likely to have free school meals compared to those in less deprived areas.

Children from Mixed Heritage, other ethnicity and white British ethnic groups are significantly more likely to have free school meals. Asian British children are less likely to have a free school meal.

Those from a special educational need and children with a long term illness are also more likely to have free school meals.



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Additional groups: *FSM- Free School Meals*
PWB – Poor Wellbeing
LLTID – Long term limiting illness or disability
SEN Special Educational Need

In an average class of thirty children about five (16.2%) reported having an illness that affects their day to day life, twenty (67.3%) report they do not have an illness, and a further five were not sure or did not want to say.

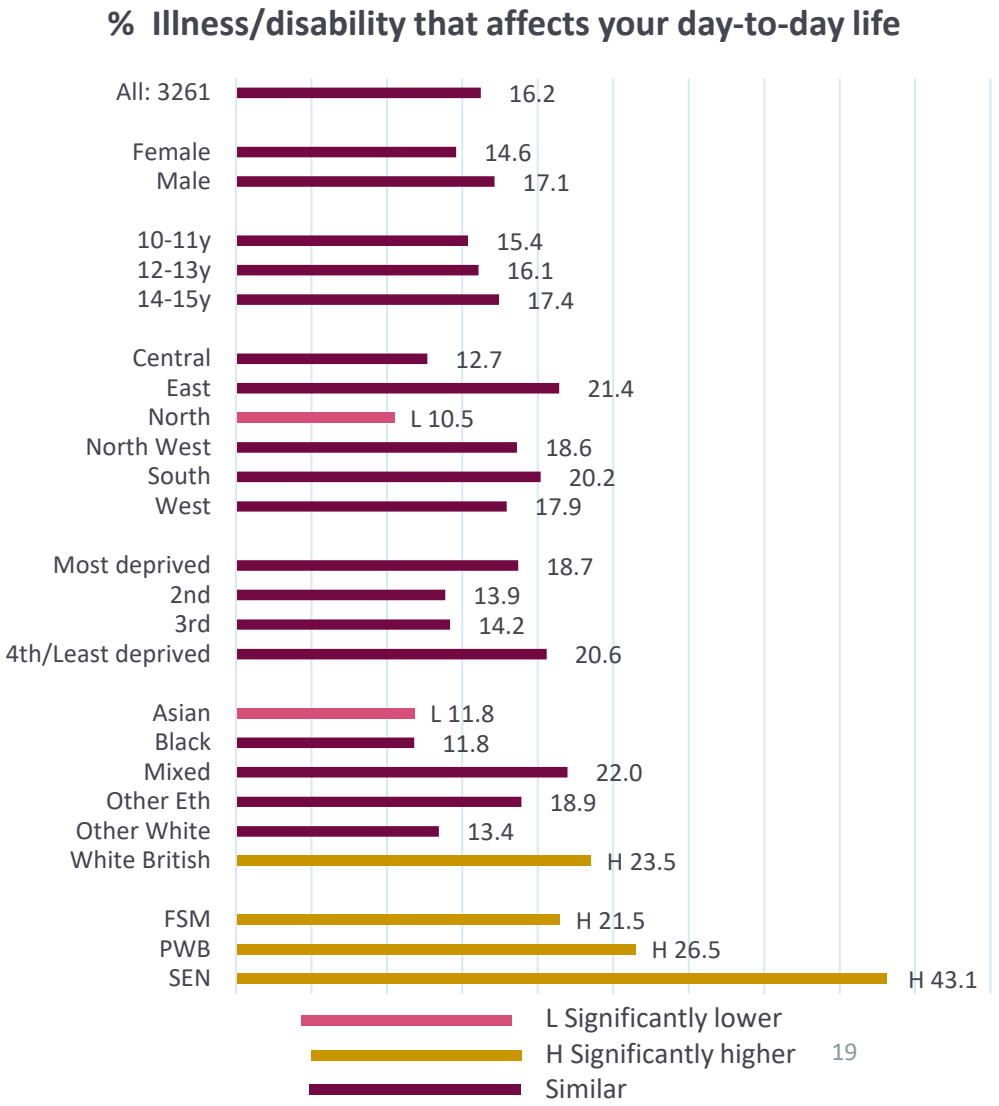
13. Do you have a health condition or illness that affects your day-to-day life?

There are small differences by age and gender.

Children living in the North of the city are significantly less likely to report having a long term illness/disability.

Asian British children are significantly less likely to report having an illness/disability and White British children are significantly more likely to report having an illness/disability.

Free school meal pupils, those with a poor mental wellbeing, and children with a special educational need all report significantly higher rates of having an illness that affects day to day life.



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Children were asked about the things they did after school. About one in five (19%) reported caring for family members.

36. Did you spend any time doing any of these things after school yesterday? Cared for family members (babysitting, minding grandparents, etc.)

Females were significantly more likely to report caring for family members, about one in four (24%) females aged 10 to 15 cared for family members after school.

There are no further significant differences but you can see higher reporting in younger children, those from the North West, and White British children.

2016/17	2021/22	Significant change
16.5%	19.3%	Increase since 2016/17

There has been a significant increase in the percentage of children caring for family members since 2016/17.

Deprivation Quintiles: *Most deprived (Living in 20% most deprived areas nationally and 4th/Least deprived (living in the 40% least deprived areas nationally)*
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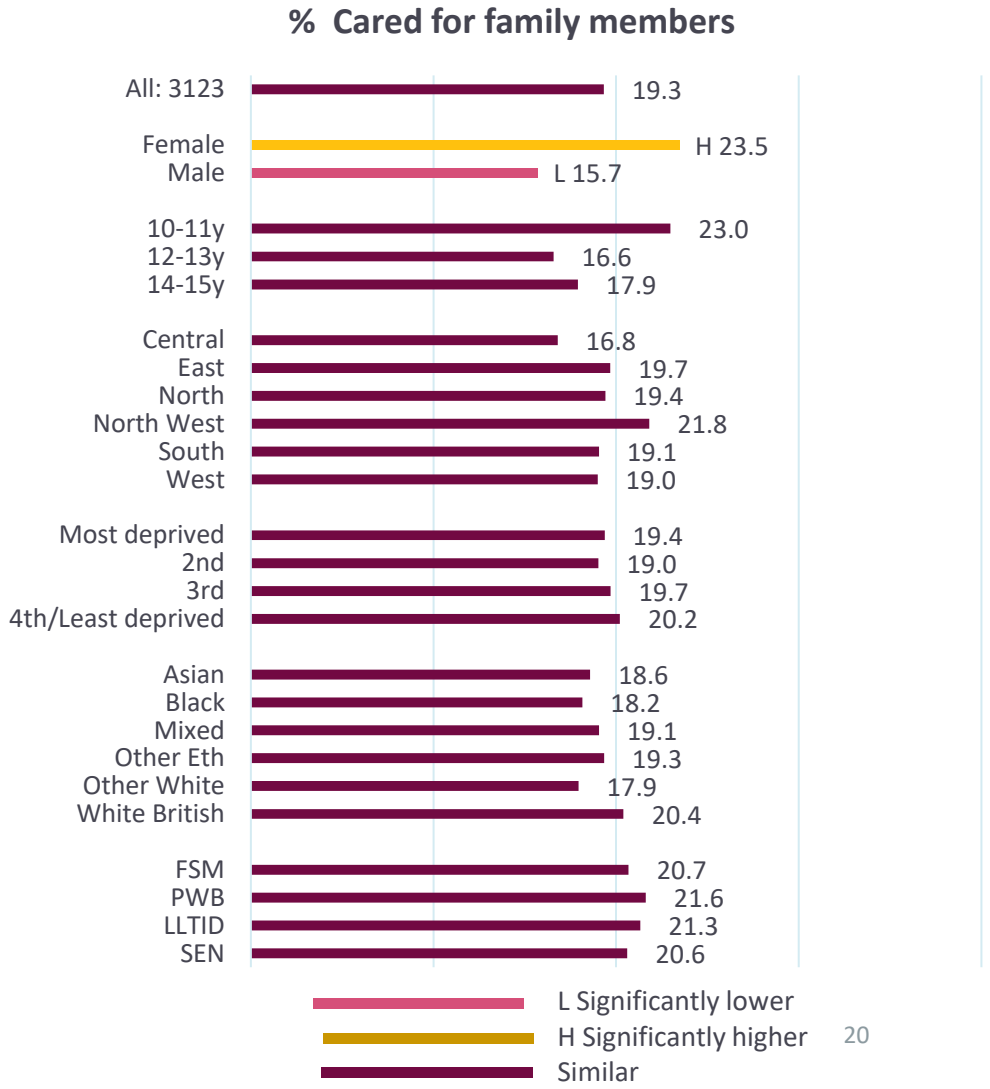


Healthy eating

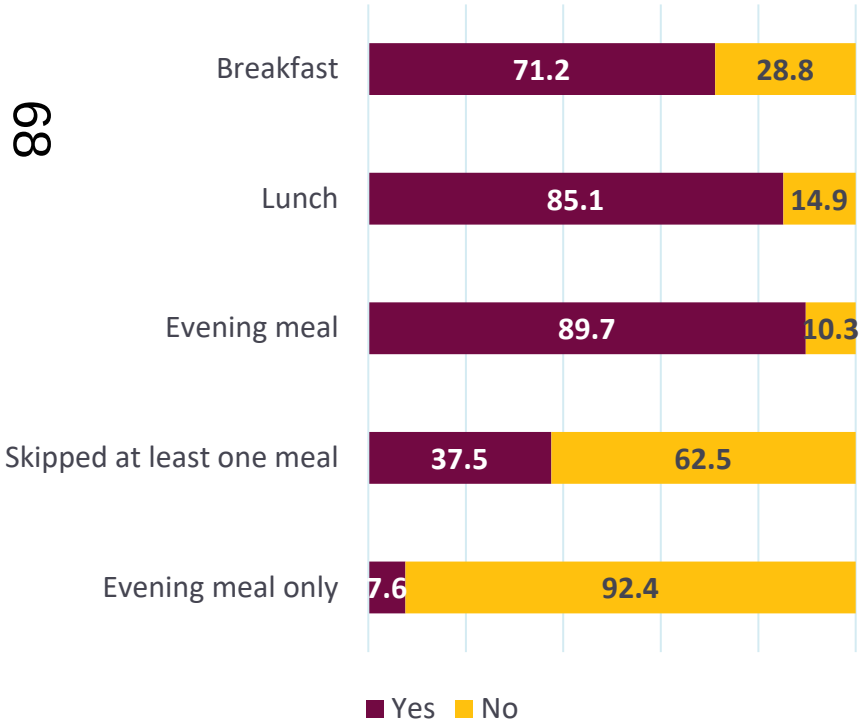
- Three out of five children ate breakfast, lunch and dinner the day before the survey. Two in five skipped at least one meal, the most common meal to skip was breakfast. A small proportion of children also reported they did not have an evening meal.
- One in five children are eating the recommended five or more portions of fruit and vegetables. Just over one in ten stated they had no fruit and vegetables the day before the survey.
- The majority of children have a home cooked meal most days or everyday, a quarter of children have ready meals more than once a week, and one in ten children have takeaways more than once a week.
- The majority of children drink water most days or everyday, one in ten children have fizzy drinks most days or everyday, one in twenty stated they have an energy drink most days or everyday.
- About five in a class of thirty worry about having enough to eat. Younger children are more likely to worry about having enough to eat. A third of children with a special educational need worry about having enough to eat.
- Four out of five children eligible for free school meals ate their school meal.
- Children were most likely to get information regarding healthy eating/diet from their family, school, and social media, and were least likely to get it from books and/or magazines.

Three out of five children had breakfast, lunch and dinner the day before the survey. About two in five (37.5%) children skipped at least one meal. The most common meal to skip was breakfast (29%), followed by lunch (15%), and then evening meal (10%).

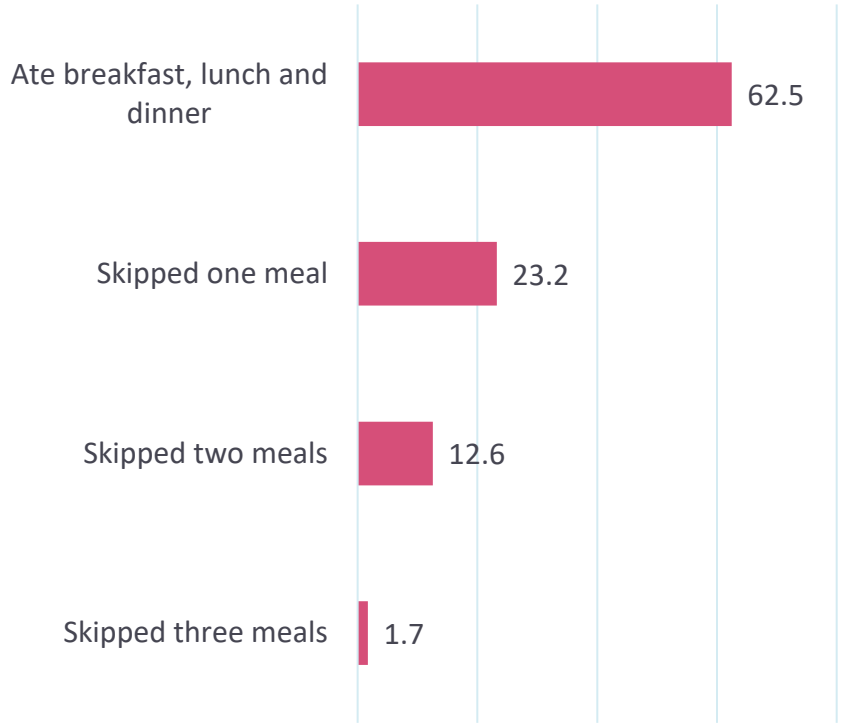
22. What meals did you have yesterday?

There is a minority of children (8%) who only had an evening meal the day before the survey. About a quarter (23%) of children skipped one meal, just over one in ten (13%) skipped two meals, and a small minority stated they skipped all meals (2%).

What meals did you have yesterday? (%)



What meals did you eat yesterday? (%)



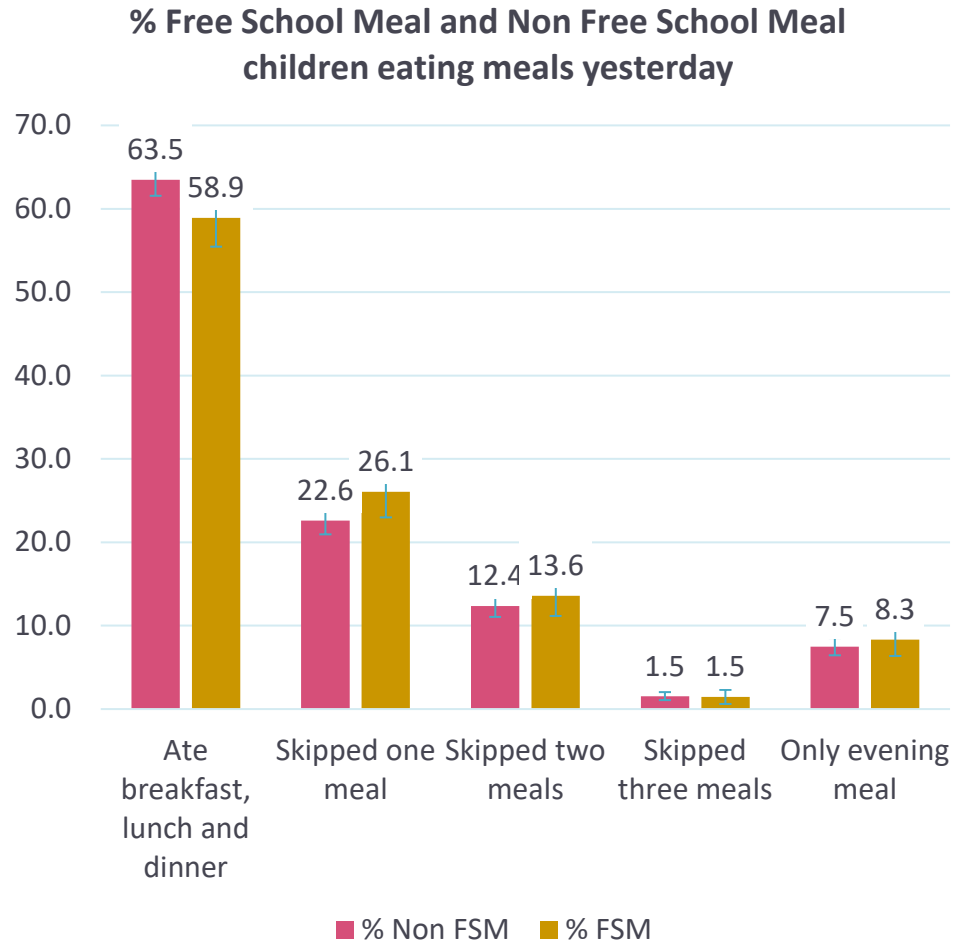
There are small differences in meal consumption for free school meal eligible pupils and non free school meals pupils.

22. What meals did you have yesterday? Analysis of children in receipt of free school meals

The chart compares meals eaten the day before the survey for free school meal pupils and non free school meal pupils.

It shows that those in receipt of free school meals are less likely to have eaten breakfast, lunch and dinner the day before the survey.

Free school meal pupils are also more likely to have skipped meals and had an evening meal only. However, these differences are not statistically significant.



Additional groups:
FSM- Free School Meals pupils
Non FSM – Non Free School Meals pupils

About four in every ten (38%) Leicester children skipped at least one meal the day before the survey. Two thirds (67%) of children reporting a poor wellbeing score skipped a meal.

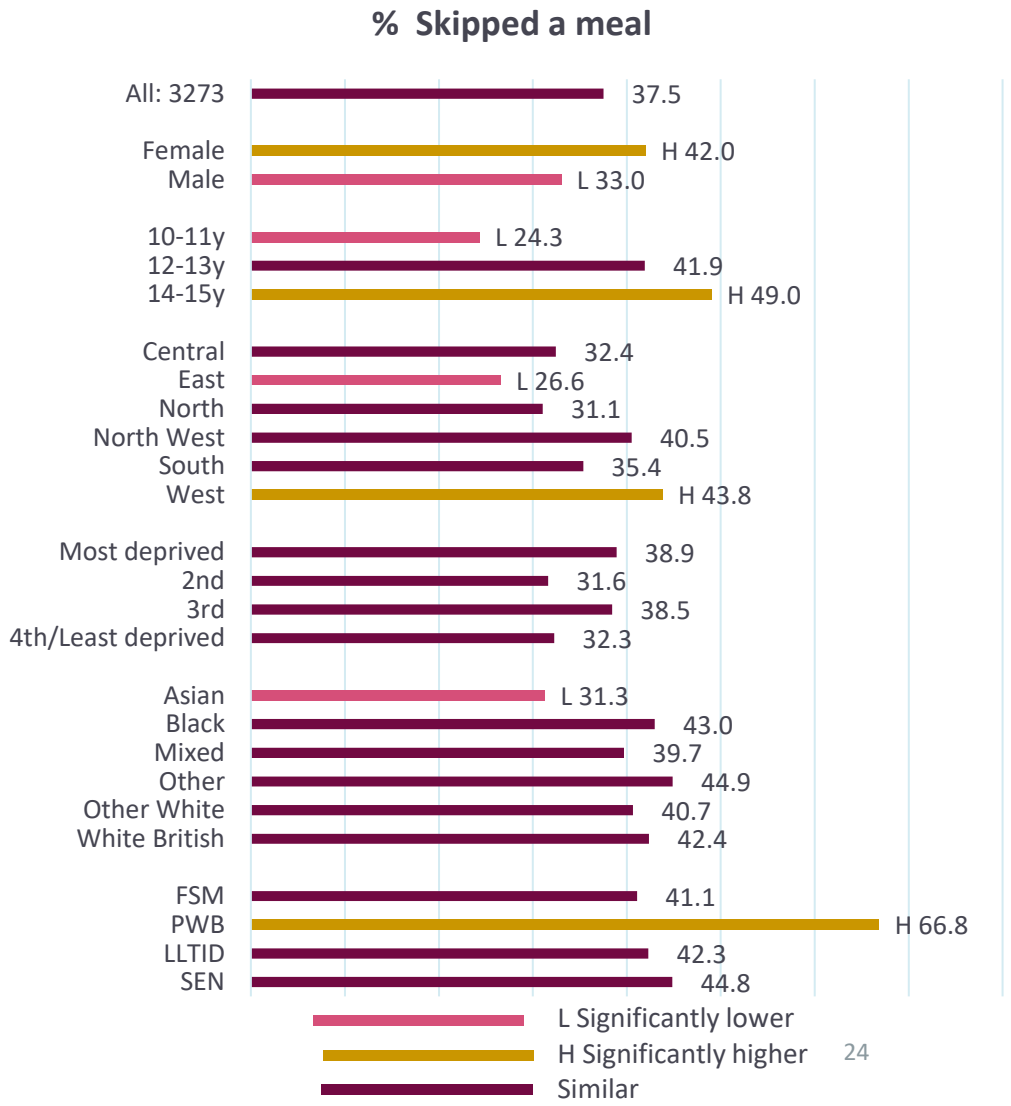
22. What meals did you have yesterday? Skipped at least one meal

Females are significantly more likely than males to skip at least one meal.

About half (49%) of 14-15 year olds skip at least one meal, this is significantly high. Children aged 10-11 years old are significantly less likely to skip a meal.

There are some geographic and ethnic differences. With Asian children significantly less likely to skip a meal.

Children reporting a poor wellbeing score are significantly more likely to skip at least one meal yesterday.



Deprivation Quintiles: *Most deprived (Living in 20% most deprived areas nationally and 4th/Least deprived (living in the 40% least deprived areas nationally)*
Additional groups: *FSM- Free School Meals*
PWB – Poor Wellbeing
LLTID – Long term limiting illness or disability
SEN Special Educational Need

About 1 in 2 children reported having a school lunch yesterday (56%). Children who are entitled to a free school meal are significantly more likely to have a school lunch.

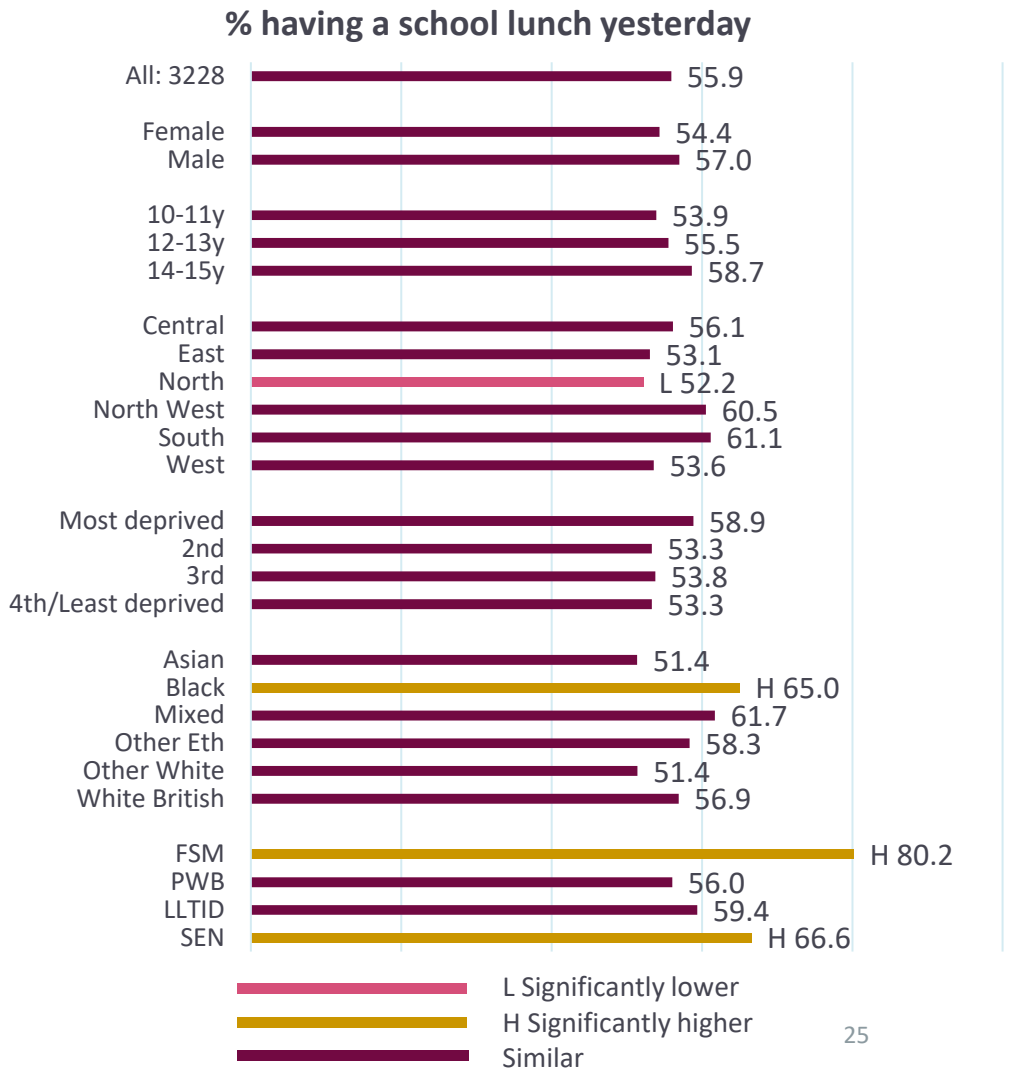
23. Did you have a school lunch yesterday? Yes

The proportion eating a school lunch increased with age-group, although differences were not significant.

Those living in the North of the City were significantly less likely to have had a school lunch (52%).

Those of Black ethnicity and those with SEN were significantly more likely to have had a school lunch.

Data suggests that while children in receipt of free school meals are significantly more likely to have a school meal, not all children are taking their entitlement.



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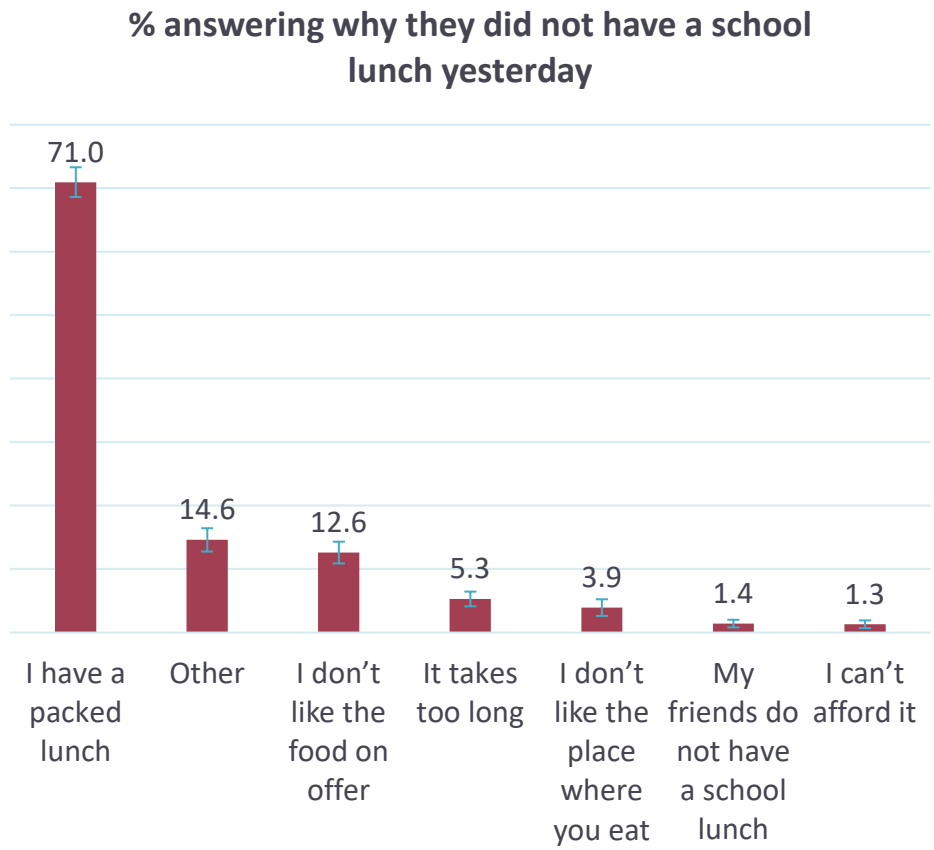
Nearly half (44%) of children reported they did not have a school meal. The majority of these children who did not have a school meal reported this was because they had a packed lunch instead (71%).

24. If you didn't have a school meal – why not?

About 7 in 10 children did not have a school meal because they already had a packed lunch (71%).

There also seemed to be contextual issues at play which reduced uptake of a school meal including: not liking the choices available (13%), food taking too long (5.3%) and not liking the dining area (3.9%).

Other unspecified reasons also seemed to be a large influence in not having a school meal (15%).



Note: *Children who said they did not have a school meal answered this follow up question.*

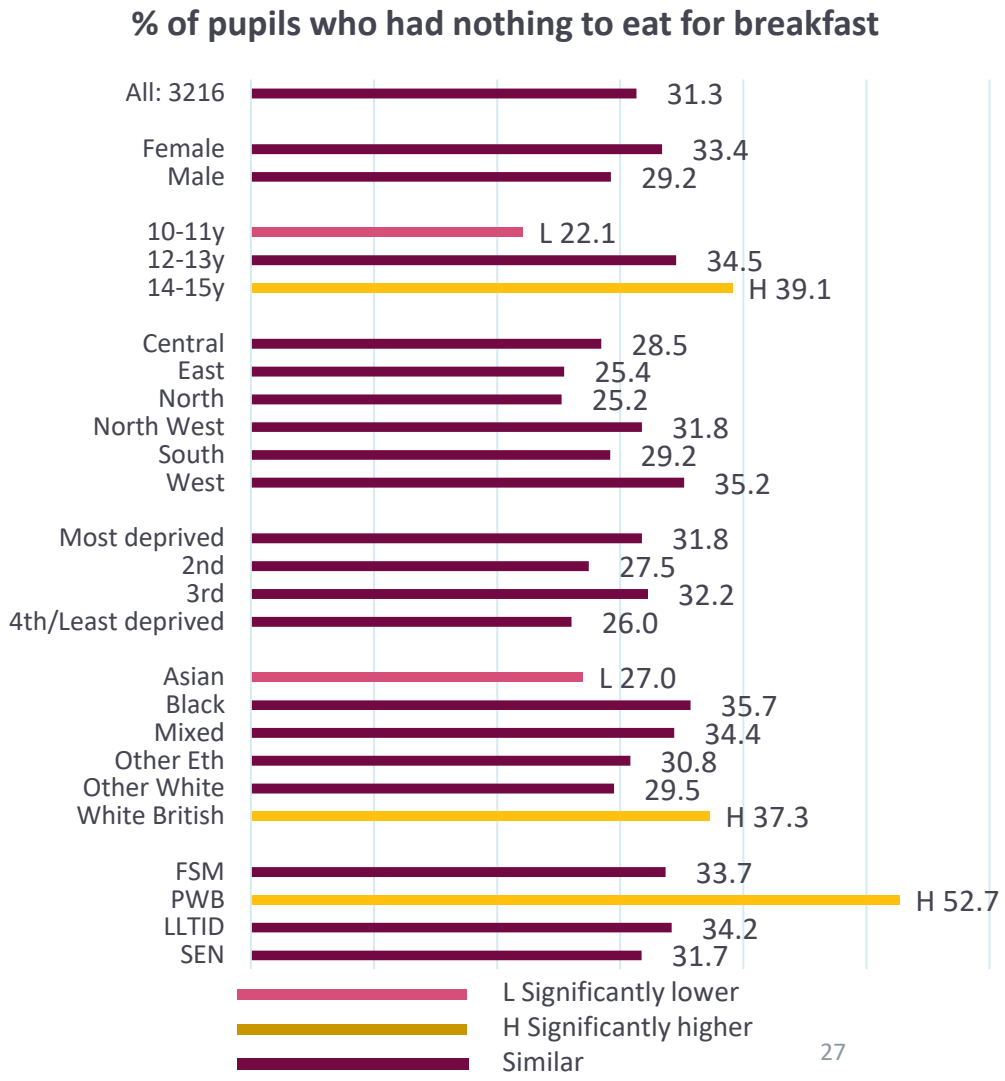
Nearly 1 in 3 children (31%) had nothing to eat for breakfast on the day of the survey. Older children were even more likely to have had nothing to eat for breakfast. This is likely to have implications on learning for the rest of the day.

25. Did you have anything to eat or drink before lessons this morning? No, nothing to eat

Younger children (10-11 yrs) were significantly less likely to have had skipped breakfast, while older children (14-15 yrs) were significantly more likely to have missed breakfast.

Children of White British ethnicity were significantly more likely to not have had breakfast. Those with a poor wellbeing score were significantly more likely to skip breakfast.

In 2016/17 16.3% of children had nothing to eat or drink for breakfast, in 2021/22 a similar percentage of children had nothing to eat or drink (17.2%).



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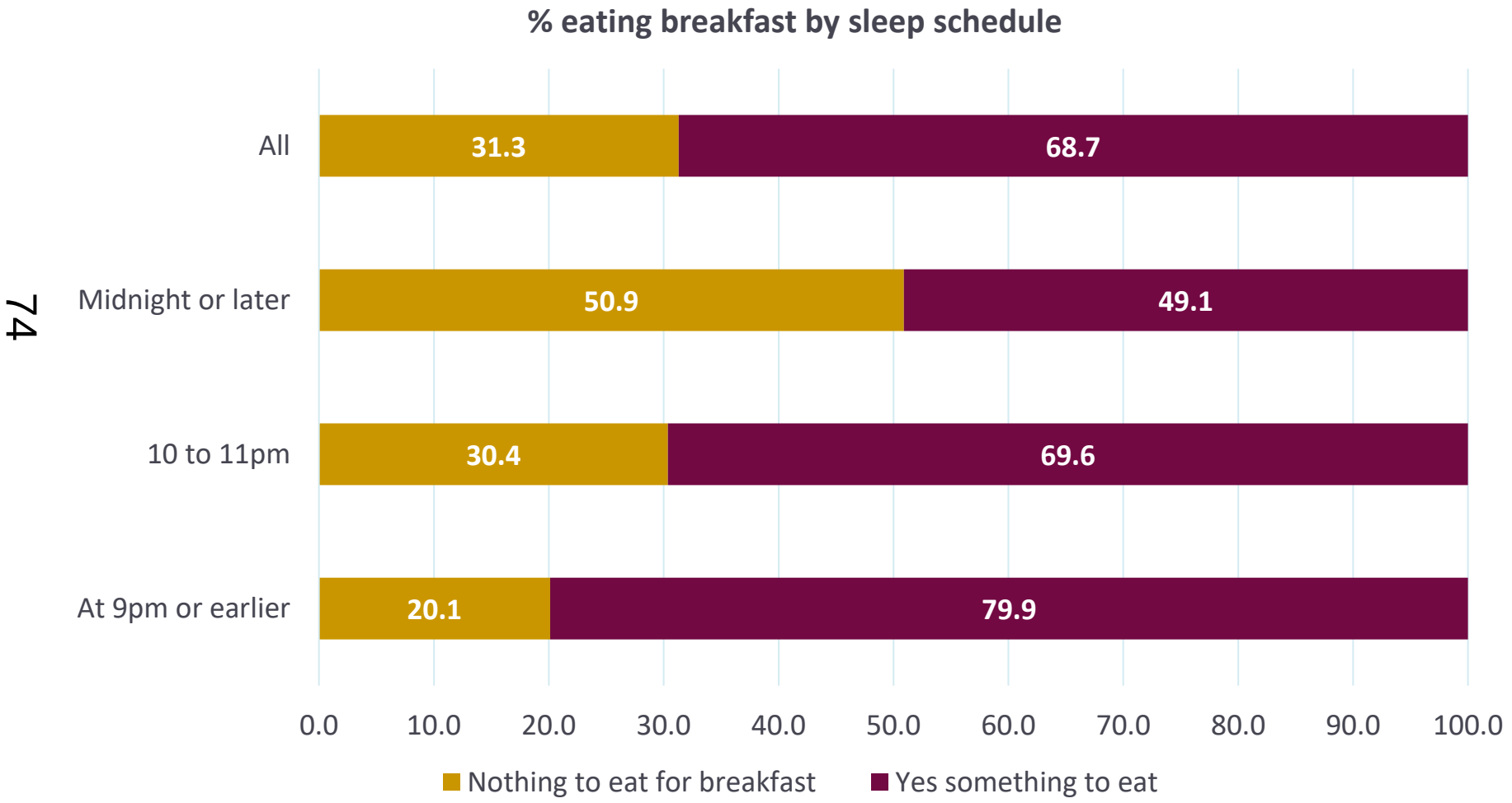
Further analysis of breakfast consumption by sleeping schedule clearly shows that children who sleep later are significantly less likely to have eaten breakfast. Half of children who went to sleep at midnight or later did not eat breakfast compared to one fifth of children who went to sleep at 9 pm.

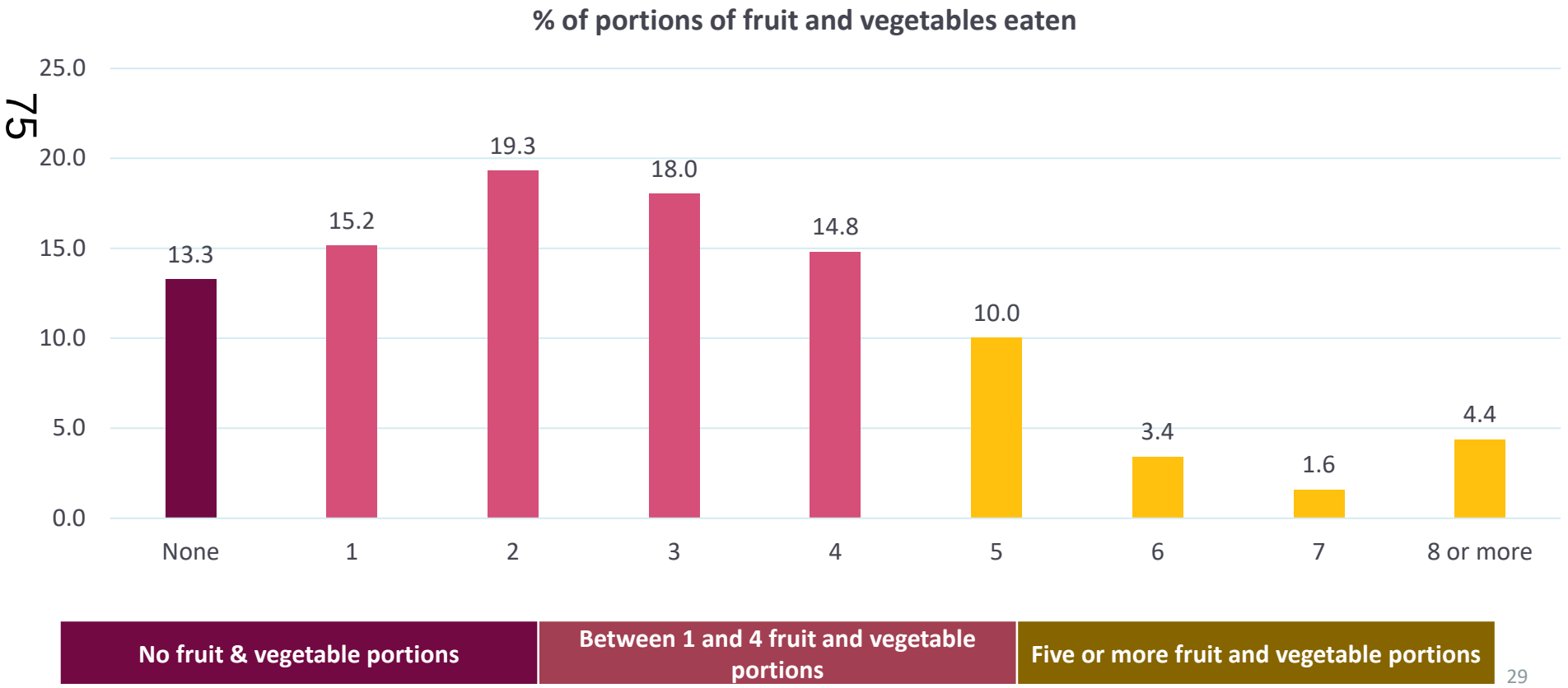
25/38. Eating breakfast and time of sleep



One in five (19%) children are eating the recommended 5 or more portions of fruit and vegetables a day, four out of five children (81%) are not.

28. How many portions of fruit and vegetables did you eat yesterday?

Over one in ten (13%) children had no fruit and vegetable portions the day before the survey. A further two thirds (67%) of children had between 1 and 4 portions.



About one in five (19%) Leicester children had the recommended five or more portions of fruit and vegetables the day before the survey.

28. How many portions of fruit and vegetables did you eat yesterday? Five or more

Younger children (10-11 yrs) were significantly more likely to eat 5 or more portions of fruit and vegetables per day, compared to older children (14-15 yrs).

Those from an Other ethnic group were significantly more likely to eat 5 or more portions.
Those with a poor wellbeing score were significantly less likely to eat 5 or more portions.

2016/17	2021/22	Significant change
22.7%	19.4%	Decrease since 2016/17

There has been a significant decrease in the percentage of children eating five or more fruit and vegetables since 2016/17.

Deprivation Quintiles: *Most deprived (Living in 20% most deprived areas nationally and 4th/Least deprived (living in the 40% least deprived areas nationally)*
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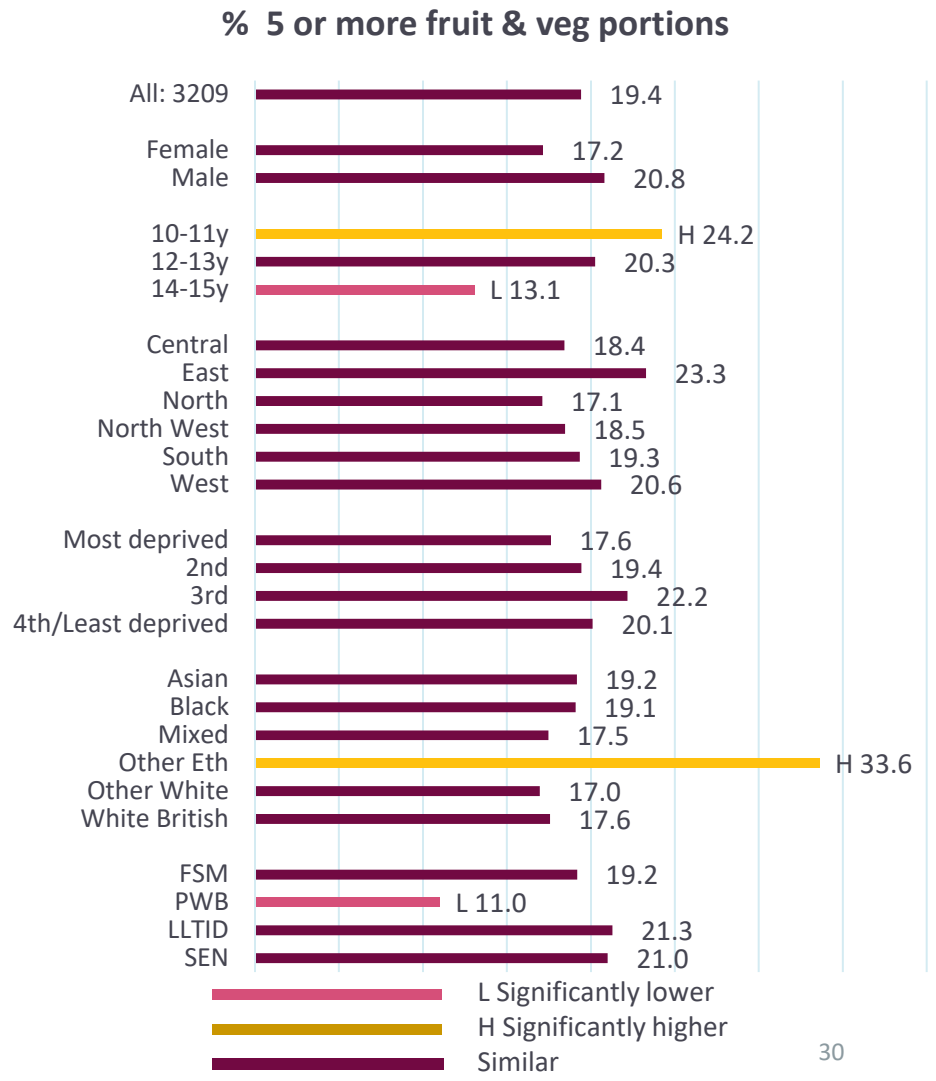
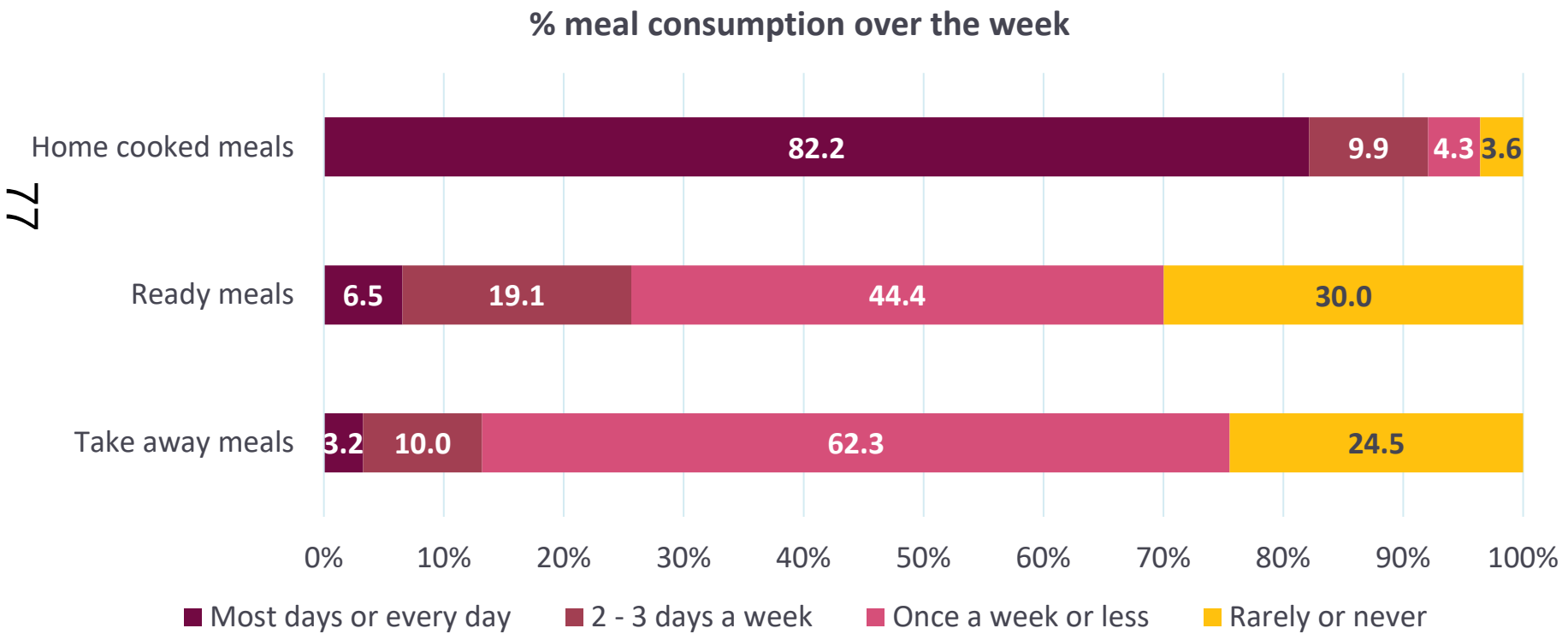


Four out of five children (82%) children reported eating home cooked meals most days or every day. Ready meals are also common with about a quarter (26%) of children eating them more than once a week.

26. How often do you eat the following? Takeaway, ready meals and home cooked meals

Just over one in ten (13%) of children eat a takeaway meal more than once a week



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Meal definitions:
Take away meals (curry, chinese, fish and chips, pizza) or similar things delivered
Ready meals (pies, Pot Noodle, pizza)
Home cooked meals (from fresh)

About 1 in 10 (13%) children reported eating takeaways more than once a week. There are differences by demographic groups below.

26. How often do you eat the following? Takeaway

Males were more likely to eat takeaway meals more than once a week compared to females, although this was not significant.

Most notably, those from the East of the City were significantly less likely to have a takeaway compared to other broad areas. There are some other demographic differences, but these were not significant.

2016/17	2021/22	Significant change
23.0%	13.2%	Decrease since 2016/17

There has been a significant decrease in the percentage of children eating a takeaway more than once a week since 2016/17.

Meal definitions:
Take away meals (curry, chinese, fish and chips, pizza) or same things delivered

Deprivation Quintiles: *Most deprived (Living in 20% most deprived areas nationally and 4th/Least deprived (living in the 40% least deprived areas nationally)*
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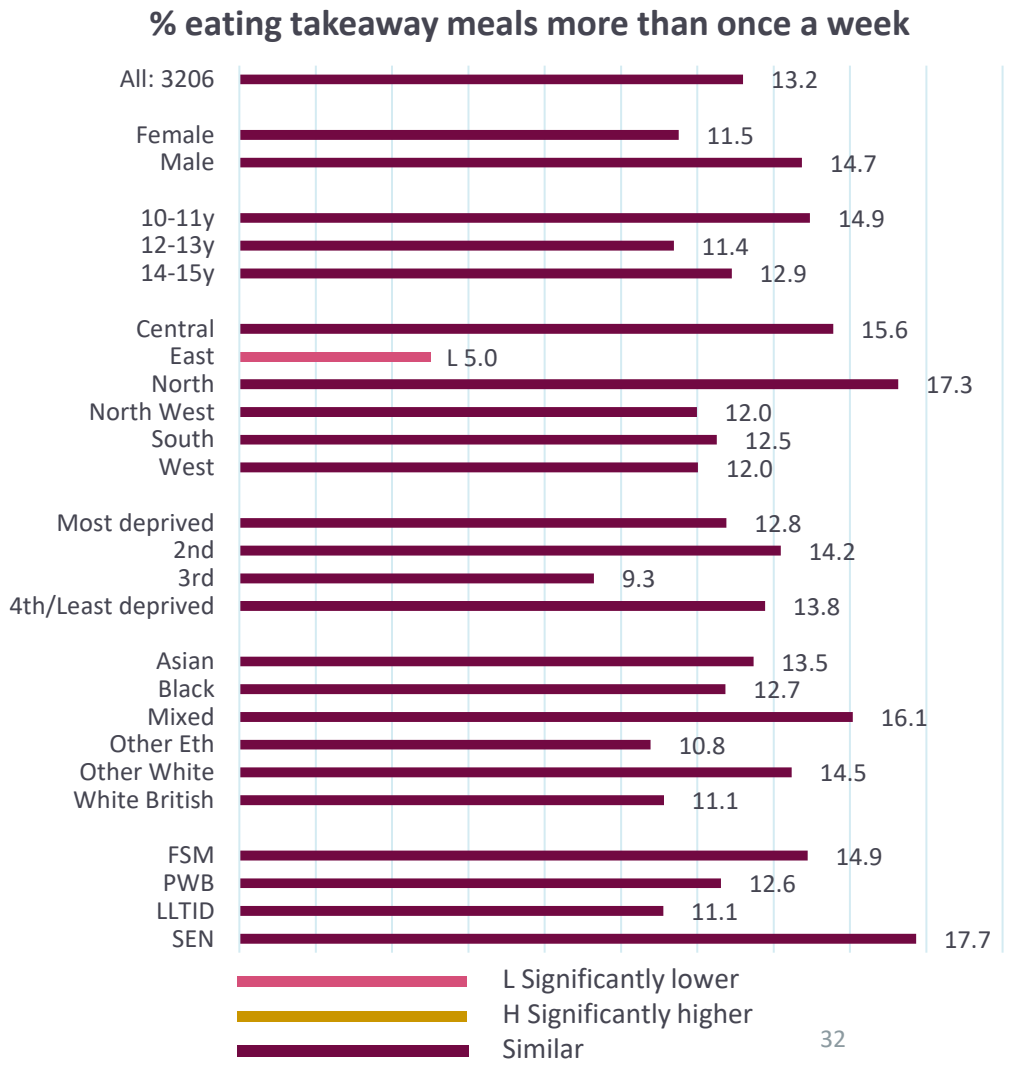
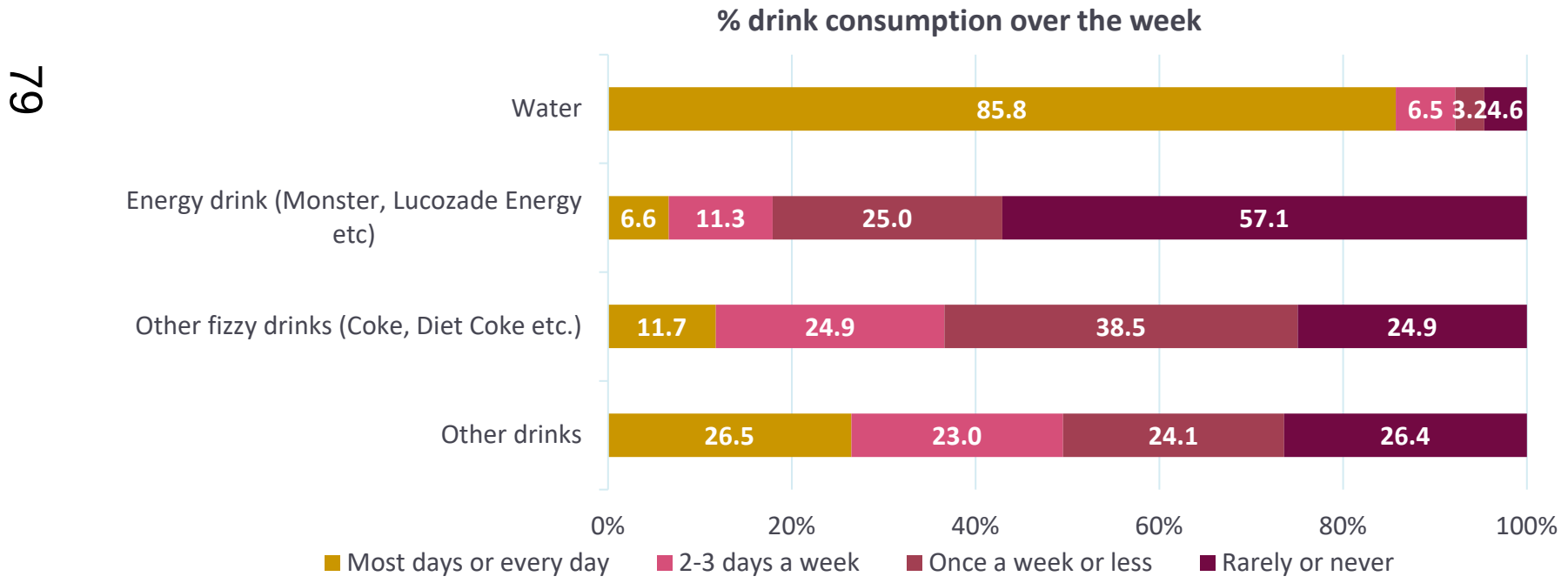


Children were asked to report their drink consumption of water, energy drinks, fizzy drinks and other drinks. The majority of children reported drinking water most days or every day (86%).

27. How often do you drink the following? Water, energy drinks, fizzy drinks and other drinks

Around 1 in 5 children (18%) and over a third (37%) of children reported drinking energy drinks and other fizzy drinks more than once a week, respectively.

Around half of children reported drinking other drinks more than once per week (50%).



Drink definitions:

- *Energy drinks (*Monster, Lucozade Energy etc)
- *Other fizzy drinks* (Coke, Diet Coke etc.)
- *Other drinks (any other drink such as milk)*

Energy drinks are soft drinks that contain higher levels of caffeine and a lot of sugar. Excessive consumption of energy drinks by children is linked to negative health outcomes. In Leicester, around 1 in 5 children (18%) reported drinking energy drinks more than once per week.

27. How often do you drink the following? Energy drinks

Females were significantly less likely to drink energy drinks compared to males. Younger children and those of Asian ethnicity were also significantly less likely to have energy drinks.

Children with SEN or a poor wellbeing score were significantly more likely to have energy drinks.

2016/17	2021/22	Significant change
20.0%	17.9%	No significant change

There has been no significant change in energy drink consumption (more than once a week) since 2016/17.

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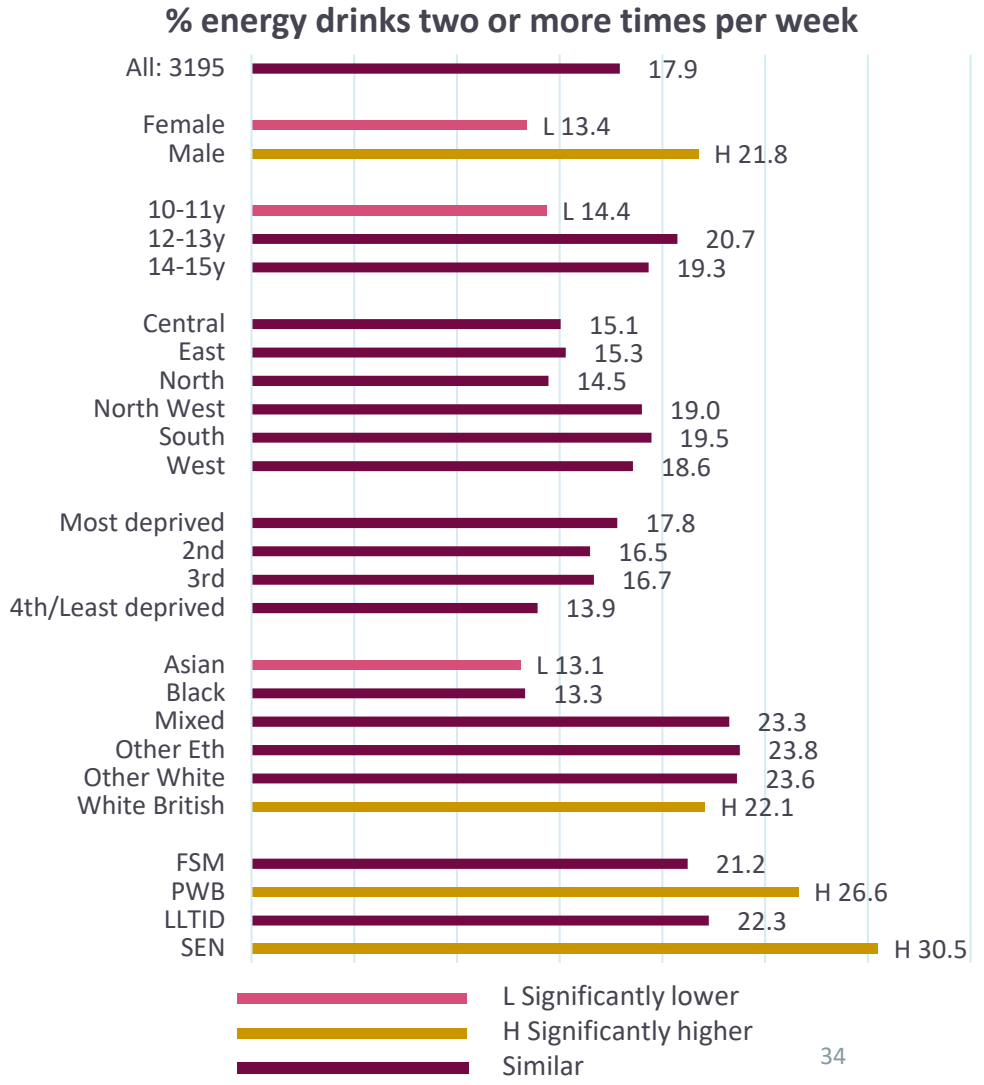

About five in a class of thirty children worry about having enough to eat (17.5%). Older children worry less about food, and younger children are worrying more.

50. How often do you worry about the following issue? Worry 'a lot or quite a lot' about Having enough to eat

Younger children (10-11yrs) were significantly more likely to worry about food compared to their older (14-15 yrs) counterparts.

Those in the East were significantly less likely to worry about food. About a third of SEN children were also significantly more likely to worry about food.

2016/17	2021/22	Significant change
18.7%	17.5%	No significant change

There has been no significant statistical change in children worrying about having enough to eat since 2016/17. Food poverty remains an important issue for Leicester children

Deprivation Quintiles: *Most deprived (Living in 20% most deprived areas nationally and 4th/Least deprived (living in the 40% least deprived areas nationally)*
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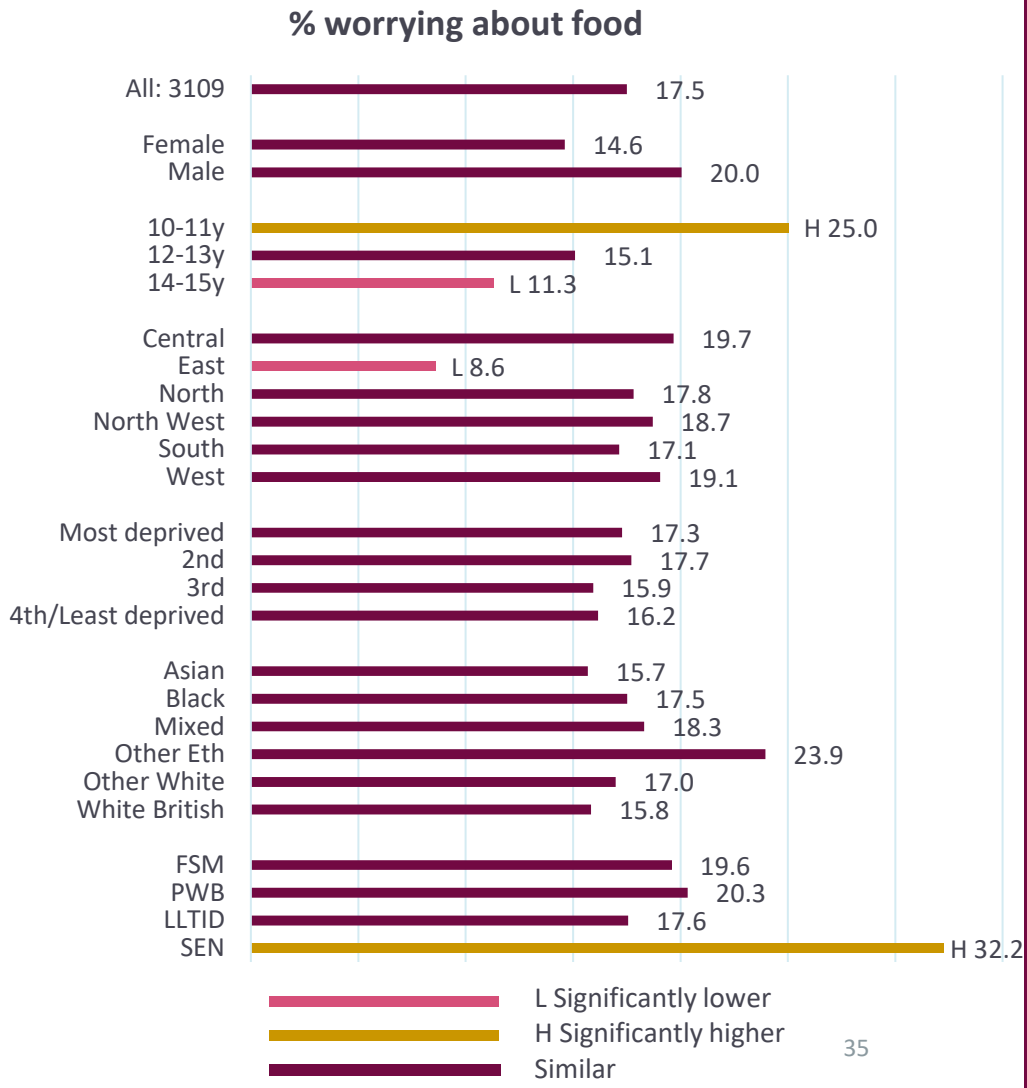


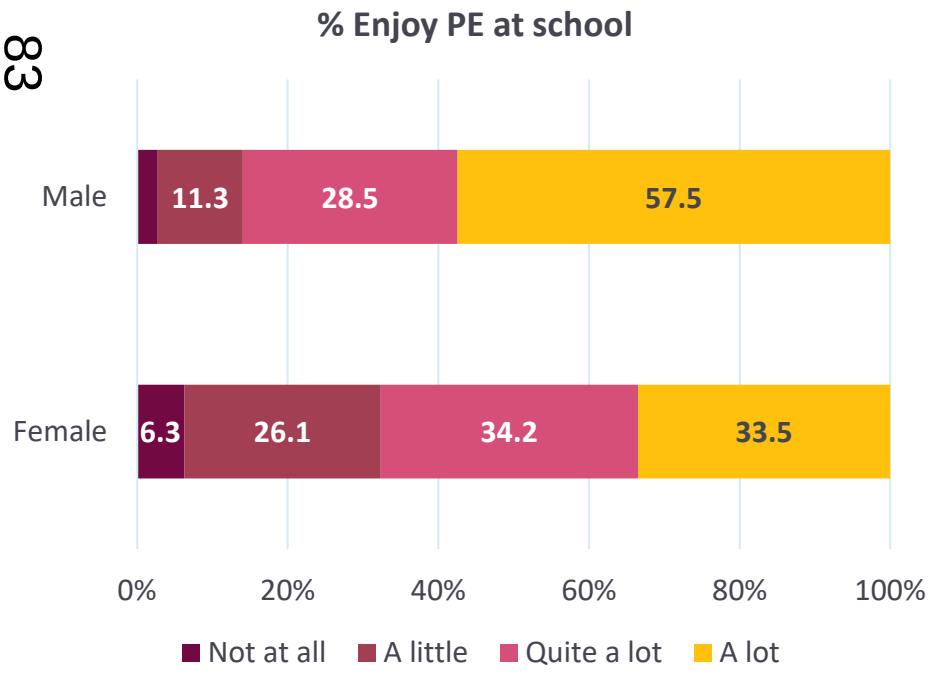
Physical activity and active travel

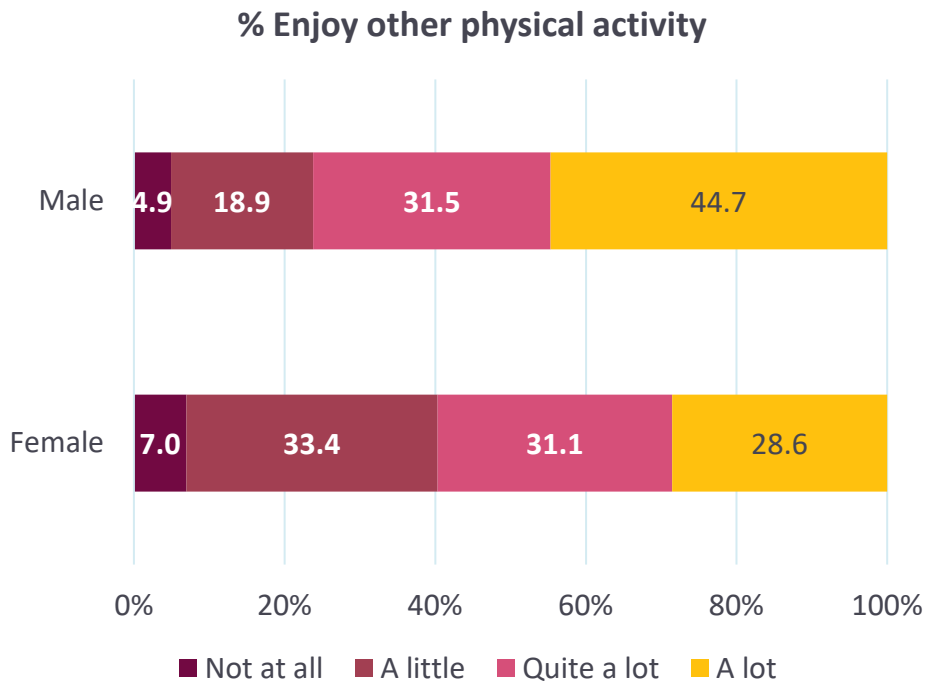
- About three out of four children enjoy physical education at school, and two thirds state they enjoy other physical activity outside of school.
- The Chief Medical Officer recommends that children achieve 60 minutes of physical activity a day to be active. In Leicester about 5 in a class of 30 are achieving this.
- Nearly half of children are completing less than 30 minutes of physical activity a day.
- One in three children have never been to a leisure centre.
- Active travel (walking & cycling) to school, the park, and to see friends is common. Private car is the most common method of travel to the city centre and to see family.

Not all children enjoy physical activity. About one in twenty Leicester children state they do not enjoy physical activity. Boys are significantly more likely to enjoy physical activity at least quite a lot.

29. How much do you enjoy…? PE in school / Other physical activity?

Over half of males (58%) enjoy PE in school a lot compared to a third (34%) of females. There is a similar pattern for enjoyment of other physical activity. Younger aged groups are also more likely to enjoy physical activity.



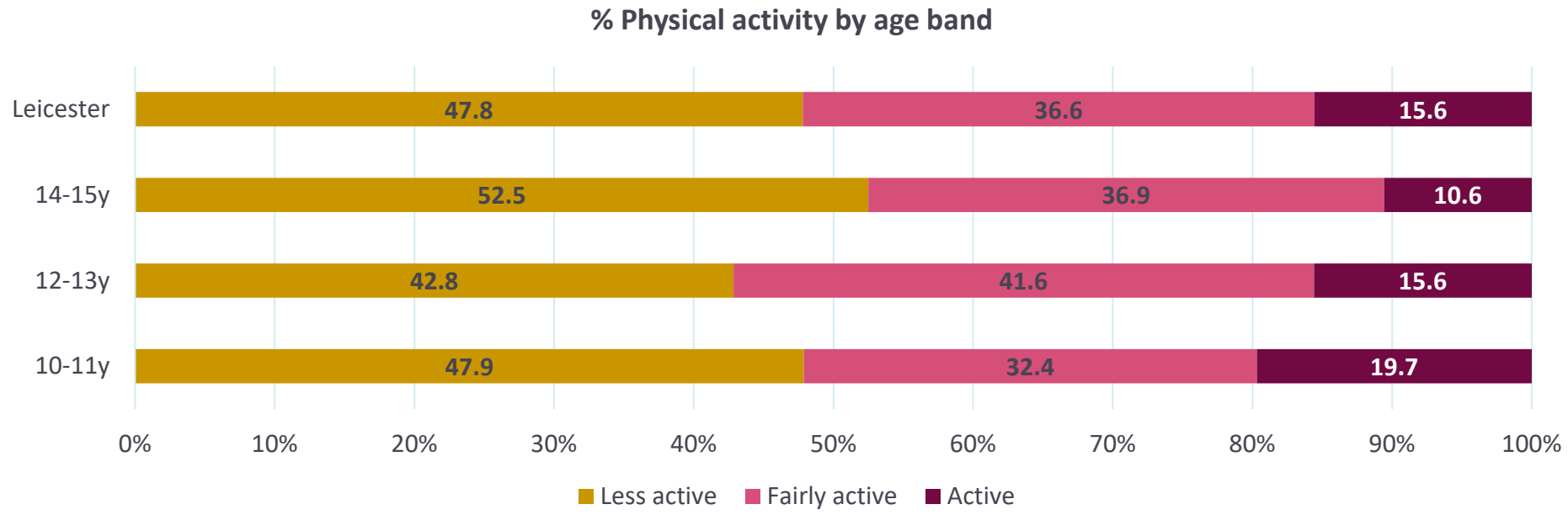


Being physically 'active' means when your heart is beating faster than normal. You are exercising hard enough so that even if you can talk while exercising, you couldn't sing. To be physically active The Chief Medical Officer advises children and young people to take part in sport and physical activity for an average of 60 minutes or more a day over the course of the week.

31. How many minutes of physical activity did you complete last week?

Children were asked how many minutes of physical activity they completed each day last week. Younger children were more likely to be active compared to older children. Levels of inactivity were slightly higher in older children but this is not a significant difference.

About 5 in a class of 30 (16%) are active according to the Chief Medical Officer recommendations, nearly half (48%) of children are completing less than 30 minutes of physical activity a day. There is a small proportion (11%) that are inactive, completing less than half an hour over the week (see the next slide for more information).



Chief Medical Officer Guidelines for weekly physical activity:
Less active – *an average of less than 30 minutes of physical activity a day;* ***Fairly active –*** *an average of 30-59 minutes a day;* ***Active –*** *an average of more than 60 minutes a day*

Most children are not reaching the desired 60 minutes a day of physical activity but they are completing some physical activity each day. About one in ten (11%) children described that they completed 30 minutes or less physical activity over the entire week.

31. How many minutes of physical activity did you complete last week? Physical inactivity

There are differences in levels of inactivity but few of these are significant, indicating that groups of physically inactive children are found in each group.

Females are more likely than males to be inactive.

White British and Mixed Heritage children report much lower physical inactivity rates.

Children reporting a poor mental wellbeing are significantly more likely to be physically inactive.

Weekly Physical activity levels:
Inactive – *less than 30 minutes of physical activity across a week;*

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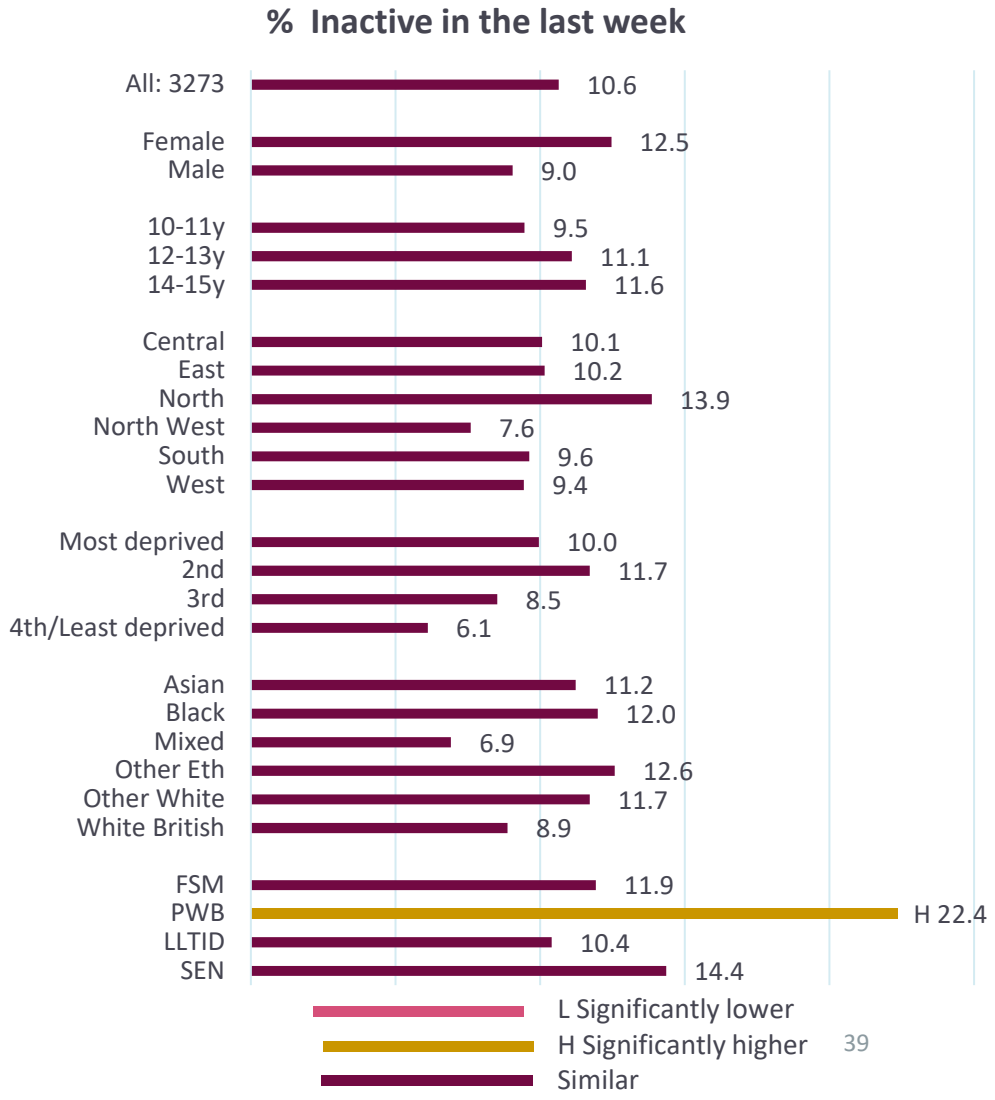


Children were asked about the services they use. A third (33%) of children reported that they had never been to a leisure centre. This is likely to have impacted on physical activity opportunities including swimming.

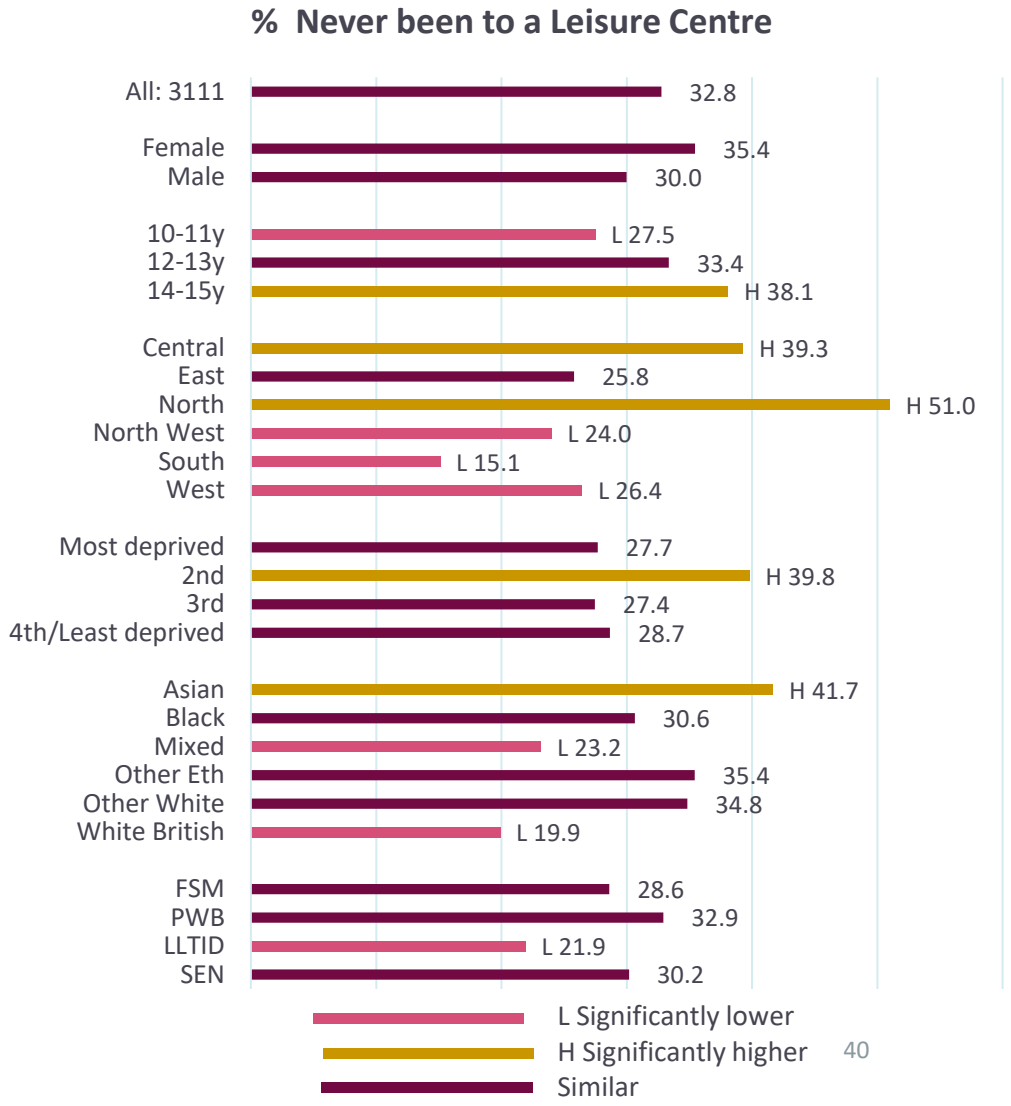
43. Have you ever used these services . . . ? Never been to a leisure centre

Overall about one in three 10 to 15 year old children report they have never been to a leisure centre.

Older children are significantly more likely to have never been compared to younger children.

Those from the Central and East areas are significantly more likely to have never been to a leisure centre.

Asian children are significantly more likely to have never been to a leisure centre.



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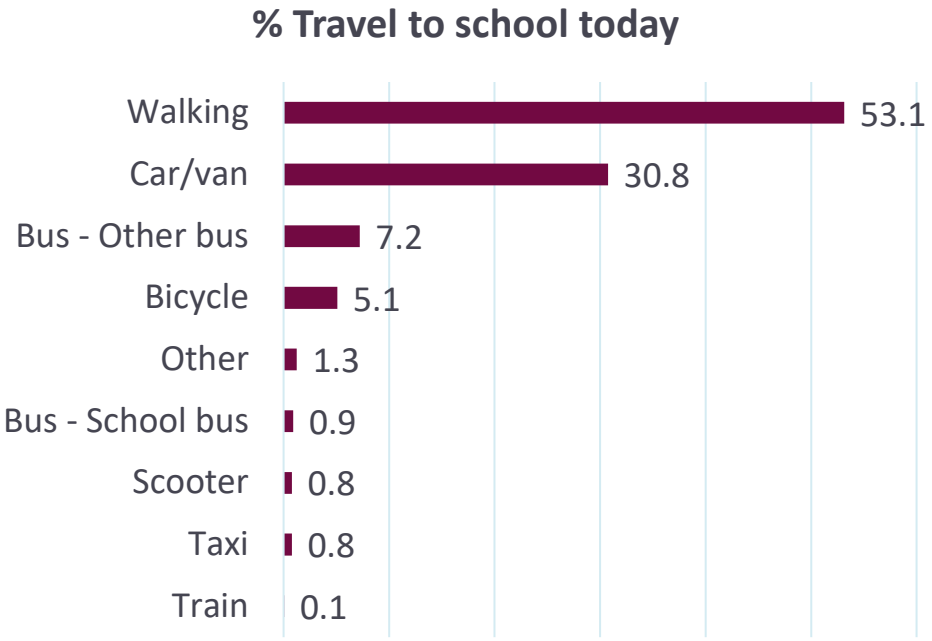
Additional groups: *FSM- Free School Meals*
PWB – Poor Wellbeing
LLTID – Long term limiting illness or disability
SEN Special Educational Need

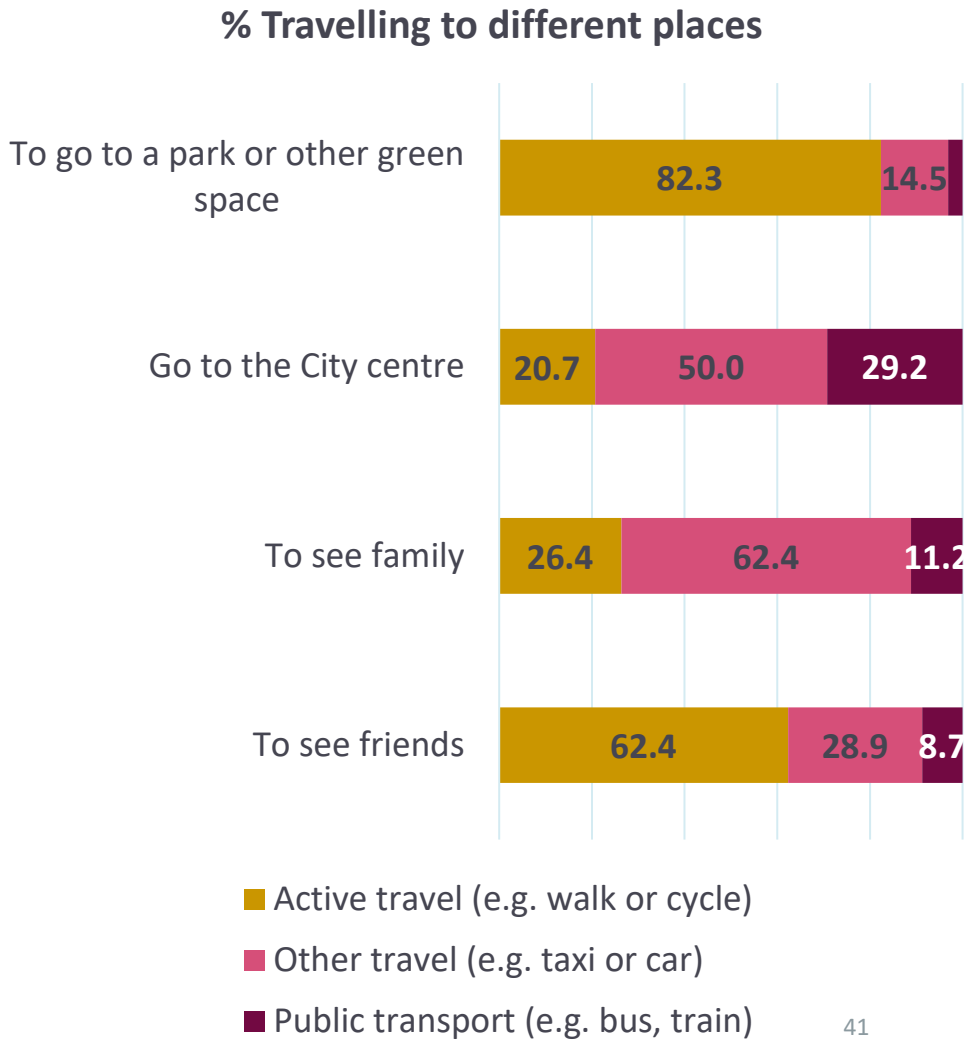
Active travel (walking & cycling) to school, the park, and to see friends is common. Private car is the most common method of travel to the city centre and to see family.

32/33. How did you travel to school today? How would you usually travel to do the following in Leicester?

Over half of children (53%) walked to school, about a third (31%) came by car/van.

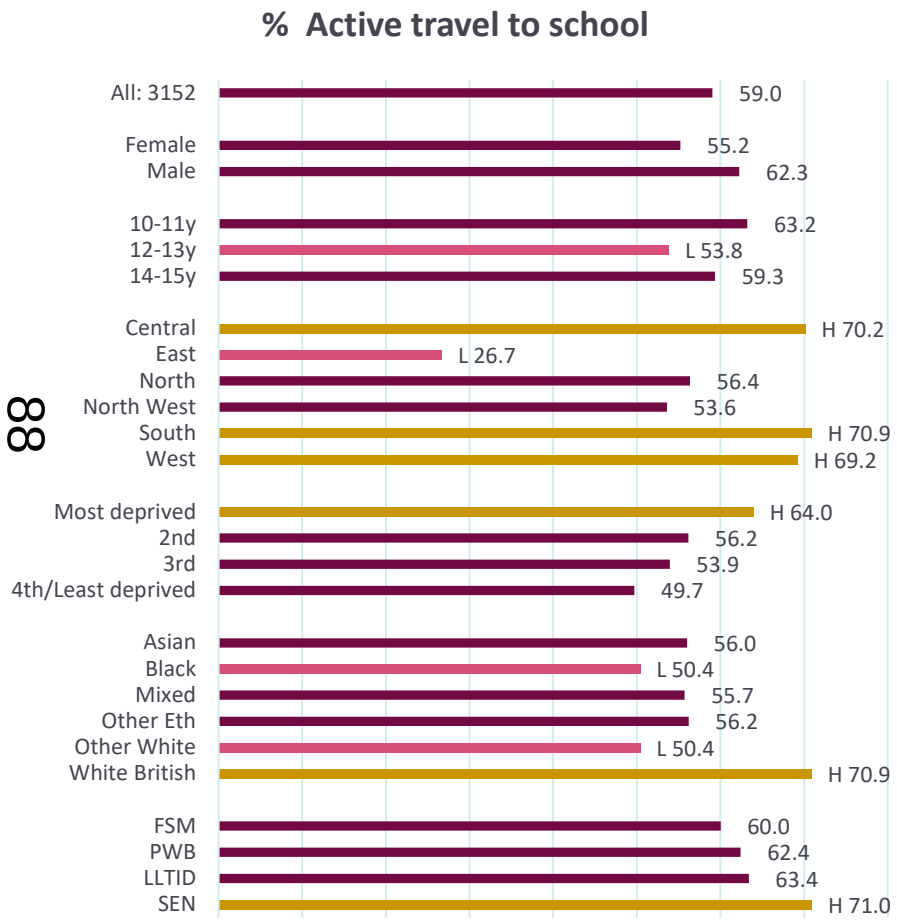
The remainder take other forms of transport including bus (7%) and bike (5%).

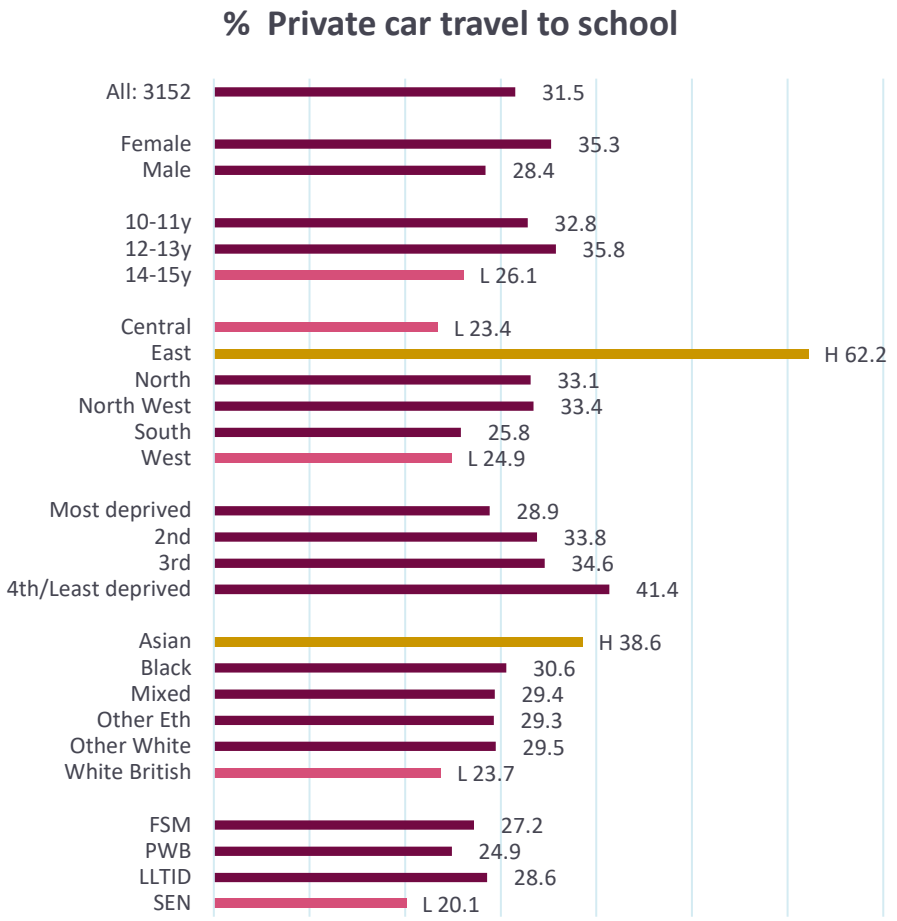




About six out of ten children (59%) actively travel to school by walking, scooting or cycling. However there are significant differences by areas and different groups. Children in the east are significantly less likely to actively travel and significantly more likely to travel by car.

32. How did you travel to school today?





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L Significantly lower
H Significantly higher
Similar

Internet use, leisure and sleep

- 99% of children have access to the internet at home. The most common way to access the internet is via a mobile phone.
- About a quarter of children spent five or more hours looking at a screen the day before the survey.
- The most popular after school activities include screen time activities such as watching tv, playing screen based games, and texting on a phone.
- Two in five children are sleeping late (11pm or later) and are at risk of not getting enough sleep.
- About four in every five children have access to electronic devices in their bedroom.

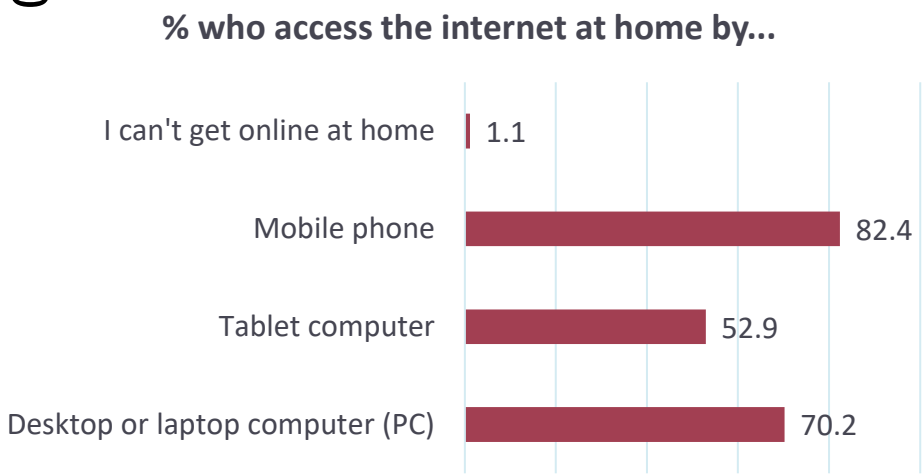
68

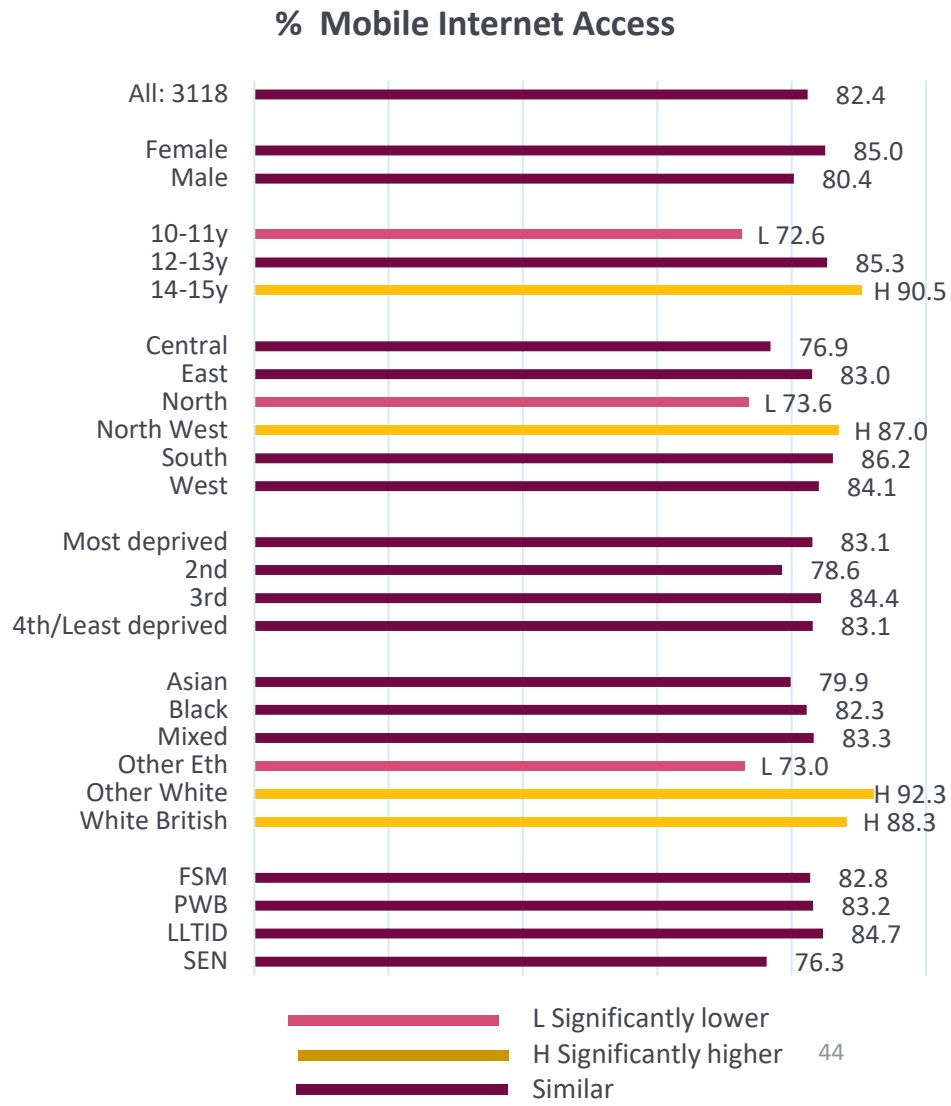
99% of children have access to the internet at home. Older children are significantly more likely to have mobile internet access. There are also differences by area and ethnicity.

34. Do you have access to the Internet ('get online') at home by…?

About four out of five (82%) children access the internet via a mobile phone, half (53%) with a tablet computer, and 70% with a laptop computer.

Some children's (15%) access to the internet is via a mobile phone only.





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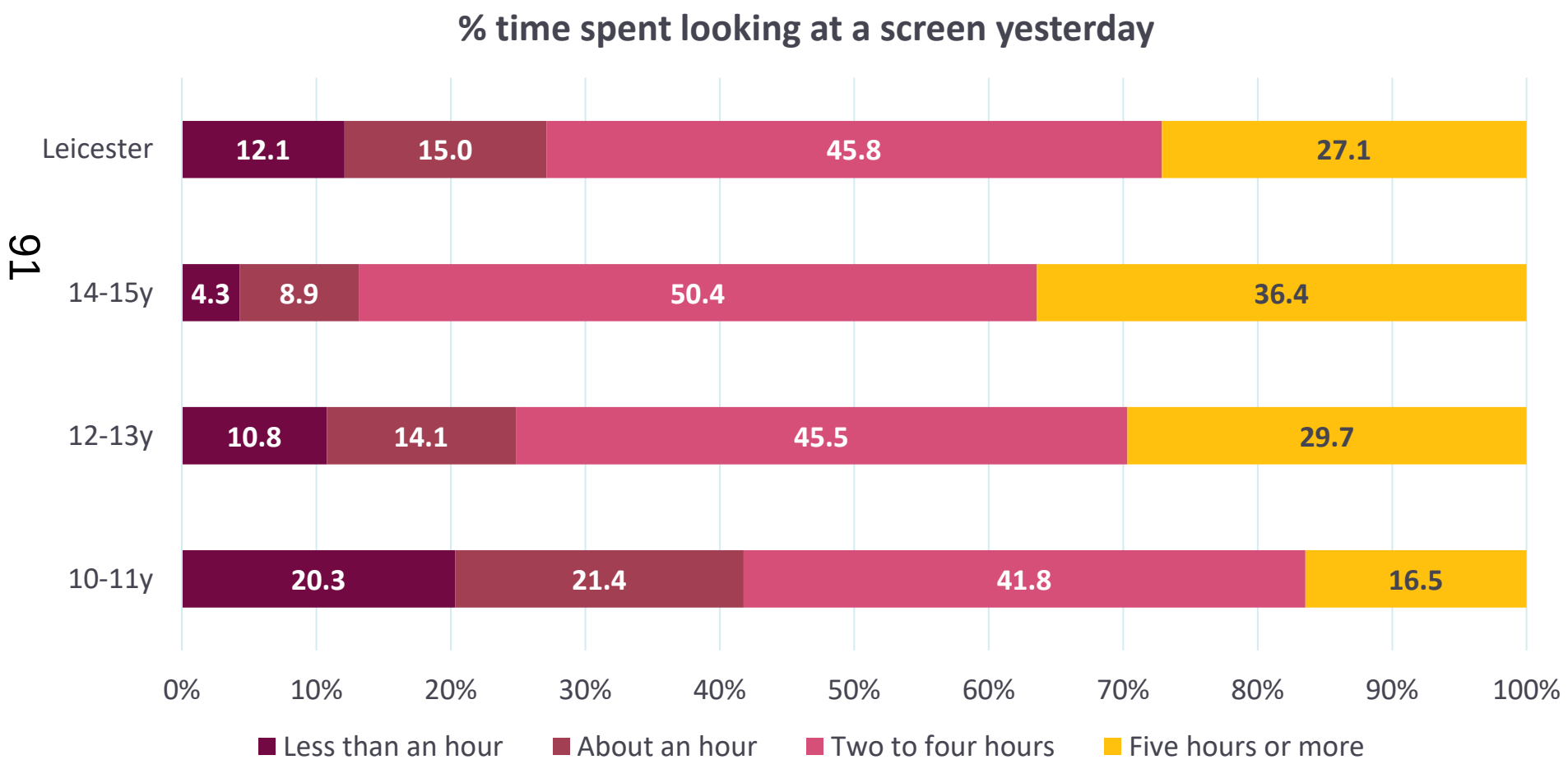
Over a quarter (27.1%) of 10-15 year olds spent five or more hours yesterday looking at a screen. The chart below shows that older children are more likely to spend more time looking at a screen.

35. How long did you spend looking at a device screen yesterday?



Looking at a screen for long periods of time is linked with sedentary and a physically inactive lifestyle. Over a quarter (27.1%) of children are looking at a screen for five or more hours. Some groups of children are significantly more likely to spend many hours looking at screens.

35. How long did you spend looking at a device screen yesterday? Five hours or more

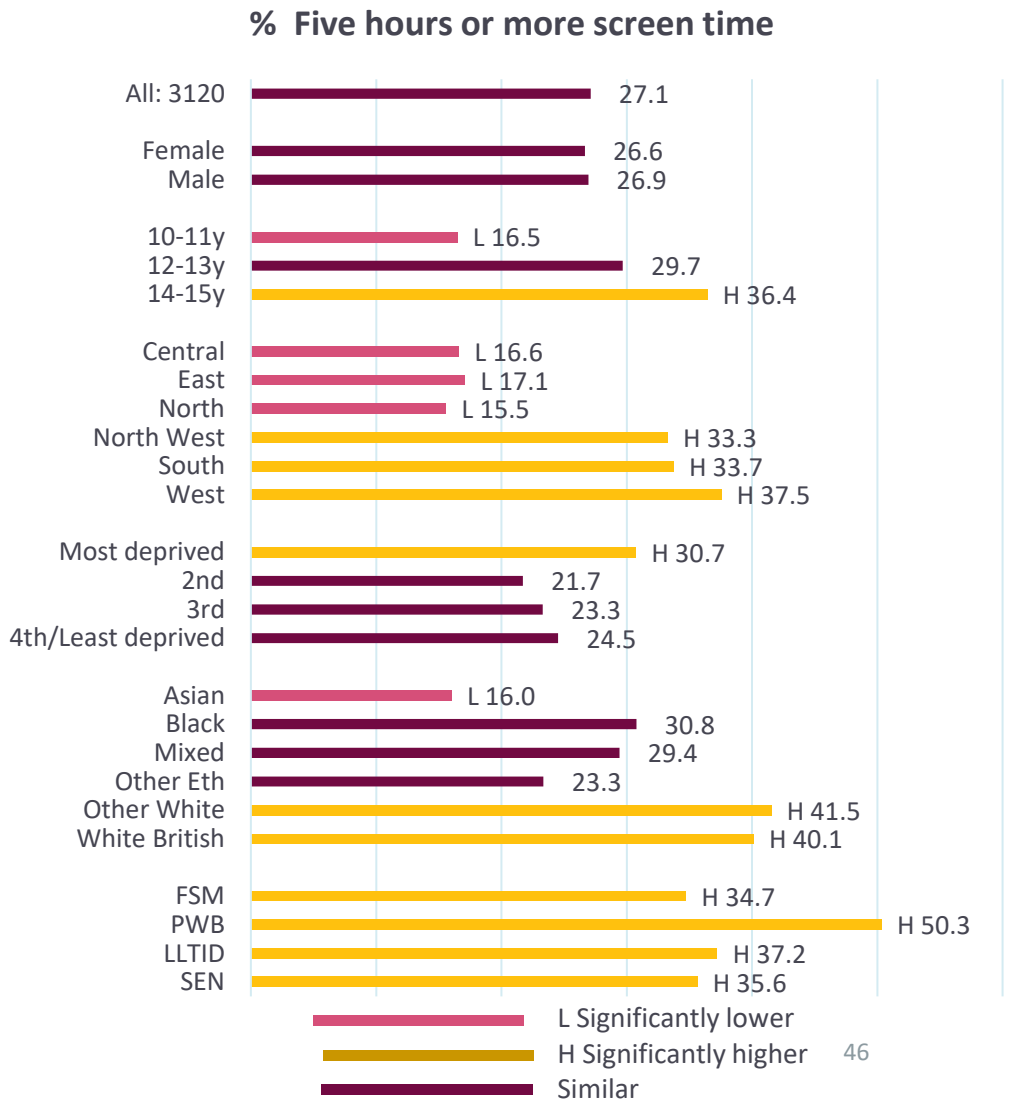
Older children aged 14 to 15 are significantly more likely to spend five or more hours looking at a screen.

Children from the North West, South, and West are significantly more likely to spend five or more hours looking at a screen. Children from more deprived areas are also likely to spend more hours looking at a screen.

Half of children with a poor wellbeing score spend five or more hours looking at a screen.

2016/17	2021/22	Significant change
22.1%	27.1%	Increase since 2016/17

There has been a significant increase in children looking at a screen for five hours or more since 2016/17.



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The most popular after school activities include screen time activities such as watching tv, playing screen based games, and texting on a phone. However, children are involved in a range of activities including doing homework, listening to music, sports, reading, pet care, and caring for family. Younger children are significantly more likely to read for pleasure compared to older children.

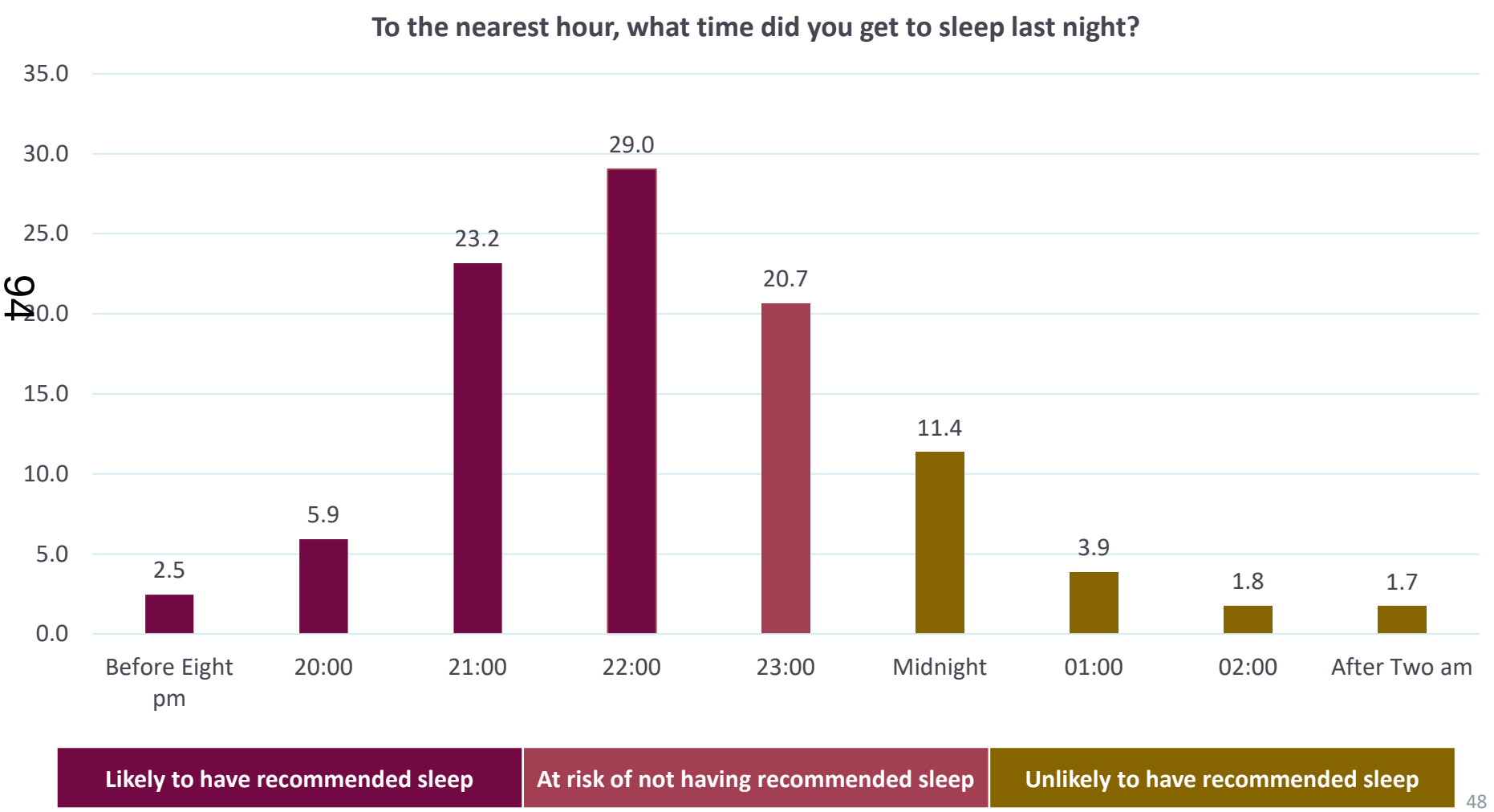
36. Did you spend any time doing any of these things after school yesterday?

Leisure Activity	All	10-11 year olds	12-13 year olds	14-15 year olds
Watching TV/film (live, online, catch-up)	76.0	83.3	71.0	72.7
Playing games on a phone, computer, tablet or console (e.g. Xbox, DS, etc.)	67.0	73.5	67.1	59.9
Talking/texting on the 'phone	59.5	47.1	62.5	70.5
Listened to music	49.2	47.4	48.5	51.9
Doing homework	47.1	48.3	51.6	41.6
Sport/physical activity	40.3	47.7	42.6	29.8
Read a book for pleasure	32.6	50.7	25.7	19.3
Talking/messaging online e.g. Facebook, Twitter	26.7	18.5	28.0	34.5
Met with friends	26.1	24.3	25.8	28.3
Cared for pets	25.7	29.3	27.5	19.9
Used a computer for school work	24.2	22.5	26.7	23.9
Cared for family members (babysitting, minding grandparents, etc.)	19.3	23.0	16.6	17.9
Helping and volunteering outside the home	8.2	12.9	7.3	3.8
Played a musical instrument	7.8	10.6	8.0	4.7
Extra lessons/tutoring	6.8	8.6	5.2	6.3
Other	6.2	5.9	6.9	5.8
None of these	0.5	0.3	0.7	0.6

Significantly Higher than Leicester | Similar | Significantly Lower than Leicester

The NHS recommends that children require 9 to 13 hours sleep. Children will be waking by at least 8 to attend school. Therefore to have the minimum recommended amount of sleep children should be asleep by 11pm. Many children (39%) are sleeping late (11pm or later) and are at risk of not getting enough sleep.

38. To the nearest hour, what time did you get to sleep last night?



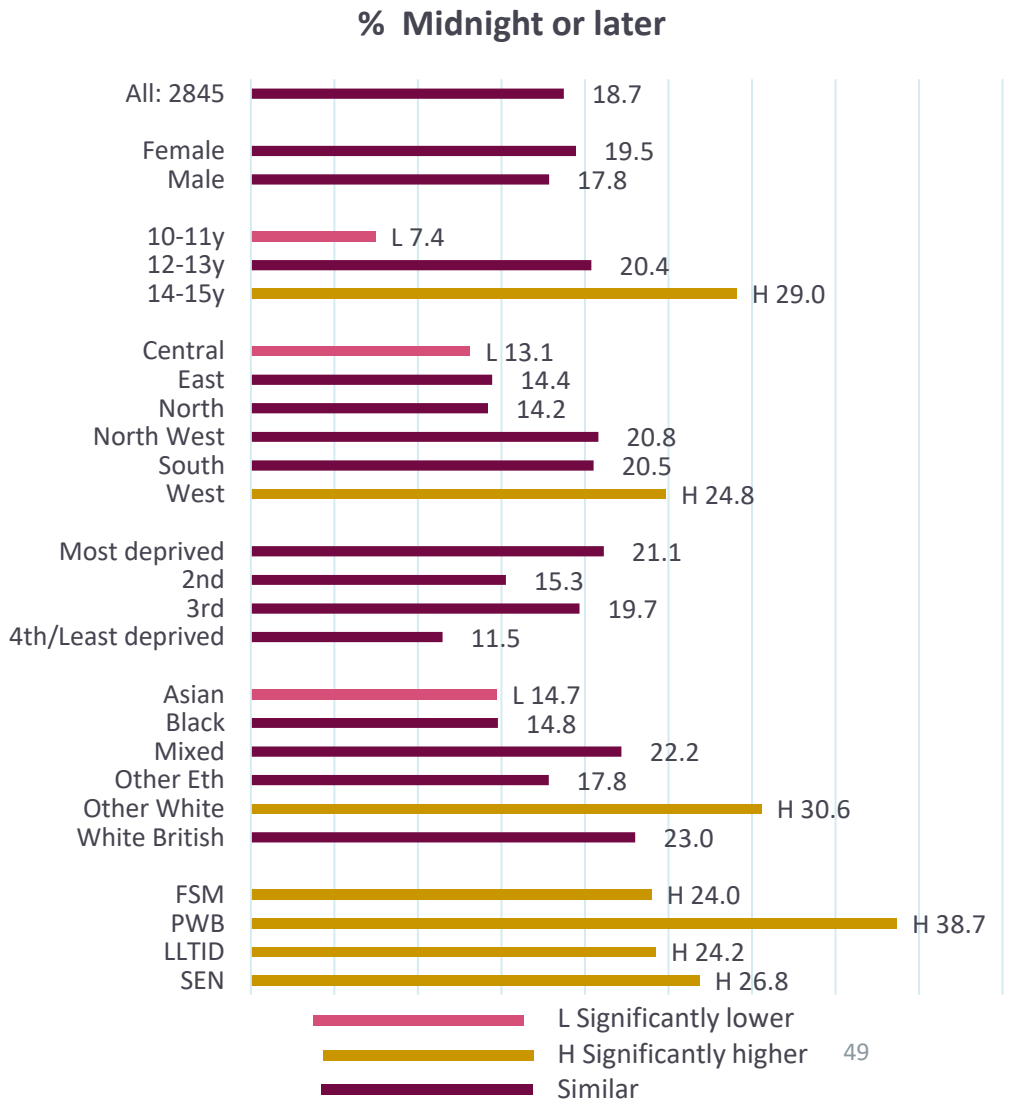
Children who are going to sleep at midnight or later are not getting the recommended amount of sleep and this is likely to affect their attention at school. About one in five (19%) of children are going to sleep at midnight or later.

38. To the nearest hour, what time did you get to sleep last night? Midnight or later

Older children aged 14 to 15 are significantly more likely to be sleeping at midnight or later.

Children from the West are significantly more likely to go to sleep at midnight or later.

Over a third (39%) of children with a poor wellbeing score sleep at midnight or later.



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Electronic devices are known to emit blue light which may affect the body's natural sleep cycle. In order to allow the mind to settle and be ready for sleep, it is advised that screens are avoided 60 minutes before planning to go to sleep.

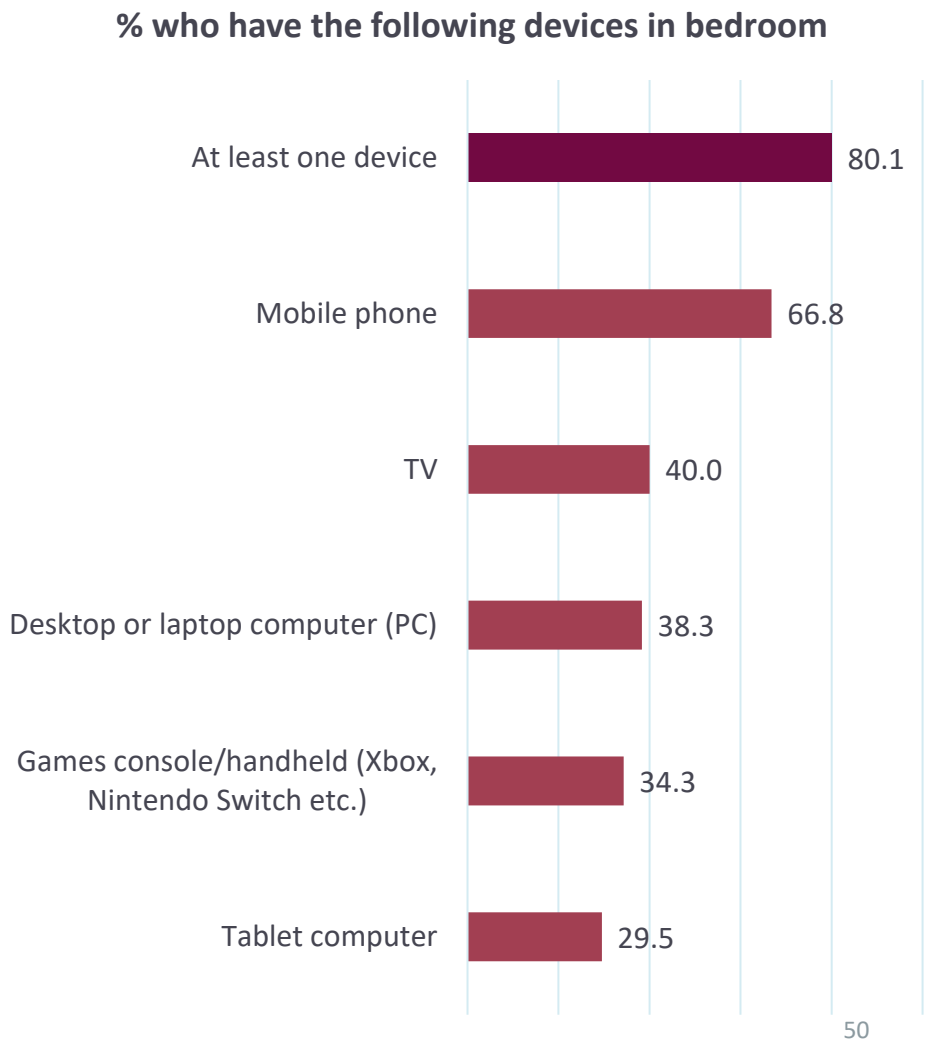
39. Do you have any of these in the room where you sleep?

About four in every five (80%) children have access to electronic devices in their bedroom.

About two out of every three have a mobile phone with them in their bedroom.

Other popular devices include tv, personal computer, and games console.

Children with devices in their room go to sleep later.

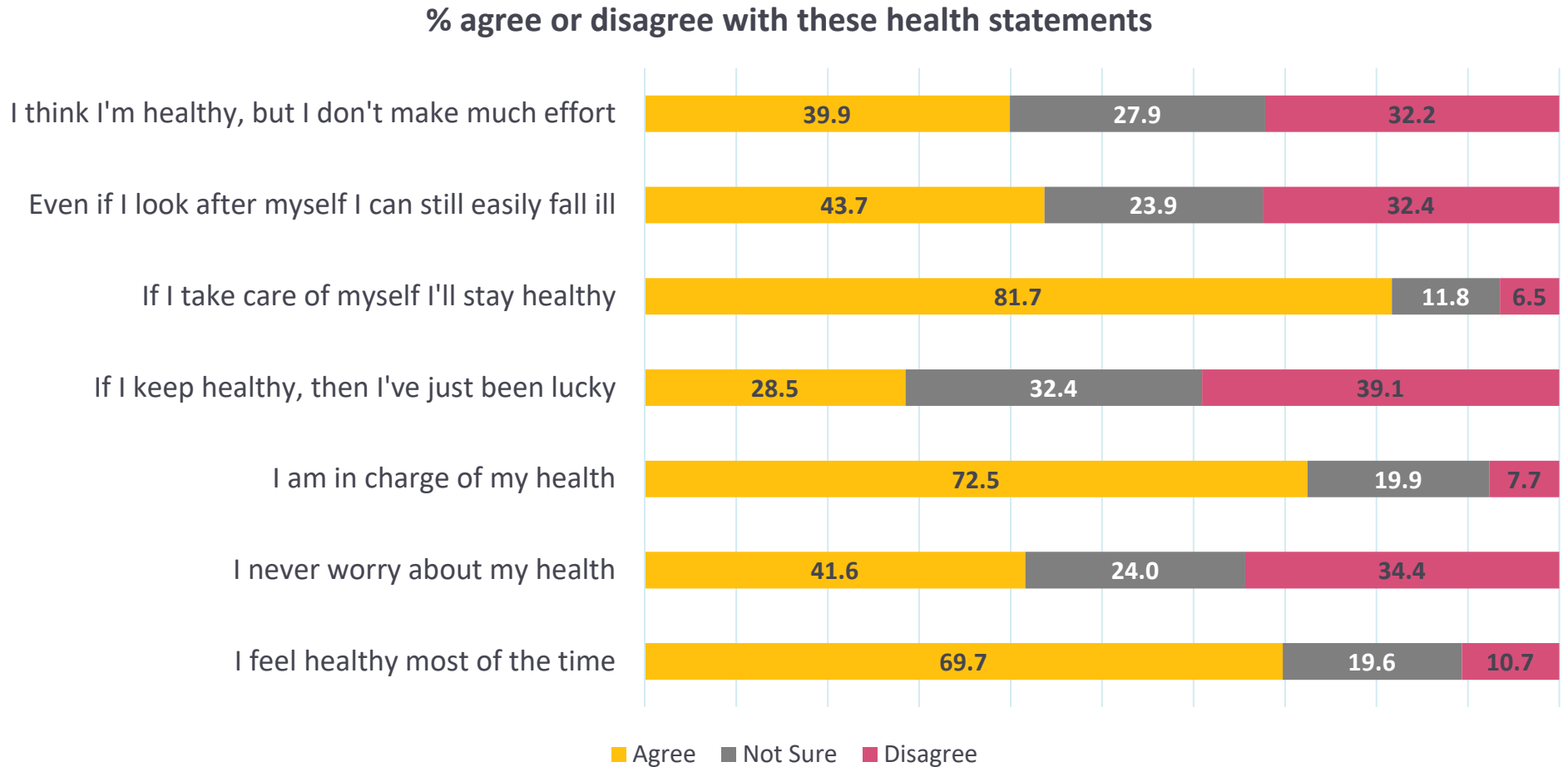


Overall health, oral health and use of services (including Covid -19)

- Most children were positive about their health and agreed with statements such as ‘if I take care of myself I’ll stay healthy’, ‘I am in charge of my health’ and ‘I feel healthy most of the time’.
- The most used health and wellbeing service is the dentist, with two thirds of children having visited a dentist in the last 12 months.
- About half or more of Leicester children have visited the following health services; doctor, pharmacy, optician, and COVID-19 test centre in the last 12 months.
- Nearly one in ten children have never been to a dentist. This is a significant increase compared to 2016/17 when about one in twenty children had never been to a dentist. There has also been a significant increase in the proportion of children brushing their teeth less than twice a day.
- Most children have reported that they have been to a COVID-19 test centre. Four in ten children have had a positive COVID-19 test, and just over six in ten live with someone who has had a positive test.
- About four in ten children are unlikely to have a COVID-19 vaccination if offered.

Secondary aged children were asked how much they agree or disagree with a range of health statements. Four out of five agreed with 'if I take care of myself I'll stay healthy'. While about two in five had a fatalistic view that 'even if I look after myself I can still easily fall ill'.

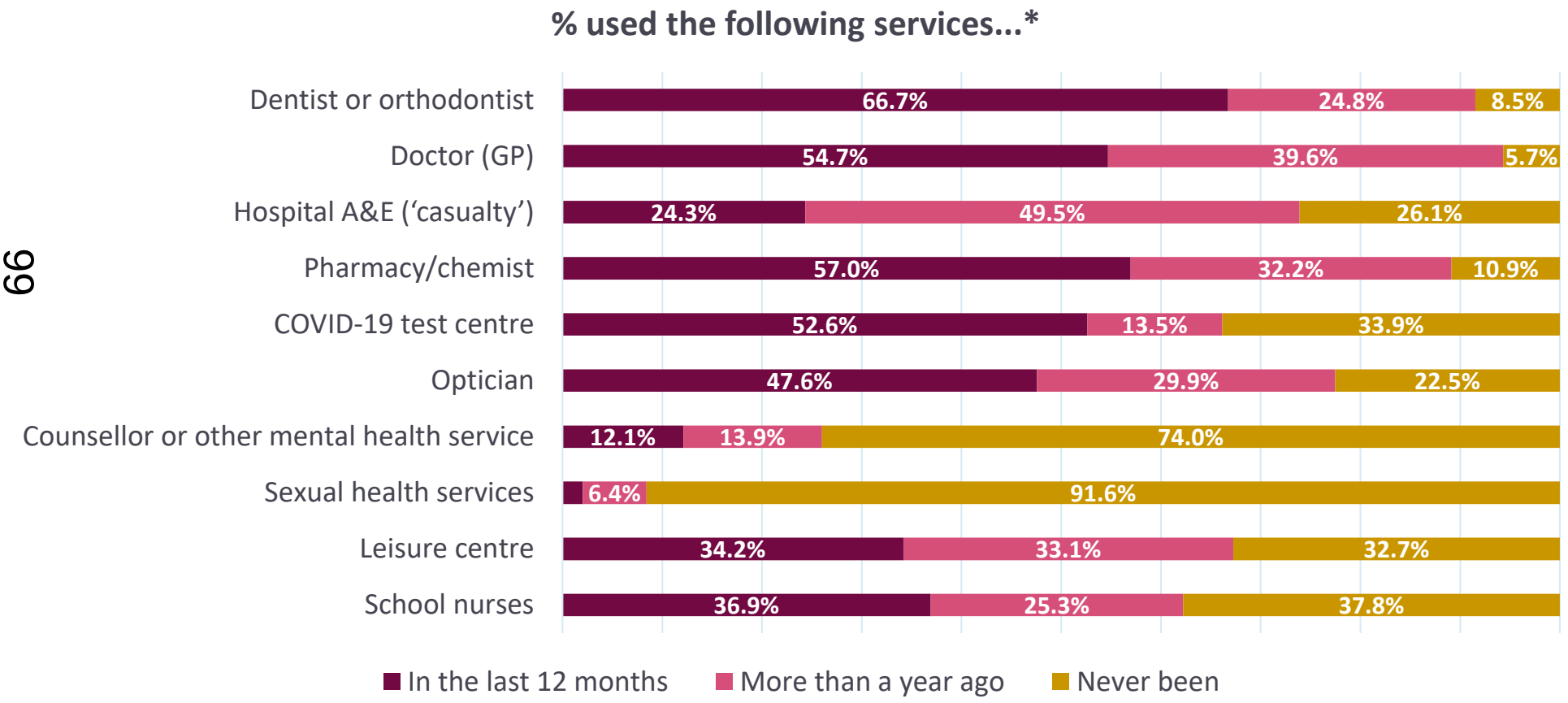
41. How much do you agree or disagree with these statements?



Note: *Secondary aged children were asked to reply to questions about their health.*

About half or more of Leicester children have visited their dentist, doctor, pharmacy, optician, and COVID-19 test centre in the last 12 months. One in four children have used A&E at the hospital in the last 12 months. One in four children have used a counsellor or other mental health service in the last 12 months or more than a year ago.

43. Have you ever used these services . . . ? List of health and wellbeing services



Health and wellbeing services:
Counsellor or other mental health services ,sexual health services, and school nurses were answered by secondary aged children only

The majority of Leicester children have visited a dentist in the last 12 months and others have visited more than a year ago. However, nearly one in ten (9%) children reported never having been to a dentist or orthodontist.

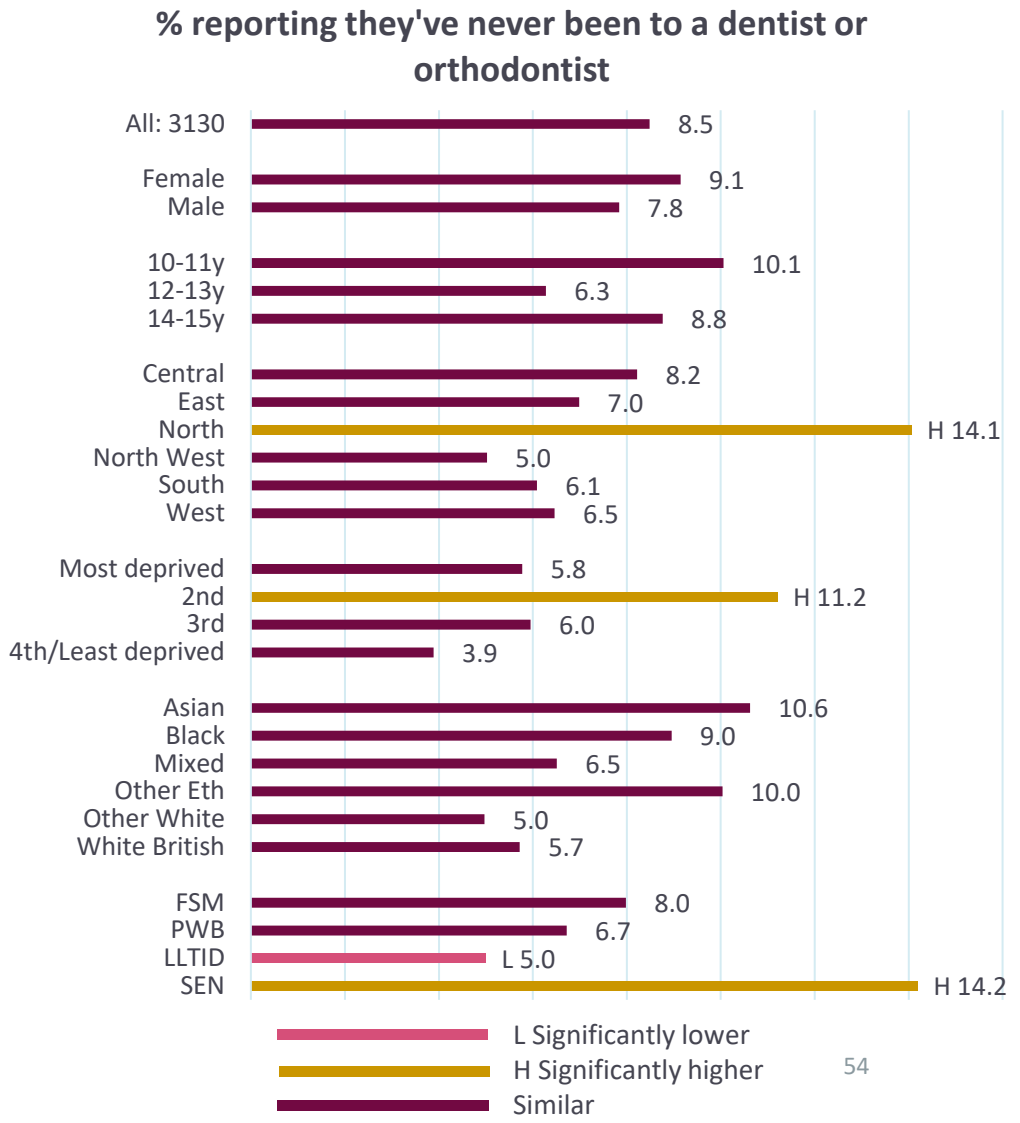
43. Have you ever used these services . . . ? Dentist or orthodontist

Children in the North of the city (14%), those living in the 2nd most deprived quintile (11%) and SEN students (14%) were significantly more likely to report having never been to a dentist or orthodontist.

Children with a LLTID were significantly more likely to have visited a dentist or orthodontist.

2016/17	2021/22	Significant change
4.3%	8.5%	Increase since 2016/17

There has been a significant increase in children never having been to the dentist since 2016/17.



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PWB – Poor Wellbeing
LLTID – Long term limiting illness or disability
SEN Special Educational Need

About one in five (19%) children brush their teeth less than twice a day. Males are significantly more likely to brush their teeth less than twice a day compared to females.

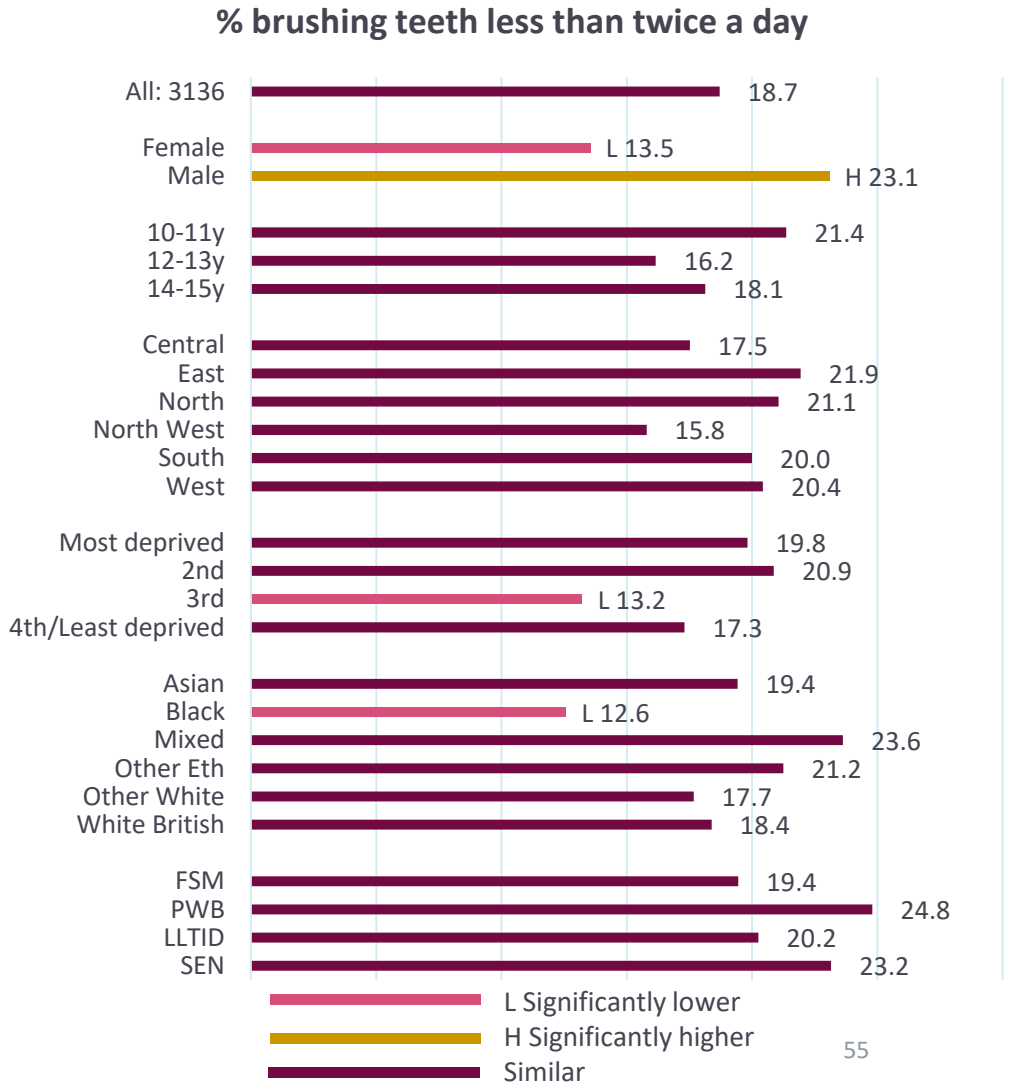
42. How many times do you usually clean your teeth each day?

Those of Black ethnicity had significantly better teeth brushing behaviour.

There doesn't appear to be a clear relationship with deprivation.

2016/17	2021/22	Significant change
15.6%	18.7%	Increase since 2016/17

There has been a significant increase in the percentage of children who brush their teeth less than twice a day since 2016/17.



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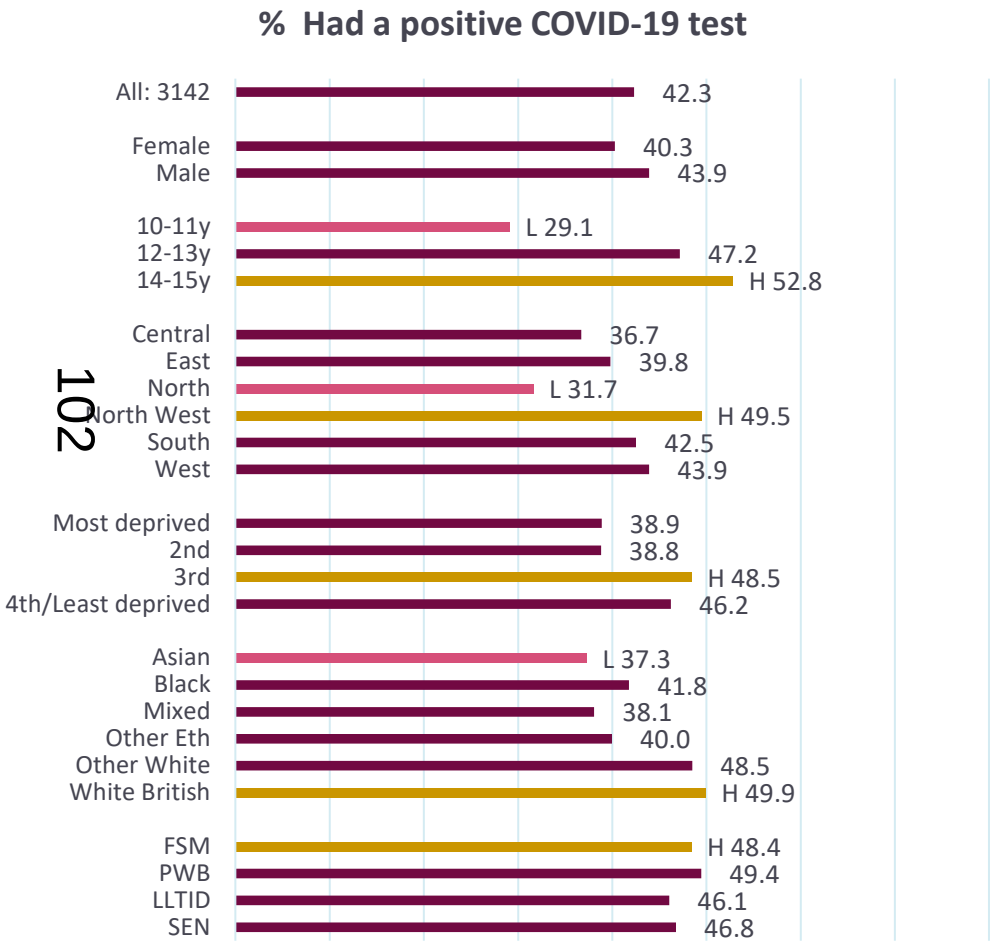
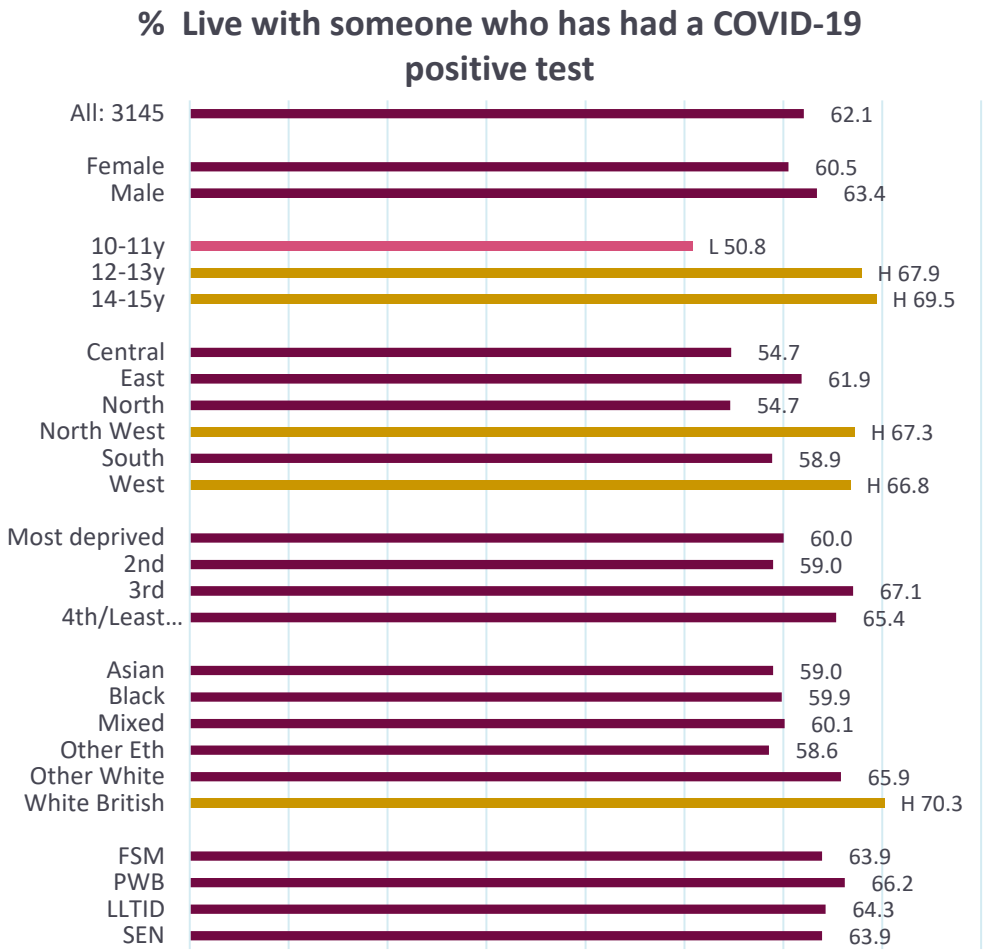
Two out of every three (66%) children have reported that they have been to a COVID-19 test centre. Over four in ten (42%) children have had a positive COVID-19 test, and just over six in ten (62%) live with someone who had a positive test. Differences can be seen below.

44/45. Have you had or a member of your household had a positive test for COVID-19? Yes





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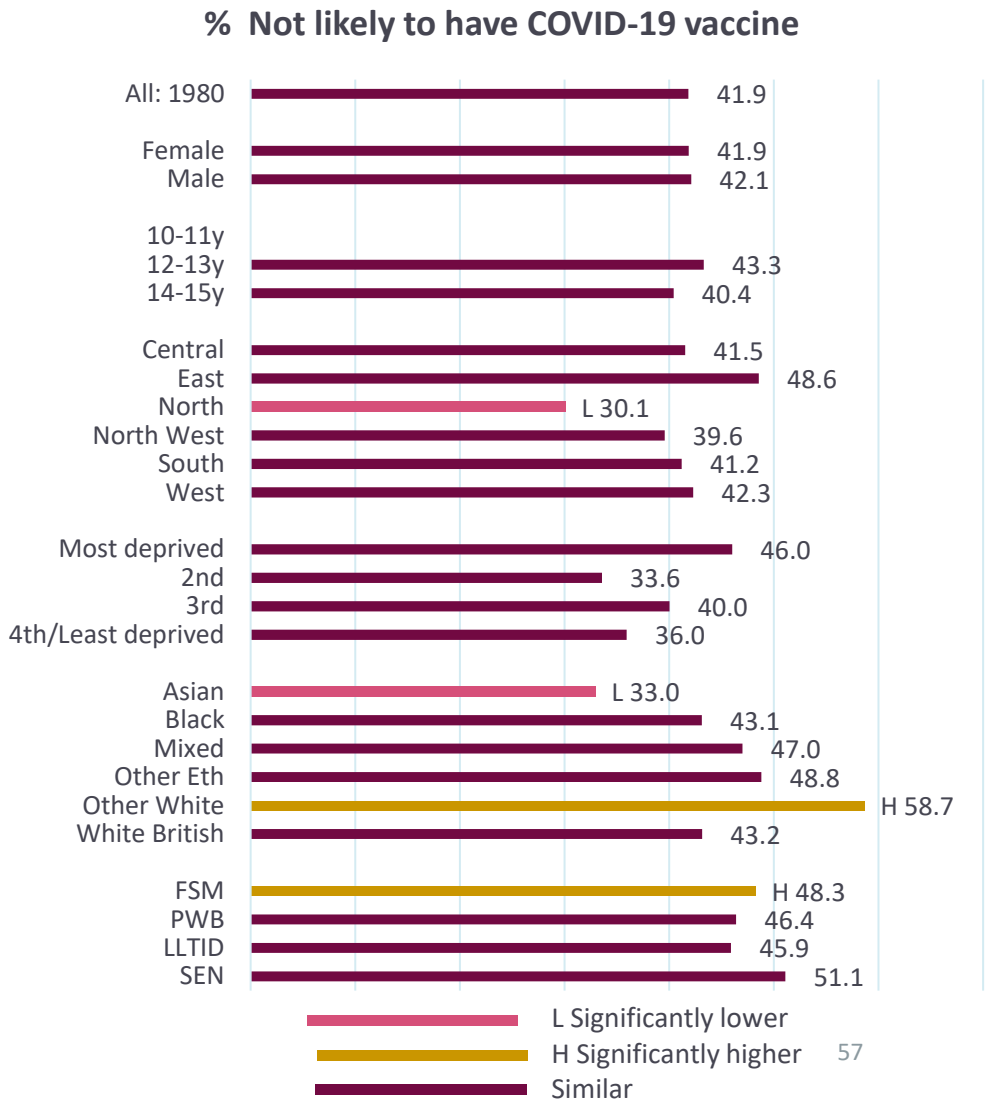
About 60% of 12 to 15 year old children report that they have already had or are likely to have the COVID-19 vaccine. This leaves about twelve children in an average class of thirty (42%) who are not likely to have a COVID-19 vaccine.

46. If you are offered a vaccine for COVID-19 (coronavirus), how likely would you be to take it? Not likely

There is little difference in age and gender regarding COVID-19 vaccine hesitancy.

There is variation by geography in the city. Children in the North of Leicester are significantly less likely to be vaccine hesitant. There is higher hesitancy in the East, but this is not a significant difference.

By ethnicity Asian children are significantly less likely to be hesitant and children from Other White backgrounds are significantly more likely to be hesitant.



Note: *Only Secondary aged children were asked to respond to this question*

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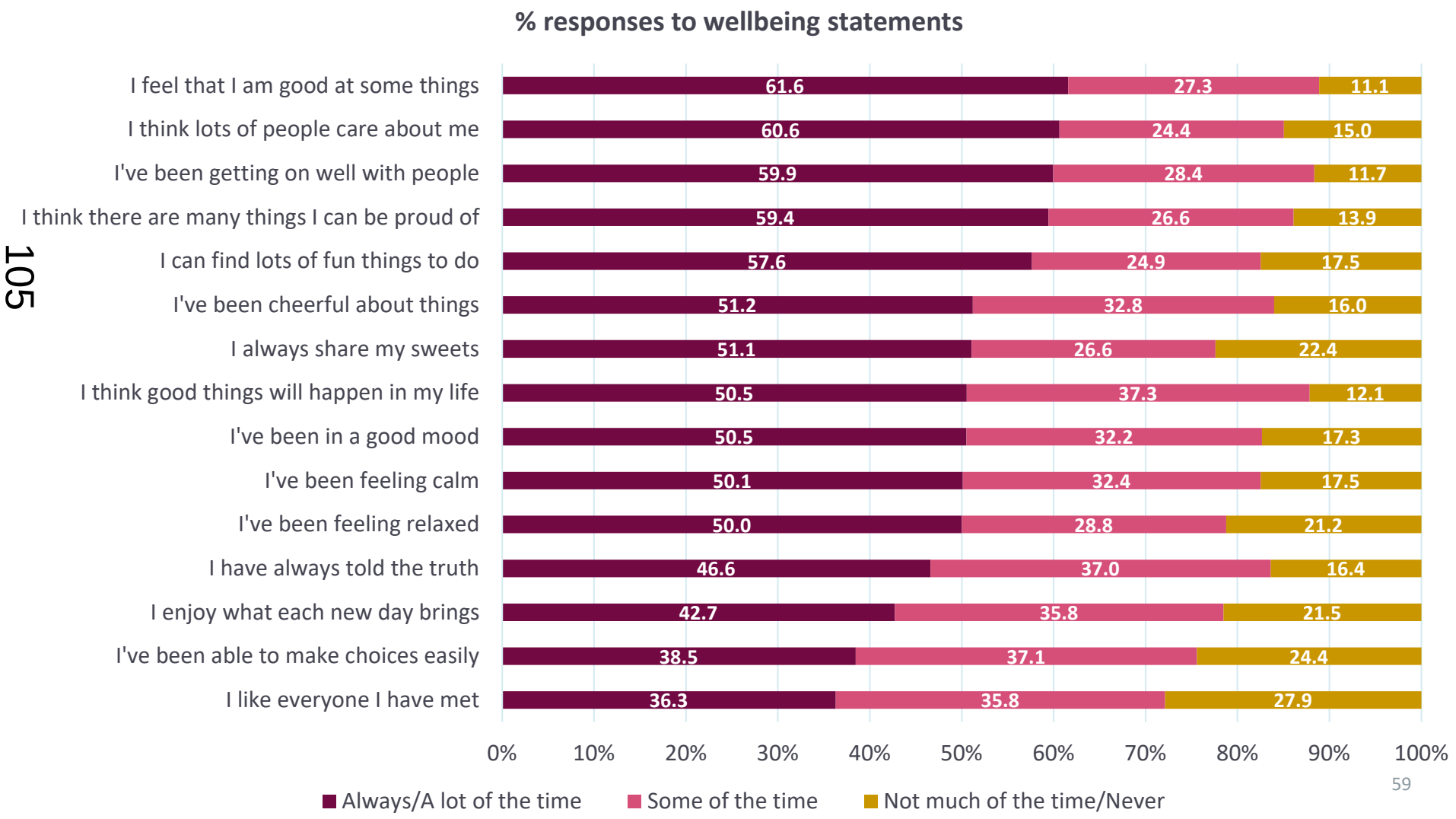
Emotional wellbeing

- Three out of four Leicester children report a medium to high wellbeing score indicative of good mental health.
- About one in ten children report a score indicative of poor mental wellbeing. Vulnerable groups such as those with a long term illness are more likely to report poor mental wellbeing.
- One in ten children report having no trusted adult to talk to. Children with no adult confidant show signs of poorer resilience, and are significantly more likely to report a poor mental wellbeing score.
- It is normal for children to worry, four out of five children worry about at least one issue quite a lot. The biggest worries include school work, health of a family member (physical and mental), and physical looks.
- Children react to their worries differently. Of concern, are the one in seven children who have at least sometimes reacted to a worry by self harming.
- An estimated 13 children in a classroom of 30 never like to talk about their feelings.

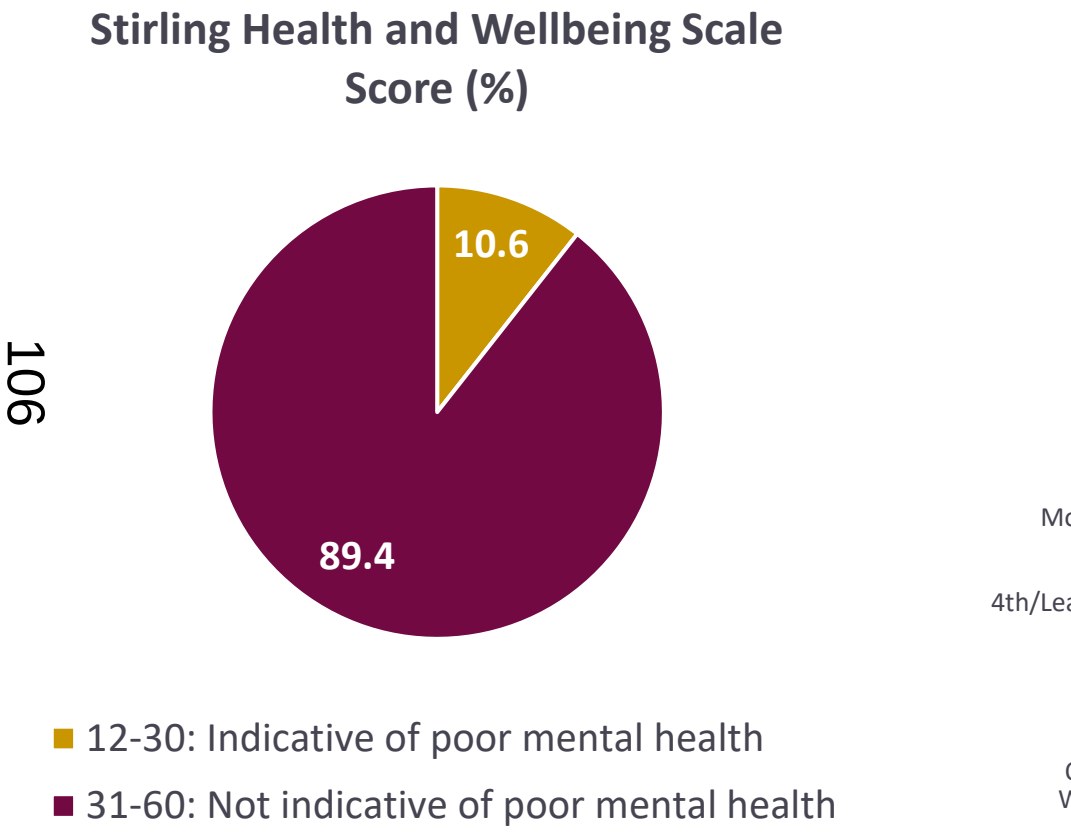
Leicester children were questioned using the Stirling Children's Wellbeing Scale. Over 60% of children always/a lot of the time feel they are good at some things. About one in five never/not much of the time share their sweets.

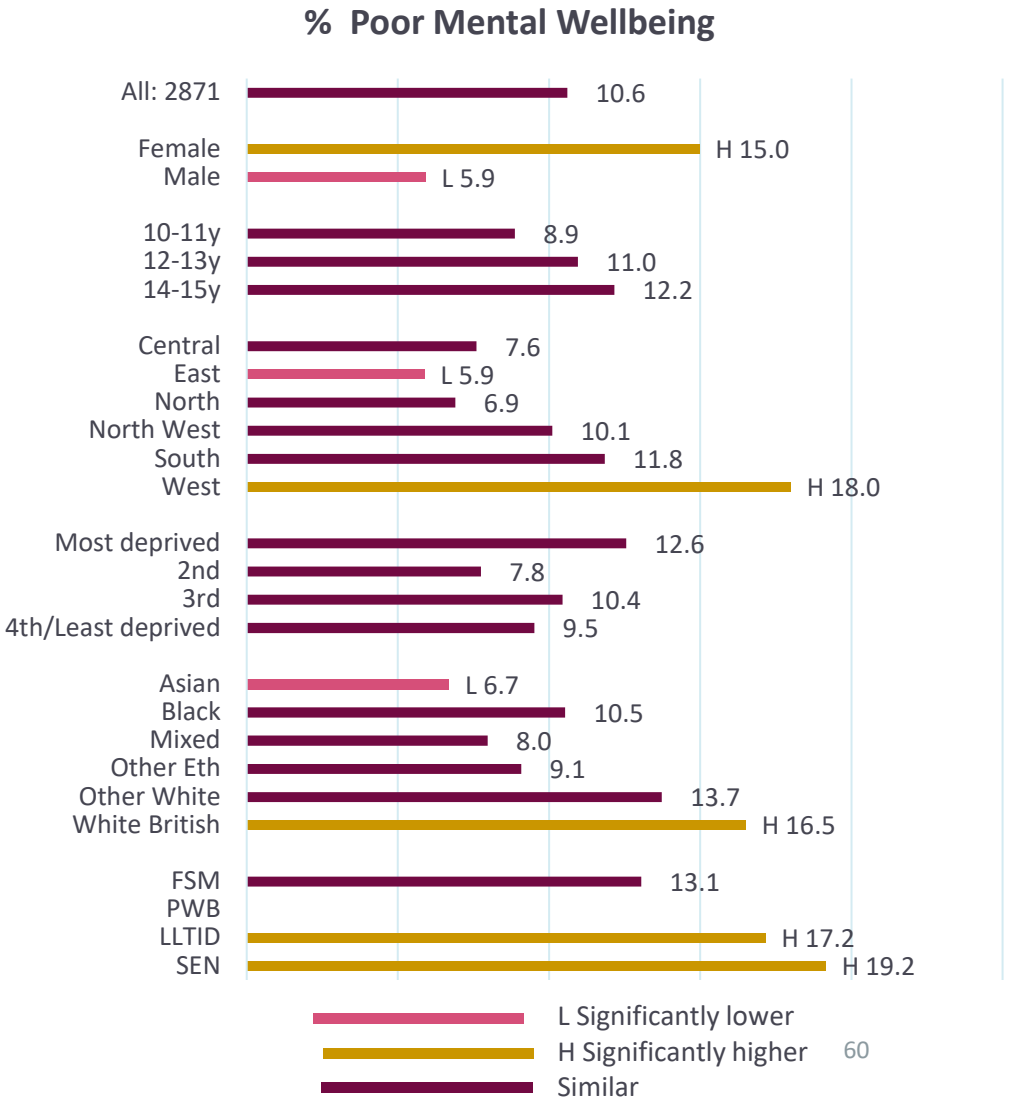
47. The Stirling Children's Wellbeing Scale. Statement analysis



One in ten Leicester children have a poor mental wellbeing score. Girls are more likely to have a poor wellbeing score. Children with a disability or long term illness and children with special education needs also report higher poor mental wellbeing scores.

47. The Stirling Children's Wellbeing Scale. Scoring indicates poor mental wellbeing





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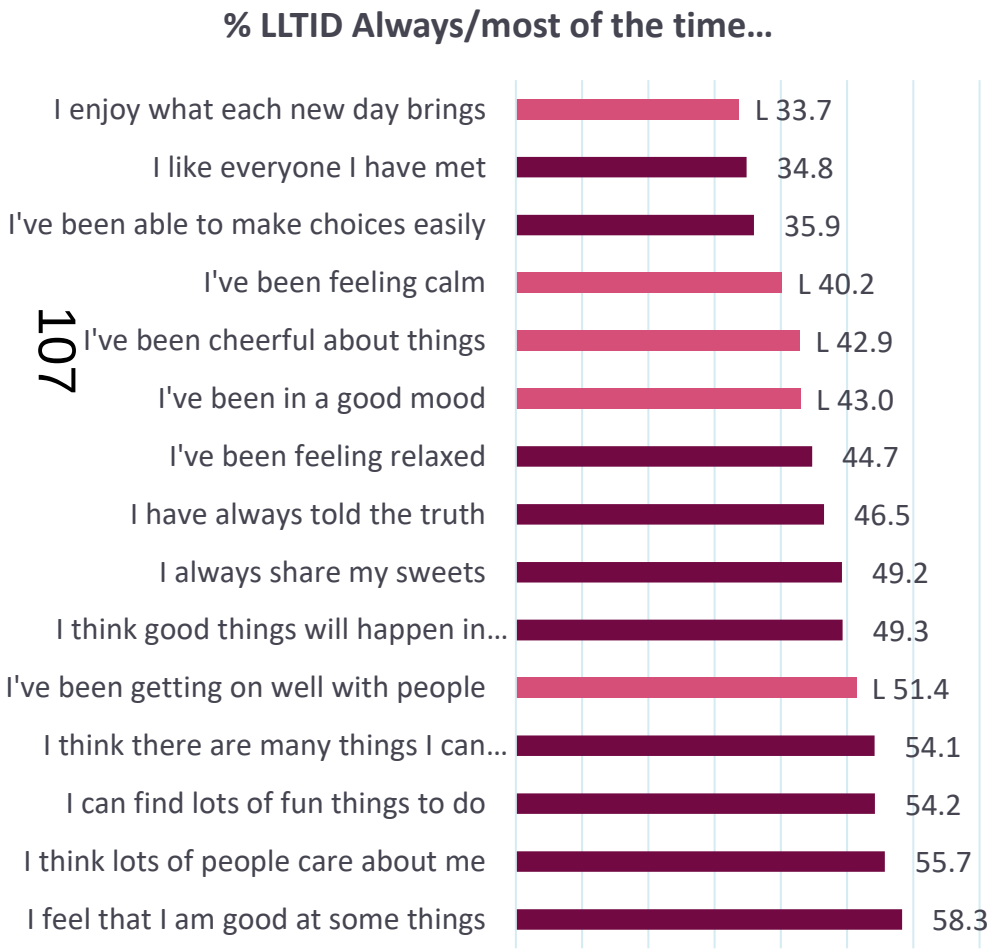
SEN Special Educational Need

Children with a long term illness or disability are significantly less likely to always/most of the time… enjoy what new days bring, feel calm, be cheerful about things, be in a good mood, and get on well with people compared to children with no long term illness or disability.

47. The Stirling Children's Wellbeing Scale. Long term illness disability statement breakdown.



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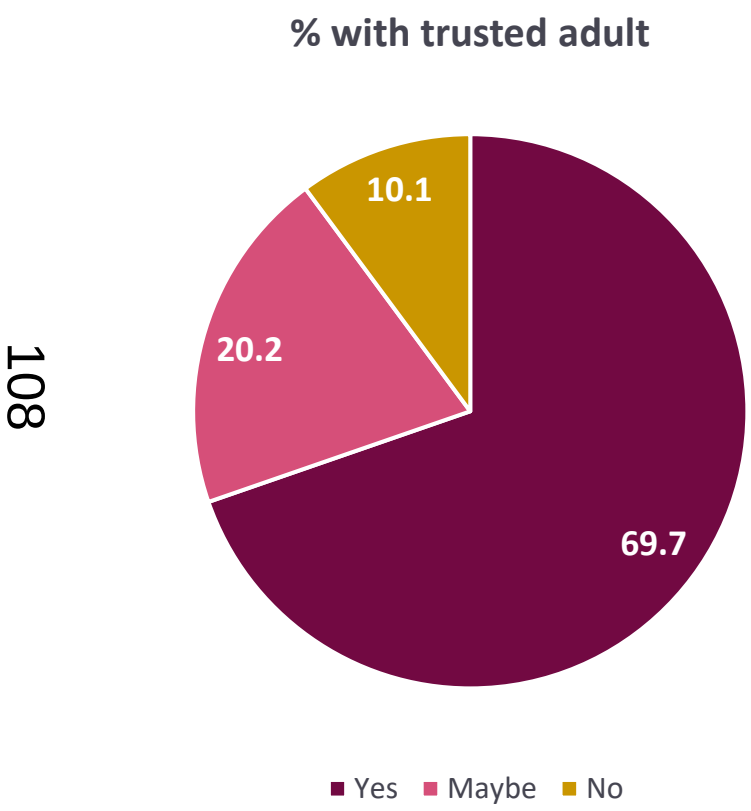
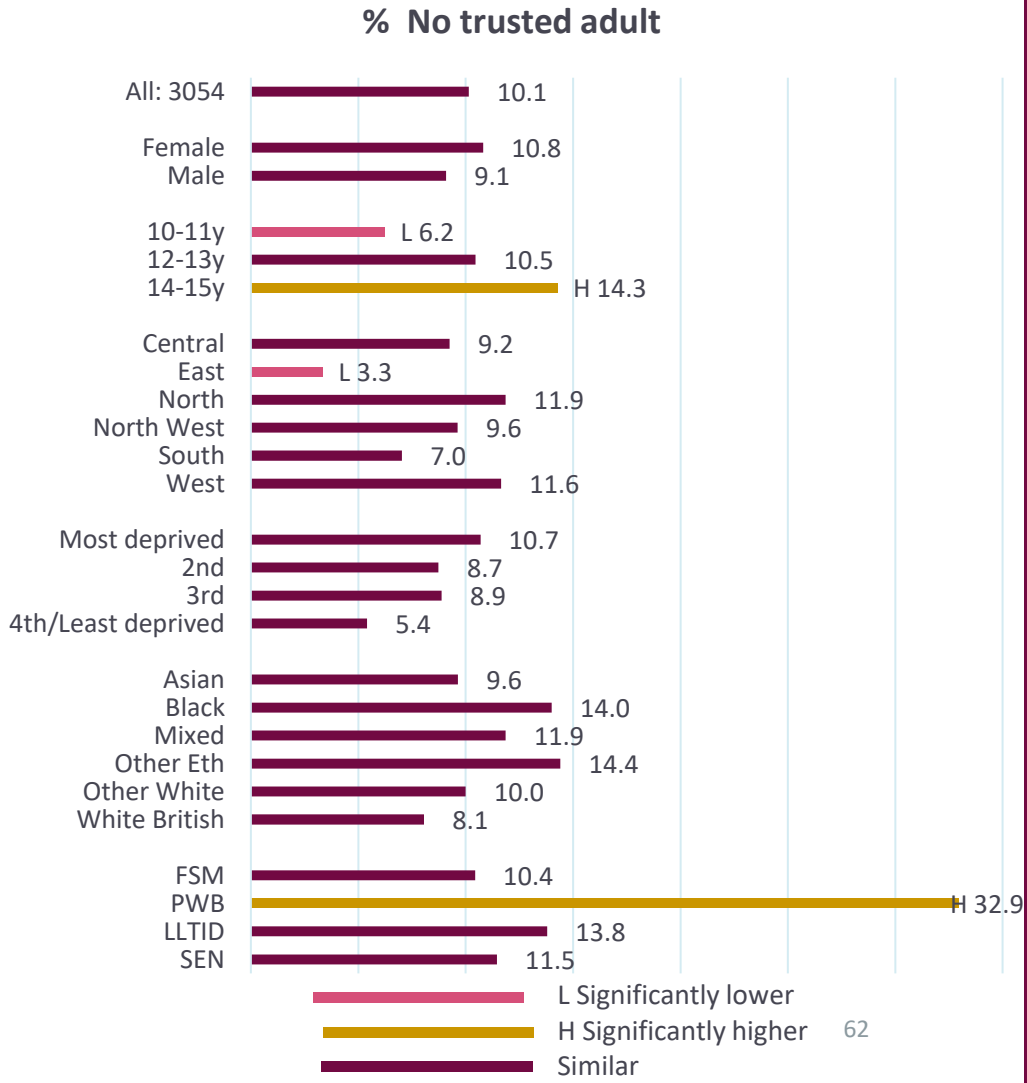
***LLTID** – Long term limiting illness or disability*

One in ten (10.1%) Leicester children do not have a trusted adult confidant, this is similar to the percentage of children who had no adult confidant in 2016/17. Older children were more likely to state they had no trusted adult. Those with a poor wellbeing score were significantly more likely to lack an adult confidant.

49. If you were worried about something, do you know an adult you trust who you can talk to about it?





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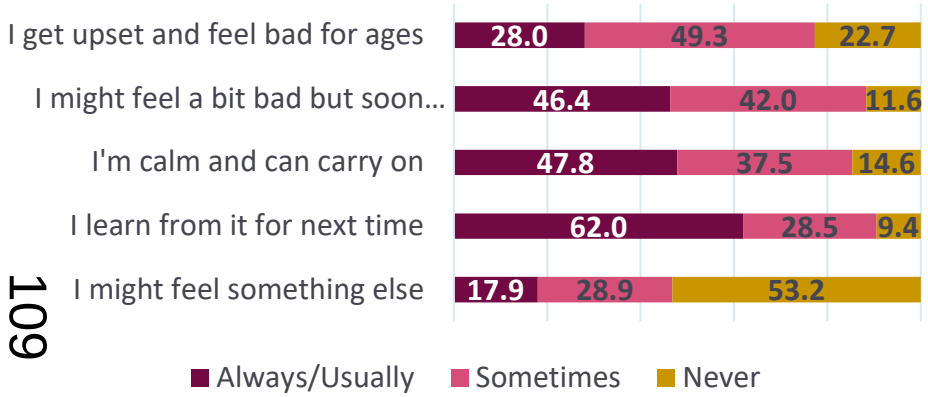
SEN Special Educational Need

Children deal with problems differently and some children find it more difficult when something goes wrong. Nearly two out of three children say they learn from bad experiences. A quarter (28%) of children always/usually get upset and feel bad for ages.

48. If something goes wrong... (resilience)

% responses if something goes wrong...



2016/17	2021/22	Significant change
22.9%	28.0%	Increase since 2016/17

There has been a significant increase in the percentage of children who show signs of **poor resilience (get upset and feel bad for ages)** since 2016/17.

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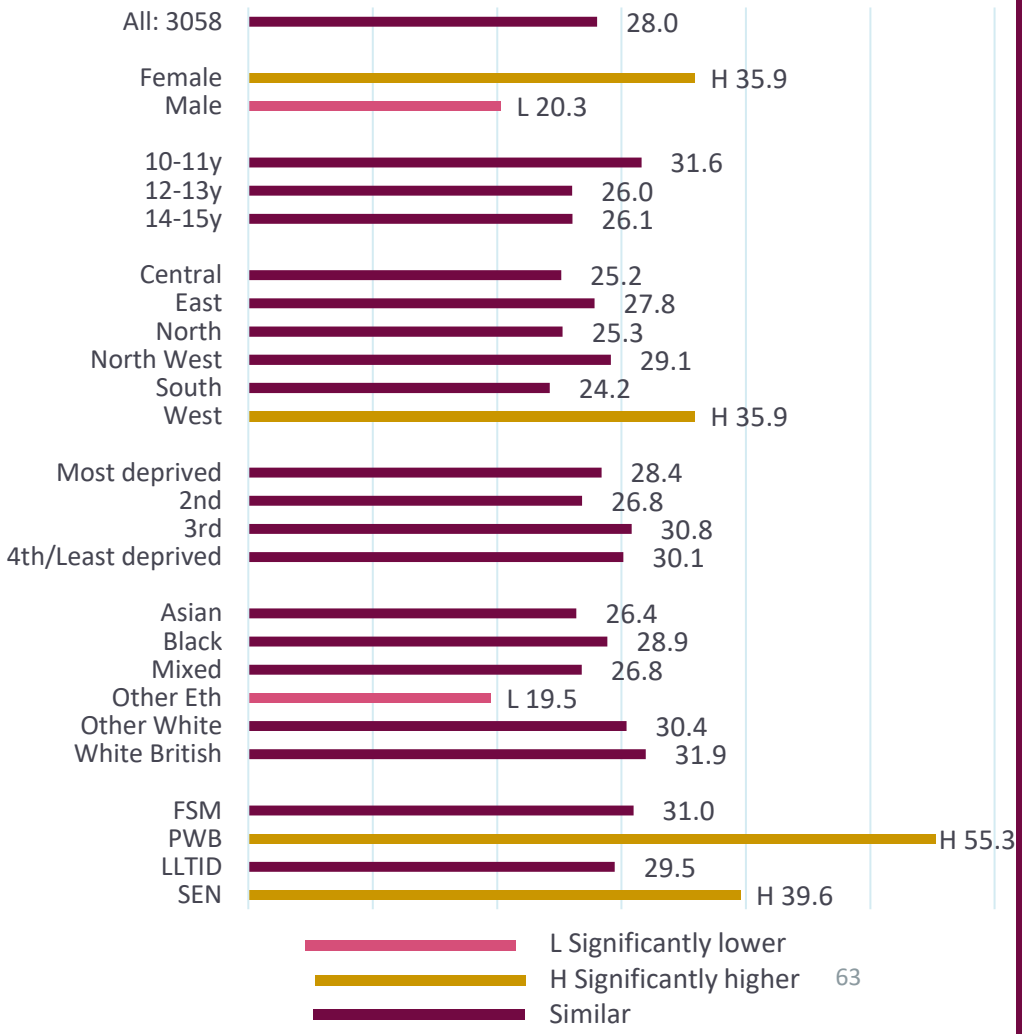
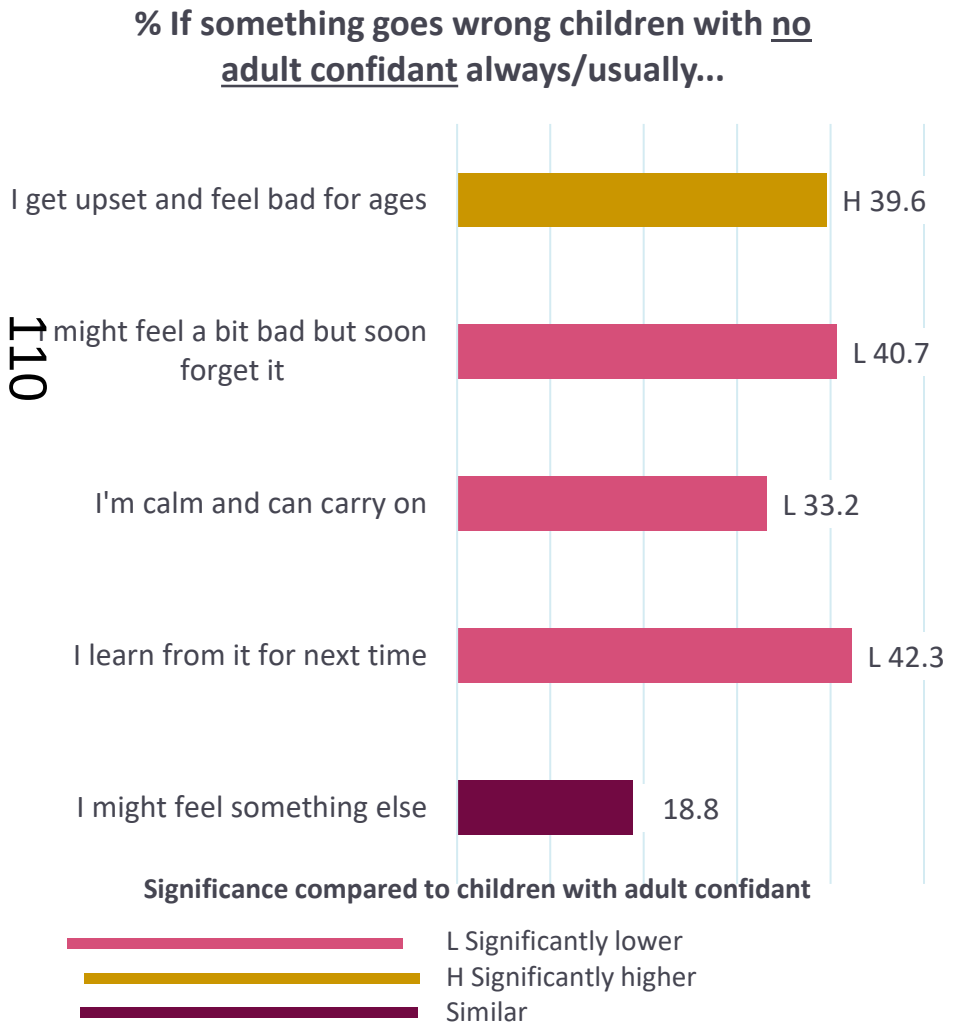
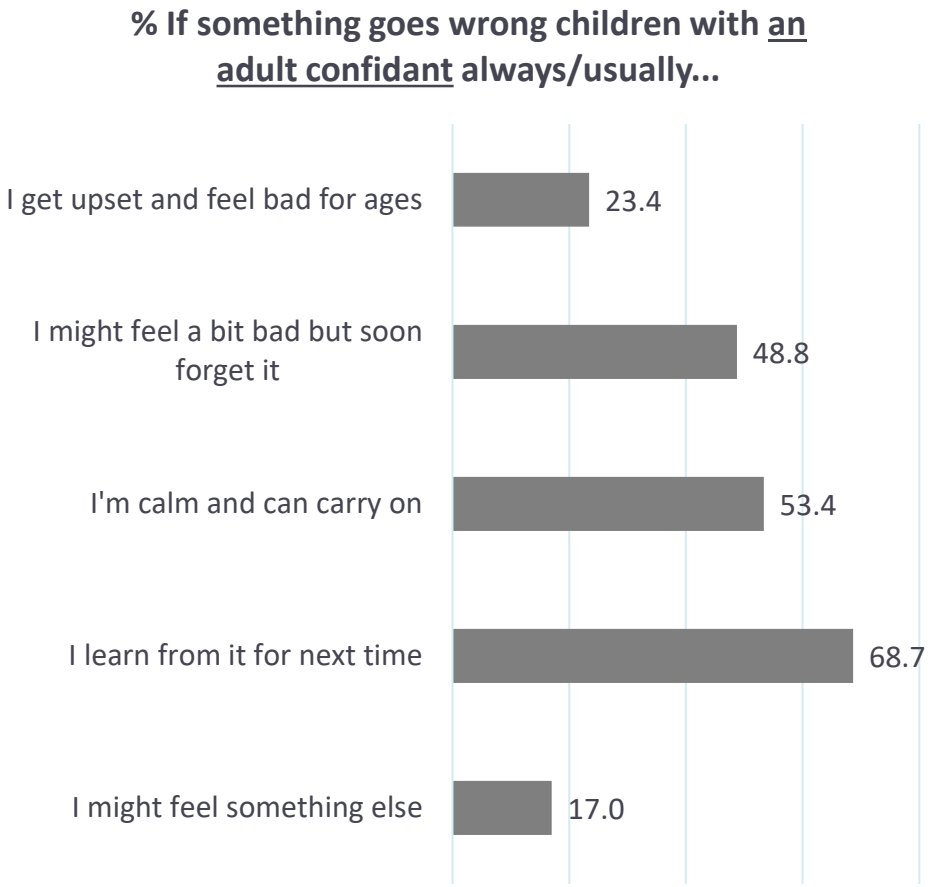
% I always/usually get upset and feel bad for ages



Children with no adult confidant find it more difficult to deal with issues when something goes wrong and show signs of poorer resilience.

48. If something goes wrong... (resilience) & 49. do you know an adult you trust?

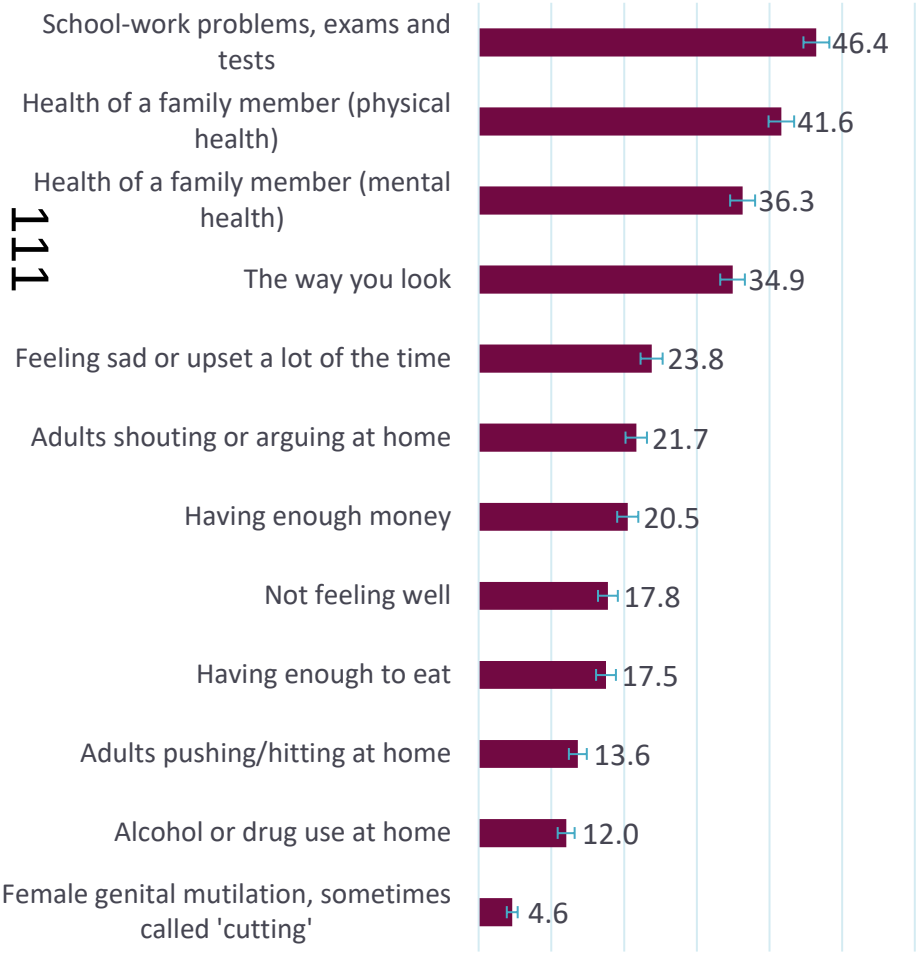




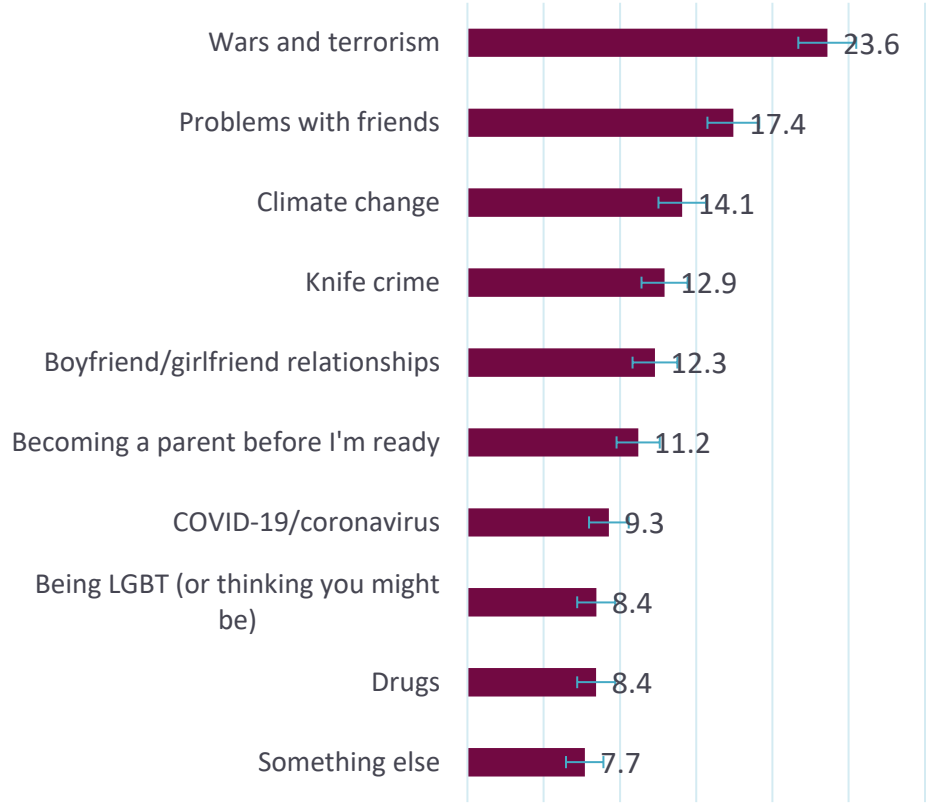
It is normal for children to worry, four out of five children worry about at least one issue quite a lot. The biggest worries include school work, health of a family member (physical and mental) and the way they look. About one in five children worry about having enough money or enough to eat.

50-52. How much do you worry about the issues listed below?

% worry about an issue quite a lot (all children)



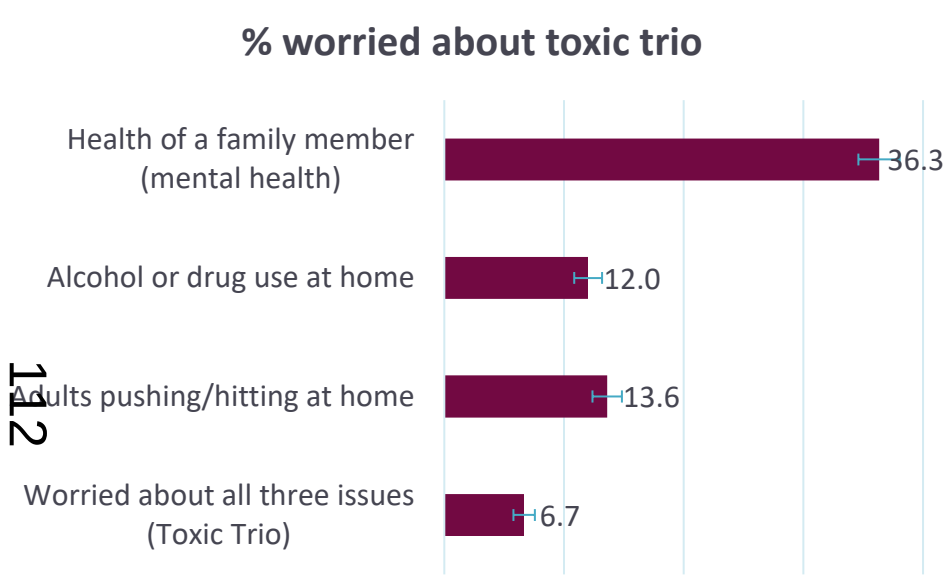
% worry about an issue quite a lot (secondary aged children)*



***Note:** Secondary children were asked about other potential worries that they may face.*

Some children are worried about the mental health of a parent (36%), substance misuse at home (12%), and domestic violence at home (14%). It is estimated that at least 2 children in a class of 30 (6.7%) are worried about all three of these toxic trio* issues.

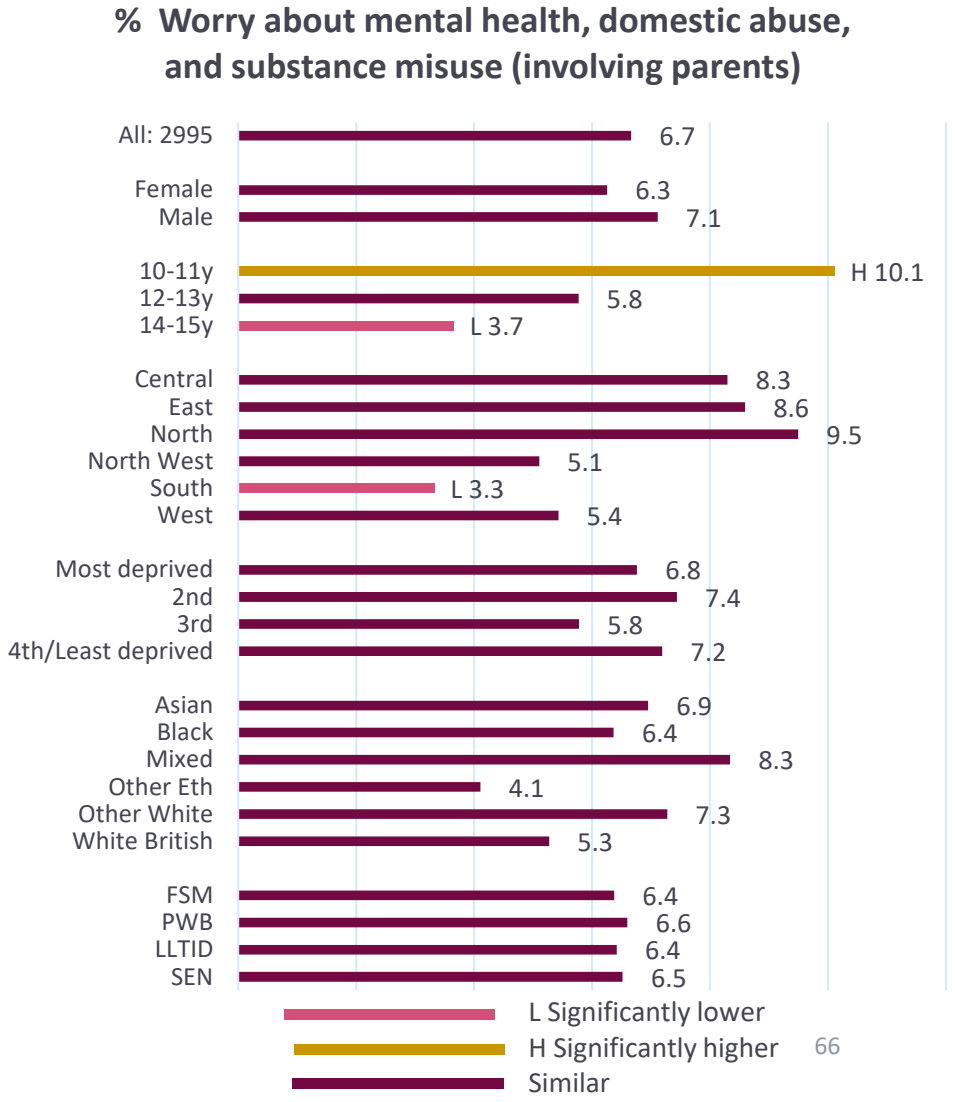
50 - 52. How much do you worry about the issues listed below? Toxic trio



Younger children are more likely to report worrying about toxic trio issues.

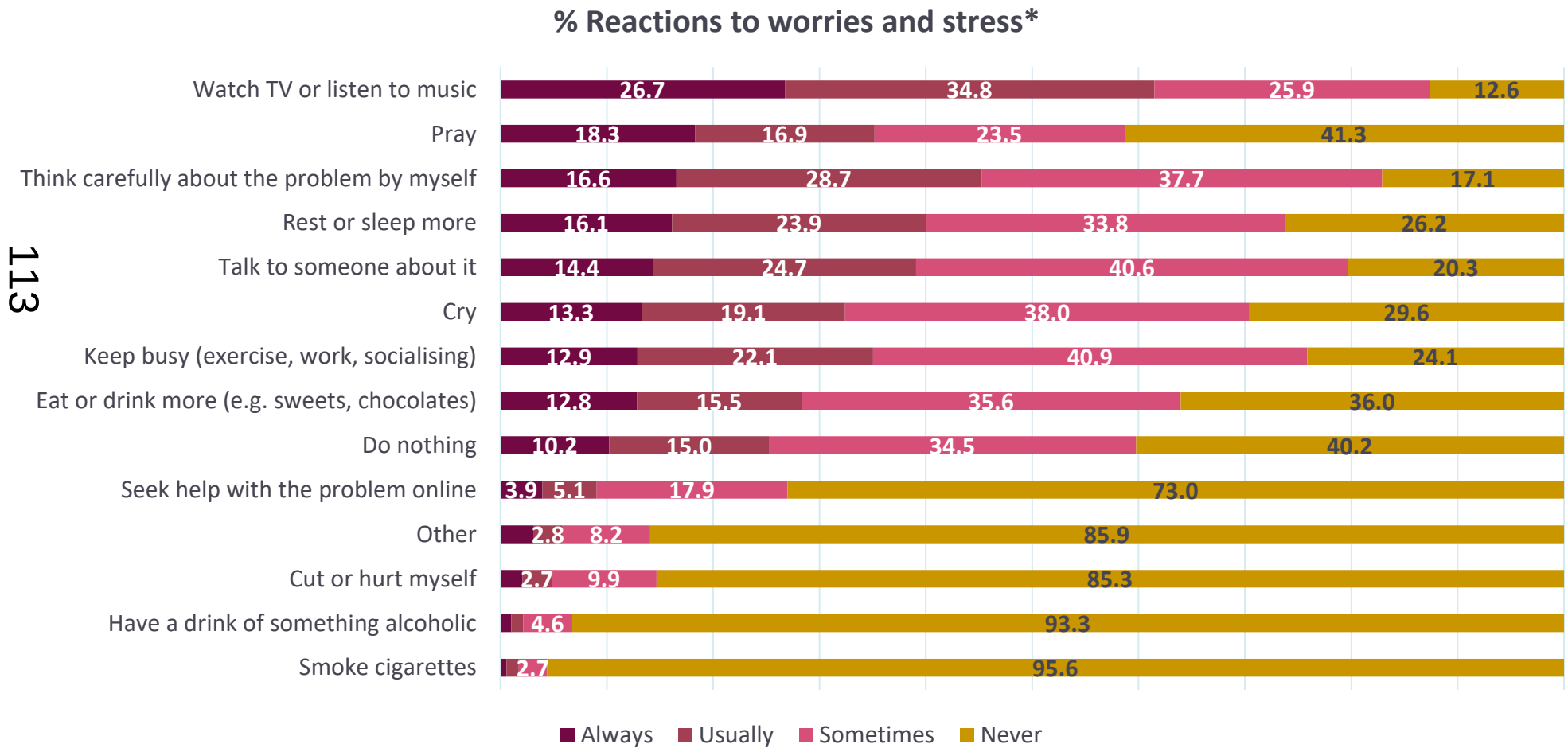
***Toxic trio:** This term describes the experience of domestic abuse, mental ill-health and substance misuse.*

***Deprivation Quintiles:** Most deprived (Living in 20% most deprived areas nationally and 4th/Least deprived (living in the 40% least deprived areas nationally)*
***Additional groups:** FSM- Free School Meals*
PWB – Poor Wellbeing
LLTID – Long term limiting illness or disability
SEN Special Educational Need



Children react to worries differently. Many decide to always/usually watch tv or listen to music (62%), think about it myself (45%), or rest or sleep (40%). 39% will always/usually talk to someone about it, while a quarter will do nothing (25%).

53. When you have a problem that worries you or you are feeling stressed, what do you do about it?



***Reactions to worries and stress:** The following options were available to secondary pupils only; Pray, smoke cigarettes, drink alcohol, self harm . These are shown as a percentage of all secondary children.*

A minority of children sometimes react to worries and stress by drinking alcohol or smoking cigarettes. A larger 15% of secondary aged children will react by cutting or harming themselves.

53. When you have a problem that worries you or you are feeling stressed, what do you do about it? Cut or hurt myself at least sometimes

Females are more likely than males to self harm. There are also broad area differences.

Some vulnerable groups such as those with a poor wellbeing and children with a long term illness or disability are significantly more likely to self harm.

2016/17	2021/22	Significant change
16.7%	14.6%	No significant change

There has been no significant change in the percentage of secondary aged children who have reacted to worries by cutting or hurting themselves since 2016/17.

Note: *Only Secondary aged children were asked to respond to this question*

Deprivation Quintiles: *Most deprived (Living in 20% most deprived areas nationally and 4th/Least deprived (living in the 40% least deprived areas nationally)*
Additional groups: *FSM- Free School Meals*
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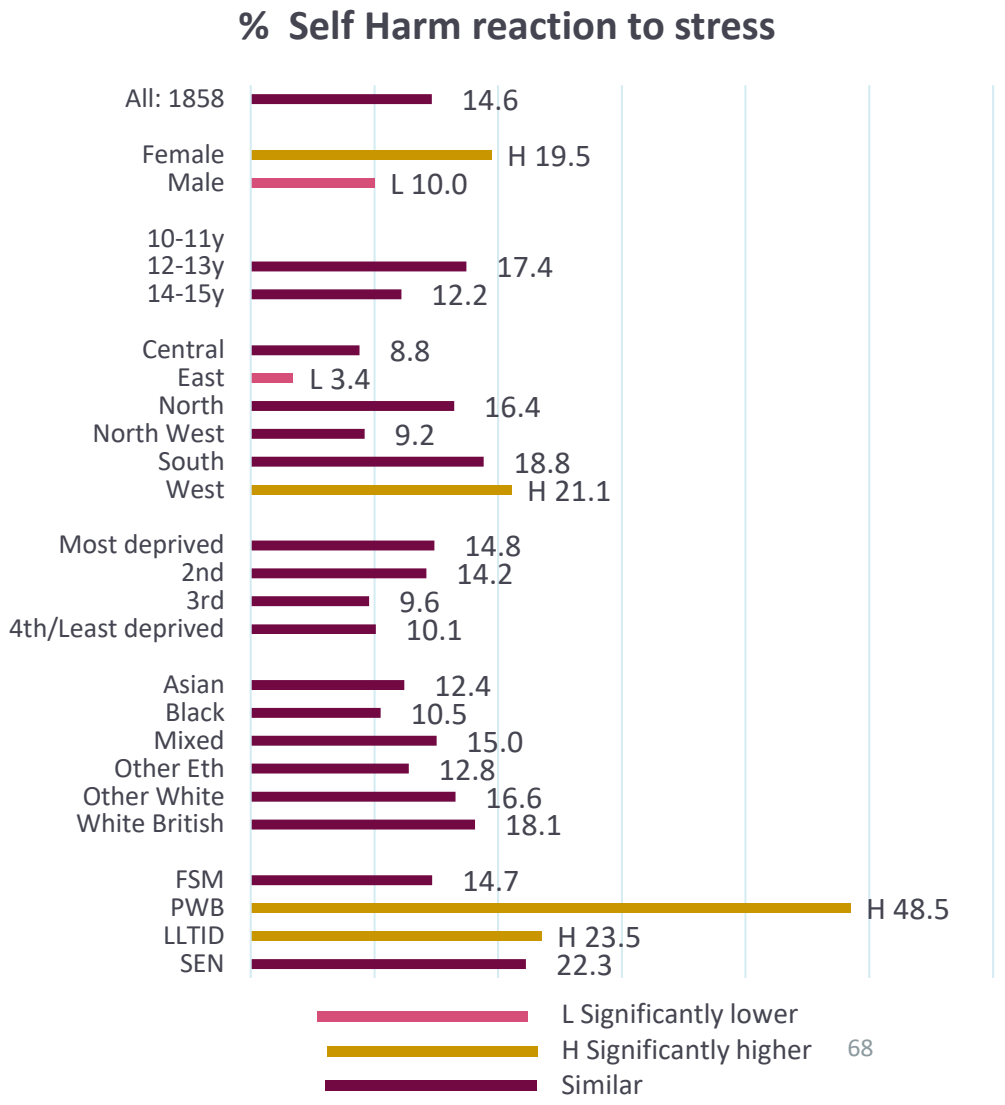
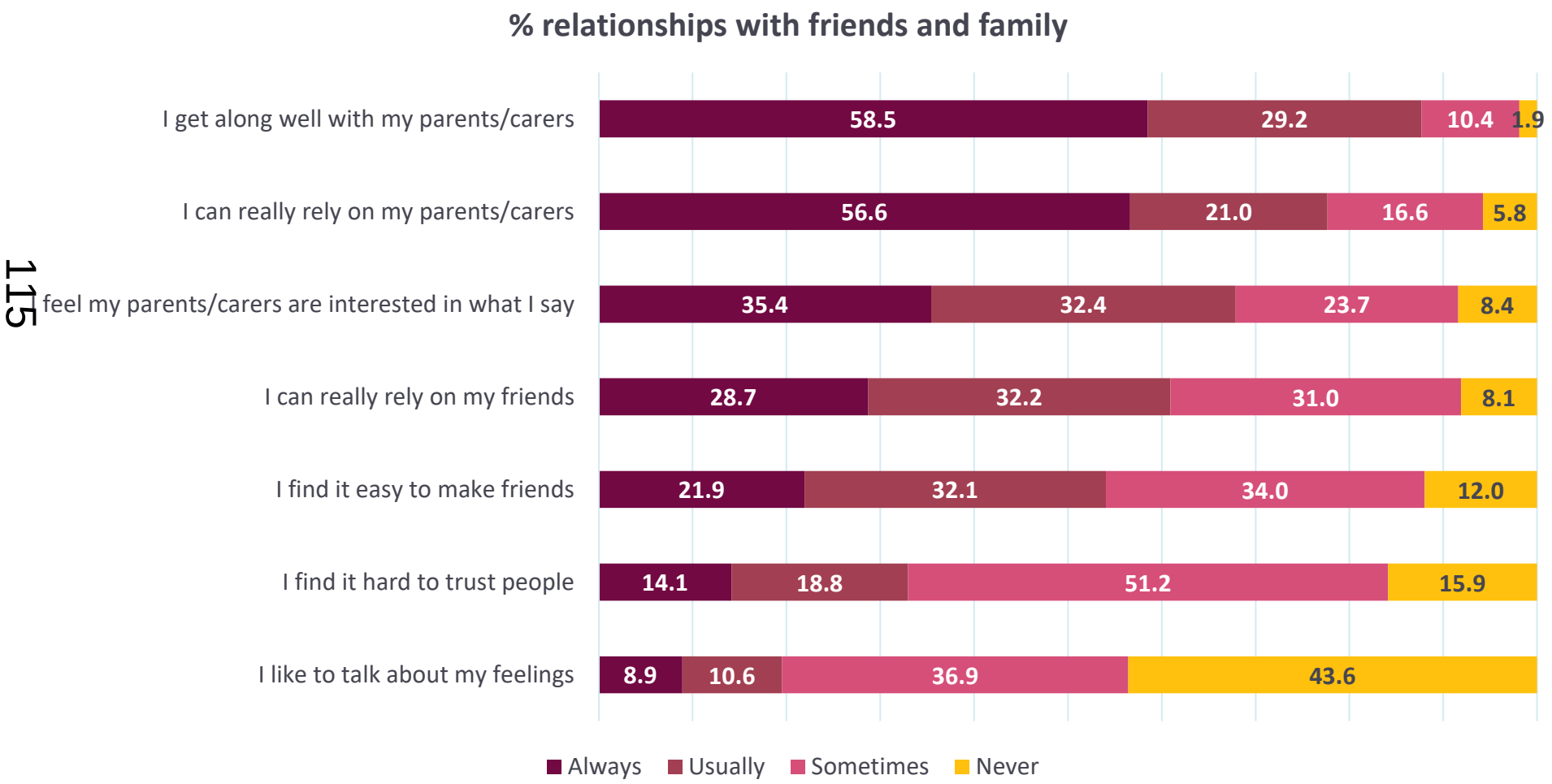


Most Leicester children report positive relationships with parents/carers, noting they always/usually get long with them (88%) and can rely on them (78%). There is a small proportion of children who do not rely on friends (8%) and never find it easy to make friends (12%).

54. Please tick one answer on each line… relationships with friends and family statements.



115

It is unusual for Leicester children to like to talk about their feelings. Less than one in ten always like to talk about their feelings and nearly half of children (44%) never like to talk about feelings. Males and females report similar levels.

54. Please tick one answer on each line…I like to talk about my feelings

Older children are significantly more likely to never like to talk about feelings compared to younger children (10-11 year olds). There are also differences by broad area and ethnic groups.

Children with special educational needs and those with poor mental wellbeing are significantly more likely to never like to talk about feelings.

2016/17	2021/22	Significant change
32.8%	43.6%	Increase since 2016/17

There has been a significant increase in the percentage of children who never like to talk about their feelings since 2016/17.

Deprivation Quintiles: *Most deprived (Living in 20% most deprived areas nationally and 4th/Least deprived (living in the 40% least deprived areas nationally)*
Additional groups: *FSM- Free School Meals*
PWB – Poor Wellbeing
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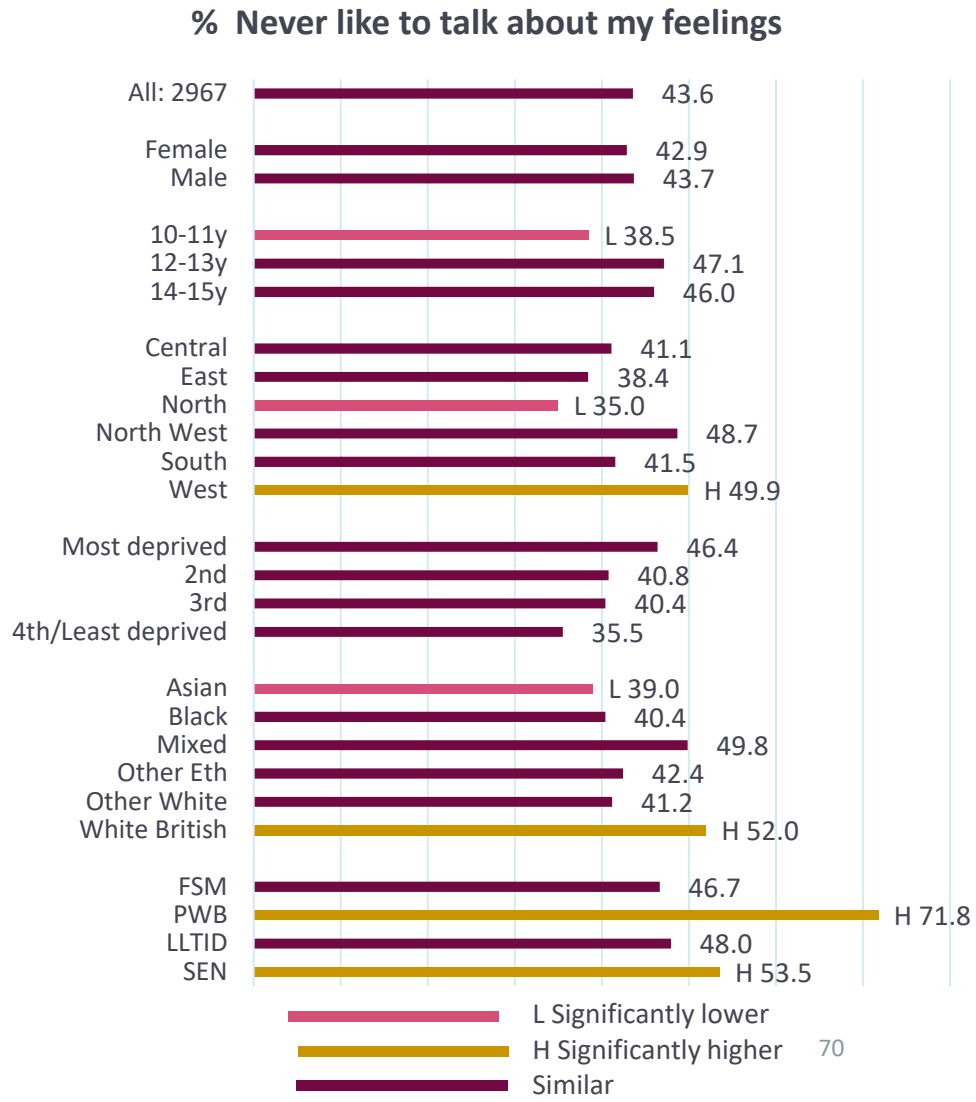


Secondary aged children were asked whether they had used a counsellor or other mental health service, a quarter (26%) of these children have used these services.

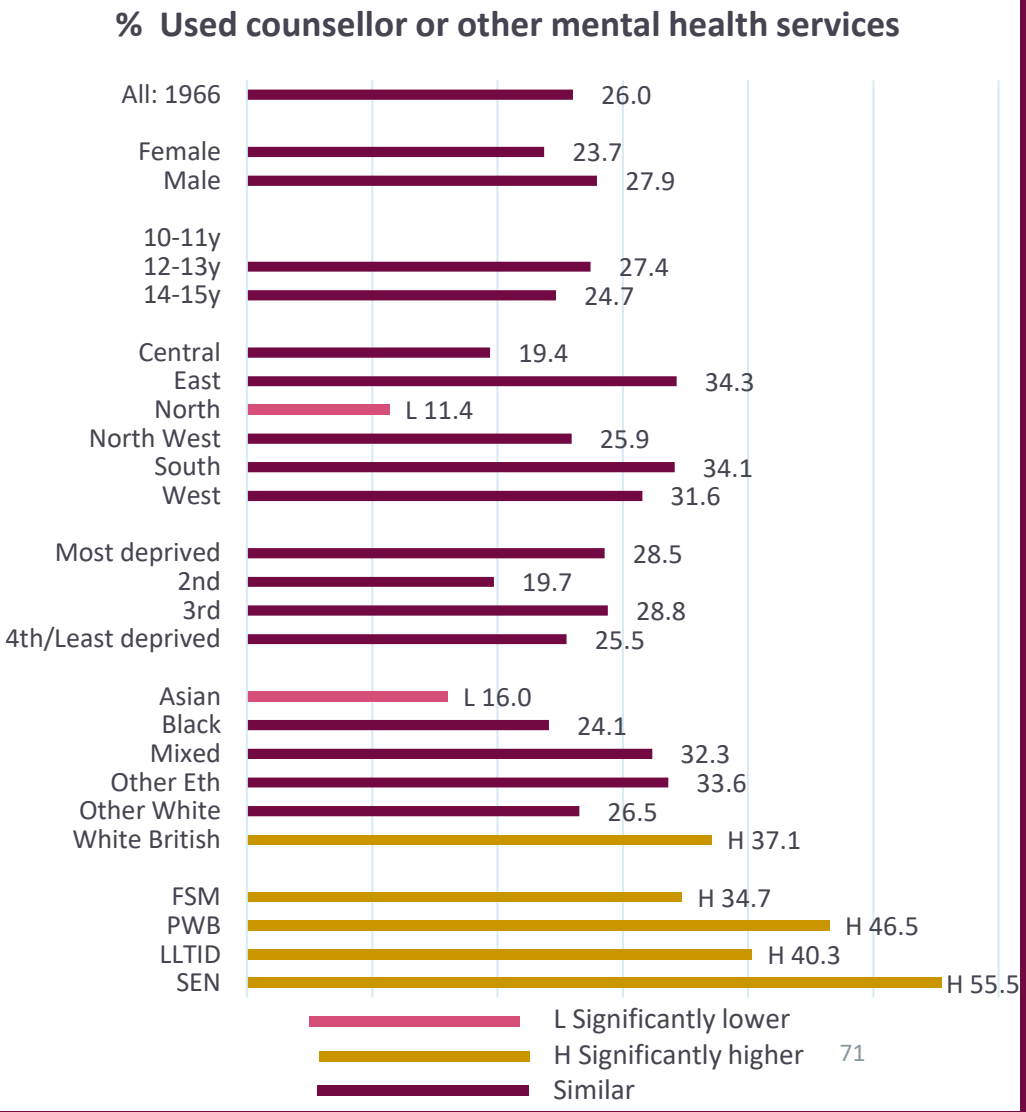
43. Have you ever used these services . . . ? Counsellor or other mental health service

Males and females report statistically similar levels of using a counsellor or other mental health services.

Children residing in the North of the city are significantly less likely to use mental health services.

Children from an Asian background are significantly less likely to use mental health services and those from a White British background are significantly more likely to use mental health services.

Children from more vulnerable groups are all significantly more likely to use mental health services.



Note: *Only Secondary aged children were asked to respond to this question*

Deprivation Quintiles: *Most deprived (Living in 20% most deprived areas nationally and 4th/Least deprived (living in the 40% least deprived areas nationally)*
Additional groups: *FSM- Free School Meals*
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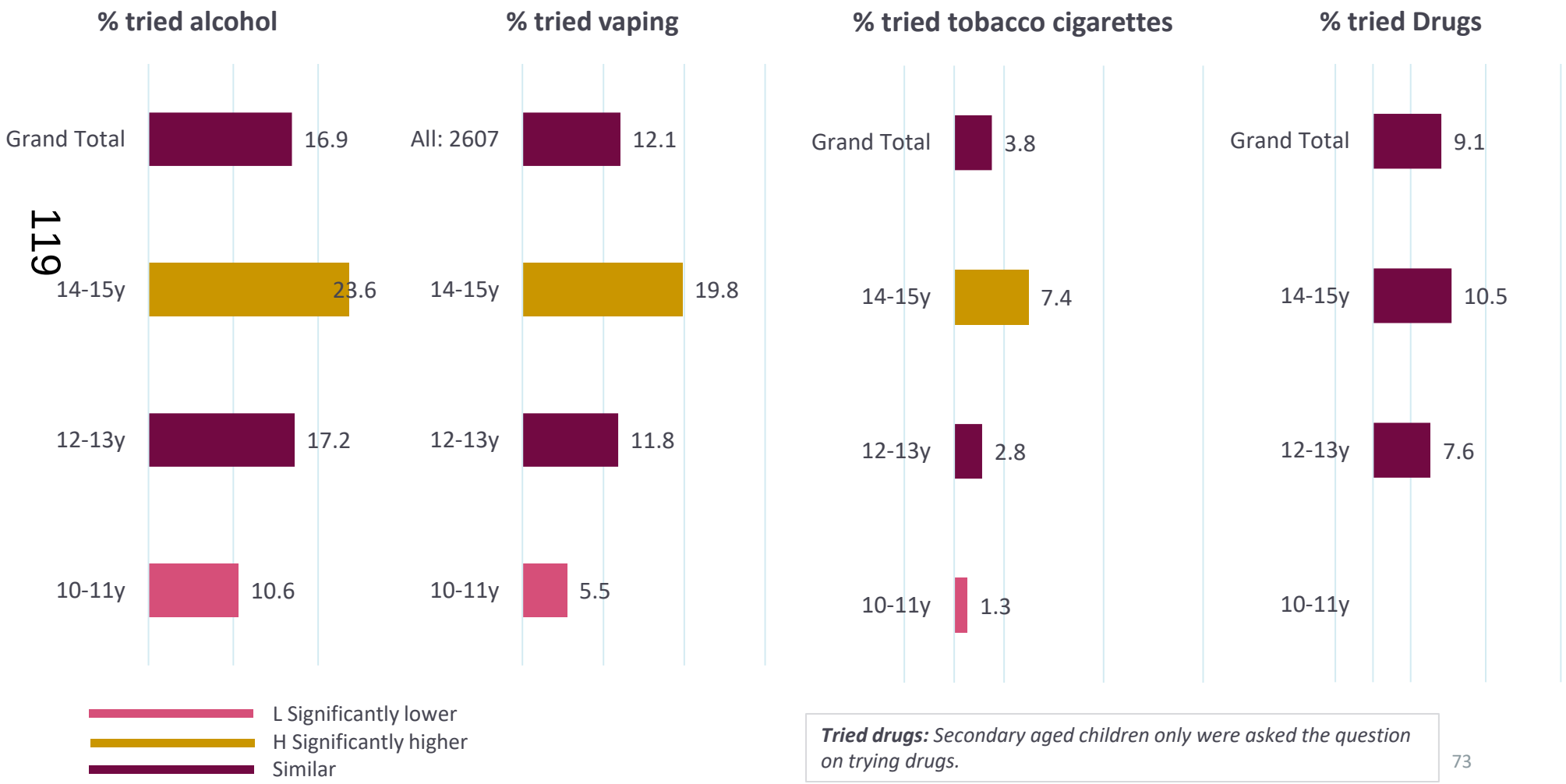
Alcohol, Tobacco and Drugs

- Trying alcohol is uncommon for Leicester children with five out of six children reporting they have never tried alcoholic drinks.
- Overall around one in six children have tried alcohol, this increases with age and a quarter of older children (14-15 year olds) have tried alcohol.
- Secondary aged children who have tried alcohol most commonly had their last alcoholic drink with their parents present. Some children who have tried alcohol drink alone.
- Some children are exposed to smoking at home. About a third of parents/carers smoke, one in ten report smoking occurring at home and in the car.
- Around one in ten children have tried vaping/e-cigarettes. A smaller proportion of children have tried tobacco cigarettes or shisha.
- Secondary aged children were asked questions about drugs. About one in ten stated that they had been offered drugs.

Children and young people were asked if they had tried alcohol, tobacco, vaping and drugs. Older children were more likely to have experimented with alcohol, tobacco, vaping or drugs compared to younger children.

55, 59 & 61 Have you tried any of the following? (Alcohol, E-cigarettes, Tobacco Cigarettes, Drugs) - by age group



Tried drugs: *Secondary aged children only were asked the question on trying drugs.*

Trying alcohol is uncommon for Leicester children with five out of six children reporting they have never tried alcoholic drinks. Around one in six children (17%) have tried alcohol, with one in one hundred children (1%) drinking alcohol at least once a week.

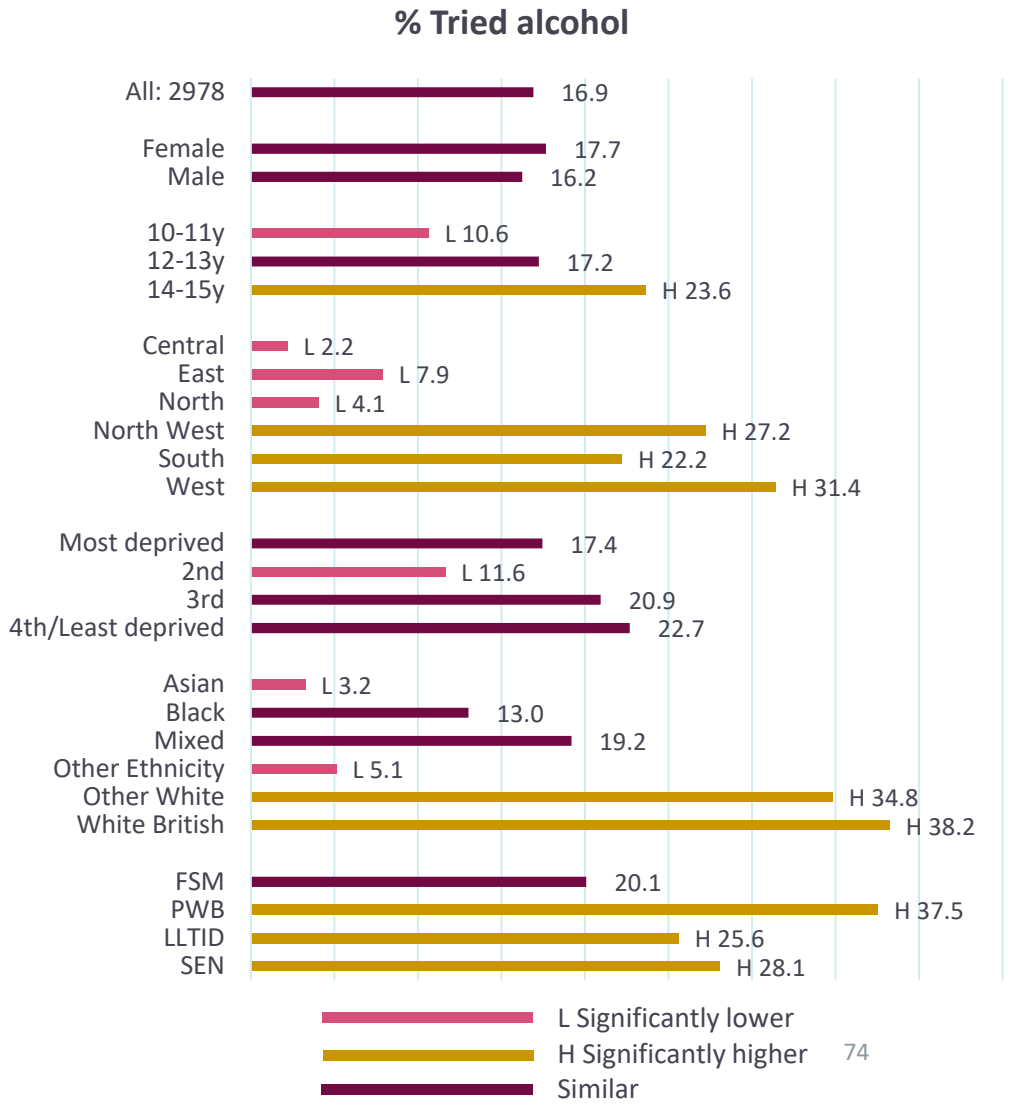
55. How often do you drink alcohol? (more than just a sip)

Almost one quarter of 14-15 year olds have tried alcohol, this is significantly more than the proportion for 10-11 and 12-13 year olds.

A significantly larger proportion of respondents in the North West, South and West of Leicester have tried alcohol.

Children of White British or Other White ethnicity are significantly more likely to have tried alcohol, whilst those of Asian or Other Ethnicity heritage are significantly less likely to have tried alcohol.

Children reporting a poor mental wellbeing, a long term illness or special educational need are significantly more likely to have tried alcohol.



Deprivation Quintiles: *Most deprived (Living in 20% most deprived areas nationally and 4th/Least deprived (living in the 40% least deprived areas nationally)*
Additional groups: *FSM- Free School Meals*
PWB – Poor Wellbeing
LLTID – Long term limiting illness or disability
SEN Special Educational Need

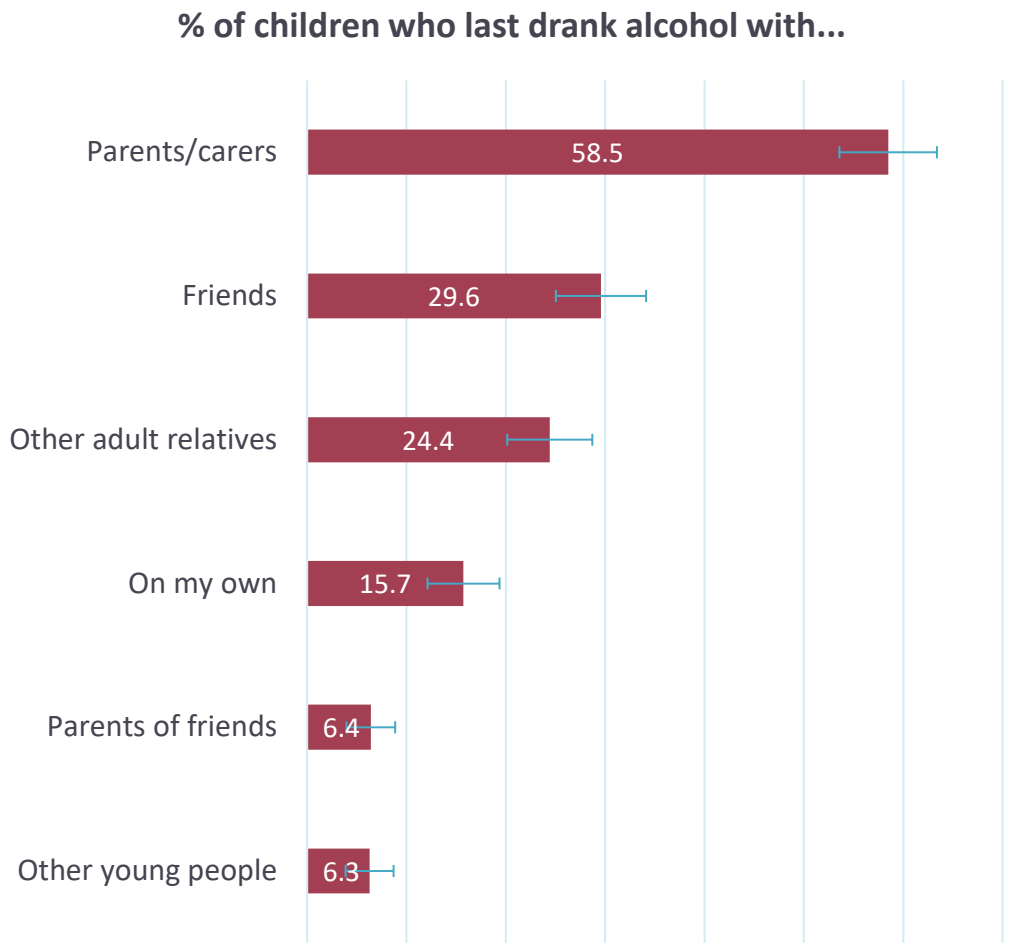
Secondary aged children who reported that they had tried alcohol were asked who they last drank alcohol with. The majority (59% of this group) last drank alcohol with their parents/carers.

56. Thinking about the last time you had an alcoholic drink, with whom did you drink it?

About half of secondary aged children who have tried alcohol last drank with their parents/carers. This is significantly higher than with any other group.

A significantly larger proportion last drank alcohol with their friends or other adult relatives than on their own, with parents of friends or with other young people.

Around a sixth (16%) of children who have drank alcohol drank their last alcoholic drink on their own.



Note: *Only Secondary aged children were asked to respond to this question*

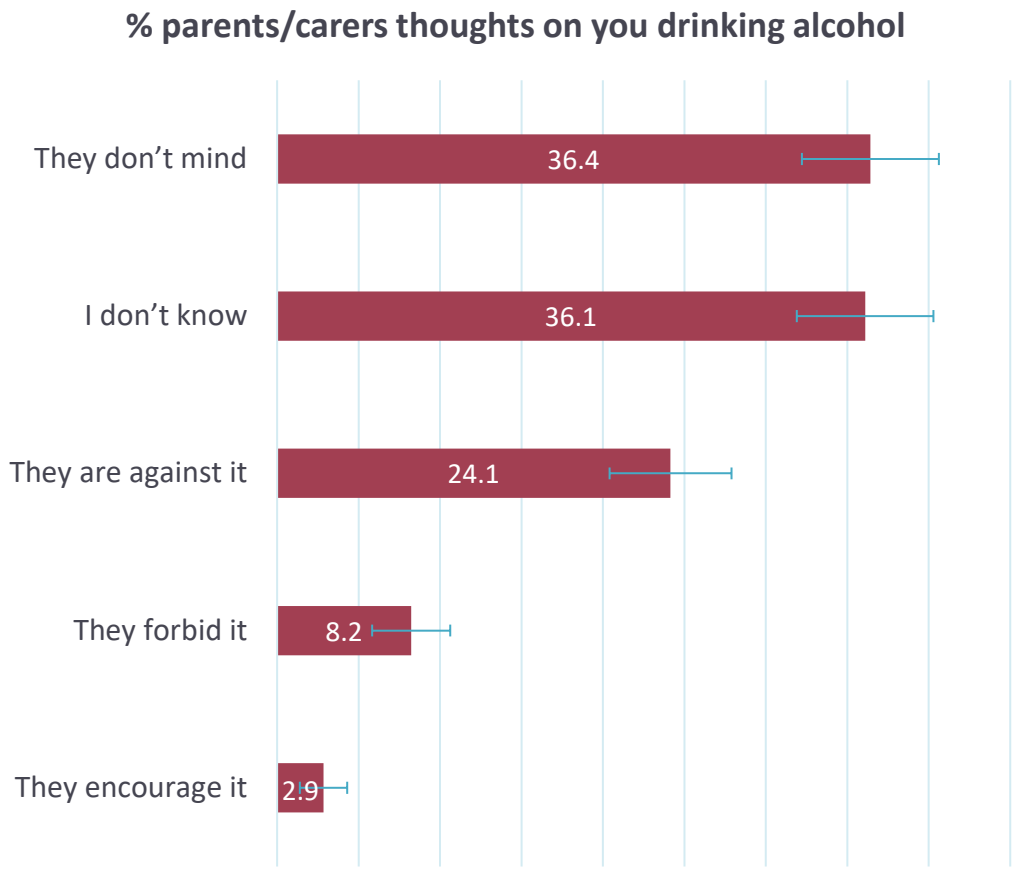
A small proportion of children (3%) that have tried alcohol reported that their parents/carers encourage them to drink alcohol. Most children that have tried alcohol reported that their parents/carers don't mind that they drink alcohol (36%) or that they don't know what their parents/carers thoughts are on them drinking alcohol (36%).

57. What do your parents/carers think about you drinking alcohol?

Just over one third (36%) of children who have tried alcohol reported that their parents/carers don't mind them drinking alcohol.

About a quarter of children that have tried alcohol reported that their parents/carers are against them drinking alcohol (24%), and a further 8% reported that their parents/carers forbid them to drink alcohol.

The proportion reporting that their parents/carers encourage them to drink alcohol was significantly smaller than any of the other parent/carer thoughts.



Note: *Only children who have tried alcohol responded to this question.*

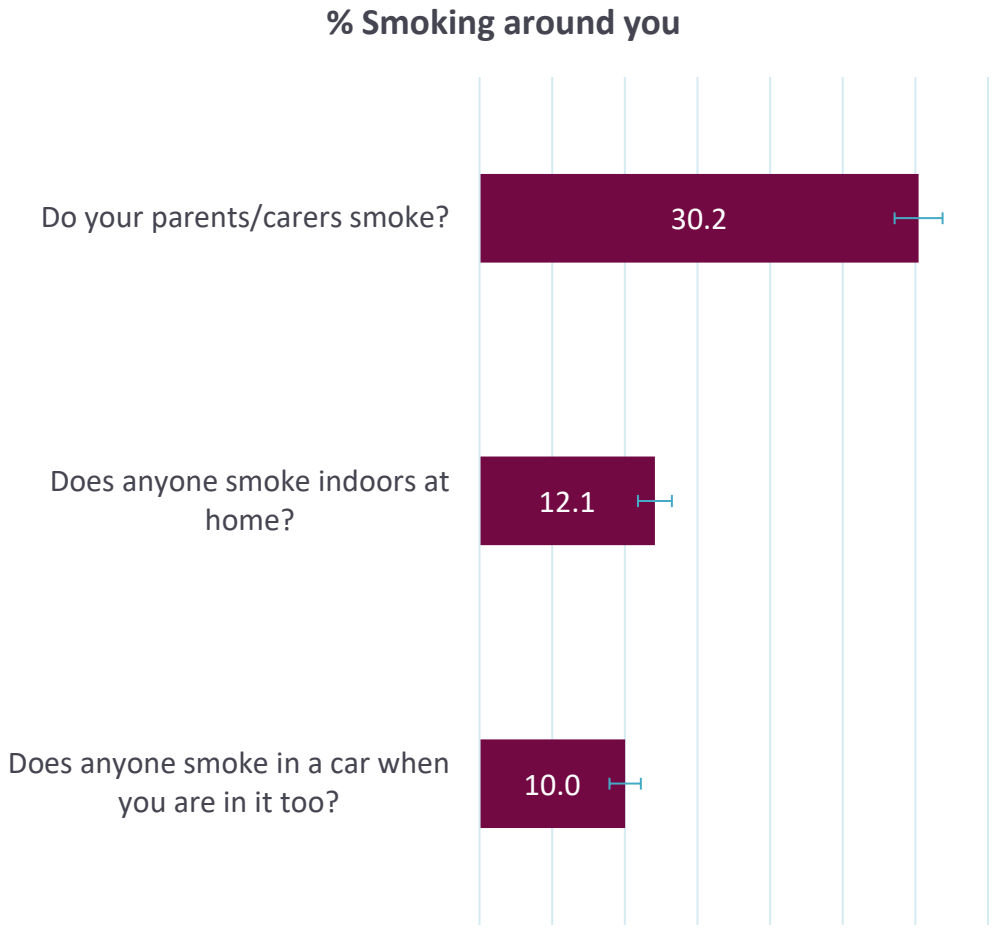
Around a third of children reported that their parents/carers smoke. Significantly fewer children reported that someone smokes at home or in the car when they are in it too.

58. Please answer on each line (statements on smoking at home)

A significantly larger proportion of children reported that their parents/carers smoke (30%) than reported that someone smokes indoors at home (12%) or in a car when they are in it too (10%).

123

There was no significant difference between the proportion of children who reported that someone smokes indoors at home and the proportion of children who reported that someone smokes in a car when they are in it too.



Around a third (30%) of children reported that their parents/carers smoke, this is similar to 2016/17 (32%). Parents/carers of children reporting to be part of any of the four vulnerable groups were more likely to smoke.

58. Smoking at home statement. Do your parents/carers smoke?

There were no significant differences between the proportion of parents/carers who were reported to smoke when comparing males and females or the three age groups.

A significantly larger proportion of children in the South and West and a significantly smaller proportion of children in the North and Central locality areas of Leicester reported that their parents/carers smoke.

Children of White British or Other White ethnicity are significantly more likely to have parents/carers who smoke, whilst those of Asian, Black or Other Ethnicity heritage are significantly less likely to have parents/carers who smoke.

Free school meal children, those with a poor mental wellbeing, a long term illness or special educational needs are significantly more likely to have parents/carers who smoke.

Deprivation Quintiles: *Most deprived (Living in 20% most deprived areas nationally and 4th/Least deprived (living in the 40% least deprived areas nationally)*
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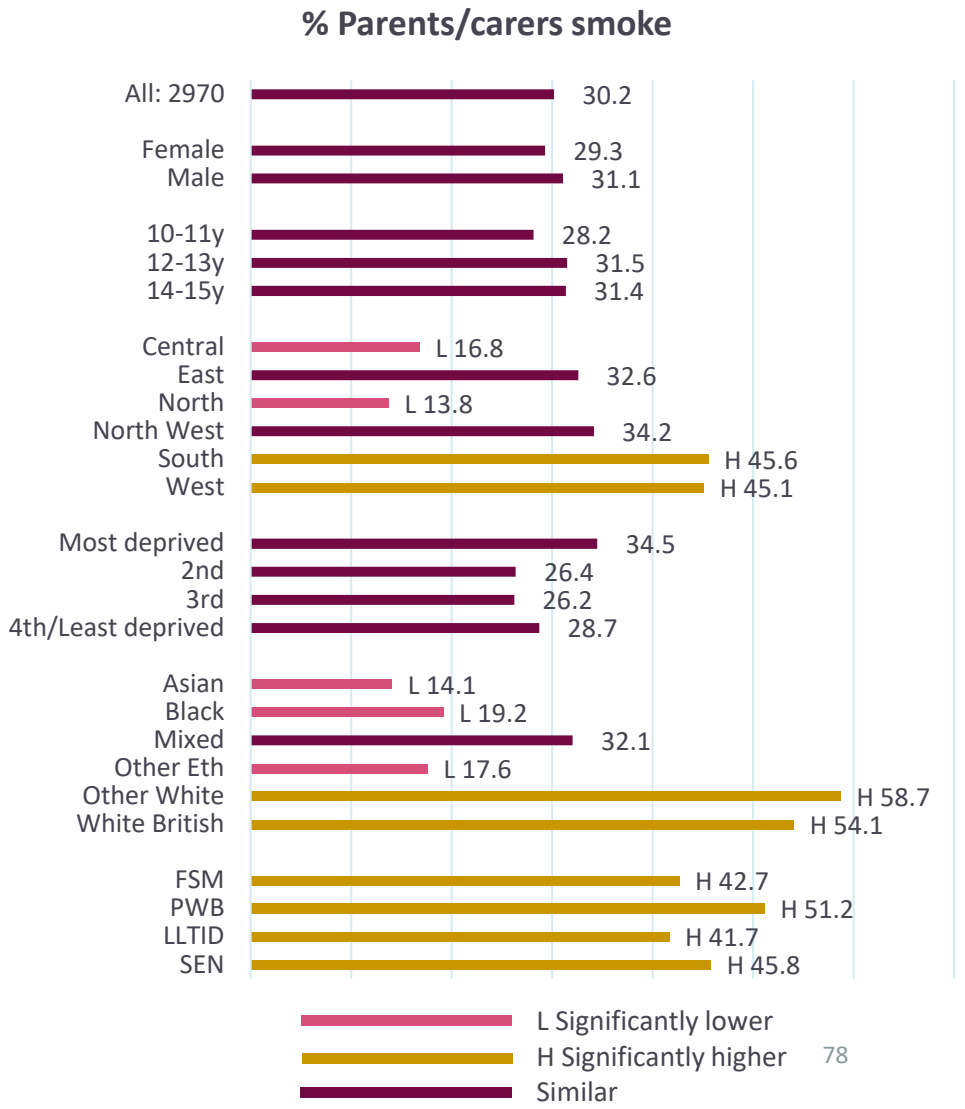
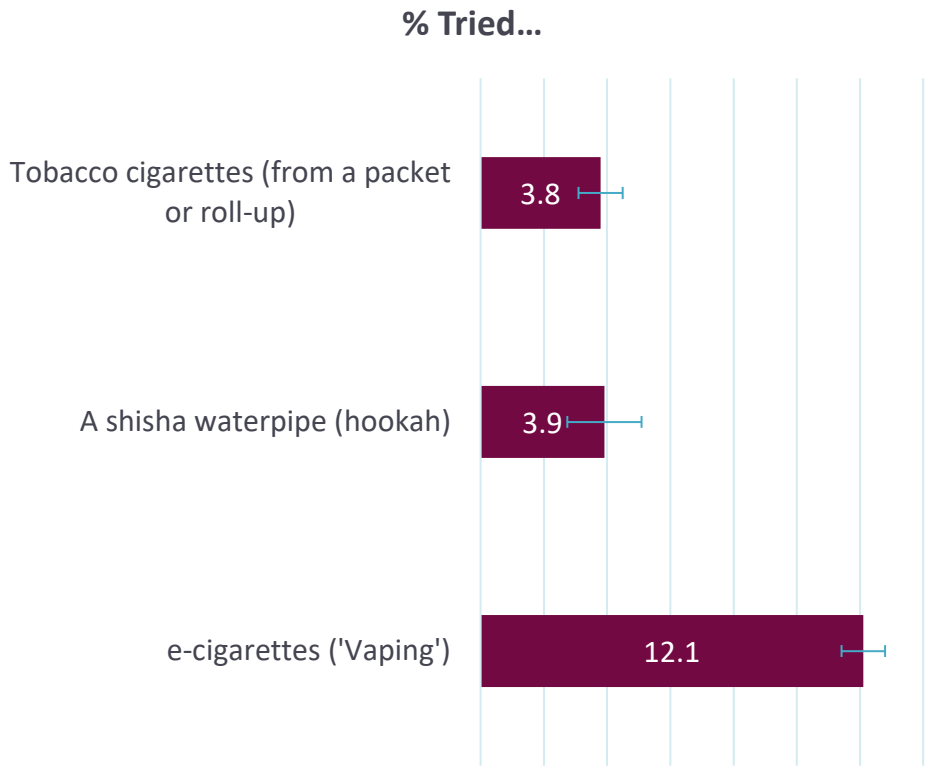


Significantly more children have tried e-cigarettes (vaping) than have tried a shisha waterpipe (hookah) or tobacco cigarettes (from a packet or roll-up).

59. Have you used any of the following? (Tobacco cigarettes, shisha waterpipe, e-cigarettes)

A significantly larger proportion of children reported that they have tried e-cigarettes (vaping) (12%) than reported having tried a shisha waterpipe (hookah) (4%) or tobacco cigarettes (from a packet or roll-up) (4%).

There was no significant difference between the proportion of children who have tried a shisha waterpipe (hookah) and the proportion who have tried tobacco cigarettes (from a packet or roll-up).



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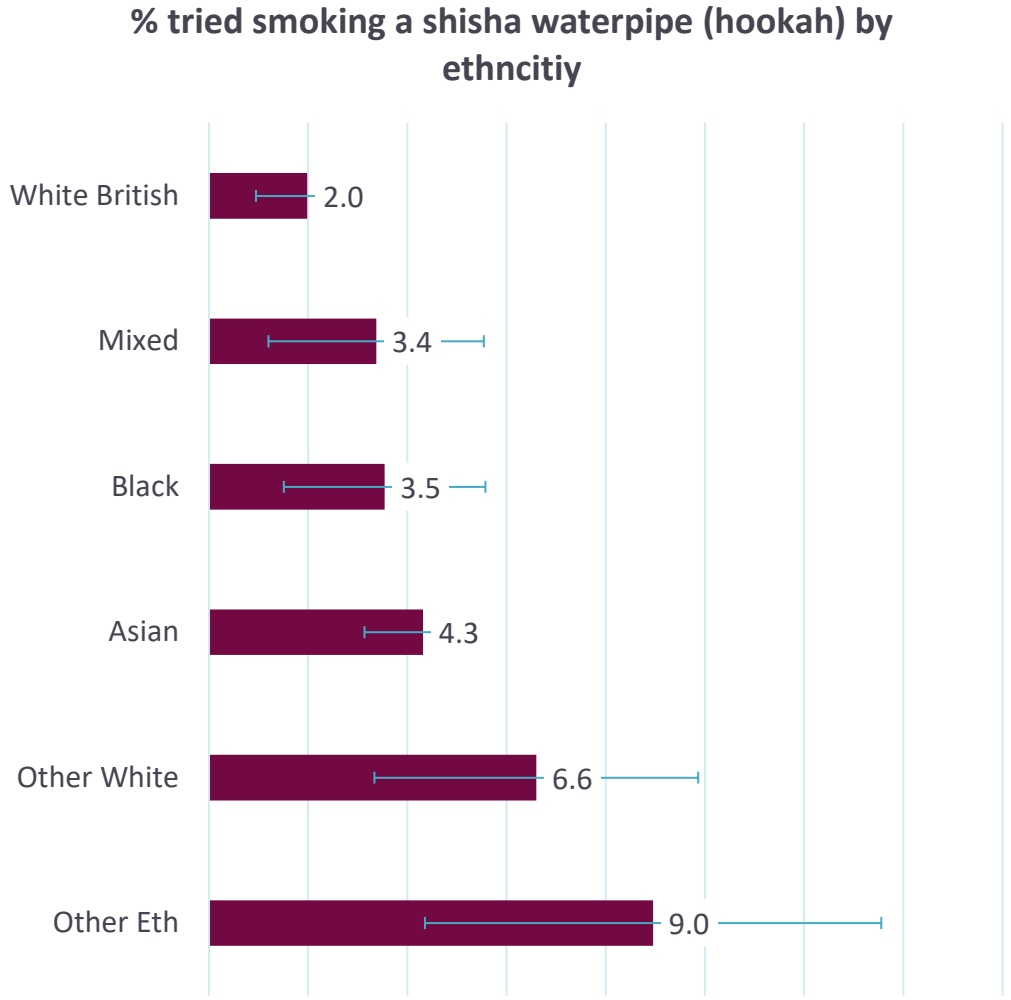
Around 4% of children reported that they have tried smoking shisha waterpipe (hookah).

59. Have you tried any of the following? Shisha waterpipe (hookah)

A significantly smaller proportion of children of White British Ethnicity (2%) had tried smoking shisha waterpipe (hookah) than the proportion of children of Asian (4%), Other White (7%) or Other Ethnicity (9%).

There were no significant differences in the proportion of children that had tried a shisha waterpipe (hookah) between children of Mixed, Black, Asian, Other White or Other Ethnicity.



Around 4% of children reported that they have tried smoking tobacco cigarettes (from a packet or roll-up). Older children (14-15 year olds – 7.4%)) are more likely to have tried smoking but this has fallen significantly since 2016/17 when 12.6% had tried smoking.

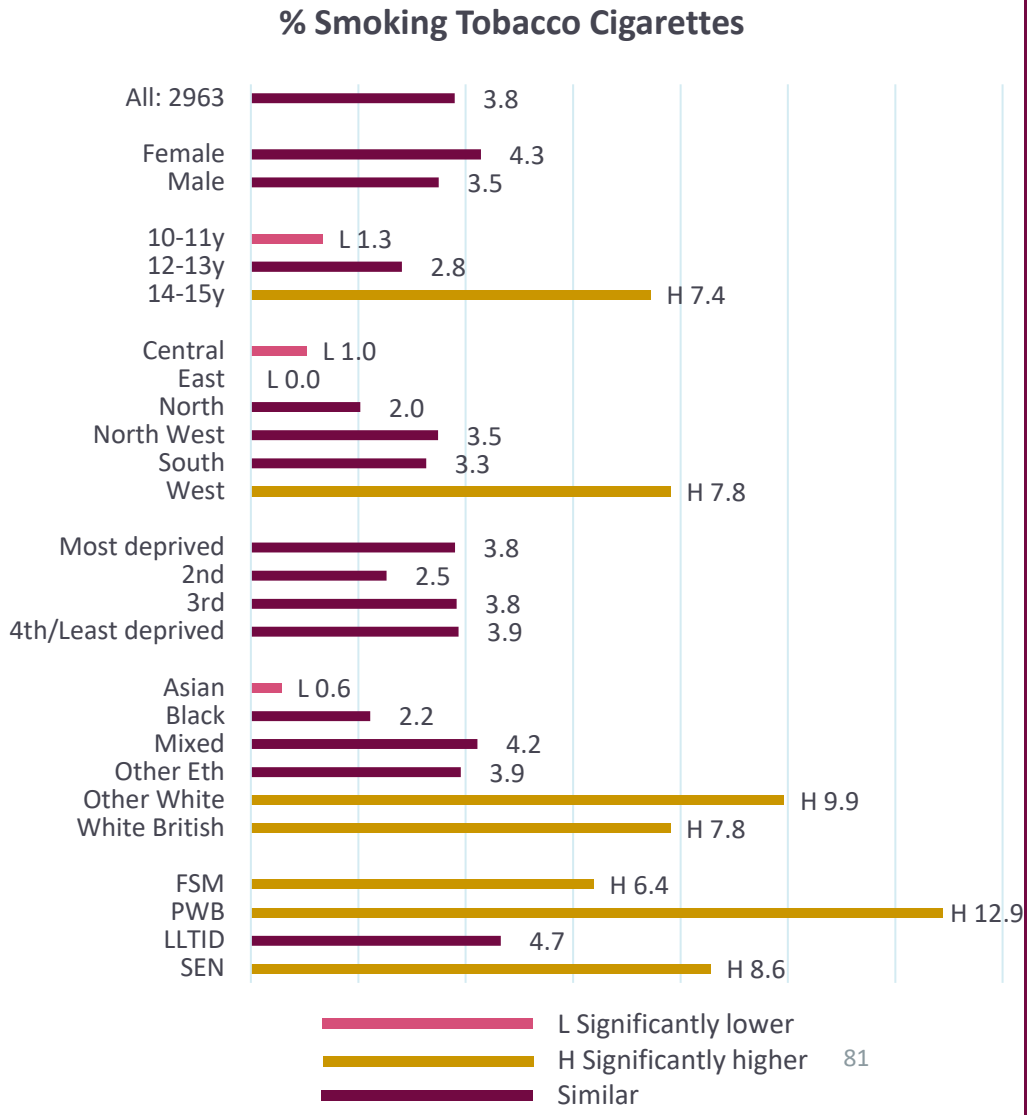
59. Have you tried any of the following? Tobacco cigarettes (from a packet or roll-up)

Children aged between 10-11 years old were significantly less likely to have tried smoking tobacco cigarettes than those aged 14-15 years old.

A significantly larger proportion of children in the West of Leicester and a significantly smaller proportion of children in the Central locality area of Leicester reported that they had tried smoking tobacco cigarettes.

Children of White British or Other White ethnicity are significantly more likely to have tried smoking tobacco cigarettes, whilst those of Asian heritage are significantly less likely to have tried smoking tobacco cigarettes.

Children reporting free school meal status, a poor mental wellbeing or special educational needs are significantly more likely to have tried smoking tobacco cigarettes.



Deprivation Quintiles: *Most deprived (Living in 20% most deprived areas nationally and 4th/Least deprived (living in the 40% least deprived areas nationally)*
Additional groups: *FSM- Free School Meals*
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Around 12% of children reported that they have tried e-cigarettes (vaping). Older children (14-15 year olds – 19.8%) were more likely to have tried vaping, this is similar to the rate in 2016/17 (21.0%)

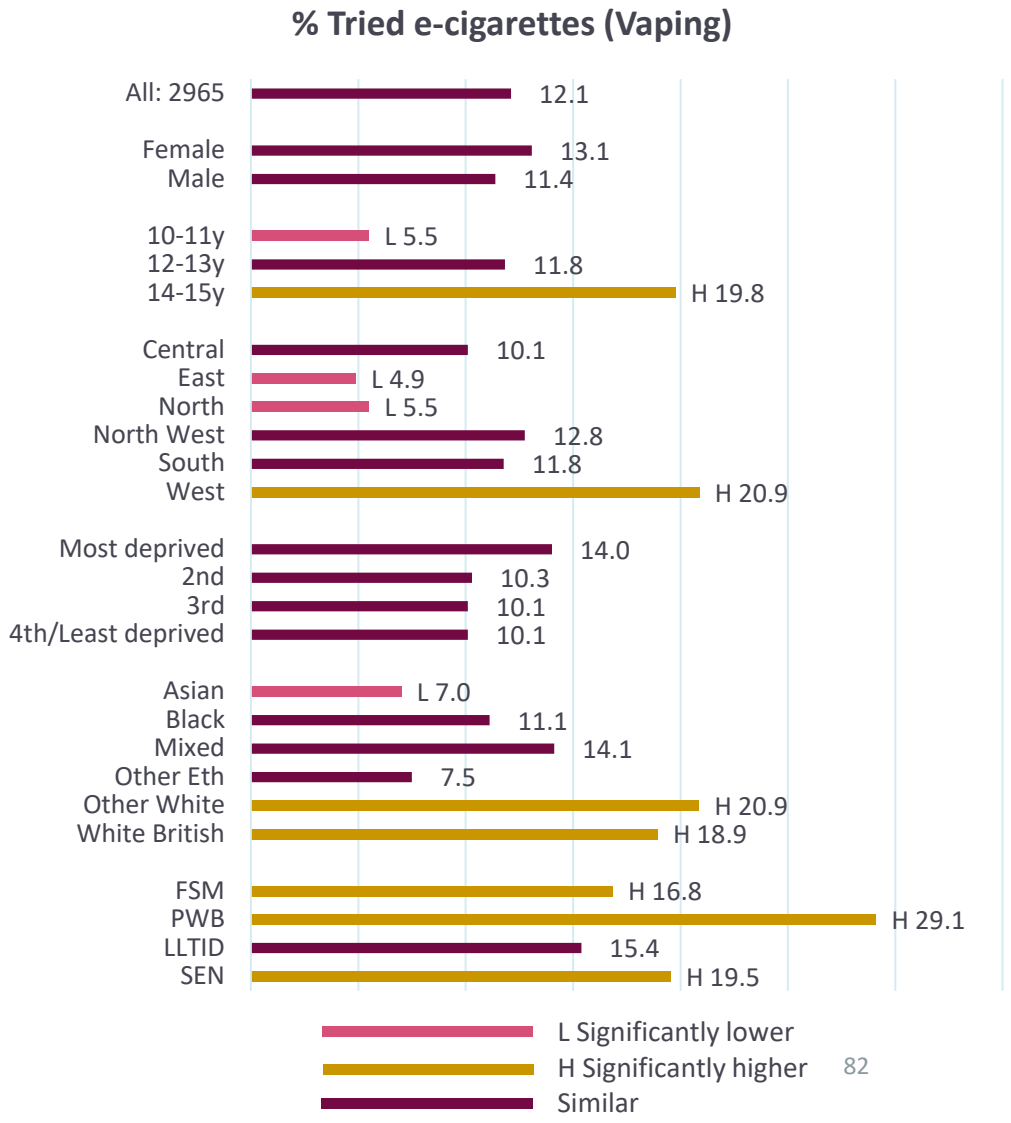
59. Have you tried any of the following? E-cigarettes (vaping)

The proportion of children reporting that they have tried e-cigarettes increased significantly with each increase in age group.

A significantly larger proportion of children in the West of Leicester and a significantly smaller proportion of children in the East and North of Leicester reported that they had tried e-cigarettes.

Children of White British or Other White ethnicity are significantly more likely to have tried e-cigarettes, whilst those of Asian heritage are significantly less likely to have tried e-cigarettes.

Children reporting free school meal status, a poor mental wellbeing or special educational needs are significantly more likely to have tried e-cigarettes.



Deprivation Quintiles: *Most deprived (Living in 20% most deprived areas nationally and 4th/Least deprived (living in the 40% least deprived areas nationally)*
Additional groups: *FSM- Free School Meals*
PWB – Poor Wellbeing
LLTID – Long term limiting illness or disability
SEN Special Educational Need

The smoking status of a parent/carer has a strong influence on whether children have tried smoking/vaping. Children who have parent/carers who smoke are more likely to have tried tobacco cigarettes, e-cigarettes or shisha.

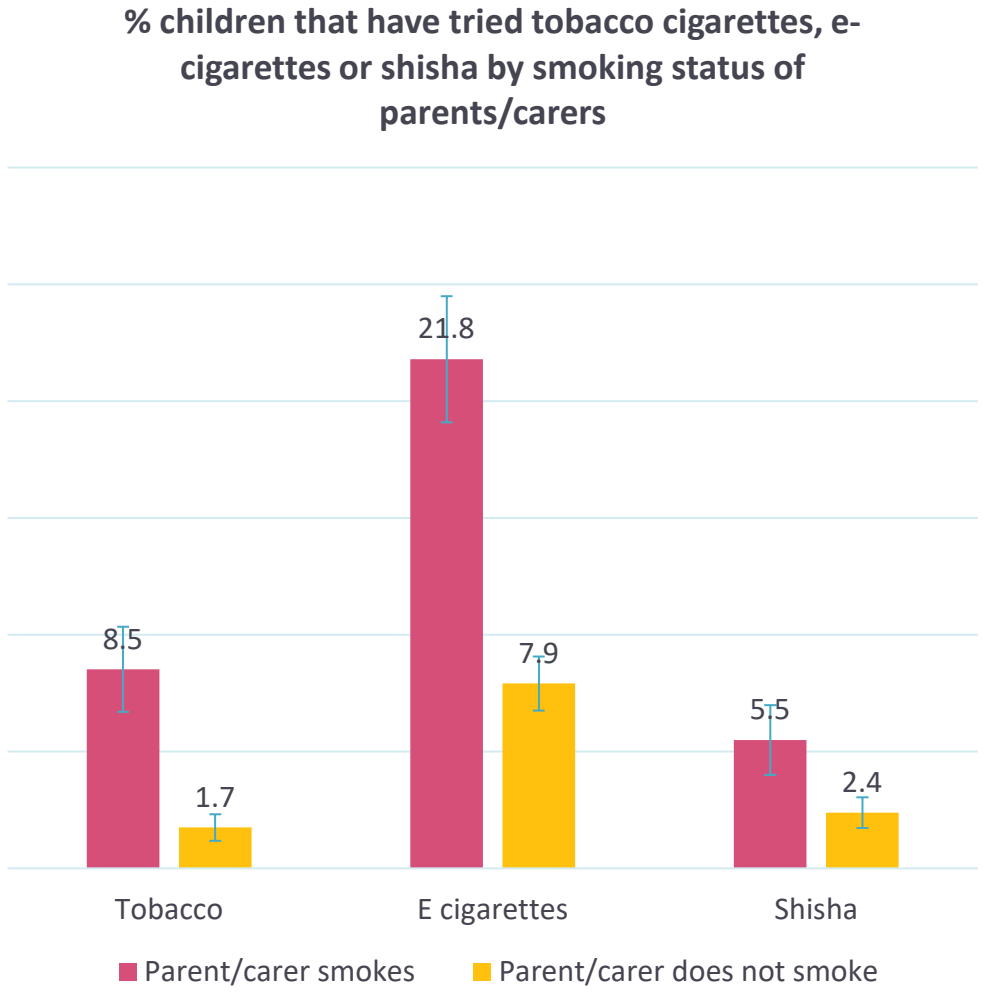
58 and 59. Have you tried any of the following? (Tobacco cigarettes, shisha waterpipe, e-cigarettes) - by smoking status of parents/carers

The proportion of children reporting that they have tried tobacco cigarettes, e-cigarettes or shisha was significantly higher in those whose parents/carers smoke than those whose parents/carers do not smoke.

129

Over one in five (22%) children with parents/carers who smoke have tried e-cigarettes (vaping).

Nearly one in ten (9%) children with parents/carers who smoke have tried tobacco cigarettes, and around one in twenty (6%) have tried shisha.



Around one in ten secondary aged children reported that they have been offered drugs.

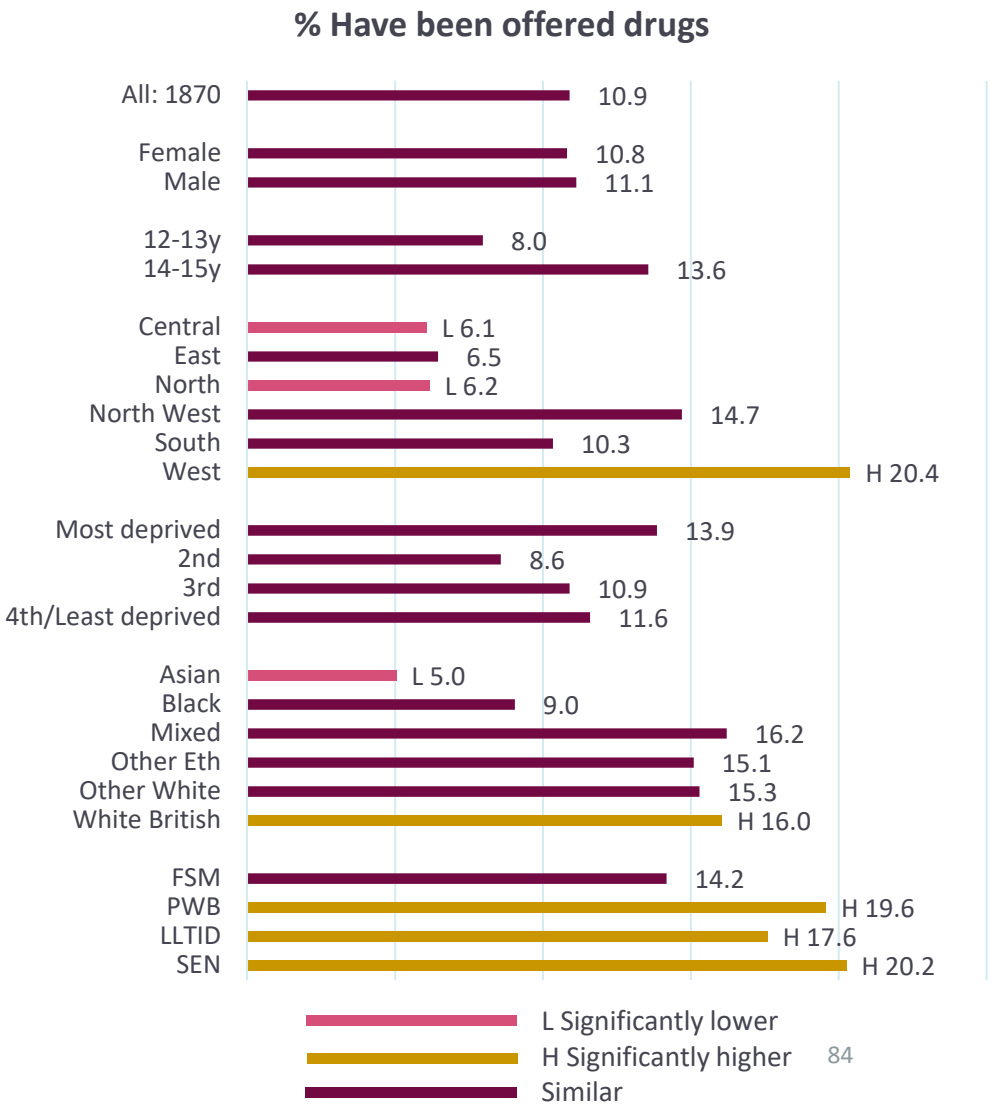
60. Have you ever been offered drugs? E.g. cannabis, ecstasy

The proportion of secondary aged children reporting that they have been offered drugs was significantly larger in the 14-15 year age group than the 12-13 year age group.

A significantly smaller proportion of secondary aged children in the Central and North locality areas of Leicester have been offered drugs, whilst those in the West are significantly more likely to have been offered drugs.

Children of White British ethnicity are significantly more likely to have been offered drugs, whilst those of Asian heritage are significantly less likely to have been offered drugs.

Children reporting a poor mental wellbeing, a long term illness or special educational needs are significantly more likely to have been offered drugs.



Note: *Only Secondary aged children were asked to respond to this question*

Deprivation Quintiles: *Most deprived (Living in 20% most deprived areas nationally and 4th/Least deprived (living in the 40% least deprived areas nationally)*
Additional groups: *FSM- Free School Meals*
PWB – Poor Wellbeing
LLTID – Long term limiting illness or disability
SEN Special Educational Need

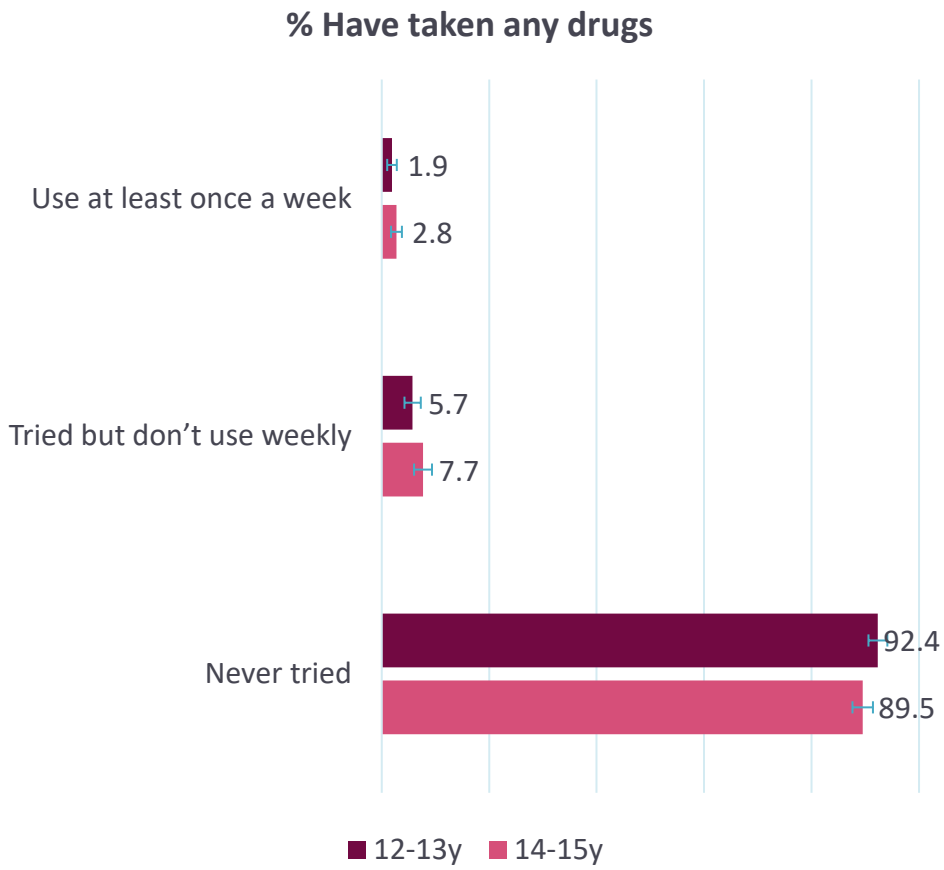
The vast majority of Leicester secondary aged children have never taken any drugs. Around one in ten secondary aged children reported that they have taken drugs.

61. Have you taken any drugs? (not tobacco, alcohol or medicine prescribed for you by a doctor)

A significantly larger proportion of secondary aged children have never tried drugs (91%) than have tried drugs (9%).

There were no significant differences between 12-13 year olds and 14-15 year olds in the proportion that use drugs at least once a week, have tried drugs but don't use them weekly and have never taken any drugs.

A significantly larger proportion of children had tried drugs but don't use them weekly than use drugs at least once a week in both the 12-13 and 14-15 year age groups.



Note: *Only Secondary aged children were asked to respond to this question*

Bullying

- Almost one quarter of children reported that they had been bullied in the last twelve months.
- Three out of five of those that had been bullied in the last twelve months had been bullied at school (not lesson time), this is significantly more than in any other location.
- Of children who were bullied in the last 12 months almost half thought that they had been picked on or bullied because of the way that they look, this is significantly more than the proportion that thought it was because of any other reason.
- Around 15% of children reported that they had been mean or unkind to someone in the last twelve months because they wanted to upset them.
- A significantly larger proportion of secondary aged children got their useful information about bullying from school (70%) than from any other source, followed by around half (51%) of secondary aged children getting their useful information about bullying from their family. Almost one quarter (23%) of secondary aged children got their useful information about bullying from social media.

Almost one quarter of children (24%) reported that they had been bullied in the last twelve months. Almost one third (32%) of 10-11 year olds had been bullied in the last twelve months, this is significantly more than the proportion of 12-13 (24%) and 14-15 year olds (16%).

62. Have you been bullied in the last twelve months?

There are differences in bullying by broad area geographies. Children of White British ethnicity are significantly more likely to have been bullied in the last twelve months, whilst those of Asian Ethnicity heritage are significantly less likely to have been bullied in the last twelve months.

Children reporting free school meal status, a poor mental wellbeing, a long term illness or special educational need are significantly more likely to have been bullied in the last twelve months.

T33

2016/17	2021/22	Significant change
22.5%	24.4%	No significant change

There has been no significant change in the percentage of children who have been bullied in the last 12 months since 2016/17.

Deprivation Quintiles: *Most deprived (Living in 20% most deprived areas nationally and 4th/Least deprived (living in the 40% least deprived areas nationally)*
Additional groups: *FSM- Free School Meals*
PWB – Poor Wellbeing
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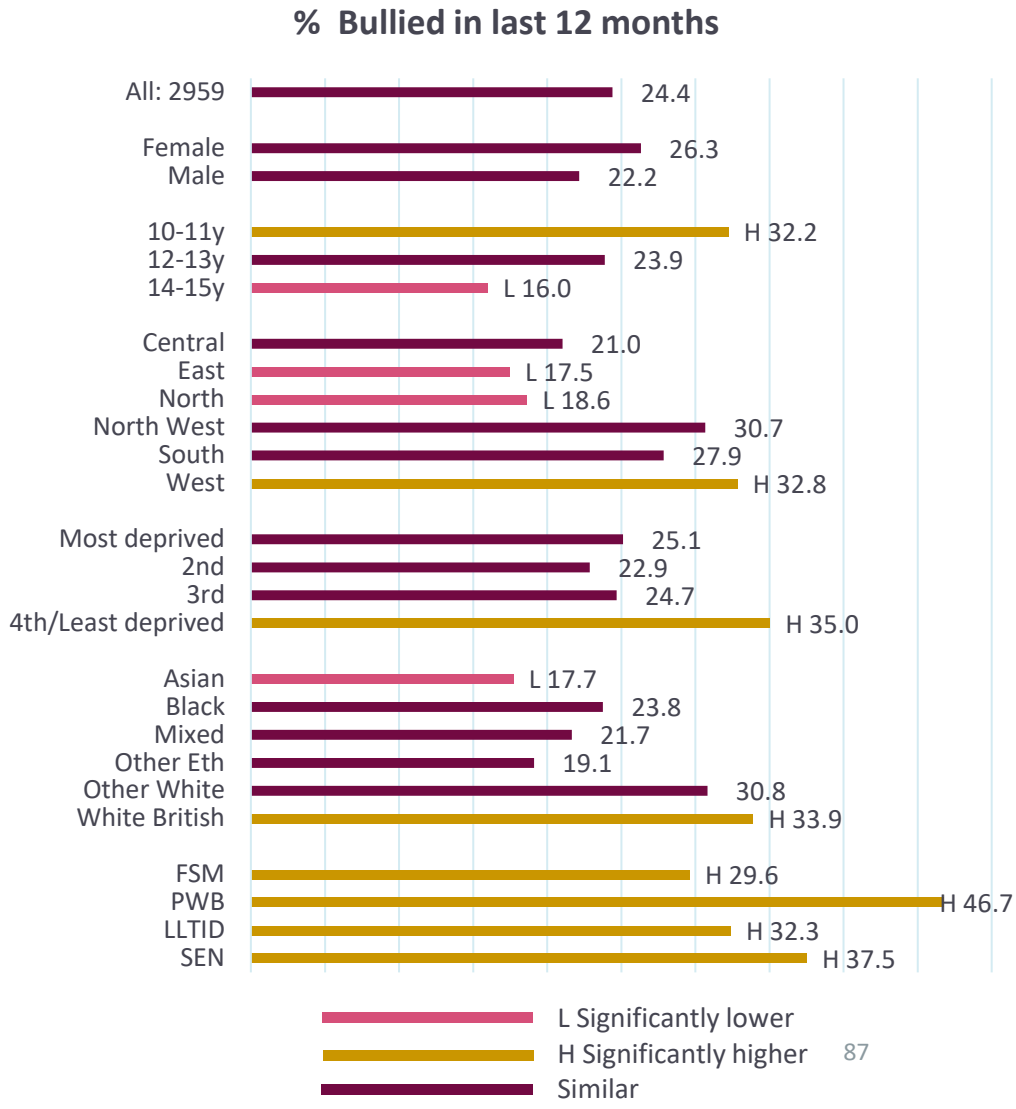
SEN Special Educational Need



Of those that had been bullied in the last twelve months, three out of five (60%) had been bullied at school (not lesson time).

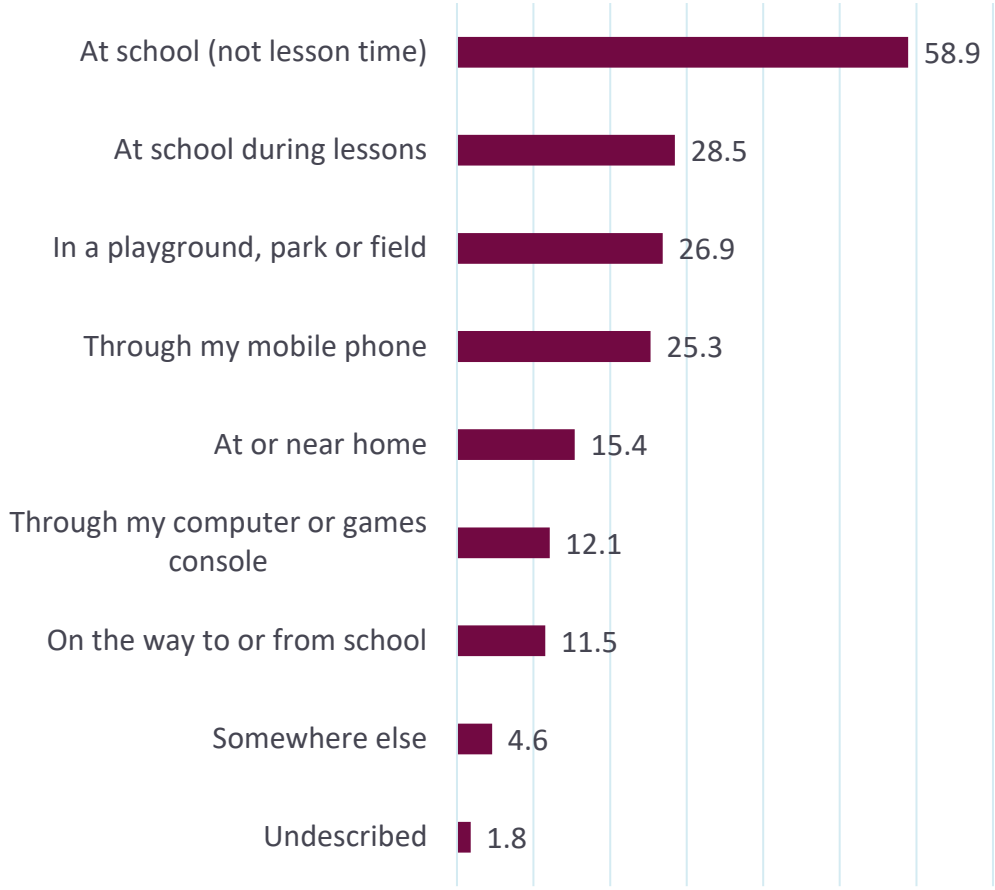
63. Where does this bullying usually happen?

A significantly larger proportion of children had been bullied at school (not lesson time) than in any other location.

Of those that had been bullied in the last twelve months, around a quarter of children had been bullied in each of the following locations: at school during lessons (29%), in a playground, park or field (27%) and through their mobile phone (25%).

Of those that reported that they had been bullied in the last twelve months, 12% had been bullied through their computer or games console.

% of children bullied by location of bullying



Note: *Total does not equal 100% as respondents were encouraged to select all options that applied*

Note: *Only children who have been bullied in the last 12 months responded.*

Of children who were bullied in the last 12 months almost half thought that they had been picked on or bullied in the last twelve months because of the way that they look.

64. Do you think you have been picked on or bullied in the last 12 months for any of the following?

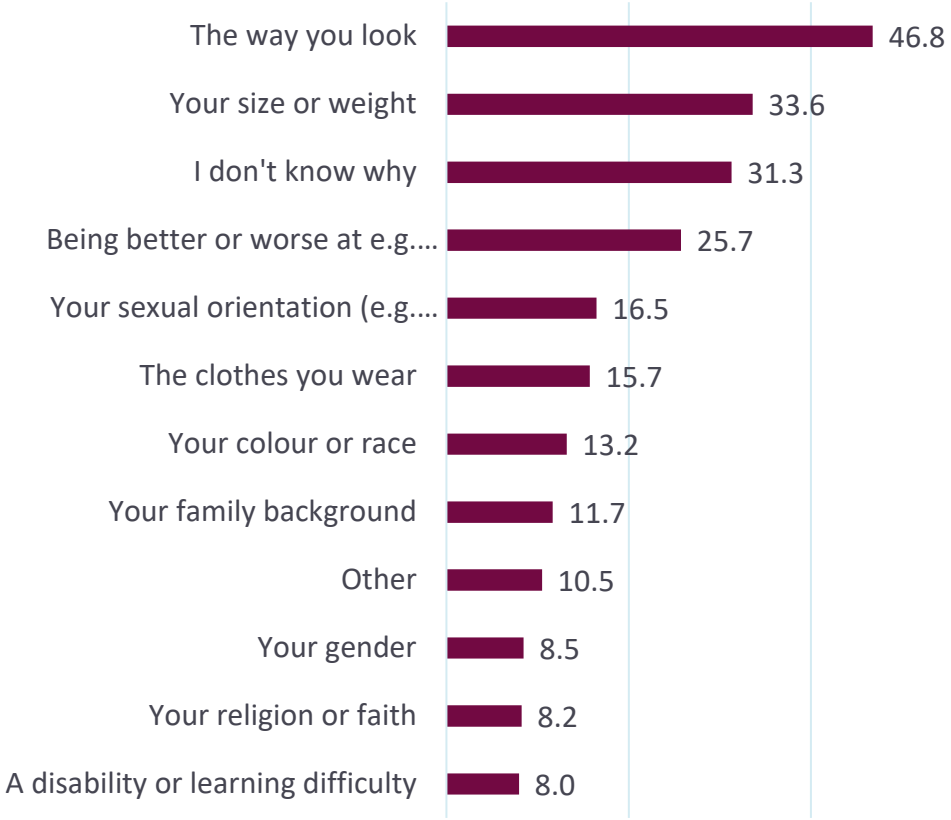
A significantly larger proportion of children (47%) thought that they had been picked on or bullied in the last twelve months because of the way that they look than for any other reason.

Around a third (34%) of children thought that they had been picked on or bullied in the last twelve months because of their size or weight.

Just over a quarter (26%) of children thought that they had been picked on or bullied in the last twelve months for being better or worse at e.g. school work.

Almost a third of children (31%) did not know why they had been bullied.

Of those that had been bullied in the last twelve months, % children that think that they have been picked on or bullied for any of the following *



% figures will not total to 100% as respondents were encouraged to select all options that applied

Note: *Only children who have been bullied in the last 12 months responded.*
** The response options 'Your sexual orientation', 'Your gender' and 'A disability or learning difficult' were only available for secondary aged children.*

Around 15% of children reported that they had been mean or unkind to someone in the last twelve months because they wanted to upset them, this is similar to 2016/17 (14.8%)

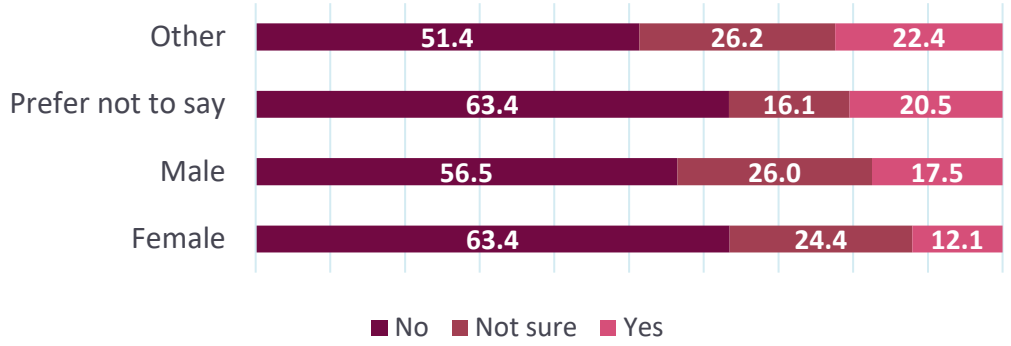
65. In the last 12 months, have you been mean or unkind to someone because you wanted to upset them?

Of all respondents, a significantly smaller proportion had been mean or unkind to someone in the last twelve months because they wanted to hurt them (15%) than had not been (60%).

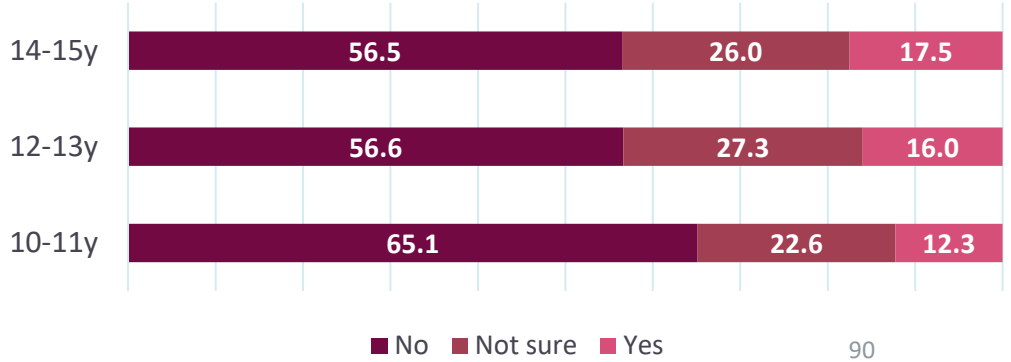
A significantly larger proportion of males (18%) than females (12%) had been mean or unkind to someone in the last twelve months because they wanted to upset them.

The proportion of children that had been mean or unkind to someone in the last twelve months because they wanted to upset them was significantly larger in those aged 14-15 years old (18%) than those aged 10-11 years old (12%).

% children that have been mean or unkind to someone in the last 12 months because they wanted to upset them by sex



% children that have been mean or unkind to someone in the last 12 months because they wanted to upset them by age group

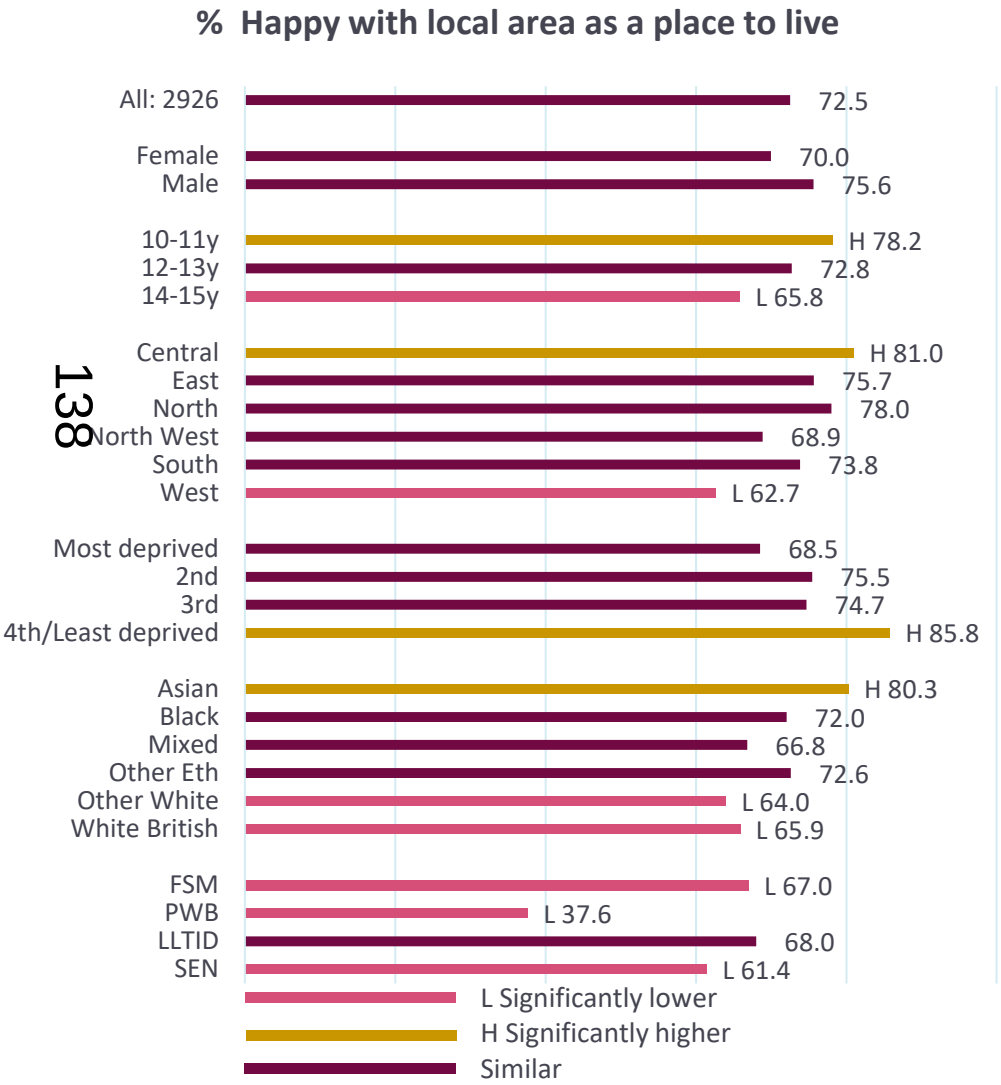


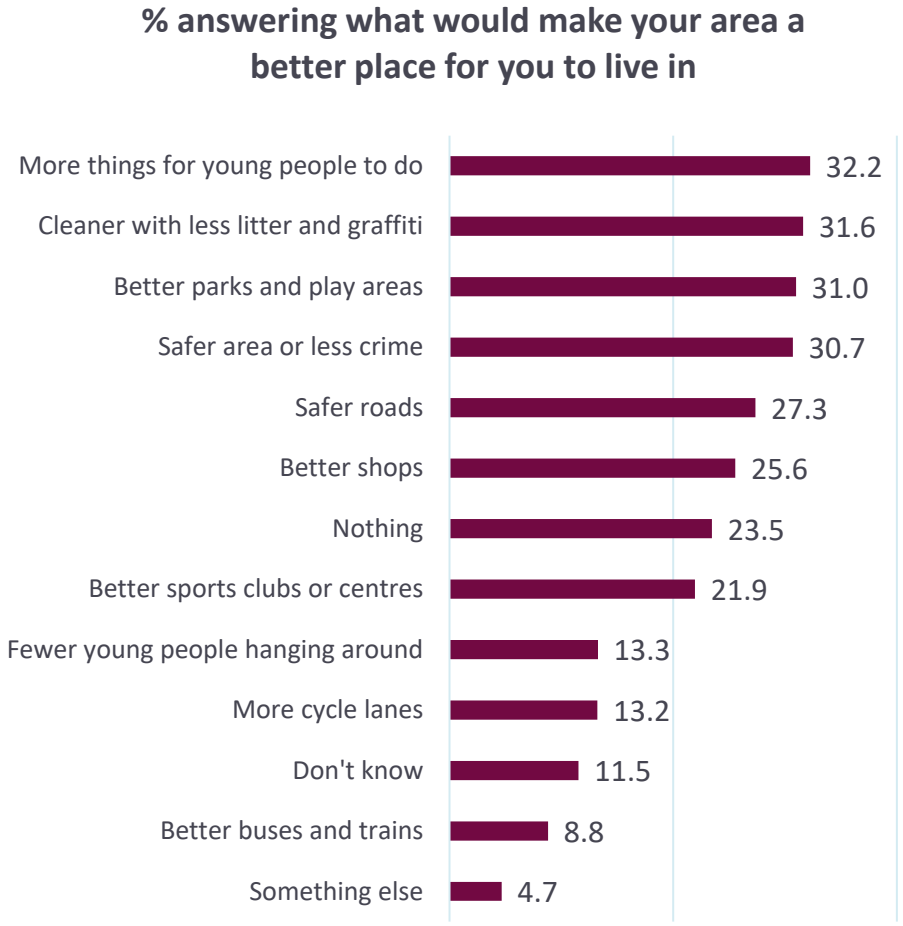
Your local area and safety (including online safety)

- Most children report being happy with their local area as a place to live and also reported feeling safe in their local area.
- Issues raised when asked what would make your area a better place to live included more activities for children, less litter and graffiti, better parks and play areas.
- One in six secondary aged females report they have experienced unwanted sexual comments.
- The majority of children recall being told how to stay safe while online. This is important given that seven out of ten children have a social media account.
- Over a third of children have viewed images that have upset them online. One in ten secondary aged children have been sent ‘sexting’ images.
- Three out of four children know where to get help if they were worried about feeling safe online.

Around 7 in 10 children (73%) reported being happy with their local area, however there are differences by group. Children reported that more things for young people to do, a cleaner local area with less litter and graffiti, and better parks and play areas would improve their area.

66. Overall, how happy or unhappy are you with your local area as a place to live? 67. What would make your area a better place for you to live in?

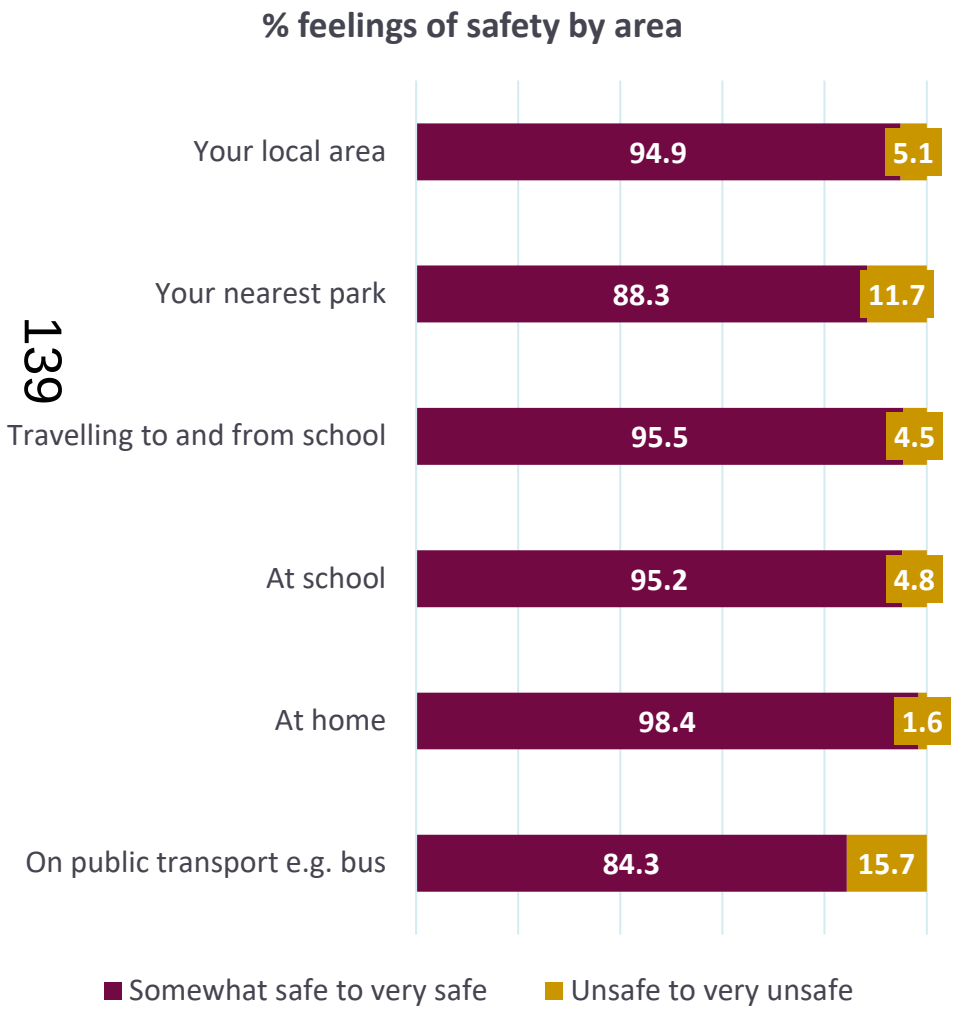


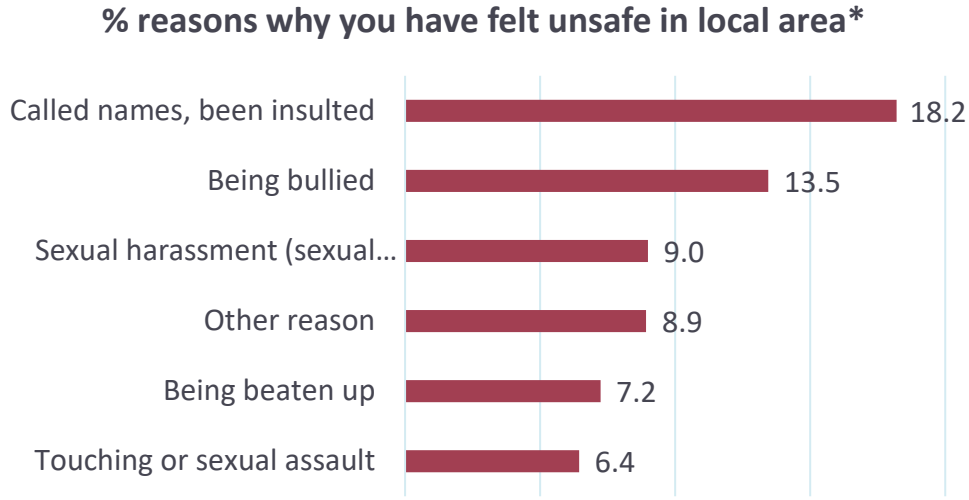


Deprivation Quintiles: *Most deprived (Living in 20% most deprived areas nationally and 4th/Least deprived (living in the 40% least deprived areas nationally)*
Additional groups: *FSM- Free School Meals, PWB – Poor Wellbeing, LLTID – Long term limiting illness or disability, SEN Special Educational Need*

Children largely felt safe in their local area (95%), and felt safest travelling to and from school, at school, and at home. Children felt least safe on public transport and in their nearest park, with over 1 in 10 children reporting they feel unsafe in these areas.

68. How safe do you feel in these places? 69. Why have you felt unsafe in your local area?





***Note:** Only Secondary aged children were asked to respond to this follow up question*

The main reasons for secondary aged children feeling unsafe in their local area include being called names and/or being insulted, and being bullied.

About one in ten (9%) children report experiencing sexual harassment and unwanted sexual comments. For females it was 17% who experienced sexual harassment.

Physical assault, inappropriate touching and/or sexual assault were the least common reasons.

Almost one in ten secondary aged children have reported they have experienced sexual harassment or unwanted sexual comments. The majority of children who have experienced sexual harassment are female, with one in six females reporting sexual harassment.

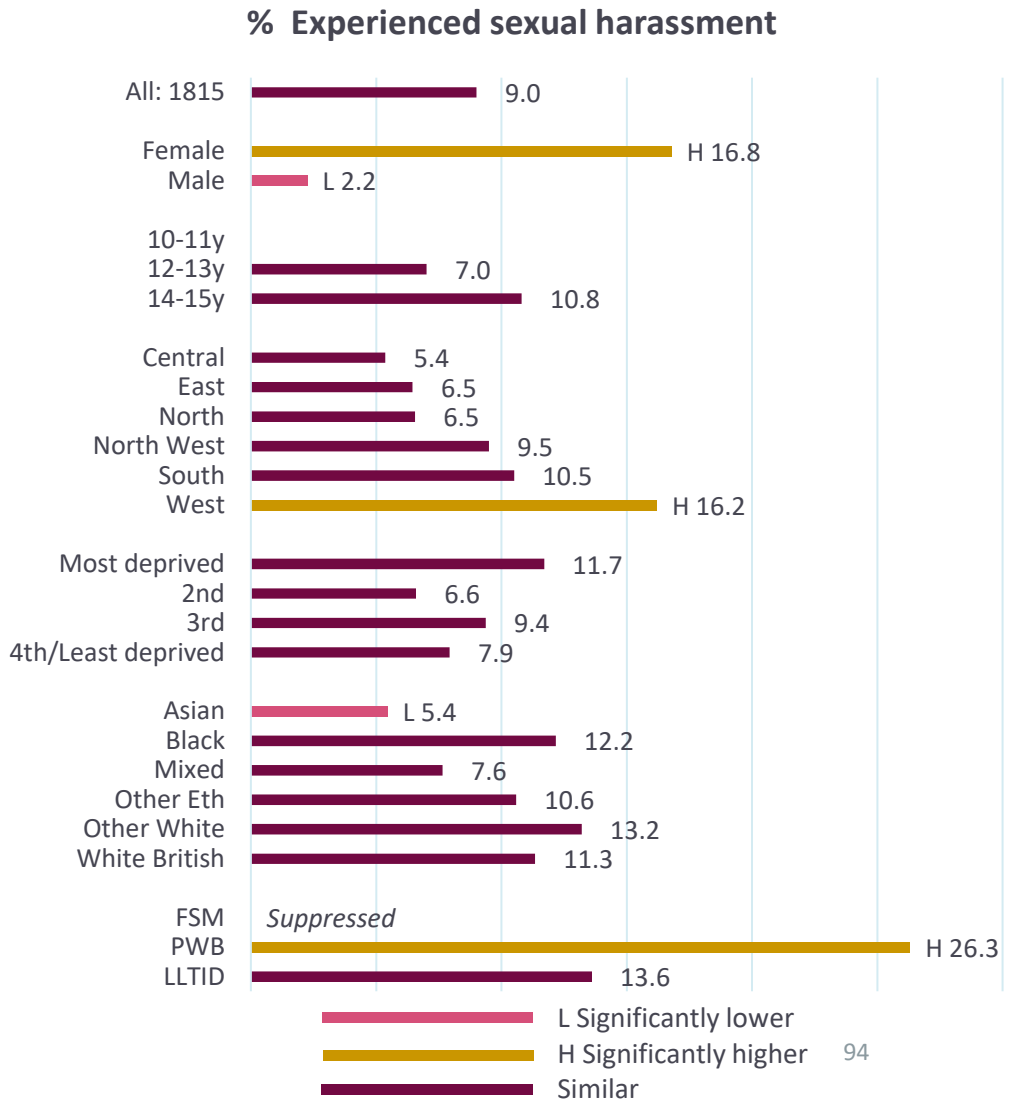
69. Why have you felt unsafe in your local area? Experienced sexual harassment

Females were significantly more likely to experience sexual harassment/unwanted sexual comments.

Older children were more likely to have experienced sexual harassment.

There are differences by geography, with children in the West significantly more likely to have experienced sexual harassment.

Asian children are significantly less likely to state they have experienced sexual harassment.



***Note:** Only Secondary aged children were asked to respond to this question*

***Deprivation Quintiles:** Most deprived (Living in 20% most deprived areas nationally and 4th/Least deprived (living in the 40% least deprived areas nationally)*
***Additional groups:** FSM- Free School Meals*
PWB – Poor Wellbeing
LLTID – Long term limiting illness or disability
SEN Special Educational Need

Almost three quarters (71%) of children reported having at least one social media account. Almost two out of five children (38%) have seen pictures or videos online that upset them.

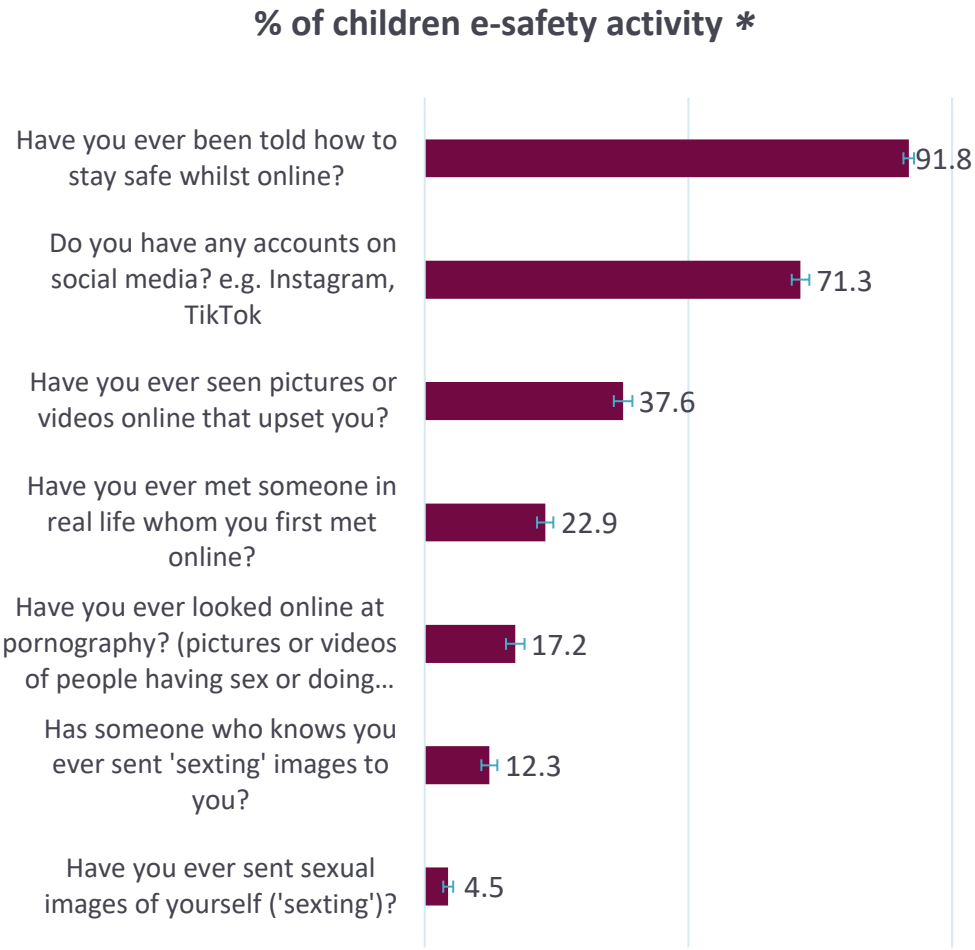
70. E-safety: being safe using computers and smart phones

The majority (92%) of children have been told how to stay safe whilst online. Of those who have been told how to stay safe whilst online, 79% reported that they always follow the advice that they have been given.

Almost a quarter of children (23%) have met someone in real life who they first met online. Of those who have met someone in real life who they first met online, 78% reported that they felt comfortable with this person. 34% reported that the person they met was quite a bit older than them.

Over one in six secondary aged children (17%) have looked online at pornography.

Over one in ten secondary aged children (12%) have been sent sexting images by someone who knows them and around one in twenty secondary aged children (5%) have sent sexual images of themselves.



***Note**: The questions 'Have you ever looked online at pornography?', 'Has someone who knows you ever sent 'sexting' images to you?' and 'Have you ever sent sexual images of yourself ('sexting')?' were only asked in the secondary school survey and therefore data for these questions includes secondary aged children only.*

Over one in ten secondary aged children (12%) have been sent sexting images by someone who knows them. The majority of secondary aged children that have received sexting images from someone who knows them did nothing/ignored it in response.

70. E-safety: being safe using computers and smart phones – Has someone who knows you ever sent 'sexting' images to you? If yes, you have received sexting images, what did you do?

A significantly larger proportion of secondary aged children did nothing/ignored it (59%) than responded in any other way.

Almost one third (29%) of secondary aged children that have been sent sexting images by someone who knows them deleted the images.

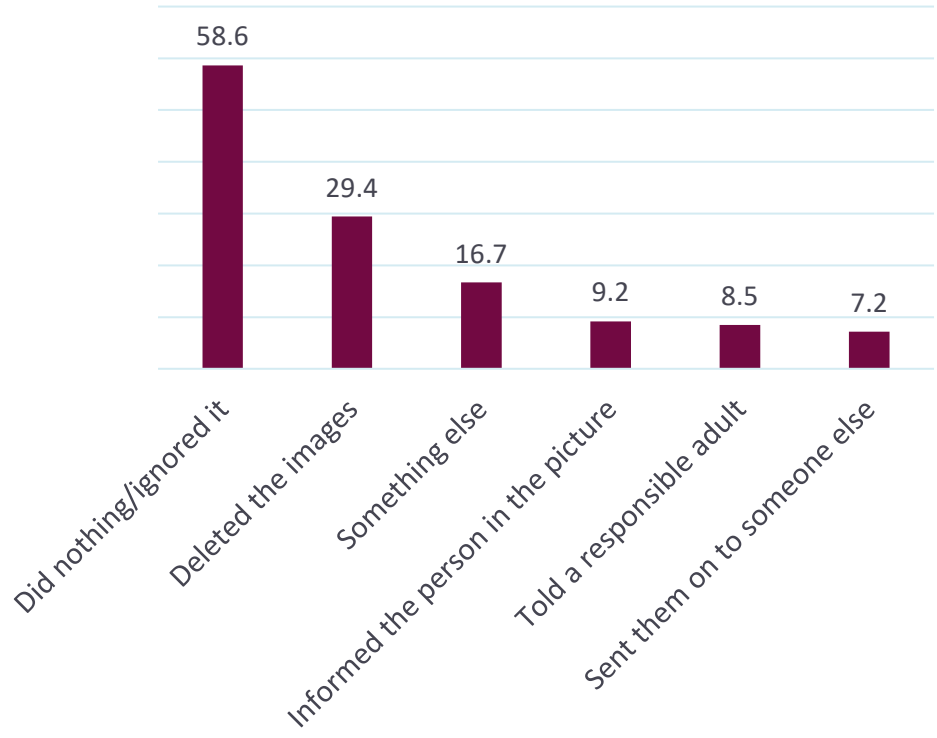
Almost one in ten (9%) secondary aged children that have received sexting images informed the person in the picture.

Fewer than one in ten (9%) secondary aged children told a responsible adult that they had received sexting images.

Of those who have received sexting images, around 7% sent them on to someone else.

Around one in six secondary aged children (17%) did something else (something that wasn't listed) in response to receiving sexting images from someone who knows them.

% of secondary aged children that responded in the following way when they receieved sexting images from someone who knows them

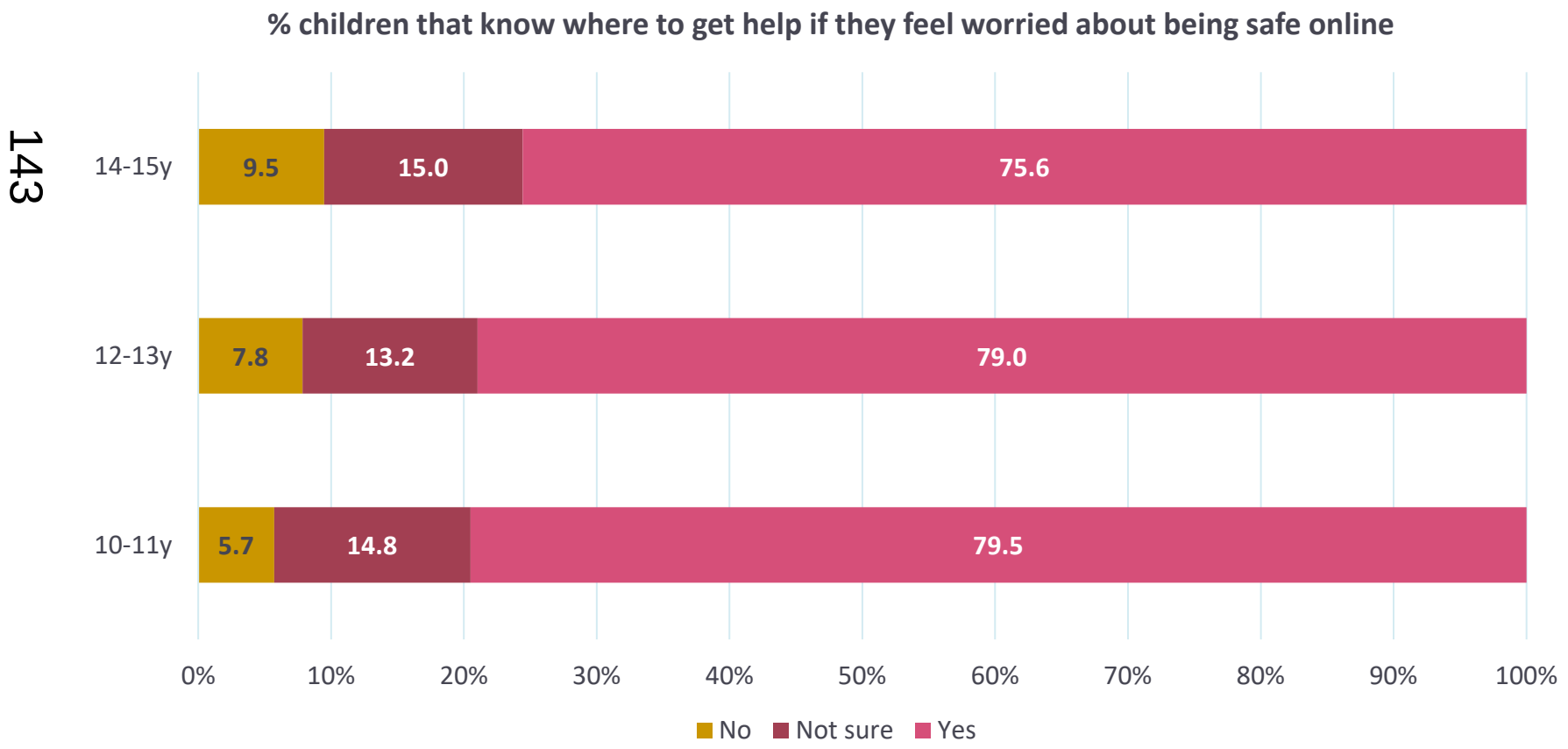


% figures will not total to 100% as respondents were encouraged to select all options that applied

Around three quarters (78%) of children reported that they know where to get help if they feel worried about being safe online.

71. Do you know where to get help if you felt worried about being safe online?

There were no significant differences between the proportion of children aged 10-11, 12-13 or 14-15 years old that know where to get help if they feel worried about being safe online (80%, 79% and 76% respectively).



Relationships and Sexual Health

- Over two thirds of secondary aged children found information from school lessons about puberty useful, and just over half reported finding information about menstruation useful. Females were significantly more likely to find this information useful.

- Almost four in five primary aged children recalled school lessons about puberty. Just over half of recalled school lessons about menstruation, females were more likely to recall lessons.

- About two in five female secondary aged children were not able to access sanitary products all of the time when on their period.

- Around 7% of children aged 14-15 years old have had sexual intercourse.

- There is limited awareness amongst 14-15 year olds of some of the sexual health services available.

- A significantly larger proportion of secondary aged children got their useful information about sex and relationships from school (70%) than from any other source, followed by over a third (36%) getting their useful information from their family. Around one in five (20%) secondary aged children got their useful information about sex and relationships from social media.

Over two thirds of secondary aged children found information from school lessons about puberty useful. Just over half of secondary aged children reported finding information from school lessons about menstruation useful, whilst almost one in four found information from school lessons around female genital mutilation useful.

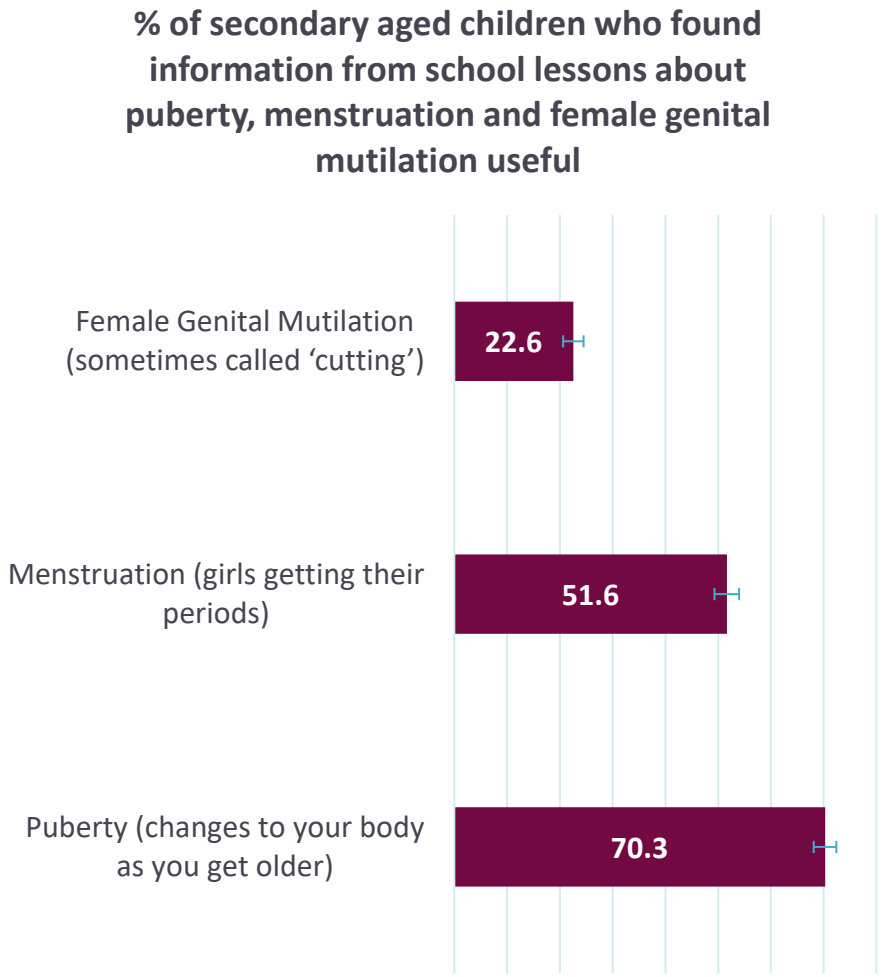
72. How useful have you found any information from school lessons about the following? Puberty, Menstruation and Female Genital Mutilation

Significantly more secondary aged children found information from school lessons about puberty useful (70%) than information about menstruation (52%) or Female Genital Mutilation (FGM) (23%) useful.

The proportion of secondary aged children that found information from school lessons about menstruation useful was significantly larger than the proportion that found information about FGM useful.

A significantly larger proportion of females than males found information from school lessons about menstruation and FGM useful.

The proportion of children that found information from school lessons about menstruation and FGM useful was significantly larger in the 14-15 year age group than the 12-13 year age group.



Note: *Only Secondary aged children were asked to respond to this question*

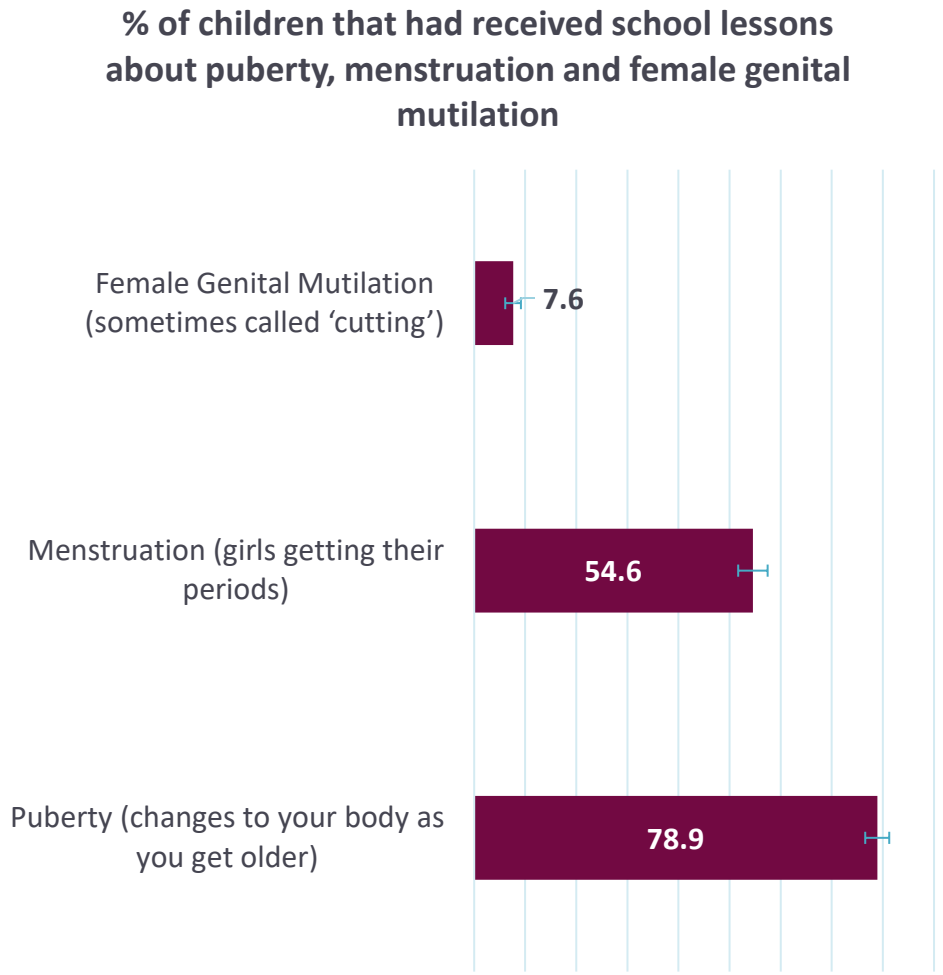
Almost one in eight primary aged children recalled that they had received school lessons about puberty. Just over half of primary aged children had recalled school lessons about menstruation, whilst less than one in ten had recalled school lessons about female genital mutilation.

Primary 26. Have you had any school lessons about the following? Puberty, Menstruation and Female Genital Mutilation

Significantly more primary aged children had recalled school lessons about puberty (79%) than had recalled school lessons about menstruation (55%) or Female Genital Mutilation (8%).

The proportion of primary aged children that had recalled school lessons about menstruation was significantly larger than the proportion that had recalled school lessons about FGM.

A significantly larger proportion of primary aged females had recalled school lessons about puberty and menstruation.



Note: *Only Primary aged children were asked to respond to this question*

Over a quarter of secondary aged children rated the quality of the relationships and sex education they received at school as good/very good. Around one in six secondary aged children rated it negatively (bad or very bad).

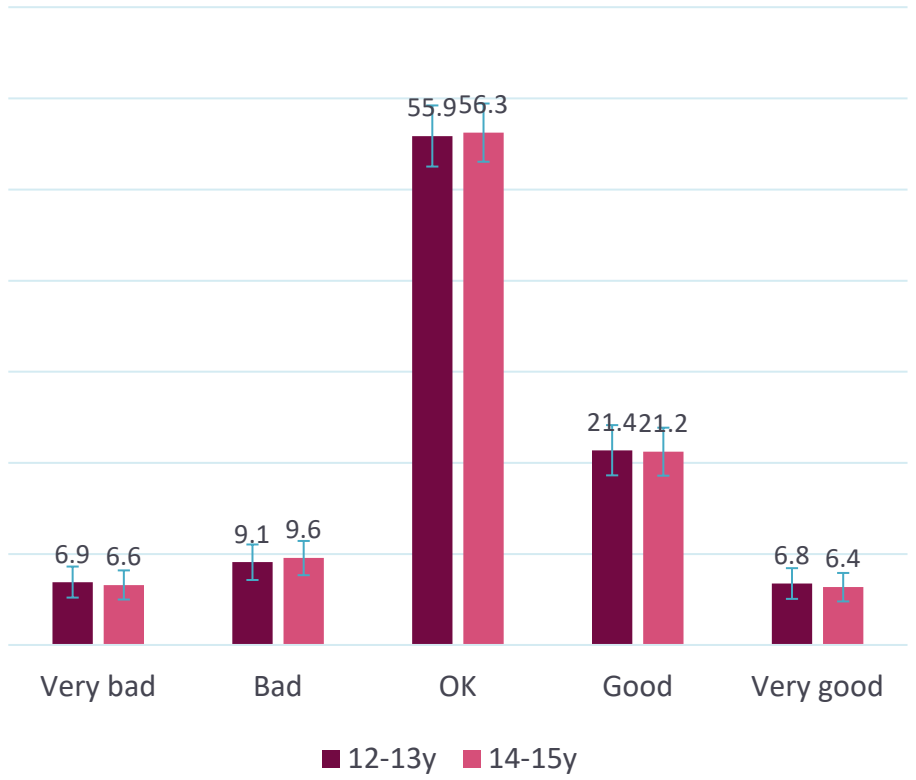
73. How would you rate the quality of the relationships and sex education you received at school?

The majority of secondary aged children rated the quality of the relationships and sex education they received at school as 'ok', this rating was given significantly more than any other rating across both the 12-13 and 14-15 year age groups.

A significantly larger proportion of secondary aged children rated the quality of the relationships and sex education they received at school positively (28%) than negatively (16%).

Significantly more children in both the 12-13 and 14-15 year age groups rated the quality of the relationships and sex education they received at school as 'good' than rated it 'bad' or 'very bad'.

% secondary aged children rating the quality of the relationships and sex education they receieved at school as very bad, bad, ok, good or very good



Note: *Only secondary aged children were asked to respond to this question*

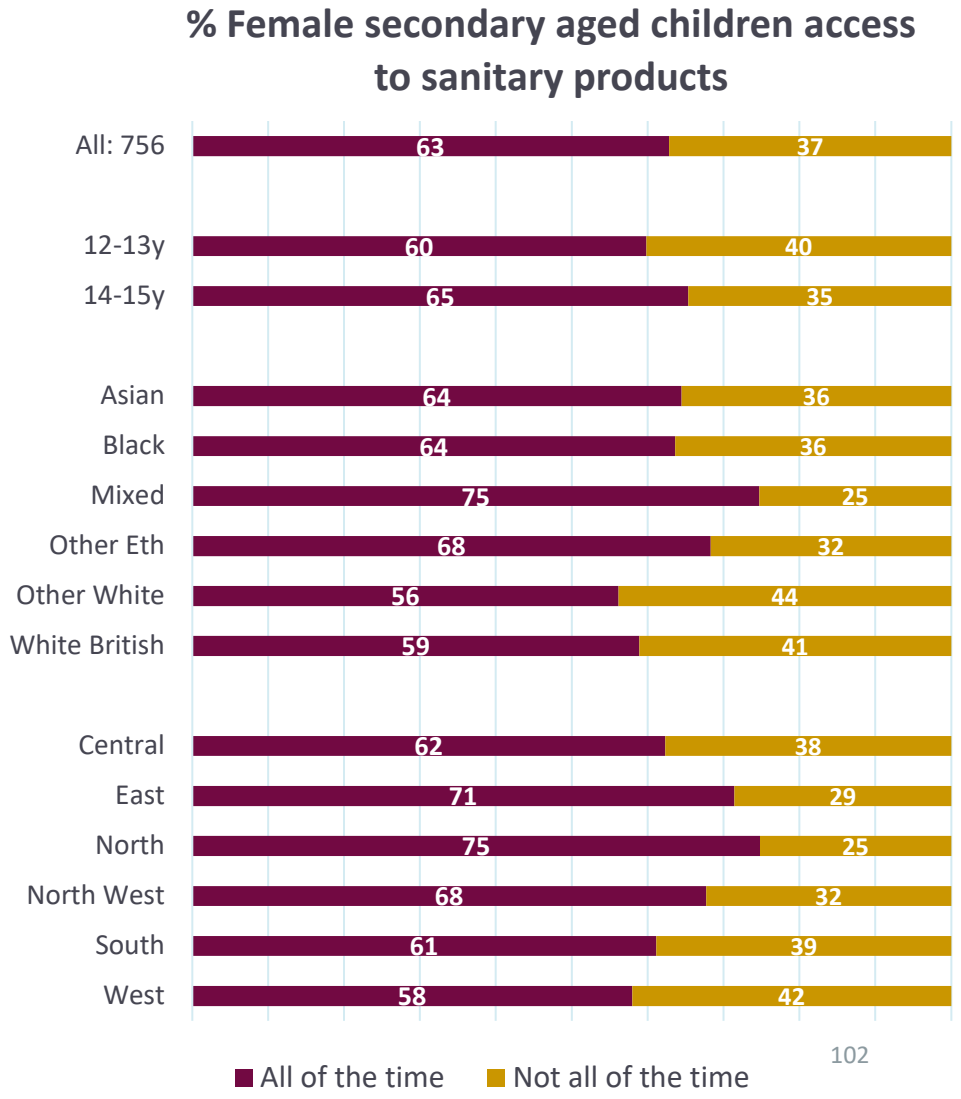
Around two in five (37%) female secondary aged children could not access sanitary products all of the time.

74. Are you always able to access sanitary products when you are on your period?

37% of female children could not access sanitary products all of the time. This was made up of almost one quarter (23%) who were able to access sanitary products most of the time, 12% able to access sanitary products some of the time, and 3% none of the time.

There are no significant differences in the proportion of female secondary aged children not able to access sanitary products all of the time when on their period by age, locality area, deprivation or ethnicity.

Female secondary aged children reporting a special educational need were significantly more likely not to have access to sanitary products all of the time when on their period.



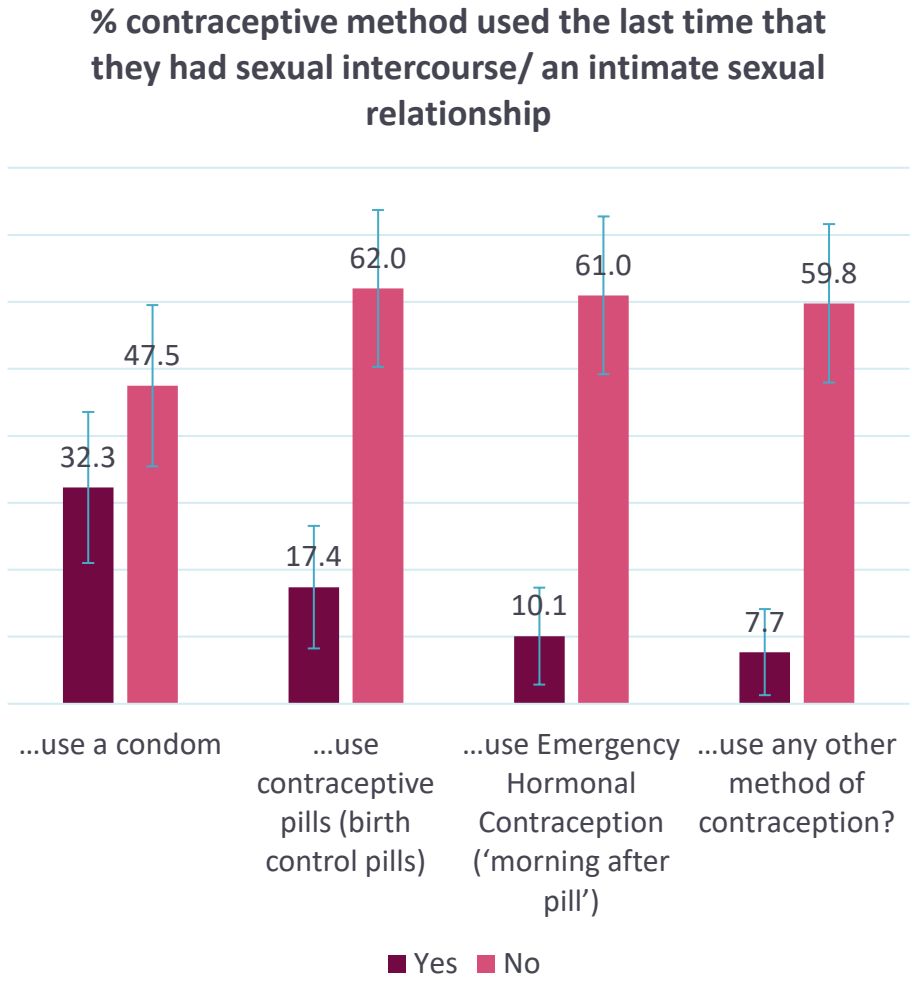
Note: *Only female secondary aged children replied to this question*

Around 7% of children aged 14-15 years old have had sexual intercourse. Condoms were the most commonly used form of contraception by children aged 14-15 years the last time that they had sexual intercourse/ an intimate sexual relationship.

75 and 76. Have you ever had sexual intercourse? The last time that you had sexual intercourse/an intimate sexual relationship, did you or your partner use contraception?

Of those 14-15 year old children who reported having sex significantly more used a condom (32%) than used Emergency Hormonal Contraception (10%) or a method other than those listed (8%).

Around a sixth of children aged 14-15 years old (17%) used contraceptive pills (birth control pills) the last time that they had sexual intercourse, although this was not significantly different to the proportion of children using other methods of contraception.



Note: *Only 14-15 year old children answered these questions*

GP and local pharmacy were the most used services by secondary aged children. Local sexual health services and c-card or other free condom services were the least known health services listed amongst secondary aged children.

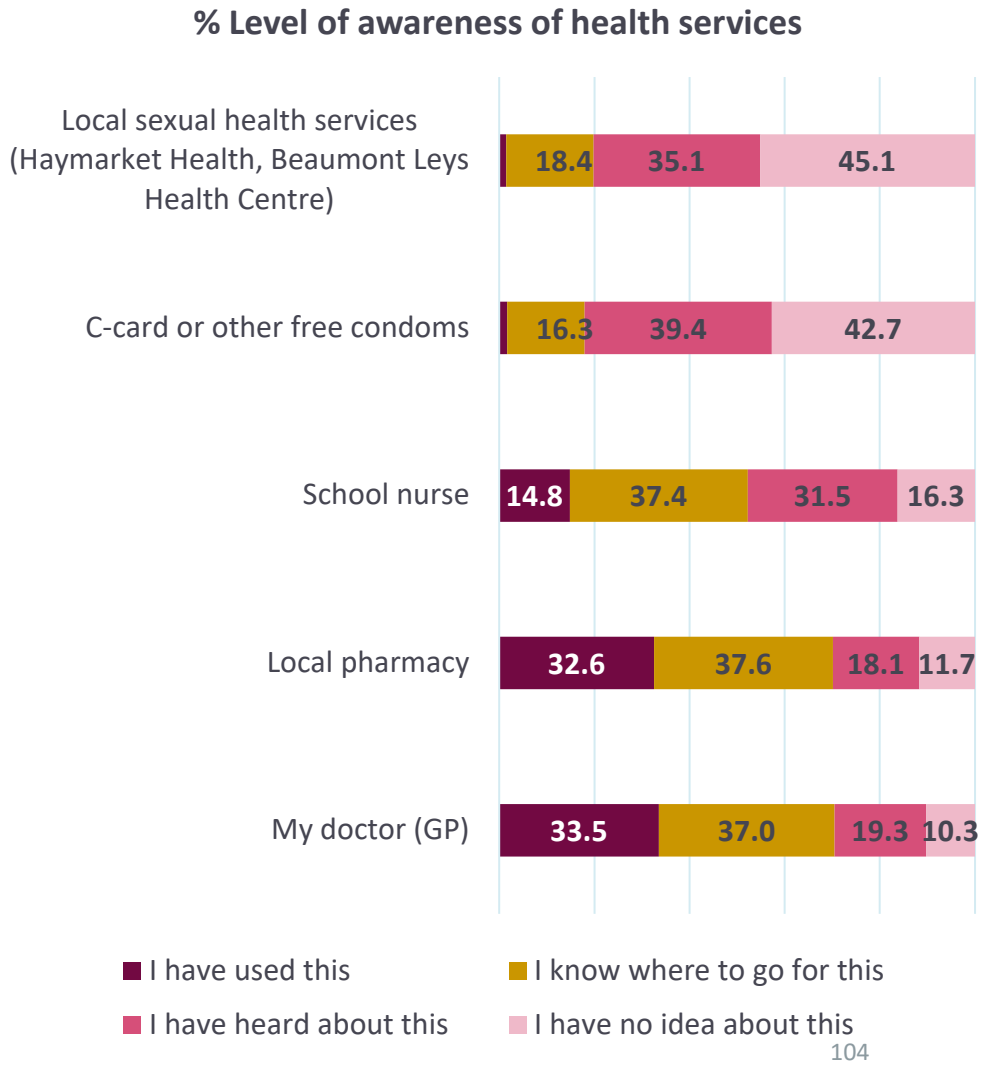
77. Which of the following best describes your awareness of these services?

A significantly larger proportion of secondary aged children have used GP or local pharmacy services than have used the school nurse, c-card or other free condoms or local sexual health services.

A significantly larger proportion of secondary aged children have used the school nurse than have used c-card or other free condom services or local sexual health services.

Almost half of secondary aged children (45% and 43% respectively) have no idea about local sexual health services or c-card or other free condom services.

Around one in ten secondary aged children have no idea about GP services (10%), a slightly larger proportion have no idea about local pharmacy services (12%).



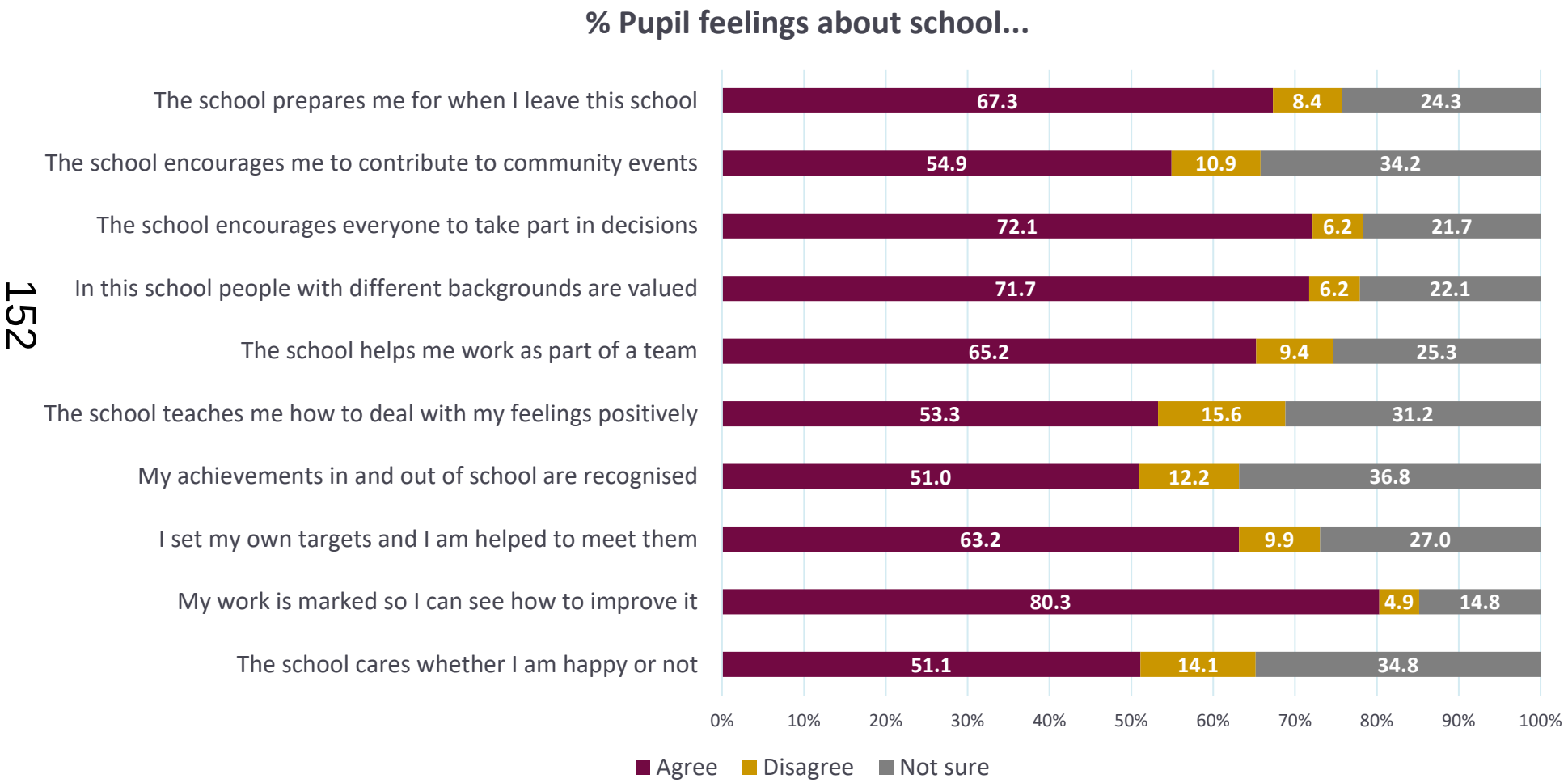
Note: *Only secondary aged children were asked to respond to this question*

Your school and pupil voice

- Most children agreed that people with different backgrounds are valued, and the school encourages everyone to take part in decisions.
- Children report being asked about their ideas and opinions in school, and some feel that their opinions make a difference. Children are less likely to feel empowered in the wider community.
- About half of children would like to continue in full time education after leaving school, and a similar proportion of children would like to continue to go to university.
- A quarter of children want to stay in the same neighbourhood they currently live.

Most children (80%) agreed that their work is marked so they can see how to improve, that people with different backgrounds are valued (72%), and the school encourages everyone to take part in decisions (72%). Half of children agree that the school cares whether they are happy (51%).

78. Please think about each of the following statements... (School statements)



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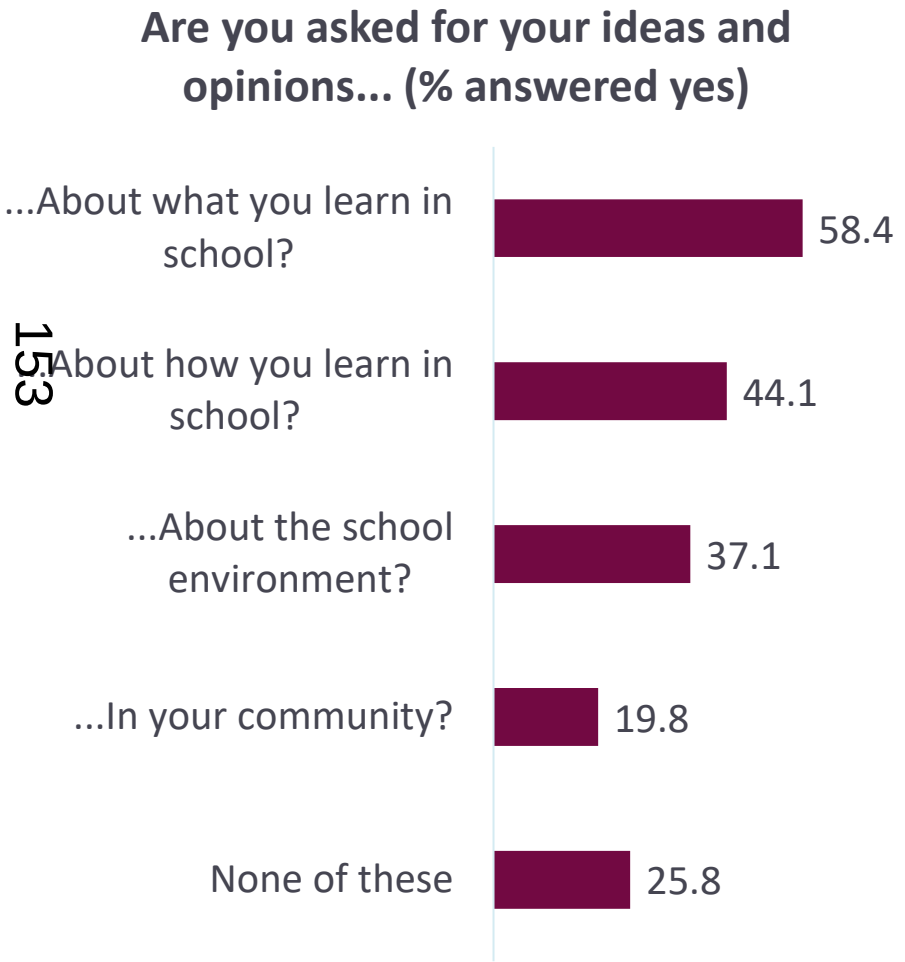
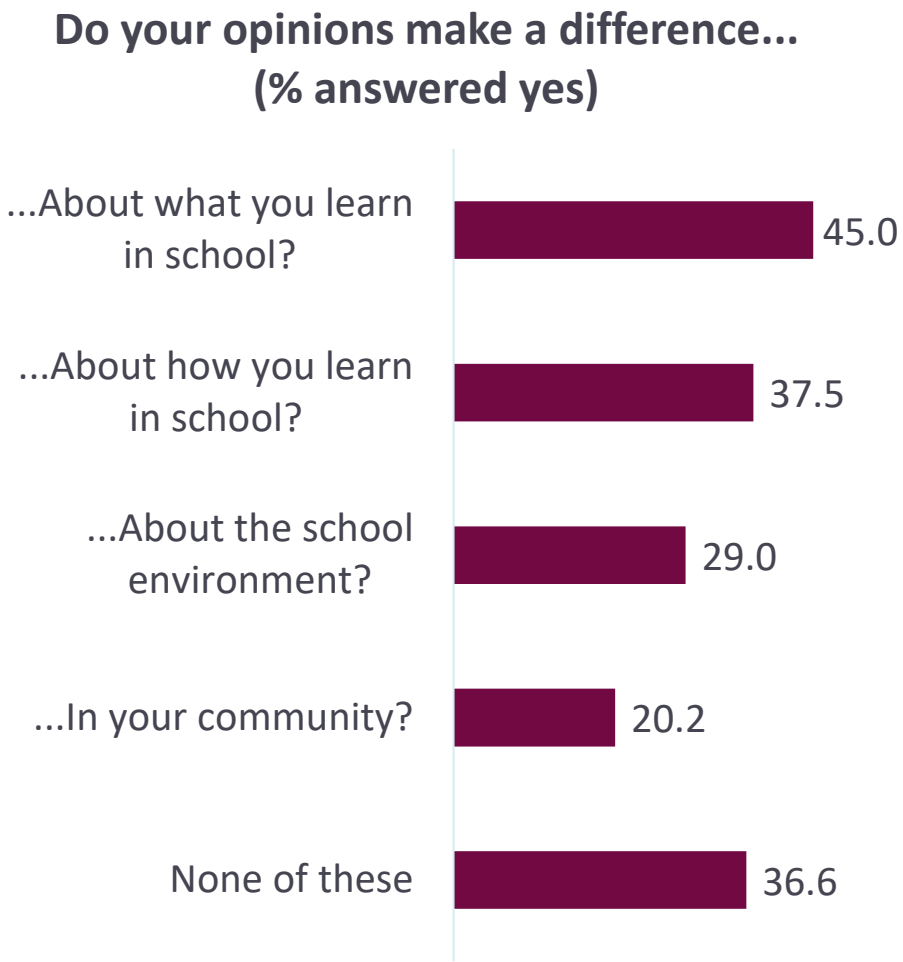
Children report being asked about their ideas and opinions in school, and some feel that their opinions make a difference. Children are less likely to feel empowered in the wider community.

81/82. Are you asked for your ideas and opinions…/Do your opinions make a difference?





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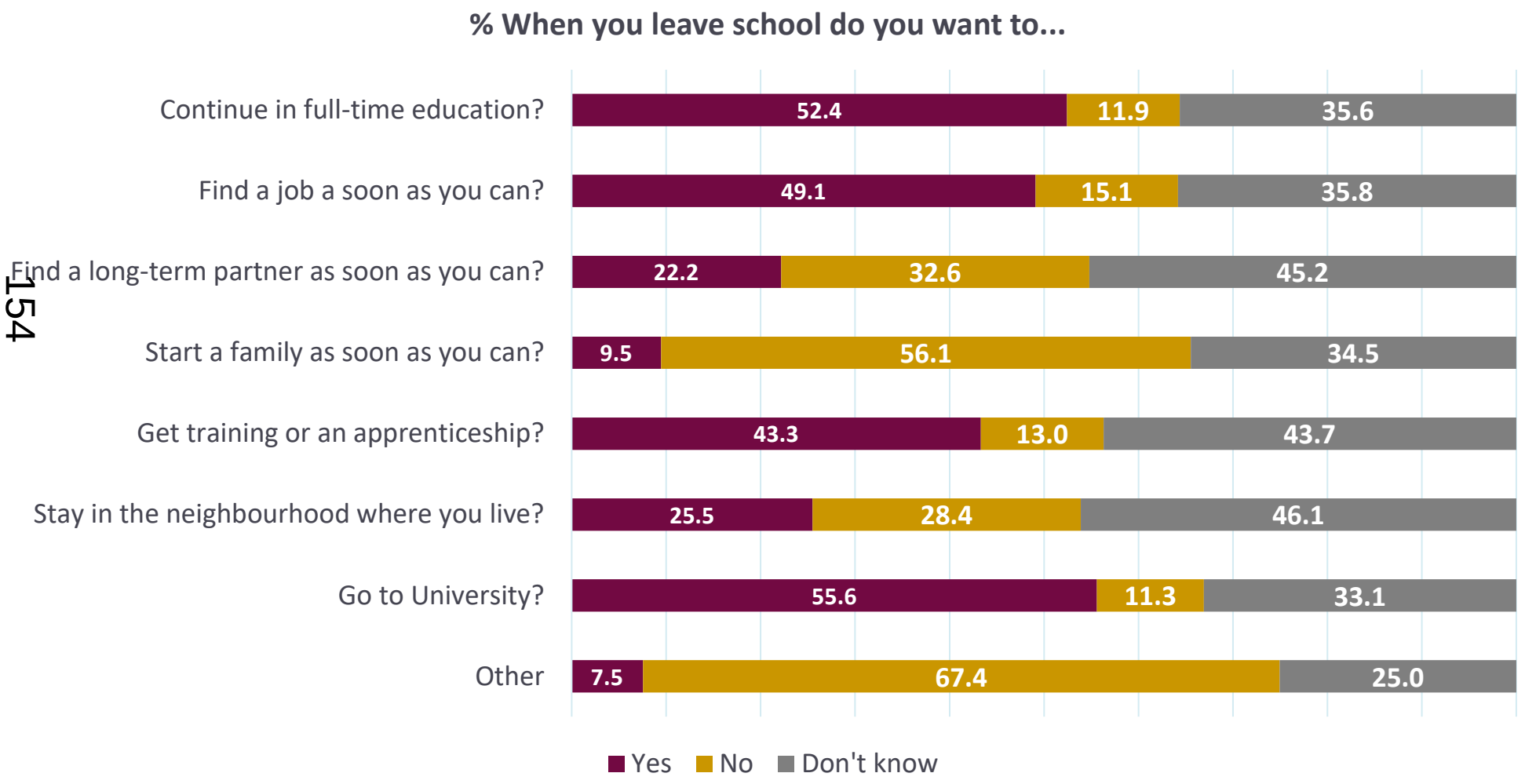
About half of children (52%) would like to continue in full time education after leaving school, and a similar proportion of children would like to go to university (56%). About half of children would like to find a job as soon as they can (49%), and about four in ten children would like an apprenticeship (43%).

80. When you leave school, do you want to…?



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Note: *Only Secondary aged children were asked to respond to this question*

Summary tables and correlations

There are many links between different risk factors. This indicates that children who report experiencing poor risk factors are likely to also be experiencing others. The summary table 'Correlations between risk factors' shows the following:

- Children who care for family members have a higher association with poor resilience.
- Children who spent five or more hours looking at a screen are also likely to be less physically active, and likely to sleep after midnight.
- Children who have nothing to eat for breakfast are also likely to sleep after midnight, and look at a screen for five or more hours.
- Children who get upset and feel bad for ages (poor resilience) are likely to sleep after midnight and have been bullied in the last 12 months.

Summary table: Risk factors by demographics and other groups

% of children	Caring for family members	Nothing to eat for breakfast	No fruit and vegetable portions	Less active (under 30 mins a day)	Five or more hours of Screen time	Going to sleep at midnight or later	Poor Resilience	No trusted adult	Worry about having enough to eat	Parent carer smokes	Bullied in the last 12 months
All:	**19.3**	**31.3**	**13.3**	**47.9**	**27.1**	**18.7**	**28.0**	**10.1**	**17.5**	**30.2**	**24.4**
Female	23.5	33.4	12.4	53.4	26.6	19.5	35.9	10.8	14.6	29.3	26.3
Male	15.7	29.2	14.0	43.0	26.9	17.8	20.3	9.1	20.0	31.1	22.2
10-11 years	23.0	22.1	9.2	47.9	16.5	7.4	31.6	6.2	25.0	28.2	32.2
12-13 years	16.6	34.5	13.0	42.8	29.7	20.4	26.0	10.5	15.1	31.5	23.9
14-15 years	17.9	39.1	18.2	52.5	36.4	29.0	26.1	14.3	11.3	31.4	16.0
Asian British	18.6	27.0	10.8	50.0	16.0	14.7	26.4	9.6	15.7	14.1	17.7
Black British	18.2	35.7	17.7	48.2	30.8	14.8	28.9	14.0	17.5	19.2	23.8
Mixed Heritage	19.1	34.4	13.9	49.6	29.4	22.2	26.8	11.9	18.3	32.1	21.7
Other Ethnicity	19.3	30.8	10.5	46.4	23.3	17.8	19.5	14.4	23.9	17.6	19.1
Other White	17.9	29.5	13.8	50.7	41.5	30.6	30.4	10.0	17.0	58.7	30.8
White British	20.4	37.3	15.2	40.9	40.1	23.0	31.9	8.1	15.8	54.1	33.9
Carers	n/a	35.4	13.1	44.4	29.7	20.5	35.2	11.2	17.6	31.1	30.4
Free Sch Meals	20.7	33.7	13.1	47.1	34.7	24.0	31.0	10.4	19.6	42.7	29.6
Poor wellbeing	21.6	52.7	28.2	55.8	50.3	38.7	55.3	32.9	20.3	51.2	46.7
Long term ill	21.3	34.2	13.4	46.5	37.2	24.2	29.5	13.8	17.6	41.7	32.3
SEN	20.6	31.7	18.3	50.8	35.6	26.8	39.6	11.5	32.2	45.8	37.5

Significantly higher | No significant differences | Significantly lower

Summary table: Risk factors by geography and deprivation

% of children	Caring for family members	Nothing to eat for breakfast	No fruit and vegetable portions	Less active	Five or more hours of Screen time	Going to sleep at midnight or later	Poor Resilience	No trusted adult	Worry about having enough to eat	Parent carer smokes	Bullied in the last 12 months
All:	**19.3**	**31.3**	**13.3**	**47.9**	**27.1**	**18.7**	**28.0**	**10.1**	**17.5**	**30.2**	**24.4**
Central	16.8	28.5	12.1	47.0	16.6	13.1	25.2	9.2	19.7	16.8	21.0
East	19.7	25.4	7.1	42.2	17.1	14.4	27.8	3.3	8.6	32.6	17.5
North	19.4	25.2	13.1	59.1	15.5	14.2	25.3	11.9	17.8	13.8	18.6
North West	21.8	31.8	13.7	45.5	33.3	20.8	29.1	9.6	18.7	34.2	30.7
South	19.1	29.2	15.0	46.6	33.7	20.5	24.2	7.0	17.1	45.6	27.9
West	19.0	35.2	15.0	46.5	37.5	24.8	35.9	11.6	19.1	45.1	32.8
Most deprived	19.4	31.8	14.1	48.3	30.7	21.1	28.4	10.7	17.3	34.5	25.1
2nd	19.0	27.5	12.7	50.8	21.7	15.3	26.8	8.7	17.7	26.4	22.9
3rd	19.7	32.2	10.6	46.0	23.3	19.7	30.8	8.9	15.9	26.2	24.7
4th/Least dep.	20.2	26.0	8.9	40.5	24.5	11.5	30.1	5.4	16.2	28.7	35.0

Significantly higher | No significant differences | Significantly lower

Summary table: Correlations between risk factors

	Caring for family members	Nothing to eat for breakfast	Less Physically Active	Screentime 5+ hours	Midnight or later	Poor resilience	Worry about having enough to eat	Parent Carer smokes	Bullied in the last 12 months
Caring for family members									
Nothing to eat for breakfast									
Less Physically Active									
Screentime 5+ hours									
Midnight or later									
Poor resilience									
Worry about having enough to eat									
Parent Carer smokes									
Bullied in the last 12 months									

Significantly higher association/likelihood | No significant differences | Significantly lower association/likelihood

Leicester Child Health and Wellbeing Survey 2021/22

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

Completed by Leicester City Council, Division of Public Health and the School Health Education Unit

Authors: Amy Chamberlain, Gurjeet Rajania & Hannah Stammers

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LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	LLR Child Death Overview Panel Annual Report for 2021-2022
Presented to the Health and Wellbeing Board by:	Rob Howard, Consultant in Public Health Dr Suzi Armitage, Designated Doctor for Child Death
Author:	Rob Howard and Dr Suzi Armitage

EXECUTIVE SUMMARY:

Annual Report of the Leicester, Leicestershire & Rutland Child Death Overview Panel is produced in line with statutory requirements as set out in Working Together to Safeguard Children, 2018.

The report provides an overview of the work of the LLR CDOP Panel during 2021-22, including:
- Family support
- Child death notifications 2021/22 (all deaths <18yrs of those usually resident in LLR)
- Infant & child mortality rates across LLR
- Completed child death reviews 2021/22 (all deaths reviewed by LLR CDOP in 2021/22)

- Key Thematic work
  - Infant Mortality in LLR
  - Deprivation and child mortality
  - Deaths occurring due to suicide and self-harm
  - Deaths in children & young people with learning disabilities

- Case learning & recommendations.

Full report is available in Appendix 1.

Key recommendations:
1. To develop a multiagency approach to safer infant sleeping
2. To prioritise development of integrated electronic records systems to support information sharing and communication, and earlier identification of emerging vulnerabilities
3. For LLR Healthy Babies Strategy Group to use the findings to support a refresh of their strategy & action plan, addressing social determinants of health.
4. For LLR CDOP to work with stakeholders to carry out a thematic review of suicide & self- harm in children and young people in LLR.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

Note the report and support multiagency delivery of key recommendations

Child Death Overview Panel (CDOP) Annual Report 2021-2022

Child Death Overview Process

Leicester, Leicestershire & Rutland

Authors

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Lisa Hydes, LLR Child Death Review Manager
Rob Howard, LLR CDOP Chair, Consultant in Public Health, Leicester City Council
Helen Reeve, Senior Intelligence Manager, Public Health, Leicester City Council

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Acknowledgement to CDOP members 2021-2022:

Rob Howard, Consultant in Public Health, Leicester City Council, CDOP Chair
Claire Turnbull, Designated Nurse Safeguarding, CCG, CDOP Vice Chair

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Dr Jeremy Tong, Consultant Paediatric Intensivist, UHL
Dr Kamini Yadav, Consultant Neonatologist, UHL

LLR Child Death Review Service
Lisa Hydes, Child Death Review Manager
Sue Stephenson, Child Death Review Practitioner
Gemma Miles, Child Death Review Practitioner
Melvinna West, Child Death Overview Process Support Officer

Contents

Glossary of abbreviations used

CAIU	Child Abuse Investigation Unit
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
CDIM	Child Death Initial Meeting
CDRM	Child Death Review Meeting
CSPR	Child Safeguarding Practice Review
EMAS	East Midlands Ambulance Service
JAR	**Joint Agency Response** A coordinated multiagency response to a death occurring in any of the following circumstances: - Death due to external causes - Death occurring in suspicious circumstances - Death that is sudden (not anticipated in preceding 24 hours) and for which no medical explanation is evident – a sudden unexpected death in infancy/childhood - Death of a child or young person detained under the mental health act or in custody - A stillbirth occurring without in the absence of a registered health professional.
LeDeR	Learning Disability Mortality Review
LLR	Leicester, Leicestershire & Rutland
LPT	Leicestershire Partnership NHS Trust
LRI	Leicester Royal Infirmary
LSCP	Local Safeguarding Children Partnership
MBRRACE-UK	Mothers & Babies: Reducing Risk through Audit & Confidential Enquiries across the UK
NCMD	National Child Mortality Database
NNU	Neonatal Unit
PMRT	Perinatal Mortality Review Tool
SUDI/C	**Sudden Unexplained Death in Infancy/Childhood** Descriptive term, used at presentation - the death of an infant/child which was not reasonably expected to occur 24 hours previously, and in whom no pre-existing medical cause of death is apparent. Following detailed investigation, a cause of death may be found.
SIDS	**Sudden Infant Death Syndrome** An unexpected death of an infant occurring during normal sleep, which remains unexplained after a thorough investigation and review of the circumstances.
UHL	University Hospitals of Leicester NHS Trust

Introduction

The national process of reviewing child deaths was established in April 2008 and updated in Chapter 5 of Working Together to Safeguard Children 2018. It is the responsibility of the Child Death Review Partners to ensure that a review of every death of a child normally resident in their area is undertaken by a CDOP. Across LLR, the Child Death Review Partners are the three Local Authorities and Clinical Commissioning Groups.

The overall purpose of the LLR CDOP is to undertake a comprehensive and multi-agency review of all child deaths, to better understand how and why children across LLR die, with a view to detecting trends and/or specific areas which would benefit from further consideration. The LLR CDOP has been gathering data since 2009 and been producing annual reports which summarise the data collected in each year.

The process for reviewing child deaths commences with Notification to the Child Death Review team and culminates in final scrutiny at the Child Death Overview Panel (please see fig 1). The Child Death Review process integrates with the Perinatal Mortality Review Programme and the Learning Disability Mortality Review Programme (LeDeR). All data from LLR Child Death Reviews is submitted to the National Child Mortality Database (NCMD) for the purposes of data analysis and learning at a national level.

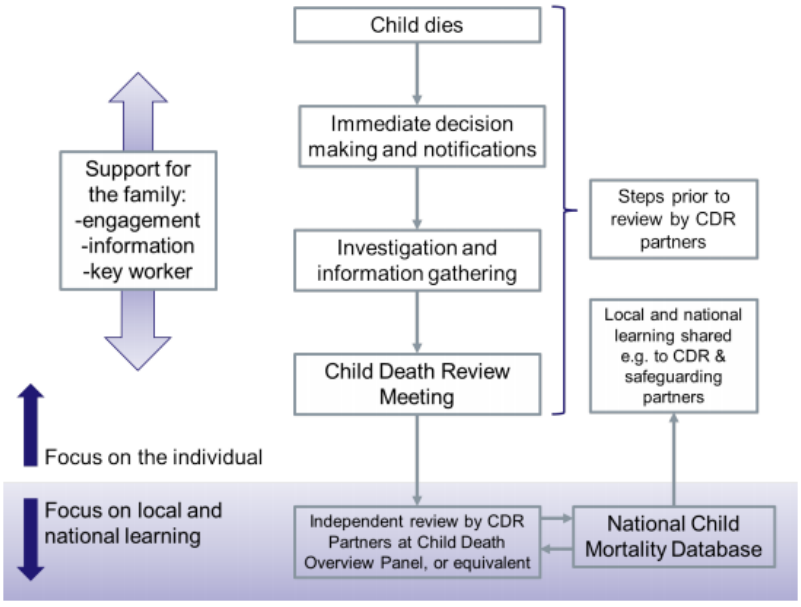


Figure 1: The Child Death Review process as set out in Working Together to Safeguard Children 2018, Chapter 5[1].

Our team: Child Death Review Practitioners

The role of supporting the families and undertaking Joint Agency Response visits with the police sits within the remit of the Child Death Review Practitioner role (CDRP). In November 2020 LLR CDOP appointed a 0.4 WTE equivalent in order to support the current 0.6 WTE post. The CDRP role is an essential aspect to the service to ensure statutory requirements are met, and families are adequately supported, through:

- Carrying out a joint home visit together with police, to gather further information around the circumstances of death. In addition, they will review the background history, identify support for the family, with signposting to specialist bereavement support where appropriate, supporting any other issues identified, preparing and submitting a report for HM Coroner (in line with guidance set out in Sudden Unexpected Death in Infancy & Childhood, 2016[2]).
- Acting as the named Key Worker for families ensuring that families are supported and engaged throughout the review process (in line with Statutory & Operational Guidance, 2018[3]), by:
    - Being a ready & accessible point of contact for the family
    - Coordinating meetings as required
    - Arranging & attending home visits with the Designated Doctor to discuss post-mortem report findings
    - Providing information to the family on the Child Death Review process
    - Liaising with Coroners Officer or Police Liaison Office
    - Representing the voice of the family at professional meetings, ensuring their questions are effectively addressed and providing feedback to family afterwards,
    - Signposting to specialist bereavement support if required.
    - Identifying any additional support needs (e.g. around housing, liaison with siblings schools, liaison with GP)

Examples of Child Death Review Practitioner work undertaken with families during 2021/22:

- Carrying out 23 Joint Agency Response home visits along with the police
- Referral to Specialist Bereavement Support
- Liaison with hospital to locate a lost item belonging to child
- Home visits with Designated Doctor to discuss post-mortem results
- Liaison with agencies to ensure equipment sensitively removed from home
- Meeting to discuss the hospital response to parents' questions with support of interpreter
- Liaison with specialist bereavement support for nursery staff
- Referral for funding towards funeral costs
- Providing telephone support to families
- Liaison with Educational Psychology for sibling support

'The team have been abundantly supportive in all aspects of our professional interactions – from the facilitation of meetings and panels to operational support and information sharing around live incidents. The team consistently strived to support joint visits in a timely and flexible way. Equally, where there have been areas for multi-agency development the team have always worked with us to find a way to make improvements in the best interests of the families and the children who sadly no longer have a voice'.

'Leicester, Leicestershire and Rutland CDOP have worked closely with [our agency] over the many years. This relationship is of course based on statutory reporting process; however it is much more than that. Frequently the bereaved families we are working with talk of the value of being able to speak to CDOP about the care of their child and the sensitivity of these interactions. As a team we have valued the advice from CDOP who have supported us around our own policy and the challenges around the death of a child. Our experience of the service is responsive, professional but importantly for our bereaved families, compassionate.'

Above: Feedback from two of our LLR multiagency partners

LLR CDOP Family Support Audit 2021-22

In order to benchmark the service offered by LLR CDOP, an audit was undertaken to review the support offered to families.

What did we learn?

- Documentation of actions required strengthening
- Stronger liaison required with key workers (who were not from CDOP) in order to ensure actions were identified and followed up

What did we do?

- Paperwork reviewed and amended to capture all information needed to demonstrate compliance with statutory guidance including a pre and post visit checklist
- CDRP pathway developed
- CDRP either keyworker or joint keyworker for all cases
- LeDeR proforma developed

Future plans: Family Feedback & enhancing family involvement in the LLR Child Death Review process

Obtaining feedback from a family is not undertaken widely by CDOPs around the Country and therefore teams need to look at alternatives to ensure they gather the voices of families. There are plans within the coming year to liaise with Rainbows, Bodie Hodges and the Diana Team to look at how we progress this with a potential to establish more regular meetings to collect feedback on a more formal basis with the aim of further developing the service and better meeting family's needs.

The team are also looking to ensure CDOP is accessible for all for families who may choose not to engage initially or have struggled to understand the role of CDOP. Options for development include:

- Plans for CDOP to have space on the BHF website where CDOP is explained using Avatars
- A local Easy read CDOP leaflet is also in development following securing funds from LLR project Launch Fund.

Notifications 2021/22

Key information

LLR CDOP received 90 notifications of deaths of LLR residents under the age of 18 years (substantially more than the previous two years). Nationally overall child mortality appeared to fall from April to December 2020 [4], which may in part explain this. Mean number of notifications per year (67.6) over the past 5 years remains similar to previous years.

30 (33%) of cases met the criteria for a Joint Agency Response. Neonatal cases continue to make up the largest proportion of notifications received to CDOP (32%).

Leicester City: 48 cases (53%)
Leicestershire & Rutland: 42 cases (47%)

82% of children died in hospital.
11% died at home.
4% died in a hospice setting.

Table 1: Death notifications by Local Authority 2017/18 to 2021/22

	2017/18	2018/19	2019/20	2020/21	2021/22
Leicester City	33	36	24	30	48
Leics & Rutland	29	35	34	27	42
Total LLR	**62**	**71**	**58**	**57**	**90**

Chart 1. Notifications by category of response 2017/18 to 2021/22

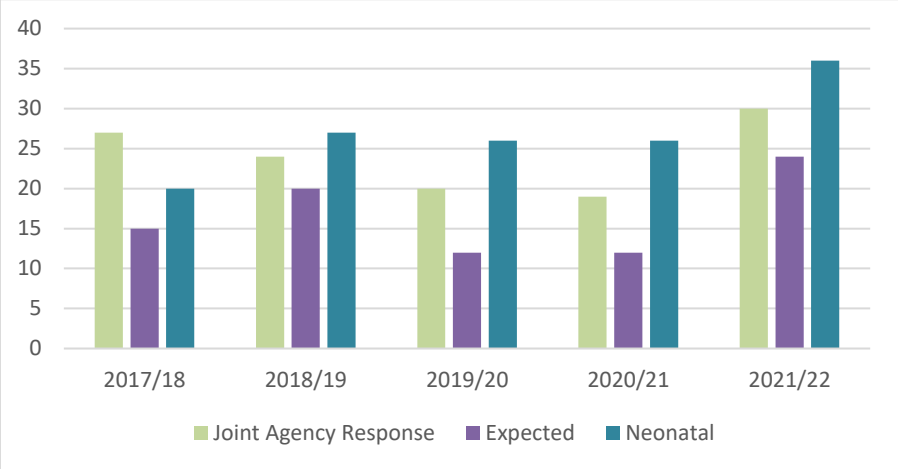


Chart 2. Notifications by place of death

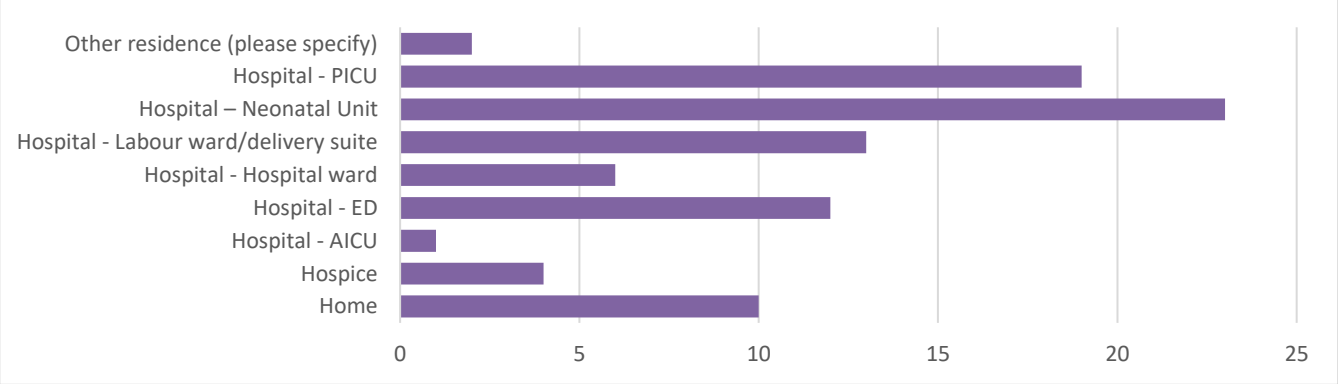


Chart 3. Notifications by age group & year

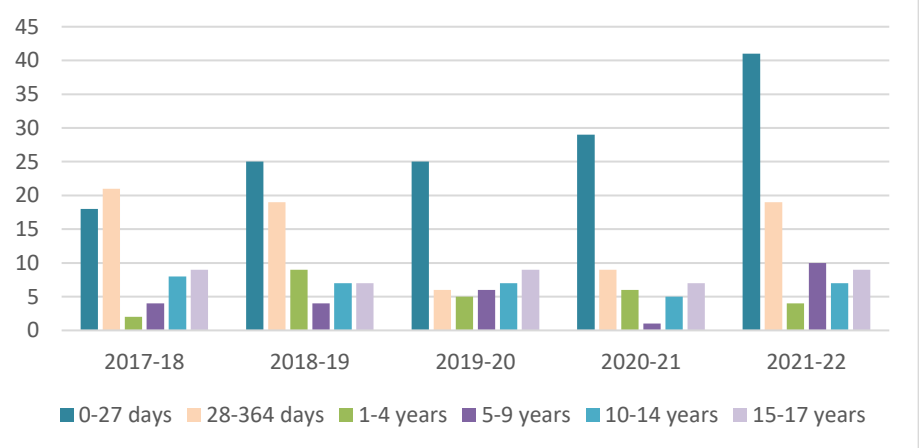


Chart 4. % of notifications by age group Inner ring LLR, Outer ring England

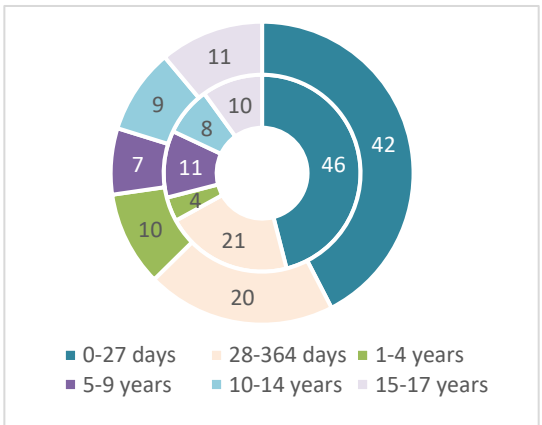


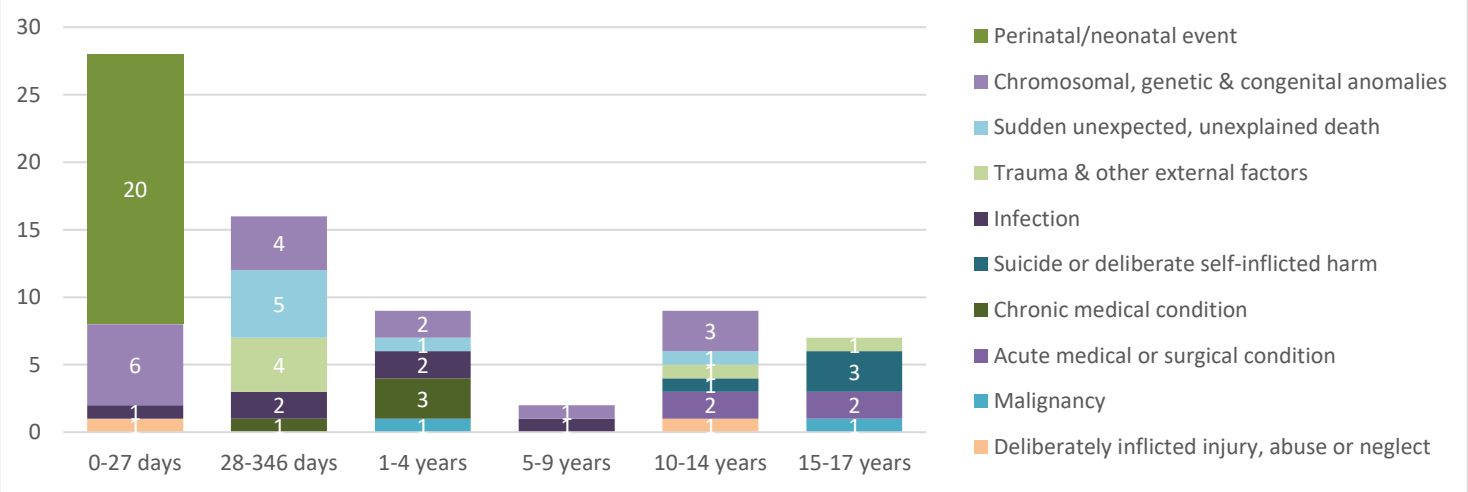
Table 2. Completed reviews by year

	2017/18	2018/29	2019/20	2020/21	2021/22
Leicester City	31	31	17	32	35
Leicestershire & Rutland	41	24	14	32	36
Total LLR	**72**	**55**	**31**	**64**	**71**

Table 3. Completed reviews by year of death 2021/22

Year of death	Cases
2017-18	2
2018-19	4
2019-20	22
2020-21	40
2021-22	3
Total	**71**

Chart 5. Completed CDOP reviews by age group & category of death 2021/22



- In 2021/22 LLR CDOP held 6 panels and reviewed 71 cases.
- Cases are only brought to panel once all other investigations (including Inquests, Police investigations, Serious Incident Investigations and Child Safeguarding Practice Reviews) are concluded and reports available to CDOP, hence there is a time lag between the year of death and completion of the review.
- The top three most frequently recorded categories of death were:
    - Deaths due to a perinatal/neonatal event (28.2%)
        - Includes perinatal asphyxia, complications of prematurity/immaturity and perinatal infection.
    - Deaths due to a chromosomal, genetic, or congenital anomaly (22.5%)
    - Sudden unexpected, unexplained deaths (10%)
        - Deaths occurring at any age, which, following a thorough investigation and post-mortem, no clear medical cause has been identified.
- Of the cases reviewed, most children (64.8%) died in hospital, with 22.5% dying at home, 4.2% in a public place, and 2.8% in a hospice setting.

Table 4. Completed reviews by ethnic group & primary category of death 2021/22

Ethnic Group	0-27 days	28-346 days	1-4 years	5-9 years	10-14 years	15-17 years	Total
White	11	14	5	2	3	6	**41**
Other	1	0	1	0	0	0	**2**
Mixed	4	1	0	0	0	1	**6**
Black or Black British	4	0	1	0	1	0	**6**
Asian or Asian British	8	1	2	0	5	0	**16**
Total	**28**	**16**	**9**	**2**	**9**	**7**	**71**

Modifiable factors 2021/22

Definition:
A modifiable factor is one which may have contributed to the death of the child, and which might, by means of a locally or nationally achievable intervention, be modified to reduce the risk of further deaths.

Working Together to Safeguard Children, 2018[1]

Table 5: Cases where modifiable factors were identified by category of death 2021/22

Primary category of death (CDOP)	Completed reviews	Modifiable factors identified	Modifiable factors identified (%)
Deliberately inflicted injury, abuse or neglect	2	2	100
Sudden unexpected, unexplained death	7	6	86
Trauma and other external factors	6	4	67
Infection	6	3	50
Suicide or deliberate self-inflicted harm	4	2	50
Perinatal/neonatal event	20	6	30
Acute medical or surgical condition	4	1	25
Chromosomal, genetic or congenital anomaly	16	2	13
Chronic medical condition	4	0	0
Malignancy	2	0	0
Total	**71**	**26**	**37**

- Modifiable factors were identified in 37 % of cases (n=26).
- Across the 26 cases where modifiable factors were identified, 60 individual factors were recorded (mean 2.3, range 1-6 per case).

Table 6: Most frequently recorded modifiable factors 2021/22

No of cases	Most frequently recorded modifiable factors:
9	Parental smoking
6	Maternal obesity
6	Service provision - education
5	Unsafe sleeping practices
4	Service provision - communication
4	Service provision - local/national commissioning
2	Safeguarding
1	Public safety
1	Vehicle/transport related
1	Service provision - human factors
1	Child physical condition
1	Child mental health condition

Parental smoking

- Most common modifiable factor nationally[5].
- Babies exposed to cigarette smoke before birth are at increased risk of preterm birth, low birthweight and Sudden Infant Death Syndrome (SIDS).
- Children exposed to cigarette smoke are at higher risk of breathing problems.

Maternal obesity

- 5th most common modifiable factor nationally[5].
- Challenges with identification of fetal anomalies on antenatal scans.
- Increased risk of gestational diabetes which can lead to adverse pregnancy outcomes.

A. Infant Mortality

Infant deaths reviewed 2021/22

Infant: liveborn (of any gestation) to 12 months of age

- Infant Mortality Rates for Leicester City remain significantly higher than for England (see Appendix B)
- 44 cases reviewed, 36% with modifiable factors
- Most frequently noted modifiable factors:
  - Parental smoking
  - Maternal obesity

Table 7. Infant deaths: completed reviews by ethnic group

Ethnic Group	0-27 days	28-346 days	Total
White	11	14	25
Other	1	0	1
Mixed	4	1	5
Black/Black British	4	0	4
Asian/Asian British	8	1	9
Total	28	16	44

Table 8. Categories of death for children under 1 year – completed reviews

Category of death	No of cases	No of cases where modifiable factors identified	% of cases where modifiable factors identified
Perinatal/neonatal event	20	6	30
Chromosomal, genetic or congenital anomaly	10	1	10
Sudden unexpected, unexplained death	5	5	100
Trauma or other external factors	4	2	50
Infection	3	1	33
Deliberately inflicted injury, abuse or neglect	1	1	100
Chronic medical condition	1	0	0
Total	44	16	

Sudden unexpected unexplained deaths of infants

In the period between 1st April 2016 and 31st March 2022, CDOP reviewed the deaths of 15 children who died under 1 year of age, and whose deaths were categorised by the panel as Sudden Unexpected Unexplained Deaths.

This categorisation is based on the medical cause of death at post-mortem and review of the circumstances of death & will include all deaths due to 'SIDS' or with an 'unascertained' medical cause (where it was not possible to determine the most likely medical cause of death), but not those as a result of external causes such as overlay or mechanical airways obstruction.

Table 9. Sudden Unexpected Unexplained Deaths - Infant case characteristics – 5 year review

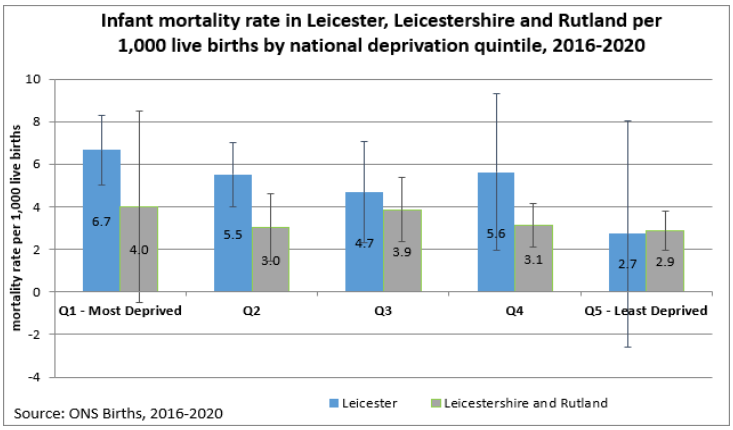
	2015/16 to 2020/21 (n=15)		2016/17 to 2021/22 (n=15)	
	N	%	N	%
Bottle fed	12	80 %	11	73 %
First born	4	27 %	6	40 %
Preterm	10	67 %	9	60 %
IMD 1&2	7	47 %	6	40 %
Birthweight <2.5kg	9	60 %	9	60 %
Mean maternal age	28.8 (20-36)		28.73 (20-36)	
Medical cause of death:				
'Unascertained'	12	80 %	11	73 %
'SIDS'	3	20 %	4	27 %
Modifiable Factors				
Unsafe sleeping	10	67 %	9	60 %
Parental smoking	9	60 %	9	60 %
One or more MF	13	87 %	13	87 %

B. Deprivation & Child Mortality

LLR CDOP submitted case data which was included in the National Child Mortality Database report into Child Mortality & Social Deprivation[6] published in May 2021, looking at the relationship between deprivation and child deaths for cases that occurred during or were reviewed by CDOPs between 1st April 2019 & 31st March 2020.

The full report is available here: https://www.ncmd.info/publications/child-mortality-social-deprivation/

Chart 6. Infant Mortality Rate in LLR by deprivation quintile 2016-2020



Key findings [6]:

1. Clear association between risk of death and deprivation across all categories except malignancy.
2. Relative 10% increase in risk of death between each decile of increasing deprivation.
3. **More than 1 in 5 deaths might be avoided if children living in the most deprived areas had the same mortality risk as those living in the least deprived.**
4. Increased proportion of deaths with modifiable contributory factors with increasing deprivation.
5. 1 in 12 child deaths reviewed in 2019/20 identified 1 or more factors related to deprivation.

C. Suicide & Self-harm

In October 2021, the National Child Mortality Database published their thematic report into Suicide in Children & Young People [7], looking at deaths that occurred or were reviewed by a CDOP between 1st April 2019 & 31st March 2020.

The full report is available here: https://www.ncmd.info/publications/child-suicide-report/

Key findings [7]:

- Services should be aware that child suicide is not limited to certain groups; rates of suicide were similar across all areas, and regions in England including urban and rural environments, and across deprived and affluent neighbourhoods
- 62% had suffered a **significant personal loss** in their life prior to their death (including bereavement and living losses e.g. loss of friends and routine due to moving home, school or other close relationship breakdown).
- Over 1/3 had **never been in contact with mental health services**.
- 16% had a confirmed **neurodevelopmental condition** at the time of their death – this appears higher than the general population.
- Almost a quarter had experienced **bullying either face to face or cyberbullying**, the majority reporting bullying in schools.

D. Learning Disability Mortality Reviews (LeDeR)

LeDeR Scope & definition: Everyone with a learning disability aged four and above who dies and every adult (aged 18 and over) with a diagnosis of autism is eligible for a LeDeR review.
Individuals with a learning disability are those who have:

- A significantly reduced ability to understand new of complex information, to learn new skills (impaired intelligence), with
- A significantly reduced ability to cope independently (impaired adaptive or social functioning), and
- Which is apparent before adulthood is reached and has a lasting effect on development.

Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) Policy 2021[8]

LLR CDOP LeDeR Reviews

Deaths of all people with learning disabilities aged 4 years and over are reviewed as part of LeDeR Programme, aiming to identify learning to reduce the increased mortality and morbidity rates seen for this cohort. In addition to the standard Child Death Review process, a 'pen portrait' of the child or young person is completed with the family, and since September 2020, areas of best practice are identified, and quality of care provided is graded.

Over the past two years (2020-21 & 2021-22), 16 LeDeR case reviews were completed.

Of these 16 cases:

- The top three most common categories for causes of death were:
  - Chromosomal, genetic or congenital anomalies
  - Acute medical condition
  - Chronic medical condition
- Modifiable factors were identified in 3 cases.
- Areas of best practice were identified in 4 cases.
- LeDeR Care Grading was completed in 13 cases:
  - Good or excellent care was noted in 9 cases
  - Satisfactory care was noted in 2 cases
  - Care fell far short of expected good practice in 2 cases.

Key learning themes identified during reviews

	Communication is key - Good communication was the most frequently cited issue in good or excellent care. - Poor communication was the most frequently noted issue in terms of issues with care, including those raised by families.
	Care Coordination/transition - Complex care needs good coordination, families need to know who their lead professional is, effective transition to adult services for vulnerable young people is vital.
	Access to services at the right time - Both in terms of physical accessibility and availability, ensuring equity of access for children and young people to the services they need.

Table 10. Cases where learning identified by category of death, 2021/22

Category of death	Total no of cases	Cases where learning identified	% of cases where learning identified
Sudden unexpected, unexplained death	7	7	100
Trauma or other external factors	6	6	100
Infection	6	6	100
Deliberately inflicted injury, abuse or neglect	2	2	100
Acute medical or surgical condition	4	3	75
Suicide or deliberate self-inflicted harm	4	3	75
Chromosomal, genetic or congenital anomaly	16	10	62.5
Perinatal/neonatal event	20	10	50
Chronic medical condition	4	2	50
Malignancy	2	1	50
Total	**71**	**50**	

Key Learning Themes identified during Child Death Reviews

	Lack of integrated IT systems impacts on communication, information-sharing and recognition of vulnerability.
	Early recognition of emerging vulnerabilities is vital, to inform an appropriate response with support, advice and information to mitigate risks to the health of babies and children.
	Importance of timely communication and information-sharing within and between agencies.
	Safer Sleeping ○ Sleep positioners can be marketed as reducing risk, when they are not recommended. ○ Impact on family sleep choices when unexpectedly out-of-routine. ○ Importance of involving partners in safer sleep conversations. ○ Importance of documenting safer sleep conversations with families. ○ Baby illness as a factor in parental decision-making around co-sleeping.
	Impact of Covid 19 pandemic: ○ Reduced service capacity impacted on ability of practitioners to spend time with families and hear their voice. ○ Reduced face-to-face contact with families & visibility of the home environment was a limitation to assessments. ○ Online only services may not be acceptable or accessible to children & young people. ○ Increased social isolation compounding existing challenges faced by children, young people & families, particularly those already experiencing isolation.

Resources developed to share case learning 2021/22:

- 7 Minute Briefing: Private Fostering
- 7 Minute Briefing: Guidance when asked for informal medical advice – for health professionals
- Rapid Read: Management of blood-stained diarrhoea – for health professionals

1. **Safer Sleeping**
   To develop a multiagency approach, based on the 'prevent and protect' practice model for reducing the risk of SUDI described by the Child Safeguarding Practice Review Panel[9] in 2020. This includes the development of guidance for all practitioners around safer sleep messaging (including with partners and families) embedded within systems & processes that support effective multiagency practice across the continuum of risk.

2. **Digital solutions to improve communication**
   To prioritise the development of integrated electronic records systems to support the appropriate sharing of information & communication between practitioners working with families, particularly to support the transition of families from maternity care to community services. Well-integrated systems would allow for better sharing of information and earlier identification of emerging vulnerabilities, allowing services to offer earlier intervention and support.

3. **Infant mortality**
   For the LLR Healthy Babies Strategy Group to use this report to refresh their strategy and action plan to address the social determinants of infant mortality, including parental smoking, maternal obesity and the impact of socio-economic deprivation.

4. **Suicide & Self-harm**
   For LLR CDOP to work with stakeholders to carry out a thematic report into deaths due to suicide and self-inflicted harm in children and young people, and to share the report & recommendations to inform strategies to support mental health and emotional wellbeing of children and young people across LLR.

5. **LeDeR Reviews**
   For LLR CDOP to work collaboratively with the LLR LeDeR Programme to commence annual thematic reviews of cases, and to work together to generate clear SMART actions based on the learning themes that have been identified to support improvements in care quality, effectiveness and accessibility for children and young people with a learning disability across LLR.

CDOP Work Plan for 2022/23

- CDOP Panels every 8 weeks, with additional themed Neonatal Panels.
- Participation in the phase 1 roll-out of MBRRACE/NCMD systems integration.
- Ongoing participation in East Midlands Regional CDOP Network.
- Delivery of multiagency training sessions.
- Thematic panel and report into Suicide & Self-harm in children & young people across LLR.
- Implementation of the latest LeDeR grading system, plan for annual thematic review and report into deaths of children & young people with a learning disability across LLR.
- Ongoing development of the Key Worker role and audit of support for families.
- Ongoing work to improve the dissemination of learning from CDOP reviews.

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2. Royal College of Pathologists & Royal College of Paediatrics & Child Health. Sudden Unexpected death in infancy & childhood: Multi-agency guidelines for care and investigation. London: Royal College of Pathologists; 2016. 105.

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6. National Child Mortality Database. Child Mortality and Social Deprivation, National Child Mortality Database Programme Thematic Report. Bristol: HQIP; 2021. 32.

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8. Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) policy 2021. London: NHS England & NHS Improvement; 2021. 62. Available at https://www.england.nhs.uk/wp-content/uploads/2021/03/B0428-LeDeR-policy-2021.pdf

9. The Child Safeguarding Practice Review Panel. Out of Routine: A review of sudden unexpected death in Infancy (SUDI) in families where children are considered at risk of significant harm. London: Department for Education; 2020. 56.

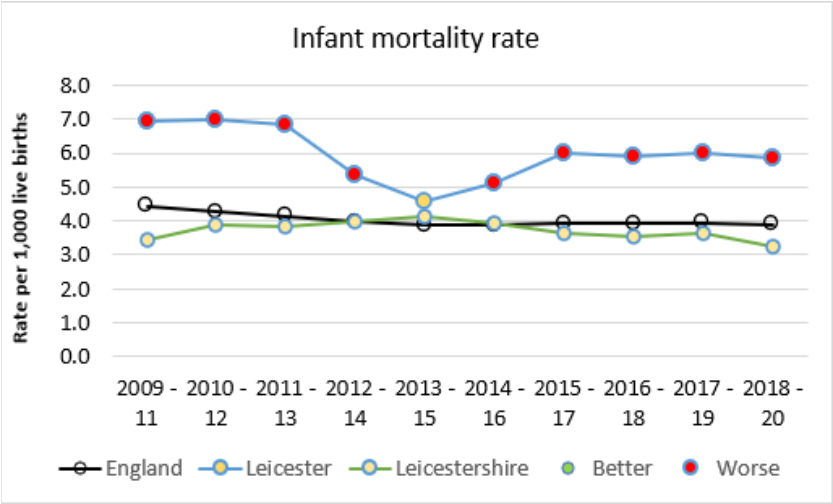
Appendix A. Cause of death categorisation

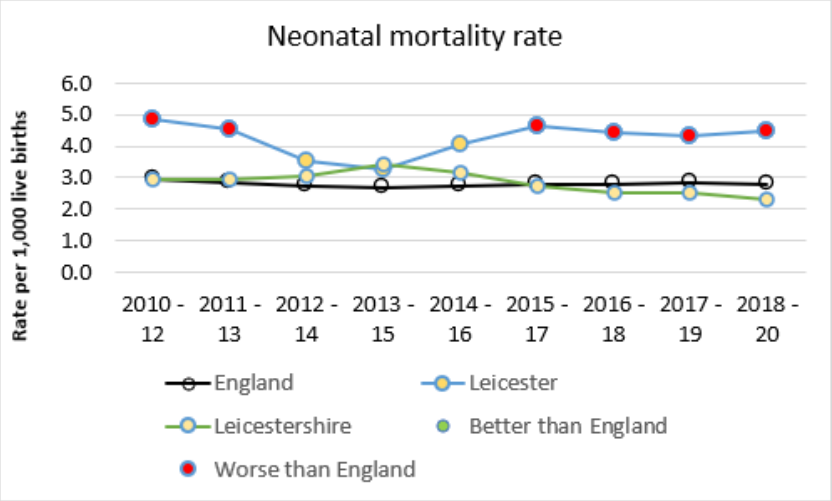
The CDOP should categorise the likely cause of death using the following schema.

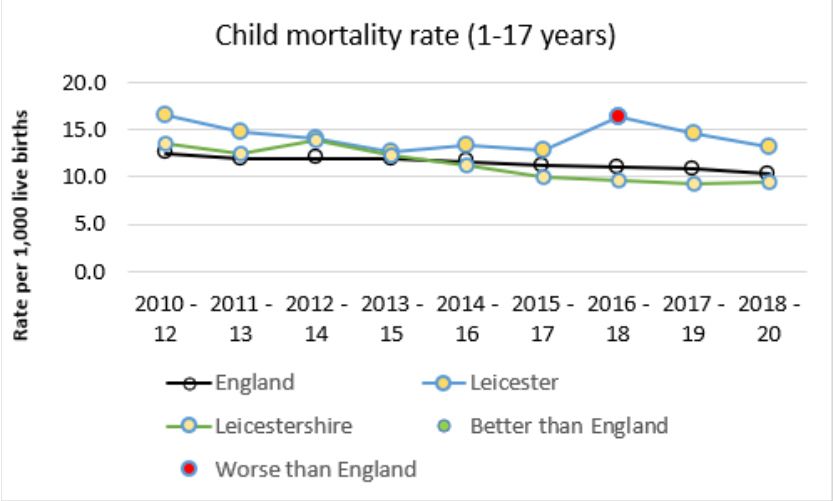
This classification is hierarchical: where more than one category could reasonably be applied, the highest up the list should be marked.

Category	Name & description of category	Tick box below
1	**Deliberately inflicted injury, abuse or neglect** This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death.	
2	**Suicide or deliberate self-inflicted harm** This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children.	
3	**Trauma and other external factors** This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. **Excludes** Deliberately inflected injury, abuse or neglect (category 1).	
4	**Malignancy** Solid tumours, leukaemia's & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.	
5	**Acute medical or surgical condition** For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.	
6	**Chronic medical condition** For example, Crohn's disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. **Includes** cerebral palsy with clear post-perinatal cause.	
7	**Chromosomal, genetic and congenital anomalies** Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis, and other congenital anomalies including cardiac.	
8	**Perinatal/neonatal event** Death ultimately related to perinatal events, e.g. sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, post-haemorrhagic hydrocephalus, irrespective of age at death. It **includes** cerebral palsy without evidence of cause, and **includes** congenital or early-onset bacterial infection (onset in the first postnatal week).	
9	**Infection** Any primary infection (i.e., not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.	
10	**Sudden unexpected, unexplained death** Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. **Excludes** Sudden Unexpected Death in Epilepsy (category 5).	

Appendix B. LLR Summary Mortality Rate Trends 2009-2020







Appendix C. LLR CDOP Annual Report All Data 2021-22

Notifications to LLR CDOP 2021-22

Number of deaths notified: 90

Notifications by LA:

- Leicester City 48
- Leicestershire 40
- Rutland 2

Is there to be a Joint Agency Response?
- Yes 30
- No 60

Table a1: Death notifications 2017/18 to 2021/22

	2017/18	2018/19	2019/20	2020/21	2021/22
Leicester City	33	36	24	30	48
Leics & Rutland	29	35	34	27	42
Total LLR	**62**	**71**	**58**	**57**	**90**

Chart a1: Death notifications by type of response 2017/18 to 2021/22

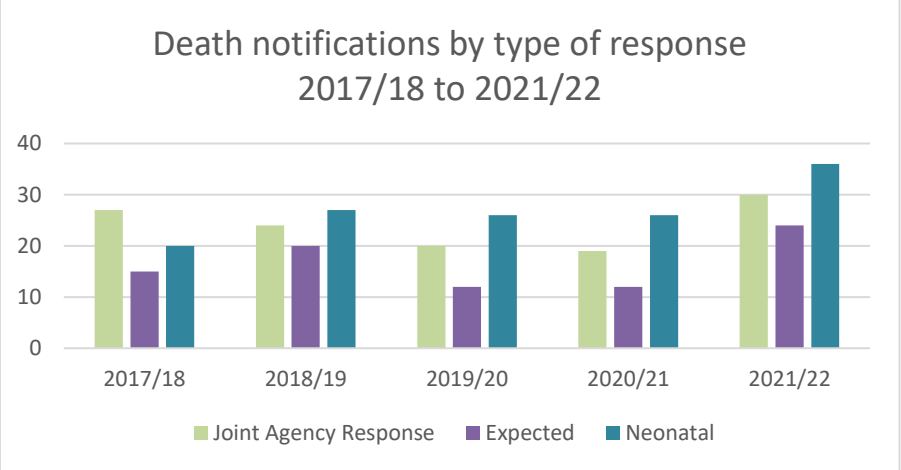


Chart a2: % of death notifications by LA and year 2017/18 to 2021/22

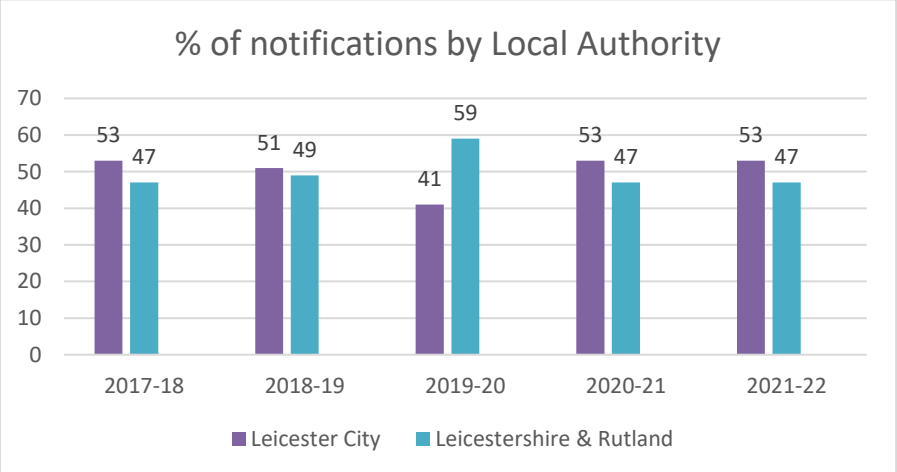


Chart a3: Death notifications by age group and year 2017/18 to 2020/21

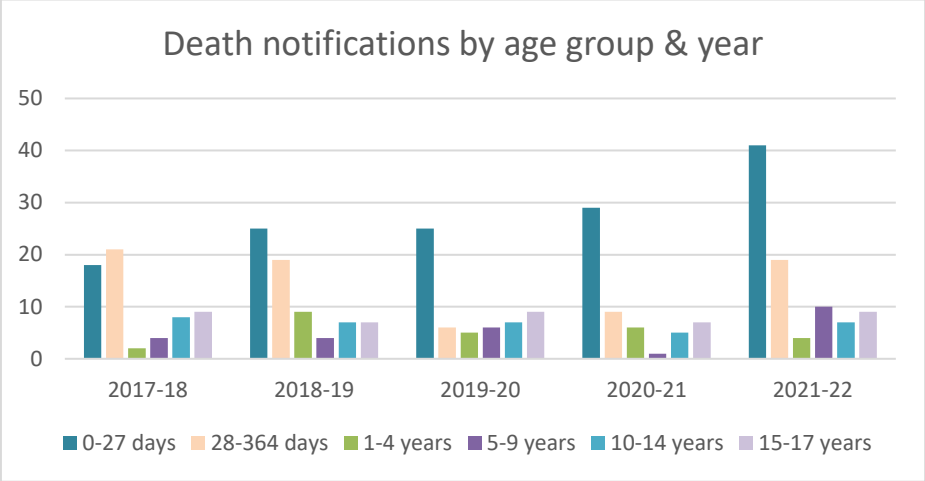


Chart a4: Death notifications by age & month of death 2021/22

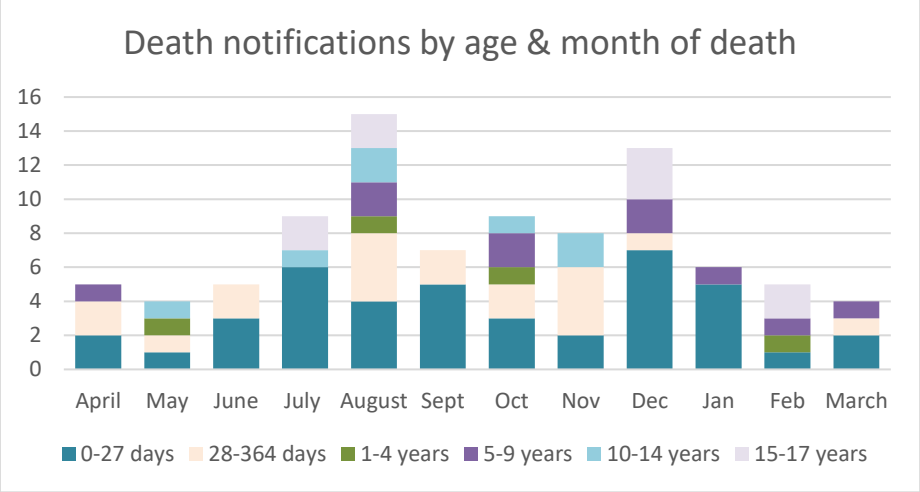


Chart a5: Death notifications by age group 2021/22

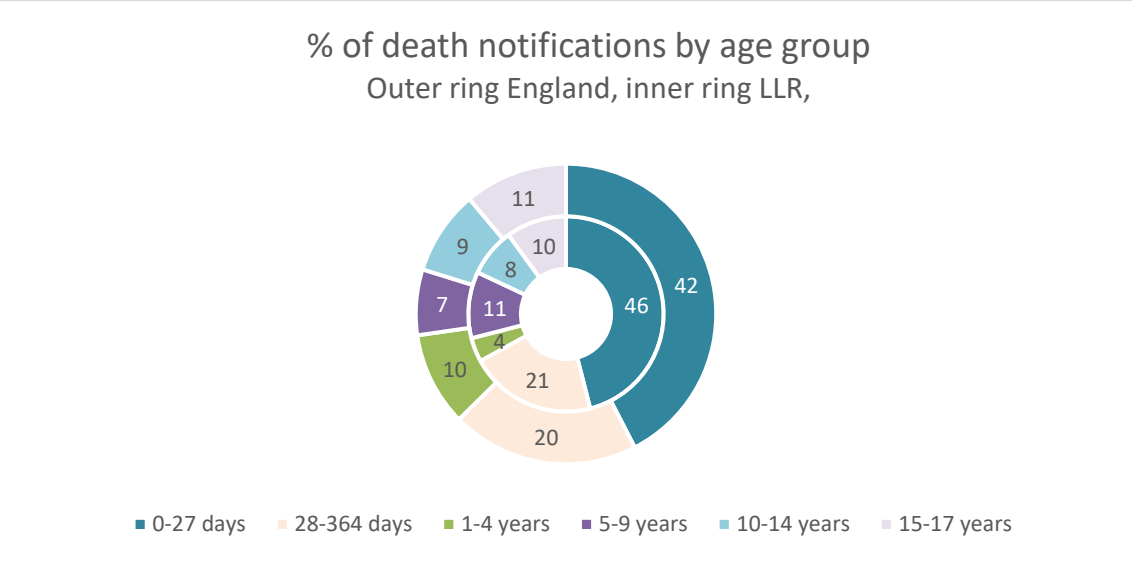
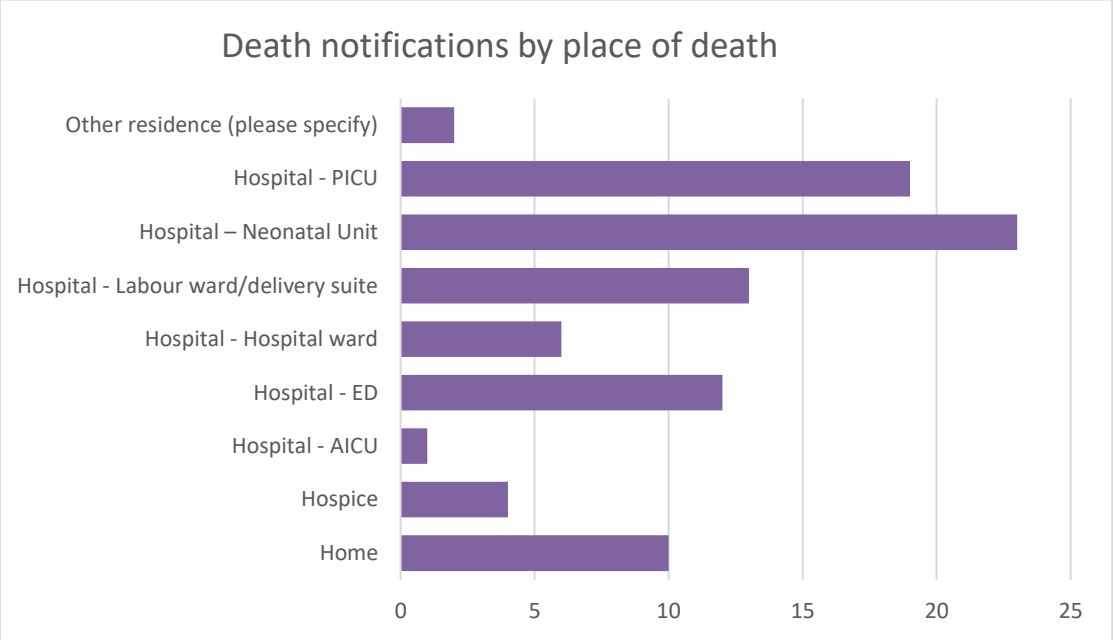


Chart a6: Death notifications by place of death 2021/22



Completed reviews 2021-2022 - Overview

Table a2: Completed CDOP reviews by year:

	2017/18	2018/29	2019/20	2020/21	2021/22
Leicester City	31	31	17	32	35
Leics & Rutland	41	24	14	32	36
Total LLR	**72**	**55**	**31**	**64**	**71**

Table a3: Completed CDOP reviews by year of death 2021/22:

Year of death	Cases
2017-18	2
2018-19	4
2019-20	22
2020-21	40
2021-22	3
Total	71

Table a4: Completed CDOP reviews by primary category of death 2021/22

NCMD Category	N	%
Perinatal/neonatal event	20	28.2
Chromosomal, genetic or congenital anomaly	16	22.5
Sudden unexpected, unexplained death	7	10
Infection	6	8.5
Trauma and other external factors	6	8.4
Acute medical or surgical condition	4	5.6
Chronic medical condition	4	5.6
Suicide or deliberate self-inflicted harm	4	5.6
Deliberately inflicted injury, abuse or neglect	2	2.8
Malignancy	2	2.8

Table a5: Completed reviews by ethnic group & age group 2021/22

Ethnic Group	0-27 days	28-346 days	1-4 years	5-9 years	10-14 years	15-17 years	Total
White	11	14	5	2	3	6	41
Unknown	0	0	0	0	0	0	0
Other	1	0	1	0	0	0	2
Mixed	4	1	0	0	0	1	6
Black or Black British	4	0	1	0	1	0	6
Asian or Asian British	8	1	2	0	5	0	16
Total	28	16	9	2	9	7	71

Chart a7: Completed CDOP reviews by age group 2021/22

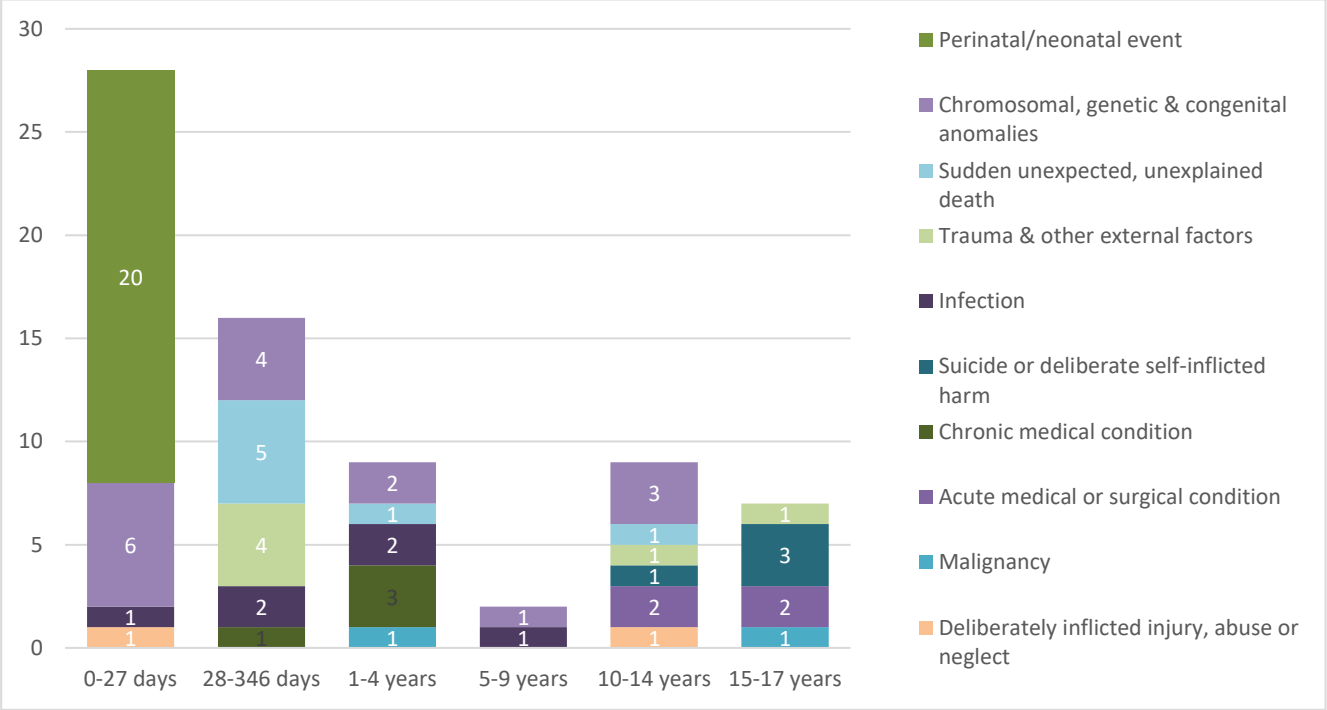


Table a6: Completed reviews by ethnic group & primary category of death 2021/22

	White	Other	Mixed	Black or Black British	Asian or Asian British	Total
Deliberately inflicted injury, abuse or neglect	2	0	0	0	0	2
Suicide or deliberate self-inflicted harm	2	0	1	0	1	4
Trauma and other external factors	5	0	0	0	1	6
Malignancy	1	0	0	1	0	2
Acute medical or surgical condition	2	0	0	1	1	4
Chronic medical condition	3	1	0	0	0	4
Chromosomal, genetic or congenital anomaly	6	0	2	1	7	16
Perinatal/neonatal event	8	1	2	3	6	20
Infection	6	0	0	0	0	0
Sudden unexpected, unexplained death	6	0	1	0	0	7
Total	**41**	**2**	**6**	**6**	**16**	**71**

Chart a8: Completed reviews by place of onset of illness/accident 2021/22

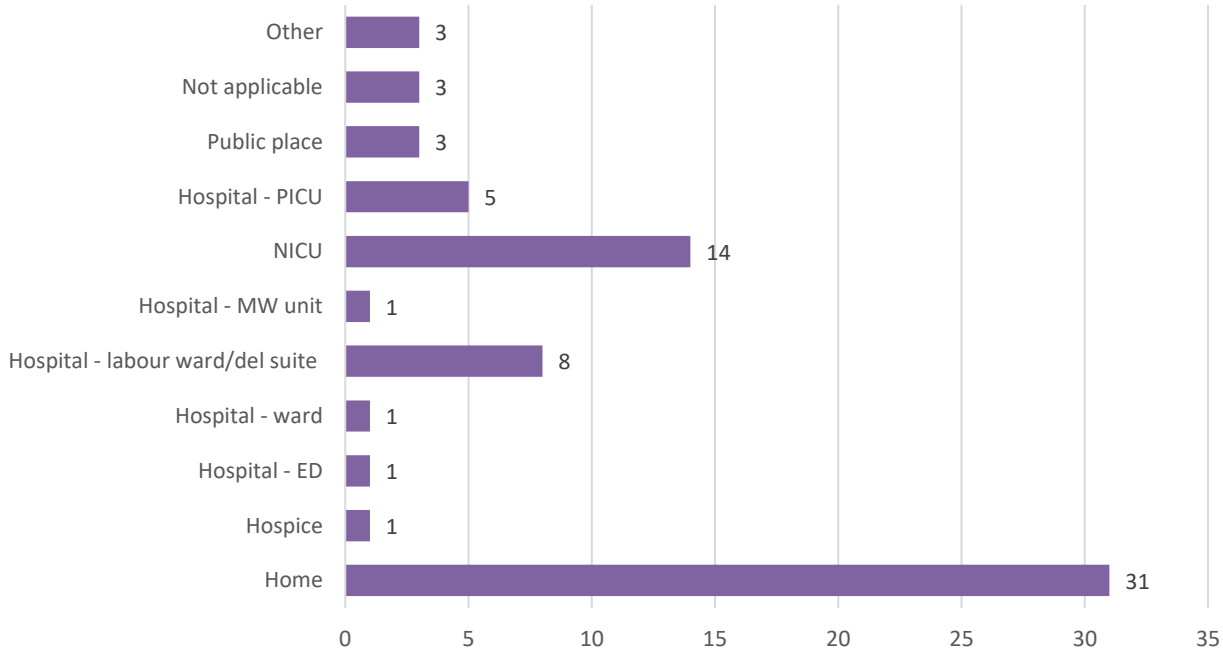
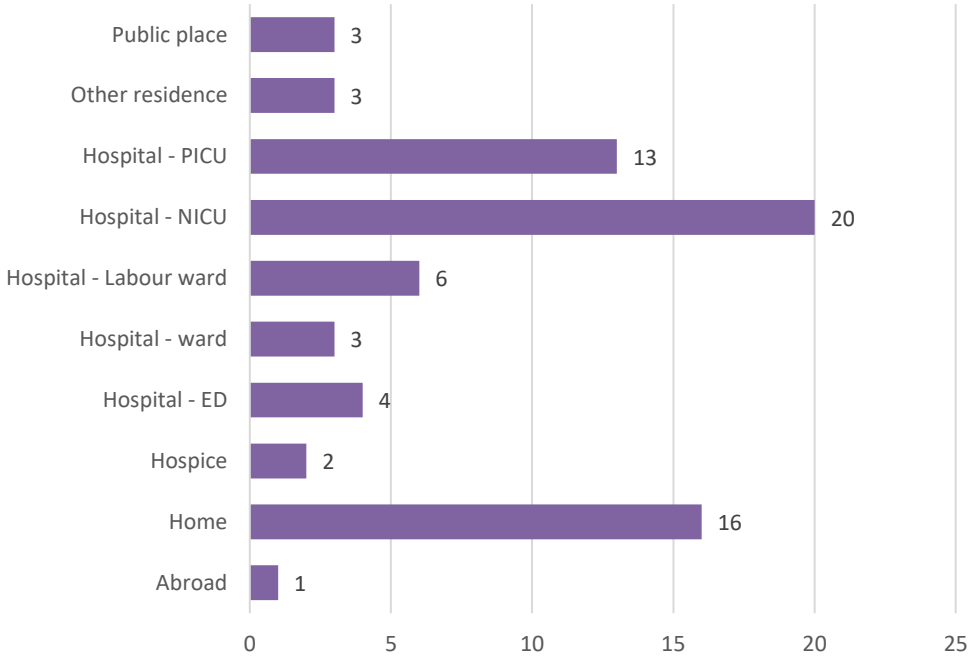


Chart a9: Completed CDOP reviews by place of death 2021/22



Completed Reviews – Modifiable Factors

% of cases with modifiable factors (CDOP): 37%
% of cases with modifiable factors (England): 37%

Table a7: Cases where modifiable factors were identified by category of death 2021/22

Primary category of death (CDOP)	Completed reviews	Modifiable factors identified	Modifiable factors identified (%)
Deliberately inflicted injury, abuse or neglect	2	2	100
Sudden unexpected, unexplained death	7	6	86
Trauma and other external factors	6	4	67
Infection	6	3	50
Suicide or deliberate self-inflicted harm	4	2	50
Perinatal/neonatal event	20	6	30
Acute medical or surgical condition	4	1	25
Chromosomal, genetic or congenital anomaly	16	2	13
Chronic medical condition	4	0	0
Malignancy	2	0	0
Total	**71**	**26**	**37**

Table a8: Cases where modifiable factors were identified by age group 2021/22

Age group	Completed reviews	Cases where modifiable factors identified	Modifiable factors identified (%)
0-27 days	28	8	29
28-364 days	16	8	50
1-4 years	9	2	22
5-9 years	2	0	0
10-14 years	9	4	44
15-17 years	7	4	57
Total	**71**	**26**	**37**

Table a9: Cases where modifiable factors were identified by ethnic group 2021/22

Ethnic Group	Completed reviews	Cases where modifiable factors identified	Modifiable factors identified %
White	41	19	46
Unknown	0	0	0
Other	2	0	0
Mixed	6	3	50
Black or Black British	6	2	33
Asian or Asian British	16	2	13
Total	**71**	**26**	**37**

Table a10: Cases where modifiable factors were identified by English Index of Multiple Deprivation (IMD) decile

IMD decile	Completed reviews	Cases where modifiable factors identified	Modifiable factors identified %
1	10	5	50
2	9	2	22
3	6	3	50
4	4	0	0
5	7	2	29
6	6	2	33
7	7	3	43
8	12	5	42
9	5	3	60
10	5	1	20
Total	**71**	**26**	**37**

Across the 26 cases where modifiable factors were identified, 6o individual factors were recorded – between 1-6 per case (mean 2.3)

Table a11: Cases with modifiable factors recorded by domain (some cases had factors identified in multiple domains) 2021/22

Domain	Cases where modifiable factors were identified by LLR CDOP	% of cases where modifiable factors were identified by LLR CDOP	% of cases where modifiable factors were identified England (2019/20)*
A: Factors intrinsic to the child	2	7	11
B: Factors relating to the family or social environment	16	62	61
C: Factors relating to the physical environment	7	27	27
D: Factors relating to service provision	11	42	35

***Data taken from NCMD 2nd Annual Report 2019/2020**

Table a12: Most frequently recorded modifiable factors 2021/22:

No of cases	Most frequently recorded modifiable factors:
9	Parental smoking
6	Maternal obesity
6	Service provision - education
5	Unsafe sleeping practices
4	Service provision - communication
4	Service provision - local/national commissioning
2	Safeguarding
1	Public safety
1	Vehicle/transport related
1	Service provision - human factors
1	Child physical condition
1	Child mental health condition

CDOP Theme: Infant Mortality

Cases reviewed 2021-22 of deaths occurring under the age of 1 year: 44

Table a13: Categories of death for children under 1 year – completed reviews

Category of death	No of cases	Cases where modifiable factors identified	% of cases where modifiable factors identified
Perinatal/neonatal event	20	6	30
Chromosomal, genetic or congenital anomaly	10	1	10
Sudden unexpected, unexplained death	5	5	100
Trauma or other external factors	4	2	50
Infection	3	1	33
Deliberately inflicted injury, abuse or neglect	1	1	100
Chronic medical condition	1	0	0
Total	44	16	

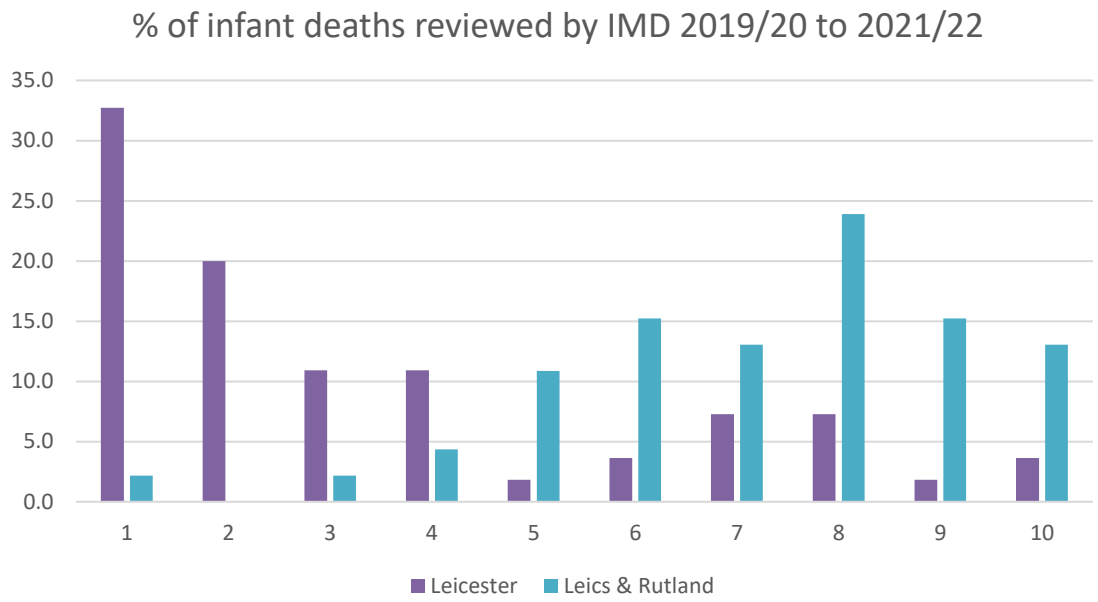
Table a14: Modifiable factors were identified in 16 cases (36%) & noted in all 5 SUUD cases. Some cases had more than one factor noted

Most frequently recorded modifiable factors:	No of cases
Parental smoking	8
Maternal obesity	6
Unsafe sleeping practices	5
Service provision issues	4
Maternal behavioural - other	2
Safeguarding-related issues	1
Maternal drug/alcohol misuse	1
Maternal health issues	1
Distance to travel to access specialist services	1

Table a15: Infant mortality & deprivation

Deprivation decile	Deaths reviewed 2019/20 to 2021/22 Leicester	Leics & Rutland	LLR	% of deaths Leicester	Leics & Rutland	LLR
D1	18	1	19	**32.7%**	**2.2%**	**18.8%**
D2	11	0	11	**20.0%**	**0**	**10.9%**
D3	6	1	7	**10.9%**	**2.2%**	**6.9%**
D4	6	2	8	**10.9%**	**4.4%**	**7.9%**
D5	1	5	6	**1.8%**	**10.9%**	**5.9%**
D6	2	7	9	**3.6%**	**15.2%**	**8.9%**
D7	4	6	10	**7.3%**	**13.0%**	**9.9%**
D8	4	11	15	**7.3%**	**23.9%**	**14.9%**
D9	1	7	8	**1.8%**	**15.2%**	**7.9%**
D10	2	6	8	**3.6%**	**13.0%**	**7.9%**
Total	55	46	101	**100.0%**	**100.0%**	**100.0%**

Chart a10: % of infant deaths reviewed by Index of Multiple Deprivation 2019/20 to 2021/22



Sudden Unexpected Deaths in Infancy (SUDI)

In the period between 1st April 2016 and 31st March 2022, CDOP reviewed the deaths of 15 children who died under 1 year of age, and whose deaths were classified as Sudden Unexpected Unexplained Deaths. This will not include those children whose medical cause of death was deemed to be due to external causes associated with unsafe sleeping.

Table a16: SUUD Infant Case characteristics – 2015/16 to 2020/21 compared with 2016/17 to 2020/21

	2015/16 to 2020/21 (n=15)		2016/17 to 2021/22 (n=15)	
	N	%	N	%
Bottle fed	12	80 %	11	73 %
First born	4	27 %	6	40 %
Preterm	10	67 %	9	60 %
IMD 1&2	7	47 %	6	40 %
Birthweight <2.5kg	9	60 %	9	60 %
Mean maternal age	28.8 (20-36)		28.73 (20-36)	
Medical cause of death:				
'Unascertained'	12	80 %	11	73 %
'SIDS'	3	20 %	4	27 %
Modifiable Factors				
Unsafe sleeping	10	67 %	9	60 %
Parental smoking	9	60 %	9	60 %
One or more MF	13	87 %	13	87 %
More than one MF	10	67 %	11	73 %

CDOP Theme: LeDeR cases

LeDeR Scope & definition: Everyone with a learning disability aged four and above who dies and every adult (aged 18 and over) with a diagnosis of autism is eligible for a LeDeR review.
Individuals with a learning disability are those who have:

- A significantly reduced ability to understand new of complex information, to learn new skills (impaired intelligence), with
- A significantly reduced ability to cope independently (impaired adaptive or social functioning), and
- Which is apparent before adulthood is reached and has a lasting effect on development.

Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) Policy 2021[8]

In addition to the Child Death Review process, information is gathered in the form of a 'pen portrait' of the child or young person, and since September 2020, areas of best practice are identified, and the quality of care provided is graded.

Modifiable factors were identified in 3 of the 16 LeDeR cases reviewed.

Table a17: Number of LeDeR cases reviewed by LLR CDOP

	2020-21	2021-22	Total
Number of cases reviewed	8	8	16

Table a18: Categories of death of LeDeR Cases

Category of death	No of cases
Chromosomal, genetic or congenital anomaly	7
Acute medical condition	4
Chronic medical condition	3
Deliberately inflicted injury, abuse or neglect	1
Infection	1
Total	16

Table a19: LeDeR care grading – completed in 13/16 cases:

Grade of care	No of cases
1. This was excellent care and met current best practice.	2
2. This was good care, which fell short of current best practice in only one minor area.	7
3. This was satisfactory care (it fell short of expected good practice in some areas, but this did not significantly impact on the person's wellbeing.	2
4. Care fell short of expected good practice and this did impact on the person's wellbeing but did not contribute to the cause of death.	0
5. Care fell short of current best practice in one of more significant areas, although this is not considered to have had the potential for adverse impact on the person, some learning could result from a fuller review of the death.	0
6. Care fell far short of expected good practice and this contributed to the cause of death.	2
Total	13

Areas of best practice were identified in 4 of these 13 cases

Top 3 learning themes from the 16 cases reviewed:

1. **Communication**
   Of the 4 cases where best practice was identified, good or excellent communication between agencies was noted, including between hospital and community teams, around areas such as end of life care and complex decision making. The role of virtual platforms in enhancing this during the Covid-19 pandemic was also noted.

   Issues with poor communication, either between different teams of professionals or between professionals and families were noted the most frequently.

2. **Issues of care coordination/transition**
   Importance of good care coordination, of families being aware of who the lead professionals were, and of effective transition of care from children's to adult services were highlighted.

3. **Access to services at the right time**
   Both in terms of physical accessibility and availability, ensuring equity of access for children and young people to the services they need.

As part of the work plan for the coming year, CDOP will work collaboratively with colleagues' from LeDeR to develop SMART actions (utilising the new grading system that LeDeR has adopted). In addition, in order to support the identification of themes, CDOP will hold an annual themed panel, which will be supported by a themed analysis report.

CDOP Theme: Suicide/Self-harm

The National Child Mortality Database published their thematic report into Suicide in Children & Young People, looking at deaths that occurred or were reviewed by a CDOP between 1st April 2019 & 31st March 2020.

https://www.ncmd.info/publications/child-suicide-report/

Key findings:

- Services should be aware that child suicide is not limited to certain groups; rates of suicide were similar across all areas, and regions in England including urban and rural environments, and across deprived and affluent neighbourhoods
- 62% of CYP had suffered a significant personal loss in their life prior to their death (including bereavement, and living losses such as loss of friends and routine due to moving home, school or other close relationship breakdown)
- Over 1/3 of CYP had never been in contact with mental health services
- 16% of CYP had a confirmed neurodevelopmental condition at the time of their death – this appears higher than the general population
- Almost a quarter of CYP reviewed had experienced bullying either face to face or cyberbullying, the majority reporting bullying in schools.

CDOP Theme: Deprivation

The National Child Mortality Database published their thematic report into Child Mortality & Social Deprivation, looking at deaths that occurred or were reviewed by a CDOP between 1st April 2019 & 31st March 2020.

https://www.ncmd.info/publications/child-mortality-social-deprivation/

Key findings:

- Clear association between risk of death and deprivation across all categories except malignancy
- Relative 10% increase in risk of death between each decile of increasing deprivation
- >1 in 5 deaths might be avoided if children living in the most deprived areas had the same mortality risk as those living in the least deprived
- Increased proportion of deaths with modifiable contributory factors with increasing deprivation
- 1 in 12 child deaths reviewed in 2019/20 identified 1 or more factors related to deprivation

Recommendation:

Use of the data in this report to develop & monitor the impact of future strategies to reduce social deprivation and inequalities

Action by:

Policy makers, Public Health Services, service Planners and Commissioners at a local & national level.

LLR CDOP Case Learning – completed reviews 2021/22

Learning identified? Yes 50/71 cases (70.4%)
No 21/71 cases (29.6%)

Table a20. Cases where learning identified by category of death

Category of death	Total no of cases	Cases where learning identified	% of cases where learning identified
Sudden unexpected, unexplained death	7	7	100
Trauma or other external factors	6	6	100
Infection	6	6	100
Deliberately inflicted injury, abuse or neglect	2	2	100
Acute medical or surgical condition	4	3	75
Suicide or deliberate self-inflicted harm	4	3	75
Chromosomal, genetic or congenital anomaly	16	10	62.5
Perinatal/neonatal event	20	10	50
Chronic medical condition	4	2	50
Malignancy	2	1	50
Total	**71**	**50**	

Key learning themes identified:

1. Lack of integrated IT systems impacts on communication, information sharing and recognition of vulnerability factors for babies, children and young people.
2. Safer Sleeping
    - Unknown risks posed by sleep positioners – not recommended for use, but often perceived by families & professionals as enhancing safety rather than increasing risk
    - Impact on family sleep choices when unexpectedly out-of-routine,
    - Importance of involving partners in safer sleep conversations,
    - Importance of documenting safer sleep conversations with families,
    - Baby illness as a factor in parental decision-making around co-sleeping
3. Importance of early recognition of emerging vulnerabilities, to inform an appropriate response with support, advice and information to mitigate risks to the health of babies and children.
4. Importance of timely communication and information-sharing within and between agencies
5. Impact of Covid 19
    - Reduced service capacity impacted on ability of practitioners to spend time with families and hear their voice,
    - Reduced face to face contact with families & visibility of the home environment was a limitation to assessments
    - For some children, young people & families, face to face work may be more accessible and acceptable than online or virtual options
    - Increased social isolation compounding existing challenges faced by children, young people & families, particularly those already experiencing isolation.

7 Minute Briefings developed to share case learning for cases reviewed 2021/22:

- Private Fostering
- Informal Medical Advice – for health professionals

Rapid Read for health professionals on Blood-stained diarrhoea

LLR Child Death Overview Panel Annual Report 2021/22

Rob Howard, LLR CDOP Chair, Public Health Consultant, Leicester City Council
Dr Suzi Armitage, LLR Designated Doctor for Child Deaths
Lisa Hydes, LLR Child Death Review Manager
Helen Reeve, Senior Data Analyst, Leicester City Council

Appendix D

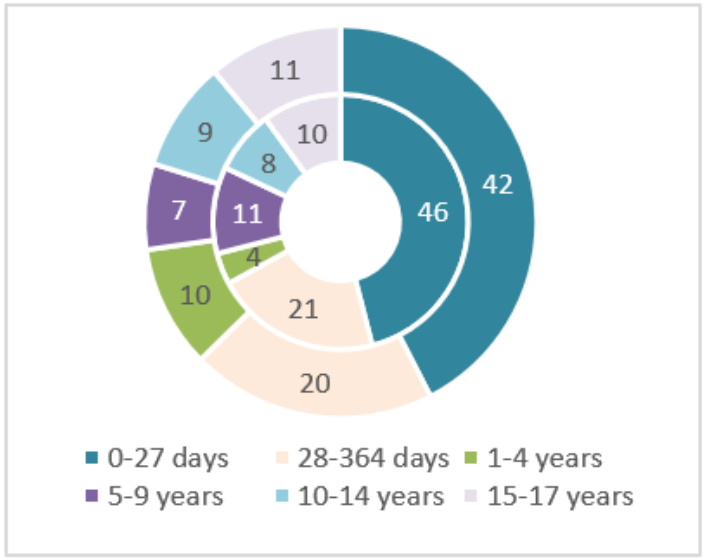
Notifications 2021/22

Death notifications by Local Authority 2017/18 to 2021/22

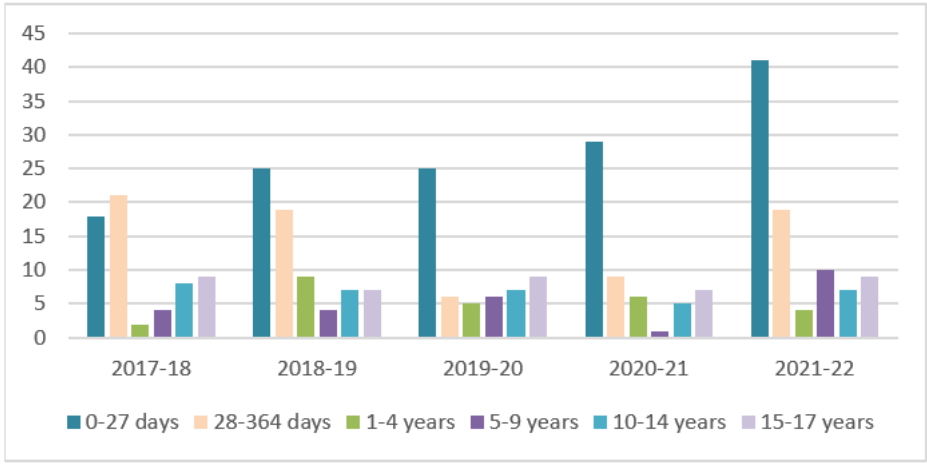
	2017/18	2018/19	2019/20	2020/21	2021/22
Leicester City	33	36	24	30	48
Leics & Rutland	29	35	34	27	42
Total LLR	**62**	**71**	**58**	**57**	**90**

% of notifications by age group

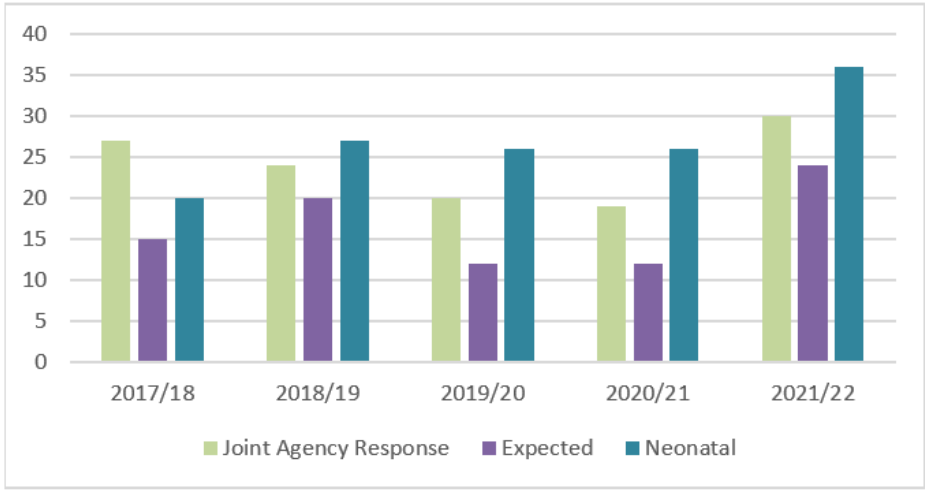
Inner ring LLR, Outer ring England



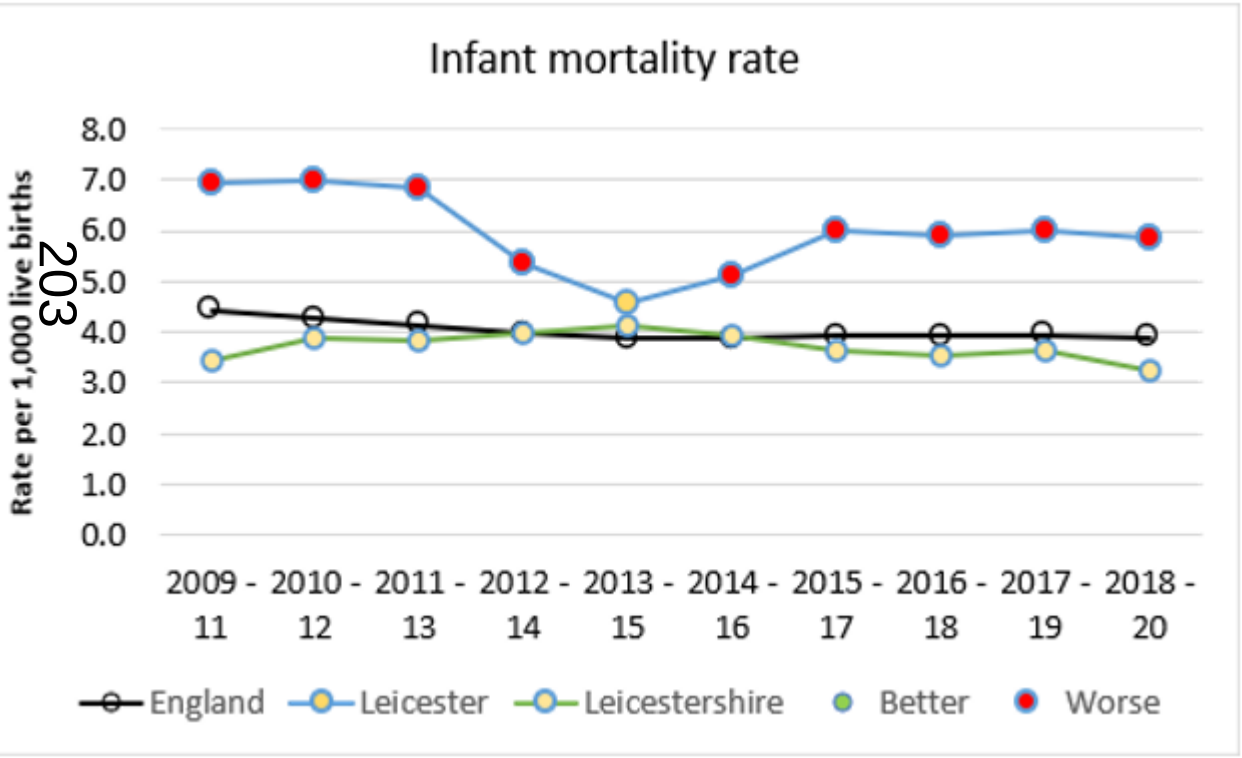
Notifications by age group & year

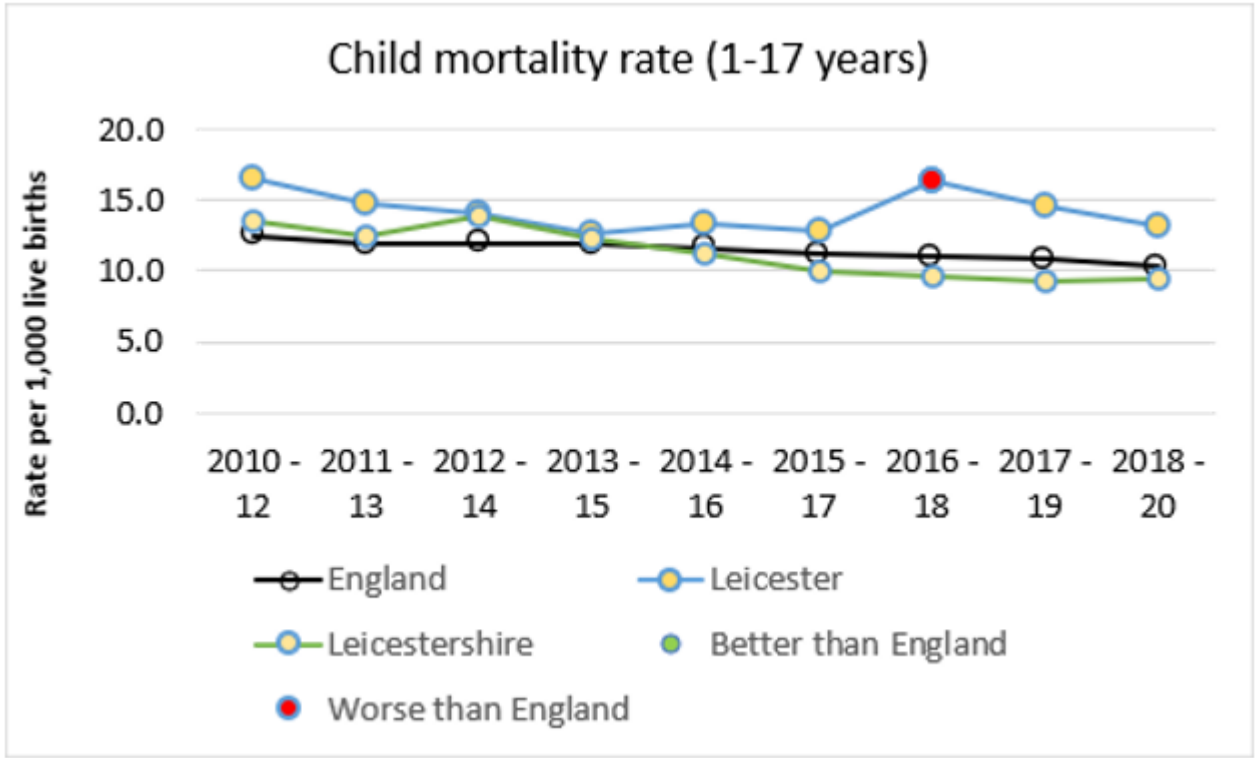


Notifications by category of response 2017/18 to 2021/22

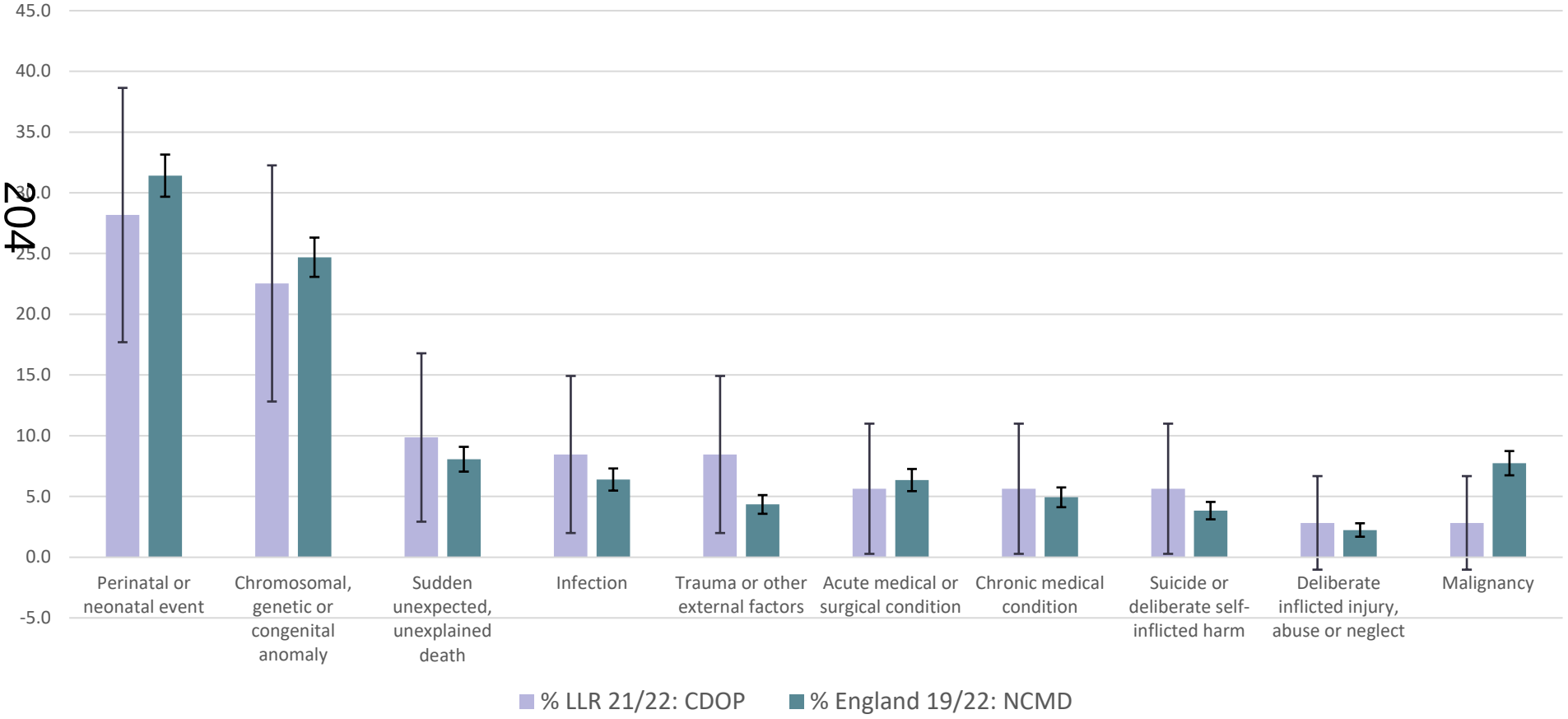


Summary Statistics





Completed Reviews 2021/22



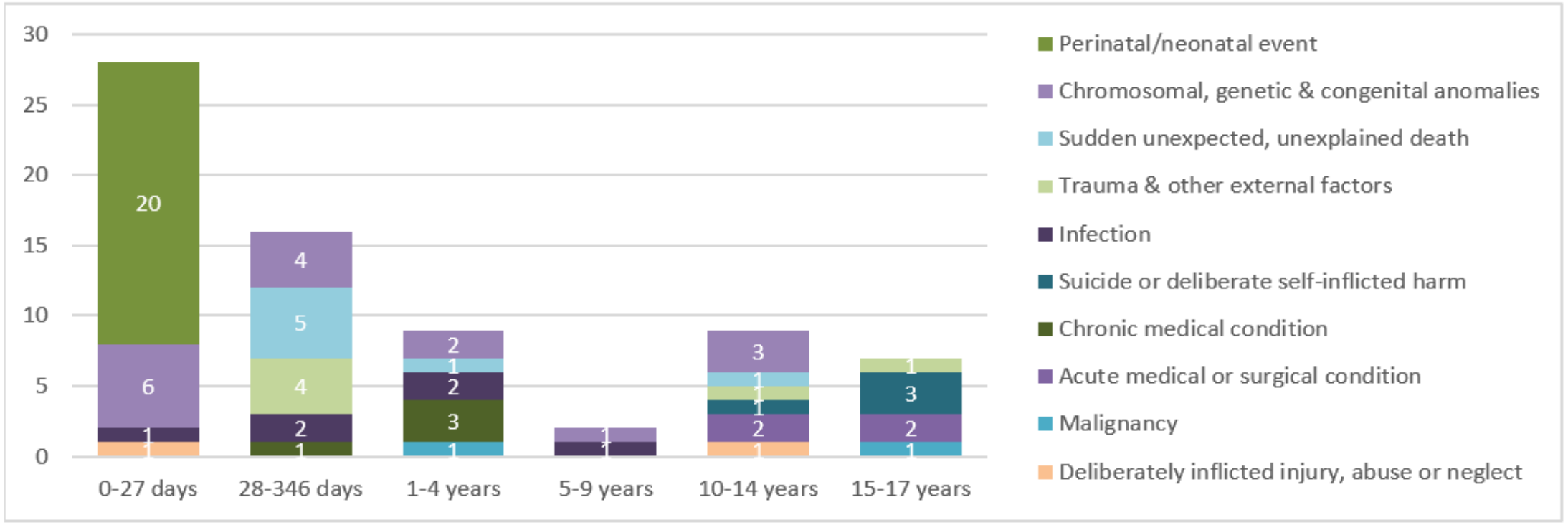
204

Completed reviews by year of death 2021/22

Year of death	Cases
2017-18	2
2018-19	4
2019-20	22
2020-21	40
2021-22	3
Total	**71**

Completed Reviews 2021/22

Completed CDOP reviews by age group & category of death 2021/22



Modifiable Factors 2021/22

Cases where modifiable factors were identified by category of death 2021/22

Primary category of death (CDOP)	Completed reviews	Modifiable factors identified	Modifiable factors identified (%)
Deliberately inflicted injury, abuse or neglect	2	2	100
Sudden unexpected, unexplained death	7	6	86
Trauma and other external factors	6	4	67
Infection	6	3	50
Suicide or deliberate self-inflicted harm	4	2	50
Perinatal/neonatal event	20	6	30
Acute medical or surgical condition	4	1	25
Chromosomal, genetic or congenital anomaly	16	2	13
Chronic medical condition	4	0	0
Malignancy	2	0	0
Total	**71**	**26**	**37**

Modifiable Factors cont'd

Most frequently recorded modifiable factors 2021/22

No of cases	Most frequently recorded modifiable factors:
9	Parental smoking
6	Maternal obesity
6	Service provision - education
5	Unsafe sleeping practices
4	Service provision - communication
4	Service provision - local/national commissioning
2	Safeguarding
1	Public safety
1	Vehicle/transport related
1	Service provision - human factors
1	Child physical condition
1	Child mental health condition

Cases with modifiable factors recorded by domain (some cases had factors identified in multiple domains) 2021/22

Domain	Cases where modifiable factors were identified by LLR CDOP	% of cases where modifiable factors were identified by LLR CDOP	% of cases where modifiable factors were identified England (2019/20)*
A: Factors intrinsic to the child	2	7	11
B: Factors relating to the family or social environment	16	62	61
C: Factors relating to the physical environment	7	27	27
D: Factors relating to service provision	11	42	35

Key Theme: Infant Mortality

Categories of death for children under 1 year – completed reviews

Category of death	No of cases	% of cases	Modifiable factors identified (%)
Perinatal/neonatal event	20	46	30
Chromosomal, genetic or congenital anomaly	10	23	10
Sudden unexpected, unexplained death	5	11	100
Trauma or other external factors	4	9	50
Infection	3	7	33
Deliberately inflicted injury, abuse or neglect	1	2	100
Chronic medical condition	1	2	0
Total	**44**		

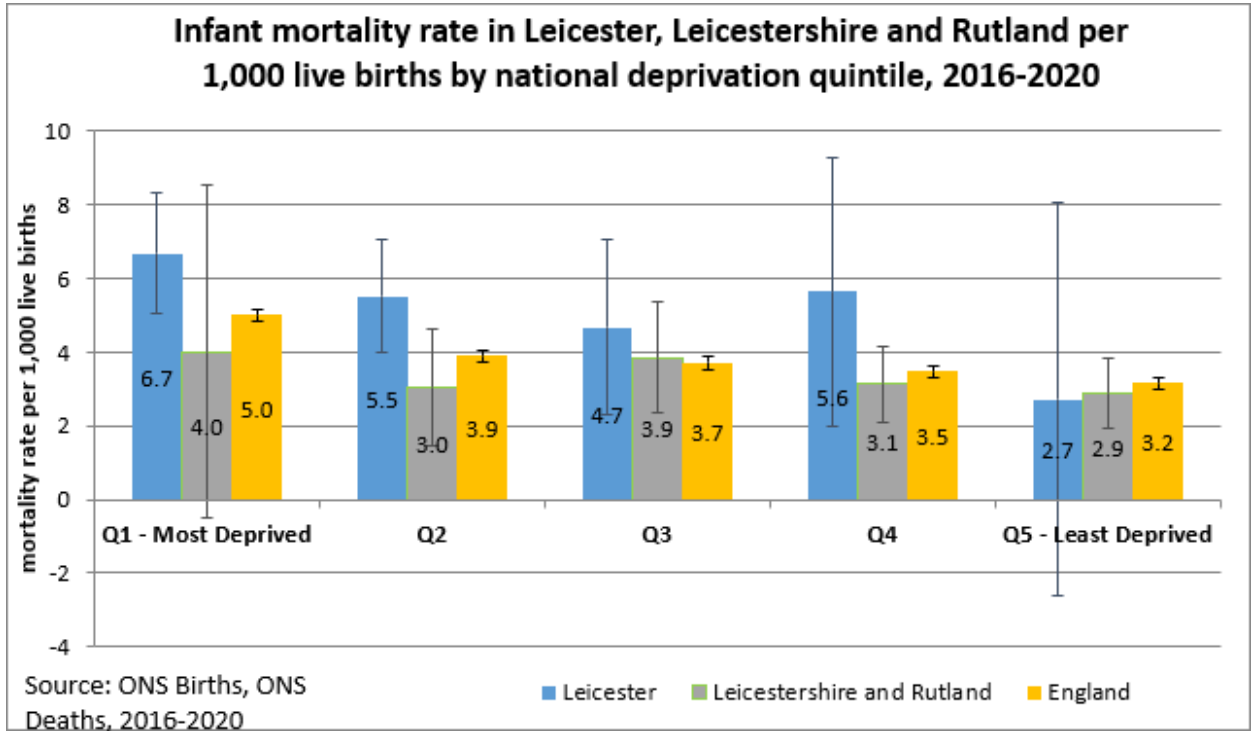
Sudden Unexpected Unexplained Deaths - Infant case characteristics – 5 year review

	2015/16 to 2020/21 (n=15)		2016/17 to 2021/22 (n=15)	
	N	%	N	%
Bottle fed	12	80 %	11	73 %
First born	4	27 %	6	40 %
Preterm	10	67 %	9	60 %
IMD 1&2	7	47 %	6	40 %
Birthweight <2.5kg	9	60 %	9	60 %
Mean maternal age	28.8 (20-36)		28.73 (20-36)	
Medical cause of death:				
'Unascertained'	12	80 %	11	73 %
'SIDS'	3	20 %	4	27 %
Modifiable Factors				
Unsafe sleeping	10	67 %	9	60 %
Parental smoking	9	60 %	9	60 %
One or more MF	13	87 %	13	87 %
More than one MF	10	67 %	11	73 %

Key Theme: Deprivation

NCMD Thematic Report: Deprivation & Child Mortality

- Clear association between risk of death and deprivation across all categories except malignancy.
- Relative 10% increase in risk of death between each decile of increasing deprivation.
- **More than 1 in 5 deaths might be avoided if children living in the most deprived areas had the same mortality risk as those living in the least deprived.**



Key theme: Suicide & Self-inflicted Harm

- NCMD Thematic Report: Suicide in children & young people
  - Key findings:
    - Suicide not limited to certain groups
    - 62% had suffered significant personal loss in their life prior to their death
    - Over 1/3 had never been in contact with mental health services
    - 16% had a confirmed neurodevelopmental condition
    - Almost ¼ had experienced bullying (face to face or online)

- LLR Thematic review of suicide & self-inflicted harm in children & young people due 2022/23

Key theme: Children with learning disabilities

- Children 4yrs or over
- 2020/21-2021/22: 16 cases
  - Most common category of death
    - Chromosomal/genetic/congenital anomaly
    - Acute medical condition
    - Chronic medical condition
  - Modifiable factors: 3 cases
  - Good or excellent care: 9 cases
  - Care falling far short of expected good practice: 2 cases

- Key learning themes:

Communication is key

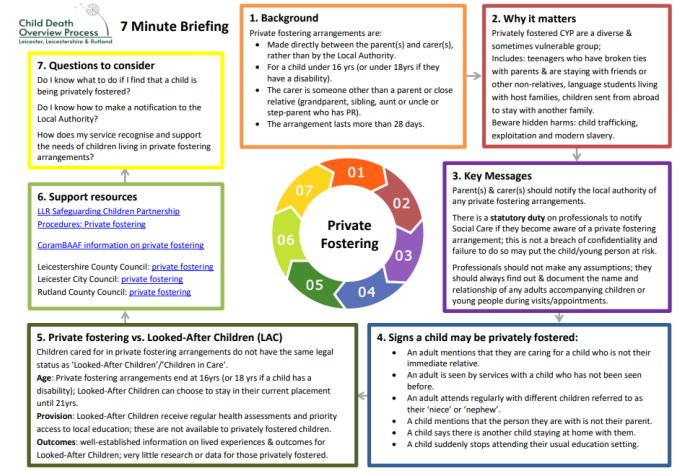
Care coordination & transition

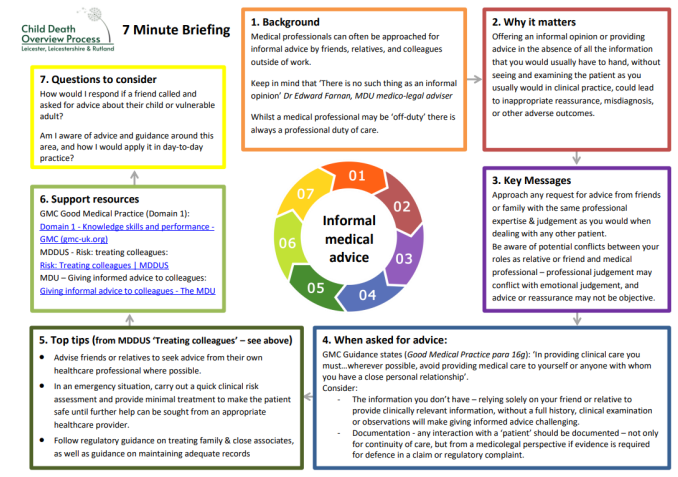
Access to services

Learning from case reviews

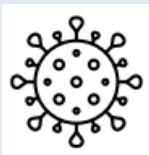
Category of death	Total no of cases	Cases where learning identified	% of cases where learning identified
Sudden unexpected, unexplained death	7	7	100
Trauma or other external factors	6	6	100
Infection	6	6	100
Deliberately inflicted injury, abuse or neglect	2	2	100
Acute medical or surgical condition	4	3	75
Suicide or deliberate self-inflicted harm	4	3	75
Chromosomal, genetic or congenital anomaly	16	10	62.5
Perinatal/neonatal event	20	10	50
Chronic medical condition	4	2	50
Malignancy	2	1	50
Total	**71**	**50**	

12 to 12





Learning from case reviews cont'd

	More integrated IT systems would improve communication, information-sharing & recognition of emerging vulnerability.
	Early recognition of vulnerability is vital to provide appropriate support, advice and information.
	Timely communication & information sharing is key.
	Safer Sleep conversations need to include partners, help families identify risks and help families plan to mitigate those risks
	Covid-19 pandemic impacted on visibility & accessibility, and compounded existing challenges.

Recommendations

1. **Safer Sleeping**

   To develop multiagency guidance for all practitioners around infant safer sleep messaging embedded within systems & processes that support effective multiagency practice across the continuum of risk.

2. **Digital solutions to improve communication**

   To prioritise the development of integrated electronic records systems to support the appropriate sharing of information & communication between practitioners working with families, and identification of emerging vulnerabilities.

Recommendations cont'd

3. **Infant mortality**

   For the LLR Healthy Babies Strategy Group to use this report to refresh the strategy and action plan to address social determinants of infant mortality.

4. **Suicide & self-harm**

   For LLR CDOP to work with stakeholders to carry out a thematic report into deaths due to suicide and self-inflicted harm in children and young people, and to share the report & recommendations across LLR.

5. **LeDeR Reviews**

   For LLR CDOP to work collaboratively with the LLR LeDeR Programme to commence annual thematic reviews of cases, and to work together to generate clear SMART actions based on learning themes identified.

Further information

- Child Death Reviews: Statutory & Operational Guidance

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1120062/child-death-review-statutory-and-operational-guidance-england.pdf

- LLR CDOP Annual Report & 7 Minute Briefings

https://lrsb.org.uk/child-death-overview-panel-cdop

- National Child Mortality Database

www.ncmd.info

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	0-19 Healthy Child Programme: Public Health Nursing (School Nursing) Offer
Presented to the Health and Wellbeing Board by:	Clare Mills, Children's Commissioner, Leicester City Council Alex Yeomanson, Family Service Manager, Leicester Partnership NHS Trust
Author:	Clare Mills, Children's Commissioner, Leicester City Council Alex Yeomanson, Family Service Manager, Leicester Partnership NHS Trust

EXECUTIVE SUMMARY:

School Nurses are Public Health Nurses who provide a vital and unique link between school, home, allied health professionals and the community. School Nurses provide a clinical service to children and young people in a safe and supportive environment, using evidence-based interventions. They provide Statutory Safeguarding support to children and young people.

In the last 12 months the School Nursing team have provided Public Health support to over 4000 City children and young people and provided Statutory Safeguarding support to over 550 children and young people.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- Note that the report contains three sensitive case studies.
- Note the successes and challenges experienced by School Nursing team.
- Support, champion and promote the role of School Nurses.
- Request an update on the School Nursing team in a year's time.

Summary

0-19 Healthy Child Programme is commissioned by Leicester City Council and delivered by Leicestershire Partnership NHS Trust (LPT) and it is known locally as Healthy Together. Healthy Together is an integrated offer containing a number of Public Health elements, this paper looks at the Public Health Nursing, School Nursing offer.

School Nurses are Public Health Nurses who provide a vital and unique link between school, home, allied health professionals and the community. School Nurses provide a clinical service to children in a safe and supportive environment, using evidence-based interventions. The School Nursing team are there from the start of primary school all the way through to secondary school and on to young adulthood. Throughout these years they guide and support children and help promote good physical and mental health. From being at forefront of spotting signs of abuse to encouraging healthy eating and providing mental health support, the range of services they provide is wide and far-reaching. They support children through difficult transitions, whether it is starting school, moving to secondary school or providing advice on sexual health. In doing so, they play a key role in reducing health inequalities, reaching out to vulnerable and marginalised young people who may otherwise fall through the gaps. Their pastoral, supportive role is needed now more than ever as our young people continue to recover from the impact of the pandemic and during the ongoing cost of living crisis.

In recent review of all Public Health services School Nursing ranked 4th out of 30 assessed. It scored the highest possible marks for prevention focus; evidence of effectiveness; cost effectiveness; health and social care integration; co-dependencies with other LCC departments; and innovation.

The School Nursing team is a small team who support all children and young people in school in Leicester, they support:

- 9 Infant Schools
- 9 Junior schools
- 67 Primary schools
- 19 secondary schools
- 1 ‘all age/all though’ school

and provide Public Health support to 8 Special Schools. There is a School Nursing offer for:

- 2 Pupil Referral Units
- Not in education or training (NEET)
- Home Educated.

To enhance this support the School Nursing team provides an award-winning digital offer for all children and young people aged 5-19.

School Nursing uses a skill mix model and the team is made up of:

- Specialist Community Public Health Nurses (Registered Nurses)
- Healthy Child Programme Nurses (Registered Nurses)
- Healthy Child Programme Practitioners (HCPP)
- Healthy Child Programme Support Workers (HCPSW)

In order to best meet the needs of children the workforce was divided in two in October 2019:

- Public Health (80% of workforce)
- Safeguarding (20 % of workforce)

This model allows the workforce to deliver a safe and effective public health service to address the complex physical and mental health issues experienced by children growing up with poverty, deprivation, and often multiple adverse experiences as set out in the service specification and Standard Operating Guidance (2020), whilst also meeting the statutory safeguarding commitments as per the LSCBP Guidance, Working Together to Safeguard Children (2020) and the national guidance 'Best start in life and beyond: Guidance to support commissioning of the healthy child programme 0 to 19' (Updated 2021).

There are 57,000 Children and Young People in Leicester Schools, and School Nursing can be accessed by any child. However, the universal offer is aligned to targeted support and evidence-based packages of care.

The School Nursing Safeguarding team is responsible for all telephone strategy calls and all Section 17 & 47. In June 2023 there are:

- 33 Active Section 17's.
- 43 Section 47's.

Statutory Safeguarding role
Children with identified safeguarding needs require a full Baseline Health Assessment. Having a Baseline Health Assessment before the initial case conference enables all professionals in the meeting to have as full a picture of the child's health needs and their lived experience as possible. School Nurses have a unique perspective and relationship with children and young people as they sit outside of the social care arena; meaning they essential information to contribute and influence safeguarding plans.

Between September 2021-September 2022 756 children have been supported by the School Nursing safeguarding team in Leicester City. 234 for Section 17 (Child in Need) and 522 for Section 47 (Child Protection Plan)

Contacting the School Nursing team
There are several ways that children, young people and their families can access the School Nursing team:

- Referrals from parents, teachers and pastoral care staff, GPs, social care, CAMHS, Early Help, community paediatricians.
- Self-referrals from young people.
- Contact via either the parent or child Chat Health text messaging service
- Digital Health and Wellbeing Contact (year 7,9,11)

<u>The School Nursing Team offer:</u>

Annual School Health Agreements
are co-produced by School Nurses and school staff coproduced the Annual School Health Agreements, which outline the responsibilities of both the school and School Nurses and the plans for delivery of care during the year. For 22/23 academic year

the team completed 100% of all primary school agreements and 22 out of the 28 senior schools (including special educational schools).

Statutory National Child Measurement Programme (NCMP) in reception and year 6

This is a mandated surveillance programme in which the height and weight of children in Reception and year 6 are taken. This provides data which helps with planning of services. In Leicester parents are sent the results of children's measurements and any child above a healthy weight is invited, along with their family, to participate in a Family Lifestyle Club (FLiC) that supports them to eat healthy and take part in physical activity (FLiC is commissioned as part of Healthy Together, more information is available).

The School Nursing team continually strive to meet emerging themes from both the results from the National Childhood Measurement Programme and general referrals. As part of this response the 5-19 workforce have developed a heathy lifestyle programme which is currently being rolled out across Leicester primary schools

School involvement in NCMP is voluntary, in academic school year 22/23 two schools did not participate.

Year 7, 9 and 11 Digital Health and Wellbeing Contact

This the local response to the national 0-19 Health Child Programmes guidance to have regular, universal, contact with children in Secondary School. Schools are offered the opportunity to have children participate in a Digital Health and Wellbeing Contact in year 7,9,11. This is facilitated in school and is a proactive means to ask young people about their health behaviors and provides universal Public Health advice. There are key words and phrases that trigger a 'red flag', all red flags are triaged by a School Nurse. This can lead to a Baseline Heath Assessment (face to face in school) and progress to evidence-based interventions of support, safeguarding, or referral to other services (e.g CAMHS) as required.

The schools receive information, on a school population level, about the key themes, and these can be used as a focus for School Health Fayres or Public Health events throughout the school year, including targeted assemblies. Engagement with the Youth Advisory Board suggested that assemblies were viewed as a good means to relay messages.

The Digital Health and Wellbeing Contact was recently evaluated by Universities of Sheffield and Bristol and found to be an effective way to identify unmet health need (papers available).

The School Nursing team are work with 2 schools (Westgate and Ellesmere) for children with additional needs in Leicester to tailor the Digital Health and Wellbeing Contact to meet the needs of pupils with Special Educational Needs. This work is ongoing and will need to reflect the individual needs of pupils attending both schools.

12 Schools have participate in the Digital Health and Wellbeing Contact this academic year, with 2 more booked in before the end of term: So far 1889 students completing the forms. Of this, 755 generated red flag responses. Last academic year 788 students completed the contact, creating 400 red flag responses.

The Digital Health and Wellbeing Contact has been shortlisted for the Health Services Journal 2023 Digital Award for Generating impact in population health through digital support.

Case Study 1: Digital Health and Wellbeing Contact (identifying unknow health needs)

Presenting Concern:
A 14 year old Asian female, who moved from Italy to the UK 2 years ago, completed the year 9 Digital health and Wellbeing Contact in school. She "red flagged" on several issues such as anger, safety in school and on line safety, self-harm, healthy eating, risk of exploitation and puberty. As a result a triage assessment was completed in school.

What we did:
During the triage assessment the young person was initially guarded in her responses and hesitated prior to answering questions relating to safety at home upon which she became very distressed.

During this assessment the young person disclosed she witnesses her dad abusing her Mum at least 3-4 times a week. She reported this had been going on since she was 7 years of age. She disclosed that her father had physically abused her and her younger brother. The young person shared she had photographic evidence of her mums physical injuries on her phone but does not know what to do to with it. The Young Person had not spoken about what has been happening at home before. She discussed being the oldest of 4 siblings and she is always worried about their and her mums safety.

The School Nurse followed safeguarding process and shared information with the designated safeguarding lead in school and made a referral to social care. As it was felt her mum would be at increased risk of harm from her father, the referral was not shared with the mother.

A safety plan was implemented for the young person, and it was assessed safe for her to return to the family home after school.

The outcome:
The Digital Health and Wellbeing Contact facilitates the opportunity for the young person to raise concerns about their physical, social, sexual and emotional health. The school Nurse uses a triage appointment to assess if there was the need for targeted support or further assessment. With this young person (and many like her) the School Nurse built a trusting relationship which allowed the YP to feel safe to share the abuse her and her family were being subjected to through the actions of her father.

Without this contact the young person may not have had the opportunity to disclose any of the abuse. The school were not aware of any concerns linked to the young persons presentation or behaviours, and as a result of the work of the School Nurse were to be able to provide support and a safety plan to protect this young person from future harm.

Triage Assessments followed, as required, by Baseline Health Assessments
All children who are referred are triaged by a School Nurse, some are provided with advice and guidance and some are invited for a Baseline Health Assessment which includes an assessment of any risks. School Nurses use this tool to understand the holistic health needs of a child including physical, social, sexual (where age appropriate to do so) and emotional health.

This assessment is completed for all referrals requiring a package of care and for any child or young person who is to be the subject of a safeguarding meeting. It is completed by either a Public Health Nurse or Healthy Child Program Nurse. The School Nurse provides clinical interpretation of any risks identified (Low, Raised, High, Increased Safeguarding Risk and Medical Emergency).

In the last 12 months 4151 Triage Assessments and 1252 Baseline Health Assessments were completed

Evidence-based packages of care to support early interventions
Baseline Health Assessments often lead to additional evidence-based care packages in accordance with local care pathways and protocols. Support is provided over several weeks for the identified health issues such as sexual health, emotional health and wellbeing and healthy weight. This work may result in referring to specialist services or the Early Help offer.

Review Health Assessments
Upon completion of a package of care, there are a number of possible outcomes:

- The identified need is resolved, and the child/young person discharged to Universal services with ongoing Universal support including the digital offer and information on how to access parent led Healthy Child clinics.
- The identified need has not been resolved and either an additional session of support is provided, or the child/young person is referred to another, more specialist, service.
- The GP is informed if there are any unmet health needs that cannot be addressed by Healthy Together and the care plan is documented.

Between April 2022 – March 2023 712 Review Health Assessments were completed.

ChatHealth
ChatHealth is an award winning, free, confidential text messaging service for Young People and their parents. There are 2 Chat Health offers. One for children and young people and one for patents.

ChatHealth was nominated for national awards through the AHSN Network and NHS Confederation's Innovate Awards. They won two awards, The Innovation Spread Award and Overall Award Both provide a free and confidential messaging service that allows young people, or their parents and carers to ask any question of the school nursing team. Depending on the question, this might result in a brief, evidence- based intervention via text or might be result in escalation to a meeting with a School Nurse and triage into the service via a Baseline Heath assessment.

Since it was created in 2014 ChatHealth has been rolled out to 70 other NHS Organisations meaning that more than 60% of School Nursing services in England, Northern Ireland and Wales offer ChatHealth. This makes it possible for around 2.8 million young people (aged 11-19) and their parents and carers to easily send a

message to get confidential help and advice about a range of health and wellbeing issues.

Case Study 2: ChatHealth

Presenting Concern:
A parent of a 13-year-old male contacted the School Nursing team via ChatHealth for advice around their son's mood and anxiety. Parent given a safety plan once no imminent risk for son was identified. Both parent and young person consented to a referral into the School Nursing team.

What we did:
A triage assessment was completed in school. The young person's presentation relating to anxiety, fear and mood, meant a Baseline Health Assessment was required. The safety plan was updated with both the young person and the parent.

The Baseline Health Assessment identified that there were no concerns relating to harmful behaviours, but that targeted support for paranoia and anger was required. Initial strategies were provided, and a plan of care was agreed with the young person which included how to contact the School Nursing team over the forthcoming coming summer holiday should they need to.

The Young Person missed their review appointment with the School Nurse, however, was seen by the GP (following parental concerns) and disclosed thoughts of wanting to harm other people. The GP made a referral to early intervention for counselling which was not accepted.

In the interim , the School Nurse completed a follow up appointment in school where the young person disclosed they were having constant intrusive thoughts and had an active plan to harm other people (stab, shoot and strangle anyone they came into contact within the park local to their home).

The young person also disclosed a previous plan to end their life over the summer holidays, although they did not actively make any attempts and denied any current active plans. The School Nurses assessment of risk of harm to the young person and other's was high. The parent was informed, a safety plan agreed and an immediate referral to the CAMHS crisis team completed by the School Nurse.

The Outcome:
Following the referral to the CAMHS crisis team by the School Nurse the young person was assessed on the same day and it was identified by CAMHS that the young person was at immediate risk of harm to other people. The young person continues to be under the care of the CAMHS.

ChatHealth is a tool for parents to contact the School Nursing team. This can, as in this case, lead to a face-to-face Baseline Health Assessment and evidence-based package of care, here this work culminated in the need for an immediate crisis intervention. School Nurses use Baseline Health Assessment to support children and young people to identify social, physical, sexual or emotional health needs that they may need support with. In this case, the School Nurse was able to identify the escalating risk of harm to not only the young person but those around them, and with support of the parent, seek the appropriate care in a timely and safe way.

www.healthforkids.co.uk
Health For Kids is a fun website for primary school aged children (5-11), and their parents, to learn about their health. Its packed full of fun characters, interactive articles and exciting games to play. In the Grown-ups area parents and carers can get health information and advice to help keep their children healthy and happy.

Between September 2021-2022 Health For Kids saw 130,594 users (114,060 new users).

Health for Kids was pioneered by LPT and has been rolled out to11 other NHS Trust.

www.healthforteens.co.uk
Health For Teens is a website for young people aged 11-19 about everything they want to know about health. It features bite-size information on a range of physical and emotional health topics, with engaging and interactive content such as movie clips, audio snippets and quizzes.

The 'your area' section brings local information to teenagers including advice, articles, events and helps them to find the right local support services.

Health for Teens was pioneered by LPT and has been rolled out to13 other NHS Trust.

The Healthy Together digital offer, including the websites, won the overall award at the 2020 Forward Healthcare Awards. For more information on ChatHealth, Health for Kids, and Health for Teens please visit *https://impacts.dhtsnhs.uk/*

Health Promotion Fayres
All secondary schools are offered Health Promotion Fayres following the completion of 7,9,11 Digital Health and Wellbeing Contact and are guided by the school level themes that emerge from it. Healthy Together work in partnership with the school and appropriate external services such as mental health support team, CAMHS, police, Turning point re substance use, dieticians.

Sexual Health Clinics
The School Nursing team offer a sexual health service to secondary schools. This provision is only delivered to schools that have consented as part of the School Health Agreement meeting. The School Nursing Team can provide support, advice and offer pregnancy testing and condom distribution using the C-C card initiative.

Currently 11 secondary schools have consented for the School Nursing team to deliver sexual health provision.

School Assemblies and Public Health events
School Nurses work in partnership with schools to deliver Public Health messages and support as identified in the School Health Agreements. In the 22/23 academic year there were 37 sessions delivered as school assemblies or pop-up lunch time events. These events targeted 1,357 children, 1527 young people and 207 Parents and covered topics such as worry, sleep awareness, dental health and Healthy Lifestyles.

Other events were School Nurses had a presence include coffee mornings with parents, sports days and parent days.

Parent Information Sessions
Parent information sessions are offered as a blended approach alongside the digital offer. Last Academic year there were 477 sessions.

Case Study 3: Self Referral

Presenting Concern:
A 14-year-old British Asian female was requested her school refer her to the School Nursing team. The referral highlighted concerns around home life following her parents' separation and exam pressures. The referral identified she was receiving support for previous self-harming behaviours through the onsite school counsellor but due to the young person herself making the request support from the School Nurse, the referral was accepted. The young person did not attend her initial triage appointment but instead sought out the School Nurse during her lunch break and requested an urgent appointment.

What we did:
Due to the young persons presentation, a triage appointment was immediately completed. She was reporting high levels of stress relating to schoolwork and home life and shared thoughts to end her life. She shared a clear plan as to how she was planning to take her life and disclosed she had made an attempt the previous evening. Due to the severity of the disclosure the School Nurse escalated the need for the young person to be immediately assessed by a mental health specialist. Both parents were contacted, and the School Nurse facilitated a meeting with the young person, her mum and school. The young person shared her concerns to the School Nurse that her parents would not understand as she felt her mum would not believe how she was feeling. It was agreed that the young person needed to be assessed immediately through Accident and Emergency and Mum (along with schools support) took the young person to Accident and Emergency.

The outcome:
The young person was assessed in Accident and Emergency and received ongoing support through CAMHS.

At the time the School Nurse saw this young person she was receiving support for the trauma of her parents separation and the impact it was having on her, however she had not disclosed any indication of the severity of this on her mental health.

Whilst the School Nursing service is not an emergency service this young person had known the School Nurse was in her school as part of the weekly 'Health Shop' and actively sought out the School Nurse as the person to whom she wanted to voice her current state of mind. The School Nurse was able to assess need, identify immediate risk and ensure access to appropriate health care, whilst raising the risk with parents and school.

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	Update from the Task and Finish Group Addressing Differential Maternal Experiences and Outcomes of Black, Asian and Minority Ethnic Women
Presented to the Health and Wellbeing Board by:	Dr Ruw Abeyratne, Director of Health Equality and Inclusion, UHL Rob Howard, Consultant in Public Health, Leicester City Council
Author:	Dr Ruw Abeyratne and Rob Howard

EXECUTIVE SUMMARY:

This task and finish group was formed at the request of Cllr. Vi Dempster former Chair of the Leicester City Health and Wellbeing Board. The group has met fortnightly since October 2022 and has heard from a series of professionals and experts to work towards a consensus agreed framework for defining action to tackle race related disparities in maternal experiences and outcomes across LLR. See Appendix 1 for the groups Terms of Reference.

Purpose of the Report

1. To provide an update on the work of the LLR Addressing Differential Maternal Experiences and Outcomes of Black, Asian and Minority Ethnic Women Task and Finish Group.
2. To share the draft framework for action to address differential experiences and outcomes for women from Black, Asian and Minority ethnic groups. This framework covers work that is already taking place where relevant as well as proposed future work.

Introduction

The national MMBRACE report demonstrates that Black and Asian people are more likely to die than White counterparts (3.7x and 1.8x respectively) during pregnancy and childbirth. Similarly, Black and Asian babies experience higher chances of stillbirth and neonatal mortality. In response to this, a task and finish group was set up to address the question of specific action being taken to address these stark inequalities, with particular reference to the outcomes and experiences of individuals of Black African and Black Caribbean backgrounds.

The task and finish group is chaired by the UHL Director of Health Equality and Inclusion. Membership of the group includes clinicians and academics across a range of disciplines including obstetrics, midwifery and public health as well as colleagues from the LLR ICS. In addition, membership also includes external

stakeholders to reflect partnership working and enable a degree of benchmarking and accountability.

The group has met alternate weekly with regularity, allowing for public holidays, annual leave and sickness, since October 2022. The group has heard from senior ICS colleagues regarding the existing LLR Maternity Equity Action Plan sanctioned by NHSE, the engagement process that informed the development of the action plan and a series of experts on a range of other areas including original research, local service improvement including the development of a maternity health inequalities dashboard and leaders on national audits and policy.

Evidence and Data

The Task and Finish Group has to date considered a wide range of evidence and data and heard from a number of national experts to inform our work. These will be presented in the final report of the group, but some examples include:

1. Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20. MBRRACE-UK November 2022.

   The report confirms that 'There remains a more than three-fold difference in maternal mortality rates amongst women from Black ethnic backgrounds and an almost two-fold difference amongst women from Asian ethnic backgrounds compared to White women, emphasising the need for a continued focus on action to address these disparities'. It also concludes that in relation to the impact of Covid-19, "The majority of women who died from Covid-19 in 2020 were from ethnic minority groups, but it is encouraging that despite this the disparity in maternal mortality rates between women from Black, Asian and Mixed ethnic groups and White women has continued to decrease slightly. Nevertheless, the maternal mortality rate amongst women who live in the most deprived areas is increasing and addressing these disparities must remain an important focus".

2. The Black Maternity Experiences Survey: A nationwide Study of Black Women's Experience of Maternity Service in the UK; Tinuke Awe and Clotilde Abe, Co-founders of Five X More MAY 2022.

   The survey found "Though both positive and negative experiences were reported, negative experiences far outweighed those in which women were happy with the care that they had received. These negative experiences were found to fit within a framework overarched by three interrelated constructs centred around the healthcare professional:

   - Attitudes (e.g., using offensive and racially discriminatory language; being dismissive of concerns),
   - Knowledge (e.g., poor understanding about the anatomy and physiology of Black women; poor understanding of the clinical presentation of conditions in babies of Black women), and
   - Assumptions (e.g., racially based assumptions about the pain tolerance, education level, and relationship status of Black women)"

3. Adverse pregnancy outcomes attributable to socioeconomic and ethnic inequalities in England: a national cohort study Jardine et al 2021. Lancet 2021; 398: 1905–12

   This study indicates that socioeconomic and ethnic inequalities were responsible for a substantial proportion of stillbirths, preterm births, and births with Fetal Growth Restriction in England. The largest inequalities were seen in Black and South Asian women in the most socioeconomically deprived quintile. It concludes that prevention should target the entire population as well as specific minority ethnic groups at high risk of adverse pregnancy outcomes, to address risk factors and wider determinants of health. It also provides evidence that even after controlling for deprivation, there remains a significant and large disparity of poor outcomes for Black and Asian women and their babies.

4. Leicester, Leicestershire & Rutland Local Maternity System Maternity Equity & Equality Analysis November 2021.

   Locally the picture mirrors the national data and over a 5-year period (2016-2021) we have had 7 maternal deaths. All 7 women were from a Non-White ethnic background.

   This analysis identified key themes that correspond to the national findings around the poor health outcomes experienced by those living in the most deprived areas as well as those from certain ethnic minority groups. This included:

   - In 2017, Leicester City had the highest percentage of births to non-UK parents (where one or both parents were born in a non-UK country) across the East Midlands, at 59.7%.
   - In Leicester City, the rate of under 18 conceptions is significantly worse than the national rate although has decreased for the past 4 years.
   - Flu uptake for pregnant women is generally lower in most deprived GP practice areas
   - Covid Vaccination uptake of pregnant women is lower amongst those aged under 30, and the lowest uptake is amongst Mixed, Black/Black British and White groups. Uptake is lowest in the most deprived areas, and highest in the least deprived areas of the City.
   - Around 50% of Asian or Asian British: Bangladeshi have antenatal complications
   - Gestational diabetes and diabetes are higher in certain ethnic groups (Asian, African and Chinese)
   - Higher proportion of caesarean sections (elective and emergency) at UHL and increasing compared with the regional position.
   - The proportion of Postpartum Haemorrhage (PPH) across LLR is generally higher than the Midlands position.
   - The highest percentage of premature births are within the Black or Black British: Caribbean ethnic group
   - Significantly higher low birthweight rate in Leicester than England and Leicestershire. Higher proportions of low birthweights are seen in areas of Leicester with larger numbers of Asian mothers
   - Highest prevalence of Smoking at the time of Delivery are White: Irish mothers, with Mixed: White and Black Caribbean mothers and Black

or Black British: Caribbean mothers also being higher than the LLR average.
- Neonatal mortality rate in Leicester is significantly higher than England.
- Perinatal Mental Health services are accessed less by patients living in the most deprived areas of LLR. There is a higher percentage of LLR teenage mothers and mothers aged over 40 accessing perinatal MH services, compared to the Midlands benchmark, and a lower percentage are from Black: Black British and Asian: Asian British ethnic groups.

Development of existing work to address inequity in maternal outcomes

The Task and Finish Group has compiled and reviewed a wide range of existing work programmes interventions and improvement plans to address this issue. Again a full description of these will be in our final report, but they include:

1. LLR Maternal Equity Action Plan
   Following the above analysis, the LLR Local Maternity and Neonatal System (LMNS) have developed an action plan to address maternal inequities and inequalities. The vision for this work is:

   "We will work towards a vision where our mothers are listened to and together, we will strive for mothers and babies In Leicester Leicestershire and Rutland to achieve health outcomes that are as good as the groups with the best health outcomes which aligns to our LLR ICB Health Inequalities Framework "Better Care for All – A framework to reduce health inequalities in Leicester Leicestershire and Rutland'. Our prime aim is to have a healthier population with everyone having a fair chance to live a long life in good health."

   The action plan contains a wide range of interventions to address the poor maternal outcomes faced by women from Black, Asian and Minority Ethnic backgrounds. The principles in developing the action include:

   Principal 1: Appropriate training and support will be given to enable people to think and act in ways that reduce health inequity.
   Principal 2: We will draw upon 'population health management' to provide us with the best evidence to take action to reduce inequalities and to evaluate the impact of our services.
   Principle 3: Prioritise prevention, helping prevent or lessen the impact of illness.
   Principle 4: A focus on gaining a fair balance between mental and physical health
   Principle 5: Local public sector organisations will seek to reduce health inequalities through offering 'social value'. This approach includes efforts to make the workforce more representative of the local population.
   Principle 6: Investment in services will be proportionate to the needs of people using those services.
   Principle 7: We will draw on the strengths of communities and individuals to reduce health inequality and inequity. Our services will aim to focus on 'what matters to people' rather than focusing on 'what is the matter' with them.
   Principle 8: We will ensure that all plans and policies put forward by the ICS partners take into account issues of health equity. This is particularly

important in relation to the wider factors that can affect people's health such as housing, education or employment.
Principle 9: We will take effective action during the key points of a person's life to help reduce health inequality and inequity. This means a specific focus on giving children the best start in life, prevention of ill health and the promotion of wellbeing and resilience.
Principle 10: The ICS is accountable for delivering on health inequalities across the local health and care system.
Principle 11: Actions will be undertaken at the most appropriate level of the ICS where they can be most effectively owned and delivered.
Principle 12: Improve access to digital technologies and seek opportunities for integration.

CDP Event on Maternal Equity

The Task and Finish Group with UHL have organised a CDP event for up to 150 people on 22nd June 2023. The event aims to improve equity in maternity, neonatal and perinatal mental health for women from Black and Asian and minority ethnic communities in Leicester, Leicestershire and Rutland. The event has a wide range of senior leaders and local and national experts in the field and will also hear from 'patient' voices from people with powerful stories to tell about their experiences if inequality in maternity service provision. See Appendix 3 for the Draft Programme and Poster.

Future work plans

There will a wide range of additional work programmes developed to continue this work. This includes the development of a framework that outlines actions against gaps that have been identified in the current approach, accounting for the comprehensive nature of the Maternity Equity Action Plan and without duplicating this. The framework attached in Appendix 2 is in draft format and is being shared for update, assurance and discussion.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:
Receive the update and be assured of ongoing work to confirm a framework for addressing maternal disparities experienced by Black, Asian and Minority Ethnic groups.

Appendix 1

Improving Maternity Access and Experience for Women from Black, Asian & Minority Ethnic Populations Task and Finish Group

Terms of Reference

About the Group
The Improving Maternity Access and Experience for Women from Black, Asian & Minority Ethnic Populations Task and Finish Group will bring together subject experts and relevant senior local professionals to discuss what we know about the issue of maternal mortality for people from Black, Asian and Ethnic minorities and develop specific actions to address the disparities in the outcomes and access of services.

Meetings will be held online via MS Teams. If the need arises for face to face meetings then these will be convened (providing it is safe to do so) at an appropriate and convenient location.

This group will function at an **operational and strategic** level and report into/be supported by the Health and Wellbeing Board and ICB Health Equity Board. The group will also have links to the Equity and Equality groups, Maternity Voices Partnership (MVP),

In line with local governance arrangements, the members of this group will:

- Review operational-level processes to improve maternity access and experiences for women from Black, Asian & Minority Ethnic Populations
- Feed into wider strategic objectives within the system
- Plan and coordinate how and when tasks will be undertaken
- Obtain additional resources if required
- Ensure the health and safety of the public and personnel

Purpose:
The Improving Maternity Access and Experience for Women from Black, Asian & Minority Ethnic Populations Task and Finish Group will be responsible for:

- Reviewing, understanding the health inequalities data and concerns
- Scrutinising local processes and pathways
- Identifying and assessing local gaps and risks to the service user and organisations
- Understanding local financial budgets across acute, community and partner organisations
- Determining priorities for allocating available resources
- Constructing business cases to illustrate opportunities across maternity services
- Providing specialist advice and guidance to wider governance structures within the ICBs, providers, partner organisations, service users and community representatives
- Ensuring good communication between key stakeholders in the coordination of maternity services in LLR. Key agencies include:
  - University Hospitals Leicester (UHL)
  - LLR Integrated Care Board (LLR ICB)
  - Leicester City Council

- Rutland County Council
- Leicestershire County Council
- Maternity Voice Partnerships (MVP)
- NHS England/Improvement
- Caribbean and African Health Network (CAHN)
- De Montfort University (DMU)
- Leicestershire Partnership Trust (LPT)
- Public Health (PH)
- Other organisations/groups with a vested interest in maternity services

Attendance:
Each person listed in the table below is expected to attend each meeting or send a nominated deputy in the event of there being insufficient representation from their respective organisation.

Name	**Job title**	**Organisation**
Dr Ruw Abeyratne (Chair)	Director of Health Equality and Inclusion	UHL
Councillor Vi Dempster	Cabinet Member for Health	Leicester City Council
Rob Howard	Consultant in Public Health	Leicester City Council
Farah Siddiqui	Consultant Obstetrician	UHL
Kerry Williams	Deputy Head of Midwifery	UHL
Elaine Broughton	Head of Midwifery and Head of Nursing	UHL
Flo Cox	Midwifery Matron for Specialist Midwifery/Antenatal and Safeguarding	UHL
Julie Hogg	Chief Nurse	UHL
Beverley Cowlishaw	Specialist Midwife in Public Health	UHL
Bina Kotecha	Associate Director of Systems Leadership and Organisations Development	UHL
Prof Angie Doshani	Consultant Obstetrician Gynaecologist	UHL/ Loughborough Uni
Dr Gillian O'Brady-Henry	Consultant Psychiatrist	LPT
Prof Bertha Ochieng	Professor of Integrated Health and Social Care	DMU
Faye Bruce	Chair of Caribbean and African Health Network Greater Manchester and Co-Chair of Black & Asian Maternity	CAHN
Steve McCue	Senior Strategic Development Manager	LLR ICB
Mina Bhavsar	Maternity Transformation Programme Manager	LLR ICB
Rabina Ayaz	CYP and Maternity Senior Officer	LLR ICB
Community/patient reps		

Quoracy:
The meeting shall be considered quorate where there is suitable operational representation from all required organisations. If commissioners or providers can't be present, notes of the meeting will be shared following the meeting.

Frequency:
Bi-weekly on Wednesday 4pm-5pm until end of March 2023.

Meetings will include:

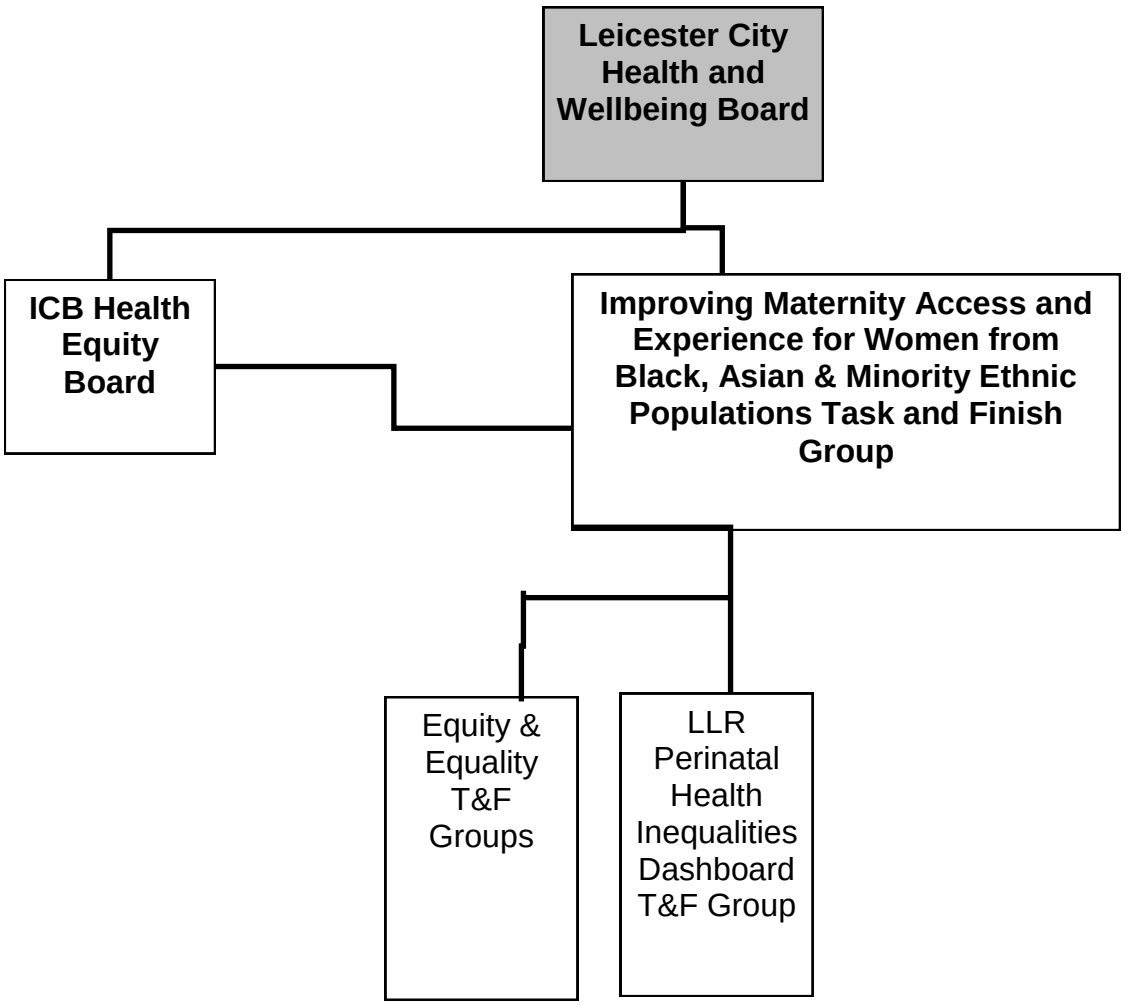
- An agenda
- Other supporting papers as required

Reporting:
Improving Maternity Access and Experience for Women from Black, Asian & Minority Ethnic Populations Task and Finish Group will report to the Health and Wellbeing Board.

Conduct of Business:

- Members will allow open discussion and respect organisational confidentiality
- Decisions will normally be reached by agreement of members present. If agreement cannot be reached, a vote may be held at the discretion of the Chair. The outcome of the vote will be on the basis of a simple majority. If the votes are tied, the Chair will have the casting vote.

Governance structure:



Appendix 2

DRAFT FRAMEWORK FOR REPORT ON ACTION TO ADDRESS RACIAL DISPARITIES IN MATERNAL OUTCOMES IN LLR

1. INTRO/CONTEXT – What is the problem?
    a. MBRRACE
    b. Local research
    c. International/migrant data
2. What do we want to achieve? Vision
        i. Access
        ii. Experience
        iii. Mortality
        iv. Morbidity
3. What is the problem? – systemic +/- structural racism
4. What **current** actions are we taking *to address racial injustice* in maternity for people in LLR?
    a. Equity Action Plan
    b. Engagement (plus others)
    c. Language
        i. CardMedic
        ii. Janam
    d. Improving early booking
    e. Pre-conception education
    f. Education and training
    g. Empowering Voices
5. **What else** do we need to do *to address racial injustice* in maternity for people in LLR? (Recommendations and what can we do differently?)
    a. Be data driven and explicit in defining the problem
        i. Where do we focus our interventions; be bold and direct guided by the data
        ii. Inequalities dashboard
        iii. Improvement approach
        iv. PPI
    b. Organisational change
        i. Systemic racism +/- structural racism
        ii. Inclusive leadership
        iii. Inclusive recruitment and retention
    c. Community relationships
        i. Academic understanding / historic context for Black and Asian communities
        ii. Trust
        iii. Celebrate to co-create
    d. Education of current workforce (post grad/CPD)
        i. Systemic racism
        ii. Cultural competency, active bystander training, (unconscious) bias?
        iii. Decolonising midwifery
    e. Support for workforce
        i. Empowering voices
        ii. Action on WRES →

        iii. Recognise trauma e.g. names?
    f. Education of future workforce
        i. Decolonising midwifery
    g. Clinical areas of focus:
        i. Maternal mental health Gillian
        ii. Improving early booking
6. Other
    a. Decolonising language
    b. Community link worker
    c. Community voices

Appendix 3: Maternal Equity Event: Programme and Poster

IMPROVING EQUITY IN MATERNITY, NEONATAL AND PERINATAL MENTAL HEALTH FOR WOMEN FROM BLACK, ASIAN AND MINORITY ETHNIC COMMUNITIES LLR

Draft PROGRAMME

0830 – REGISTRATION AND COFFEE/TEA
0900 – OPENING WELCOME – Caroline Trevithick
0905 – Counsellor Dempster – Interest in Equity in Leicester
0910 – Julie Hogg – What is the RCM approach to equity
0915 - Richard Mitchell – How is equity on the agenda for our Trust
0920 – Service Users Story – Esi (sickle cell and pregnancy experience)
0930 – Ruw Abeyratne – Pursuing Equity
0945 – Liz Draper – National data on Perinatal Health outcomes
1005– Rob Howard – National data on Maternal Mortality
1020 – Penny McParland – Local data from LLR on Maternal Mortality
1035 – Opportunity to hear from our stands (x5)
1040 – BREAK – tea/coffee
1055 – Service Users Story – Victoria Seidu
1105 – Tilly Pillay – Neonatal mortality/morbidity equity plan
1115– Gillian O'Brady-Henry – improved accessibility of Perinatal Mental Health Services
1125– Adebimpe Matiluko – challenges in clinical practice
1135 – Panel Discussion (Richard, Julie, Liz, Rob, Jonathan, Danni, MNVP)
11.55 - Opportunity to hear from our stands (x5)
1200 – LUNCH and Networking
1300 – Service User - MNVP
1310 – Marit Bodley – healthcare inequalities, pathways in place
1320 - Cornelia Weisender - FGM clinic
1330 – Helena Maybury – Diabetes in pregnancy
1340– Annabelle Foxwell – Homebirth Report
1350- Academic view
1400 – Mina Bhavsar and Rabina Ayaz(Equity and Equality Plan)
1420 – BREAK
1435 – BREAK OUT SESSIONS
1600 – Farah Siddiqui -CLOSING

LEICESTER CITY HEALTH AND WELLBEING BOARD
29th JUNE 2023

Subject:	*Understanding and acting on low 1-year colorectal cancer survival in Leicester City*
Presented to the Health and Wellbeing Board by:	Pawan Randev, GP, East Midlands Cancer Alliance CRUK Primary Care Lead, LLR ICB Cancer Lead and Chair of the Leicester City 1-year colorectal cancer survival task and finish group Julia Emery, Consultant in Public Health - Strategic Healthcare Public Health and NIHR Doctoral Fellow
Authors:	Slides produced in April 2023 by Chris Bentley, Julia Emery and Helen Reeve on behalf of the task and finish group (chaired by Pawan Randev)

EXECUTIVE SUMMARY:

Leicester City had the lowest proportion of people surviving colorectal cancer to one-year post diagnosis at least up to 2019. This situation, which has been developing gradually over a twenty-year period was identified initially by regional public health colleagues. A multidisciplinary, system-wide task and finish group was formed within LLR to investigate. This drew together partners from across public health, community, primary and hospital care and the voluntary sector.

The investigation centred on carrying out a “system diagnostic” based on data and insights to look below the surface of the observed trend and identify (and where possible test) hypotheses about why the difference in survival (in comparison to local and national neighbours) was occurring. The ambition was to remove preconceptions about population or service factors and instead objectively determine possible causes from the triangulation of appropriate datasets.

The process was interrupted by the COVID-19 pandemic, but then by difficulties in obtaining and collating various datasets and other information. This clearly demonstrated opportunities that exist – at every level - for further integration of data plus capacity and capability to interpret and understand it, to build improved intelligence-led system insights.

The picture that now emerges shows that in fact the poor figures for colorectal cancer survival, are set against a picture of colorectal cancer numbers (incidence) that are also falling, driven by the dynamic demographic profile in Leicester City. An important epidemiological study based on Leicester City itself showed that the incidence of colon cancer in the British Indian population is only half that of the white British population. The changing ethnic mix in the City clearly illustrated over successive Censuses, means that an increasing proportion of the colon cancers now emerging are seen to be in a white British (particularly male) population, over 60 years of age and from more disadvantaged parts of the City.

This new intelligence is enabling a much more appropriately and proportionately targeted action plan to be pulled together which plans to identify and manage cases earlier. The plan is coordinating contributions across the sectors and aiming to work with inputs from ICS, Place and PCN connecting into and with communities.

Further investigative work is still ongoing, to fill in remaining gaps and help answer outstanding questions. It will also be necessary to help drive, monitor and evaluate change. UHL-based colorectal cancer surgery achieves good clinical outcomes; a finding validated at an early stage through National Bowel Cancer Programme. Clinicians at UHL are undertaking a detailed audit of several years data to provide more necessary detail, and this is linking in to audit work in primary care, and insight work through public health into the community. A range of policy and resourcing opportunities are already being explored as components of a change programme.

RECOMMENDATIONS:

Members of the Leicester City Health & Wellbeing Board are invited to note the findings of the investigative work and support the next steps and actions set out in the table on slide 16.

Members are asked to raise awareness of this distinctive pattern of disease burden in the City and support the appropriate focus of policy initiatives and resources to enable effective interventions to address this outlier survival status from this serious condition.

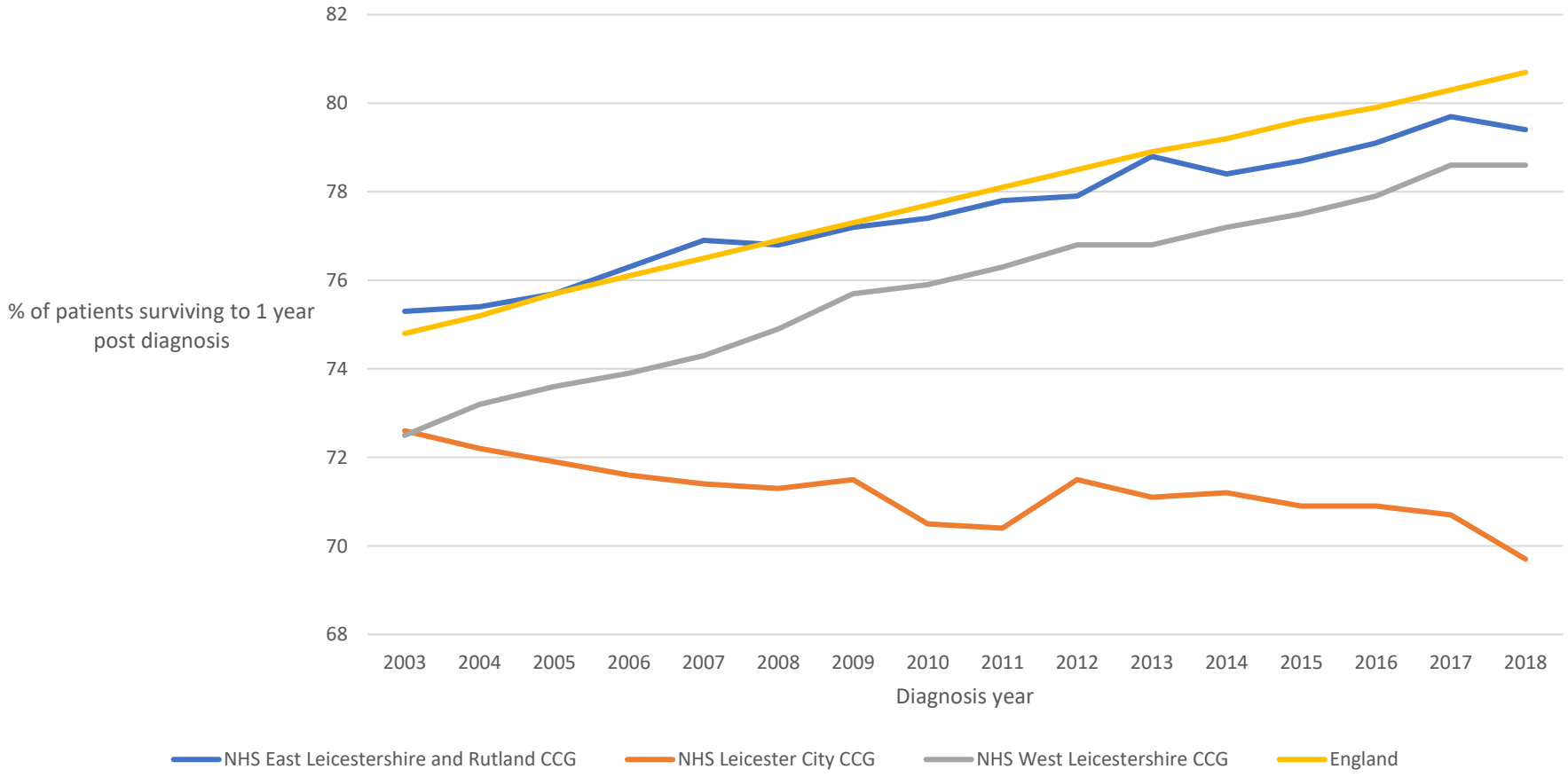
This work presents an opportunity for Board members to further discuss (and obtain assurance on):

- how poor outcomes, inequalities and/ or inequities are routinely identified, investigated and acted on based on the particular demographics of the LLR System,
- opportunities to further enable and ensure data integration for intelligence-led system understanding of issues, and for drawing in insight from across partnership networks.

1

- **Leicester City was the worst performing area in the country for colorectal cancer (CRC) 1 year survival.**
- The colorectal cancer survival index up to 2019 showed a continuing worsening trend with the proportion surviving CRC to one-year post diagnosis down at 69.7 (decreasing from 70.7% in the previous period and 11% lower than the England average).

1 year coloectal cancer survival over time in Leciester, Leicestershire and Rutland
(Source: NCRAS data, analysis performed by ONS and PHE up to 2019)



Source: https://www.gov.uk/government/statistics/cancer-survival-index-for-clinical-commissioning-groups-2003-to-2018

2

- As well as being the worst performing area in the country, Leicester City had fallen markedly behind the other CCGs over the last ~15 years.

Variation in survival by CCG relative to England

The charts here show how the variation of survival by CCG changes over time for the index of cancer survival, breast, colorectal (bowel) and lung cancers separately, which can be selected by choosing from the drop-down menu. The CCGs are coloured and shaped depending on whether their survival was better or worse than the net survival for England in 2004.

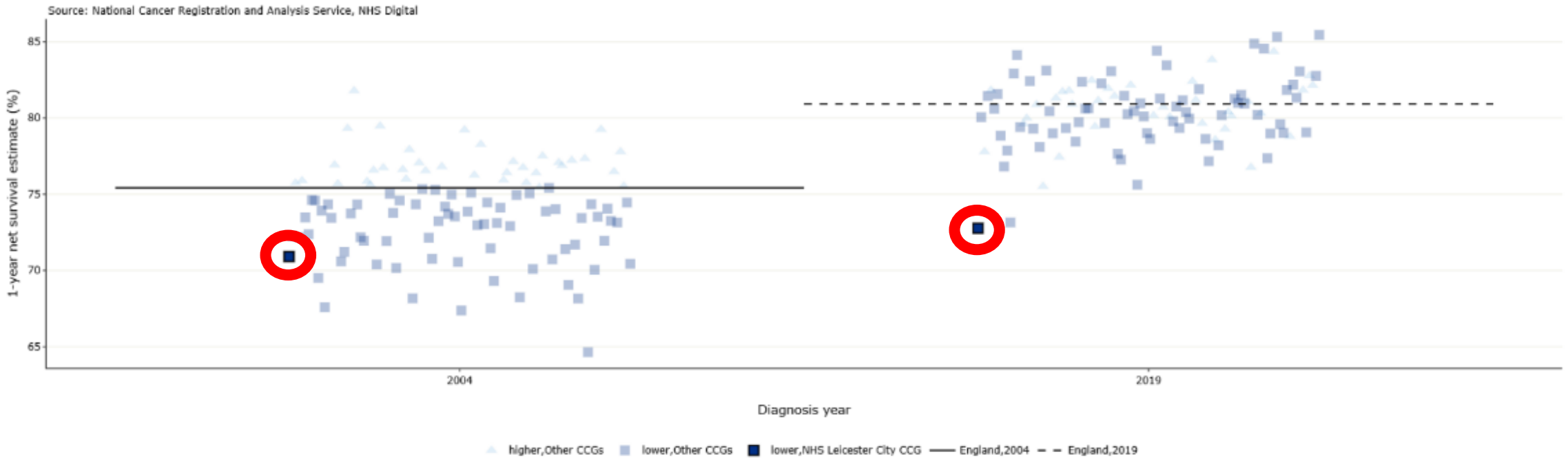
Hover over a plot for information about the data points. Click on the camera icon at the top of a plot to save the plot as a .png file.

Select a site to view survival by

Colorectal

Select the area you want to highlight

NHS Leicester City CCG



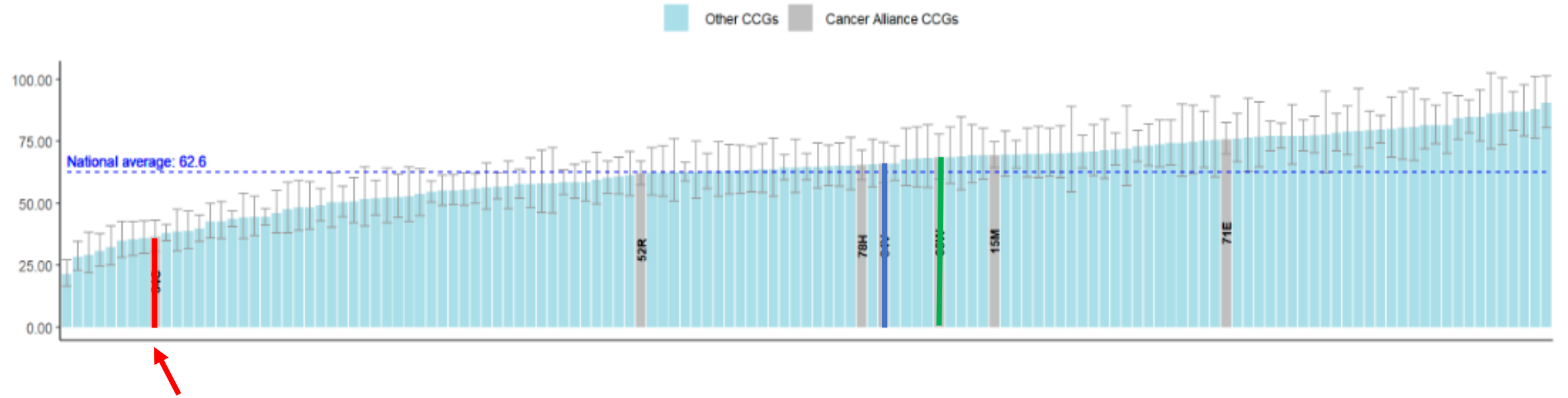
Please note that the y-axis for this graph does not start at 0 and varies to automatically to select a good range for comparing survival trends among the selected areas.

Source: https://nhsd-ndrs.shinyapps.io/index_of_cancer_survival/

4

- Leicester City however only had a moderate mortality rate for colorectal cancer, which may have covered up the poor 1-year survival.
- This is likely to be driven by another finding - the very low **colorectal cancer incidence** in comparison to many other CCGs.

Incidence of colorectal cancer per 100,000 population (all ages) - 2017



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Colour Key

Leicester City

West Leicestershire

East Leicestershire/Rutland

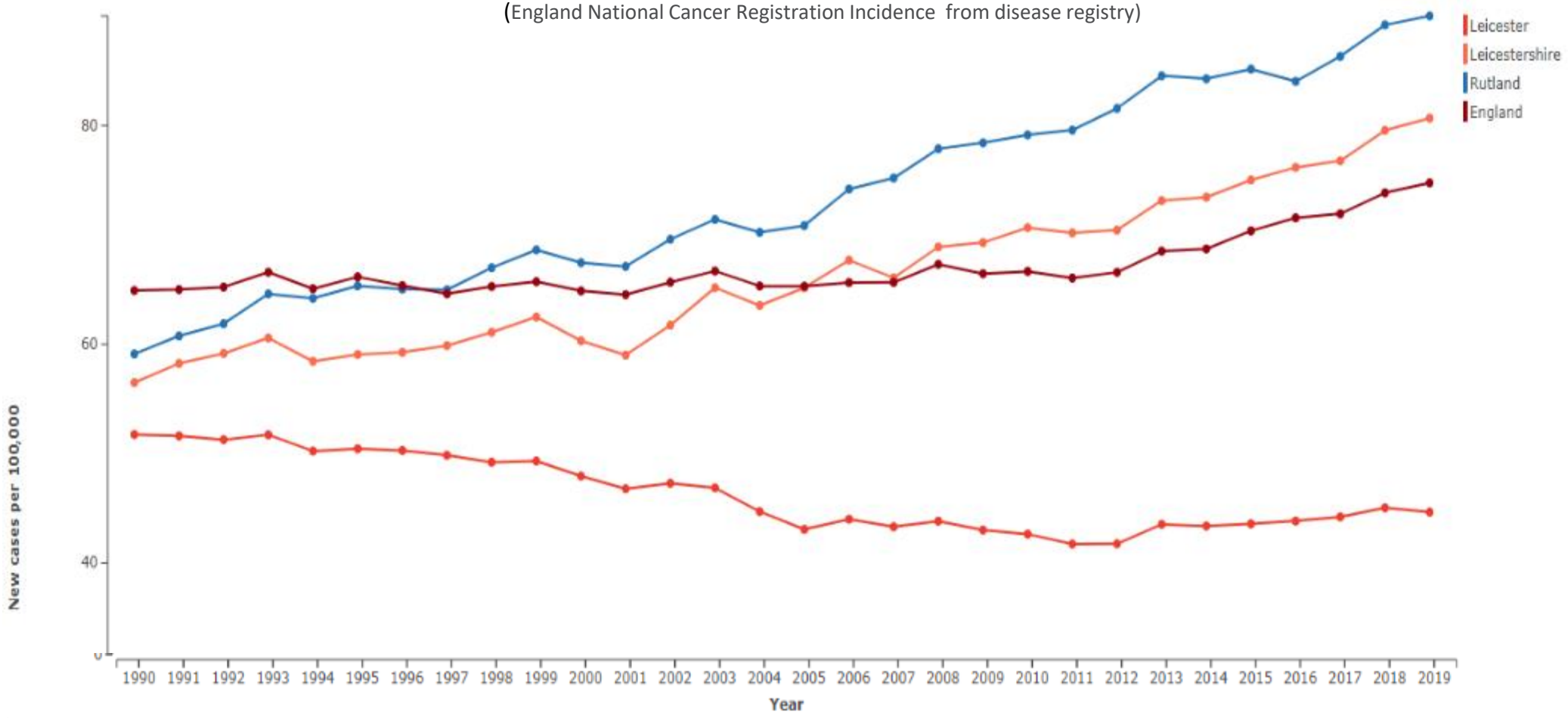
Other East Midland CCGs

Source: RightCare Cancer Focus Pack, NHS Leicester City CCG

5

- The relatively **low and declining incidence** of colon and rectum cancer is part of a long-standing downward trend in Leicester since the 1990s.
- The key question is what is accounting for this low incidence? Is it due to age, ethnic/cultural mix or something else?

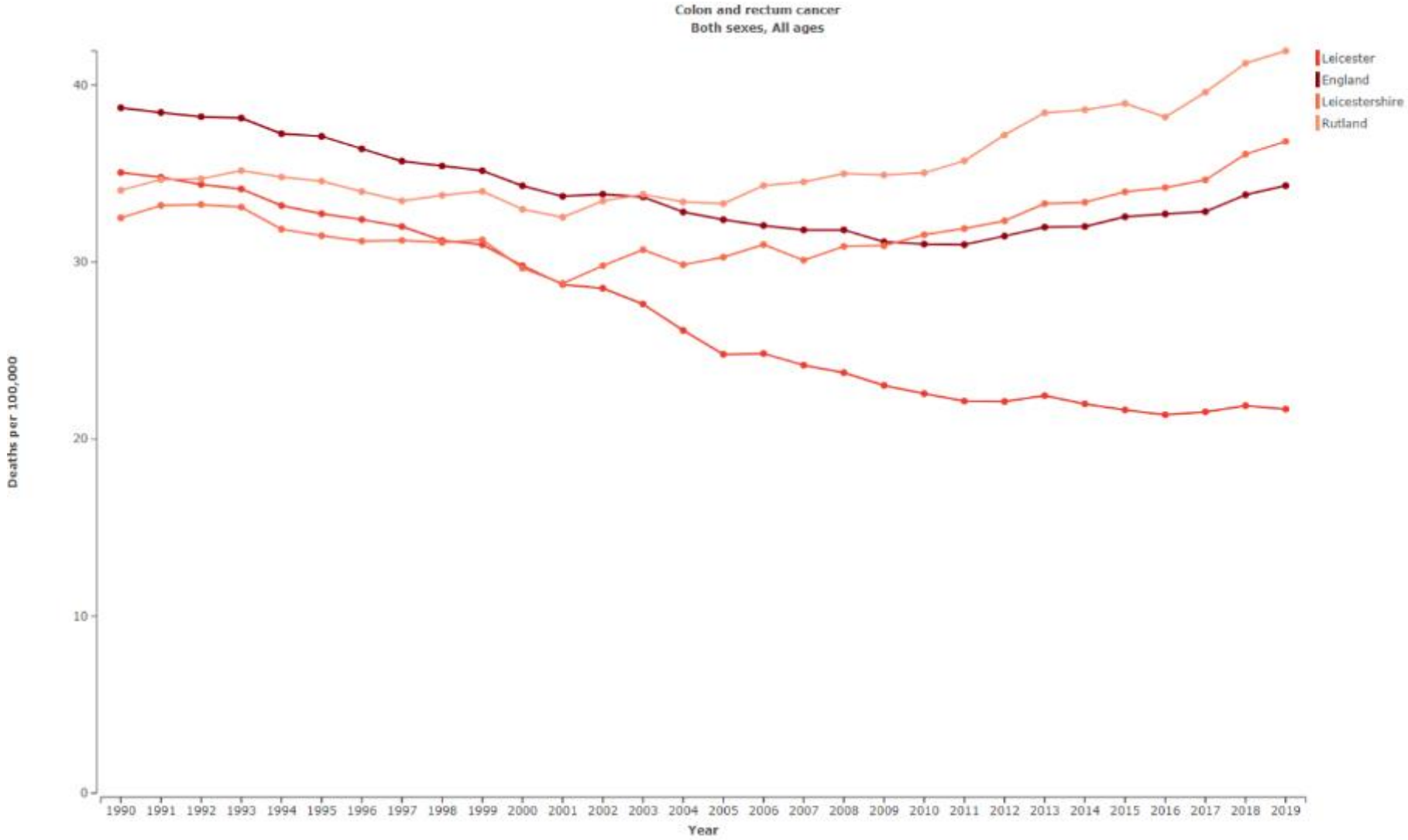
Colon and rectum cancer: **Both sexes, All ages**
(England National Cancer Registration Incidence from disease registry)



Source: https://vizhub.healthdata.org/gbd-compare/

6

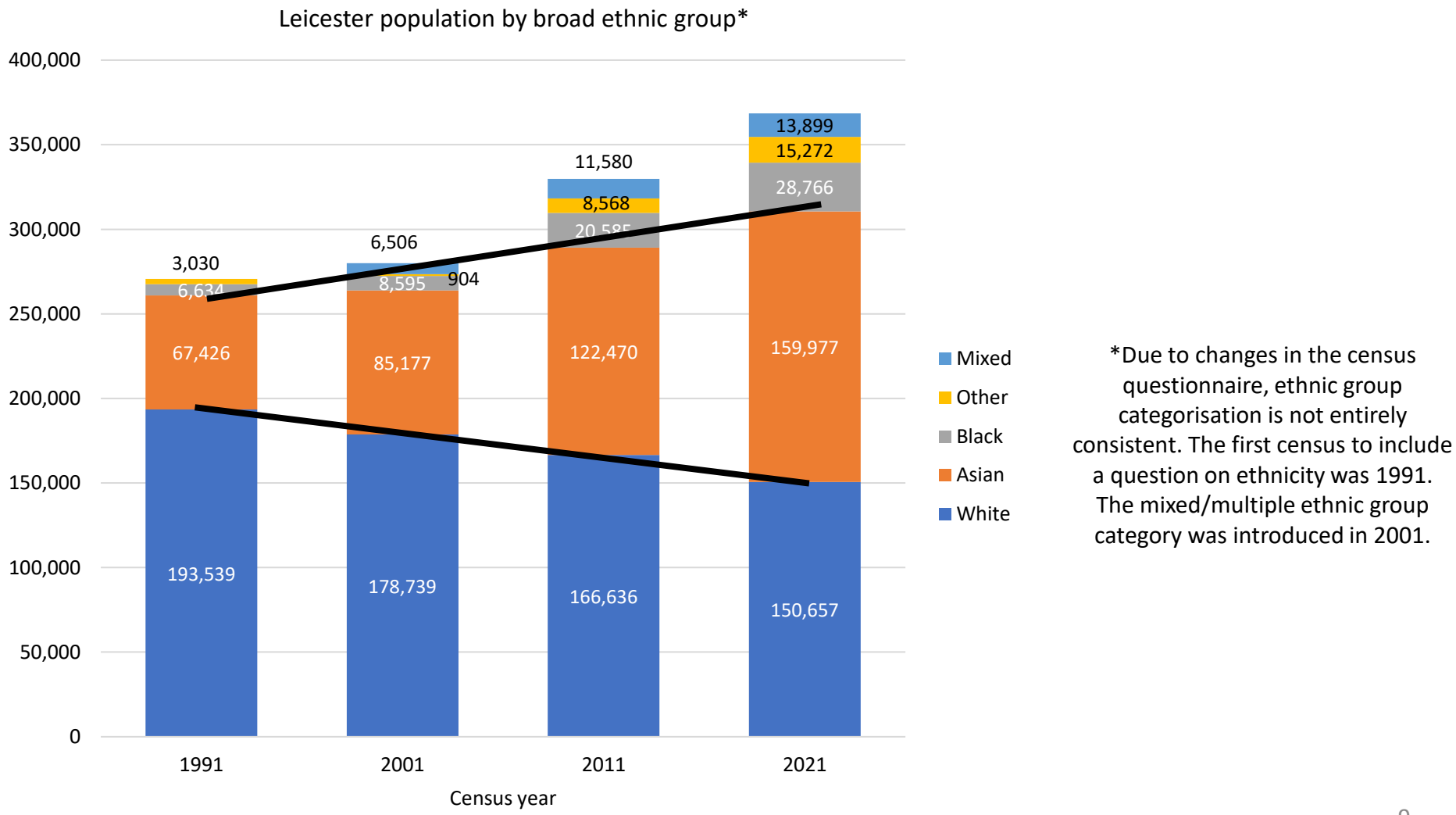
- Further adding to this picture is data about the **colon and rectum cancer death rate in** Leicester.
- In comparison to both the England and other areas within the Integrated Care System (ICS) we can observe a longstanding downward trend in deaths per 100,000 due to colon and rectum cancer.



Source: https://vizhub.healthdata.org/gbd-compare/

7

- A critical key point emerges from the last 3 Censuses, however, which show that the proportionate ethnic make-up of the Leicester population has also followed a continuing trend of change.
- Between 1991 and 2021, Leicester's total population has increased by almost 100,000 from, 270,629 to 368,571.
- Over the last forty years, the number of White residents has decreased while the number of residents from all other broad ethnic groups has increased.

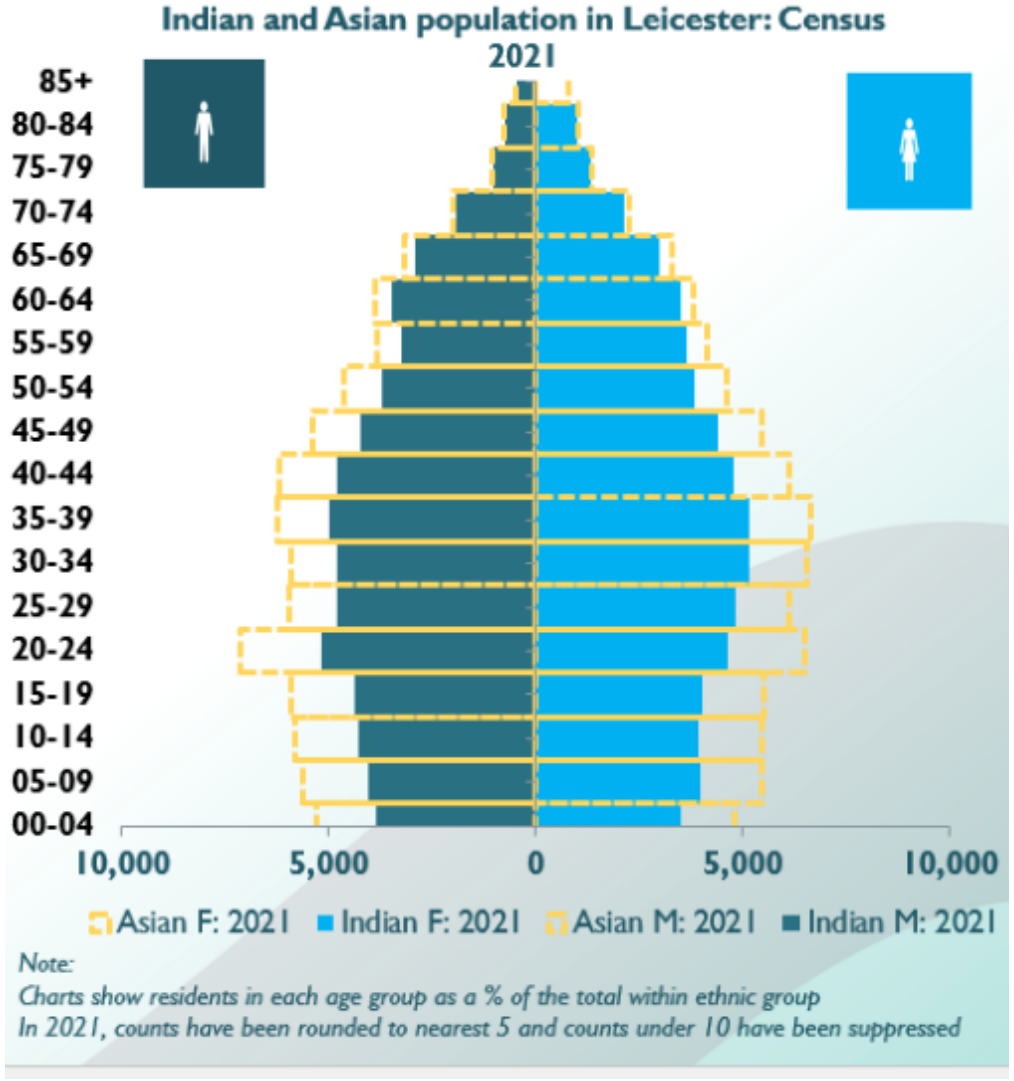


*Due to changes in the census questionnaire, ethnic group categorisation is not entirely consistent. The first census to include a question on ethnicity was 1991. The mixed/multiple ethnic group category was introduced in 2001.

Source: Census/ Leicester City public health team

8

- A high proportion of the Asian population in Leicester are Asian Indians. This is across the age structure, but even more so in the over 60's.
- Leicester is now home to the largest number of British Indians of any English city, standing at 6.6% of the national total.



Source: Census/ Leicester City public health team

- This leads us to ask, is there a differential incidence of Colorectal Cancer in ethnic groupings within Leicester City?
- Evidence (paper below) shows that the incidence rate of colon cancer (but not rectal cancer) in British Indians is around half that of British whites.

	British whites	British Indians	Mumbai Indians
Male			
Colon	18.2 (1)	9.9 (0.52)	3.0
Rectum	11.7 (1)	9.8 (1.19)	2.6
Female			
Colon	15.5 (1)	5.9 (0.38)	2.4
Rectum	6.5 (1)	7.8 (0.98)	1.8

Source: British Journal of Cancer (2010) Cancer incidence in British Indians and British whites in Leicester, 2001 – 2006
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2905295/

10 Summary

- **The substantial change in the demographic, ethnic make-up of the Leicester population, with an increasing and sizeable proportion shown to have around half the incidence of colon cancer, is likely to account for the decline in incidence and deaths seen over approximately the same period.**
- **But, what – therefore- might account for the prolonged fall in the 1-year survival for colorectal cancer in Leicester in parallel over a similar time trend?**

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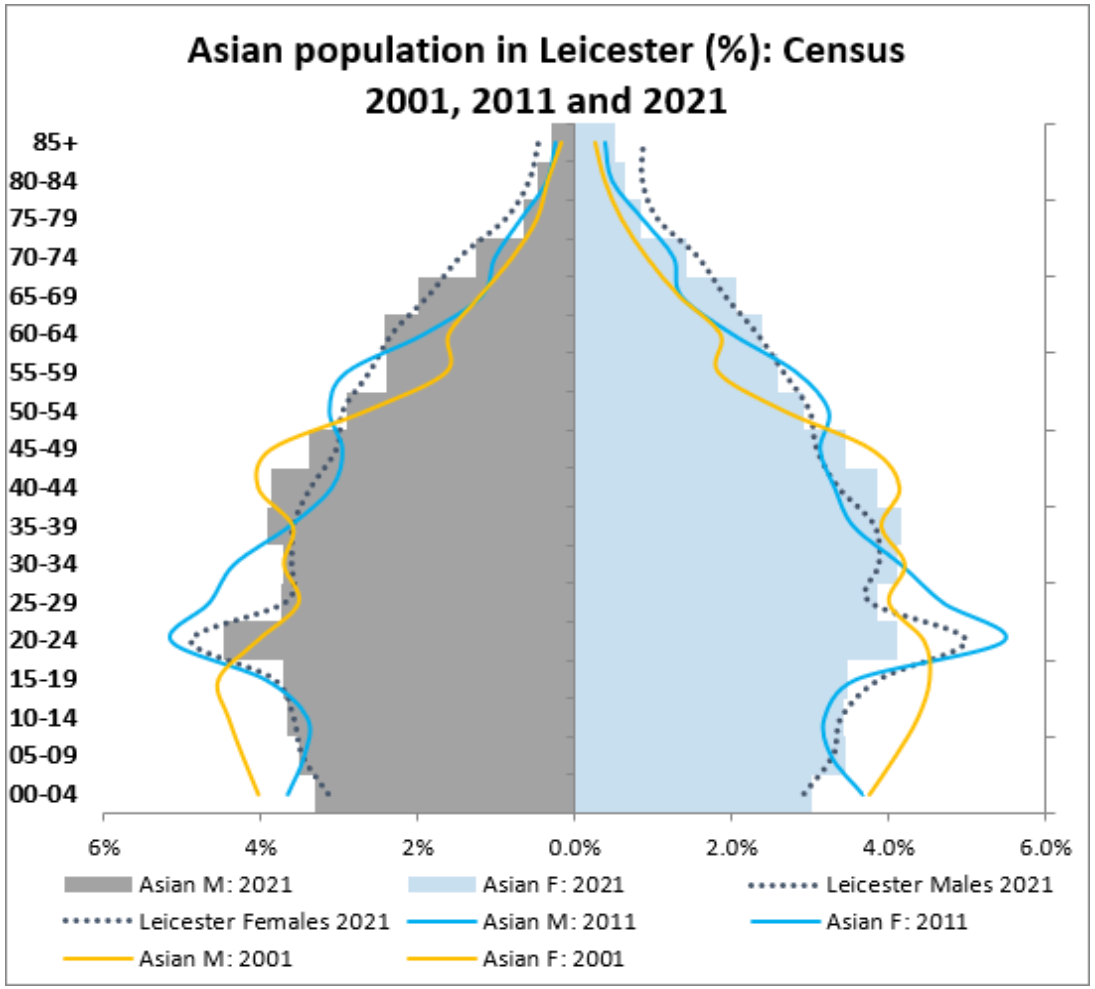
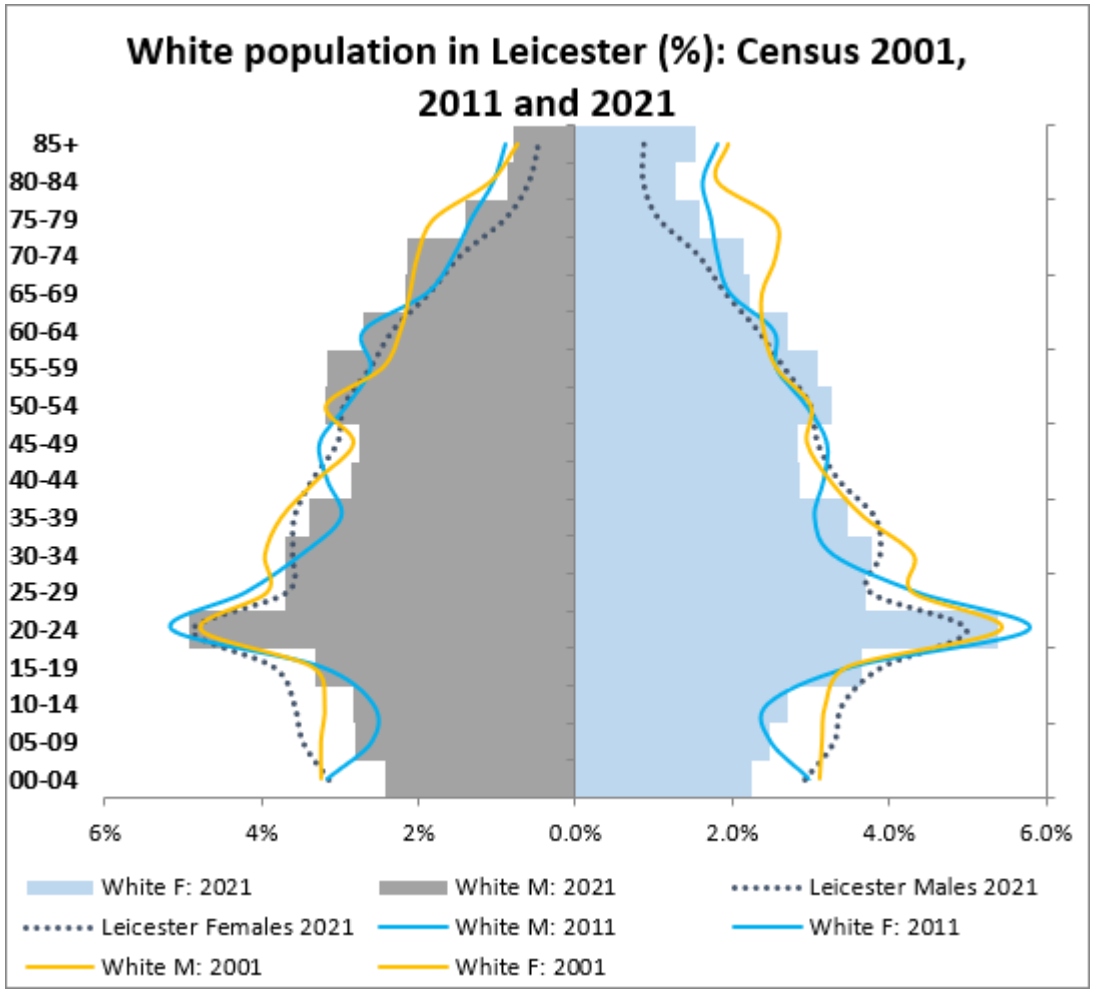
- Patients diagnosed with colorectal cancer via an emergency admission are more likely to have later-stage disease and are likely then to have a poorer prognosis.
- Recent Leicester data (for a single year) suggests that such patients were largely white males with age range 60 -79.
- Over half of patients diagnosed through this route were from the most deprived areas in the city.

Bowel cancer activity for Leicester City CCG (2022)
1st diagnosis emergency admission. Annual rate per 100,000 population

Source: Health Economics Unit — Midlands Cancer Alliance Dashboard
Variation in activity by demographics

- While the proportion of white males and females has fallen relative to the Asian population overall, there is still a persistent higher proportion of white males (and females) in the 60 – 79 age group.
- This persistent cohort may help to account for an increasing proportion of poor 1-year survivors as the overall number of deaths falls.





Source: Census/ Leicester City public health team

13 Further work

- **With these insights in mind, we now need to <u>examine</u> (via secondary care work and planned primary care audit):**
  - **Case mix of people (age, sex, ethnicity, deprivation etc.) diagnosed with colorectal cancer in Leicester city via all routes over time (not just via emergency presentation).**
  - **The relationship between age, ethnicity and stage of colorectal cancer at diagnosis.**
  - **Demographic differences in incidence, presentation and survival between colon and rectal cancers.**
  - **The contribution of health service factors to this picture e.g., uptake on screening; access to and use of primary care etc.**
- **This analysis demonstrates the need for us to continue targeted <u>action</u> on colon cancer particularly in the most deprived white British communities and PCNs.**
- **The consequences of the particular demographics of LLR for better understanding the disease burden, particularly of certain other cancers, e.g., lung, will also be explored**

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- The Task and Finish Group has therefore pulled together the actions and roles of partners across the System which will contribute to the overall coherent plan, detailed below along the pathway of engagement, treatment and care.
- It has been agreed to extend the timescale for the Task and Finish Group to accommodate the changes resulting from the most recent analysis

1 year survival following Colorectal Cancer (CRC) diagnosis in Leicester City: summary of actions to address high risk of poorer outcomes in identified priority population*

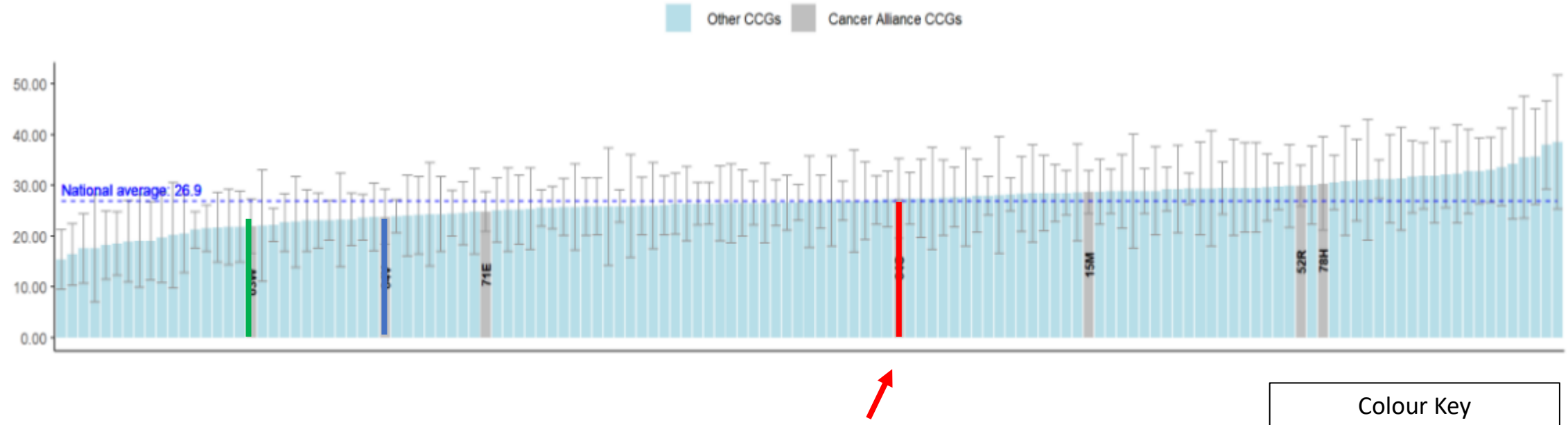
Community	Primary Care	Hospital Care	Patient Support
• Use multi-year data on first diagnosis of CRC via emergency presentation (EP) / admission to expand understanding of high-risk target area/PCN coverage for intervention programme • Conduct "attitudes and barriers to screening" focus group work with priority population* • Set in place programme management support to focus prevention/ health promotion approach to people diagnosed with CRC in priority population* • Explore whether there are any differential issues related to uptake on offer of colonoscopy after a query positive screening/FIT test especially for priority population* • Explore possible pilot use of patient symptom attribution awareness measure (in partnership with CRUK)	• Work in partnership with Leicester PCN leads to: - Set in place methods to prioritise early CRC diagnosis as part of DES - Explore options for expanding video/text reminders for target population* - Embed package of educational support for all PCNs in Leicester City - Expand use of E-crest virtual training tool by primary care MDT • Conduct "City South PCN CRC audit" using CRUK/PHE tool to learn about common patient pathway improvement opportunities • Augment symptomatic FIT pathway for priority population*: - Address delays/difficulty in access to kits / explore practice held kits for direct distribution in target practices or PCNs - Explore possible arrangements with Lincolnshire hub for test processing - Explore possible adjustment in suspicion threshold for testing in priority population* • Explore suitability of developing Colon-flag/ other AI tools to identify individuals at higher risk of CRC from blood count(s)/ other information	• Determine whether access to diagnostics (colonoscopy; imaging) is causing delays in CRC diagnosis/staging • Conduct "UHL CRC pathway audit" (underway) with a particular focus on: - People diagnosed with CRC from Leicester City (WL and ELR used as 'controls') - Expanding to include WL and ELR residents if hypotheses about priority population confirmed - Exploring whether priority population pattern extends to other referral sources (than just EP) - Providing staging data for correlation - Separating analyses by colon and rectal cancers (due to differential incidence rates by ethnicity) - Reviewing frequency/importance of differential "DNA" rates - Benchmarking risk appetite for surgery - Exploring survival of people with CRC on medical care plans	• Determine whether there are any specific barriers to completing a holistic needs assessment (through Macmillan cancer care or other) and receiving support for people in the priority population • Explore possibility of new Community Lead Cancer Nurse to help shape and plan the delivery of community cancer care

*** "priority population" defined as people in ≥60yrs white cohort in inner city deprivation areas**

Additional slides for information

- Despite the very low 1 year survival, Leicester City colorectal cancer mortality rate has been only average nationally.

Mortality from colorectal cancer: all ages directly age-standardised rates (DSR) per 100,000 European Standard - 2017

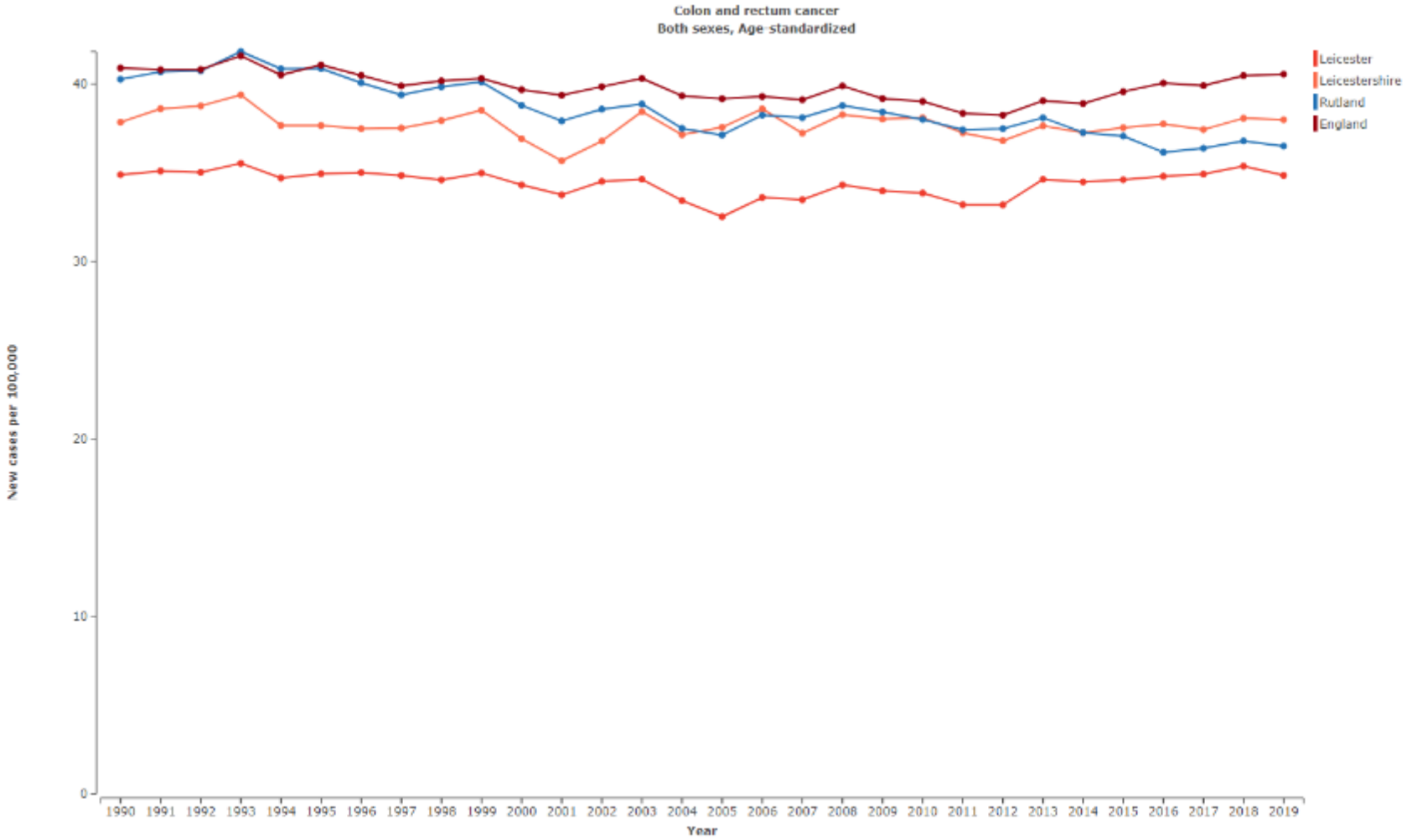


Colour Key
Leicester City
West Leicestershire
East Leicestershire/Rutland

Other East Midland CCGs

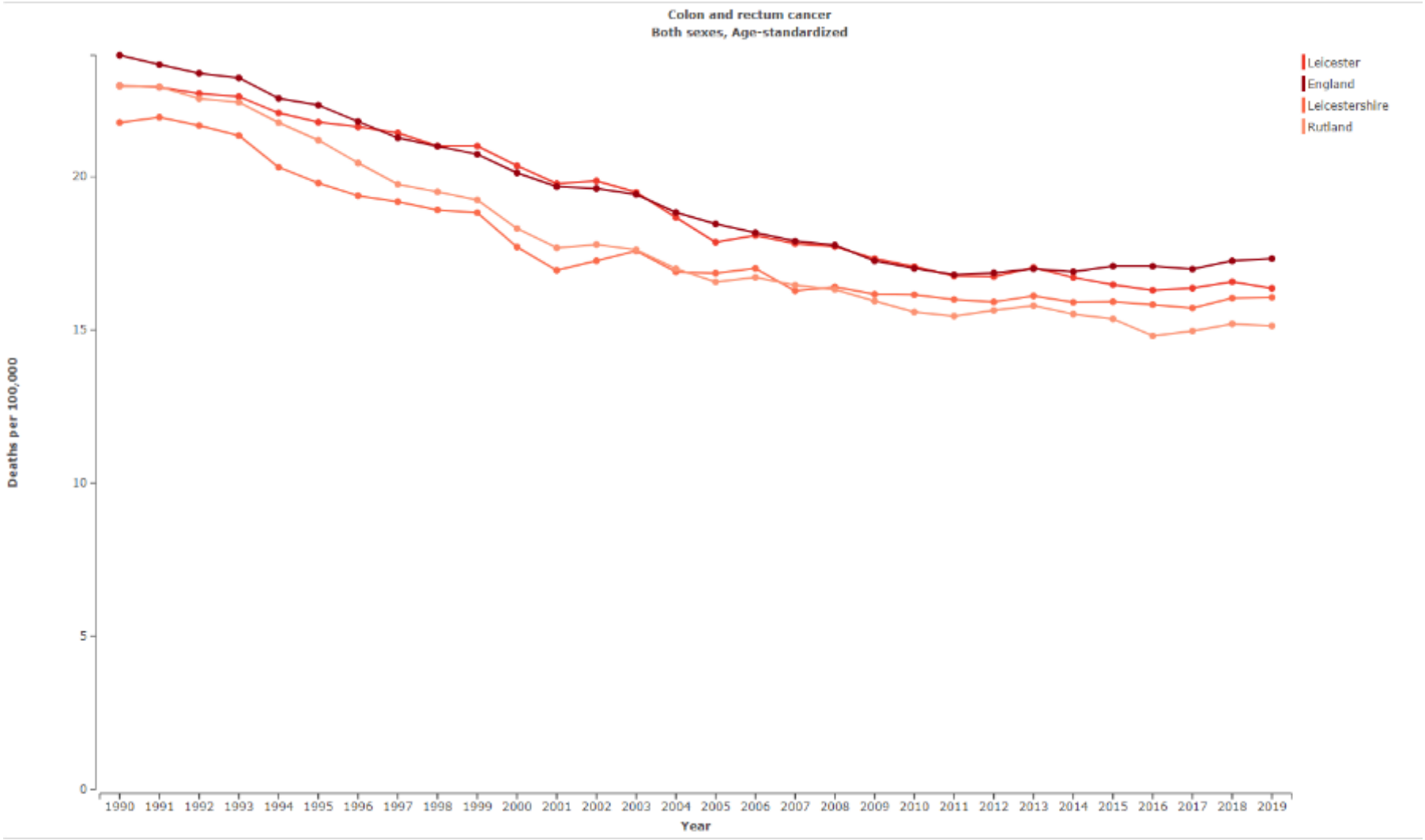
Source: Cancer Focus Pack, NHS Leicester City CCG

- When the incidence rate is age standardised, we can observe that - although comparatively lower- it has changed little over that period.
- We need to explore whether there has been a change in the age structure in Leicester, particularly in the commonest age cohorts presenting with cancer.



Source: https://vizhub.healthdata.org/gbd-compare/

- As with incidence, the falling relative trend disappears when age standardised.
- If this means the incidence and death rates have not changed overall, has the age structure particularly in those age cohorts where cancer incidence and deaths are commonest, altered? To explore this we need to examine population structure data.



Source: https://vizhub.healthdata.org/gbd-compare/

- Leicester's population structure remains substantially the same as in 2011. Leicester is still a young city, median age 33years.
- Adults in most age bands between 35 and 74 now make up a slightly larger proportion of the population, and so will not alone account for falling incidence and deaths from colorectal cancer.

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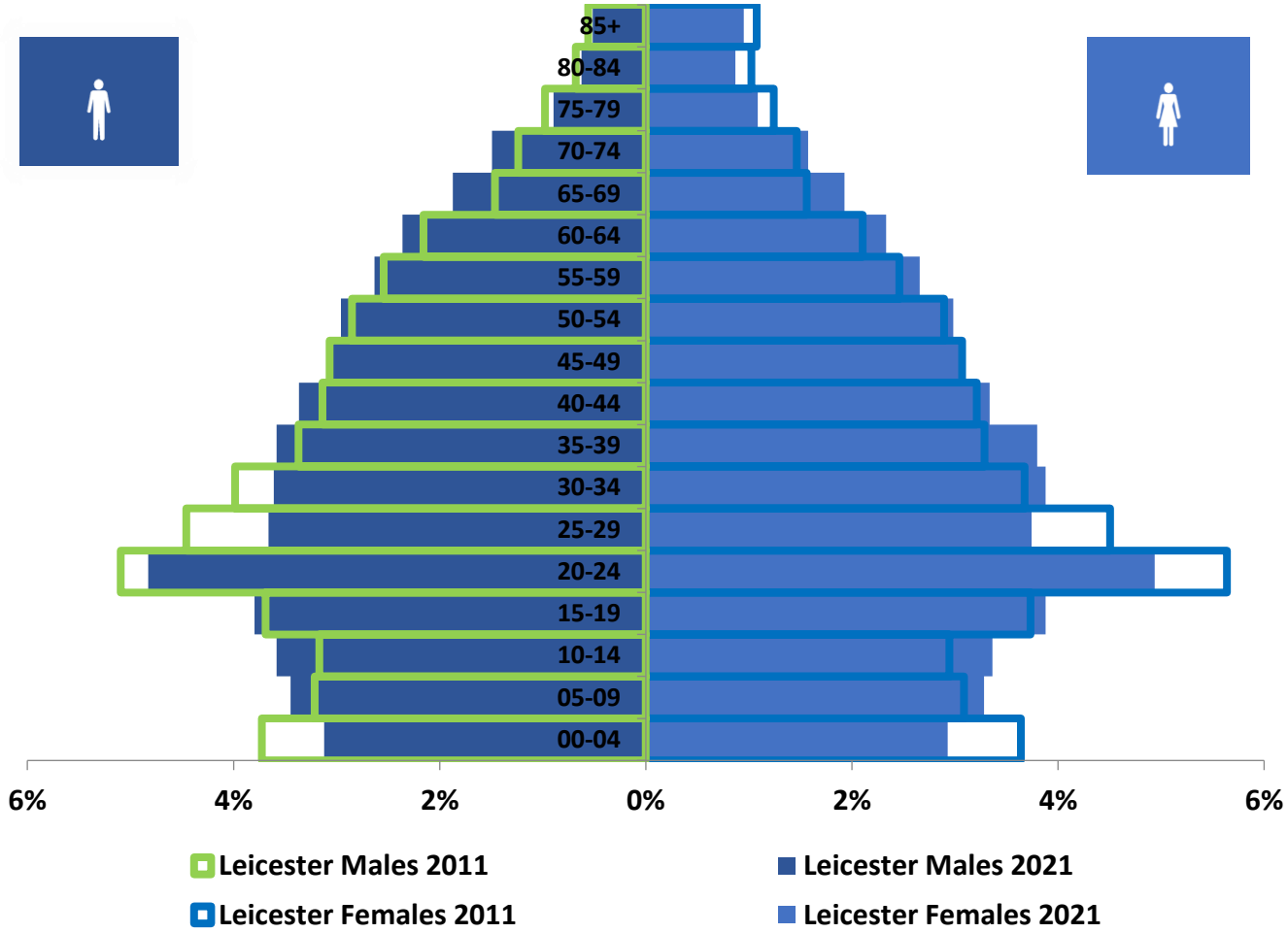
Leicester population structure: 2011 and 2021



Source: Census/ Leicester City public health team

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	Leicester's joint Health, Care and Wellbeing Strategy delivery plan – quarterly update
Presented to the Health and Wellbeing Board by:	Amy Endacott
Author:	Amy Endacott/Katherine Packham

EXECUTIVE SUMMARY:

Leicester's Joint Health, Care and Wellbeing Strategy (JHCWS) outlines the health and wellbeing needs of Leicester's population, and highlights 19 priorities for action. These are categorised into 'do,' 'sponsor,' and 'watch' in recognition that equal resource and focus cannot be given to all 19 priorities simultaneously. This update reflects progress highlights, next steps, and key risks against the six 'do' priorities which were selected, through a public consultation, for initial focus, and for which a full action plan has been developed to run from 2023-2025. The period covered by this update is February – May (inclusive) 2023.

The following pages provide a summary of each of the five 'Healthy' theme areas, and a summary of communications and engagement activity to support the delivery of individual actions.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- Review the detail of the report.
- Provide feedback on any topics or matters arising from updates where more detailed discussions would facilitate delivery.
- Provide feedback on opportunities for strategic leadership to enhance progress against individual priority areas.
- Provide any feedback on mitigation of risks and issues that are included within the report.
- Provide feedback on the format and detail of this report, with a view to enabling decisions about how future updates should be brought to the Health and Wellbeing Board.

Healthy Start Priority: We will mitigate against the impacts of poverty on children and young people.
An anti-poverty strategy and framework has been developed through a co-design approach, engaging with more than 500 people. Leicester's approach has been recognised as good practice by Greater Manchester Poverty Action[1]. Anti-poverty community grants have been awarded to a number of organisations to develop and run projects which mitigate against the impacts of poverty for residents across Leicester with currently 13 organisations in receipt of just over £102k supporting projects across the themes of food, clothing, digital exclusion, welfare support and community spaces. The Adult Learning/Public Health collaboration to extend the 'Let's Get Resourceful' programme has been agreed and is being worked up at present for launch in September. The previous programme provided 54 slow cookers to participants that attended the 2-day course and positive feedback was received by those attending. The offer of vouchers to carpet the living room in new Leicester City Council (LCC) lets for those eligible for Community Support Grants has been well-received, with around £100k of vouchers distributed. In collaboration with the Public Health fuel poverty programme with National Energy Action (NEA), funding for 8 further places on the 3-day Energy Awareness course to train advisors within community groups has been agreed by the anti-poverty board. Developments have been made against Maternity and Neonates Equity and Quality co-produced actions plans, which focus on areas of deprivation and vulnerable/complex groups. Preparatory work has taken place to support the relaunch of a Peer Support Programme to ensure women accessing perinatal mental health support have access to someone who can act as an advocate for them. A task and finish group meet monthly to address the impacts on service accessibility and experience of women from the Black and Asian ethnic minority (BAME) community. This has included reviewing national and local data, carrying out focus groups with key community groups, and planning events to increase engagement and awareness within the community. Learning from these activities has helped to shape further discussions and events to address the issue.
Next steps: An event aiming to improve equity in maternity, neonatal and perinatal mental health for women from BAME communities across Leicester, Leicestershire and Rutland is planned in June 2023. This will focus on multiple determinants of health, co-production with patients, eliminating unconscious bias, mitigating against digital exclusion, and making health equity a strategic priority.

[1] GMPA-Local-anti-poverty-strategies-report-2023-final.pdf (gmpovertyaction.org)

Healthy Places Priority: We will improve access to primary and community health and care services.
Work to develop Integrated Neighbourhood Teams (INTs) to work in a more coordinated way with partners at local level through enabling the evolution of Primary Care Networks (PCNs) is progressing. Five key priorities for this workstream have been identified (bowel cancer screening, women's health, obesity, integrated chronic kidney disease, and hypertension). PCN's have recruited 202 Additional Roles Reimbursement Scheme (ARRS) staff across Leicester, Leicestershire and Rutland (as of October 2022). The Integrated Care Board (ICB) continue to develop and optimise the use of social prescribing and other ARRS workforce across Leicester City. Training events and network sessions have been held monthly for social prescribers to share learning, with active signposting facilitated by the training team. PCNs are required to meet the Investment and Impact fund (IIF) indicator focussed on social prescribing referrals. Training has been delivered via Reaching People to volunteers around the NHS app, online GP services and a range of other digital skills, to enable them to support patients in medical practices. This aims to empower citizens to use technology where appropriate by enabling people to improve their literacy of local technology. Reaching People have also developed a range of communications materials to support this project. This includes hyperlocal support for the Accident and Emergency department (A&E) through the ICBs Voluntary, Community and Social Enterprise (VCSE) Alliance funding individual organisations to support signposting to appropriate or alternative services. Delivery of the Enhanced Access (EA) service in Primary Care – dashboard data is indicating an improvement in learning disability (LD) health checks compared to previous months, as well as achievement of increased recording of ethnicity data by PCNs. Monthly EA returns indicate that PCNS are offering appointments/hours above their contracted hours. As part of a strategic review of urgent care services (UCS's) for patients with minor illness and injuries, streaming off-site from the emergency department front desk to 4 urgent treatment centres and 10 urgent care centres and EA hubs has been agreed for 2023/24.
Next steps: Clinical directors will continue to meet monthly to progress city INT working delivering on the identified priorities. Workshops designed and tailored to address priorities and links with INTs will be held to support progress. Work will take place to develop a dashboard to report on individual practice support for engagement. Development of the social prescribers network and active signposting training will take place to align with the direction of travel for 2023/24, focussing on alleviating access pressures and increased INT working. There will be ongoing monitoring of EA and a review of the benefits, with feedback from patients and PCNS. Proposals for improvement will be the subject of a public engagement consultation, currently planned for summer 2023. Emergency department and urgent treatment centre off-site streaming will continue to be monitored.

Healthy Minds

Priority 1: We will improve access for children & young people to Mental Health & emotional wellbeing services.

Priority 2: We will improve access to primary & neighbourhood level Mental Health services for adults.

Children and young people (CYP) - A pathway review of CYP mental health and Emotional Health and Wellbeing Services took place at the end of 2022, leading to contracts being extended for two years with possible 24-month extensions for four of the high-performing services. An up-to-date CYP directory of services is in development to support promotion of services. A CYP online self-referral to the Triage and Navigation service went live on May 23rd, removing the requirement to see a GP first, with the aim of improving access and removing barriers to services. Roll-out of Mental Health Support Teams (MHSTs) in schools has continued, with funding awaited for Wave 9 which will lead to an additional three teams in the City in areas of deprivation, to help with improved access.
Data has been used to identify areas within the City where health inequalities and deprivation exist, and where there are low referrals, with a view to better understanding whether there are barriers to access and how these can be addressed.

Adults - 13 city organisations have been awarded grants for Getting Help in Neighbourhoods in round 2 of the grant awards scheme. Five additional crisis cafes have been awarded during round 2, bringing the total to 11. Five out of nine Primary Care Networks (PCNs) have a Mental Health Practitioner and an additional Peer Support Worker working alongside them. Three Mental Health Leads are in place in the City, facilitating new ways of working, organising local mental health networks and facilitating improvement projects in line with the LCC strategy and local needs. The newly rebranded NHS Talking Therapies Service (previously known as Improving Access to Psychological Therapies (IAPT)), provided by VITA MIND, have provided promotional information to pharmacies, and communications activity is taking place via the local lead.
A draft of the refreshed Dementia Strategy has been completed and is due to be shared with relevant governance boards. A Voluntary and Community Sector (VCS) dementia forum hosted by Leicester City Council has been well attended and has offered opportunities to strengthen relationships between the VCS and other relevant services to better support people experiencing dementia.

Next steps:

CYP - Recruitment for Wave 9 to begin, and specific schools where the new MHSTs will be based are to be decided upon. Key areas in the city for work to address low referrals into mental health services will be agreed.
Work will begin to progress increasing new roles in PCNs with support of adult Additional Roles Reimbursement Scheme (ARRS) teams to share learning and best practice from the work they have done in implementing these roles.
Adults - Organisations who have successfully been awarded grants will be announced, followed by implementation by all sites. There will be increased local communications and engagement activity with GPs and the developing Integrated Neighbourhood Teams to promote the NHS Talking Therapies service, including local promotional events hosted by VITA MIND to raise their profile and circulate information on the psychological offers. A primary care engagement plan will be developed and VITA MIND will work towards reporting NHS Talking Therapy activity at neighbourhood/GP practice level.
An 8-week consultation on the draft refreshed Dementia Strategy is planned for the summer of 2023. This is being led by Leicestershire County Council.

Healthy Lives

Priority: We will increase early detection of heart & lung diseases and cancer in adults.

A pilot scheme to identify people with undiagnosed hypertension has concluded and is being evaluated to provide information on the demographics of those identified, and demographics of those who responded to invitations.
A project to recruit and develop long term conditions (LTCs) champions which was funded until March 2023 has concluded, with no further funding secured. Across the duration of the project three champions engaged with nine practices, and developed specific action plans. An evaluation of this programme is underway as of May 2023, with indications that practices who had a LTCs champion attached to them demonstrated improved LTCs process.

A range of activity has taken place to increase early diagnosis in cancer pathways through early detection and follow-on pathway developments:
Prostate cancer identification in Black and Asian minority ethnic (BAME) men is being supported through the use of a video text message to raise awareness, targeted at black men, and men with a family history. A Health Inequalities manager is now in post to progress this work.
Year one of the NHS Galleri clinical trial (a blood test aimed at fit and healthy people aged over 50 to detect cancer markers) was considered successful, and roll-out of year two is due to begin in the next quarter with a focus on retention, rather than recruitment, of participants.
Work to improve colorectal cancer detection at an early stage has resulted in significant changes to the faecal immunochemical test (FIT) pathway, including a reduction in screening age to 56, and intentions to provide more GP surgeries with access to testing kits to reduce postal delays. A multi-partner task and finish group have led on a targeted project to increase the 1-year survival rate in the LE4 area of Leicester.
Work continues to implement a pathway to address 'did not attend' rates for breast cancer screening amongst Black African/Black Caribbean women.
A cervical cancer text project has been launched, using video texting to target patients who have not attended cervical screening. This will be developed into a range of languages.

Next steps:

<u>Hypertension</u>

Learning from the PCN based pilot will be used to look for associations with inequalities gaps and recommend methods to address them.
A project to enable better case-finding and management for hypertension within specific communities (Sharma Women's Centre and South Asian Health Action are key delivery partners) will be developed in the coming months.
Exploratory work will take place with the Public Health team to identify what work can be done within current resources to support the LTC work.

<u>Cancer pathways</u>

Communications activity to support retention of participants for the Galleri trial.
Development and delivery of training, in collaboration with primary and secondary care colleagues, to support the significant changes to the FIT pathway.
Evaluation of the value of purchasing/using a colonoscopy chair to support cervical screening for people with learning disabilities and a decision on whether to adopt this approach.

Healthy Ageing Priority: We will enable Leicester's residents to age comfortably and confidently through a through a person-centred programme to support self-care, build on strengths and reduce frailty.
There has been a range of activity to support development of a framework for local delivery of anticipatory care (now proactive care). A proactive care project group have been mobilised and are meeting regularly to progress this work. Early adopter sites have been identified and Care Navigators are taking part in MDT's. There is active pursual of confidentiality agreement from PCN's for the MDT facilitator. Training needs for staff have been identified and training costs agreed via LOROS. Care Navigators have also received MECC training and are using this approach with any new people they start to work with. Development of the MyChoice directory is progressing to include local voluntary sector preventative services and community assets to reduce loneliness and isolation. A feedback function has been identified, and Personal Assistants listed. Community Connectors are now part of the MyChoice steering group to enable actions relating to community connectors to move forward. A business case has been created to develop a 'social prescribing' add-on, which will enable people to contact support agencies directly without the need for a referral. There has been activity to support commissioning of a range of services and opportunities to provide alternatives to residential care. The hospital bridging service has been brought in-house within the Homefirst suite of service provided by Leicester City Council, offering greater ability to meet the demand for this service. A commissioning review for Homecare is in progress, with a model of delivery agreed by the project board, and is on target for new contracts to be in place for 2024. A review of respite services is underway to establish demand and use. A commissioning review has begun into carer support services and is at the 'soft market test' stage, with planned engagement activity with carers during National Carers week. An Operational Project Lead has been appointed to lead a project team working to increase reablement capacity, and to make a transformative change whereby all hospital discharges (unless there are specific reasons) will be supported by the reablement service, with £500k initially released by the Integrated Care Board to fund this work.
Next steps: Proactive care – Guidance will be sought form early adopter sites to inform next steps, and sign-off will be sought for data protection impact agreements and memorandum of understanding. Training dates to be agreed with LOROS to upskill Care Navigators. Commissioning – Proposals will be drafted to pilot a short breaks service with the care home market which will inform the design and scope of the longer-term model. Remodelling work to increase reablement capacity – The project lead will commence in post at the start of June to drive this project forward, and five sub-groups will commence to drive this work forward.
Risks: Funding to increase reablement capacity will not exceed the £500k allocated as part of the Discharge Grant. There are concerns that this will fall short of the funding required to help make this transformative change possible. More budget planning work is due to take place to map out risks and mitigations.

Communications and engagement activity

A range of communications and engagement activity has taken place across the ICB and through the local authority and community wellbeing champions to facilitate progress against the identified actions. This has included:

- Supporting delivery of the new Maternity and Neonatal Voices Partnership contract.
- A volunteering campaign for individual at practice level to support development of integrated neighbourhood team working
- Supporting activity to empower citizens to use technology where appropriate
- Planned engagement and consultation with the public on options for urgent care services
- Cancer screening
- Implementation of the joint LLR Dementia Strategy, and planning the Dementia Strategy consultation
- Promotion of the emotional health and wellbeing service, including the digital offer for schools for CYP and their families.

Progress against 'sponsor' and 'watch' priorities

The working group who have developed and implemented the initial 'do' priorities delivery action plan are due to reconvene in July to consider approaches for reviewing and monitoring progress against the 'sponsor' and 'watch' priorities, and to identify the governance structure, reporting frequency and level of detail in which updates against these priorities should be provided.

Appendix I

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	**BCF End of Year Submission 2022-23** **BCF Planning 23-25**
Presented to the Health and Wellbeing Board by:	Ruth Lake (Director, Adult Social Care and Safeguarding Social Care and Education Leicester City Council)
Author:	Mayur Patel, Head of Transformation, LLR ICB Muhammad Kharodia, Integration & Transformation Manager, LLR ICB

EXECUTIVE SUMMARY:

Please refer to the following papers;

1. LLR BCF Annual report 22-23 EOY Paper

As the 22/23 BCF programme comes to an end, Leicester City, along with Leicestershire and Rutland were all required to submit EOY reports to NHSe. LLR successfully submitted 3 separate submissions on time (one for each place). A summary of this submission for Leicester City can be found within paper 1 in the appendix.

2. LLR BCF 23-25 Planning Paper

On the back on this Leicester City is required to submit its plans for 23-25, this is currently being worked up and due to be submitted to NHSe by the end of June 23. Paper 2 provides detail on submission requirements, our planning approach and governance model.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

1. LLR BCF Annual report 22-23 EOY Paper

- **NOTE & APPROVE** the BCF End Of Year submission to NHSe on 23/05/23
- **NOTE** the local and system successes, challenges, and next steps

2.LLR BCF 23-25 Planning Paper

- **REVIEW** the planning framework and requirements for 2023-2025
- **NOTE** the key deadlines and submission requirements
- **NOTE** the approach taken, including the engagement & governance as per annual arrangements and national requirements

Appendix I

Name of meeting:	**Joint Integrated Commissioning Board (JICB)**		
Date:	**25th May 2023**	**Paper:**	
Report title:	**BCF Planning 23-25**		
Presented by:	Mayur Patel, Head of Transformation, LLR ICB		
Report author:	Mayur Patel, Head of Transformation, LLR ICB Muhammad Kharodia, Integration & Transformation Manager, LLR ICB		
Executive Sponsor:	Rachna Vyas, Chief Operating Officer, LLR ICB		

To approve ☐	**For assurance** ☐	**To receive and note** ☒	**For information** ☒
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

Joint Integrated Commissioning Board members are asked to:

- **REVIEW** the planning framework and requirements for 2023-2025
- **NOTE** the key deadlines and submission requirements
- **NOTE** the approach taken, including the engagement & governance as per annual arrangements and national requirements

Purpose and summary of the report:

1. BCF 2023 to 2025 Policy framework and the Planning Requirements were released on 4th April 2023 (Appendix A)
2. As outlined within the planning requirements each of our places (Leicester City, Leicestershire and Rutland) need to meet the following submission deadlines:
    - By **19th May 2023** Submit and optional BCF planning submission (which was extended to 30th May 2023 by the regional team)
    - By **28th June 2023** Submit a BCF planning submission (including intermediate care and short term care capacity and demand plan; and discharge spending plan) from local HWB areas (agreed by the ICB's and local government)
3. For LLR, this means we will need to submit 3 x BCF submissions – one for each place
4. Each submission will have the following components:
    - A narrative plan
    - A completed BCF planning template, including:
        i. planned expenditure from BCF sources
        ii. confirmation that national conditions of the fund are met, as well as specific conditions attached to individual funding streams
        iii. ambitions and plans for performance against BCF national metrics
        iv. any additional contributions to BCF section 75 agreements.
        v. a demand and Capacity plan
    - A completed discharge funding template
        i. There is now a requirement for a fortnightly return, and a separate monthly return
5. Each set of documents will need to be agreed by each place governance structure, including engagement with lead councillors.
6. We will continue using our existing engagement, assurance and governance process as we have done in 22/23 and previous years.

Leicester City BCF – Planning approach

7. On 14th Feb 2023 we met with our system partners to initially discuss our 23-25 plans.

8. This was followed up with an additional system partner discussion on 17th May 2023 (following the publication of national guidance on planning requirement) during which it was provisionally agree that the majority of our 22-23 schemes would continue into 23/24 and 24/25. In indication of the Leicester City Schemes and projected financials have been included in Appendix B. We are having an ongoing discussion with our partners to finalise these schemes and agree on the appropriate uplift from previous allocations.

Appendices:	• Appendix A – BCF 23-25 Framework and planning requirements BCF Framework 23-25 · Planning Requirements 23-25 · BCF 23-25 Planning Template • Appendix B – Leicester City BCF Schemes and projected financials Projected spend for 23-25
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	ISOC 18th April 2023 ISOC 16th May 2023 JICB 27th April 2023

The report is helping to deliver the following strategic objective(s) – *please tick all that apply***:**		
1. Health outcomes	Increase the health outcomes of the Leicester, Leicestershire and Rutland population.	☒
2. Health inequalities	Reduce health inequalities across the Leicester, Leicestershire and Rutland population.	☒
3. Reduce variation	Reduce the variation in health outcomes across the Leicester, Leicestershire and Rutland population.	☒
4. Sustainable finance plan	Deliver a sustainable system financial plan, ensuring funding is distributed to where services are delivered.	☒
5. NHS Constitution	Deliver NHS Constitutional requirements.	☒
6. Value for money	Develop and deliver services with providers that are evidenced based and offer value for money.	☒
7. Integration	Deliver integrated health and social care.	☒

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	

☐	Conflict noted, conflicted party to be excluded from the meeting.	

Implications:	
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	The final BCF 2023-25 report will provide details of a range of BCF-funded services which have contributed to mitigating BAF risks on health inequalities and financial stability.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	See Tabs 5 and 6 of the Planning Template which outline the planned income and expenditure for 2023-25 of the Better Care Fund in Leicester City.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	The final 2023-25 BCF report will identify a range of BCF-funded services which contribute to keeping people independent and safe at home and which support safe and effective discharge from hospital for older people. Quality Impact Assessments for individual services are undertaken by those services as part of the commissioning or service redesign process
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	Public and Patient representation at the Integrated Systems of Care (ISOC), Integration Delivery Groups (Leicestershire and Rutland) Groups which oversees development of the BCF investment plans each year is through the Health Watch representative who sits on these groups. Periodically, a representative of the ICB Communications and Engagement team also attends these groups and reports on outcomes of the numerous patient and public consultations and engagements undertaken by members of the Integrated Care Partnership. Individual services or pathways are expected to include the views of those with lived experience as part of re-design or commissioning processes.
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	Equality Impact Assessments for Individual services are undertaken by each service as part of the commissioning or service re-design services.

Briefing paper – BCF Planning 2023-2025

Context

1. BCF Planning Requirements and subsequent documents for the financial years 2023-2025 were released on 4th April 2023 (Appendix A) with two submission deadlines of 19th May 2023 and 28th June 2023. Each plan will need to be approved by the relevant HWB (or its chair), CEO of Council and Accountable Officer of ICB prior to submission as per previous years, and as per the national governance requirements.

2. As we were already in M1 of 2023 we have already started to work together with our system partners to ensure these deadlines are met across each place, with a clear understanding that narrative will be written once where system programmes are referenced, with localisation for each section of the plan where required.

3. Our three Place submissions will have the following components:

   • A narrative plan – this is mandatory and has been completed for each Place

   • A completed BCF planning template, including:

   - planned expenditure from BCF sources
   - confirmation that national conditions of the fund are met, as well as specific conditions attached to individual funding streams
   - ambitions and plans for performance against BCF national metrics
   - any additional contributions to BCF section 75 agreements.
   - demand and Capacity plan for those patients receiving intermediate care

   • A completed discharge funding template

   - There is now a requirement for a fortnightly return, and a separate monthly return

4. For LLR, there will be three BCF submissions – one for each of our places (Leicester City, Leicestershire and Rutland).

BCF income

Contribution to each LA based on RNF for social care mapped to 153 UTLAs (LAs as of April 2023)

LA152	Local Authority (upper tier 152)	RNF 2022/23 (£'000	RNF 2023/24 (£'000	RNF 2024/25 (£'000	Total ICB contribution by LA 2022/23 (£'000)	Total ICB contribution by LA 2023/24 (£'000)	Total ICB contribution by LA 2024/25 (£'000)
E06000016	Leicester	9,392	9,923	10,485	28,135	29,727	31,410
E06000017	Rutland	810	856	904	2,634	2,783	2,941
E10000018	Leicestershire	14,408	15,223	16,085	46,137	48,748	51,508

ICB Allocation

ICB22	ICB22NM	Discharge allocation 2023/24 (£'000)	Discharge allocation 2024/25 (£'000)
QK1	NHS Leicester, Leicestershire and Rutland ICB	4,749	8,732

ICB Totals

ICB22	ICB22NM	Total ICB contribution 2023/24 (£'000)	Total ICB contribution 2024/25 (£'000)	Discharge allocation 2023/24 (£'000)	Discharge allocation 2024/25 (£'000)	Total 2023/24 (£'000)	Total 2024/25 (£'000)
QK1	NHS Leicester, Leicestershire and Rutland ICB	81,259	85,858	4,749	8,732	86,008	94,590

Requirement Snapshot (Please refer to Appendix A for full requirements

5. Each year, each BCF plan and template must demonstrate compliance against a set of national conditions. The BCF Policy Framework sets out the four national conditions that all BCF plans must meet to be approved. These are:
    - National Condition 1: Plans to be jointly agreed
    - National Condition 2: Enabling people to stay well, safe and independent at home for longer
    - National Condition 3: Provide the right care in the right place at the right time
    - National Condition 4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services.

6. NHS England has published allocations from the national ringfenced NHS contribution for each ICB and HWB area for 2023-24 and 2024-25. As with 2022-23, the allocations of the NHS contribution to the BCF have been increased by **5.66%** for each HWB area.

7. The grant determination for the iBCF in 2023-24 was issued on 4th April 2023. Since 2020-21, funding that was previously paid as a separate grant for managing winter pressures has been included as part of the iBCF grant but is not ringfenced for use in winter.

8. Ringfenced DFG funding continues to be allocated through the BCF and will continue to be paid to upper-tier local councils. The statutory duty to provide DFGs to those who qualify for them is placed on local housing authorities. Therefore, each area must ensure that sufficient funding is allocated from the DFG monies to enable housing authorities to continue to meet their statutory duty to provide adaptations to the homes of eligible people of all ages.

9. In 2023-24, the Government is providing £600 million (£300 million for ICBs, £300 million for local councils) to enable local areas to build additional adult social care (ASC) and community-based reablement capacity to reduce delayed discharges and improve outcomes for patients. As in 2022-23 the ICB will agree with relevant local HWBs how the ICB element of funding will be allocated rather than being set as part of overall BCF allocations, and this should be based on allocations proportionate to local area need.

10. Spending related conditions: In each HWB area, the minimum expected expenditure on social care spending and spending on NHS commissioned out of hospital services from

the NHS minimum contribution is maintained in line with the percentage uplift in the NHS minimum contribution to the BCF. The NHS minimum contributions for social care and NHS commissioned out of hospital spend for all HWB areas in both 2023-24 and 2024-25 has been uplifted by 5.66%.

11. The 2023-25 BCF Policy Framework sets national metrics (performance objectives) that must be included in BCF plans.

Approach across health and care

12. Given the strength of our BCF submissions in previous years, our approach remains largely the same – where possible, system level narrative through each programme lead will be provided, with localisation where required. This year, once again, the system has the opportunity to learn from each of the 3 place based BCF programmes, taking the strength of each to continuously improve.

13. Each plan will describe the alignment of BCF delivery plans with its Joint Health and Wellbeing Strategy and it priorities. This includes:
    - The life course approach
    - Action to reduce health inequalities
    - Actions to deliver improvements in the areas described in the CORE20Plus5 and CORE20Plus5CYPframework

14. Each plan will be localised and augmented by each place completing locally driven detail, including confirmation of compliance against the four national conditions.

15. For the data template, we will used metrics and trajectories associated with the relevant programmes which have been agreed by system partners (i.e. Discharge and Home First)

Governance process to date

16. Each place is still operating under slightly different governance arrangements; where possible, we have standardised the engagement with stakeholders such as our PCN Clinical Directors and Clinical Leads and elected members in each place, as well formal approval routes.

Governance arrangements	Leicester City	Leicestershire	Rutland
Draft Plan 23-25 Placed based Groups to receive for information	JICB – 25th May 2023 22nd June 2023 (Planned)	Integration Executives -	IDG –
HWBB approval (virtual or retrospective where applicable)	TBC	TBC	TBC
Exec/Lead notifications and sign off (ICB and HWBB – virtual where applicable)	Andy Williams: Rachna Vyas: Martin Samuels: Lead member (TBC):	Andy Williams: Rachna Vyas: Jon Wilson: John Sinnott: Tracey Ward: Cllr L Richardson:	Andy Williams: Rachna Vyas: Kim Sorsky: Cllr Harvey:

Recommendation

- **REVIEW** the planning framework and requirements for 2023-2025
- **NOTE** the key deadlines and submission requirements
- **NOTE** the approach taken, including the engagement & governance as per annual arrangements and national requirements

Name of meeting:	**Joint Integrated Commissioning Board (JICB)**		
Date:	**25th May 2023**	**Paper:**	
Report title:	**BCF End of Year Submission 2022-23**		
Presented by:	Mayur Patel, Head of Transformation, LLR ICB		
Report author:	Mayur Patel, Head of Transformation, LLR ICB Muhammad Kharodia, Integration & Transformation Manager, LLR ICB		
Executive Sponsor:	Rachna Vyas, Chief Operating Officer, LLR ICB		

To approve ☐	**For assurance** ☐	**To receive and note** ☒	**For information** ☒
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

Joint Integrated Commissioning Board members are asked to:

- **NOTE** the BCF End Of Year submission to NHSe on 23/05/23 (Appendix A)
- **NOTE** the local and system successes, challenges, and next steps

Purpose and summary of the report:

Summary:

Reporting on the overall BCF programme for 2022-23 is limited to an End of Year (EOY) return. On 20th March 2023 NHS England published the BCF end of year reporting template (available on the Better Care Exchange).

The EOY template asks for confirmation of;

- The BCF national conditions continued to be met throughout the year.
- Confirmation of actual income and expenditure in BCF section 75 agreements for 2022-23 (covering the whole of the BCF plan including the Adult Social Care Discharge Fund monies).
- Details of significant successes and challenges during the year and, this year's template also requires all local systems to provide details on actual numbers of packages and actual spend in relation to the Adult Social Care Discharge Fund.

This year there were two deadlines for submission:

- By **Tuesday 2nd May 2023 –** Complete the cover sheet (as far as possible) and the Adult Social Care Discharge Fund tab and return it. (Completed)
- By **Tuesday 23rd May 2023** – Complete the whole template – all tabs. This must also be signed off by the Health and Wellbeing Boards in line with normal BCF requirements. (Completed)

This template includes the following components:

- National Conditions – A declaration if these have been achieved or not for each respective BCF
- Metrics – Using data and narrative to declare achievement against expected sets of targets.
- Income & Expenditure – Local allocations, IBCF, voluntary contributions etc are incorporated in this section.
- Year-end feedback – Narrative related to successes and challenges.
- ASC fee rates – Reflect the fees paid by local authority.

For LLR, there were three separate BCF year-end submissions – one for each of our places (City, Leicestershire, Rutland). The final drafts submissions needed to be approved by the chair of the Health and Wellbeing Board in each place and reviewed by the local Integrated Care forums

(ISOC/JICB in the City, IDG in County and Rutland) prior to coming to EMT for approval and submission to NHSE by 23rd May 2023.

Briefing paper – Annual Report: Leicester, Leicestershire, and Rutland BCF 2022-2023

2022-2023 marked another challenging yet a successful year for LLR's Better Care Fund (BCF) partnerships. The BCF allows the NHS to pool certain monies with the local authority to spend in ways that joins up care more effectively. The main focus of the 2022-23 year-end reporting requirements was on how well our system was able to respond to one of the national conditions related to 'improving outcomes for people being discharged from hospital.

While the challenges presented by the pandemic are less acute, there were ongoing challenges presented by the aftermath of the pandemic and the impact of the Omicron variant, Long Covid, and now the cost of living crises.
Each place based BCF has either achieved or come very close to achieving a stretching set of targets around hospital discharge, avoidable admissions, admissions to residential care in those over 65 years, and outcomes from reablement. All of these results have been the outcome of strong system partnership relationships twinned with effective integrated working in the face of very challenging circumstances related to increase in the cost of living and a stretched domiciliary care and residential care market.

Leicester City Year End Position
Financial Position

Income

	2022-23	
Disabled Facilities Grant	£2,714,004	
Improved Better Care Fund	£17,556,473	
NHS Minimum Fund	£28,134,913	
Minimum Sub Total		£48,405,390

	Planned		Actual			
NHS Additional Funding	£0		Do you wish to change your additional actual NHS funding?	No		
LA Additional Funding	£0		Do you wish to change your additional actual LA funding?	No		
Additional Sub Total		£0				£0

	Planned 22-23	Actual 22-23
Total BCF Pooled Fund	£48,405,390	£48,405,390

	ASC Discharge Fund					
	Planned		Actual			
LA Plan Spend	£1,311,449		Do you wish to change your additional actual LA funding?	No		
ICB Plan Spend	£1,800,443		Do you wish to change your additional actual ICB funding?	No		
ASC Discharge Fund Total		£3,111,892				£3,111,892

	Planned 22-23	Actual 22-23
BCF + Discharge Fund	£51,517,283	£51,517,283

Please provide any comments that may be useful for local context where there is a difference between planned and actual income for 2022-23	

Expenditure

	2022-23
Plan	£48,405,390

Do you wish to change your actual BCF expenditure?	No

Actual	£48,405,390

	ASC Discharge Fund
Plan	£3,111,892

Do you wish to change your actual BCF expenditure?	No

Actual	£3,111,892

Please provide any comments that may be useful for local context where there is a difference between the planned and actual expenditure for 2022-23	Supporting details included within the 'ASC Discharge Fund-due 2nd May' tab of this template which includes scheme(s) costs and narrative around differences between original planned spend and actual expenditure.

Key Metrics

Metric	Definition	For information - Your planned performance as reported in 2022-23 planning	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	960.4	On track to meet target	None	Over achieving on all UCR metrics
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	93.3%	On track to meet target	Limited rehabilitation capacity at home is arguably driving an increase in intermediate care (IC) supported P2 placements	Good outcomes for patients receiving IC bedded support, 88% returning to usual place of residence (LLR), To date for the city 30 patients have benefited, As of 24/04/23 we only have 1 patient on the
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	569	On track to meet target	None	We benchmark well nationally for P3 (c.1%) across LLR (permanent residential). The City outturn is: Numerator: 247; Denominator: 45,680; Outturn per 100,000: 540.7
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	90.3%	On track to meet target	Workforce/recruitment/recurrent funding in relation to our intention to grow the current model to an intake (rather than selective) model, and the challenge of consistent demand and	We benchmark very well on our reablement outcomes metrics (91% LLR) The City figures are: Numerator: 148; Denominator: 167; Outturn: 88.6%

Key Successes

Success 1	3. Integrated electronic records and sharing across the system with service users	One of the key aims of all our strategies is to support integrated working across health and care to the benefit of Leicester people of all ages. The Leicester, Leicestershire, and Rutland Care Record (LLR CR) programme is part of the national Shared Care Record. We are seeing our adult social care teams now able to access more of the information they need directly. It is anticipated this will accelerate and inform processes, save time for others including local GP practices, and improve individuals' care experience.
Success 2	2. Strong, system-wide governance and systems leadership	In 2022/23 the LLR system agreed to hold a Flow Summit. The aims of this were to develop a better understanding of the barriers to supporting flow in the system, to identify solutions to address these barriers and to address the behavioural change required to ensure full usage of existing discharge/flow pathways. A set of 9 KLOE's were agree with the clinical assessment teams which were worked on for a period of 3 months to make improvements to flow and discharge timescales. Within the timeframe, improvements were made to the percentage of patients counted as a lost discharge, the percentage of patients with plans and discharged prior to midday and 3pm, reduction in LOS post-MOFD and a voice of the person review. The result being that LLR has become the best system nationally for overall performance against a set of discharge metrics.

Key Challenges

Challenge 1	6. Good quality and sustainable provider market that can meet demand	We have faced major challenges with the residential and care home provider market. The availability of nursing beds within the overall system has also dramatically reduced despite demand increasing, The result is believed to be the low levels of CHC and FNC awards which has in turn resulted in a reduction in the amount of nursing care registered and dual registered homes. LLR is an outlier in the number of awards nationally. As a result, the system is undertaking an independent led review to look at decision making across the system and mitigations that could provide short, medium and long-term solutions for increasing availability and providing a more sustainable market.
Challenge 2	1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)	Workforce/recruitment/recurrent funding in relation to our intention to grow the current model to an intake (rather than selective) model, and the challenge of consistent demand and capacity modelling – particularly regarding the ICS-wide NHS therapy resource at HWBB footprint

Summary

It is fair to say that all our schemes are having a huge impact on our residents and really transforming the way services are delivered to our residents. (See 22/23 BCF schemes: Appendix B).
One programme in particular has been fundamental in supporting our health and social care transformation. The home-first collaborative has continued to deliver a core element of the city's step up

/ admission avoidance offer, focusing on responding to people in crisis to enable them to remain at home with timely, holistic support.

The service has been largely funded by BCF for a number of years, with the plan to continue to build on these successes in driving the ambition for integration over 22/23 and well in 23/24.

The priorities for 23/24 include:

- Virtual Wards: Min 276 VW beds by March 24, 80% occupancy by Sept 23.
- Care Homes: Reduce conveyance rates from top 10 CHs by 25% by the end of March 24
- Urgent Community Response: 80% for 2 hours and 2 days response by end of March 2024
- Falls Management Tier 1 and Tier 2 falls response across LLR: Consistent falls offer across LLR by the end of March 2024. 10% reduction in admissions from falls by the end of March 2024
- UCCH: Reduce EMAS activity by 15% (from the stack), Increase referrals from 111, self referrals, PC and EMAS by 25%
- Intermediate Care: Roll out step-up/step-down intake model by March 25. Increase P1 discharges and decrease P2 discharges by 20% by the end of March 24
- INTs/ Community Health and Wellbeing Teams at Place: Formation and delivery of 9 (7) in the County CHWTs (INTs) across LLR by the end of March 2024
- Carers: 35,000 identified informal carers across LLR by the end of March 2024

Some notable successes include:

- The UCR (urgent community response service. Compliance for 2 Hour 2022/23 to date (Apr-Mar), is 93.7%, and is achieving the target of =>70%. Compliance for 2 day 2022/23 to date (Apr-Mar), is 84.8% therefore achieving the target of =>70%. The City is overachieving on all its targets.
- LLR unscheduled care Hub: For the first time we have a real time, joint decision-making process as an integrated team that helps us understand the community services offer, share risk and resources and embed the shared ethos of right care, right time, right place. 5580 cases have been supported, with 98% of cases diverted from the EMAS stack to alternative community pathways. 80% of all cases (where UCCH intervened) remained at home, which is an amazing achievement.

LLR System Summary

- Developing system wide governance and systems leadership: Effective partnership working has been vital during 2022/23. Partners have built on existing strong relationships ensuring a joined-up approach to discharge, case management, “bridging” of domiciliary care offers and therapy needs. Strong governance and leadership supported the delivery of most aspects of patient and resident care. The BCF budgets supported the use of community assets, the resources of the voluntary sector, public health, NHS and social care resources to deliver support to Leicester, Leicestershire, and Rutland residents in all settings.
- The coming together of our 3 commissioning groups as part of the ICB has allowed us to join up commissioning and further collaboration between health and social care.
- We are starting to see how BCF funded work aligns with other system wide initiative as well as support the delivery of various strategic goals. Across LLR our Joint Health& Wellbeing Plans have set out strategic vision for Place. Our Community Health & Wellbeing Plans link into these by agreeing local priorities dependent on population need. With our Community Health & Wellbeing Teams (INTs) acting as the Delivery vehicle for the priorities agreed to within each CHWP.
- Maintaining workforce capacity: This is a system wide issue but is particularly acute in the domiciliary care market. There has been a sense of constant firefighting across the year, often

with multiple issues at play at any one time. The BCF funds dedicated roles who work actively with care providers, and this has been vital to sustaining services.

- Pressures such as Covid outbreaks, staff sickness and staff isolation took their toll, as well as recruitment and retention challenges in a low paid, over-stretched sector within an increasingly competitive labour market.
- The care market is not sustainably funded and, while some issues have abated as we emerge from the pandemic, remaining pressures are now being compounded by rising fuel prices which are having a marked impact on the viability of homecare delivery in rural areas.

Looking towards BCF 2023 and beyond..:

BCF Planning for 2023-25: It should be noted that the BCF allocation for 2023/24 and 2024/25 has been released, the conditions for utilisation of these funds and the planning requirement/guidance were published on 4th April 2023.

This two-year BCF plan will allow the system to have strategic approach to address place-based challenges through collaborative approach in planning and delivery of BCF across LLR.

The ICB will be required to draft and submit an **optional** BCF planning submission including intermediate care and short-term care capacity and demand plan by the **19th May 2023.** (Assurance partners in our region have agreed to extend this date to **Tuesday 30th May)**

Followed by another full submission by the **28th June 2023** including intermediate care and short term care capacity and demand plan; and discharge spending plan, from local HWB areas (agreed by the ICB and local government.

Schemes from 22/23 as outlined in Appendix B: Tab 5a are likely to be continued in 23/24 and 24/25. Planning for this has started and will be covered via a separate paper.

Joint Integrated Commissioning Board members are asked to:

- **NOTE** the BCF End Of Year submission to NHSe on 23/05/23 (Appendix A)
- **NOTE** the local and system successes, challenges, and next steps

Appendices:	• Appendix A – City EOY Submission Appendix A • Appendix B- 22/23 BCF Planning template BCF 2022-23 Planning Template
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	ISOC – 16th May 2023

The report is helping to deliver the following strategic objective(s) – *please tick all that apply***:**

1. Health outcomes	Increase the health outcomes of the Leicester, Leicestershire and Rutland population.	☒
2. Health inequalities	Reduce health inequalities across the Leicester, Leicestershire and Rutland population.	☒
3. Reduce variation	Reduce the variation in health outcomes across the Leicester, Leicestershire and Rutland population.	☒
4. Sustainable finance plan	Deliver a sustainable system financial plan, ensuring funding is distributed to where services are delivered.	☒
5. NHS Constitution	Deliver NHS Constitutional requirements.	☒
6. Value for money	Develop and deliver services with providers that are evidenced based and offer value for money.	☒
7. Integration	Deliver integrated health and social care.	☒

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	

Implications:	
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	The final BCF 2022-23 report will provide details of a range of BCF-funded services which have contributed to mitigating BAF risks on health inequalities and financial stability.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	See Tabs 5 and 6 the EOY template which outline the outturn position for income and expenditure in 2022-23 of the Better Care Fund in Leicester City.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	The final 2022-23 BCF report will identify a range of BCF-funded services which contribute to keeping people independent and safe at home and which support safe and effective discharge from hospital for older people. Quality Impact Assessments for individual services are undertaken by those services as part of the commissioning or service redesign process
d) Does the report demonstrate patient and public involvement? If so, provide which	Public and Patient representation at the Integrated Systems of Care (ISOC), Integration Delivery Groups (Leicestershire and Rutland) Groups which oversees development of the BCF

page / paragraph this is outlined in within the report.	investment plans each year is through the Health Watch representative who sits on these groups. Periodically, a representative of the ICB Communications and Engagement team also attends these groups and reports on outcomes of the numerous patient and public consultations and engagements undertaken by members of the Integrated Care Partnership. Individual services or pathways are expected to include the views of those with lived experience as part of re-design or commissioning processes.
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	Equality Impact Assessments for Individual services are undertaken by each service as part of the commissioning or service re-design services. It is anticipated that a refreshed BCF EIA will be undertaken as part of the BCF planning for 2023-25.