LEICESTER CITY
HEALTH AND WELLBEING BOARD

Date: THURSDAY, 28 FEBRUARY 2019

Time: 5:30 pm

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.

G. J. Carey

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 Adam Clarke, Deputy City Mayor, Environment, Public Health and Health Integration (Chair)

Councillor Piara Singh Clair, Deputy City Mayor, Culture, Leisure, Sport and Regulatory Services

Councillor Sarah Russell, Deputy City Mayor, Children and Young People's Services

Councillor Vi Dempster, Assistant City Mayor, Adult Social Care and Wellbeing

Councillor Danny Myers, Assistant City Mayor, Entrepreneurial Councils Agenda

City Council Officers:

Phil Coyne, Strategic Director City Development and Neighbourhoods

Steven Forbes, Strategic Director of Social Care and Education

Ivan Browne, Director Public Health

Vacancy

NHS Representatives:

John Adler, Chief Executive, University Hospitals of Leicester NHS Trust

Professor Azhar Farooqi, Co-Chair, Leicester City Clinical Commissioning Group

Sue Lock, Managing Director, Leicester City Clinical Commissioning Group

Dr Peter Miller, Chief Executive, Leicestershire Partnership NHS Trust

Dr Avi Prasad, Co-Chair, Leicester City Clinical Commissioning Group

Roz Lindridge, Locality Director Central NHS England – Midlands & East (Central England)

Healthwatch / Other Representatives:

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

Lord Willy Bach, Leicester, Leicestershire and Rutland Police and Crime Commissioner

Chief Superintendent, Andy Lee, Head of Local Policing Directorate, Leicestershire Police

Andrew Brodie, Assistant Chief Fire Officer, Leicestershire Fire and Rescue Service

STANDING INVITEES: (Not Board Members)

Mark Gregory, General Manager, Leicestershire, East Midlands Ambulance Service NHS Trust

VACANT, Senior Responsible Officer, Better Care Together Programme

Information for members of the public

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- ✓ to respect the right of others to view and hear debates without interruption;
- ✓ to ensure that the sound on any device is fully muted and intrusive lighting avoided;
- ✓ where filming, to only focus on those people actively participating in the meeting;
- ✓ where filming, to (via the Chair of the meeting) ensure that those present are aware that they may be filmed and respect any requests to not be filmed.

Further information

If you have any queries about any of the above or the business to be discussed, please contact Graham Carey**, Democratic Support on (0116) 454 6356 or email graham.carey@leicester.gov.uk** or call in at City Hall, 115 Charles Street, Leicester, LE1 1FZ.

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

PUBLIC SESSION

AGENDA

FIRE/EMERGENCY EVACUATION

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1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

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

3. MINUTES OF THE PREVIOUS MEETING **Appendix A (Pages 1 - 12)**

The Minutes of the previous meeting of the Board held on 22 November 2018 are attached and the Board is asked to confirm them as a correct record.

4. INTERNATIONAL WOMEN'S DAY - INTRODUCTION

There will be a short introduction for the theme to the meeting of International Women's Day.

5. NHS SCREENING IN LEICESTER **Appendix B (Pages 13 - 40)**

Dr Tim Davies, Consultant Screening & Immunisation Lead, NHS England/Pubic Health England to give a presentation on the benefits to achieved from screening programmes. The uptake on screening services in Leicester is generally below the national average.

6. WOMEN'S HEALTH AND WELLBEING **Appendix C (Pages 41 - 62)**

Khudeja Amer-Sharif, Shama Women's Centre, to give a presentation on the delivery of mental health Support Services for bereaved Black Minority Ethnic Women and their families in Leicester through the pioneering 'Bereavement to Achievement programme that overcomes cultural, social and economic barriersthrough early interventions, which has been delivered by Shama Women's Centre since 2014.

7. LOCAL AUTHORITY APPROACH TO FEMALE GENITAL MUTILATION

Appendix D (Pages 63 - 92)

Etain McDermott, Public Health Leicester City Council and Nicola Bassindale, Social Care & Education, Leicester City Council to submit a report and to give a presentation on proposals to strengthen Leicester City Council and its partners' stance against Female Genital Mutilation (FGM). The report provides some basic information about the practice, sets out what has been addressed so far in terms of the approach to FGM and provides some options for further work, drawing on examples from nationally recognised good practice.

8. DOMESTIC AND SEXUAL VIOLENCE AND ABUSE IN LEICESTER

Appendix E (Pages 93 - 108)

Stephanie McBurney, Team Manager Domestic and Sexual Violence, Leicester City Council and DCI Lucy Batchelor to submit a report and give a presentation on Domestic and Sexual Violence and Abuse in Leicester, setting out the current situation, challenges and what can be done to improve pathways and support to those affected.

9. ARMED FORCES COVENANT

Appendix F (Pages 109 - 120)

Miranda Cannon – Leicester City Council, Director champion for Armed Forces Covenant (AFC) & Co-Chair Leicester, Leicestershire and Rutland (LLR) Civil & Military Partnership Board, supported by Dr Richard Hurwood - Co-Chair LLR Civil & Military Partnership Board and Brendan Daly – Leicestershire Partnership NHS Trust, to give a presentation on delivering the Armed Forces Covenant.

10. LEICESTER HEALTH AND WELLBEING SURVEY

Appendix G (Pages 121 - 150)

Nicola Moss & Joe Wheeler, Ipsos MORI North to give a presentation on results of the Leicester Health and Wellbeing Survey 201, which provides a snapshot of the health and wellbeing issues of the population aged 16 years and over in Leicester. The current report follows on from the previous surveys in 2010, 2015 and 2016 (Children and Young People). The report will be made available on the Leicester City Council website and data will be shared via the Leicester Open Data Platform at the following link:-

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

11. QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair to invite questions from members of the public.

12. DATES OF FUTURE MEETINGS

To note that future meetings of the Board will be determined at the Annual Meeting of Leicester City Council held on 16 May 2019.

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

13. ANY OTHER URGENT BUSINESS

Appendix A

Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: THURSDAY, 22 NOVEMBER 2018 at 10:00 am

P R E S E N T :

Present:

Councillor Clarke (Chair)	–	Deputy City Mayor, Environment, Public Health and Health Integration, Leicester City Council.
Lord Willy Bach	–	Leicester, Leicestershire and Rutland Police and Crime Commissioner.
Kate Galoppi	–	Head of Commissioning, Social Care and Education, Leicester City Council.
Harsha Kotecha	–	Chair, Healthwatch Advisory Board, Leicester and Leicestershire.
Councillor Piara Singh Clair	–	Deputy City Mayor, Culture, Leisure, Sport and Regulatory Services, Leicester City Council.
Councillor Vi Dempster	–	Assistant City Mayor, Adult Social Care and Wellbeing, Leicester City Council.
Professor Azhar Farooqi	–	Co-Chair, Leicester City Clinical Commissioning Group.
Michael Iliffe		Director of Finance, Leicester City Clinical Commissioning Group.
Wendy Holt	–	Better Care Fund Implementation Manger, Central NHS England, Midlands and East (Central England)
Councillor Danny Myers	–	Assistant City Mayor, Entrepreneurial Councils Agenda, Leicester City Council.
Inspector Nicola Preston	–	Local Policing Directorate, Leicestershire Police.

Councillor Sarah Russell	–	Deputy City Mayor, Children and Young People's Services, Leicester City Council.
Ruth Tennant	–	Director of Public Health, Leicester City Council.
Rachna Vyas	–	Head of Strategic Development, University Hospitals of Leicester NHS Trust

In attendance

Graham Carey	–	Democratic Services, Leicester City Council.

149. APOLOGIES FOR ABSENCE

Apologies for absence were received from:-

John Adler	Chief Executive, University Hospitals of Leicester NHS Trust
Andrew Brodie	Assistant Chief Fire Officer, Leicestershire Fire and Rescue Service
Phil Coyne	Strategic Director City Development and Neighbourhoods, Leicester City Council
Steven Forbes	Strategic Director of Social Care and Education, Leicester City Council
Mark Gregory	General Manager, Leicestershire, East Midlands Ambulance Service NHS Trust
Roz Lindridge	Locality Director Central NHS England – Midlands & East (Central England)
Chief Supt Andy Lee	Head of Local Policing Directorate, Leicestershire Police
Sue Lock	Managing Director, Leicester City Clinical Commissioning Group
Dr Peter Miller	Chief Executive, Leicestershire Partnership NHS Trust
Dr Avi Prasad	Co-Chair, Leicester City Clinical Commissioning Group

150. DECLARATIONS OF INTEREST

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

151. MINUTES OF THE PREVIOUS MEETING

RESOLVED:-

That the Minutes of the previous meeting of the Board held on 20 September 2018 be confirmed as a correct record.

152. DIABETES IN LEICESTER

Consideration was given to an Executive Summary report outlining the work being undertaken in Leicester to deliver initiatives to raise awareness, educate and train communities to deliver type 2 diabetes prevention and introduce lifestyle education programmes.

It was noted that diabetes was one of the most pressing health challenges of the decade. The Cities Changing Diabetes partnership has been developed as a platform for cross-disciplinary, cross sector collaboration. Leicester, with its high prevalence of diabetes and ethnic diversity, was the 1st UK member of Cities Changing Diabetes.

The Leicester Changing Diabetes programme was intended to be inclusive of a range of community stakeholders and was being delivered through a series of projects/activities/initiatives/events that were all pertinent and tailored to the needs of individual or collaborating groups of stakeholders, yet all contributing to the delivery of the overarching flag ship mission.

The diabetes delivery group considered the whole of the patient's journey in relation to diabetes from prevention, screening and early detection through to management of diabetes, education programmes and treatment of complications.

The local professional sports clubs, Leicester Changing Diabetes and Leicester City Council had formed the Strategic Alliance for Physical Activity. They had recently developed a pledge to commit to tackle diabetes across Leicester by continuing to be healthy role models for fans, supporting fans to make healthy lifestyle choices and working with key partners to provide accessible and inclusive community sessions.

RESOLVED:-

That the work and initiatives of the organisations above to tackle diabetes across the City be supported.

153. DIABETES IN LEICESTER - LEICESTER DIABETES GROUP

The Board received a presentation from Professor Azhar, Farooqi, Co-Chair Leicester City Clinical Commissioning Group on the work of the Diabetes Delivery Group.

During the presentation it was noted that:-

- Approximately 30,000 people in Leicester were diagnosed with diabetes and a further 60,000 were at risk of diabetes.

- Approximately 8.7% of the population in Leicester were either diagnosed with diabetes or were at risk of diabetes. The rate was 3 times higher in BAME communities.

- Diabetes shortened life expectancy; a person diagnosed with diabetes at age 60 years was likely to lose 4-5 years in life expectancy. A person diagnosed at 40 years old could expect to lose 7 years of life expectancy.

- Diabetes could be brought on by a wide range of factors including political and socio-economic conditions as well as medical conditions.

- The national Diabetes Prevention Programme was designed to empower patients to take control of their condition and to reduce or prevent the onset of Type 2 diabetes in individuals at risk from developing diabetes. Leicester was one of the highest referrers into this scheme. There was some initial evidence that it was having effect, especially in weight reduction.

- Newly diagnosed Type 1 diabetes patients were referred to a 5 day structured training course to learn from experiences and shared group work.

- Type 2 patients were also offered the opportunity to attend a 4 hour course designed to help people understand their condition and its effect on their body as well as make achievable changes to the food they eat in their daily life. These courses were available across the whole LLR footprint.

- The CCG had invested in a primary care diabetes enhance service education programme for healthcare workers and it was considered that it was now one of the best diabetes trained workforces in the country with some staff attained degree level qualifications in diabetes.

- This was already showing reductions in hospital admissions for patients with hyperglycaemia and diabetic ketoacidosis, reduced outpatient department referrals (50% less) and better achievement of 3 treatment target and care processes and an holistic One Stop care for patients.

- The youngest patient in Leicester diagnosed with type 2 diabetes was is 10 years old and was a reflection of obesity and lifestyles such less physical activity and junk food.

- Approximately half of GP practices (mainly the larger ones) were signed up for the enhanced diabetes service and but work was progressing to provide embed specialist nurses in smaller practices. It was hoped that by next summer all GP practices would offer enhanced services. Each practice would advise patients of the enhanced service available and arrangements would be put in place to consult with hospital staff for the patient's after care following discharge from hospital.

Members of the Board commented that:-

- Public health programmes were escalating in being embedded in schools for healthy eating programmes. 36 school had signed up last year. Schools were also engaged in keeping active and healthy programmes and positive outcomes were already being seen in some schools in relation to educational and health outcomes and behavioural changes in some instances.

- Whilst it was recognised that schools and children's centres had been engaged around healthy eating and increased activity for some years, it was somewhat surprising that there was an increase in diabetes and there was a need to understand the impact these initiatives had in relation to diabetes and moreover what more could be done to reduce diabetes in young children.

- There were good communications between ambulance staff attending patients with hyperglycaemia and notifying GPs to prevent further episodes in the future.

- There was a view that in some groups, especially the elderly, blood sugars were managed very well to maintain normal levels and this in itself could lead to instances of hypoglycaemia should levels drop for any reason. It could therefore be beneficial to maintain blood sugar levels at a slightly higher level in some instances to avoid hypoglycaemia should levels drop unexpectedly.

RESOLVED:-

That Professor Farooqi be thanked for his informative presentation and the work of the Diabetes Delivery Group be supported.

154. LEICESTER CHANGING DIABETES

The Board received a presentation from Melanie J Davies CBE on behalf of the Cities Changing Diabetes Group.

During the presentation is was noted that:-

- The Cities Changing Diabetes Programme (CCDP) aimed to address the global problem and most pressing health challenge of the decade. 425m people globally had diabetes and this was projected to reach 629m by 2045. The majority of people with diabetes lived in urban areas.

- Leicester was the 1st city to join the UK programme which was the first of its kind to create a platform partnership for cross-disciplinary and cross sector collaboration. The programme aimed to map the problem in five 'study cities', share learning experiences with many cities around the world and act as a catalyst to meaningful action which could defeat the incidence of urban diabetes.

- Leicester Changing Diabetes had been launched in May and was a true collaboration of sports organisations, faith centres and health organisations. The initiative aimed to create a new paradigm for tackling diabetes involving all the partners and their services and initiatives to reduce the incidence of diabetes in the urban environment.

- Leicester was the 1st city in the world where the four elite sports teams for football, rugby union basketball and cricket had signed up to the initiative to work together with all the other partners.

- Leicester was the only city to put up programme to look at Type 2 Diabetes in children.

- The project focused on raising awareness, educating and training communities to deliver Type 2 diabetes prevention and lifestyle education in the City through school-based offerings, healthy food environments, community-based programmes and increasing the uptake and use of local amenities and services.

- Research had shown that:-

    - There were higher number of cases of diabetes and obesity in Leicester where people lived within 500m of a fast food outlet; and
    - The prevalence of Type 2 diabetes in Leicester in neighbourhoods with a higher provision of green spaces was 5% lower than areas with the lowest green space provision.

- The work in Leicester was already receiving international recognition.

The Chair commented he was delighted the City Council was part of initiative and the benefits that have already been seen through the leverage of the partnerships with the professional sporting clubs in Leicester in promoting health and education of the issues. This work had already highlighted a deficiency of services for the elderly population and there were now walking cricket, football and basketball initiatives to promote healthier lifestyles for the elderly. He was also pleased to be attending a summit next month in Westminster.

Members of the commented that:-

- That whilst fast food outlets and lower green spaces could be mapped and matched in social economic terms it was important to not drawn the wrong conclusion but recognise all factors involved as it may be that the issue was more linked to people's financial opportunity to access both the food and the lifestyle that makes a difference.

- The data around the prevalence of obesity in Year 6 and reception ages it did not follow the same pattern of socio-economic deprivation that were seen in other health models and there were specific differences within it, such as areas having lower rates of obesity, but higher rates of other health related and socio-economic issues and was any work being done to explore those differences to see what has worked in those areas and could be extrapolated to other areas.

In response it was stated that:-

- Childhood obesity was not a simple issue and was multi factorial. Type 2 diabetes was linked to social deprivation as well and it was recognised that there also some issues around awareness and safe walking areas and that exposure to fast food outlets not a simple causal effect.

- Some excellent work was taking place with schools' youth sports trust and to work with teenagers. In the younger age group there was less research results available. Measuring obesity especially within specific groups was not entirely clear, but there some ongoing projects with young children to understand what drivers and social determinants and other factors were contributing to these variants.

- A statistician and analyst had been appointed to support this research and to identify the quick wins and opportunities that could be achieved through the sports clubs and faith centres. It was recognised that these conversations had only started recently but they were already having an amplifying effect for what could be achieved in the future.

- The conversations with the sports clubs had been particularly useful to match the data with their history of working with some schools particularly where there were incidents of higher levels of obesity in schools where they were already and identifying what could be done

differently to address this.

- The sports clubs had already indicated that they were going to launch projects in the two most deprived schools and were working in collaboration with the researcher. It was felt that this would make a real difference in the future.

RESOLVED:-

That everyone involved be thanked for their participation in scheme and the initiatives and joint working to take the project forward.

155. SOCIAL VALUE CHARTER

The Board received a presentation on Social Value in Procurement from Councillor Danny Myers, Assistant City Mayor, Entrepreneurial Councils, together with a copy of the Council's Social Value Charter and Delivering Social Value for Leicester (a guide for suppliers and contractors).

During the presentation it was noted that:-

- That the Council buys £360m of services from 5,800 businesses. Over half what is bought is from suppliers in the city and county and two thirds of expenditure was spent in the city and county areas.

- The challenge was to get more out of this spending power activity and use social value to work together with partners so that every public pound spent in the city benefits the city and gets all public voluntary and business sectors in the city working together to tackle the city's problems.

- The aim of the initiative was to change a commercial activity to a commercial activity that has a civic element. Social value within procurement aimed to provide additional benefits generated by a service beyond its primary purpose.

- The aim was for social gain to be added to contracts. This was principle similar to when there is a large development, developers often contribute with a quota of affordable social housing or provide new roads and highways improvements or playgrounds and in some large schemes developers make a contribution to a new school.

- Legislation in 2012 enabled the Council to pursue approach with services and since then apprenticeships have been secured, more services have been procured more locally and this principle has been broadly applied across the supply chains.

- Although the legislation was laudable and had decent intent, it sadly

coincided with austerity and public-sector budget cuts and reductions.

- The principles of the social value charter had been translated into a guide that set out the Council's priorities and ambitions and was aimed at those providing goods and services purchased by the Council and encouraged a change in relationships so suppliers appreciated there was a civic and social element to transactions.

- The guide set out that the Council expected certain standards including applying the living wage, universally if possible, and that there were ethical environmental supply chains with none involving human slavery.

- The guide encouraged an imaginative approach so that suppliers of services could offer social value which may not necessarily be immediately linked to the service being purchased. Eg companies already had staff volunteering programmes and bulk buying arrangement that could benefit charities etc in the city. They had back office systems which could provide work experience opportunities in finance and IT for young people to improve their skills. Suppliers may also have mass transport arrangements for their workers which could be of benefit to others or they may have meeting space that could be offered to voluntary organisations to use.

- It was recognised that some supply chains were not suited to this process as services purchased from overseas such as It etc did not allow much opportunity to interact with local economy. However, there were 1,000s of business in city that would welcome this approach.

- The Council was also working with the Police to develop the initiative. as well.

- Discussions had also started with others to share learning and expertise and forge links with partners on the board to maximise the public-sector investment in the City.

- The guide would be regularly updated and issued with every invitation to tender for services.

The Police and Crime Commissioner welcomed the joint discussions with the Police and echoed the principles supporting social value which he felt should be adopted by all public bodies. He also referred to the Leicestershire Cares Wire project which provided encouragement to the business community to employ ex-offenders. This provided had a community value that benefited all partners.

RESOLVED:-

That the presentation be noted and that the guide be commended to all other public-sector partners in Leicestershire and Leicester sand they that be encouraged to secure social value from their

procurements.

156. AUTISM SELF ASSESSMENT FRAMEWORK

Consideration was given to a report from the Strategic Director Social Care and Education, Leicester City Council; outlining the process for completing the Autism Self-Assessment Framework 2018 across health and social care organisations.

It was noted that further updates were still awaited before the Self-Assessment Framework could be submitted on 10 December 2019. The feedback on the Self-Assessment Framework would be incorporated into the Strategic Delivery Plan of the Leicester, Leicestershire and Rutland (LLR) draft joint health and social care Autism Strategy (2019-2022) which was due proceed to consultation in January 2019. The delivery of the LLR Strategy would be overseen by the LLR Autism Partnership Board.

In response to a question, it was confirmed that the template for the Self-Assessment Framework had been prescribed nationally.

RESOLVED:-

1) That the submission of the Self-Assessment Framework be supported.

2) That the final version of the Self-Assessment Framework be sent to Board members for comments and that the Chair be authorised to make any final amendments as a result of any comments received before it was submitted by the deadline of 10 December 2018.

157. THE HOMELESSNESS CHARTER

Wayne Henderson, Inclusion Healthcare, addressed the Board to ask whether it wished to sign up to the Homelessness Charter and whether a formal pledge by the Board or individual Board members would be appropriate. The Board also received a copy of the Homelessness Charter and a Pledge Form.

During the presentation it was noted that:-

- Increases in levels of homelessness were being experiencing nationally.

- It was fortunate in Leicester that there were many organisations, charity groups and individuals who wished to be involved and wanted to help addressing and reducing homelessness. A number of businesses also wanted to be involved.

- It had been identified that there was a lack of awareness and

communication of what was available and being delivered to help the homeless and there were also instances of services being replicated and duplicated.

- The challenge had been to bring organisations and groups together over the last 18 months and the Charter aimed to bring people to together to work more effectively in collaboration and partnership than could be achieved by working individually and to have a shared vision, with shared leadership and expertise and encourage all partners to pledge to be active in supporting the Charter.

- The Charter had been launched jointly by Leicester Cathedral, the Police and Crime Commissioner and the City Mayor.

- There were 5 work streams within the Charter and members of the Board were urged to pledge themselves to the Charter either as a Board or individual organisations. The CCG, UHL and the LLP were asked to provide individuals to be members of the group driving the 5 work streams forward

The Director of Public Health commented that work was progressing to develop multi-issue initiatives under the umbrella of the Charter and these would be reported to future Board meetings. The City was fortunate to have a lot of resources available in the City to help the homelessness and it was important to co-ordinate resources to the best effect in reaching those most in need and providing intensive psychological support, especially the relatively small cohort that were known to the Police and health services. St Mungos had been approached to see it they were able to assist in setting up a recovery college in the City aimed at helping the homeless to get back into work.

The Police and Crime Commissioner commented that the Police and City Council met regularly to discuss street lifestyle issues. It was important for the homelessness issue to have momentum and efforts be kept going to address them.

It was also noted that the Young Peoples Council had put forward within their 7 area of work, children's access to mental health and a day of action to focus on homelessness and how promote knowledge and provide information the support that was available.

RESOLVED:-

That all partners be encouraged to pledge their individual organisations to the Charter.

158. QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions from members of the public.

159. DATES OF FUTURE MEETINGS

The Board noted that the next meeting of the Board would be held on Thursday 28 February 2019 at 5.00pm in Meeting Room G01 at City Hall unless stated otherwise on the agenda for the meeting.

The dates of meetings for the Board for 2018/19 will be determined at the Council's Annual Meeting in May 2019.

160. DIRECTOR OF PUBLIC HEALTH

The Chair reported that this would be the last meeting of Ruth Tennant as Director of Public Health before she took up her new post as Director of Public Health at Solihull Metropolitan Borough Council. The Chair paid tribute to her work and contributions to public health in Leicester with both the Board and the Council and wished her well for the future.

161. ANY OTHER URGENT BUSINESS

There were no items of Any Other Urgent Business.

162. CLOSE OF MEETING

The Chair declared the meeting closed at 11.40 am.

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE: 28th February 2019

Subject:	Adult screening in relation to women in Leicester City
Presented to the Health and Wellbeing Board by:	Dr Tim Davies
Author:	Dr Tim Davies

EXECUTIVE SUMMARY:

Screening is an important part of the prevention agenda within health. Uptake for screening services in Leicester City is generally below the national average and therefore the benefits of screening are not being fully realised in the City.

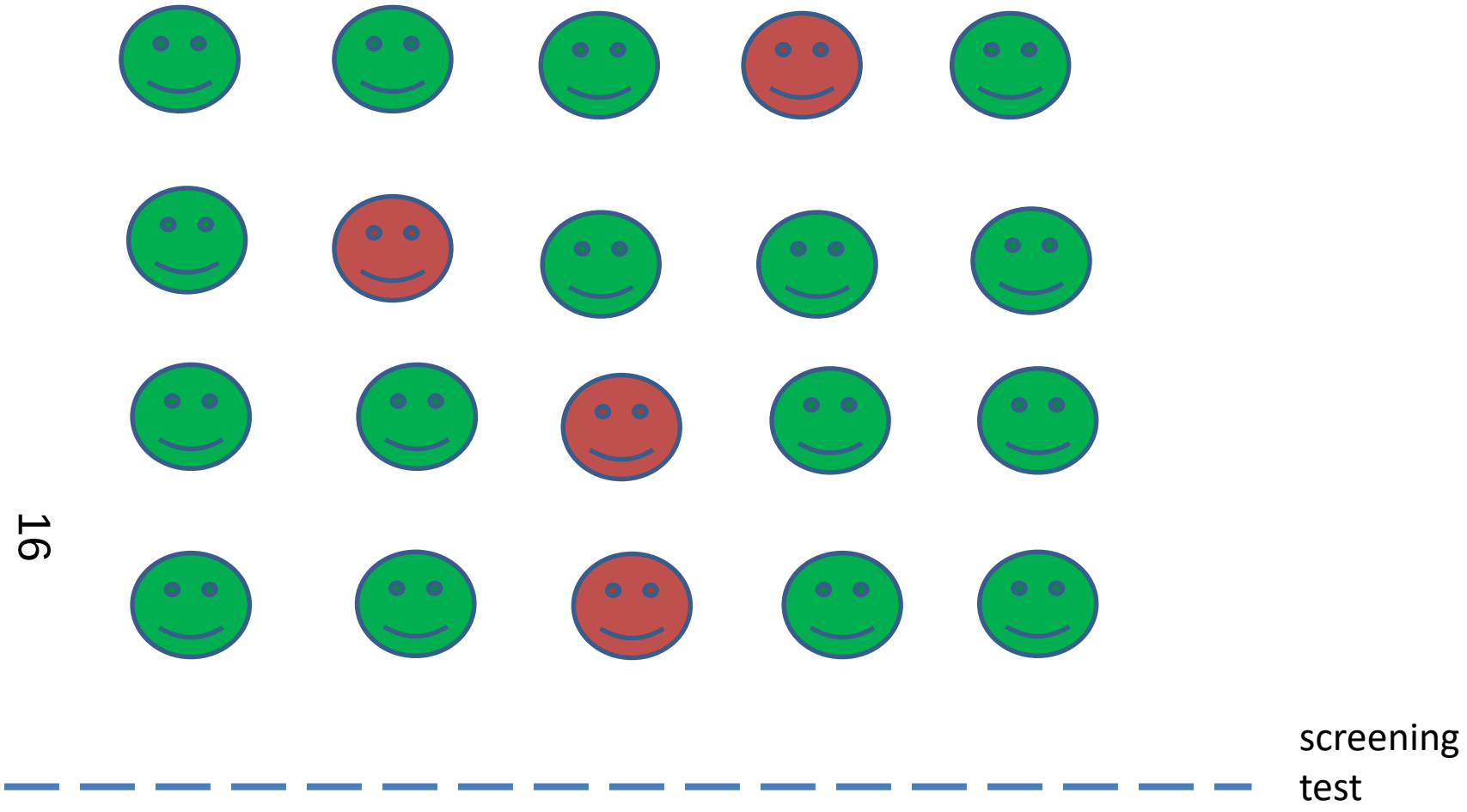
RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

Note the presentation

Adult Screening Programmes

Dr Tim Davies
Consultant Screening & Immunisation Lead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screening
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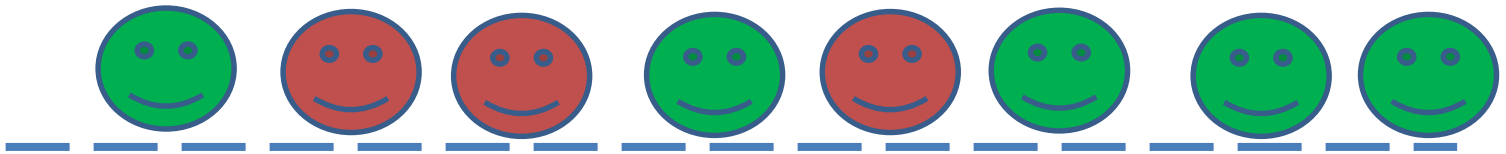
Screening test positive



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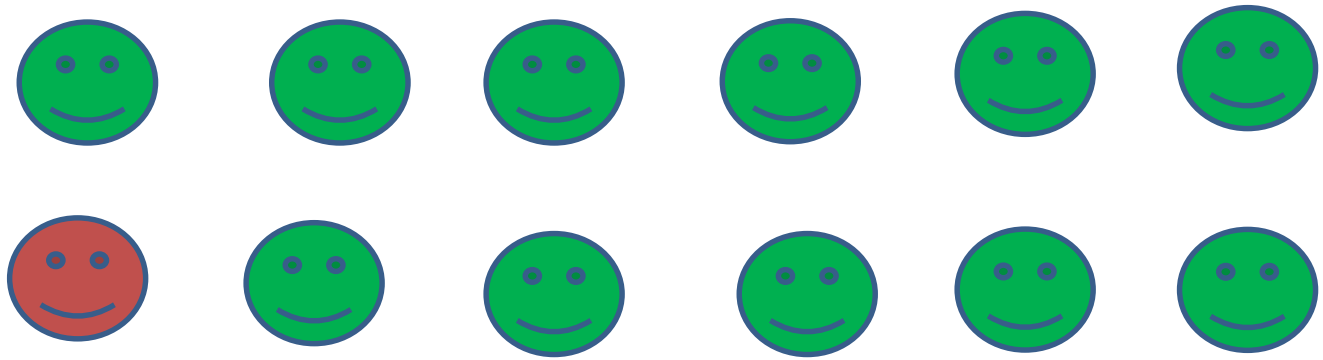

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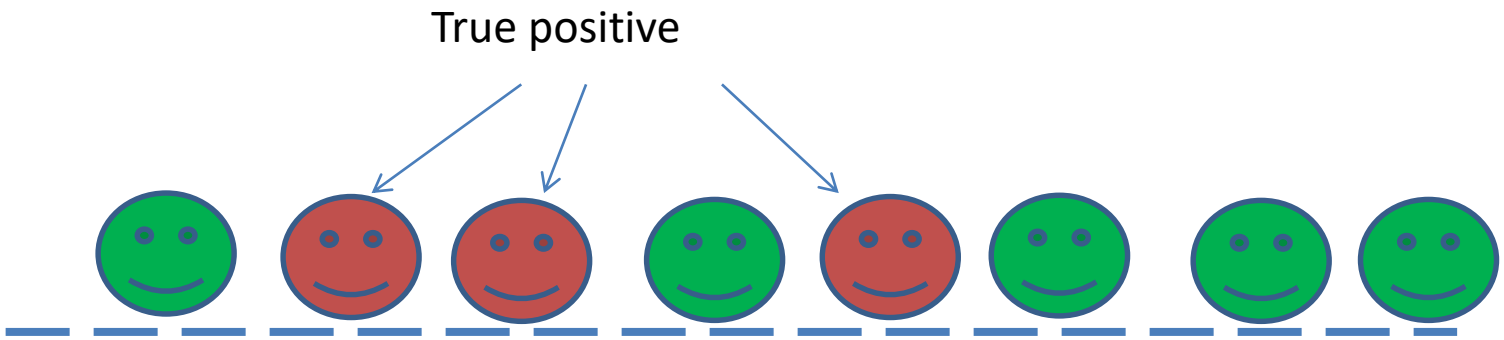

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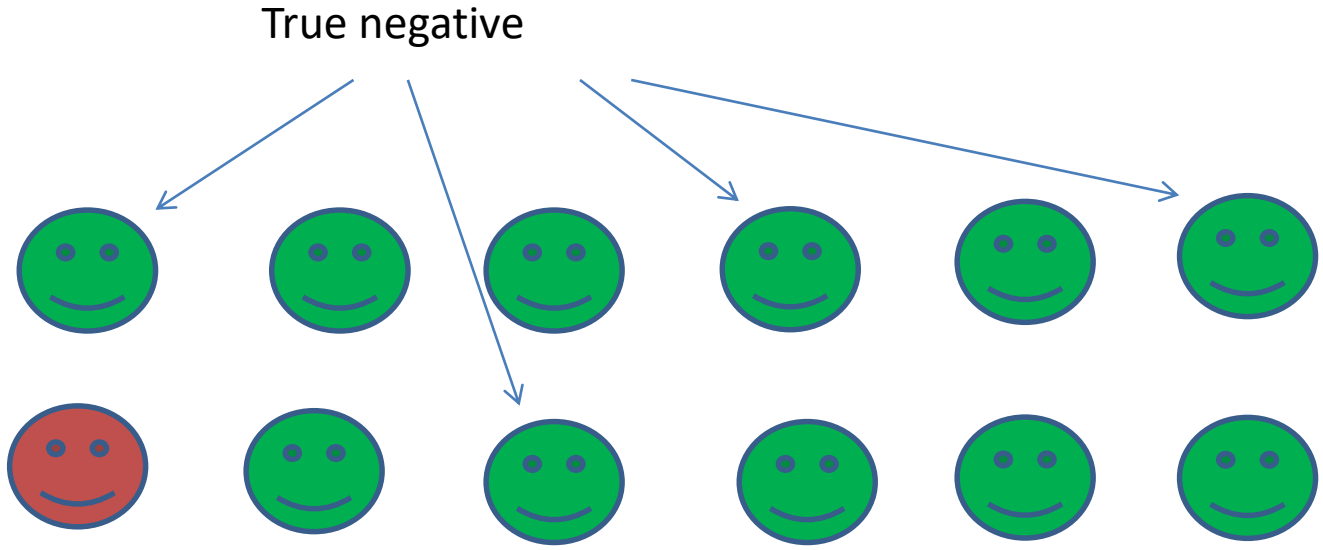

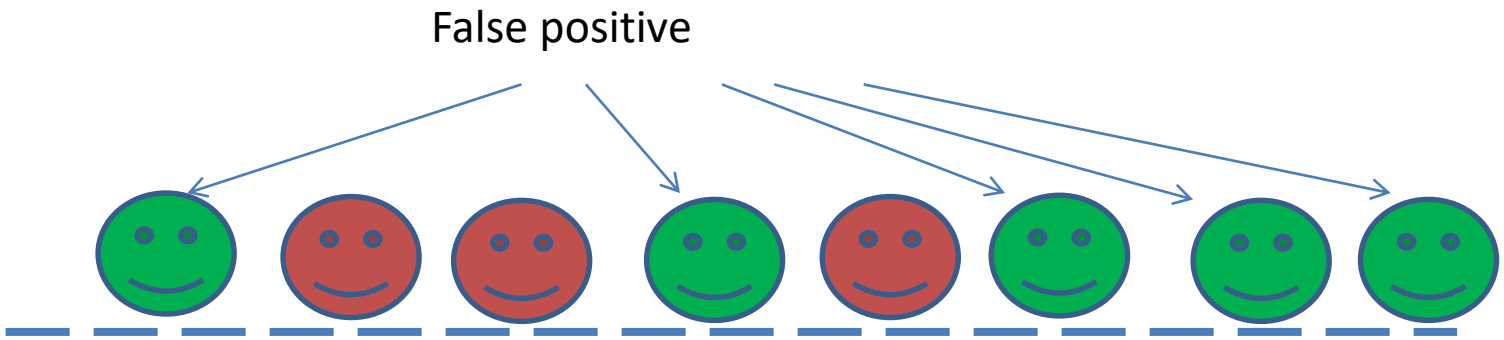

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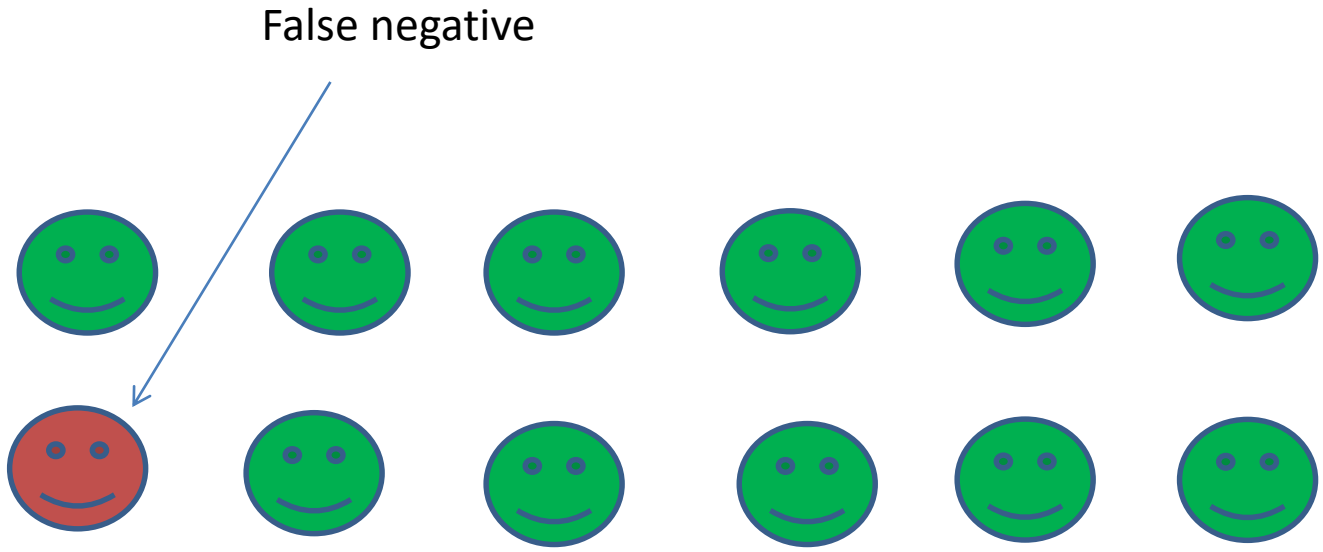


Why do we screen?

- To reduce the risk or impact of a disease in a community

- To identify those with early disease or most at risk of a disease and offer earlier treatment

- Based on evidence of who will benefit and effectiveness of intervention

What is cervical screening?

- It is not a test for cancer
- Tests for the presence of abnormal cells which may become cancerous at a later date
- Smears offered to all women according to age
  - 24 yrs and 6 months – 49 years; 3 yearly
  - 50 – 64 yrs; 5 yearly

Public Health England

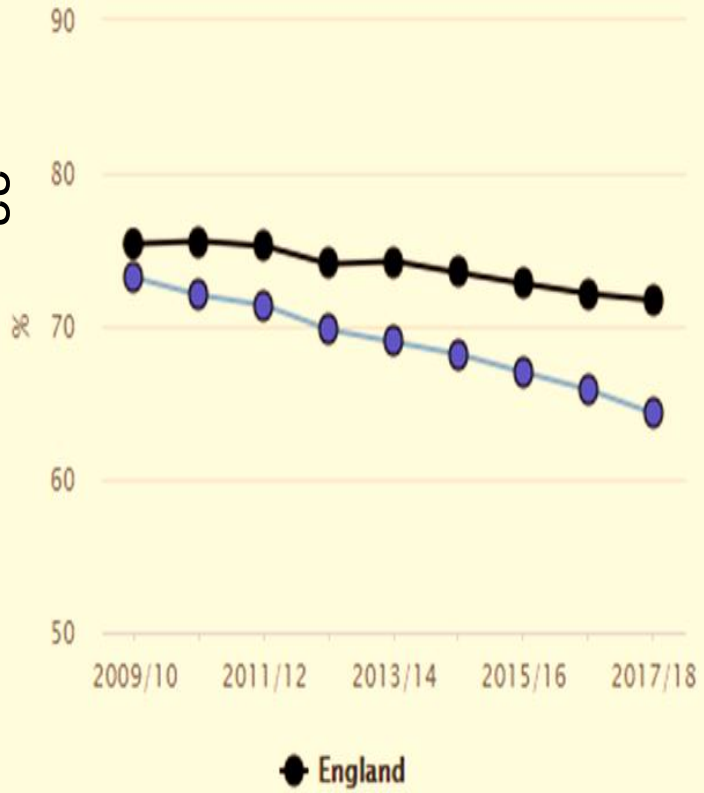
Protecting and improving the nation's health

Cervical Screening

NHS England

Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %) NHS Leicester City CCG

Proportion - %



Recent trend: ↓

Period		Count	Value	Lower CI	Upper CI	Central Midlands	England
2009/10	●	58,901	73.2	72.9	73.5	77.3*	75.4
2010/11	●	58,800	72.0	71.7	72.3	77.6*	75.5
2011/12	●	60,093	71.4	71.0	71.7	76.8*	75.2
2012/13	●	60,842	69.8	69.5	70.1	75.3*	74.1
2013/14	●	61,537	69.0	68.7	69.3	75.0*	74.2
2014/15	●	62,460	68.1	67.8	68.4	74.6*	73.5
2015/16	●	63,038	67.0	66.7	67.3	74.2*	72.8
2016/17	●	62,990	65.9	65.6	66.2	73.4*	72.1
2017/18	●	62,992	64.3	64.0	64.6	72.9*	71.7

Source: Data was extracted from the NHAIS via the Open Exeter system. Data was collected by the NHS Cancer Screening Programme.

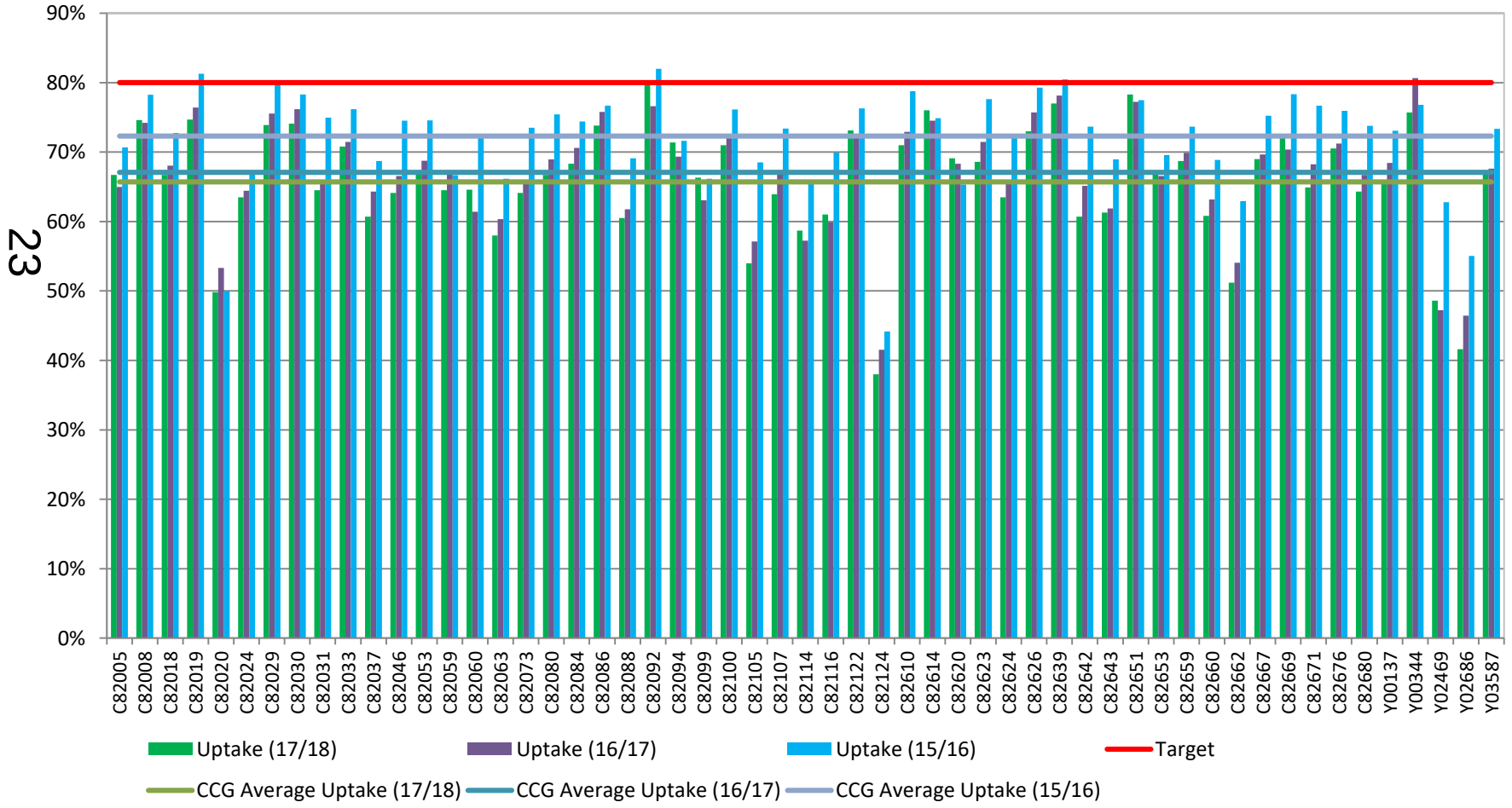
Public Health England

Protecting and improving the nation's health

Cervical Screening

NHS England

Time Series Cervical Screening Uptake by GP Practice - NHS Leicester City CCG



Cervical Screening Local Initiatives

- Leicester Sexual Health Service commissioned to provide "cervical screening only" appointments
- UHL Colposcopy Service
  - collaborative working with city GP practices
  - staff amnesty clinic
- Public Health England first national multi media cervical screening campaign to start on 5th March 2019 under the Be Clear on Cancer Campaign

Public Health England

Protecting and improving the nation's health

Don't fear the smear

NHS England

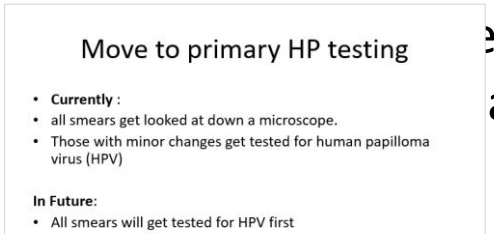
- Collaborative working between De Montfort University, NHS England/Public Health England (PHE), Leicester City CCG and CRUK
- Student led social media campaign, the aim is to raise awareness about the screening programme and potentially increase uptake

The campaign consists of 3 elements:

1) students posting regularly on managed social media sites (Facebook, Twitter, Instagram and LinkedIn)

2) marketing campaign in Leicester City, students to approach local businesses/community venues to request their support by displaying posters and using the stickers

3) # Don't fear the smear selfies, sample takers to ask women who have ... a selfie on their **own** phone with the # and post on their ... a account and tag 5 friends



Move to primary HP testing

- **Currently** :
- all smears get looked at down a microscope.
- Those with minor changes get tested for human papilloma virus (HPV)

In Future:

- All smears will get tested for HPV first
- Only those that are positive will be looked at down a microscope
- Number of labs being reduced from around 45 to 9
- Due to be fully in place by end of 2019.

Public Health England

Protecting and improving the nation's health

Breast Screening

NHS England

- The major aim of the NHS Breast Screening Programme is to reduce mortality from breast cancer and contributes to the reduction of the number of women in the target population who die from breast cancer by 20%
- Experts estimate that the NHS Breast Screening Programme saves the lives of 1,400 women each year
- Breast cancer screening is available to eligible women aged 50 - 70 years
- Age extension has been implemented for age ranges 47-49 and 70-73
- Women are screened every three years
- The mammogram is the screening test and assessment will diagnose or exclude cancer
- The unit annually organise a charity Butterfly Walk to raise awareness

Public Health England

Protecting and improving the nation's health

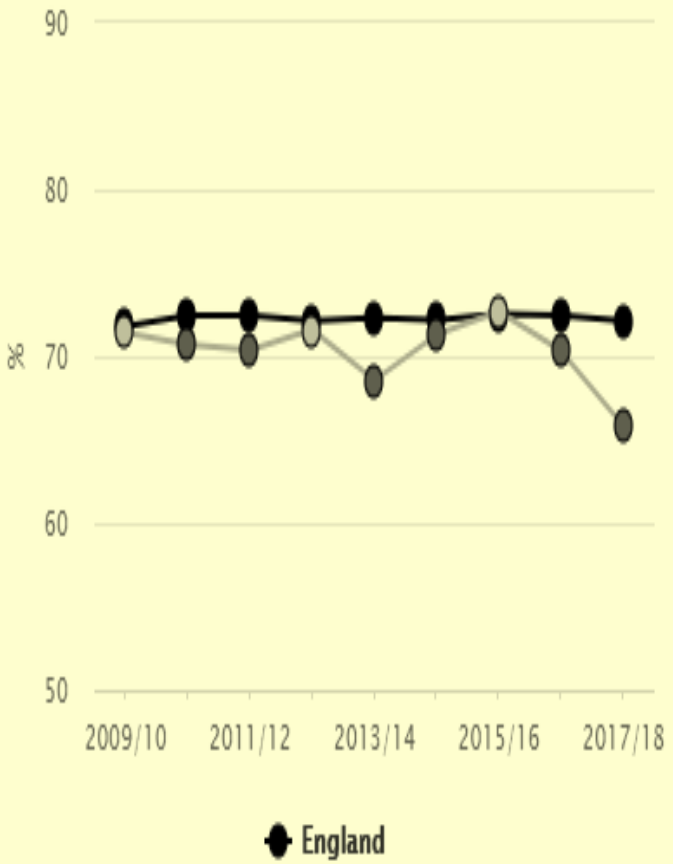
Breast Screening

NHS England

Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) NHS Leicester City CCG

Proportion - %

Export chart as image Show confidence intervals



Recent trend: ↓

Period		Count	Value	Lower CI	Upper CI	Central Midlands	England
2009/10	○	22,285	71.4	70.9	71.9	74.5*	71.8
2010/11	●	22,449	70.7	70.2	71.2	75.4*	72.4
2011/12	●	23,048	70.4	69.9	70.9	74.4*	72.4
2012/13	○	24,427	71.6	71.1	72.1	74.2*	72.1
2013/14	●	23,918	68.6	68.1	69.0	74.6*	72.3
2014/15	●	25,494	71.3	70.8	71.8	74.9*	72.2
2015/16	○	26,559	72.7	72.2	73.1	75.3*	72.5
2016/17	●	26,265	70.3	69.9	70.8	74.5*	72.5
2017/18	●	24,996	65.8	65.3	66.3	73.9*	72.1

Source: Data was extracted from the NHAIS via the Open Exeter system. Data was collected by the NHS Cancer Screening Programme.

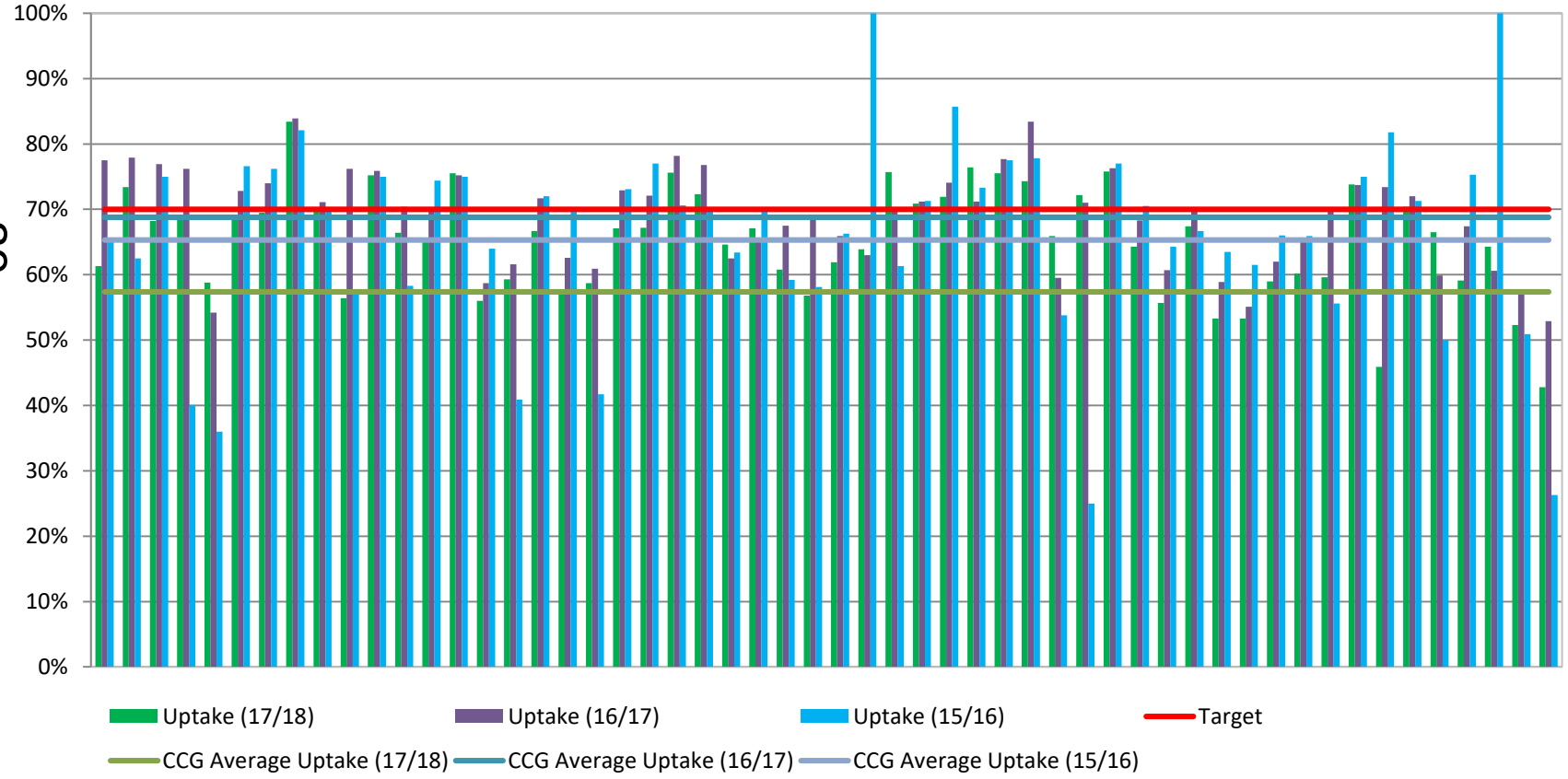
Public Health England

Protecting and improving the nation's health

Breast Screening

NHS England

Time Series BreastScreening Uptake by GP Practice - NHS Leicester City CCG

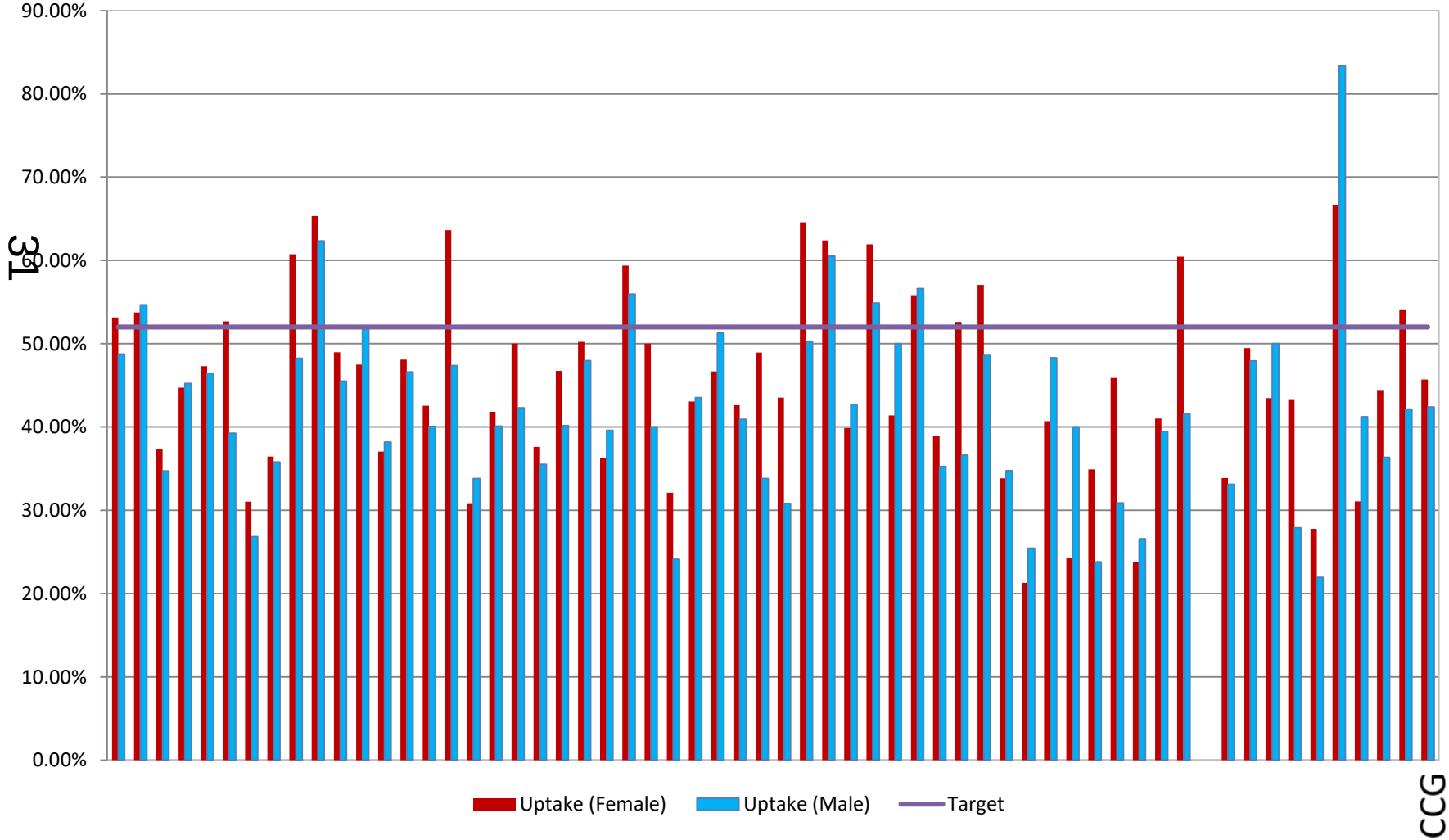


Bowel Screening

- Detects and prevents bowel cancer
- Faecal occult blood test every 2 years
- Age 60-74
- Kit sent in the post, returned in the post
- If positive, offered a colonoscopy

Bowel Screening

2017/18 Bowel Screening Uptake by Gender and Practice



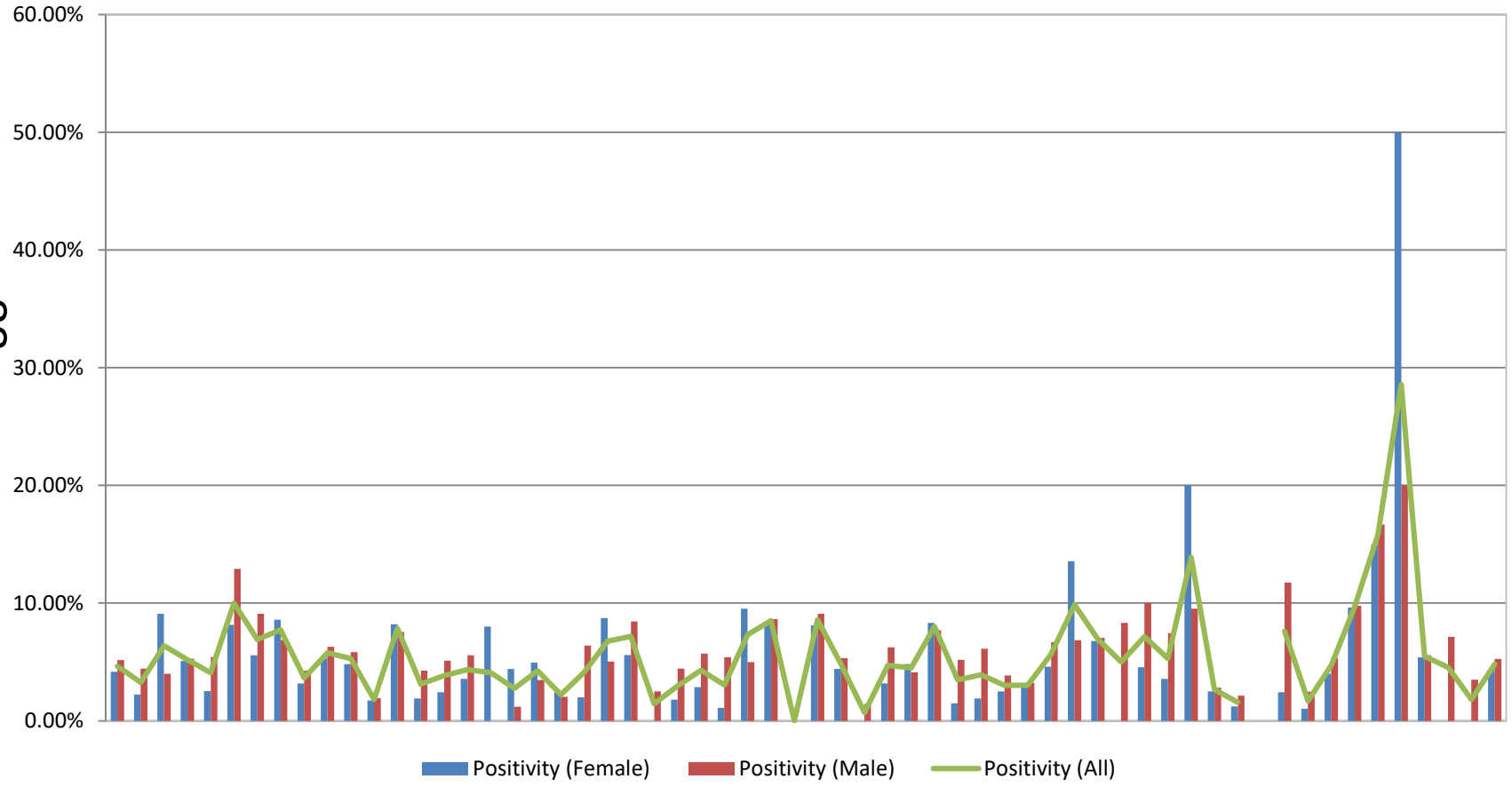
Public Health England

Protecting and improving the nation's health

Bowel Screening

NHS England

2017/18 Leicester City CCG Bowel Screening Positivity by Gender and GP Practice



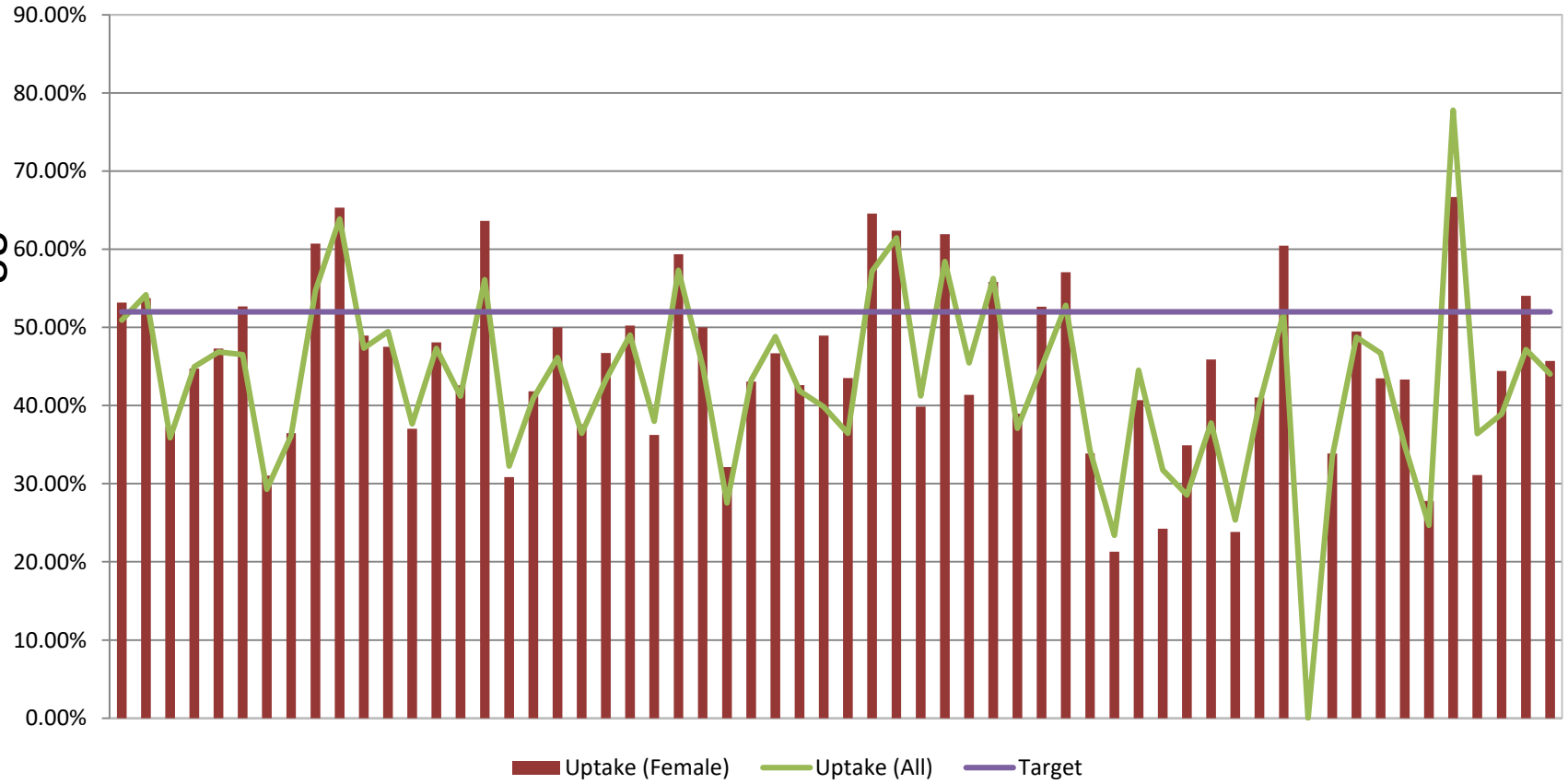
Public Health England

Protecting and improving the nation's health

Bowel Screening

NHS England

2017/18 Leicester City CCG Female Bowel Screening Uptake by GP Practice



Public Health England

Protecting and improving the nation's health

Bowel Screening

NHS England

- UHL Bowel Cancer Screening Centre (BCSC) regularly promote and raise awareness about the screening programmes to GP practice staff and the public
- Bowel Screening pop-up shop in Haymarket Shopping Centre in April 2017. Collaborative working between UHL BCSC, De Montfort University, Leicester City CCG and NHS England/Public Health England
- Better Care Together "Did Not Attend" (DNA) Project in 2017 - consisted of UHL BCSC phoning DNA patients at 10 Leicester City GP practices with low uptake to better understand their reasons for not completing their screening test and issue of a second test kit if requested

Public Health England

Protecting and improving the nation's health

Bowel Cancer Screening Programme test kit changes in 2019

NHS England

Current -
Faecal Occult Blood Test (FOBt)

April 2019 -
Faecal Immunochemical Test (FIT)

Public Health England

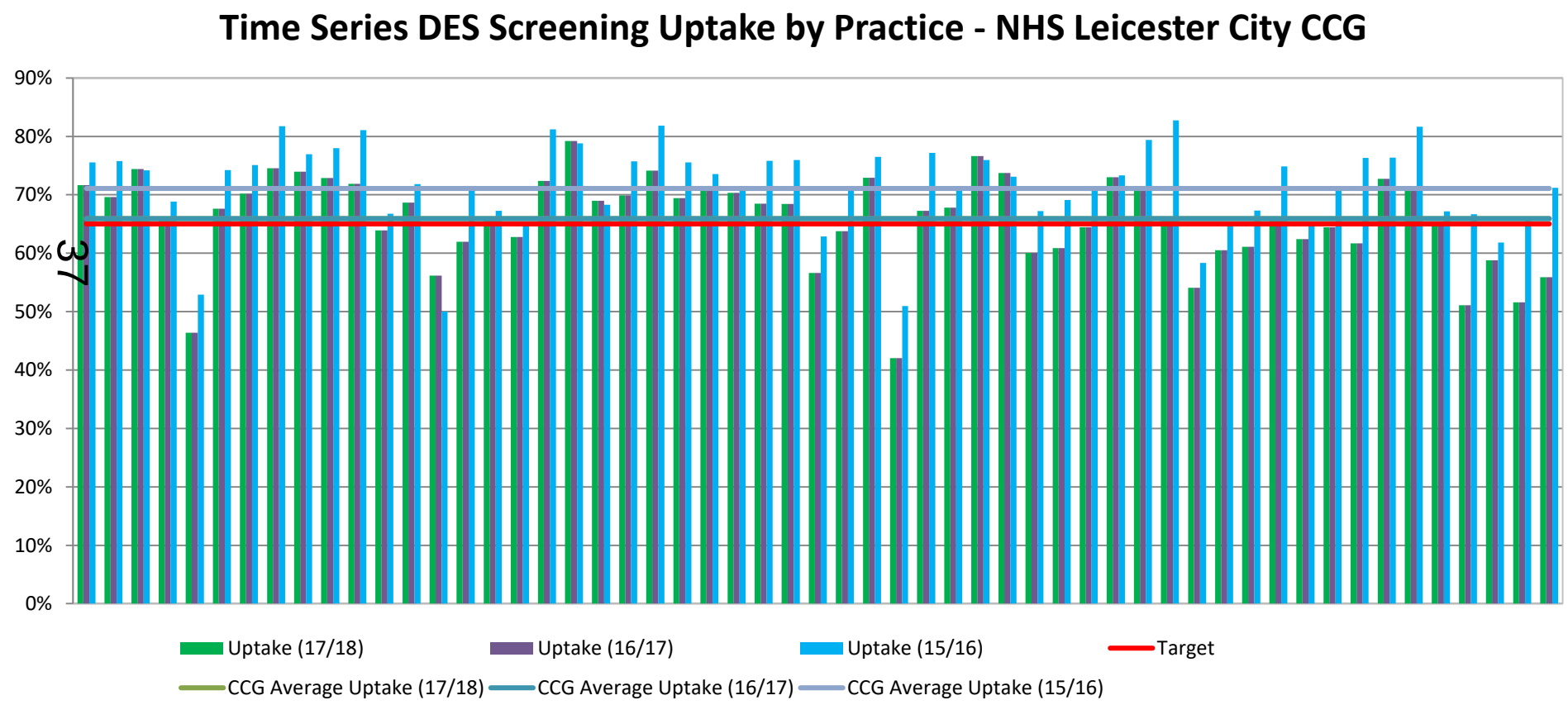
Protecting and improving the nation's health

Diabetic Eye Screening

NHS England

- The aim of the NHS Diabetic Eye Screening Programme (NHSDESP) is to reduce the risk of sight loss in people with diabetes
- A digital photo is taken of the back of the eye to check for signs of diabetic retinopathy and maculopathy
- The patient should receive a letter from their local NHSDESP inviting them to attend a screening appointment. This letter will include a leaflet about diabetic eye screening.
- This is usually done every year
- Eligible people for screening are:-
  - over 12 years of age
  - have either Type 1 or Type 2 diabetes
  - registered with a GP

Diabetic Eye Screening



NHS Screening Programme information links

- https://www.gov.uk/topic/population-screening-programmes

- https://www.nhs.uk/conditions/nhs-screening/

Public Health England

Protecting and improving the nation's health

NHS England

Contact Details

NHS England, Central Midlands, Public Health Screening & Immunisation Team

Screening enquiries via england.lladultscreening@nhs.net

Immunisation enquiries via england.llimms@nhs.net

Appendix C

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE: 28th February 2019

Subject:	Mental Health Services
Presented to the Health and Wellbeing Board by:	Khudeja Amer-Sharif, Shama Women's Centre
Author:	Khudeja Amer-Sharif

EXECUTIVE SUMMARY:

The is a need for continued delivery of Mental Health Support Services for bereaved Black Minority Ethnic Women and their families in Leicester, through the pioneering 'Bereavement to Achievement programme that overcomes cultural, social and economic barriers through early interventions, delivered by Shama Women's Centre since 2014.

Through its holistic approach to mental health support, the programme has benefited 1,225 women and their families, with 98% showing improved emotional and physical wellbeing, 73% seeing a reduction in the need to utilise statutory mental health services, with a cost saving of £2.1 million to the local Health and Social Care budget in the first years 4 of the programme. Currently the programme is funded until March 2019, by the BIG Lottery; awaiting outcomes of extended funding for an additional 3 years.

There has been a marked increase of referrals of clients from GP's by 28% since the start of the programme; highlighting the benefits of social prescribing. Our future delivery includes increased mental health support for bereaved children and young people through family counselling; which reflect the priorities of the NHS Long Term plan.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to note that there is a risk that this service cannot continue after March 2019 due to financial uncertainty.

Shama
women's centre
educational, social and wellbeing services

Khudeja Amer-Sharif

Shama
women's centre
educational, social and wellbeing services

Shama Womens Centre

1. Mission
2. Our Community
3. Bereavement to Achievement Mental Health Service
4. Recommendations

Empowering Women To Achieve……

Shama women's centre
educational, social and wellbeing services

Mission

'Empower women to become more active, economically, educationally and socially',

Through a ***range of activities*** that *develop their* ***confidence, language, employability skills and improve health & well being'.***

Shama women's centre
educational, social and wellbeing services

Holistic Offer

Barriers

English (ESOL)

Textiles/IT

Creative/Social Activities

Help to Find Work

Volunteering

Counselling :

Bereavement

Domestic Abuse

Holistic Therapies

Health awareness

Gym/ Sauna, Nursery

Empowering Women To Achieve……

Shama women's centre
educational, social and wellbeing services

Impact

- **Work: 15,000 +**
- **Qualifications: 30,000+**
- **Volunteers: 2000 (Highly Commended Lloyds)**
- **Improved Health and Well being : 87%**
- **Seen as 'experts' by professionals**

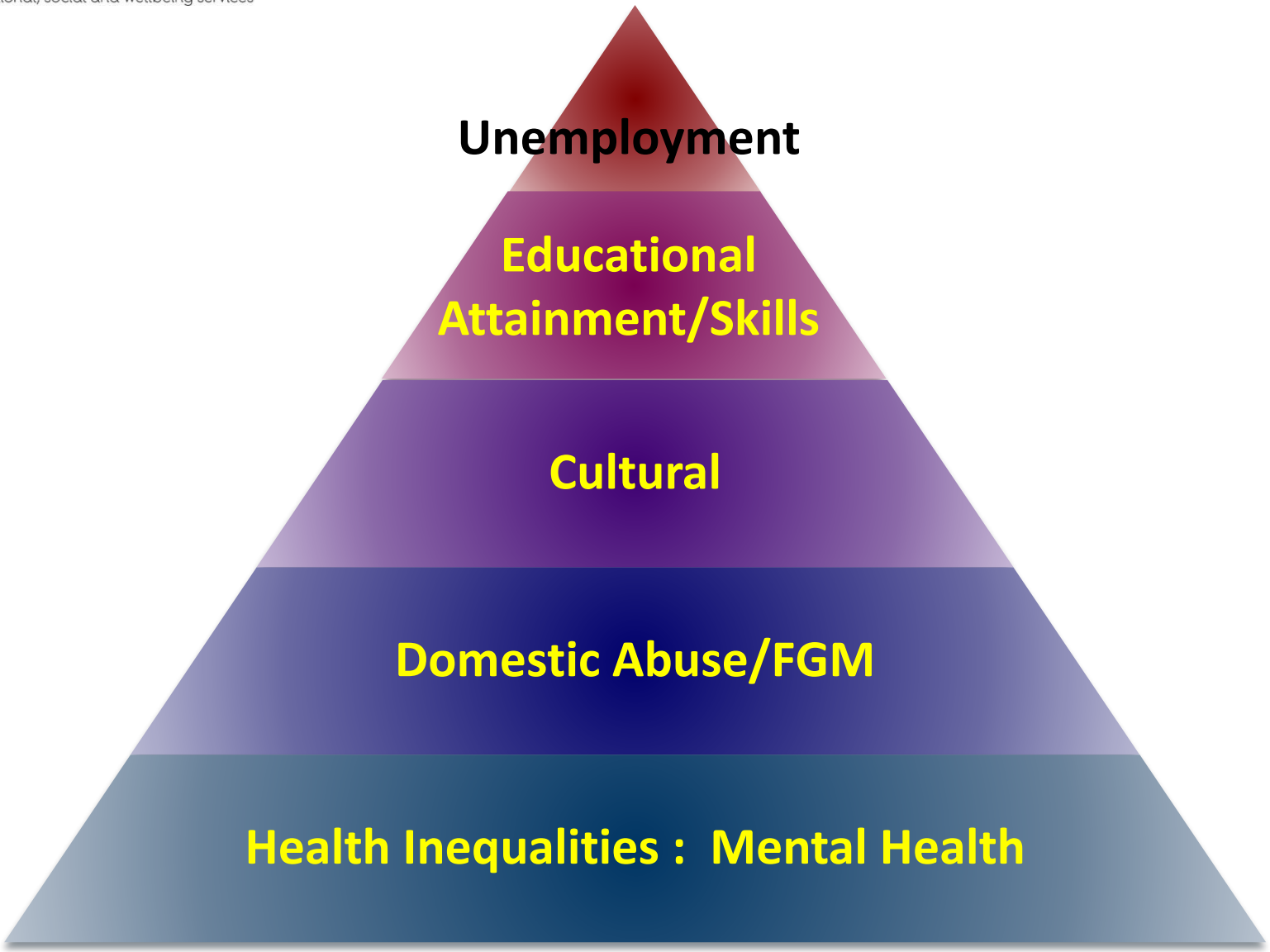
Shama women's centre
educational, social and wellbeing services

Who Are They?

- **Majority BME women of Leicester**
- **Increasingly refugees/asylum seekers**

Shama women's centre
educational, social and wellbeing services

Barriers



Empowering Women To Achieve……

Shama women's centre
educational, social and wellbeing services

Local Context

Mental Health

- In Leicester BME communities experience **inequalities** in accessing mental health services
- **‘**mental health in SE Asian women in Leicester goes unrecognised’
- Suicide higher in Asian women.
- 'are **dissatisfied with the mental health services they receive and are over represented in compulsory detention** (JSNA 2017)

Shama women's centre
educational, social and wellbeing services

Issues

- **Mental Health**
  - Increase in mental health within BME Women
  - Bereaved BME Women suffer in Silence
  - Expected Norm/Stigma

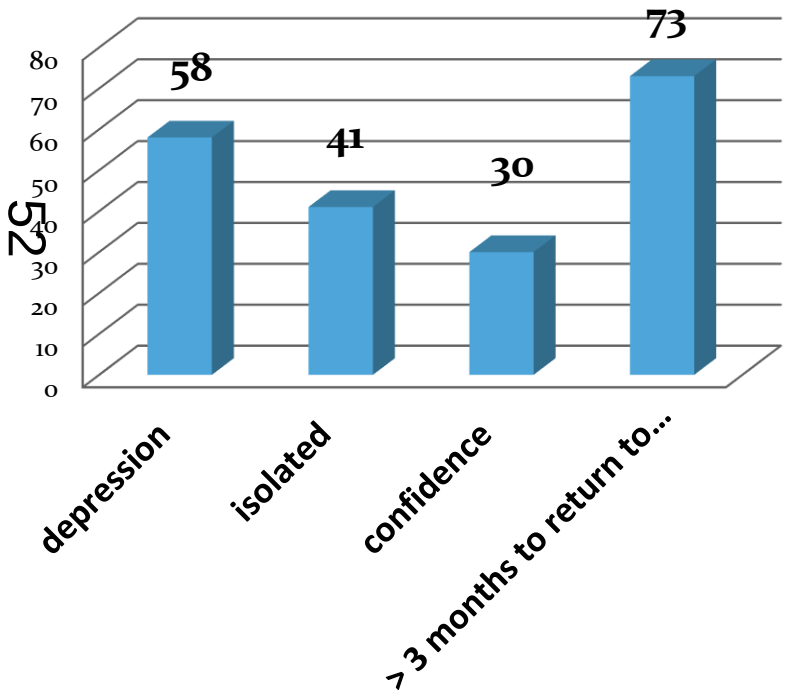
Mapping of Local Services highlighted : 2014

- Only **11%** BME women take up of local bereavement counselling services by BME women
- **89%** (Bereaved clients) used IAPT **Services found it didn't meet cultural expectations and ,** only **7%** would use it again

Shama women's centre
educational, social and wellbeing services

Mental Health Research

Bereaved BME women suffered



WHY?

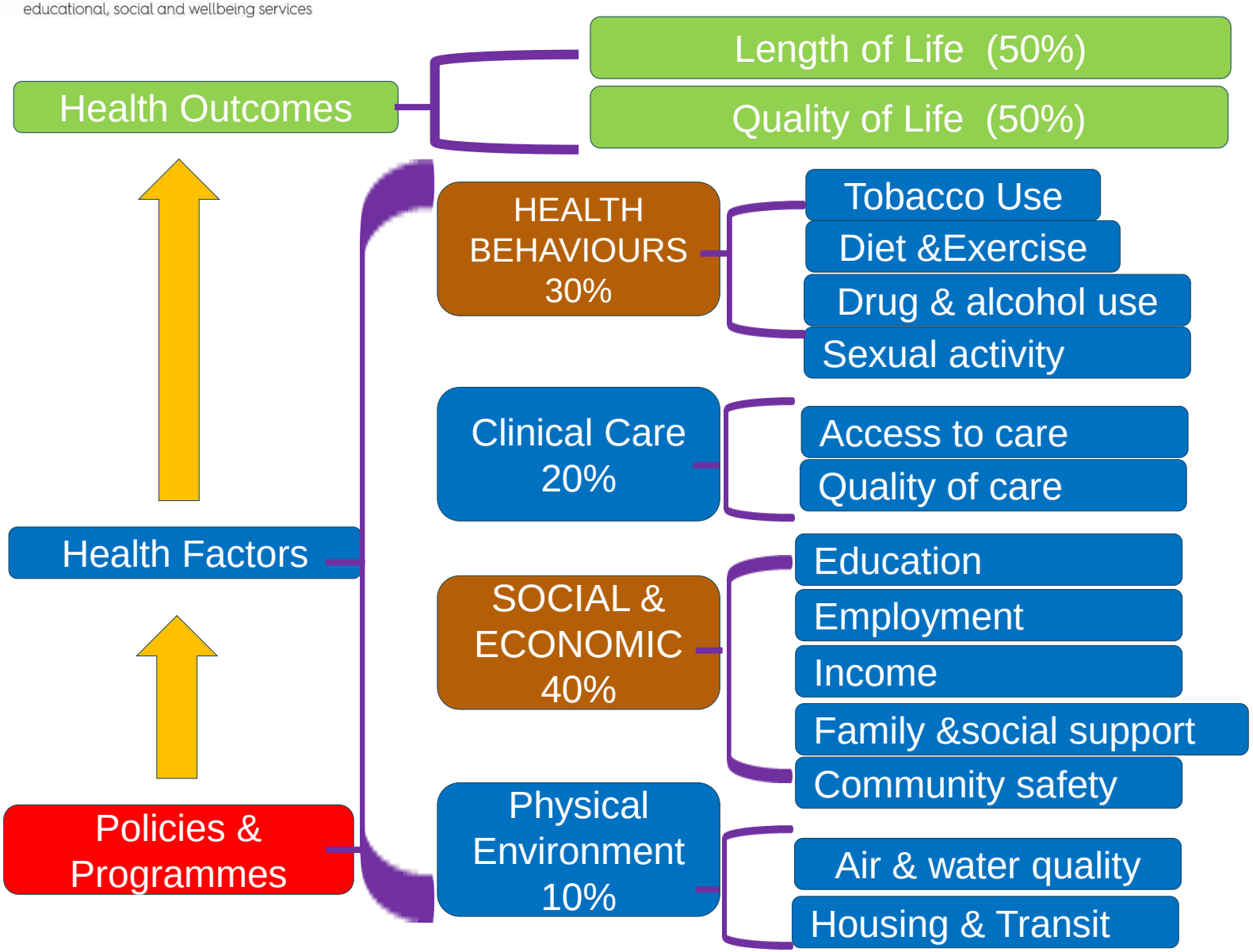
- SWC research **(474)**BME women related this **to lack of culturally conducive service**
- **NEED FOR:** :
  - **97%** **Multi-lingual** Bereavement Counsellors , **independent** of family. **Ongoing support**
  - **95%** **local accessible, women's only** service to **share experiences** with other bereaved women
  - **91%** Opportunity to **participate in activities** to gain confidence, **overcome isolation** and help into work
  - **2017 Research :**

    Extended to **family Counselling**

Empowering Women To Achieve……

Shama women's centre
educational, social and wellbeing services

Bereavement to Achievement

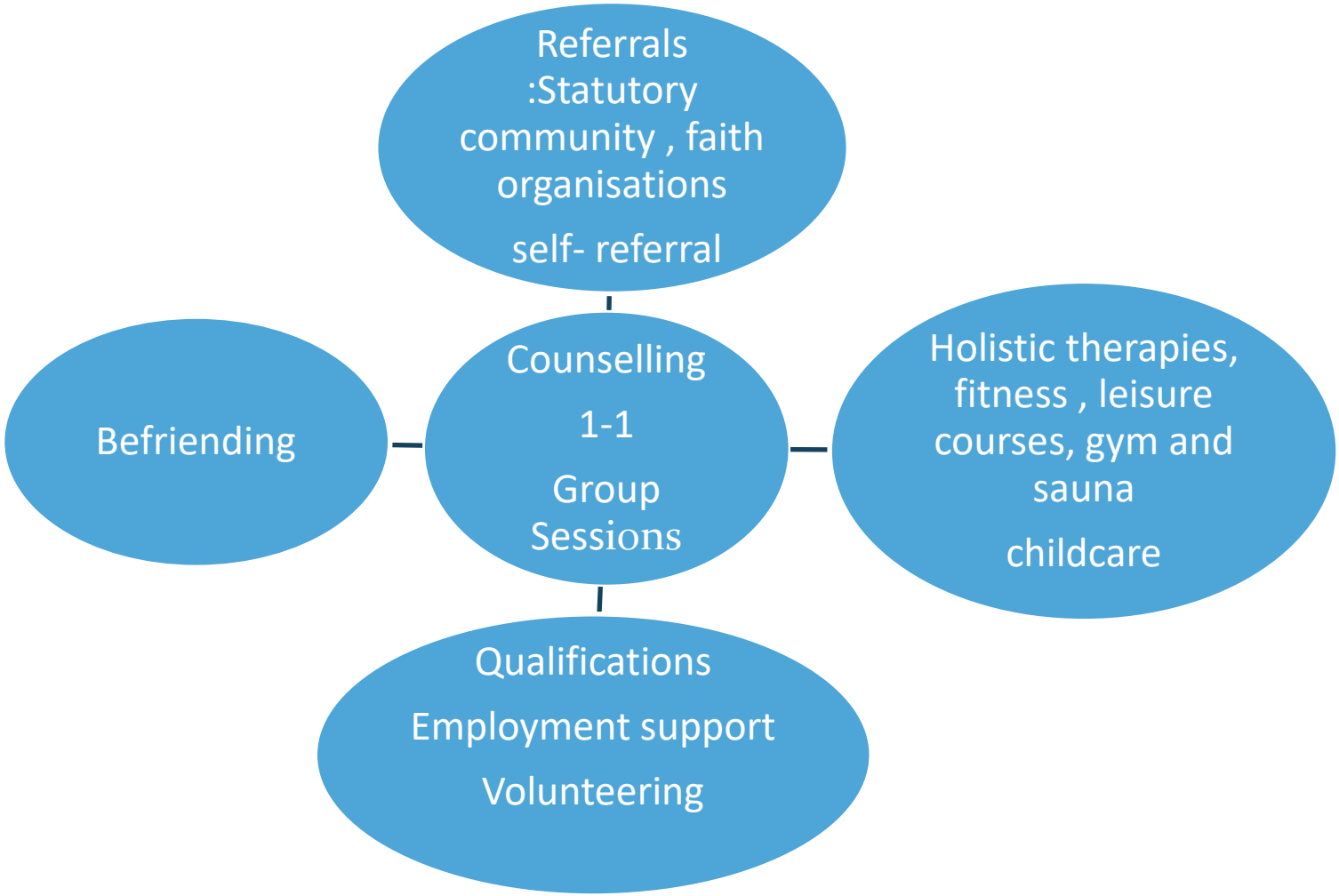


Empowering Women To Achieve……

Shama women's centre
educational, social and wellbeing services

Bereavement to Achievement

Bereavement to Achievement



Empowering Women To Achieve……

Bereavement to Achievement

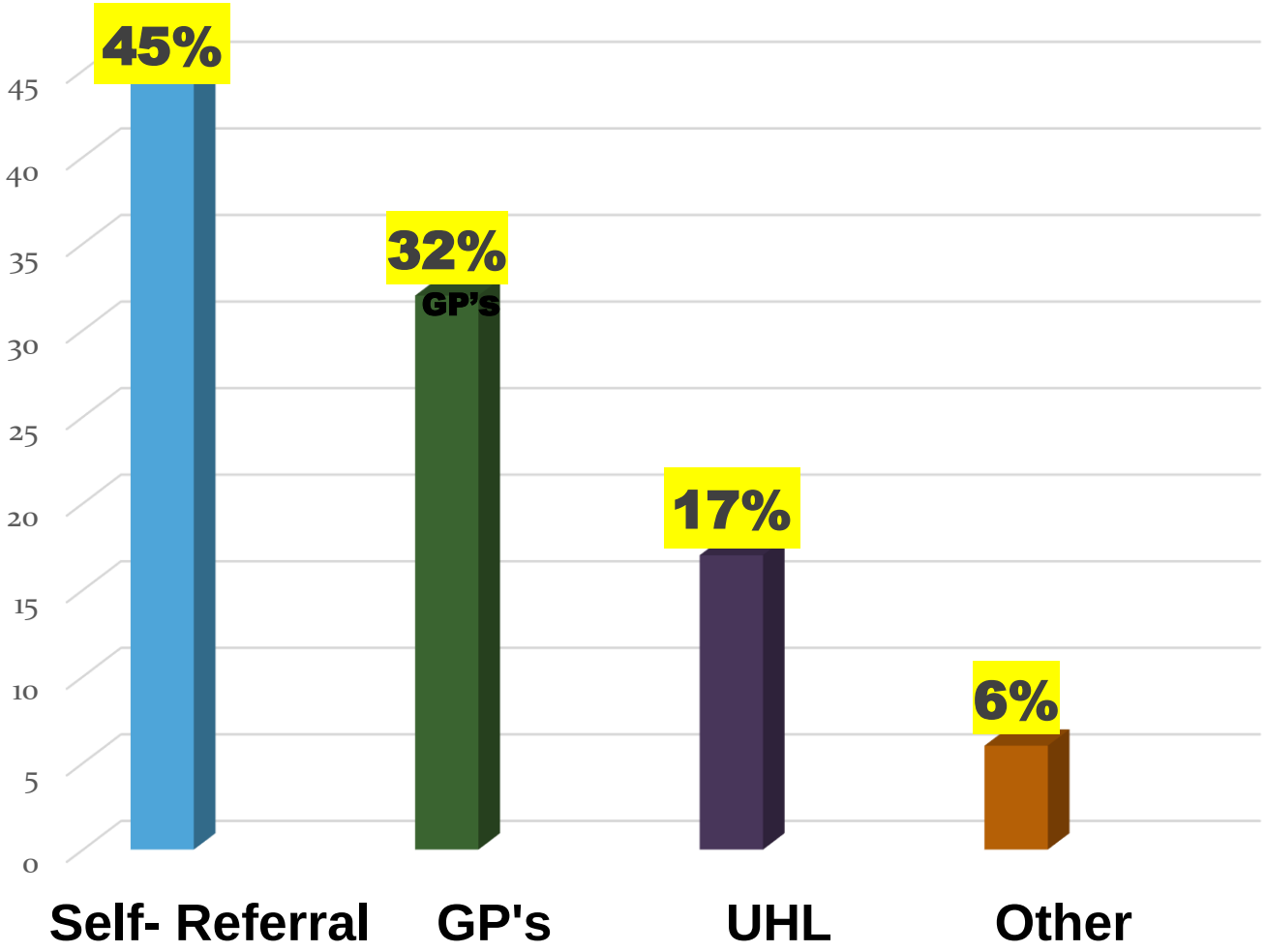
- 2014-2019 funded by Big Lottery.
- Integrated with Primary and Secondary Care:
- UHL Bereavement Services, LPT, IAPT, Health agencies, Laura Centre
- Hospices, Community/Faith groups
- Described as ' **Inspirational**' by NHS England

Empowering Women To Achieve……

Shama women's centre
educational, social and wellbeing services

Bereavement to Achievement

Referrals



Empowering Women To Achieve……

Shama women's centre
educational, social and wellbeing services

Bereavement to Achievement

Impact of BTA

- **1,225** women/families accessed the programme
- **98%** Improved emotional/physical well being
- **73%** reduction in requiring statutory mental health services
- **89%** less isolated
- **95%** increase in confidence
- **45%** signposted other agencies
- **363** **Accredited qualifications**
- **150** **gained employment**

Empowering Women To Achieve……

Shama women's centre
educational, social and wellbeing services

Bereavement to Achievement

Cost Savings : Health & Social Care

Over 4 years

- Primary Care : 50% reduction in seeing GP
- Prescription Costs : 20%
- Secondary Care: £1.7m
- A&E : £160,000
- Ambulance : 270
- £66,000 employability skills
- Total : £2.1 million *(Public Health Leicester, 2018)*

Shama women's centre
educational, social and wellbeing services

Recommendations

- The Health & Wellbeing Board notes that there is a risk that this service cannot continue after March 2019 due to financial uncertainty.

- It is noted that the work of the service can support the **NHS Long Term Plan** with priorities such as:

  - Address health inequalities through social prescribing
  - Children and young people's mental health

What our users say

https://shamawomenscentre.co.uk/bereavement-counselling

Shama
women's centre
educational, social and wellbeing services

More Information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shama_womens_centre@hotmail.com


39-45 Sparkenhoe Street, Leicester LE2 0TD


@shamacentre


Shama Women's Centre

www.shamawomenscentre.co.uk

Empowering Women To Achieve……

Appendix D

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE: 28th February 2019

Subject:	Addressing Female Genital Mutilation (FGM) in Leicester
Presented to the Health and Wellbeing Board by:	Etain McDermott Nicola Bassindale
Author:	Etain McDermott Nicola Bassindale

EXECUTIVE SUMMARY:

This report makes some proposals for future work to strengthen Leicester City Council and its partners' stance against FGM. Whilst the council condemns the practice in all its recognised forms, no dedicated work has been undertaken to formally publicise this stance, or indeed to invite partners to stand alongside us in this stance.
This paper provides some background information about the practice, sets out what we have addressed so far in terms of our approach to FGM and provides some options for further work, drawing on examples from nationally recognised good practice.
A group of officers from a range of partner agencies has been identified and approached with a view to forming a task and finish group, for which there has been strong support.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- Note the content of the report
- Support the approach to set up a multi-agency group tasked to:
    - Seek to understand the current prevalence of FGM and how it is affecting women and girls in Leicester
    - Review current procedures and ensure the support available is accessible and effective
- Support the development of a joint action plan focusing on community engagement to understand and educate about the issue within communities

REPORT:

1. Background

1.1 What is FGM?

Female Genital Mutilation (FGM), also known as female circumcision or female genital cutting, is defined by the World Health Organisation (WHO) as "all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons". The WHO has classified FGM into 4 types. Further detail on definitions can be found in **Appendix A**.

1.2 Implications of FGM

There is evidence that there can be significant health implications arising from FGM, both immediately and long-term. Immediate complications can include severe pain, shock, haemorrhage, tetanus, gangrene or sepsis, urine retention, open sores in the genital region and injury to nearby genital tissue, wound infections, as well as blood-borne viruses such as HIV, hepatitis B and hepatitis C and in some cases death.

Long-term consequences can include recurrent bladder and urinary tract infections, abnormal periods, cysts, infertility, chronic vaginal and pelvic infections, kidney impairment and possible kidney failure and the need for later surgeries.

There can also be significant psychological and mental health implications that result from FGM including depression and anxiety, and flashbacks during pregnancy and childbirth.

As well as the physical and psychological impacts set out above, it is recognised that FGM results in an increased risk of childbirth complications and new-born deaths.

Appendix B contains a diagram setting out the effects of FGM throughout the life course for girls and women.

1.3 Cultural underpinnings / motives

Although FGM is practised by secular communities, it is most often claimed to be carried out in accordance with religious beliefs. However, FGM predates Christianity, Islam and Judaism, and the Bible, Koran, Torah and other religious texts do not advocate or justify FGM. In most societies, FGM is considered a cultural tradition, which is often used as an argument for its continuation. Religious leaders take varying positions with regard to FGM: some promote it, some consider it irrelevant to religion, and others oppose it and contribute to its elimination. Local structures of power and authority, such as community leaders, religious leaders, circumcisers, and even some medical personnel can contribute to upholding the practice.

It is useful to understand the some of the reasons parents and communities continue the practice of FGM as this may help us to plan future engagement around the issue. Parents may feel they are genuinely doing the best to protect their daughters. Some reasons given for practising FGM are that it:

- brings status and respect to the girl
- preserves a girl's virginity/chastity
- is a rite of passage
- gives a girl social acceptance, especially for marriage
- upholds the family honour
- cleanses and purifies the girl

- gives the girl and her family a sense of belonging to the community
- fulfils a religious requirement believed to exist
- perpetuates a custom/tradition
- helps girls and women to be clean and hygienic
- is cosmetically desirable
- is (mistakenly) believed to make childbirth safer for the infant

1.4 Prevalence

National

It is estimated that 137,000 women and girls are living with FGM in the UK and that 60,000 girls aged 13 and under are at risk of FGM.

A report by City University London and Equality Now (2015) found that:

- London as a whole has the highest prevalence rates, with 21 women per 1,000 affected by FGM. The 10 highest prevalence rates are located in local authorities within the capital.
- Manchester, Slough, Bristol, Leicester and Birmingham have high prevalence rates, ranging from 12 to 16 per 1,000,
- Milton Keynes, Cardiff, Coventry, Sheffield, Reading, Thurrock, Northampton and Oxford had rates of more than seven per 1,000.
- Rural areas show prevalence's of well below one per 1,000, but cases were found in all local authorities in England and Wales.

Local

Between April 2015 and March 2016 NHS Leicester City CCG Trust recorded 30 observations of FGM, 15 were pregnant women in midwifery services. This was the second highest number of recorded FGM in that year in the Midlands and East CCGs. During October 2016 to December 2016 University Hospitals of Leicester NHS trusts identified FGM in 10 pregnant women attending midwifery services.

It is likely that these figures are much lower than actual prevalence and issues around reporting and data sharing needs to be looked at as part of the future work to be planned. The FGM lead within Leicestershire Police has been contacted and is keen to work with us to help strengthen our understanding of local prevalence, as it is likely that they will have a record of FGM reports and referrals.

See **Appendix C** for further information on FGM prevalence locally, nationally and internationally.

1.5 Legal position

Current law

Under the Female Genital Mutilation Act 2003 it is an offence for any person in England, Wales or Northern Ireland (regardless of their nationality or residence status) to perform FGM (section 1); or to assist a girl to carry out FGM on herself (section 2).

It is also an offence to assist (from England, Wales or Northern Ireland) a non-UK national or resident to carry out FGM outside the UK on a UK national or permanent UK resident (section 3).

Section 4 extends sections 1 to 3 to extra-territorial acts so that it is also an offence for a UK national or permanent UK resident to: perform FGM abroad; assist a girl to perform FGM on

herself outside the UK; and assist (from outside the UK) a non-UK national or resident to carry out FGM outside the UK on a UK national or permanent UK resident.
Against that background, section 70(1) of the Serious Crime Act 2015 ("the 2015 Act") amends section 4 of the 2003 Act so that the extra-territorial jurisdiction extends to prohibited acts done outside the UK *by* a UK national or a person who is resident in the UK. Consistent with that change, section 70(1) also amends section 3 of the 2003 Act (offence of assisting a non-UK person to mutilate overseas a girl's genitalia) so it extends to acts of FGM done *to* a UK national or a person who is resident in the UK.

Other sections of the 2015 Act protect the identity of victims of FGM and make the failure to protect a girl from risk of FGM a criminal offence. There is also a legal duty for professionals (including all healthcare workers, teachers and social workers) to notify the police of FGM. See **Appendix D** for further information on the legal position.

Although the law is clear that FGM has been illegal in the UK since 1985, prosecutors have found it difficult to secure a conviction. There have been only three previous trials, all of which ended in acquittals. However, in a landmark case on 1 February 2019, a Ugandan woman from east London became the first person to be found guilty of performing (or allowing someone else to perform) FGM on her 3-year-old daughter in 2017. The National Police Chiefs' Council commented that while prosecutions alone will not stop this abuse, the guilty verdict sends a strong message and it is hoped will encourage other victims to report the crime. Sentencing will take place on 8 March 2019; carrying out FGM carries a maximum sentence of 14 years in custody.

Female Genital Mutilation Protection Orders (FGMPOs)
Section 73 of the 2015 Act provides for FGMPOs for the purposes of protecting a girl against the commission of a genital mutilation offence or protecting a girl against whom such an offence has been committed. Almost 300 FGMPOs have been granted since 2015. Breach of an FGMPO would be a criminal offence with a maximum penalty of five years' imprisonment, or as a civil breach punishable by up to two years' imprisonment. See **Appendix E** for further information about FGMPOs.

2. Work to date

2.1 Policy & Procedure

FGM is clearly referenced throughout the Leicester, Leicestershire & Rutland Safeguarding Children procedures manual, including links to national guidance and the Statement opposing FGM (often referred to as a health passport). These policies and procedures were developed by a Task and Finish Group that was led by Children's Safeguarding at the time.

Section 2.23 of the manual is entitled "Safeguarding Children at Risk of Abuse through Female Genital Mutilation" and sets out who is at risk and how professionals should respond, record and report FGM. There is a clear referral process and pathway for professionals to follow in cases where either a girl is at risk of FGM, has undergone FGM or where a girl or woman has given birth and has already undergone FGM. (The referral process is attached at **Appendix F**.)

In 2016 the Leicester Safeguarding Children Board (LSCB) published their findings from a multi-agency audit on a small number of FGM cases. This summary is attached at **Appendix G**.

2.2 Awareness raising campaign

Some awareness raising work was undertaken by the LSCB in 2017 prior to the school summer holidays, including the commissioning of a video narrated by a local GP, Dr Sethi, and the publishing of a leaflet. Copies of both can be found at http://www.lcitylscb.org/information-for-practitioners/safeguarding-topics/female-genital-mutilation/school-awareness-raising-for-summer-holidays/.

2.3 Strategic response

FGM has been referenced by Leicester City Council through its strategic partnerships over past years. Most recently Leicester's Children's Trust Board (LCTB) members identified it as an issue around which they wanted to hold a focus session, in terms of identification and safeguarding of children at risk through to the risk to babies born to mothers who have undergone FGM, and the physical and psychological impact that may have on the parent/child.

On 2 March 2017, a focus meeting of the LCTB was held. Experts from Public Health, local health providers and voluntary support organisations were invited to give presentations (Leicestershire Partnership Trust, Somali Development Service and Zinthiya Trust). These presentations were followed by small group work discussing the following questions:

- Do processes need to change in order to better support children who are at risk of, or have experienced FGM?
- How can we effectively increase awareness of FGM?
- What information do we collect and how is it used?
- What don't we know?

The key themes that emerged from the group discussions were:

- More community engagement is needed to increase awareness
- Communities need help to understand that FGM is not required by their religion (with the aid of religious leaders and other respected community figures)
- The importance of the use of positive language and a sensitive approach
- The need to share and effectively allocate resources
- The need to share and tap into information and good practice from other areas e.g. Bristol has developed a training pack for teachers and has champions from each agency or youth ambassadors to engage with schools and young people in order to increase awareness
- The need to support schools in increasing their involvement in raising awareness without segregating or causing conflict between pupils
- The need for local information about prevalence and trends to inform communication and sharing information to protect girls and women

This session was felt by members to be very useful; however, it was very clearly the beginning of a conversation about a complex issue about which many attendees were learning for the first time. The links made by members with community groups that support on issues around FGM were invaluable, but further developmental work would be needed to

strengthen awareness, knowledge and support for the council's condemnation of the practice.

3. Planning and identifying future work

Many of the points raised at the LCTB focus session will be addressed if it is decided to take up some of the opportunities set out below, providing an up-to-date and more detailed, integrated partnership response to the issue of FGM in Leicester.

3.1 Tackling FGM through Community Behaviour Change

The REPLACE Approach is a new way to tackle FGM and replaces the dominant methods used to end FGM in which the focus was previously on raising awareness of the health and human rights issues associated with the practice and then expecting individuals to change their behaviour concerning FGM.
Behaviour change theories combined with community engagement are central to the REPLACE Approach. The REPLACE Approach empowers FGM-affected communities through community leaders, influential people within the community and community peer group champions to challenge the social norm supporting FGM. The approach is based on encouraging behavioural change through engaging and working with communities and is supported by good evaluation throughout the process.

3.2 Task and Finish Group

A Task and Finish Group has been established and will hold an initial meeting in March 2019. The purpose is to gather knowledge and intelligence on the extent of FGM in Leicester, how it is being addressed by various partners and the barriers to dealing with FGM. Membership will include:

- Public Health
- Social Care & Education (Safeguarding (Children & Adults) & Education reps)
- Leicestershire Police
- Clinical Commissioning Group
- Leicestershire Partnership Trust (Health Visiting rep)
- University Hospitals Leicester (Midwifery rep)
- Specialist violence against women rep (Voluntary & Community Sector)
- University of Leicester
- Community representatives
- Community Safety (Domestic Violence/Sexual Violence Manager)

Further members will be identified as the work progresses.

The Task and Finish Group's purpose is to use the knowledge and intelligence gathered to form an action plan that addresses key priorities. These might include:

- Prevention through awareness raising and education
- Community-led initiatives to ensure appropriate messages, campaigns, etc.
- Training and empowerment through the implementation of training & education programmes across the City tailored to professionals and communities.
- Continued support to law enforcement officers safeguarding, reporting and recording

- Ensure that professionals access the LSCB multi-agency safeguarding training to include the issue of identifying girls at risk of FGM and referring them as part of child safeguarding.
- Take a life course approach to treatment, services and support
- Support University Hospitals Leicester NHS Trust in their work to offer women access to a specialist FGM midwife and increase access to psychological support
- Data collection and sharing - Agencies including health, social care, safeguarding, police and midwifery should collect and share data where appropriate

3.3 Community Engagement

Effective engagement with communities to develop local FGM priorities and initiatives is vital to ensure they are effective and appropriate to their audience.

Community engagement events to discuss FGM should be held in partnership with the voluntary & community sector. Events for women and children should be held separately, with a particular focus on engagement with men and older females.

Key stakeholders should all commit to fully engage and consult with communities on all FGM interventions.

4. Next steps

The Task and Finish Group will be convened in March 2019 and begin to plan actions that can be taken immediately (those surrounding data gathering and reviewing current processes and support available) and proposed future actions.

An action plan will be developed and will be brought back to the Health and Wellbeing Board for comment and sign off at a future date.
Some opportunities and ideas that will be considered include:

- A council motion and/or partnership pledge
- Preventative work through awareness raising, community engagement and training
- Support to law enforcement activity
- Review and update safeguarding processes
- Consideration of specialist services and clinics

Appendix A – Further background detail

Definitions

The World Health Organisation (WHO) has classified Female Genital Mutilation into four types:

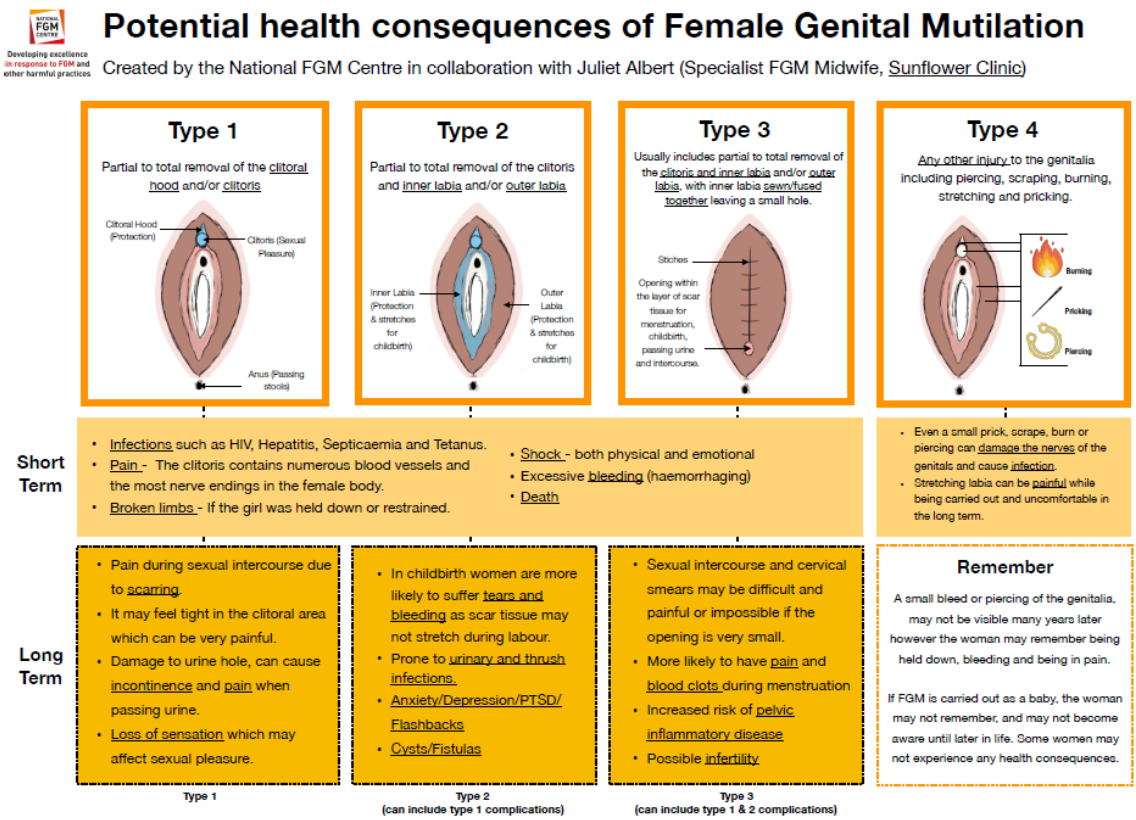
Type 1 - excision of the prepuce, with or without excision of part or all of the clitoris

Type 2 - excision (Clitoridectomy) of the clitoris with partial or total excision of the labia minora (small lips which cover and protect the opening of the vagina and the urinary opening). After the healing process has taken place, scar tissue forms to cover the upper part of the vulva region;

Type 3 - Infibulation - This is the most severe form of female genital mutilation. Infibulation often (but not always) involves the complete removal of the clitoris, together with the labia minora and at least the anterior two-thirds and often the whole of the medial part of the labia majora (the outer lips of the genitals). The two sides of the vulva are then sewn together with silk, catgut sutures, or thorns leaving only a very small opening to allow for the passage of urine and menstrual flow. This opening can be preserved during healing by insertion of a foreign body;

Type 4 - Unclassified - pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purpose of tightening or narrowing it; and any other procedure that falls under the definition given above.

The practice is mostly carried out by traditional circumcisers, who often play other central roles in communities, such as attending childbirths. Procedures are mostly carried out on young girls sometime between infancy and aged 15, and occasionally on adult women.



Appendix B – Life Course impacts of FGM

Appendix C – FGM Prevalence

Global Prevalence

- It is estimated that 125 million women and girls worldwide have undergone FGM.
- It is estimated that 3 million girls are subjected to FGM every year.

Groupings of the 29 countries where FGM is concentrated, by FGM Prevalence amongst girls and women aged 15-49.

Groupings by FGM prevalence levels (15-49 year old females)

Countries		
Very high prevalence countries	Prevalence rates >80%	Somalia, Guinea, Djibouti, Egypt, Eritrea, Mali, Sierra Leone, Sudan
Moderately high prevalence countries	Prevalence rates 51-80%	Gambia, Burkina Faso, Ethiopia, Mauritania, Liberia
Moderately low prevalence countries	Prevalence rates 26-50%	Guinea-Bissau, Chad, Ivory Coast, Kenya, Nigeria, Senegal
Low prevalence countries	Prevalence rates 10-25%	Central African Republic, Yemen, Tanzania, Benin
Very low prevalence countries	Prevalence rates <10%	Iraq, Ghana, Togo, Niger, Cameroon, Uganda

National Prevalence

It is estimated that 137,000 women and girls are living with FGM in the UK and that 60,000 girls aged 13 and under are at risk of FGM.2

A report by City University London and Equality Now (July 2015)[1] looked at prevalence of FGM in England and Wales and developed estimates of the numbers of women with FGM living in England and Wales, the numbers of women with FGM giving birth and the numbers of girls born to women with FGM. To derive these estimates the report used the results of household interview surveys in the countries in which FGM is practised, demographic data about women born in these countries and girls born to them was derived from the 2011 census and from birth registration.

The survey found that;

[1] City University London and Equality Now. Prevalence of Female Genital Mutilation in England and Wales: National and local estimates, July 2015

- London as a whole has the highest prevalence rates, with 21 women per 1,000 affected by FGM. The 10 highest prevalence rates are located in local authorities within the capital.
- Manchester, Slough, Bristol, Leicester and Birmingham have high prevalence rates, ranging from 12 to 16 per 1,000,
- Milton Keynes, Cardiff, Coventry, Sheffield, Reading, Thurrock, Northampton and Oxford had rates of more than seven per 1,000.
- Rural areas show prevalence's of well below one per 1,000, but cases were found in all local authorities in England and Wales.

Prevalence of FGM in Leicester

Since 2014 Acute NHS Trusts (Foundation and non-Foundation) must provide returns to the Department of Health on a monthly basis of the prevalence of FGM within their treated population.

Between April 2015 and March 2016 NHS Leicester City CCG Trust recorded 30 observations of FGM, 15 were pregnant women in midwifery services. This was the 2nd highest number of recorded FGM in that year in the midlands and east CCGs.

During October 2016 – December 2016 University Hospitals of Leicester NHS trusts identified FGM in 10 pregnant women attending midwifery services.

Evidence suggests that for these women there may be an increased risk of childbirth complications and new-born deaths. For those mothers who have undergone FGM there is also the potential risk that their female children will also undergo the procedure.

It would be beneficial to identify the FGM lead within Leicester City Police as it is likely that they will have a record of FGM reports and referrals.

Estimating at risk females of Female Genital Mutilation

To estimate the population affected or at risk of female genital mutilation analysis has been carried out to identify the number of females in Leicester from countries where FGM prevalence is high. The 2011 Census and the 2018 Leicester School Census have been used to calculate estimates, both sources currently collect country of birth information.

To note: the pattern of migration increases the complexity of producing an estimate for females at risk of FGM. We are aware that some people from countries where FGM prevalence is high have migrated (possibly more than once) and had children in countries not traditionally associated with high rates of FGM. Females born in these countries therefore will not be included in the estimate but because of their ethnicity they would still be considered at risk of FGM. For example, some east African communities have settled in European countries before moving again to the United Kingdom.

In addition to this other ethnic groups may have been born in countries where FGM prevalence is high however do not share the practice of FGM. For example, Leicester has a sizable East African Asian population.

Table 1. Census 2011 - Numbers of females born in at risk countries by age.
Source: ONS, Census 2011

Country of Birth	Age 0 to 15		Age 16 to 49	
	Number	%	Number	%
Women in Leicester	33828		87520	
Africa: North Africa	73	0.2%	298	0.3%
Africa: Central and Western Africa	115	0.3%	982	1.1%
Africa: South and Eastern Africa	708	2.1%	7252	8.3%
Africa: Africa not otherwise specified	5	0.0%	326	0.4%
Middle East and Asia: Middle East	338	1.0%	1034	1.2%
Total born in region where FGM is prevalent	1239	3.7%	9892	11.3%

1,239 or 3.7% of Leicester females aged 0 to 15 were born in regions where FGM prevalence is high. These females are at risk of becoming a potential victim of FGM.

9892 or 11.3% of Leicester females aged 16 to 49 were born in regions where FGM prevalence is high. These females have potentially already been a victim of FGM.

Table 2. School Census 2018 - Numbers of school aged (4-16) females currently attending Leicester schools who were born in countries where FGM prevalence is high. *Source: Leicester School Census 2018*

Country of birth	Females aged 4-16
Cameroon	5
Egypt	12
Eritrea	11
Ethiopia	6
Gambia, The	4
Ghana	17
Guinea	4
Iraq	101
Kenya	22
Mauritania	0
Nigeria	49
Senegal	0
Sierra Leone	3
Somalia	56
South Sudan	1
Sudan	13
Tanzania	7
Togo	1
Uganda	5
Yemen	2

Total females born in country where FGM is prevalent	**319**
Total females in Leicester schools	27425

319 or 1.2% of Leicester females aged 4 to 16 were born in regions where FGM prevalence is high. These females are at risk of becoming a potential victim of FGM.

Table 2.1 School Census 2018 - Numbers of school aged (4-16) females currently attending Leicester schools by ethnicity *Source: Leicester School Census 2018*

Ethnic Group	Total	Percentage	
African Asian	188	0.7%	
Bangladeshi	618	2.3%	
Indian	8300	30.3%	
Other Asian	1526	5.6%	
Any Oth Asian b'ground	23	0.1%	
Pakistani	1077	3.9%	
Sri Lankan Other	1	0.0%	
Black African	19	0.1%	
Other Black African	1062	3.9%	
Black Caribbean	232	0.8%	
Other Black	2	0.0%	
Any Oth Black b'ground	409	1.5%	
Black Somali	1015	3.7%	
Chinese	75	0.3%	
Asian and Black	1	0.0%	
Asian & Any Oth Eth G'p	3	0.0%	
Any Oth Mixed b'ground	560	2.0%	
Other mixed background	2	0.0%	
White and Asian	516	1.9%	
White and Black African	244	0.9%	
White & Black Caribbean	606	2.2%	
Info not yet obtained	168	0.6%	
Arab Other	3	0.0%	
Iranian	1	0.0%	
Kurdish	3	0.0%	
Any other Ethnic Group	614	2.2%	
Refused	113	0.4%	
White British	7220	26.3%	
White Eastern Euro'n	10	0.0%	
White English	5	0.0%	
White European	1648	6.0%	
White Irish	25	0.1%	
Traveller - Irish Heritage	40	0.1%	
Any Oth White b'ground	2	0.0%	
White Other	328	1.2%	
Other white British	1	0.0%	

Gypsy	3	0.0%	
Gypsy/Roma	86	0.3%	
Other Gypsy/Roma	7	0.0%	
Roma	47	0.2%	
White Western Euro'n	3	0.0%	
No information recorded	621	2.3%	
	27427		

When considering ethnicity we have an at-risk population of 2,099 or 7.7% of the female Leicester school population

Appendix D – Legal position

Current law

Under the 2003 Act it is an offence for any person in England, Wales or Northern Ireland (regardless of their nationality or residence status) to perform FGM (section 1); or to assist a girl to carry out FGM on herself (section 2). It is also an offence to assist (from England, Wales or Northern Ireland) a non-UK national or resident to carry out FGM outside the UK on a UK national or permanent UK resident (section 3).

Section 4 extends sections 1 to 3 to extra-territorial acts so that it is also an offence for a UK national or permanent UK resident to: perform FGM abroad; assist a girl to perform FGM on herself outside the UK; and assist (from outside the UK) a non-UK national or resident to carry out FGM outside the UK on a UK national or permanent UK resident.

Extension of extra-territorial jurisdiction

Against that background, section 70(1) of the Serious Crime Act 2015 ("the 2015 Act") amends section 4 of the 2003 Act so that the extra-territorial jurisdiction extends to prohibited acts done outside the UK *by* a UK national or a person who is resident in the UK. Consistent with that change, section 70(1) also amends section 3 of the 2003 Act (offence of assisting a non-UK person to mutilate overseas a girl's genitalia) so it extends to acts of FGM done *to* a UK national or a person who is resident in the UK.

Anonymity of victims of FGM

Section 71 of the 2015 Act amends the 2003 Act to prohibit the publication of any information that would be likely to lead to the identification of a person against whom an FGM offence is alleged to have been committed. This is similar, although not identical, to the anonymity given to alleged victims of sexual offences by the Sexual Offences (Amendment) Act 1992. Anonymity will commence once an allegation has been made and will last for the duration of the victim's lifetime.

Offence of failing to protect a girl from risk of FGM

Section 72 of the 2015 Act inserts new section 3A into the 2003 Act; this creates a new offence of failing to protect a girl from FGM. This will mean that if an offence of FGM is committed against a girl under the age of 16, each person who is responsible for the girl at the time of FGM occurred will be liable under this new offence. The maximum penalty for the new offence is seven years' imprisonment or a fine or both.

Duty to notify police of female genital mutilation

Section 74 inserts new section 5B into the 2003 Act which creates a new mandatory reporting duty requiring specified regulated professionals in England and Wales to make a report to the police. The duty applies where, in the course of their professional duties, a professional discovers that FGM appears to have been carried out on a girl aged under 18 (at the time of the discovery). The duty applies where the professional either is informed by the girl that an act of FGM has been carried out on her, or observes physical signs which appear to show an act of FGM has carried out and has no reason to believe that the act was necessary for the girl's physical or mental health or for purposes connected with labour or birth. The duty applies to professionals working within healthcare or social care, and teachers. It therefore covers:

- Professionals regulated by a body overseen by the Professional Standards Authority

(with the exception of the Pharmaceutical Society of Northern Ireland). This includes doctors, nurses, midwives, and, in England, social workers,

- Teachers
- Social care workers in Wales.

The duty does not apply where a professional has reason to believe that another individual working in the same profession has previously made a report to the police in connection with the same act of FGM. For these purposes, professionals regulated by a body which belongs to the Professional Standards Authority are considered as belonging to the same profession.

Appendix E – Female Genital Mutilation Protection Orders

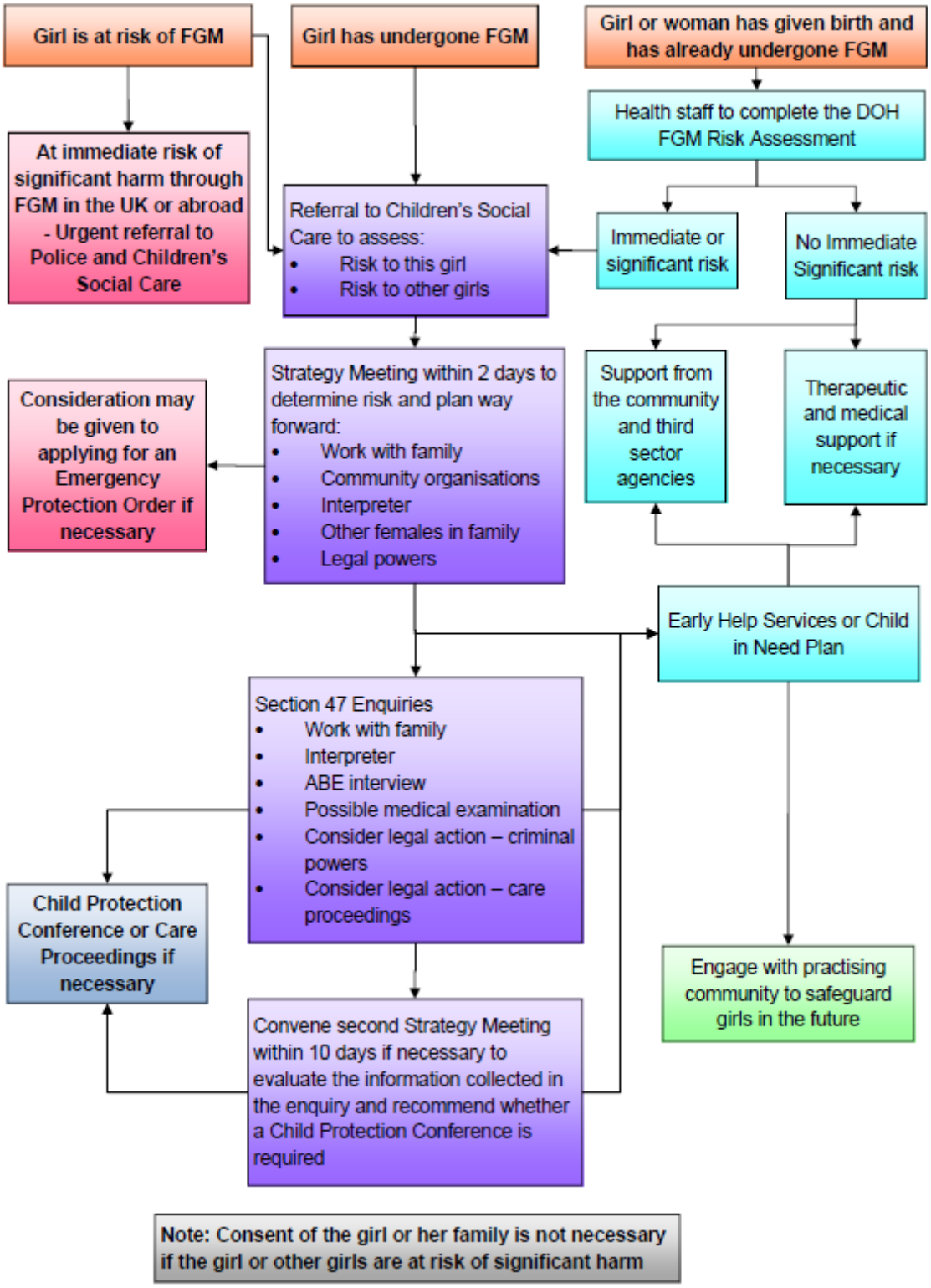
Section 73 of the 2015 Act provides for FGMPOs for the purposes of protecting a girl against the commission of a genital mutilation offence or protecting a girl against whom such an offence has been committed. Breach of an FGMPO would be a criminal offence with a maximum penalty of five years' imprisonment, or as a civil breach punishable by up to two years' imprisonment. The court may make a FGMPO on application by the girl who is to be protected or a third party. The court must consider all the circumstances including the need to secure the health, safety, and well-being of the girl.

https://www.gov.uk/government/consultations/female-genital-mutilation-proposal-to-introduce-acivil-protection-order

Under the new provisions an FGMPO might contain such prohibitions, restrictions or other requirements for the purposes of protecting a victim or potential victim of FGM. This could include, for example, provisions to surrender a person's passport or any other travel document; and not to enter into any arrangements, in the UK or abroad, for FGM to be performed on the person to be protected.

Appendix F – Safeguarding Referral Processes

Referral Process for Female Genital Mutilation (FGM) Flowchart



Appendix G – LSCB Multi-agency audit summary

Leicester Safeguarding Children Board

Leicester LSCB Multi-agency Audit: Female Genital (FGM) 2016 Summary

This summary (briefing) is aimed at managers and practitioner working with children and families in Leicester. Key findings/conclusions from the audit and information about FGM is presented. Please share this summary (briefing) with colleagues.

Background

- Working Together to Safeguard Children (2015) requires Local safeguarding Children Boards to evaluate multi-agency working through joint audits of case files.
- Female Genital Mutilation (FGM) is a priority for the LSCB.
- Locally, there is a need to understand the scale and needs of children and young people vulnerable to FGM to safeguard them from the risk to FGM.
- A multi-agency LSCB audit on FGM was conducted in July 2016, to check compliance and seek assurance to the application of the LLR LSCB multi-agency safeguarding procedures; partner agency identification and response to cases where FGM is a theme; identify learning to improve practice in safeguarding children and young people vulnerable to FGM.
- The audit report will be presented to the LSCB Performance, Analysis and Assurance Group (PAAG).

Methodology

The audit process, sample and selection of cases, scope and audit tool was discussed and agreed by the LSCB Lead Audit Commissioners group representatives from the following agencies:

- Clinical Commissioning Group
- Leicestershire Police
- Children Social Care, Safeguarding Unit, Leicester City Council
- Leicestershire Partnership Trust (LPT)
- LSCB office

The audit included accuracy of case details, referrals and response and identification of FGM and underpinning this was the 'voice of the child' and compliance to procedures.

Seven cases were selected from a list supplied by Leicestershire Partnership Trust (LPT) to the LSCB office. Two of the cases were siblings. Not all 7 cases were known to the agencies (other than LPT), and although the sample was small the audit identified good practice and areas for improvement and learning.

The audit was completed by: Safeguarding Unit (Children Social Care); School (Learning Services); Leicestershire Partnership Trust (LPT), Clinical Commissioning Group (CCG), University Hospitals of Leicester (UHL), Leicestershire Police.

Definition of FGM

The World Health Organisation (WHO) defines female genital mutilation (FGM) as: *"all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons"* (WHO, 2014). FGM is physical abuse, and it is also a form of sexual violence.

Internationally FGM is recognised as a violation of the human right s of girls and women.

Legislation

The FGM Act introduced in 2003 came into force in 2004:

- Makes it illegal to practice FGM in the UK;
- Makes it illegal to take girls who are British nationals or permanent residents of the UK abroad for FGM whether or not it is lawful in that country;
- Makes it illegal to aid, abet, counsel or procure the carrying out of FGM abroad;
- Has a penalty of up to 14 years in prison and/or a fine.

The FGM Act 2003 was amended by the Serious Crime Act 2015 and now includes:

- An offence for failing to protect a girl from the risk of FGM
- Extra-territorial jurisdiction over offences of FGM committed abroad by UK nationals and those habitually (as well as permanently) resident in the UK
- Lifelong anonymity for victims of FGM
- FGM Protection Order which can be used to protect girls at risk
- A mandatory reporting duty which requires specified professionals to report known cases of FGM in under 18s to the police.

Conclusion

Although a small number of FGM cases were audited, the audit evidenced variability in relation to the quality of practice.

- Case recording of demographic information remains an issue particularly in relation to recording accurate details and of language, ethnicity and religion.
- The voice of the child/lived experience was lacking within practice. It was unclear whether siblings, cousins and other female members of the family and extended family were spoken to, as there might have been female children within the family and/or community who might have been vulnerable to FGM.
- There was no evidence of contingency planning for children vulnerable to FGM in the future, and a need was identified for direction/guidance from the LSCB and partner agencies on the way forward in relation to this issue.

The audit found that the compliance to LLR LSCB procedures was variable:

- Where strategy discussions took place these were timely and the appropriate practitioners were invited, however, there is need for GPs to be informed and invited to strategy discussions.
- Where FGM was identified/known at GP practices, FGM was recorded on the mother's and child's case notes and alerts noted on the child's case notes.
- Interpreters were not used for all the cases where this was required. However, cultural perspectives were considered by social care in the cases audited by Children's Social Care.
- Within UHL and LPT there was compliance to the practice of routinely questioning women in relation to FGM, but there was a need identified to embed use of the FGM tool in clinical practice in UHL and training of practitioners in LPT to use the FGM tool.
- Children's Social Care did not always provide feedback on the outcome of their decision to the referrals made by partner agencies, and partner agencies did not follow up for feedback when non was received, which showed a lack of compliance to the LLR LSCB multiagency safeguarding procedures.

Recommendations

- Awareness of the LLR LSCB procedures including FGM (and the FGM assessment tool) should be raised by agencies. This should include awareness of the 'Whole family' approach to identify and speak to family and extended family members when undertaking assessments as there might be other female children within the family, extended family and community who might be vulnerable to FGM.
- Partner agencies have in place processes and management oversight to ensure that practitioners within their agencies are compliant with the LLR LSCB multi-agency safeguarding procedures.
- LSCB partner agencies should consider the issue of contingency planning (and guidance) for children where families where FGM has been identified to reduce the risk posed to these children and young people in the future.
- Future FGM audits should be conducted jointly with the LSAB.

Further Information

- LSCB Websites: http://www.lcitylscb.org/ and http://lrsb.org.uk/
- LLR LSCB Multi-agency Safeguarding Procedures: http://llrscb.proceduresonline.com/chapters/contents.html
- LLR LSCB Resolving Practitioner Disagreements and Escalation of Concerns: http://llrscb.proceduresonline.com/chapters/p_res_profdisag.html

Female Genital Mutilation

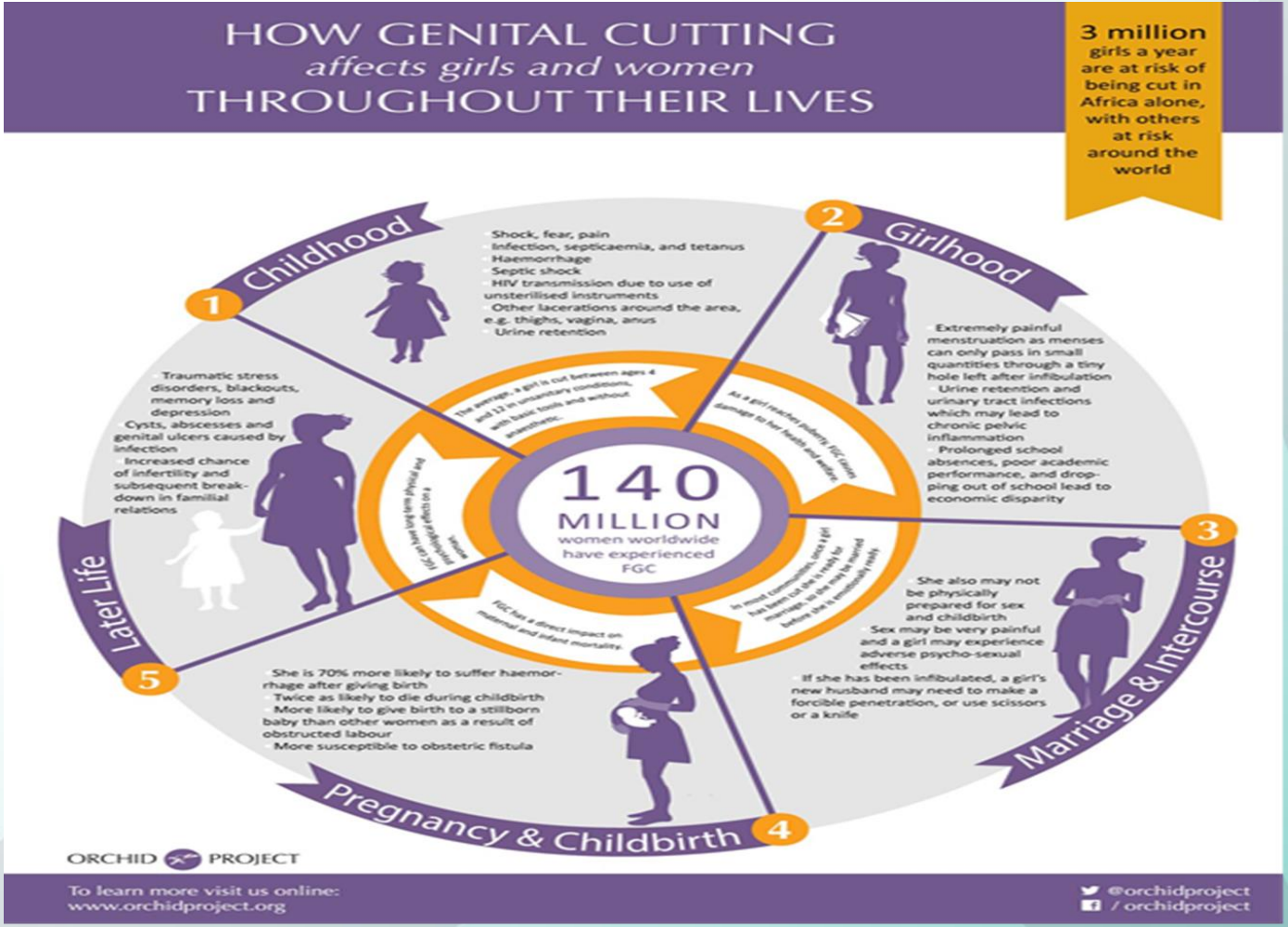
Etain McDermott, Public Health
Nicola Bassindale, Social Care & Education

Leicester City Council

What is Female Genital Mutilation (FGM)

"All procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons"

(World Health Organisation)


HOW GENITAL CUTTING
affects girls and women
THROUGHOUT THEIR LIVES
3 million girls a year are at risk of being cut in Africa alone, with others at risk around the world
1 Childhood
Shock, fear, pain
Infection, septicaemia, and tetanus
Haemorrhage
Septic shock
HIV transmission due to use of unsterilised instruments
Other lacerations around the area, e.g. thighs, vagina, anus
Urine retention
2 Girlhood
Extremely painful menstruation as menses can only pass in small quantities through a tiny hole left after infibulation
Urine retention and urinary tract infections which may lead to chronic pelvic inflammation
Prolonged school absences, poor academic performance, and dropping out of school lead to economic disparity
3 Marriage & Intercourse
She also may not be physically prepared for sex and childbirth
Sex may be very painful and a girl may experience adverse psycho-sexual effects
If she has been infibulated, a girl's new husband may need to make a forcible penetration, or use scissors or a knife
4 Pregnancy & Childbirth
She is 70% more likely to suffer haemorrhage after giving birth
Twice as likely to die during childbirth
More likely to give birth to a stillborn baby than other women as a result of obstructed labour
More susceptible to obstetric fistula
5 Later Life
Traumatic stress disorders, blackouts, memory loss and depression
Cysts, abscesses and genital ulcers caused by infection
Increased chance of infertility and subsequent breakdown in familial relations
140 MILLION
women worldwide have experienced FGC
ORCHID PROJECT
To learn more visit us online:
www.orchidproject.org
@orchidproject
/ orchidproject

Cultural underpinnings / motives

- Brings status and respect
- Preserves virginity/chastity
- Rite of passage
- Social acceptance, especially for marriage
- Upholds family honour
- Cleanses and purifies
- Gives a sense of belonging to the community
- Fulfils a religious requirement believed to exist
- Perpetuates a custom/tradition
- Clean and hygienic
- Cosmetically desirable
- Believed (mistakenly) to make childbirth safer for the infant

Prevalence

- 137,000 women and girls are living with FGM in the UK
- 60,000 girls aged 13 and under are at risk
- Manchester, Slough, Bristol, Leicester and Birmingham have high prevalence rates, ranging from 12 to 16 per 1,000,
- 30 recorded observations of FGM (April 2015 to March 2016), 15 were pregnant women in midwifery services.
- 1,239 or 3.7% of Leicester females aged 0 to 15 were born in regions where FGM prevalence is high
- 9892 or 11.3% of Leicester females aged 16 to 49 were born in regions where FGM prevalence is high

Work to date

- Policy & Procedure
- Awareness raising campaign 2017
- Leicester's Children's Trust Board (LCTB) session

Proposed approach

- Tackling FGM through Behaviour Change
- Community Engagement

Task and Finish Group

Leicester City Council

Leicestershire Police
Protecting our communities

Shama women's centre
educational, social and wellbeing services

Zinthoya
Ganeshpanchan Trust

UNIVERSITY OF LEICESTER

NHS
University Hospitals of Leicester
NHS Trust

NHS
Leicester City
Clinical Commissioning Group

UAVA
UNITED AGAINST VIOLENCE & ABUSE

Panahghar
safehouse.org.uk

Next steps

Actions to be considered:

- Partnership pledge

Ending Female Genital Mutilation in Coventry

Female Genital Mutilation (FGM) is recognised internationally as a violation of the human rights of girls and women. FGM has been proven to have a devastating impact on women's and girl's emotional, physical, and mental health and well-being. That's why together we strongly condemn the practice of FGM.

Our pledge

We will tackle FGM by

- Supporting culture change
- Protecting girls at risk
- Supporting women affected by FGM
- Supporting communities to oppose FGM
- Raising awareness
- Enforcing the law

Signatories

Cllr Ann Lucas,
Leader of the Council

Cllr Allison Gingell,
Chair, County Health & Wellbeing Board

Cllr Phillip Townshend,
Chair, Police and Crime Board

Dr Adrian Canale-Parola,
Chair, County & Rugby Clinical Commissioning group

Janet Mokades,
Chair, Children's Safeguarding Board

Steven Banbury,
Chief Executive,
Voluntary Action County

Claire Bell,
Commander Chief Superintendent
West Midlands Police

Rachel Newson,
Chief Executive,
County & Warwickshire Partnership Trust

Christine McNaught,
Chief Operating Officer
FWT - A Centre for Women

Fadel Takrouri,
Chair, British Arab Federation

Virginia Ringane,
Founder, Celestial Community Organisation

Andy Hardy,
Chief Executive Officer
University Hospital County and Warwickshire

John Latham,
Vice Chancellor,
County University

Dr Sue Ibbotson,
Centre Director,
Public Health England

Joan Beck,
Chair, Adults Safeguarding Board

Next Steps continued

- Prevention through awareness raising, community engagement and training
- Support law enforcement activity
- Review and update safeguarding processes
- Consideration of specialist services and clinics

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE: 28th February 2019

Subject:	Domestic and Sexual Violence and Abuse in Leicester
Presented to the Health and Wellbeing Board by:	Stephanie McBurney and DCI Lucy Batchelor
Author:	Stephanie McBurney

EXECUTIVE SUMMARY:

Domestic and Sexual Violence and Abuse affects large numbers of adults and children in Leicester. It can have a significant impact on the health and wellbeing of those individuals directly involved and the communities around them.

Domestic violence and abuse includes forced marriage, female genital mutilation and so called 'honour based' violence. It can take place between those aged 16 years and over and be within an intimate partner (current or past) or familial relationship.

A 2019 Home Office report estimated the unit cost of domestic abuse to be £34,015. Each domestic homicide is estimated to cost £2.2 million, arising from the cost of harms, health services and lost output. In

Leicester there have been 7[1] domestic homicides since domestic homicide reviews were made a statutory requirement.

Sexual abuse can take place inside or outside of a domestic violence situation. Roughly a third of all sexual offences take place within a setting that would meet the definition of domestic violence and abuse.

Current Picture

Sexual offences and domestic abuse is a priority for many local partnerships due to the high volume and harm taking place. Offences are increasing year on year and there is still a large volume of under-reporting. Research indicates that only 37% of those who have experienced domestic or sexual violence will have told an 'official agency' about it.

Leicester City Council is a lead contributor to specialist independent services for those affected and is a key partner in terms of provision of housing, safeguarding, licensing, community safety and neighbourhood services.

The local specialist voluntary sector provider of services for those affected by sexual and domestic violence is United Against Violence and Abuse Limited (UAVA). This is a co-operative consortium of further specialist organisations with a long-standing history of working with the issues in specific contexts.

UAVA deliver four main services in Leicester; an intervention service for men and women wishing to change their abusive behaviour (perpetrators), a Safe Home Service offering refuge accommodation and housing support, a Children, Young People and Family Service offering individual and group support including respite an creche facilities, and a Support and Information Service, which runs a helpline, group and individual support for anyone affected by the issues across Leicester, Leicestershire & Rutland. 2313 referrals came into these services last year[2].

[1] Another four referrals for a domestic homicide review have been received 2018-19 - criminal justice process not concluded.

[2] 2017-18

Challenges

Domestic and sexual violence and abuse is highly sensitive and personal. The issues carry many implications for victim-survivors, perpetrators and other family members, colleagues, neighbours and friends. The prevalence of judgement and fears of further harm thread through the challenges faced in seeking to reduce it.

These are high volume occurrences, often happening repeatedly and over a prolonged amount of time in what should be trusted and safe relationships.

In general discussion, much emphasis is often placed on the need for the people involved to 'separate', yet this is often the trigger for homicide and no indication that the abuse will stop.

Data can be difficult to collect and analyse but we have a growing understanding in Leicester of the needs and vulnerabilities people are sharing and what makes a difference in terms of services meeting their needs.

What comes through repeatedly from victim-survivors is the need for people to listen and not judge them, and for them to understand the realities and impact of domestic and sexual abuse and violence. People do not want to have to build up the courage to disclose such personal fears and experiences to be then blamed for them, or be told to repeat them to someone else, or be dismissed.

What can be done

Leicester partners are working together with Leicestershire & Rutland to develop an overarching strategic vision. There is also work on undertaking further joint commissions of specialist services.

Leicester has an active Multi-Agency Risk Assessment Conference system, for those victim-survivors identified as at highest risk of homicide or serious injury, aiming to improve the safety of those 'top 5%' of cases.

There is a comprehensive training package for local practitioners provided by UAVA through the four contracts the city council manages. This creates around 800 training spaces each year.

As those affected do not often tell any official agency, even a helpline, we need to reach the friends and family members they might confide in more easily. To this end, the role of community champions becomes very important. Community champions training opportunities are built in to the training programme.

After 'friends and family', health agencies are the most commonly accessed avenue for help and support. We need to make sure that all agencies can provide reassurance that their staff can identify and respond appropriately to domestic and sexual violence and abuse.

UAVA provide support and information to such large numbers of people due to their volunteer base and the other partner agencies working closely with them but many more agencies and individuals need to improve their response to domestic and sexual violence and abuse to make a significant impact on the harm these issues reflect, particularly around prevention.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

1. Note the risks to the health and well-being of people of Leicester that domestic and sexual violence and abuse present and the value of having effective provision.

2. Support awareness raising, identification, better data and more efficient pathways for those affected by sexual and domestic violence and abuse.

3. Establish clear links and accountability with and to the Vulnerabilities Executive in relation to the Domestic and Sexual Violence and Abuse Strategy.

Domestic and Sexual Violence and Abuse Presentation

Leicester Health & Wellbeing Board

February 2019

Stephanie McBurney and DCI Lucy Batchelor

Presentation Outline

- Current Picture
- Challenges
- What Can Be Done
- How the Health & Well-Being Board Can Help

Estimated Number Of People Affected In Our Area Since The Age Of 16

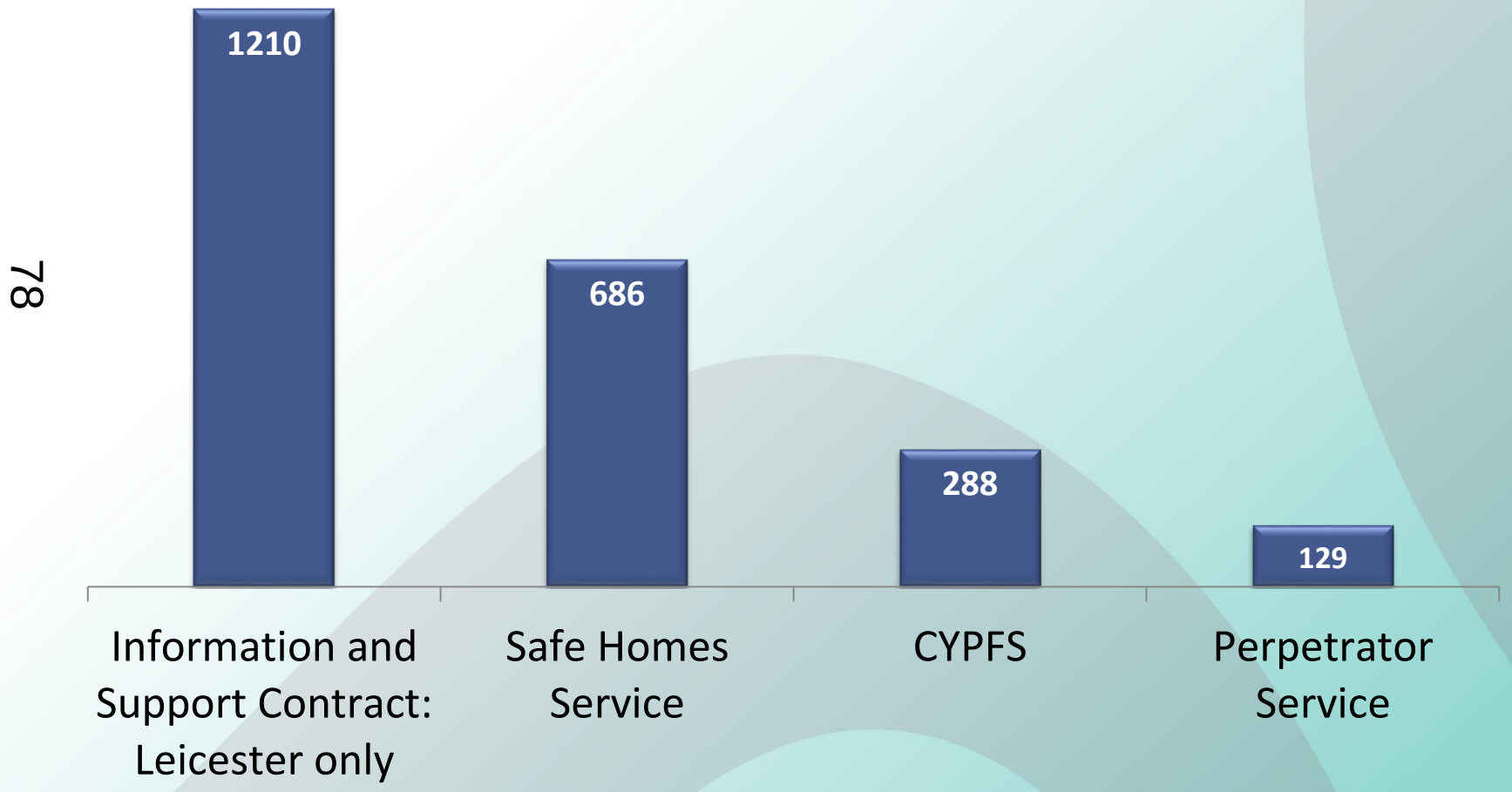
Domestic Violence	Sexual Offences	Total
17,973	5,254	**23,226**
40,462	28,323	**68,785**

- **64%** of adults affected by domestic abuse had children in the household (*Insights Data*). An average of **2 children per household.** Would mean **74,797** children and young people affected in Leicester through exposure/direct impact of parental domestic violence and abuse alone

Crime Survey England and Wales 2018 - Estimates

Leicester City Council

Referrals Received – City Contracts - 2017/18



2017/18 Contract Raw Data and Workbooks

Victim-Survivor Needs Identified

Mental health

41%

Multiple Perpetrators

10%

Housing

54%

Alcohol

5% **9%**

No Recourse Public Funds

25% **10%**

X3.5

Interpreter

14% **4%**

Key: *Red = Leicester figure*
Black = National figure
Where there is only one number – Leicester is equal to the National figure

SafeLives Insights Data 2017/18 – Leicester (n=422)

Leicester City Council

Children Needs/Risks Identified

Sleep Problems

21% 18%

Depression / Anxiety

22% 18%

In trouble with Police

9% 4%

Self Harm

13% 6%

Drugs

5% 1%

Homeless

2% **9%**

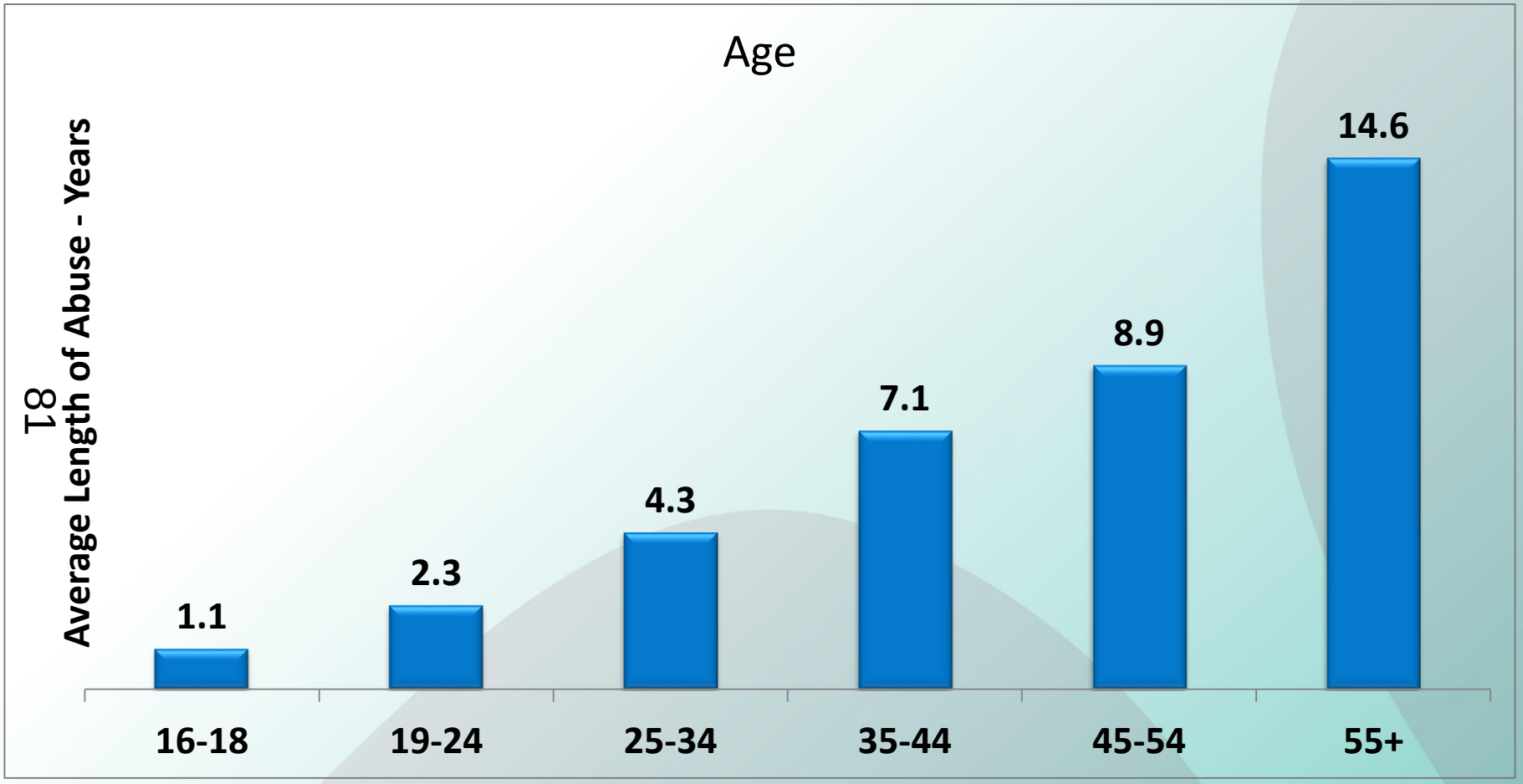
Key:

Red = Leicester figure
Black = National figure
Where there is only one number Leicester is equal to the National figure

Leicester City Council

SafeLives Insights Data - Leicester - 2017/18 (n=92)

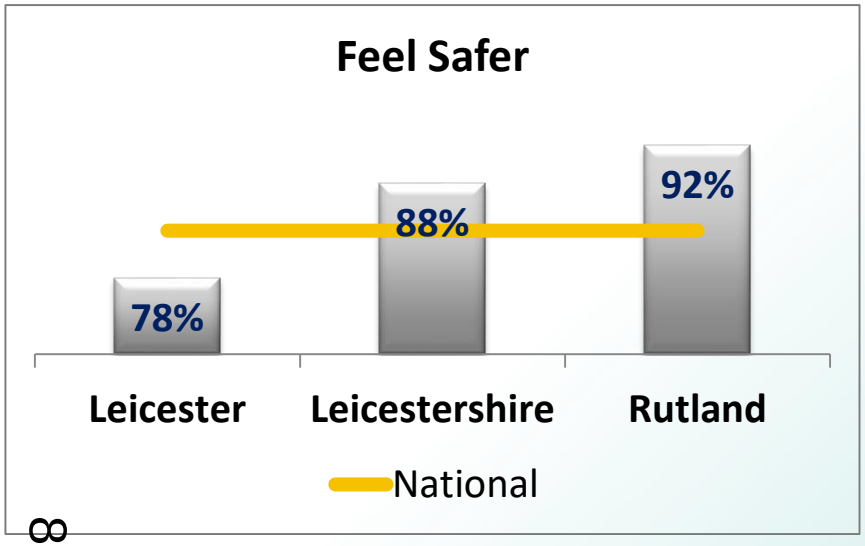
What Can Make A Difference – Age Example

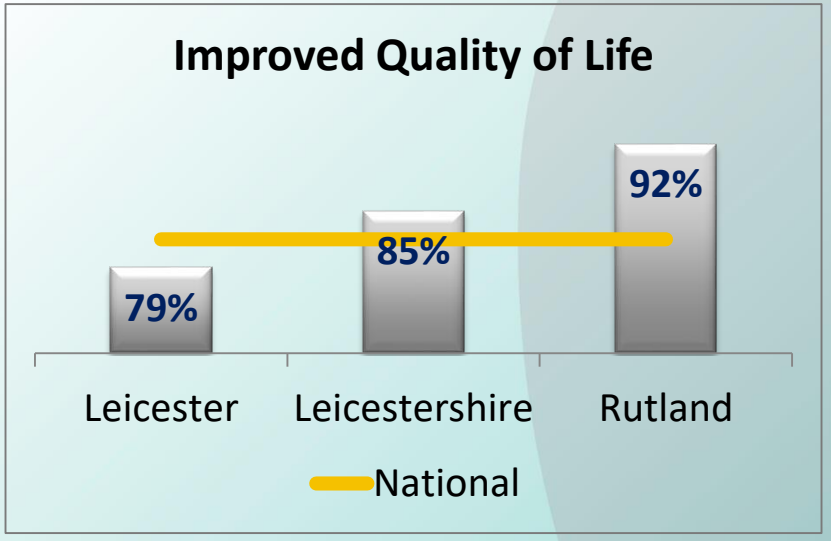


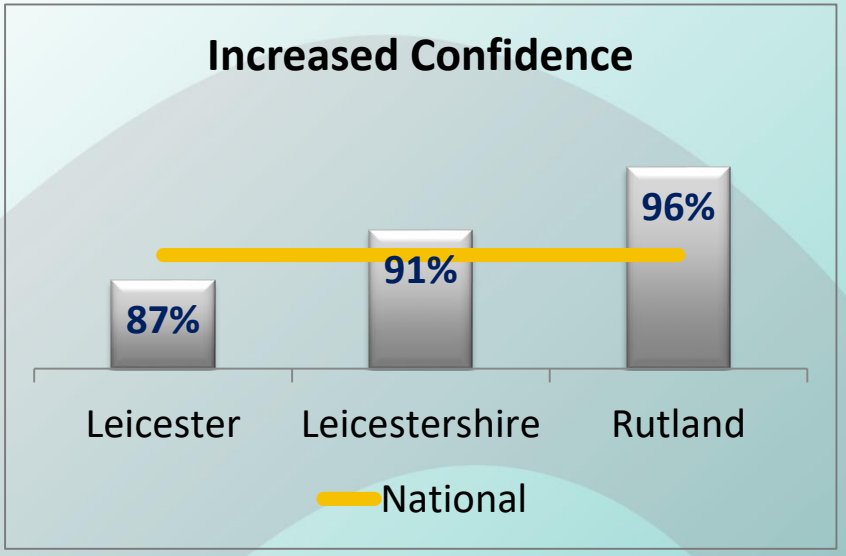
Leicester City Council

SafeLives Insights Data 2017/18 – Leicester (n = 445)

Victim-Survivor Outcomes







SafeLives Insights Data 2017/18 – Leicester (n=235)

Leicester City Council

Voluntary Programme Perpetrator Outcomes

82% of perpetrators reduced the use of abuse behaviour *(n=34)*

96% of perpetrators sustained reduced use of abusive behaviour *(n=24)*

87% partners and ex-partners engaged in support *(n=87)*

Leicester City Council

Perpetrator Workbook Data Returns 2017/18

Service User Voice

I can support my child better emotionally because I understand that the situation wasn't normal

'You & Me Mum Group'

Gave me space to talk without being judged and time to reflect

'Perpetrator Feedback – Intervention Sessions'

Very good course. I wish I had got on the course earlier. It has made me realise how far I have come in the past 12 months and I have been able to let go of some of the historic issues etc.

'Unbroken Feedback'

I would not have known how to leave unless x had kept me going and kept in touch with me. Even when I ignored her, she kept showing me that I was important. I am now in a safer place and can sleep finally

'YPIDVA'

If I didn't have the support, I wouldn't have ever had the confidence to get out and about

'Service User Evaluations'

Thank you for inviting me on this course, your energy and positivity keeps us going and I hope that the other mums can benefit in the way that I have

'You & Me Mum Group'

Leicester City Council

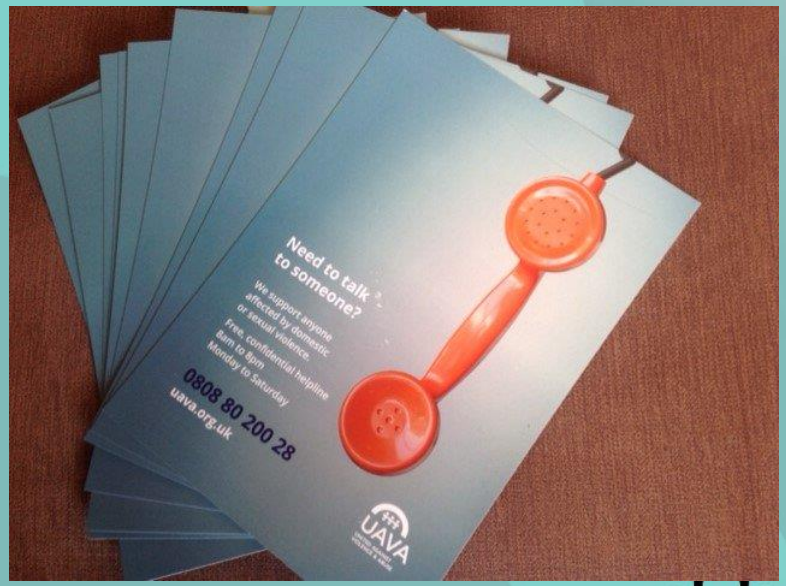
What Can Be Done

Cup sleeves

For events, takeaway cafes

Electrostatic stickers

For toilet doors and washrooms



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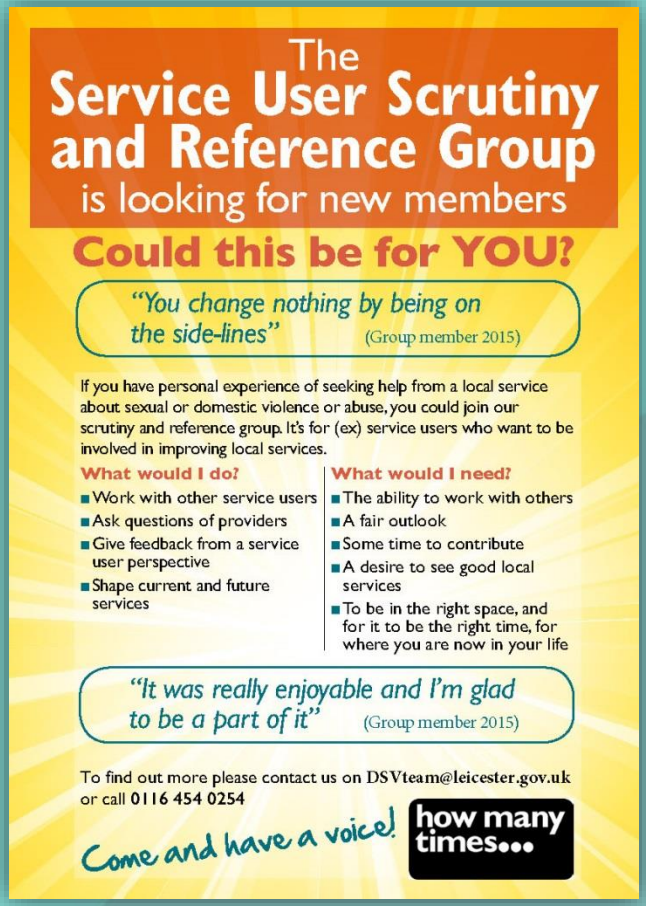
Involvement

Service user group



Community champion training

Leicester City Council

Appendix F

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE: 28th February 2019

Subject:	Delivering on the Armed Forces Covenant (AFC)
Presented to the Health and Wellbeing Board by:	Miranda Cannon – Leicester City Council Director champion for AFC & Co-Chair LLR Civil & Military Partnership Board Supported by: Dr Richard Hurwood - Co-Chair LLR Civil & Military Partnership Board Brendan Daly – Leicestershire Partnership NHS Trust
Author:	Miranda Cannon, Director of Delivery, Communications and Political Governance, Leicester City Council

EXECUTIVE SUMMARY:

The Armed Forces Covenant (AFC) is a national commitment seen as a promise by the nation to ensure that those who serve or who have served in the armed forces, and their families, are treated fairly and with respect.

Local Authorities initially and in more recent years the wider public sector, voluntary sector and private sector organisations have signed local covenants which set out commitments they will make to

supporting the Armed Forces community locally. By the Armed Forces community we mean serving personnel including reservists, service leavers, veterans, and their families. The aim of the covenant is not about preferential treatment, but it is about addressing disadvantage so that Armed Forces personnel get the same treatment and access to services as the civilian community.

The presentation aims to cover how as partners locally we are currently supporting the Armed Forces Community and delivering on our commitments made under the Armed Forces Covenant. We want to seek the support of the Health and Wellbeing Board in both raising awareness and contributing to the ongoing work. The presentation will cover:

- What the AFC is about and how it is put into practice
- What we know about the Armed Forces community nationally and locally
- How we are working in partnership to support the Armed Forces Community
- Health and wellbeing in relation to the Armed Forces community
- Areas for the Board to consider

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- Confirm their support in raising awareness of the Armed Forces Covenant and of the needs of the Armed Forces Community;
- Consider ways in which the Board can help with the aim of reducing under-reporting and improving the collection and use of relevant data including in the Board's own needs assessments;
- Confirm how they would like to be made aware of the work of the LLR Civil and Military Partnership Board going forward;
- Help in promoting the veteran friendly GP accreditation scheme within primary care; and
- Include consideration of the Armed Forces Community in relevant health and well-being projects and programmes for example within the ongoing Time to Change and Start a Conversation campaigns.

Delivering on the Armed Forces Covenant

Presentation to Leicester City
Health and Wellbeing Board

Miranda Cannon – Director champion for AFC & Co-Chair LLR Civil & Military Partnership Board

Leicester
City Council

Armed Forces Covenant (AFC)

What is the AFC?

- A promise by the nation
- Reflected in local Covenant commitments
- Addressing disadvantage so armed forces personnel, past and present, get the same treatment and access to services as the civilian community
- UK-wide Strategy for Veterans published Nov 2018. Consultation open until 21 Feb to support implementation
- Armed Forces Covenant Fund - £10m p.a.

Armed Forces Covenant in practice

Local commitments by organisations vary but can include:

- Access and provision of services eg housing, healthcare, schools
- Supporting employment eg veterans and service leavers, reservists
- Working with and supporting cadet forces
- Discounted services
- Raising awareness and supporting community engagement
- Working in partnership
- Celebrating the contribution of the Armed Forces

Leicester City Council

Armed Forces community

- Data gaps and under-reporting - 2021 Census to include veterans.
- Covenant-funded ‘Map of Need’ in development
- In 2016*estimated 2.5million UK Armed Forces Veterans across Great Britain (approx. 5% of household residents aged 16+ in England)
  - 98% white
  - 90% male
  - 63% aged 65 or over
  - 92% veterans compared to 89% non-veterans have a qualification but less likely to be at degree level (20% versus 30%)
  - 78% working age veterans in employment compared to 79% non-veterans
  - 75% veterans own their own home compared to 77% non-veterans

** Based on ONS annual population survey*

Leicester City Council

Armed Forces Community locally

Locally based / connected regiments and facilities include:

- Chetwynd Barracks, Chilwell - 7th Infantry Brigade / HQ East ‘The Desert Rats’
- Kendrew Barracks, Cottesmore – Royal Anglian Regiment, Royal Logistic Corps, Princess of Wales's Royal Regiment
- Melton Defence Animal Training Regiment including Canine and Equine Training Squadrons, Veterinary Training Squadron
- Army Reserves incl Medical Regiment, Royal Logistic Corps, Royal Yeomanry, Royal Anglians
- Army Reserve Centres eg Ulverscroft Rd, Glen Parva, Loughborough
- Defence and Medical Rehabilitation Centre in Stanford Hall, Rushcliffe
- Local cadet forces across LLR and localised facilities eg cadet detachment huts etc

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Armed Forces Community in Leicester

In East Midlands veterans estimated to make up 6-8% of population (i.e. 14,000 – 19,000)

Some local indications of numbers in the city:

- School census identified 7 children for service pupil premium
- 20 registered service voters on the Electoral register
- 4 applications on the housing register and 1 housed in 2018
- No rough sleepers identifying as veterans
- 155 veterans from Leicestershire in HM Prisons
- 888 Veterans received payments under the Armed Forces Compensation Scheme

***But*.....does everyone declare their Armed Forces service??**

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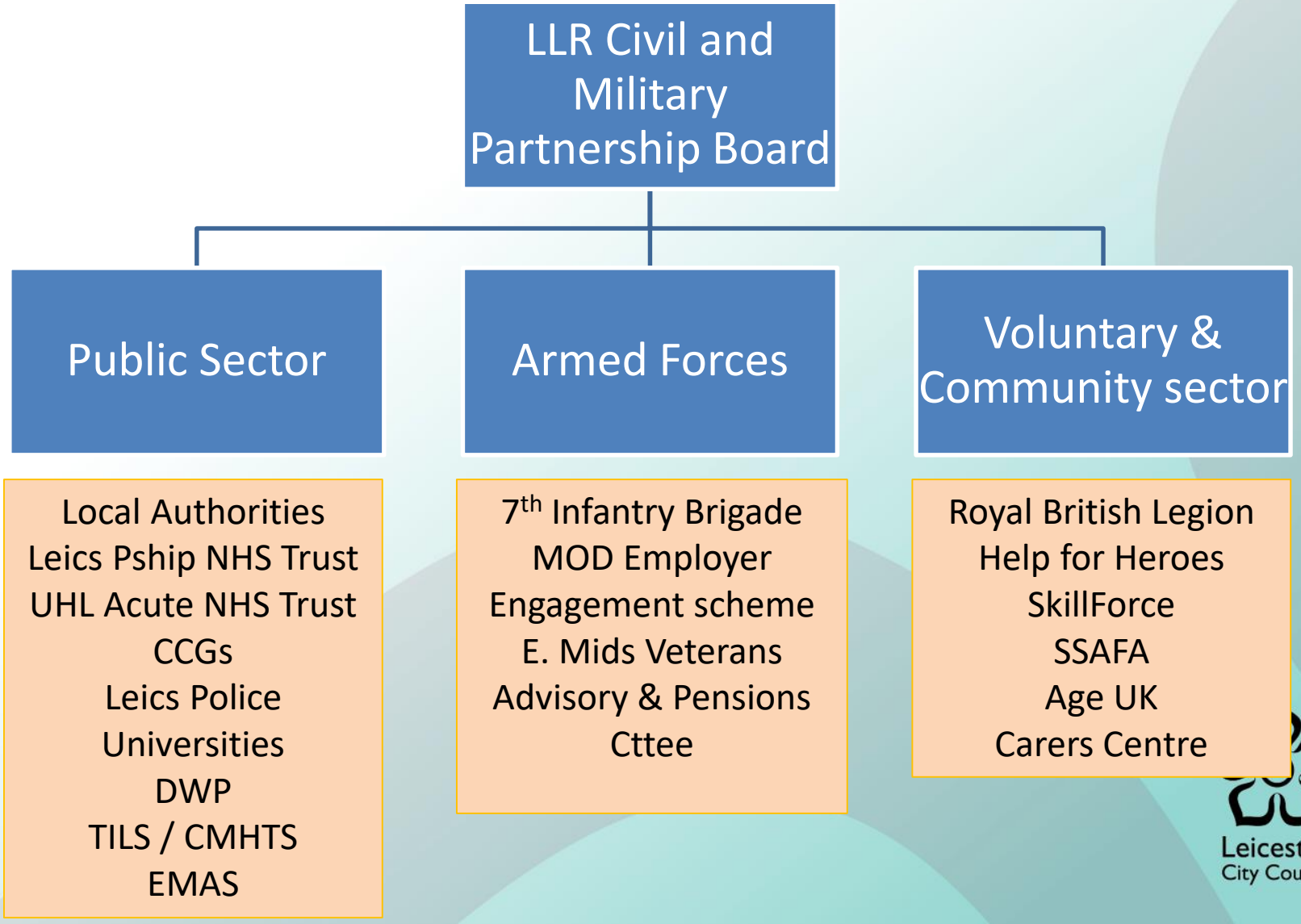
Working in partnership



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Armed Forces & health needs

- Evidence from Govt/ONS suggests Veterans' health and wellbeing is generally consistent with – or better than – the rest of the population?
- PTSD prevalence broadly comparable to general population as is common mental disorder?
- KCL research suggests conflicts in Iraq and Afghanistan may have led to an increase in PTSD - 9% compared to 5% for those not deployed.
- Early service leavers (<4 yrs), deployed reservists, combat troops, those with pre-existing risk factors - all at increased risk
- Suicide and self-harm rates reportedly lower than UK general population except males under 20 which are equivalent to
- *Implications of public perception and stigma?*
- *Only 25 – 50% who need help actually seek it?*

Leicester City Council

Armed Forces & health provision

- National strategies: Defence People Health and Wellbeing and Defence People Mental Health and Wellbeing
- Priority access for service-related conditions subject to clinical need
- Specific GP coding at registration for veterans
- ‘Veteran friendly GP practices’ - Military Veteran Aware Accreditation
- Veterans and Armed Forces issues now part of the GP curriculum
- Veterans Trauma Network
- Transition, Intervention and Liaison Service (TILS) and Complex Mental Health Service
- Veterans Gateway support and signposting

Leicester City Council

Health and Wellbeing Board support

- Links with Civil and Military Partnership Board
- Awareness raising especially primary care
- Promotion of the veteran friendly GP accreditation scheme
- Addressing data gaps and under-reporting
- Consideration of Armed Forces needs and provision as part of wider needs assessments and activity eg Time to Change and Start a Conversation campaigns
- Wider preventative activity eg social prescribing, role of sport

Leicester City Council

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE: 28th February 2019

Subject:	Leicester Health and Wellbeing Survey 2018
Presented to the Health and Wellbeing Board by:	Nicola Moss and Joe Wheeler (Ipsos Mori)
Author:	Gurjeet Rajania, Public Health Intelligence Analyst Matthew Curtis, Research Officer

EXECUTIVE SUMMARY:

Background

The Leicester Health and Wellbeing Survey 2018 provides a snapshot of health and wellbeing issues for the Leicester population (aged 16 and over). The survey was undertaken by Ipsos MORI on behalf of Leicester City Council. It follows previous health and wellbeing surveys carried out in the city in 2010, 2015 and 2016 (children and young people). The report will be made available on the Leicester City Council website and data will be shared via the Leicester Open Data Platform.

A key purpose of the survey is to monitor health inequalities across the city and help identify those who are most in need. The survey informs both strategic and specific need assessments; essential for commissioning by the council and partners' and for policy making for improved health and wellbeing.

The survey was completed by Ipsos Mori working closely with staff from the Division of Public Health. Mori surveyed 2,224 residents aged 16 and over in Leicester between March and July 2018. Quotas were set to ensure the sample was representative of Leicester's population. Further details about the methodology of the survey are included in the report.

Results

Overall the survey shows a more positive picture of health and wellbeing since the previous survey in 2015. Residents are more likely to rate their health as good, want to make healthy lifestyle changes, and accept personal responsibility for their own health. Most residents are positive about their local area, parks and home. There are fewer physically inactive residents in the city and more are regularly walking and cycling. Most residents would ask for support if they were faced with personal or financial difficulties.

The survey also identifies several health and wellbeing challenges facing Leicester residents. Half of city residents are classed as overweight or obese, one in five smokes, and one in ten are physically inactive. Further analysis reveals that it is our most vulnerable groups who are more adversely affected. The most deprived, those with a long-term health condition and those with poor mental health are more likely to have poor health and wellbeing experiences.

Contents

The 'Executive summary' and 'Groups of interest' provide an overview of the results, followed by sections on:

- Health in general
- Diet & healthy eating
- Physical activity
- Smoking
- Alcohol Use
- Mental health and wellbeing
- Carers/caring responsibilities
- Financial
- Local area.
- Your home

Dissemination

Results have been presented to:

- Public Health DMT and LMB
- Joint Integrated Commissioning Board (JICB)
- City Development and Neighbourhoods DMT
- City Mayor Briefing
- Children's Trust Board
- Leicester City CCG Governing Body (Development Session)

The survey report is available on the Leicester City Council website: https://www.leicester.gov.uk/your-council/policies-plans-and-strategies/health-and-social-care/data-reports-information/leicester-health-and-wellbeing-surveys/

It has been circulated widely.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- Receive and provide comment on the attached report
- Support dissemination, consideration and use of the survey results

Attachments:

1. Leicester Health and Wellbeing Survey Report 2018
2. Ipsos Mori presentation of survey findings.

Leicester Health & Wellbeing Survey 2018

101

Presentation prepared for Leicester City Council

Nicola Moss & Joe Wheeler, Ipsos MORI North

February 2019

This work was carried out in accordance with the requirements of the international quality standard for market research, ISO 20252

2,224 residents gave us their views

Health in general

Lifestyle choices

Impact of where they live

At a glance…what is going well?

Since 2015, more residents….

- Rate their health as good
- Accept personal responsibility for their health
- Are making healthy lifestyle changes

High levels of satisfaction with…

- Parks, waterways and green space
- The local area
- The home

Physical activity has increased…

- Particularly walking and cycling

At a glance…the challenges

→Since 2015 move towards….

- Fewer GP visits
- More A&E visits

50% of residents are overweight or obese BUT…

- Most think they have a healthy diet
- Only 20% get their '5 a day'

1 in 5 currently smoke

70% of residents do not have a bike…

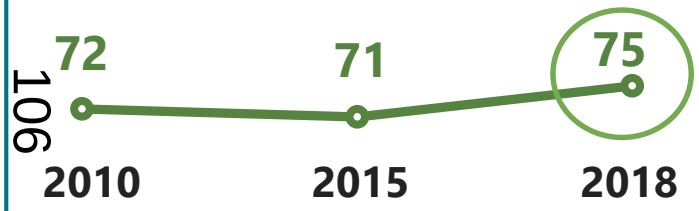
- Most have not used a cycle route
- Half of residents are concerned with air quality

Increased number of residents with a poor mental health & wellbeing score

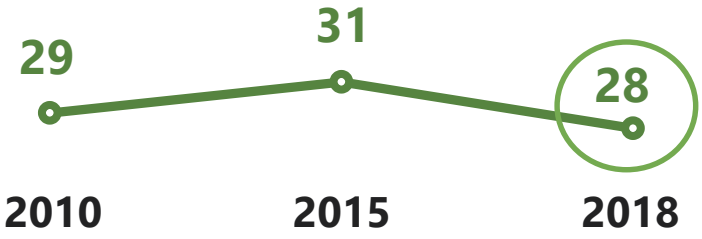
HEALTH OVERALL

More residents rate their health as good

My health in general is good



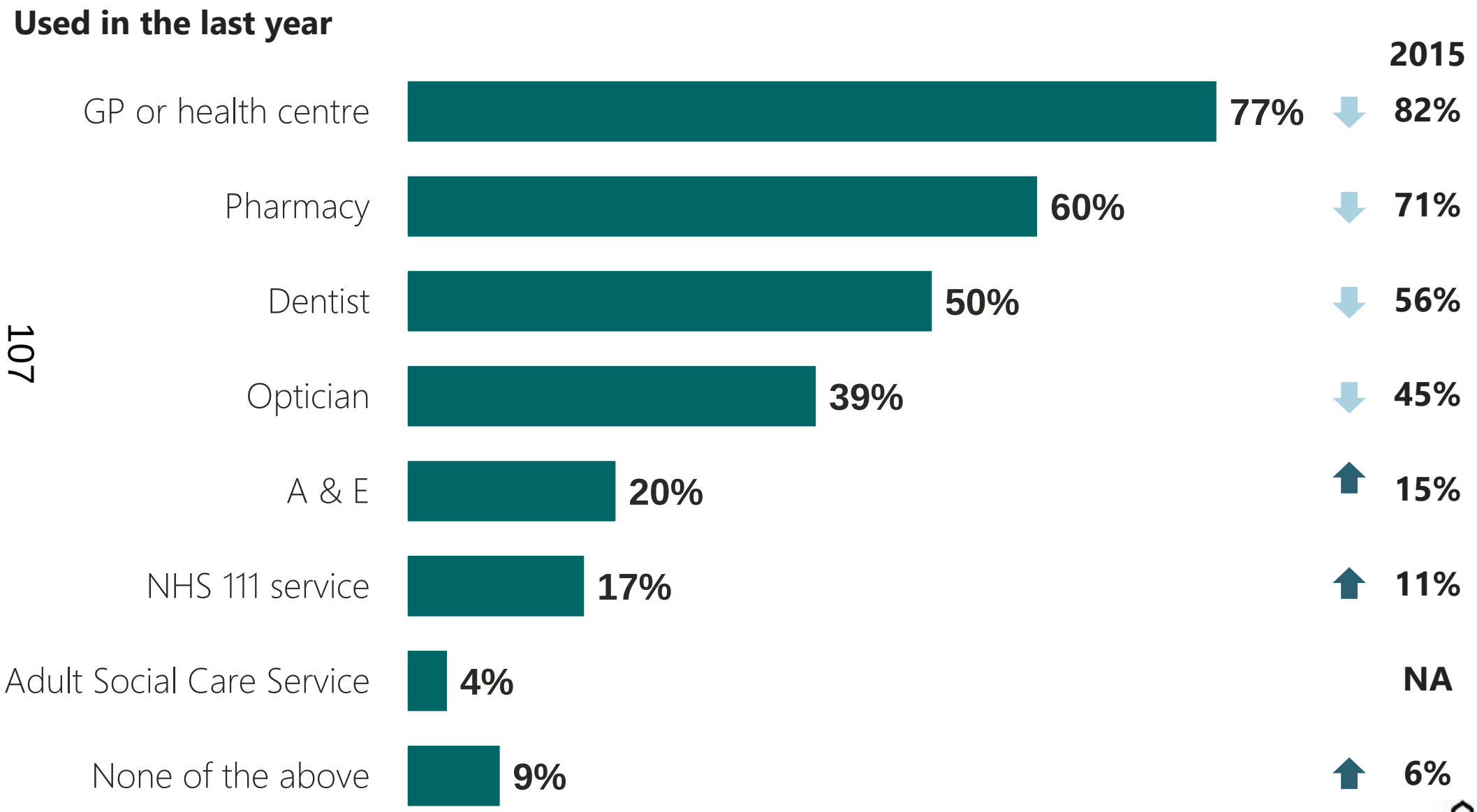
I have a long standing illness, disability or infirmity



18% of the population has a life limiting disability

Leicester City Council

Use of A&E and NHS 111 has increased

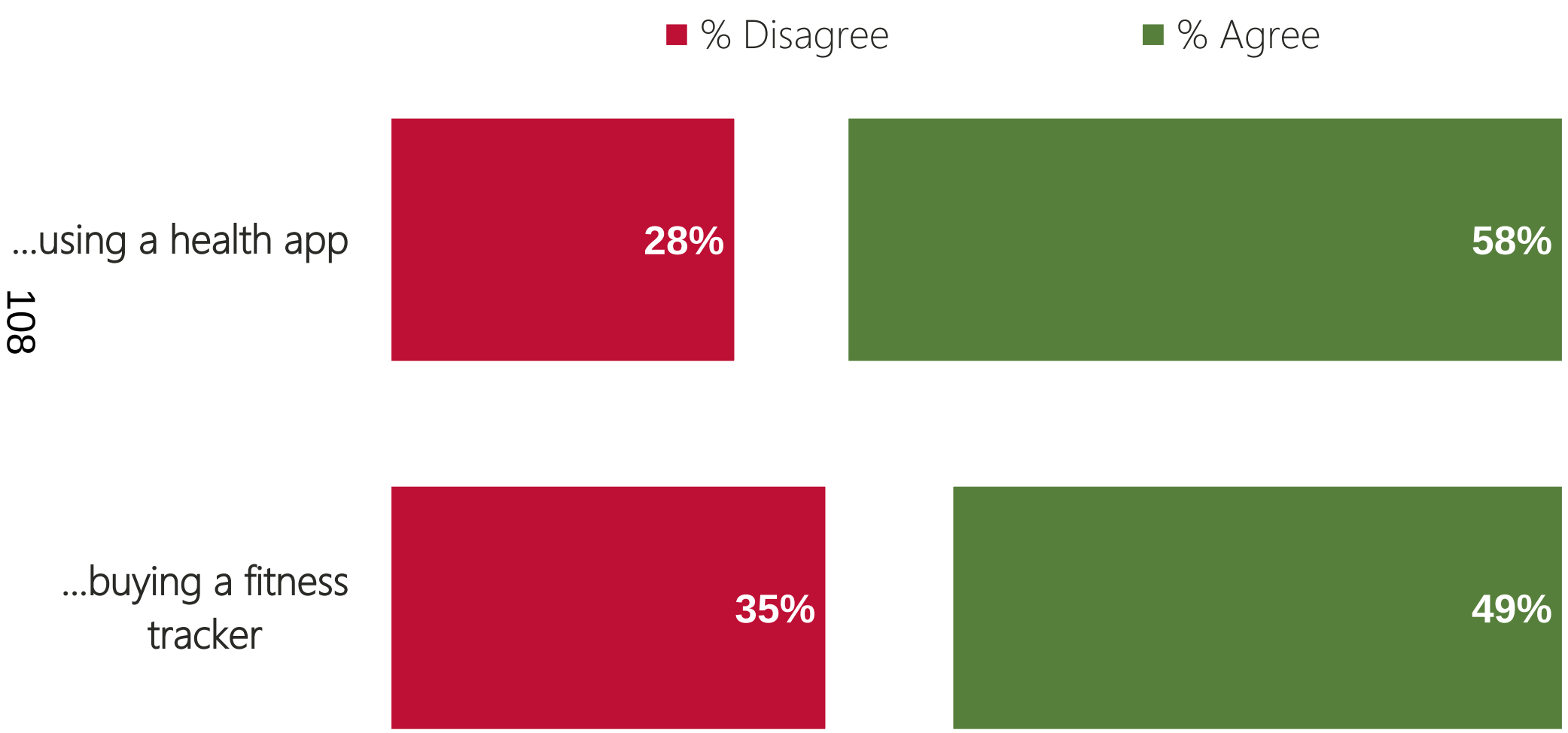


Base: All valid responses (2224) : Fieldwork dates : 5th March – 25th July 2018

Source: Ipsos MORI

The majority do not use health tech…but would consider it

If recommended by a GP or health care professional



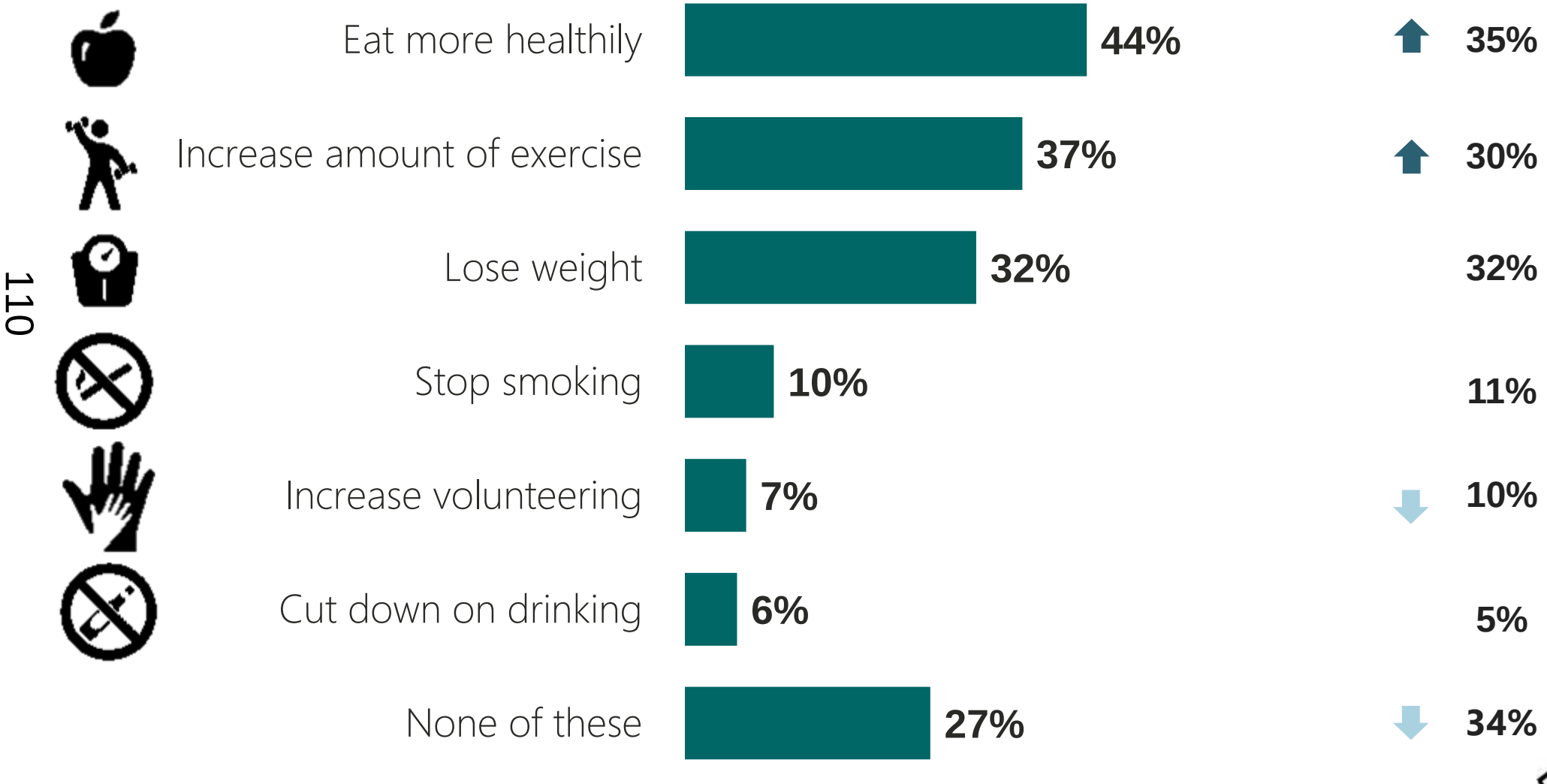
Base: All valid responses (2224) : Fieldwork dates : 5th March – 25th July 2018

Source: Ipsos MORI

LIFESTYLE CHOICES

More say that a better diet and more exercise is planned

Over the next 6 months

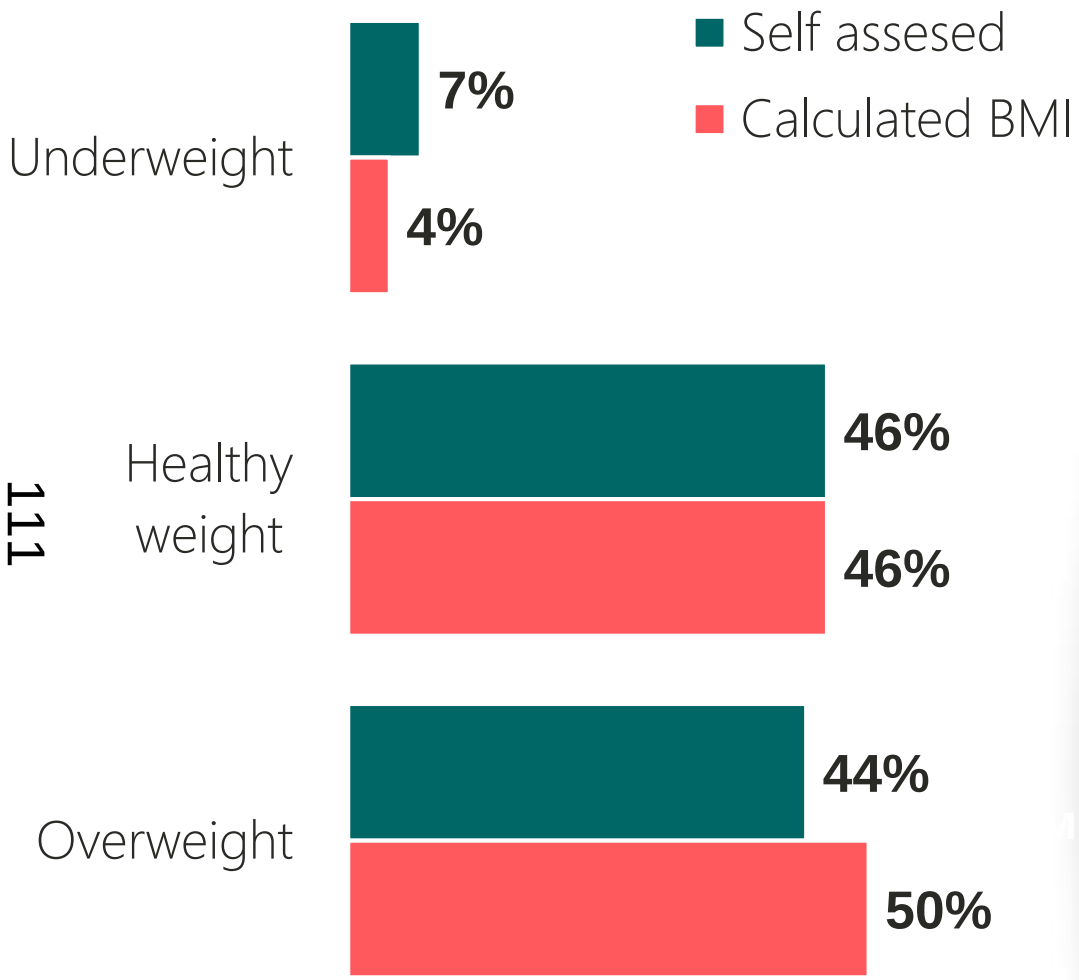


110

Base: All valid responses (2224) : Fieldwork dates : 5th March – 25th July 2018

Source: Ipsos MORI

Generally residents are realistic about their weight



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Average BMI
Leicester 26.2 **National 27.3**

Source: Ipsos MORI

But misinterpret a ‘healthy diet’

87% believe they have a healthy diet

Only 21% eat their 5-a-day

National average 26%

39% eat fast food at least once a week

Alcohol consumption has fallen

51%
Never drink alcohol

45% 2015

East Midlands 13.5
National average 15.5

9% exceed the recommended limit

More likely to be

Men
Aged 65+
No religion/belief
White British residents
Who report to be in poor health

Overall, smoking prevalence remains static

Higher prevalence among…

20 – 24 yr olds
25 - 34 yr olds

Men

White British
White other

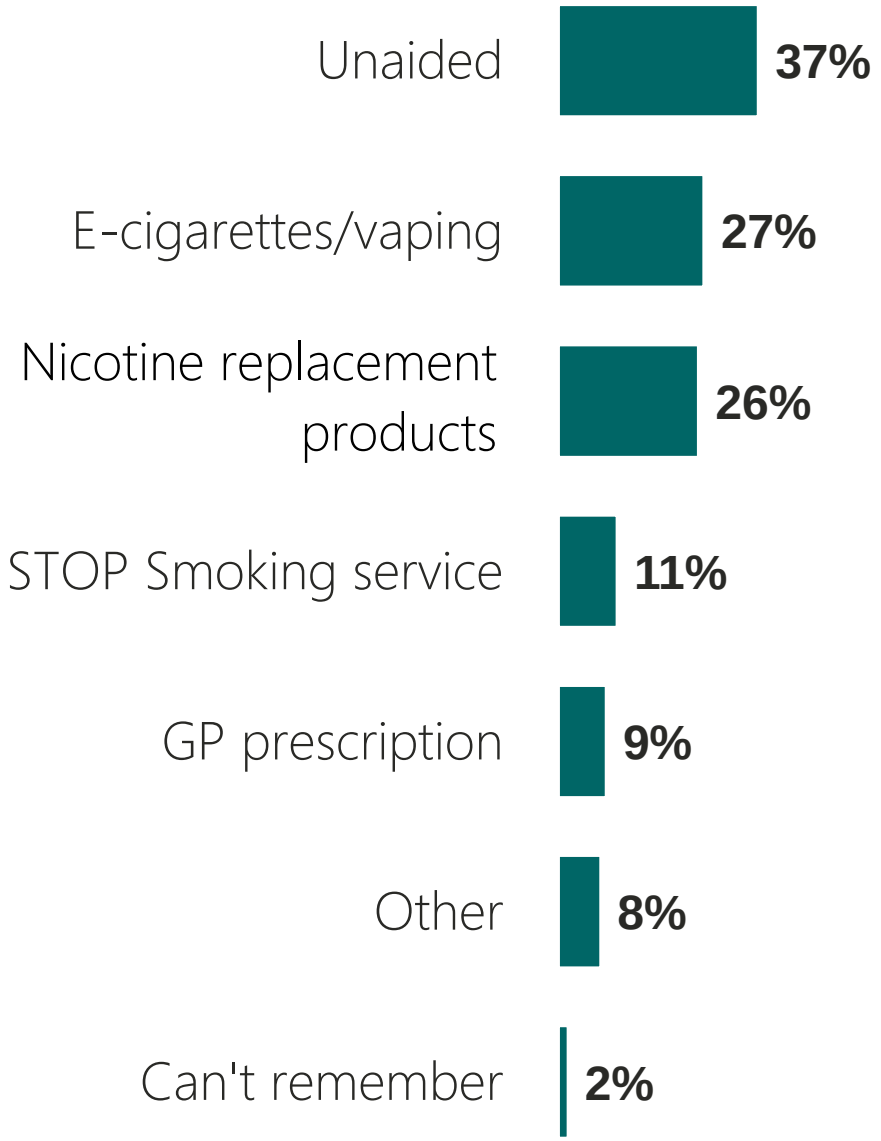
Unemployed
Sick/disabled

59% would like to give up smoking

115

73%

Have tried to stop smoking

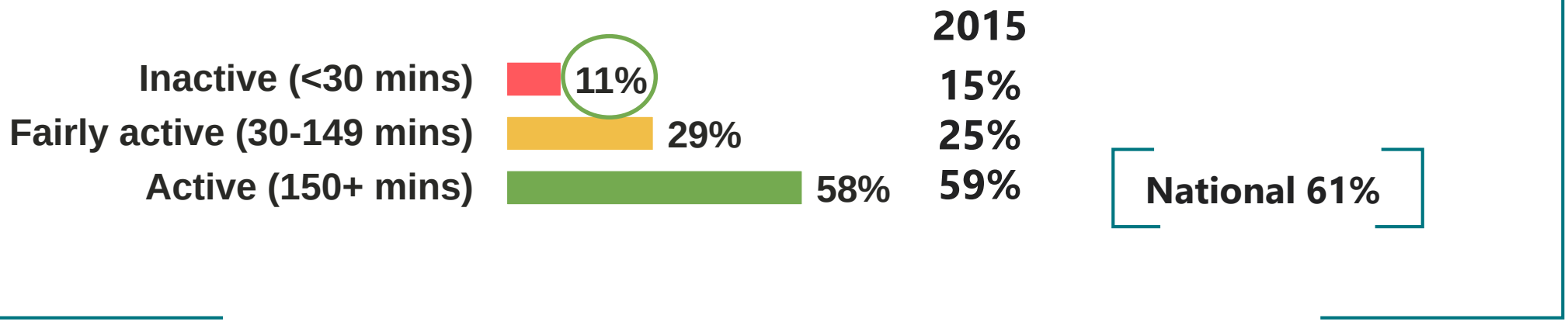


Base: Q33. All valid responses who currently smoke cigarettes or other tobacco products (479); Q33a. All valid responses who currently smoke but have tried to quit smoking (354) : Fieldwork dates : 5th March – 25th July 2018

Source: Ipsos MORI

Leicester City Council

Inactivity has decreased



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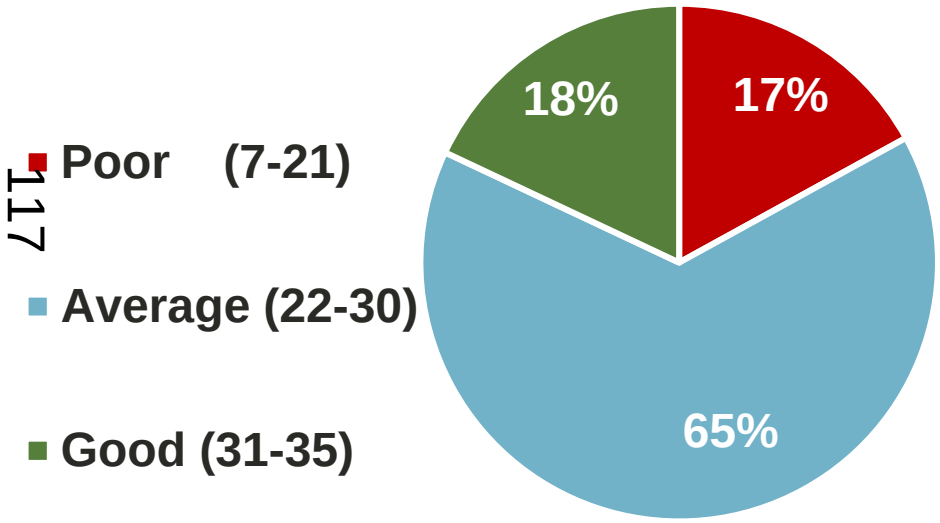
Grown in popularity

- Jogging/running
- Cycle for travel
- Yoga/pilates
- Sports
- Heavy gardening

Increase in poor mental health & wellbeing



14% scored 'poor' in 2015

Close relationship between poor mental health and wellbeing and social isolation

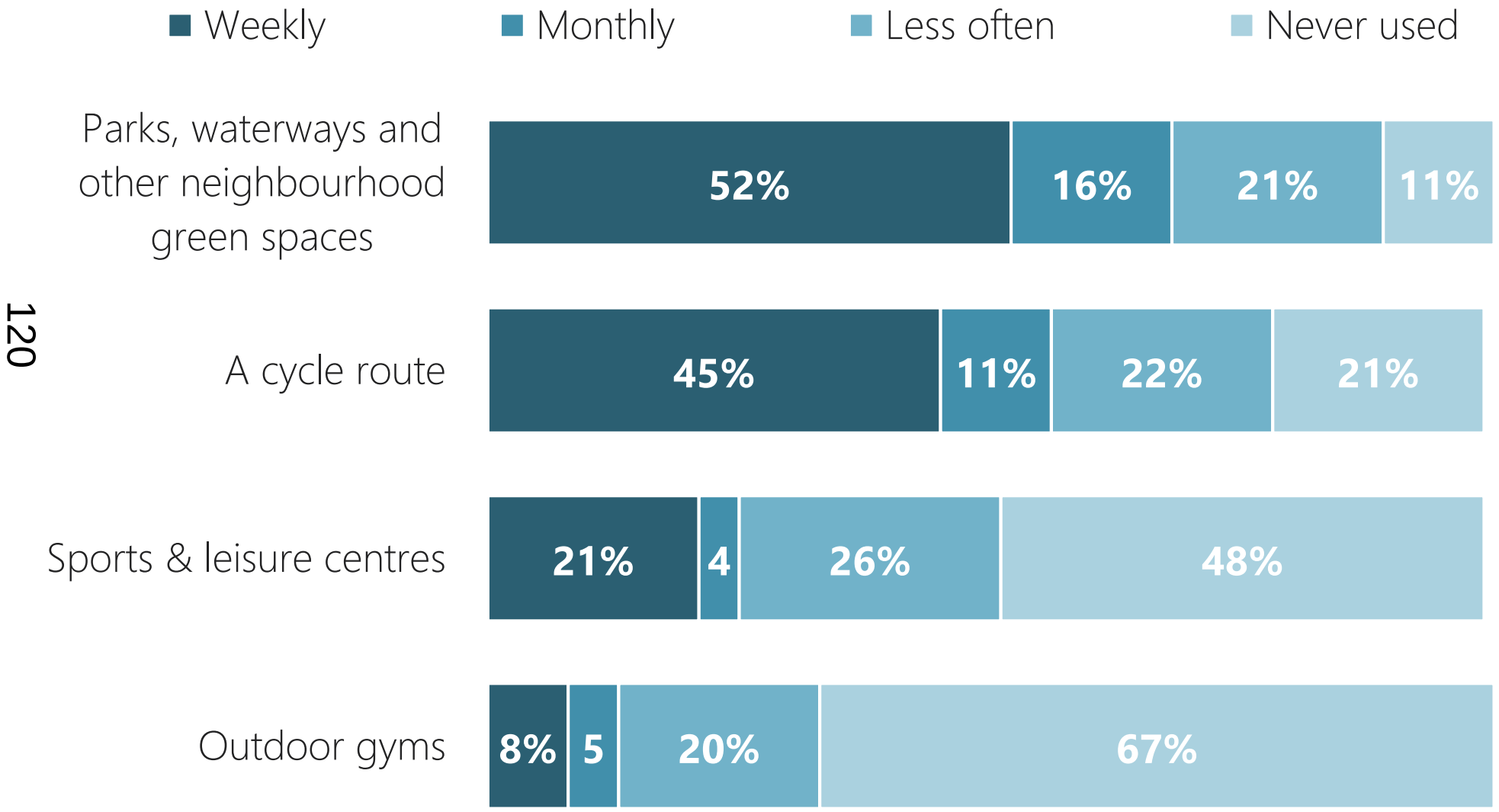
	Mental health and well-being score		
Feel…	**Poor**	**Average**	**Good**
…excluded, lonely or alone	**30%**	**8%**	**5%**
…that you lack companionship	**21%**	**9%**	**3%**
…left out of activities/events that you would enjoy or like to go to	**22%**	**9%**	**5%**
…isolated from others	**22%**	**5%**	**3%**

Base: All valid responses (2224) : Fieldwork dates : 5th March – 25th July 2018

Source: Ipsos MORI

IMPACT OF THE ENVIRONMENT ON HEALTH

More than half of residents use green spaces at least once a week



120

Base: All valid responses (2224) : Fieldwork dates : 5th March – 25th July 2018
*Base: All those who use a bicycle (445)

Source: Ipsos MORI

Leicester City Council

Some residents are more frequent users

	Outdoor gyms	Cycle routes	Sports and leisure centres	Green spaces
Men	✓	✓	✓	✓
Aged 16-19	✓			
Aged 16-34			✓	✓
Private renters	✓		✓	✓
Children in household	✓			✓
Living alone		✓		
Non-disabled residents	✓		✓	✓
North	✓			
West		✓	✓	✓
Central			✓	

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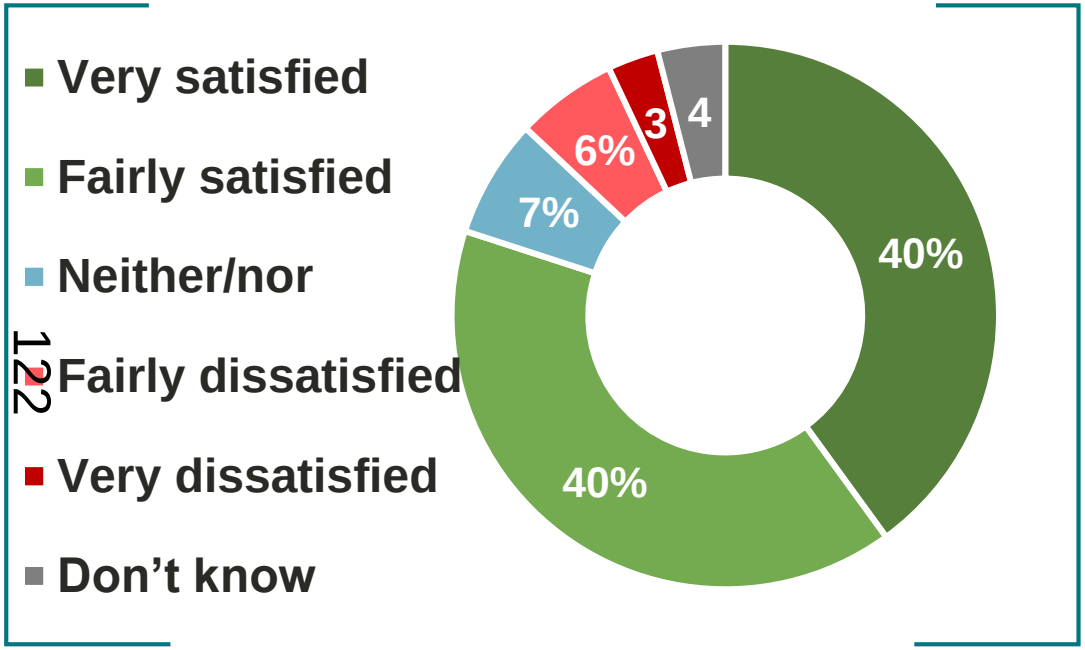
Base: All valid responses (2224) : Fieldwork dates : 5th March – 25th July 2018

Source: Ipsos MORI

80% are satisfied with the quality of green space in Leicester



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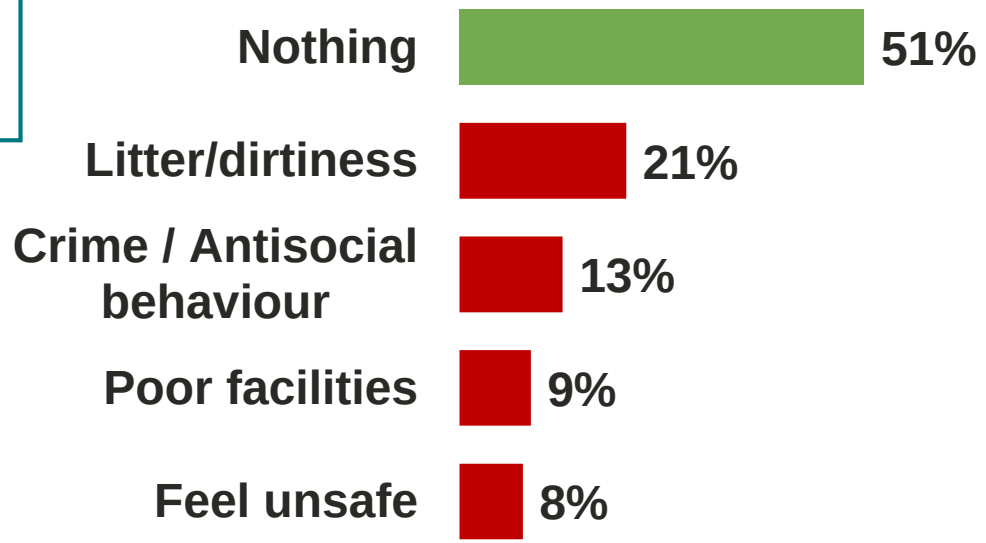
51% say no improvements needed



Cycle routes are being used in the West part of the city

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54%

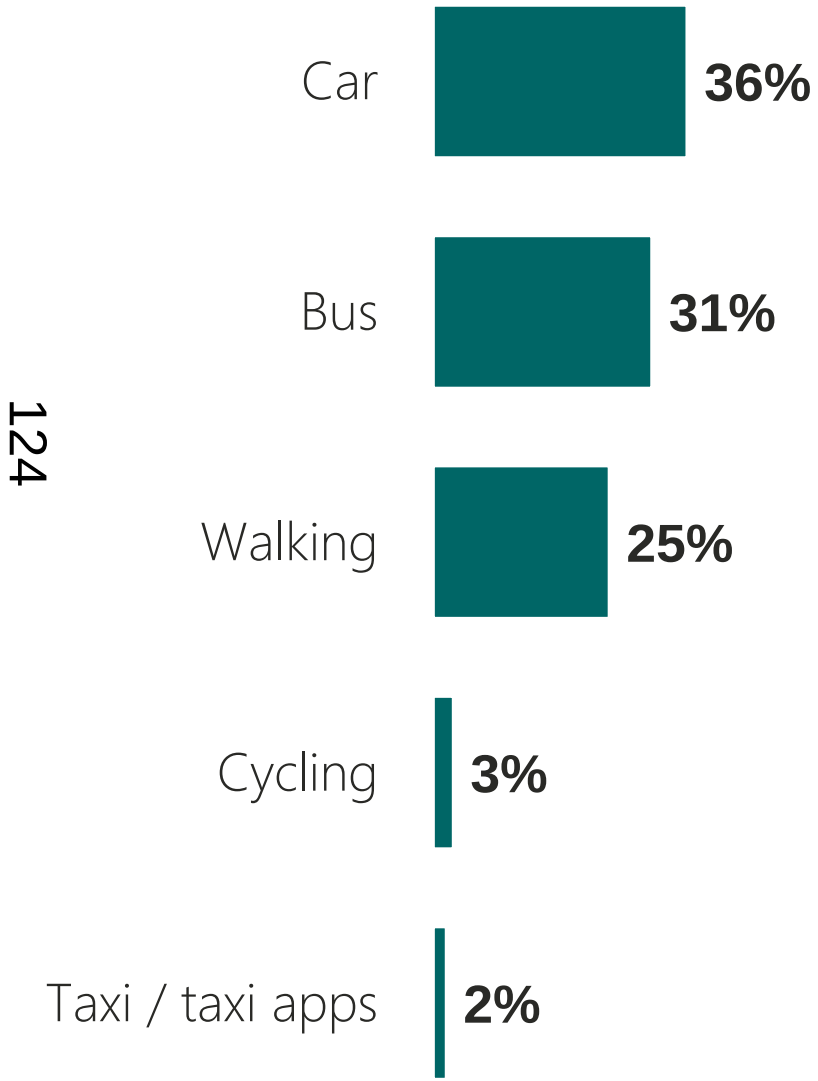
27%

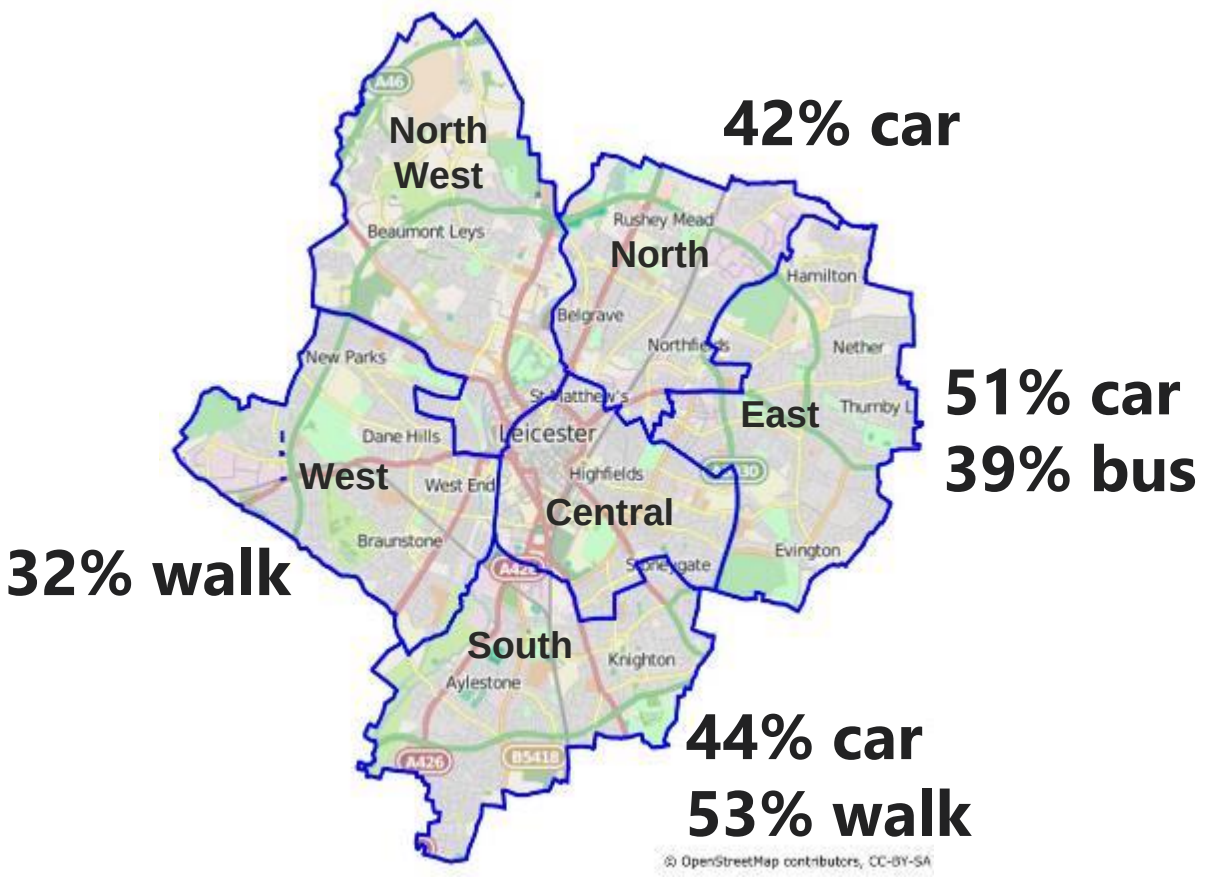
Base: All valid responses (2224) : Fieldwork dates : 5th March – 25th July 2018

38% active travel (walking or cycling)

Source: Ipsos MORI

But the car is the most common means of reaching the city centre





Base: All valid responses (2224) : Fieldwork dates : 5th March – 25th July 2018

* Personal transport refers to usage of car, taxi and motorcycles combined

Source: Ipsos MORI

Leicester City Council

...and we have all this data by groups of interest

Risk factor	Long-term condition	65+ years	White British	Social tenants
Currently smoke	●	●	●	●
Less than 150 mins exercise per week	●	●		
High BMI	●	●	●	●
Drink alcohol more than recommended limit		●	●	
Poor mental wellbeing	●	●		●
Always/mostly run out of money be end of month	●	●	●	●

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ANY QUESTIONS?

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Over to you

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