Leicestershire County Council

Meeting: **Health Overview and Scrutiny Committee**

Date/Time: **Wednesday, 20 January 2016 at 2.00 pm**

Location: **Sparkenhoe Committee Room, County Hall, Glenfield**

Contact: **Mrs. R. Palmer (0116 305 6098)**

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Membership

Dr. S. Hill CC (Chairman)

Mrs. R. Camamile CC	Mr. J. Kaufman CC
Mrs. J. A. Dickinson CC	Mr. W. Liquorish JP CC
Dr. T. Eynon CC	Mr. J. Miah CC
Dr. R. K. A. Feltham CC	Mr. A. E. Pearson CC

Please note: this meeting will be filmed for live or subsequent broadcast via the Council's web site at http://www.leics.gov.uk/webcast – Notices will be on display at the meeting explaining the arrangements.

AGENDA

Item		Report by	
1.	Minutes of the meeting held on 11 November 2015.		(Pages 5 - 12)
2.	Question Time.		
3.	Questions asked by members under Standing Order 7(3) and 7(5).		
4.	To advise of any other items which the Chairman has decided to take as urgent elsewhere on the agenda.		
5.	Declarations of Interest.		
6.	Declarations of the Party Whip in accordance with Overview and Scrutiny Procedure Rule 16.		

7.	Presentation of Petitions under Standing Order 36.		
8.	Medium Term Financial Strategy 2016-17 - 2019-20.	Director of Public Health and Director of Corporate Resources	
9.	Urgent and Emergency Care Update Winter Performance and Vanguard.	West Leicestershire Clinical Commissioning Group, University Hospitals of Leicester NHS Trust and East Midlands Ambulance Service.	(Pages 13 - 42)
10.	Update of Progress of Actions Related to the Care Quality Commission Inspection at Leicestershire Partnership NHS Trust.	Leicestershire Partnership NHS Trust	(Pages 43 - 48)
11.	Health Performance Update.	Chief Executive and GEM Commissioning Support Performance Service	(Pages 49 - 62)
12.	Sexual Health Needs Assessment and Draft Leicestershire Sexual Health Strategy 2016-19.	Director of Public Health	(Pages 63 - 114)

13. Date of next meeting.

The next meeting of the Committee is scheduled to take place on 30 March 2016 at 2.00pm.

14. Any other items which the Chairman has decided to take as urgent.

QUESTIONING BY MEMBERS OF OVERVIEW AND SCRUTINY

Members serving on Overview and Scrutiny have a key role in providing constructive yet robust challenge to proposals put forward by the Cabinet and Officers. One of the most important skills is the ability to extract information by means of questions so that it can help inform comments and recommendations from Overview and Scrutiny bodies.

Members clearly cannot be expected to be experts in every topic under scrutiny and nor is there an expectation that they so be. Asking questions of 'experts' can be difficult and intimidating but often posing questions from a lay perspective would allow members to obtain a better perspective and understanding of the issue at hand.

Set out below are some key questions members may consider asking when considering reports on particular issues. The list of questions is not intended as a comprehensive list but as a general guide. Depending on the issue under consideration there may be specific questions members may wish to ask.

Key Questions:

- Why are we doing this?
- Why do we have to offer this service?
- How does this fit in with the Council's priorities?
- Which of our key partners are involved? Do they share the objectives and is the service to be joined up?
- Who is providing this service and why have we chosen this approach? What other options were considered and why were these discarded?
- Who has been consulted and what has the response been? How, if at all, have their views been taken into account in this proposal?

If it is a new service:

- Who are the main beneficiaries of the service? (could be a particular group or an area)
- What difference will providing this service make to them – What will be different and how will we know if we have succeeded?
- How much will it cost and how is it to be funded?
- What are the risks to the successful delivery of the service?

If it is a reduction in an existing service:

- Which groups are affected? Is the impact greater on any particular group and, if so, which group and what plans do you have to help mitigate the impact?
- When are the proposals to be implemented and do you have any transitional arrangements for those who will no longer receive the service?
- What savings do you expect to generate and what was expected in the budget? Are there any redundancies?
- What are the risks of not delivering as intended? If this happens, what contingency measures have you in place?

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Agenda Item 1

Leicestershire County Council

Minutes of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Glenfield on Wednesday, 11 November 2015.

PRESENT

Dr. S. Hill CC (in the Chair)

Mrs. R. Camamile CC	Mr. J. Kaufman CC
Mrs. J. A. Dickinson CC	Mr. W. Liquorish JP CC
Dr. T. Eynon CC	Mr. J. Miah CC
Dr. R. K. A. Feltham CC	Mr. A. E. Pearson CC

In attendance.

Mr. E. F. White CC, Cabinet Lead Member for Health;
Rick Moore, Chair of Healthwatch Leicestershire;
Tim Sacks, Chief Operating Officer from East Leicestershire and Rutland CCG (ELRCCG) (Minute 43 refers);
Ian Potter, Head of Primary Care Delivery from West Leicestershire CCG (WLCCG) (Minute 43 refers);
Martin Watts; General Manager Ophthalmology Service, University Hospitals of Leicester (UHL) (Minute 44 refers);
Kate Shields, Director of Strategy UHL (Minutes 45 and 46 refer);
Giuseppe Garcea, Consultant Surgeon UHL (Minute 45 and 46 refer).

34. Minutes.

The minutes of the meeting held on 9 September 2015 were taken as read, confirmed and signed.

35. Question Time.

The Chief Executive reported that no questions had been received under Standing Order 35.

36. Questions asked by members under Standing Order 7(3) and 7(5).

The Chief Executive reported that no questions had been received under Standing Order 7(3) and 7(5).

37. Urgent items.

There were no urgent items for consideration.

38. Declarations of interest in respect of items on the agenda.

The Chairman invited members who wished to do so to declare any interest in respect of items on the agenda for the meeting.

The following declarations were made:-

Dr. T. Eynon CC declared a personal interest in all items on the agenda as salaried GP.

Mrs J. A. Dickinson CC declared a personal interest in all items on the agenda as she had a relative employed by the University Hospitals of Leicester NHS Trust, and a personal interest in the Ophthalmology Action Plan, as a current service user (minute 44 refers).

Dr. R. K. A. Feltham CC declared a personal interest in the Congenital Heart Centre at University Hospitals of Leicester NHS Trust (minute 45 refers) as a part-time employee of Northampton General Hospital NHS Trust.

Mr. J. Miah CC declared a personal interest in all items on the agenda as he had relatives employed by the University Hospitals of Leicester NHS Trust.

39. Declarations of the Party Whip in accordance with Overview and Scrutiny Procedure Rule 16.

There were no declarations of the party whip.

40. Presentation of Petitions under Standing Order 36.

The Chief Executive reported that no petitions had been received under Standing Order 36.

41. Annual Report of the Director of Public Health.

The Committee considered the Annual Report of the Director of Public Health for 2015. The focus of the report was on the role of communities in supporting health and wellbeing, which would become increasingly important over the next few years as public services across Leicestershire faced very difficult financial challenges. A copy of the report marked 'Agenda Item 8' is filed with these minutes.

Arising from consideration of the report the following comments were made -

(i) Developing community capacity was vital to the Council's strategy to reduce demand. In this regard comments were made on the need for the Council and partners to support the development of local networks so as to build resilience;

(ii) Timebanking offered opportunities to promote volunteering and consideration should be given to greater promotion of this, and to responding more promptly to people wishing to register;

(iii) Local area coordinators would play a key role in supporting and galvanising community action;

(iv) Greater use of social media should be explored as a means of promoting the advantages of volunteering;

(v) The development of credit unions in the Hinckley and Bosworth area aimed to help tackle poverty. Credit unions had been referenced in the report of the Bishop of Leicester's Poverty Commission.

Members welcomed the report and its focus and asked the Council and statutory partners to work more closely together, noting good work already taking place with the CCGs and Leicestershire Partnership NHS Trust.

RESOLVED:

(a) That the Annual Report of the Director of Public Health be welcomed;

(b) That the comments now made be submitted to the Cabinet for consideration at its meeting on 18 November 2015.

42. Unified Prevention Board Update.

The Committee considered a report of the Director of Public Health which provided an update on the work undertaken by the Unified Prevention Board, including examples of successes achieved to date. A copy of the report marked 'Agenda Item 9' is filed with these minutes.

The Committee welcomed the developments outlined in the report, in particular the Local Area Coordinator (LAC) pilot which had been very well received in those communities where it was operating. It was expected that the LAC project would support the development of existing assets within communities.

The Committee was also pleased to note the expansion of the 'First Contact' project to include support with lifestyle behaviours such as smoking and physical activity. However, concern was expressed that, by rebranding the project as 'My Health My Life', there could be a loss of association with the project, particularly by busy service providers such as GPs. Members suggested that the project be named 'First Contact Plus' to ensure continuity for everyone used to the existing system.

RESOLVED:

(a) That the report be noted;

(b) That the Director of Public Health be asked to consider renaming the 'My Health My Life' project 'First Contact Plus' to ensure continuity of association with this well-established project.

43. Seven Day Working.

The Committee considered a joint report of West Leicestershire, East Leicestershire and Rutland and Leicester City Clinical Commissioning Groups (CCGs) which provided an update on the progress and actions taken across the health system to support the delivery of seven day working. A copy of the report marked 'Agenda Item 10' is filed with these minutes.

The Chairman welcomed Tim Sacks, Chief Operating Officer from East Leicestershire and Rutland CCG (ELRCCG) and Ian Potter, Head of Primary Care Delivery from West Leicestershire CCG (WLCCG) to the meeting for this item.

Arising from discussion the following points were raised:-

(i) It was acknowledged that urgent and emergency services, along with some services provided in acute hospitals, were already available seven days a week and that an out of hours service was already in place. Members were advised that seven day services would not include routine outpatient appointments. The aim was to make services available for the 2.5 percent of complex patients that evidence had shown would benefit from a seven day service. It was hoped that this would prevent unnecessary hospital admissions for this group of patients;

(ii) It was acknowledged that an increase in primary and community care services would only be affordable if funding was transferred out of acute services. In addition, there was a significant amount of duplication in out of hours services which could be reduced if services became more integrated. The Urgent Care Vanguard project across Leicester, Leicestershire and Rutland, which had been the subject of

a successful national bid, would include an integrated approach to seven day working;

(iii) Concern was expressed over the effectiveness of the Urgent Care Centre in Oadby. Anecdotal evidence indicated that waiting times at the weekend could be up to three and a half hours and that patients did not always get to see a GP. The Committee was advised that a GP was present at the Centre at all times and patients were triaged to see either the GP or a nurse. The Centre had a target of a maximum wait of two hours, which was only met in 92 percent of cases. Regular contract meetings were taking place to address these issues and the staff rota was being reorganised so that more staff were available during busy periods. Members were also advised that there was a high level of demand for the service, including a significant number of patients from Leicester City. It was hoped that the four new healthcare hubs recently set up in Leicester would make demand for the service more manageable;

(iv) Members were pleased to note the success of the Acute Visiting Service (AVS) pilot scheme in the West Leicestershire area which provided a rapid way of seeing patients in their own homes, including care homes, and was staffed by Emergency Care Practitioners in tandem with GPs. The evaluation had been positive and the service would be extended to weekends from December. The Committee was also pleased to note that some pilot seven day working schemes which had not had an impact were not being continued;

(v) Members welcomed the work undertaken by UHL to support seven day discharge but expressed concern that the services in the community were not able to respond to this. It was confirmed that the CCGs supported seven day discharge through the provision of community and virtual beds, although there could be difficulties in providing nursing care at weekends and overnight. County Council social care staff also worked on the UHL site during the weekend in order to commission care packages to support seven day discharge. A range of social care services were available seven days a week, such as domiciliary care services, reablement and crisis support. However, there were some practical difficulties to commissioning a new care package at the weekend;

(vi) It was clarified that only nursing homes had nursing oversight; residential care homes were not allowed to provide nursing care. Community nurses provided nursing oversight to residents in residential care homes. There was a joint health and social care oversight group for care homes which provided assurance that services were appropriate and co-ordinated any input into the homes;

(vii) The Committee was of the view that training provided to care workers needed to be of an adequate standard and that there should be a clear pathway for career progression. Members were advised that the skills and status of care workers was a national issue. National initiatives were in place to address this such as the Care Certificate which aimed to improve the level of training provided to carers. Within Leicester, Leicestershire and Rutland, a workforce strategy was being developed and subsidised training was also offered. The County Council's Member Reference Panel on Quality and Safeguarding in Residential Care Homes also provided assurance that service users received an appropriate standard of care. It was recognised that there was more work to do in this area, particularly as the need for carer staff was expected to increase in the coming years.

RESOLVED:

That the update on the progress and actions taken across the health system to support delivery of seven day working be noted.

44. Ophthalmology Action Plan.

The Committee considered a report of the University Hospitals of Leicester NHS Trust (UHL), which provided an update on the progress of the Ophthalmology Action Plan developed in response to the Healthwatch visit to the service earlier this year. A copy of the report marked 'Agenda item 11' is filed with these minutes.

The Chairman welcomed Martin Watts, General Manager Ophthalmology Service University Hospitals of Leicester NHS Trust (UHL) for this item.

Members welcomed the report and commended Healthwatch's work on the 'Four Days at LRI', during which Ophthalmology Eye Clinic and Eye Casualty were visited.

Arising from discussion the following points were raised:-

(i) Members welcomed all actions included in the Ophthalmology Action Plan put in place following Healthwatch's visit and in particular emphasised the importance of cleanliness. It was confirmed that a deep clean had been undertaken during the previous week and that assurance had been given to the Ophthalmology Service that this level of cleaning would continue. In addition, work was underway to update the seating and overall décor of the facility. Members were also advised that all rooms within the Ophthalmology service were utilised at full capacity and the next year's move to the new Accident and Emergency suite at the Leicester Royal Infirmary would address the space and overcrowding issue;

(ii) It was felt that the booking system required improvement, particularly given the high level of cancellations and difficulties in rescheduling appointments. The Committee was advised that the introduction of a partial booking system was being considered to reduce the number of cancelled appointments. Under the partial booking system a patient was booked into a timeslot and the actual appointment was confirmed nearer the time. Most patients left the Ophthalmology service with an appointment booked; where it was not possible to do so within the timeframe recommended by the consultant, the consultant was asked at the end of his or her clinic to determine when the appointment should be made for;

(iii) Members were advised that attendance at eye casualty was very high and that the service regularly saw over 80 patients a day. The Committee was pleased to note that improvements in performance had been made over the last six months. The four hour wait target applied to the service and performance was currently at 99 percent;

(iv) It was acknowledged that there were issues regarding the timeliness of appointments. However, this was improving. The General Manager walked through the clinic every day and the service was hardly ever running more than an hour late;

(v) Concern was raised over the length of time between referrals and treatment. The Committee was advised that on average it took less than twelve weeks and six days between the referral from GP and being seen at the Eye Clinic which was within the national target. In addition patents were being triaged to prevent them from attending the wrong clinic;

(vi) Members were advised that some of the routine services for patients with stable conditions were being provided in the community and it was intended that this provision would be expanded further in due course. The Committee welcomed the joined-up working between UHL, LPT, the GPs and CCGs, for example in providing some glaucoma services at Melton Mowbray, Hinckley and Oakham Hospitals and was pleased to note the intention to provide services in other appropriate community settings.

Members were of the view that although there were issues including long waits and appointment booking, which were acknowledged and being worked on, the clinical service provided was of an excellent standard.

Rick Moore, Chairman of Healthwatch Leicestershire, welcomed the continued focus on improving the Ophthalmology Service but emphasised the importance of making short term improvements that were visible to patients despite the fact that a longer term solution was expected.

RESOLVED:

(a) That the report be noted;

(b) That the work being undertaken to enable the provision of intraocular pressure tests for stable glaucoma patients (IOP 2) in appropriate community setting be supported.

45. <u>The Congenital Heart Centre at University Hospitals of Leicester NHS Trust.</u>

The Committee considered a report of University Hospitals of Leicester NHS Trust (UHL), which provided an update on the delivery of strategy for the East Midlands Congenital Heart Centre (EMCHC) at the Glenfield Hospital (GH), including the Children's Hospital Project which aimed to co-locate paediatric congenital heart disease (CHD) patients from GH with other children's services at the Leicester Royal Infirmary (LRI). A copy of the report marked 'Agenda Item 12' is filed with these minutes.

The Chairman welcomed Kate Shields, Director of Strategy and Giuseppe Garcea, Consultant Surgeon from UHL for this item.

Arising from discussion Members were advised as follows:-

(i) It was confirmed that there was a link between the number of patients treated by an individual surgeon and outcome. Concern was expressed that the consultants were still not seeing sufficient patients to meet the national standard. Schemes to increase the number of patients seen by each consultant included the emerging network with Birmingham. This would enable surgeons to work in a collegiate way and share their skills, such as assigning a surgeon with the most appropriate skills to treat a particular patient. Surgeons would not be able to work across sites, because of the team that was wrapped around each surgeon. However, the Clinical Director, a pre-eminent surgeon from Birmingham, would be able to come to Leicester and support surgeons there and learning could be shared across the two sites;

(ii) The Committee was advised that the birth rate was increasing so it was expected that the demand for paediatric congenital heart services would increase. The volume of work was also growing due to a greater number of cardiac abnormalities being detected before birth and referred directly to UHL. UHL had put new fetal

clinics in place in hospitals where it had not previously had a relationship so that new pathways into the congenital heart services in Leicester could be established.

Members welcomed the networking model, including working closely with Northampton and Lincolnshire, as there was a clear geographical advantage of this partnership.

RESOLVED:

That the plan to continue providing congenital heart services in Leicester be supported.

46. Improvements to Intensive Care Provision at University Hospitals of Leicester NHS Trust.

The Committee considered a report from the University Hospitals of Leicester NHS Trust (UHL) providing an update on the improvement to intensive care provision. A copy of the report marked 'Agenda Item 13' is filed with these minutes.

Members were pleased to note that the involvement of Healthwatch in the project had been useful and that this would be continued when other project boards were established.

It was not expected that the Stabilisation and Retrieval Service proposed for the General Hospital would need to be used frequently as the vast majority of high risk patients would either be treated at the Leicester Royal Infirmary or the Glenfield Hospital.

RESOLVED:

That the planned transfer of Intensive Care Unit services to the Leicester Royal Infirmary and Glenfield Hospital and revised timescales be supported.

47. Healthwatch Annual Report 2014-15.

The Committee considered the report of Healthwatch Leicestershire (HWL), which provided an annual review of the work carried out by HWL in 2014-2015. A copy of the report marked 'Agenda Item 14 is filed with these minutes.

The Committee commended HWL on the presentation of its annual report, and was pleased to note the effective work of the organisation in engaging with patients and representing their views to service providers and commissioners. Members were pleased to note that the reduction in HWL's budget had led to a more focussed approach to its work and also that its membership had grown. The Committee also welcomed HWL's partnership working, including the SIMTEGR8 project with Loughborough University which used a computer simulation system to gather evidence of patient's experience and analyse it with the aim of developing more integrated services.

Members were advised that HWL preferred to undertake announced rather than unannounced visits, despite having the statutory right to enter and view. Seven days' notice was usually given, which in many cases gave the facilities under investigation enough time to make some improvements to their services, which was seen as a benefit to the patients.

HWL was procured by Voluntary Action Leicestershire (VAL) and although some members felt that there would be advantages to being an independent organisation which could manage its own budget, others welcomed the support from VAL such as managing the building and providing the infrastructure for HWL. It would also be possible for HWL to integrate more with the VAL database, for example when looking to gain insight from hard to reach groups.

RESOLVED:

That Healthwatch Leicestershire's Annual Review be welcomed.

48. Date of next meeting.

It was noted that the next meeting of the Committee would be held on 20 January at 2.00 pm.

2.00 - 4.36 pm CHAIRMAN
11 November 2015

Agenda Item 8

Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 20 JANUARY 2016

JOINT REPORT OF THE DIRECTOR OF PUBLIC HEALTHAND THE DIRECTOR OF CORPORATE RESOURCES

MEDIUM TERM FINANCIAL STRATEGY 2016/17 – 2019/20

Purpose

1. The purpose of this report is to:

   a) provide information on the proposed 2016/17 to 2019/20 Medium Term Financial Strategy (MTFS) as it relates to the Public Health Department; and

   b) ask the Committee to consider any issues as part of the consultation process and make any recommendations to the Cabinet accordingly.

Background

2. The provisional MTFS for 2016/17 – 2019/20, a report on was circulated to all members via the Members' News in Brief Service was approved by the Cabinet on 12th January 2016 as a basis for consultation, which will include scrutiny.

3. A detailed supplementary report on the Public Health Departmental budget will be prepared in the light of the Cabinet's decision and will be circulated to members in due course. The views of this Committee, together with the views of other Scrutiny bodies, will be reported to the Scrutiny Commission on 27th January 2016. The Cabinet will consider the results of the scrutiny process before recommending a MTFS including a budget and capital programme for 2016/17 to the County Council on the 17th February.

Recommendation

4. The Committee is asked to consider and comment on the contents of a supplementary report on the Medium Term Financial Strategy 2016/17 – 2019/20.

Equality and Human Rights Implications

5. Many aspects of the County Council's MTFS and the budget are directed towards the needs of disadvantaged people. Specific proposals will be subject to equality impact assessments where necessary.

Background Papers

None.

Circulation under the Local Alert Issues Procedure

None.

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Agenda Item 9

NHS
West Leicestershire
Clinical Commissioning Group

HEALTH OVERVIEW AND SCRUTINY COMMITTEE 20JANUARY 2016

REPORT OF WEST LEICESTESHIRE CLINICAL COMMISSIONING GROUP

URGENT AND EMERGENCY CARE UPDATE: WINTER PERFORMANCE AND VANGUARD

Purpose of report

1. The purpose of this report is to update the Health Overview and Scrutiny Committee on the winter performance of the Urgent and Emergency Care system and to brief the Committee on the progress on the Urgent and Emergency Care Vanguard.

Background

Current Performance

2. The Leicester, Leicestershire and Rutland (LLR) System Resilience Group and Urgent Care Board are responsible for managing the urgent care system, including allocation of winter pressures funding and ensuring delivery of performance standards. The Urgent Care Board has agreed an Urgent Care Improvement Plan including a communications plan to cover the winter period. The Urgent Care Improvement Plan is organised into three workstreams: Inflow, Flow (within Accident and Emergency (A&E) and hospital) and Discharge; each with their own action plan.

3. The latest dashboard showing urgent care system demand and performance is attached as Appendix 1. Performance, particularly against the A&E 4 hour wait target and ambulance handover standards, has been challenged for several months. The year to date performance against the 95% of 4 hour standard at University Hospitals of Leicester NHS Trust (UHL) is 85.6% with 75% of patients being treated in under 4 hours in the week ending 3January 2016.

4. In the light of the challenges to the system, NHS England requested LLR to submit a Recovery Action Plan (RAP) for performance. Following an escalation meeting with NHS England and the Trust Development Agency (TDA), LLR were asked to resubmit the action plan on 11 December 2015, with more details on the delivery of actions and the expected impact on A&E performance and ambulance handovers. The latest version of the RAP is attached as Appendix 2.

Winter Pressures

5. Winter pressures funding of £2 million was allocated for 2015/16. In 2015/2016, £1.65 million has already been committed by the Urgent Care Board against a range of schemes already in place to manage demand for urgent care, both in community settings and within UHL .The detail of these schemes is shown in the RAP (Appendix 2). Some of these have already been completed and the remainder are monitored on a monthly basis.

6. In addition to the above, £260,000 is committed to improvements in Bed Bureau patient flow and 'GP Urgent' patient transport. Some of this work has already started and the remainder is due to commence next week.

7. £110,000 is on hold for three UHL schemes. Confirmation is being awaited that the monies are still required and the receipt of the associated project briefs.

8. This brings the subtotal of committed spend for winter pressures to **£1,972,575**.

9. Following from the original planning in August/ September 2015, a further funding requirement has been identified of £441,000 in respect of the early termination of the George Eliot (Urgent Care Centre (UCC) Leicester) contract. Any slippage from winter funding will contribute to this.

10. Work continues to analyse and assess the outcomes/outputs of the schemes, and this will be shared with the Health Overview and Scrutiny Committee when this work is completed.

CQC Inspection

11. On Monday 30 November 2015, the Care Quality Commission (CQC) conducted an unannounced inspection of the Emergency Department at the Leicester Royal Infirmary (LRI). The team of four Inspectors arrived at 7.25pm and left just before 1am.

12. The unannounced inspection followed what the CQC had seen during their planned inspection of East Midlands Ambulance Service (EMAS) in November when their inspectors had witnessed lengthy delays and patients waiting for care in the back of ambulances at LRI.

13. At the time of inspection, the LRI Emergency Department was under severe pressure and very overcrowded. The Trust had declared an Internal Major Incident (IMI) in response to this.

14. The Inspectors witnessed at first hand the pressures and constraints the Emergency Department (ED) Team works under and the sometimes poor experience of patients when the Department is very busy. The inspection focussed on the Adults' Emergency Department although at the time there were severe pressures in the Children's Emergency Department as well.

15. On Friday 4 December 2015 the Trust was issued with a Notice of Decision by the CQC to impose conditions on its registration as service provider. The conditions relate to:-

    - operating an effective system which will ensure that all patients attending the Emergency Department have an initial assessment of their condition carried out by appropriately qualified clinical staff within 15 minutes of their arrival;

    - ensuring that sufficient numbers of appropriately qualified clinical staff are employed by the Trust to operate the triage system mentioned above;

    - ensuring an appropriate skill mix to provide a safe standard of care to patients, who require care and treatment within the Emergency Department;

- ensuring that there is an effective system in place to deliver sepsis management for patients with sepsis attending the Emergency Department.

16. The Trust is required to submit reports weekly and, in some cases, monthly to the CQC on its performance in respect of the conditions set out above.

17. The Trust has complied with the weekly and monthly reporting requirements. As yet, the Trust has not received feedback from the CQC.

18. On Friday 18 December 2015, the NHS Trust Development Authority (TDA) and NHS England hosted a risk summit for UHL regarding the Emergency Department. The CQC attended the summit. When a risk summit is held, it brings together representatives from the provider organisation, commissioners, key clinical leaders, and other regulatory bodies and stakeholders to explore and understand key issues. Together, they agree what interventions, if any, may be necessary to ensure patient safety and quality care can be guaranteed in the short, medium and longer term, and whether further risk summits are required.

19. It was agreed that a range of actions were already being undertaken by the Trust and across the LLR health system to address the key issues. Some further actions were identified at the summit; some of these were for the Trust individually, others in association with health partners (such as the TDA, EMAS and the LLR System Resilience Group) and some for individual NHS organisations attending the summit.

20. The next risk summit is scheduled for 1 February 2016. Progress is monitored in the interim by the TDA and NHS England via the Clinical Oversight Group.

21. The Trust Chief Executive will report orally at the Committee meeting on the Trust's current performance in relation to the matters identified above.

Urgent and Emergency Care (UEC) Vanguard

22. In July 2015 LLR was successful in bidding to become one of eight Urgent and Emergency Care (UEC) Vanguards nationally. The Vanguards will develop new models of care as set of in the NHS Five Year Forward View, and be supported to innovate and develop local approaches which can be replicated nationally. The UEC Vanguards will also be expected to implement the requirements of the Keogh Review of Urgent Care and go ‘further, faster’ than other areas of the country in this respect.

23. The vision for LLR is of an urgent and emergency care system which is organised to deliver person-centred care that wraps around the individual; promoting self-care and independence, enhanced recovery and enablement, and reducing harm through integrated services that exploit innovation and promote care in the right setting at the right time. Our vision is founded on the consistent provision of care across linked settings, each with defined outcomes and the ability to respond to the physical and mental health needs of our diverse population in a way that blurs organisational boundaries. We will develop an integrated UEC service across the system, including mental health parity of care and seven day services as key planks for the delivery of the vision.

24. All partners in the Vanguard recognise the need to work together to ensure local consistency, whilst interacting with neighbouring healthcare economies to realise benefits at scale.

Table 1

Strategic Aims of the Vanguard

Aim	Description	Objective
Reduced duplication and fragmentation of services, simplification of patient pathways	Development of services and pathways that minimise patient handoffs, that are readily understood and accessed by patients and enable efficiencies within the system through integration	• Improved patient outcomes and experience • Patient receives the right care in the right place at the right time • Decreased costs to the health economy • Improved system resilience
Aligning providers to work towards common system goals	Service offers that blur organisational boundaries and enable patient care to be wrapped around the patient not constrained by organisations	• Improved patient outcomes and experience • Patient receives the right care in the right place at the right time • Decreased costs to the health economy • Improved system resilience • Integrated clinical governance • Integrated workforce plans
System Management	Understanding patient flow, resources and capacity in a real time way will enable the system to flex and respond, providing resources and moving capacity to ensure that the right care is available in the right place	• Improved patient outcomes and experience • Patient receives the right care in the right place at the right time • Decreased costs to the health economy • Improved system resilience

25. Over the last two months, we have established governance and programme management arrangements for the Vanguard. The LLR Vanguard is overseen by the System Resilience Group, with the Urgent Care Board (UCB) having programme management responsibility. Toby Sanders is the Senior Responsible Officer for the Vanguard, with Tamsin Hooton, Director or Urgent and Emergency Care leading the Vanguard team. The Vanguard work will form the majority of the Better Care Together Urgent Care workstream, with interfaces with a number of other BCT workstreams such as End of Life and bed reconfiguration.

26. The LLR Vanguard is broad and ambitious in its scope and will be taken forward via six workstreams, described below.

- ***Integrated Community Urgent Care***
  This project will see the integration of pathways across EMAS, NHS111, Out of Hours and the Single Point of Access (SPA) services for health and social care, via a Navigation Hub providing clinical triage, advice and signposting.

- ***LRI Front Door***
  We will redesign the access to urgent and emergency care at the LRI site to provide an enhanced senior clinical assessment team with direct referral access to ambulatory clinics, assessment beds and the ability to refer patients to the UCC, ED or back into primary/ community services.

- ***Mental Health***
  We will develop our mental health services to better meet the demands of patients and enable parity of care. This will be delivered through investment in Psychiatric Liaison

within the acute Trust, mental health workers embedded within the police and paramedic services and improved access and referral processes to crisis support.

- ***Seven day services (acute hospital)***
  We will deliver standards 2,5,6,7 and 8 of the Clinical standards for Urgent and Emergency Care and Supporting Diagnostics. In addition we will seek to deliver standard 9, enabling support services, both in the hospital and primary, community and mental health settings so the next steps of a patients care pathway can be taken.

- ***Contracting for Transformation***
  Using our experience of Alliance Contracting we will develop a new UEC alliance based model that incentivises providers to work as a network. This will be underpinned with new measures of clinical quality and patient experience increasingly focusing the whole system on a clinical outcome focus and the implementation of the new payment model.

- ***Predictive Modelling***
  We will work to develop a demand and activity model with a view to informing operational resource/capacity levels. We will use real time data to inform our navigation services (as above) and to provide direct information to the public about service pressure and waiting times to enable informed choices.

Proposals/Options

27. We are developing a 'Value Proposition', which is in essence a business case for the Vanguard work, which will be submitted to NHS England. The value proposition will set out what we plan to do across each of the workstreams, the impact this work will have on patient outcomes and long term financial sustainability of the urgent care system. NHS England requires a first draft of the Value proposition for the 8th January with a final draft on the 8 February 2016.

Consultation/Patient and Public Involvement

28. Healthwatch are involved via the UCB. We are developing a communications and engagement strategy for the Vanguard, including how we will engage with people of developing the model of integrated urgent care. Communication with LLR residents, particularly about how to access services and to support people to care for themselves where appropriate, is a critical part of our plans for the Vanguard.

Resource Implications

29. The winter pressures funding of £2 million described above will be used to support the Urgent Care Board improvement plan and includes things such as seven day social work support, additional patient transport to improve discharge and additional input to community services to manage surges in demand.

30. We have received £300,000 so far for Vanguard Programme management in 2015/2016. We submitted an overall funding request of £2.6 million from the national budget of £12million, and will receive notification of non-recurrent resources in 2015/2016 on 24 December 2015.

31. Funding for the Vanguard in 2016/2017 and beyond will be from a combination of non-recurrent pump priming from the central Vanguard allocation and mainstream investment in Urgent and Emergency care from the health and social care partners in LLR. Match

funding from local health and social care organisations will be a condition of any central funding, and there will be further conditions in terms of expectations around implementing the Keogh review.

32. The Vanguard Value Proposition submission made on the 8 January will set out the costs of taking forward the Vanguard work in LLR and our bid for additional funding, supported by evidence of the impact of any non-recurrent funding and the value for the system that will be achieved. There is £40 million national funding for the UEC Vanguards, so on average the Vanguards should receive £5 million each.

Timetable for Decisions

33. The next risk summit is scheduled for 1 February 2016. Progress is monitored in the interim by the TDA and NHS England via the Clinical Oversight Group.

34. The Trust Chief Executive will report orally at the Committee meeting on the Trust's current performance in relation to the matters identified above.

Conclusions/Recommendations

35. Urgent Care services are under intense pressure across LLR as well as nationally at the moment, driven by an increase in demand, particularly at A&E. The urgent care system is experiencing challenges relating to capacity in some parts of the system, particularly workforce. Despite these challenges, we have a well-developed plan for managing the system from an operational system resilience perspective. The Vanguard programme represents our approach to strategic change and service improvement, with accelerated delivery of the future model of integrated care.

Circulation under the Local Issues Alert Procedure

None.

Officers to Contact

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Samantha Merridale
Head of Operational Resilience and Emergency Planning
Email: Samantha.merridale@nhs.net

List of Appendices

Appendix 1: LLR Urgent and Emergency Care Dashboard
Appendix 2: LLR Urgent Care Recovery Action Plan
Appendix 3: EMAS Winter Pressures

Relevant Impact Assessments

Equality and Human Rights Implications

19. The Urgent Care Improvement Plan and Vanguard work pay due regard to equalities including the impact on protected characteristics and vulnerable groups within the population. We have not conducted an Equality and Human Rights Impact Assessment (EHRIA) on the whole vanguard programme to date but will keep this under review and undertake an assessment as and when the workstream proposals are sufficiently well developed.

Risk Assessment

20. The UCB has a risk register covering its work and this is reviewed at each meeting.

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Urgent Care Board - Dashboard

Updated to Sunday 03/01/2016

Arden&GEM

Inflow

- 111 Total Calls
- % of 111 Calls sent to 999/ED
- Total Calls to EMAS
- EMAS Disposition - Non Conveyed
- EMAS Ambulance Handover: Hours Lost
- GP OOH Activity
- ED: LRI Attendances
- ED: UCC Attendances
- UHL Emergency Admissions
- GP Referrals to Bed Bureau that are Diverted to ED
- % of UHL Emergency Admissions that were Avoidable

Flow

- % of UHL & UCC Attendances seen within 4 Hours
- % of UHL ED with Decision about Onward Care within 120 mins
- % of UHL Ward Response to ED/Bed Requests within 30 mins
- % of UHL GP Referrals Direct to AMU
- UHL Empty Beds at Start of Day on AMU Ward
- % of UHL wards Achieving Targeted Weekly Discharges
- Aged 75+ with Length of Stay >10 Days at UHL
- % of Discharges before 12pm at UHL

Discharge

- UHL Discharges against Admissions
- UHL Discharges
- LPT Discharges
- % of UHL Delayed Transfer of Care
- % of LPT Delayed Transfer of Care
- % of UHL Discharged to Admitting Address
- % of LPT Discharged to Admitting Address
- Community Beds Open
- UHL Delayed Transfer of Care - Bed Days Lost
- LPT Delayed Transfer of Care - Bed Days Lost
- 30 Day Readmission Rate

Latest Week meets the Target

Latest Week is within 5% of the Target

Latest Week is > 5% from the Target

Information

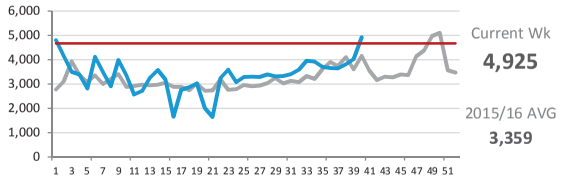
Delayed discharges data are based on a snapshot of midnight census of every Thursday.

All Metrics are shown Weekly with the Year Running from 1st April

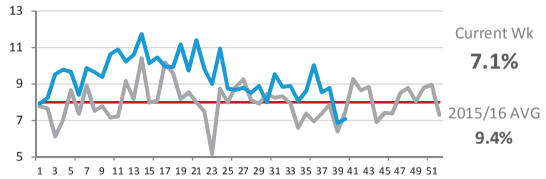
APPENDIX 1

INFLOW

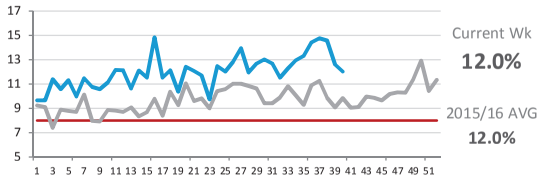
111 Total Calls



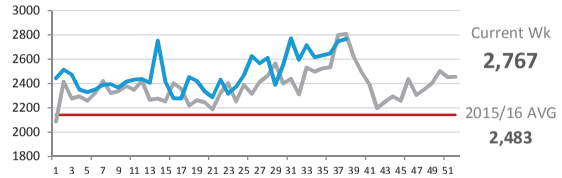
% of 111 Calls sent to Emergency Department



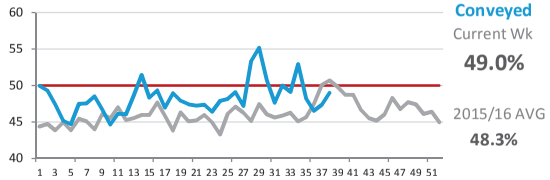
% of 111 Calls sent to 999



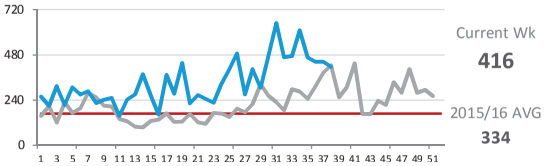
Total Calls to EMAS



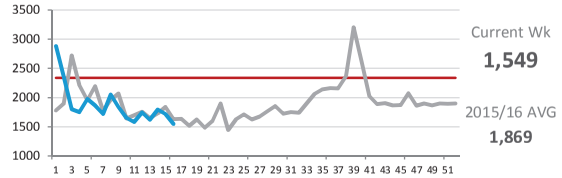
EMAS Disposition



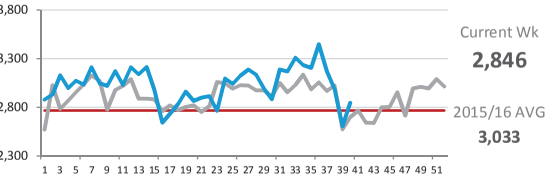
EMAS Ambulance Handover: Hours Lost



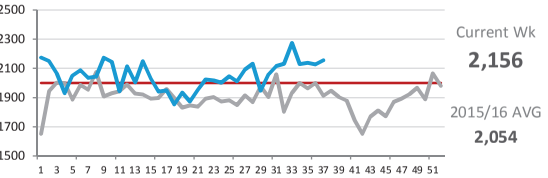
GP Total OOH Activity



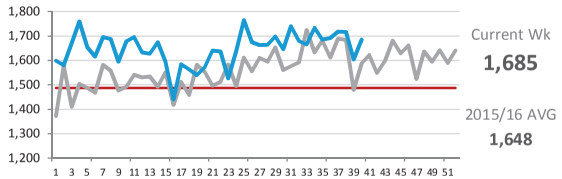
ED: LRI Attendances



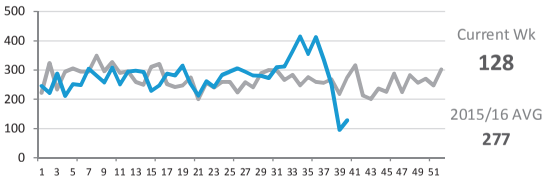
ED: UCC Attendances



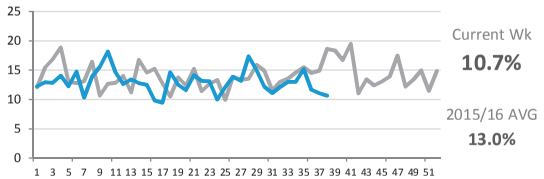
UHL Emergency Admissions

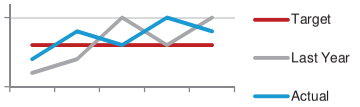


GP Referrals to Bed Bureau that are Diverted to ED



% of UHL Emergency Admissions that were Avoidable

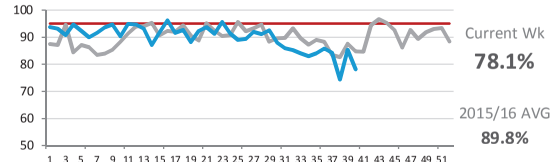




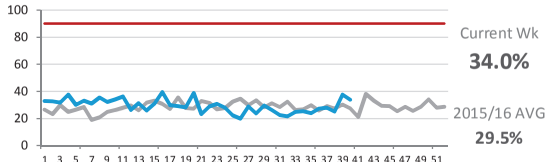
All Metrics are shown Weekly with the Year Running from 1st April

FLOW

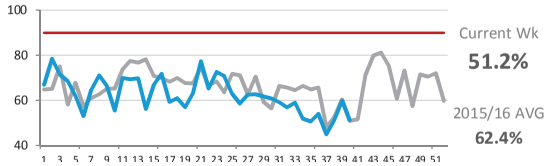
% of UHL and UCC Attendances seen within 4 Hours



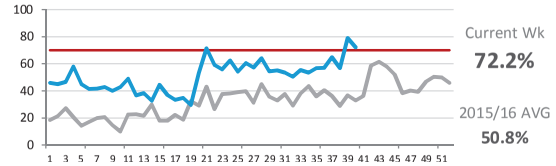
% of UHL ED with Decision about Onward Care within 120 mins



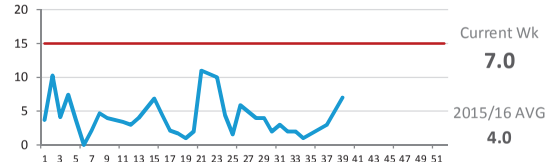
% of UHL Ward Response to ED/Bed Requests within 30 mins



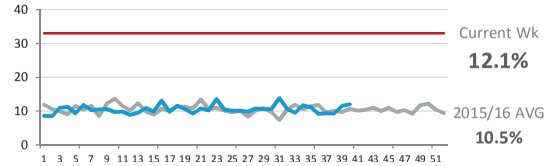
% of UHL GP Referrals Direct to AMU



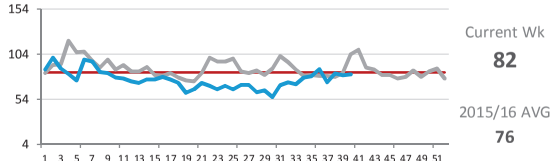
UHL Empty Beds at Start of Day on AMU Ward

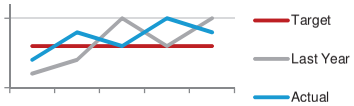


% Discharges before 12pm at UHL



Patients aged 75+ with Length of Stay >10 days at UHL

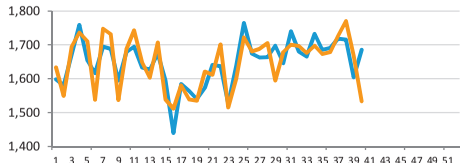




All Metrics are shown Weekly with the Year Running from 1st April

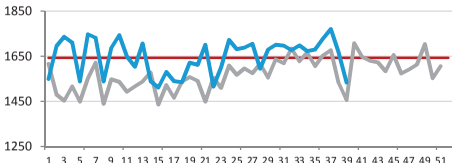
DISCHARGES

Patients Admitted to & Discharged from UHL



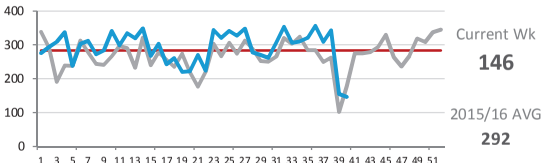
	ADM	DIS
Current Wk	1,685	1,533
2015/16 AVG	1,648	1,648

Patients Discharged from UHL



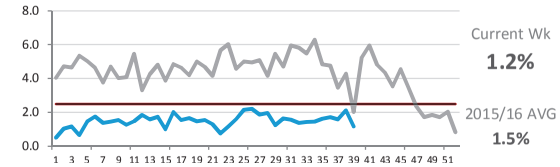
Current Wk **1,533**
2015/16 AVG **1,648**

Patients Discharged from LPT



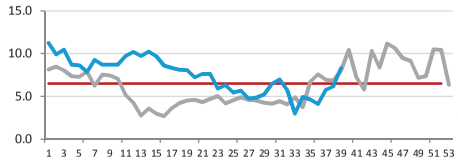
Current Wk **146**
2015/16 AVG **292**

% UHL Delayed Transfers of Care



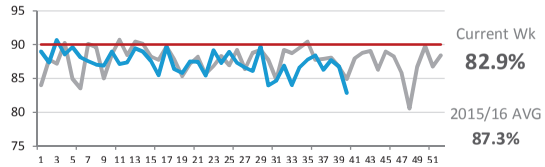
Current Wk **1.2%**
2015/16 AVG **1.5%**

% LPT Delayed Transfers of Care



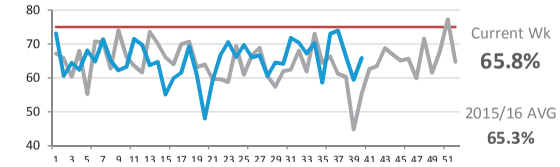
Current Wk **8.3%**
2015/16 AVG **7.5%**

% of UHL Patients Discharged To Admitting Address



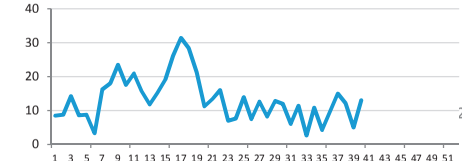
Current Wk **82.9%**
2015/16 AVG **87.3%**

% of LPT Patients Discharged to Admitting Address



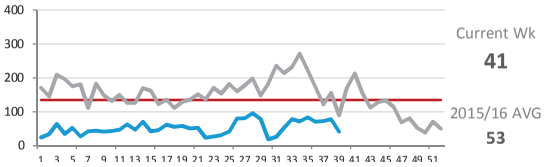
Current Wk **65.8%**
2015/16 AVG **65.3%**

Average Patients Community Beds Available at Start of Day



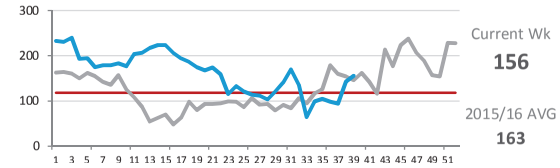
Current Wk **13**
2015/16 AVG **13**

UHL Delayed Transfers of Care - Bed Days Lost



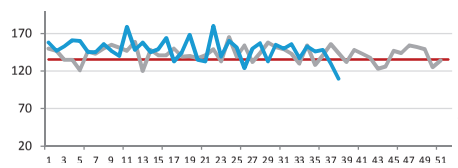
Current Wk **41**
2015/16 AVG **53**

LPT Delayed Transfers of Care - Bed Days Lost



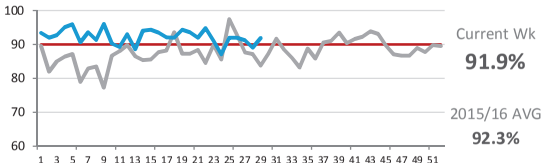
Current Wk **156**
2015/16 AVG **163**

30 Day Readmission Rate

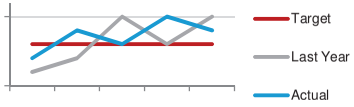


Current Wk **110**
2015/16 AVG **149**

% of LPT ICS Beds Used by Patients



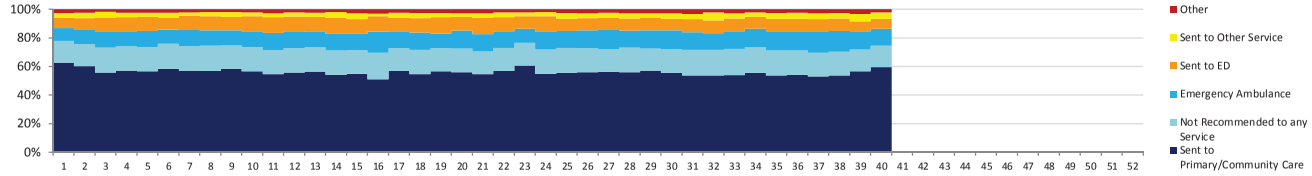
Current Wk **91.9%**
2015/16 AVG **92.3%**



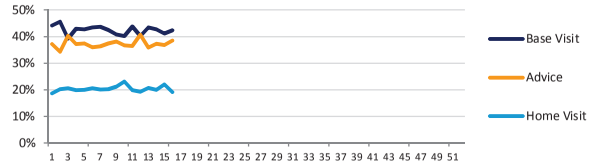
All Metrics are shown Weekly with the Year Running from 1st April

111 or 999

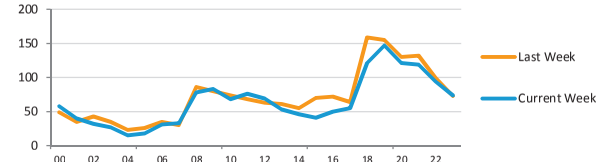
% of Dispositon of 111 Calls



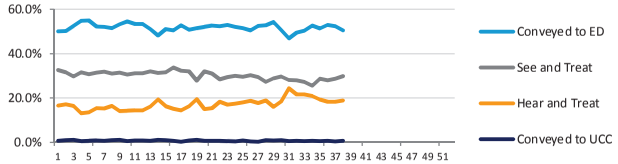
% of Disposition from Out of Hours

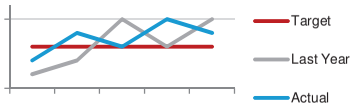


Time Profile of Out of Hours Patients



% of Disposition of EMAS Calls

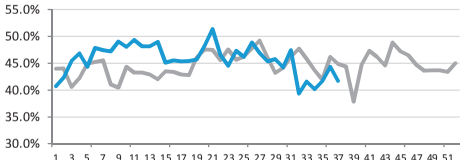




All Metrics are shown Weekly with the Year Running from 1st April

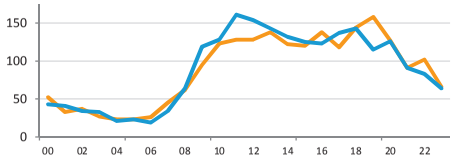
AE Interface

% of Outcome at LRI UCC



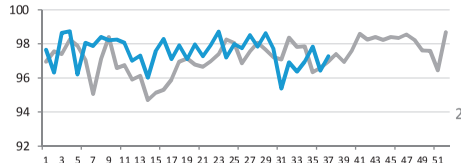
Referred
Current Wk
41.7%
2015/16 AVG
45.8%

Time Profile of LRI UCC Attendances



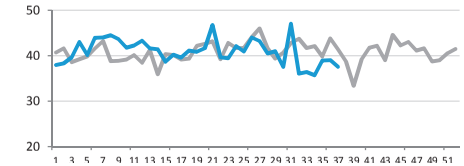
Last week affected by Incorrect UCC Data.

% of LRI UCC Triaged within 20 minutes



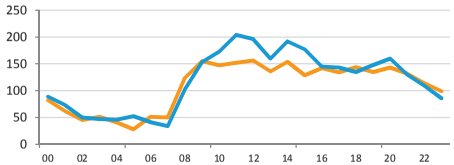
Current Wk
97.3%
2015/16 AVG
97.6%

% of Patient Transfers from LRI UCC to LRI ED

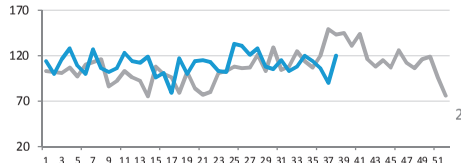


Current Wk
37.5%
2015/16 AVG
40.9%

Time Profile of UHL AE Attendances

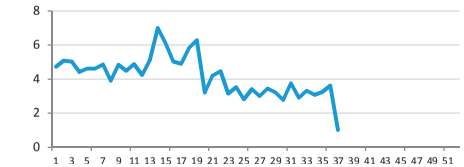


UHL Admissions with Ambulatory Care Sensitive Conditions



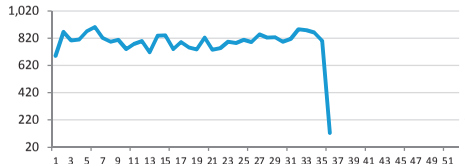
Current Wk
120
2015/16 AVG
111

% of AE VB11Z: No investigation with no significant treatment



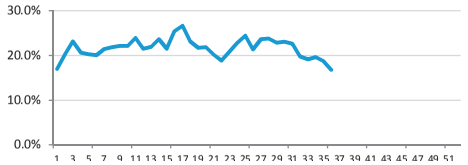
Current Wk
1.0%
2015/16 AVG
4.2%

Loughborough UCC Attendances



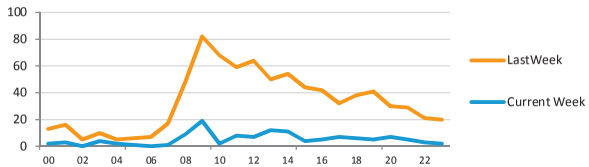
Current Wk
125
2015/16 AVG
785

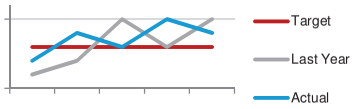
% Loughborough UCC Outcome



Referred
Current Wk
16.8%
2015/16 AVG
21.6%

Time Profile of Loughborough UCC Attendances

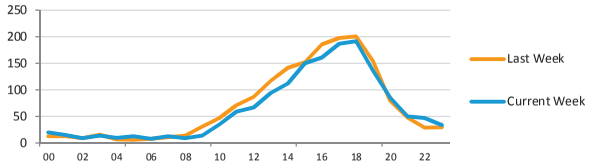




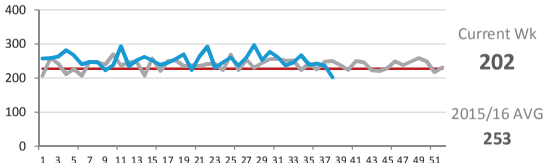
All Metrics are shown Weekly with the Year Running from 1st April

Additional Discharge

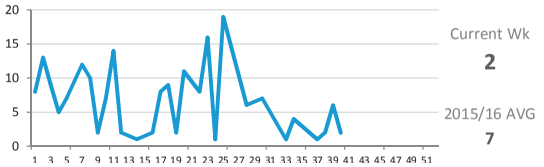
Time Profile of UHL EM Discharges



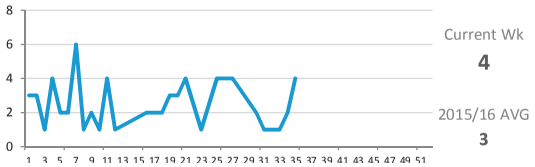
90 Day Readmission Rate



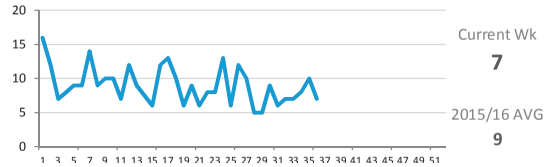
Number of Re-Beds (Arriva Aborts)

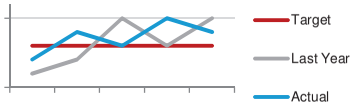


UHL Discharge to Assess Number of Patients - Pathway 1 & 2



UHL Discharge to Assess Number of Patients - Pathway 3

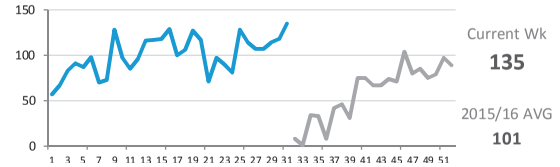




All Metrics are shown Weekly with the Year Running from 1st April

Crisis Resolution

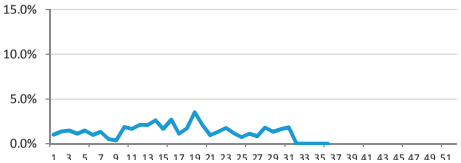
Patients Referred to Leicester City CCG Crisis Resolution Team Utilisation



Current Wk
135

2015/16 AVG
101

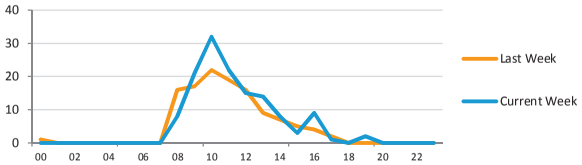
% of Outcome at Leicester City CCG Crisis Resolution Team

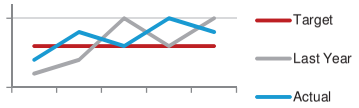


Referred
Current Wk

2015/16 AVG
1.3%

Time Profile of Leicester City CCG Crisis Resolution Team





All Metrics are shown Weekly with the Year Running from 1st April

Group	Objective	Action area	Delivery description & detail	Senior accountable lead	Delivery date	Expected impact	Activity Monitoring	Delivery Status	Progress to date
Inflow	1.1 To provide consistent and useable information to enable patients to make informed choices about when and how to access the most appropriate urgent and emergency care service	1.1.1 - Targeted Patient Information campaigns	CCGs reviewing potential to increase flu vacc uptake; LC offering vaccination to patients with a BMI >40 and their care homes workforce WL / ELR to develop proposal for similar service	R Vyas (LC CCG) / I Potter (WL CCG) / D Eden (ELR CCG)	LC - Nov 2015 WL - 21/12/2015 ELR - 21/12/2015	Reduced risk of major flu epidemic	Increase in uptake of flu vaccs in targeted groups. CCGs baselines @ 31/10/2015 for Over 65y (target 75%) / Under 65y (target to increase on 2014/15 of 49.6%); LC - 61.5% / 36.6% WL - 60.6% / 32.7% ELR - 62.3% / 33.8%	3. Some delay – expected to be completed as planned	LC care homes workers initiative completed. Patients with a BMI >40 to commence (Rach to advise date) LC scheme details being reviewed by WL and ELR with a view to implementation Review completed in WL - to trial care homes workers initiative from mid-January 2016 **Update 05/01:** ELR will review potential for care home staff vacination
Inflow	1.1 To provide consistent and useable information to enable patients to make informed choices about when and how to access the most appropriate urgent and emergency care service	1.1.1 - Targeted Patient Information campaigns	To deliver Stay Well (inc Flu) outreach campaign across LLR targeting hard to reach and at risk groups, carers, parents of children 0-10y, Partnership with voluntary sector and GEM outreach - ways to stay well, appropriate attendance locally per CCG Series of local public events Dec 2015 - Feb 2016	R Crabb (LLR Urgent Care)	Dec 2015 - Feb 2016	Increase public awareness of alternatives available	Target cohorts for outreach campaign per CCG to include; Parents of 0-5y, patients 65+y, LTC, carers groups, Age UK contacts, multiple deprivations Niche voluntary sector groups will in-reach to moderate/frequent flyers who are low volume high impact users	4. On track	LC have Patient Engagement event 10/12/2015 WL have Patient Engagement event Jan 2016 ELR to advise of any planned events Outreach campaign commenced in WL Nov 2015 To undertake cross-referencing exercise during December for the identified lists with the hard to reach moderate/frequent flyers
Inflow	1.1 To provide consistent and useable information to enable patients to make informed choices about when and how to access the most appropriate urgent and emergency care service	1.1.1 - Targeted Patient Information campaigns	To develop consistent patient information for each UCC, WIC, City Hubs, ED Streaming Service, CRT, AVS, OPU To be disseminated in leaflet format; Artwork confirmed 11/12/2015 Distribution of info w/c 14/12/2015 Implement PDSA for direct public engagement @ LRI campus	R Crabb (LLR Urgent Care)	w/c 14/12/2015	All front line clinicians to hand to patients at the end of their clinical consultation Increase public awareness of alternatives available	No of leaflets handed out and patient contacts made @ LRI campus, UCC Lo, City Hubs, EMAS See & Treat calls and CRT/AVS visits Baseline - not currently monitored Aiming for 100% distribution rate Average distribution per week based on current activity circa; UCC Le - 2,000 UCC Lo - 700 EMAS S&T - TBA CRT - 600 AVS - 350 City Hubs - 850, to be 1,740	6. Complete and regular review	Discussion with printers complete and artwork confirmed GEM comms staff to undertake direct public engagement PILs distributed w/c 21/12/2015
Inflow	1.1 To provide consistent and useable information to enable patients to make informed choices about when and how to access the most appropriate urgent and emergency care service	1.1.2 - Roll out Patient service navigation app 'NHS Now'	Pilot launch and refinement in EL&R	T Sacks (ELR CCG)	30/11/2015	Increase awareness & utilisation of alternatives	ELR baseline 600 downloads in first 2w	5. Complete	Completed - roll out and refinements
Inflow	1.1 To provide consistent and useable information to enable patients to make informed choices about when and how to access the most appropriate urgent and emergency care service	1.1.2 - Roll out Patient service navigation app 'NHS Now'	Roll out to LC and WL CCGs: Review information databases Develop marketing & comms Go live	R Vyas (LC CCG) / I Potter (WL CCG)	w/c 07/12/2015 w/c 14/12/2015 w/c 21/12/2015	Increase awareness & utilisation of alternatives	Anticipating 1000 downloads per week across LLR over next four weeks	2. Significant delay – unlikely to be completed as planned	ELR to write analytics and advise of downloads as hosts of the app. Update 05/01 - analytics available from 11/1/16 WL data further updated over Christmas 2015. Now on hold for WL & LC pending resolution to inaccuracy of data Task & Finish Group post Demand Group mtg 08/01/2016
Inflow	1.1 To provide consistent and useable information to enable patients to make informed choices about when and how to access the most appropriate urgent and emergency care service	1.1.2 - Roll out Patient service navigation app 'NHS Now'	Explore link to real time waiting information for ED/UCC services	S Smith (LLR Urgent Care)	31/03/2016	Increase awareness & utilisation of alternatives	Monitoring on a weekly basis of hits per CCG	3. Some delay – expected to be completed as planned	To be added to Phase 2 as functionality not available for Phase 1 Discussions commenced with TPP re: availability of data feed - awaiting their confirmation
Inflow	1.2 To improve 7 day urgent access (same/next day) to primary care services	1.2.1 - Extended GP services	Leicester City CCG: Hubs hours of operation M-F 18:30-22:00 S-S 09:00-22:00 Increasing utilisation of City Hubs; Continue application of comms strategy Implement remote booking by EDSS Implement remote booking by NHS111	S Prema (LC CCG)	Weekly Weekly Live from 23/11/2015	Decrease in ED attendance/Increased access primary care	Current baseline for LC w/e 06/12/2015 - 782 appts booked of the 1,700 available per week (45.2%)	3. Some delay – expected to be completed as planned	Increase in weekly utilisation to be reported Sundays remain significantly more quiet than the rest of the week LC CCG to advise of EDSS remote booking functionality NHS111 direct appt booking already in place EDSS direct appt booking to be established in Jan 2016
Inflow	1.2 To improve 7 day urgent access (same/next day) to primary care services	1.2.1 - Extended GP services	West Leics CCG: Implement West Leics GP on the day access scheme	A Bright (WL CCG)	07/12/2015	Increased availability of appointments	Expected 85% uptake by general practice which would give additional 367 appointments per day	4. On track	Spec to all WL practices 03/12/2015 Confirmation of practice uptake by 14/12/2015 Current position @ 04/01/2016 48 of the 49 practices have confirmed participation, giving 1,899 additional appts per week
Inflow	1.2 To improve 7 day urgent access (same/next day) to primary care services	1.2.1 - Extended GP services	West Leics CCG: Hours of operation 08:00-22:00 Implement West Leics primary care weekend access scheme targeting 2% at risk / end of life / moderate-frequent flyer patients	A Bright (WL CCG)	05/12/2015	Reduction in ED attendance and EA for at risk cohort	Can accommodate up to 100 extra patient contacts per weekend Will monitor the number of patient passports issued	6. Complete and regular review	Federations all signed up Implemented service 05/12/2015 in conjunction with AVS @ 04/01 1000 passports issued
Inflow	1.2 To improve 7 day urgent access (same/next day) to primary care services	1.2.1 - Extended GP services	ELR CCG: Coverage of total ELR population increased from 10% to 30% (95,000 patients) in Dec 2015. This equates to 3%-5% (2,850 to 4,750) complex patients who have weekend access	T Sacks (ELR CCG)	21/12/2015	Reduction in ED attendance and EA for at risk cohort	Supporting an anticipated 50 patient contacts per weekend day	3. Some delay – expected to be completed as planned	Update 05/01 - 4 GP practice hubs to commence 9/1/16

APPENDIX 2

Group	Objective	Action area	Delivery description & detail	Senior accountable lead	Delivery date	Expected impact	Activity Monitoring	Delivery Status	Progress to date
Inflow	1.3 To extend range and timing of alternative UCC services for immediate but non-life treatening conditions	1.3.1 - Urgent home visiting service (Crisis Referral Team /Acute Visiting Service) including direct referrals from care homes	LC CCG & WL CCG: Optimise appropriateness of use of existing SSAFA CRT and AVS services by; ECPs to undertake daily audit of referrals SSAFA to inform CCGs weekly of any inappropriate use CCGs leads to contact practices directly to discuss WL to submit BCF request for funding of 1 WTE ECP for dedicated triage to allow extended daily coverage Extend AVS West Leics hours of operation at weekends	A Bright (WL CCG) / S Prema (LC CCG)	Monthly review 08/12/2015 05/12/2015	Urgent home visit requests earlier in the day, reduction in care home calls to EMAS	Monthly monitoring Current utilisation as at 31/10/2015; LC - 611 visits per month of 502 contracted capacity WL - 340 visits per month of 350 capacity Additional appoinments offered and utilised Linked to the WL Weekend Access Scheme to see 100 extra patients per weekend	4. On track	Enhanced phone system and dedicated triage within CRT & AVS Address the highest and lowest GP practice users to target both inappropriate referrals and under-utilisation ELR SSAFA service commencement 18/01/2016 TBC WL shared data on comparative usage of AVS @ Dec 2015 locality mtgs Audit to be completed by 31/01 on appropriateness of referrals to AVS SSAFA to advise of WL recruitment status
Inflow	1.3 To extend range and timing of alternative UCC services for immediate but non-life treatening conditions	1.3.1 - Urgent home visiting service (Crisis Referral Team /Acute Visiting Service) including direct referrals from care homes	ELR CCG: Establish ELR in-car visiting service by; Activity review to inform pilot area Identify level of funding to requested through BCF Identify workforce Implement for trial	T Sacks (ELR CCG)	01/12/2015 08/12/2015 09/12/2015 18/01/2016	Urgent home visit requests earlier in the day, reduction in care home calls to EMAS	Anticipated 100 patient contacts per month to Service	4. On track	An initial area of Oadby/Wigston/Blaby/LFE identified Rob has approached SSAFA Board for sign off BCF funding application approved ELR SSAFA service commencement 18/01/2016 TBC
Inflow	1.3 To extend range and timing of alternative UCC services for immediate but non-life treatening conditions	1.3.2 - Implement Loughborough UCC extended care pathways	Maximise appropriate use of increased specialist medical cover 9am - 10pm Monday-Friday, 10am - 10pm at weekends to allow increased referrals from GPs, AVS and EMAS UCC Lo clinicians to ride with EMAS crews to promote referrals to UCCs during Dec-Jan	C Tierney-Reed (WL CCG) S Court (CNCS) / Tim Slater)EMAS)	01/11/2015 31/01/2016	Reduction in referrals to ED for ambulatory conditions	Number of referrals to extended pathways; Phased trajectory of avoidable emergency attends Nov 2015 - anticipated 130, actual 30 Cumulative total of extended pathways capacity at 31/03/2016 anticipated to be 850, of which 450 would be avoidable emergency attends No. of EMAS shifts attended by UCC clinicians Utilisation of UCC Lo for Oct 2015 was 3,604 appts vs capacity of 3,750 appts	4. On track	Completed - implemented on time Updated EMAS Pathfinder and NHS111 DoS Additional GP comms to practices regarding no of cases seen during November, types of cases, case studies, match real time data during December to measure impact on acute care/999 conveyances Tim Slater has provided assurance that EMAS will provide insurance cover for CNCS staff riding with ambulances
Inflow	1.3 To extend range and timing of alternative UCC services for immediate but non-life treatening conditions	1.3.3 - Increase referrals from OOH GPs to alternative services	Communication to OOH GPs regarding UCC Lo enhanced GP pathways Weekly review of ED attendances following OOH contact within preceeding 24h Reinforce all LLR non-ED options available to OOH GPs Improve internal tracking of referrals by OOH GPs	R Haines (CNCS)	14/12/2015 15/12/2015 15/12/2015 14/12/2015	Increased use of alternatives to admission by OOH GPs	Increased utilisation of alternatives to admission above current baseline position Current baseline TBC Weekly monitoring of final patient dispositions; telephone consult face to face consult referral to OOH clinic, UCC, ED, CRT, social care	2. Significant delay – unlikely to be completed as planned	Awaiting activity monitoring
Inflow	1.3 To extend range and timing of alternative UCC services for immediate but non-life treatening conditions	1.3.4 - ELR CCGs 4 Urgent Care Centres	Deliver increased utilisation of appts Winter 2015/16 compared to Winter 2014/15	T Sacks (ELR CCG)	18/12/2015	Reduction in referrals to ED	Utilisation of 3,200 additional appointments available 18/12/2015 - 31/01/2016 than last Winter Reduction in LLR and OOA ED attendances at peripheral hospitals over the Christmas & New Year period	6. Complete and regular review	Weekly utilisation to be demonstrated within enhanced Inflow Dashboard ELR to scope potential for increased capacity @ Oadby site Update 05/01 - New Nurse triage service from 4/1 to increase throughput
Inflow	1.3 To extend range and timing of alternative UCC services for immediate but non-life treatening conditions	1.3.5 - Implementation of live waiting times data feeds for the public to access	Web page, with URL links available for other devices to use, showing the live waiting time at each LLR UCC/WIC	R Crabb (LLR Urgent Care)	11..01.16	Reduction in self-referrals to ED	Once service commenced, to monitor no. of hits	2. Significant delay – unlikely to be completed as planned	Adastra feed available UHL feed available but still outstanding TPP not willing to commit to availability or timescale of information feed for SystmOne sites Discussion to be had around manual workaround@ UCB 07/01
Inflow	1.4 To reduce EMAS conveyance to LRI	1.4.1 - Implement mobile device (smartphone) with MDoS access	Rapid roll out across LLR crews with link to live waiting times web page, 400 front line staff to have use of devices.	T Slater (EMAS)	Jan-Mar 2016	Awareness for crews of alternatives to admission	Increased utilisation of alternatives to admission above current baseline by front line staff	3. Some delay – expected to be completed as planned	Pilot testing occurred to decide device of choice
Inflow	1.4 To reduce EMAS conveyance to LRI	1.4.2 - Increase use of alternatives to admission by EMAS crews by referral to UCC Lo and OPU, ELR UCCs, LC Hubs and use of Falls Pathway	EMAS CAT to be able to directly book into City Hubs All new services to align to Pathfinder outcomes ELR UCCs to confirm that they capture direct and indirect EMAS referrals	T Slater (EMAS)	weekly review 14/12/2015	Increased use of alternatives to admission by EMAS crews	EMAS to develop own metric for reduction of conveyances to ED/UCCs Current baseline for use of alternatives by EMAS crews @ Oct 2015; UCC Le - 0 (not currently measured) WIC Le - 0 (not currently measured) UCC Lo - 33 (target 40) OPU - 4 (target 18) AVS - 1 (target 40) CRT - TBA LC Hubs - 0 (not currently measured) UCCs ELR - 0 (not currently measured) Falls Pathway - c50% (target up to 75%)	3. Some delay – expected to be completed as planned	EMAS to devlop own metric for reduction of conveyances to UHL ED. EMAS (WL) doing ground work on proposal to increase nursing capacity in CAT
Inflow	1.4 To reduce EMAS conveyance to LRI	1.4.3 - SSAFA to be reflected as a Pathfinder disposition	Include AVS/CRT as alternative service on version2	T Slater (EMAS)	14/12/2015	Referrals by EMAS to SSAFA	see above	6. Complete and regular review	Pending the new Pathfinder booklet, we have provided our crews and clinicians with a local directory of services including AVS, CRT and back-office GP numbers.
Inflow	1.4 To reduce EMAS conveyance to LRI	1.4.4 - Develop process to enable EMAS access to GP medical opinion and prescriptions; In hours Out of hours Circulate Service description to all front line staff (daily to ensure all EMAS shifts covered)	In hours via UCC Lo enhanced GP resource as a pilot (assuming CNCS CG approval) Out of hours via the CNCS HCP line	T Slater (EMAS) / S Court (CNCS)	14/12/2015	Non conveyance and increased use of alternatives to admission	EMAS use of OOH HCP line TBA No of consults to UCC Lo to be advised once commenced	2. Significant delay – unlikely to be completed as planned	Simon Court at CNCS mtg 10/12/2015 to discuss and sign off Tim Slater to advise of current EMAS contact levels with CNCS OOH HCP line

Group	Objective	Action area	Delivery description & detail	Senior accountable lead	Delivery date	Expected impact	Activity Monitoring	Delivery Status	Progress to date
Inflow	1.4 To reduce EMAS conveyance to LRI	1.4.5 - Dedicated GP patients transport as pilot extension to existing service where transport is provided for a range of clinics	Implement additional service via Bed Bureau for appropriate GP urgent transport for patients not requiring a clinical chaperone Rapid testing in Leic City with focus on LE2, LE3, LE5 to inform roll out Comms to GP practices to promote default of self-transportation where a clinical chaperone is not required	Sarah Smith (LLR Urgent Care) / Julie Dixon (UHL)	w/c 14/12/2015	Freeing up EMAS capacity/reduction in batching	No of patients transported by dedicated transport crews	2. Significant delay – unlikely to be completed as planned	RVS now unable to deliver to required specification and timetable In contact with TMAS and CNCS OOH for an immediate solution CNCS have provided costing Julie Dixon provide Trust Medical costing 10/12/2015 Comms to Bed Bureau / GPs and implementation w/c 14/12/2015
Inflow	1.4 To reduce EMAS conveyance to LRI	1.4.6 - Reduce referrals to EMAS from NHS111 and OOH	Review referral activity to identify scope for alternative dispositions to LRI ED	EMAS/CCGs	TBC				New action identified through UNIPART exercise
Inflow	1.5 To minimise the need for GP initiated/related admission to acute hospital	1.5.2 - Improve process by which GPs refer to UHL for specialist opinion/admission	Review early experience in November of Pathway Co-ordinators in Bed Bureau	Sarah Smith (LLR Urgent Care)	10/12/2015	Review has informed a discontinuation of this service	Review has informed a discontinuation of this service	7. Closed	Changes in UHL pathways have resulted in no need for clinical navigator roles. Bed Bureau Call Assessment Frameworks being written for each patient pathway to inform a gap analysis of breakdowns in patient flow
Inflow	1.5 To minimise the need for GP initiated/related admission to acute hospital	1.5.2 - Improve process by which GPs refer to UHL for specialist opinion/admission	Implementation of 'Consultant Connect' telephone advice for respiratory and gastro patients who are at risk of admission	Julie Dixon (UHL)	14/12/2015	Reductions in inappropriate emergency attends where there are suitable alternatives available	Collate nos of contacts for advice by GPs	2. Significant delay – unlikely to be completed as planned	UHL liasing with Consultant Connect to develop consultant hunt groups and agree implementation date Further update required at next EQSG. **Update on 05/01:** Consultant connect have completed set up for Endocrinology and are progressing towards Gastroenterology and Neurology. It is not currently feasible to extend this to respiratory due to the exceptionally high levels of activity. All GP numbers are with Consultant Connect. Service will start within next 7-10 days once Consultant telephone and GMC numbers are provided.
Inflow	1.5 To minimise the need for GP initiated/related admission to acute hospital	1.5.2 - Improve process by which GPs refer to UHL for specialist opinion/admission	Understanding remit and current specification of ambulatory clinics to understand appt timeframes	Catherine Free	10/12/2015	Ensure 'rapid' clinics are in fact rapid Increase utilisation of clinics by GPs and EDSS	All rapid access pathways accessible within intended timeframes. Improved utilisation of ambulatory clinics capacity by GPs and EDSS	6. Complete and regular review	Timeframes have been checked with each service and added to front of directory to facilitate feedback if issues arise with slot availability
Inflow	1.5 To minimise the need for GP initiated/related admission to acute hospital	1.5.2 - Improve process by which GPs refer to UHL for specialist opinion/admission	Implement rapid cycle testing by placing a GP in ED to observe the assessment and decision making process by ED clinicians, producing recommendations for community-based alternatives and the role of the care plan in supporting decision making	C Tierney-Reed (WL CCG)	10/12/2015	Increased utilisation of care plans to inform treatment pathway Feedback to GPs where care plans are not available for at risk patients	No of primary care records accessed, to include care plans and medications	6. Complete and regular review	Visit has been done Report produced Recommendations to be reviewed @ Demand Group mtg 08/01
Inflow	1.5 To minimise the need for GP initiated/related admission to acute hospital	1.5.2 - Improve process by which GPs refer to UHL for specialist opinion/admission	Deploy LHIS support to; Access GP care plans for ED clinicians and upskill ED ward clerks in accessing primary care information Reinstate dedicated IT support to ED	C Tierney-Reed (WL CCG) John Clarke (UHL)	14/12/2015 TBC	Increased utilisationof care plans to inform treatment pathway Feedback to GPs where care plans are not available for at risk patients	No of care plans accessed	4. On track	See above Dr Ffion Davies contacted John Clarke to request support - awaiting update Action plan developed and ongoing monitoring now required CTR to liaise with LHIS and IM&T Steering Group for progress updates
Inflow	1.6 To continuously review activity data to identify patients/groups potentially amenable to alternative care plans/services	1.6.1 - Regular attenders picked up and management plans agreed across agencies	WL to develop SOP based on current process for weekly review of real time data to share with ELR & LC Utilise review of real time data to target moderate/frequent flyers, paeds (particularly 0-10y) CCG leads to contact individual GP practices directly to discuss alternative services ELR and LC to circulate and adopt WL SOP	C Tierney-Reed (WL CCG) / D Eden (ELR CCG) / R Vyas (LC CCG)	11/12/2015 14/12/2015 14/12/2015	Reduction in frequency of attendance/admission for target patients	Target cohort is ED attends via ambulance to be reviewed Nos of patients who died in the department (consider presence of care plan) Nos of frequent attenders Nos of patients admitted where an alternative service could have been considered (UCC, OPU, AVS) Baselines per CCG; WL - circa 250 records reviewed every week with circa 110 reviewed in more detail, circa 5 GP practices contacted per week	3. Some delay – expected to be completed as planned	WL CCG system fully operational & their SOP shared LC CCG have amended and implemented from 04/01/2016 Reviewing 6y-18y and 50+y conveyed via 999 to Minors/Majors w/o Em Adm **Update 05/01:** ELR to adopt Leicester City SOP
Inflow		1.6.2 - Short stay admissions	Specific review of ED attends / Em Adms for Paeds & Gynae LC CCG to Organise Patient info sessions in high usage areas; undertake a book bag drop in every city school 'when should I worry' booklet; To Assess viability of providing community pathway at Westcotes Health Centre WL to develop targeted comms campaign as part of outreach campaign (see 1.1) re: use of UCC Lo by parents / carers ELR conducting deep dive analysis of all Em Adms	R Vyas (LC CCG) / R Mitchell (UHL) S Venables (WL CCG) / R Crabb (LLR Urgent Care) D Eden (ELR CCG)	21/12/2015 11/12/2015 14/12/2015	Detailed understanding of short stay presentations	Reductions in Paeds and Gynae short stay activity Increase in Paeds presentations to UCC Lo	4. On track	LC CCG - Data analysis complete to understand activity flow and Leaflets ordered, Book bag drop in place before by 18.12.15 GP's representatives from across the CCGs to observe in both ED and GAU/UAU/CAU to understand what primary care can do differently on Thurs 17th and w/c 21st Dec - awaiting feedback Previously written SOP for gynae community pathway being re-assessed WLCCG - Plan in place to target Surestart, Mother and Toddler groups and similar with winter messages.
Inflow		1.6.3 - UHL admission variance YTD by CCG and condition	UHL to identify key variances YTD by CCG and condition to inform development of further targeted plans	R Mitchell (UHL)	18/12/2015	Detailed understanding of presentations	Review commenced, analysis to be shared with CCG colleagues w/c 21.12.15	2. Significant delay – unlikely to be completed as planned	We are further analysing the information presented at UCB in October to identify where the greatest increases have occurred by age, presenting condition and CCG. The aim is to complete by 18th December. This has been delayed because of recent CQC requests. **Update on 05/01:** This is continuing to be worked on, but continuing CQC requests have delayed this action further

Group	Objective	Action area	Delivery description & detail	Senior accountable lead	Delivery date	Expected impact	Activity Monitoring	Delivery Status	Progress to date
Flow	2.1 To reduce delays in ambulance handover times at the LRI site	2.1.2 - Learning from best practice elsewhere	Look at QMC systems and processes	Richard Mitchell	w/c 30/11/15		Overall improvement in key KPIs	2. Significant delay – unlikely to be completed as planned	QMC has been contacted and planning a visit w/c 21st **Update on 05/01:** Visit was cancelled due to operational pressures both at UHL and NUH. Phone conversations have taken place and the plan is to visit NUH in January.
Flow	2.1 To reduce delays in ambulance handover times at the LRI site	2.1.3 - Pre-admission space	Transition area protocol and staffing arrangements	Richard Mitchell	w/c 30/11/15	EMAS crews freed up to respond to incoming calls in the community	Fewer lost hours and zero 2 Hr+ delays	6. Complete and regular review	Transition area protocol signed off. We are trying to staff facility every shift and this has been used 3 times in the last 14 days.
Flow	2.1 To reduce delays in ambulance handover times at the LRI site	2.1.5 - To complete SOP supporting the streaming of patients from EMAS to the streaming service and implement		Sam Leak	31/12/2015		Increase in ambulance streaming to UCC	5. Complete	**Update on 16/12:** SOPs in place. Updates needing following latest changes. **Update on 05/01:** Completed and circulated internally and externally.
Flow	2.1 To reduce delays in ambulance handover times at the LRI site	2.1.6 - Introduce routine flow management/co-ordination for patients arriving at LRI by ambulance to increase referrals to non-ED majors dispositions		UHL/EMAS					New action identified through UNIPART exercise
Flow	2.1 To reduce delays in ambulance handover times at the LRI site	2.1.7 - Agree a consistent handover assessment process/approach/tool/template		UHL/EMAS					New action identified through UNIPART exercise
Flow	2.1 To reduce delays in ambulance handover times at the LRI site	2.1.8 - Agree data and reporting to monitor impact of new arrangements and ensure operational process changes are embedded and sustained		UHL/EMAS					New action identified through UNIPART exercise
Flow	2.1 To reduce delays in ambulance handover times at the LRI site	2.1.9 - Agree and implement 'B list' of logistical issues (e.g. availability of chairs/trollies/blanket, sheet and battery replen for EMAS crews) which just need to be resolved to optimise handover slow/support multi-agency relationships		UHL/EMAS					New action identified through UNIPART exercise
Flow	2.2 To ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service	2.2.3 - Consider extension of current service to 12am		Richard Mitchell	Lead in time once funding has been confirmed	Reduction in number of patients attending main ED and therefore a reduction in ED occupancy	Further decrease in referral rate from UCC to ED	4. On track	RM, Julie Dixon and Lakeside have met to discuss this. Lakeside would like to extend the hours per day that the service is provided but are cautious because of challenges in fully staffing the current 0900 – 2100 rota. If authorised by the CCGs we beleive we can deliver an extension to midnight noting an extension will cost more money. A three hour extension will cost circa £87,000 per month. RM has already authorised Lakeside to look at extending the scope of their service eg increased interaction with UCC and minors and are working up a proposal at the moment. **Update 05/01:** Request submitted as part of Vanguard Bid.
Flow	2.2 To ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service	2.2.4 - To increase the number of patients redirected by the streaming service to community alternatives/ambulatory clinics		Julie Dixon	31/01/2016	Reduction in number of patients attending main ED and therefore a reduction in ED occupancy	Increased proportion of patients diverted to alternative services	5. Complete	Julie and Stuart Maitland- Knibb will explore this **Update 05/01:** Piloted having one of the Urgent Care GP's at the front desk screening all attendances and referrals. This was successful in diverting higher volumesof patients and the proposal is to continue this between 9am and 9pm.
Flow	2.2 To ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service	2.2.5 - To relocate OOH service from clinic 4 to the UCC		Julie Dixon	31/01/2016	better flow within UCC	N/A	4. On track	Julie and Stuart Maitland- Knibb will explore this. **Update 05/01:** Sarah Smith scoping current activity levels to assess capacity requirements.
Flow	2.2 To ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service	2.2.6 - To increase the range of near patient testing within the UCC		Julie Dixon	31/01/2016	Reduction in number of patients attending main ED and therefore a reduction in ED occupancy	Further decrease in referral rate from UCC to ED	1. Not yet commenced	New action
Flow	2.2 To ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service	2.2.7 - To establish pathway in UCC to assess ambulatory patients from GPs		Julie Dixon	31/01/2016	Reduction in number of patients attending main ED and therefore a reduction in ED occupancy + reduction in admissions	Reduction in volume of GP referrals needing to access ED	5. Complete	Update on 05/01: All patients asked to attend ED by GP (GP urgents) are redirected from minors reception to UCC and are seen in an ambulatory setting.
Flow	2.2 To ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service	2.2.8 - To establish pathway to direct OOH patients through the streaming service		Julie Dixon	31/01/2016	Reduced demand on OOH service	Reduction in OOH attendances	6. Complete and regular review	**Update on 05/01::** In which forum was this agreed? Is the purpose of this action screen all OOH referrals by another GP? Patient feedback is poor from this pathway.
Flow	2.2 To ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service	2.2.9 - To establish observation room in UCC to both reduce admissions and if appropriate enable direct admissions by passing ED		Julie Dixon	31/01/2016	Reduction in number of patients attending main ED and therefore a reduction in ED occupancy + reduction in admissions	Reduction in ED attendances and in majors congestion	4. On track	**Update on 05/01:** Estates have reviewed building work needed. Two rapid cycle tests have been conducted which were successful - patients were safe and some were able to be discharged. For this to run on an ongoing basis nursing cover is required. These shifts have been put out to agency.

Group	Objective	Action area	Delivery description & detail	Senior accountable lead	Delivery date	Expected impact	Activity Monitoring	Delivery Status	Progress to date
Flow	2.2 To ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service	2.2.10 - To route all GP urgents through bed bureau including those with a GP letter currently presenting to minors		Lee Walker	31/01/2016	Reduction in number of patients attending main ED and therefore a reduction in ED occupancy + reduction in admissions	Imprrovement in GP referrals via ED metric	4. On track	New action **Update on 05/01:** Temporary business case (up until end of March) for extra funding in AAU has been approved pre christmas to increase direct admissions coming to AAU. This will allow: More nurses (already in place), 1 more junior in the evening (due to start in next couple of weeks), a senior in the evening (start to be confirmed as part of CESR). Longer term we are looking to further increase capacity by trying to separate the ambulatory and non-ambulatory streams with the former being directed into the UCC. In the meantime, reviewing the possibility of a least moving the follow ups down to UCC as a sort of 'separate the streams LITE'. We mat be able to do this without additional funding but reallistically will take at least a few weeks to organise IT, admin and get an agreement with the clinicians in UCC and AIM to support.
Flow	2.3 To ensure adequate ED nurse staffing levels to maintain 5/6 assessment bays	2.3.1 - Increase ED nursing establishment to 28 plus 2/3 for transition area	Agency 'long lines' increased through to 11 Jan	Julie Smith	Complete	ED assessment bays operating at full capacity	No. assessment bays and resus bays operational	6. Complete and regular review	Authorisation to long line agreed w/c 23 November. Fill rate has been marginal although has increased ability to fill the baseline staff levels.
Flow	2.3 To ensure adequate ED nurse staffing levels to maintain 5/6 assessment bays	2.3.2 - ED establishment and skill mix review	Review skill mix, numbers of staff and roles in place and refresh if indicated	Julie Smith	31/01/2016	Balance of staffing and skill mix to demand	No. assessment bays and resus bays operational	4. On track	Julie Smith and Maria McAuley are working on this as part of the establishment review process that is taking place on all wards and departments.
Flow	2.3 To ensure adequate ED nurse staffing levels to maintain 5/6 assessment bays	2.3.3 - Review impact of current nurse shift length and handover timing on clinical 'downtime' (est around 7pm) and staff productivity/safe operating							New action identified through UNIPART exercise
Flow	2.4 To accelerate the admissions process from ED to base wards	2.4.1 - Scope feasibility of introducing movement of patients from ED to base wards earlier in bed identification process to streamline admission	Development of protocol for consideration by UCB and discussion with CQC	Richard Mitchell	10/12/2015	Improved flow out of the ED	Reduced time from decision to admit to patients leaving ED	6. Complete and regular review	Draft SOP completed and signed off at EQSG. Trialed last week on Wards 37 and 38. Feedback coming to EQSG this week. Sharron Hotson discussed with CQC in November. **Update on 16/12:** Julie S, Julie D and Gill to develop short paper with summary of trial, updated protocol and next steps **Update on 05/01:** Protocol updated and summary of initial trial produced and to be discussd at EQSG on 06/01. Further trial took place 29-31st December and results being analysed.
Flow	2.4 To accelerate the admissions process from ED to base wards	2.4.2 - To consider Relocation of bed bureau to enable expansion of service-.		Julie Dixon	End of January	More efficient working	Reduced time to bed allocation and improvement in GP refs via ED metrics	1. Not yet commenced	**Update on 05/01:** Options being considered - for this to have full benefit, move would need to involve telephone system updated and headsets to minimise noise.
Flow	2.4 To accelerate the admissions process from ED to base wards	2.4.3 - To develop patient facing script for bed bureau service re mode of transport to reduce EMAS dispatch /late arrivals		Julie Dixon	End of January	Reduction in patient trasnport demand	Reduction in number of transports booked	1. Not yet commenced	New action
Flow	2.5 To maximise availablilty/flexibility of safely staffed bed capacity	2.5.1 - Reschedule some elective activity from Monday's to weekends	Reduce elective work for 2-3 weeks in January 2016 in anticipation of the predicted spike in non-elective activity	Richard Mirchell	01/01/2016	Surgical ward capacity freed up to support medicine	Additional medical bed capacity during January	4. On track	Plans to reduce elective work between Christmas and the third week in January. However, in reality this is already taking place due to the very high cancellation rate. This means that we will not see a further benefit from this action. **Update 05/01:** We have stratified our adult elective work and only cancer, urgent and previously cancelled patients are having operations. We currently do not have paediatric capacity challenges.
Flow	2.5 To maximise availablilty/flexibility of safely staffed bed capacity	2.5.2 - Identify opportunities to deliver UHL activity away from the 3 acute sites	Scope feasibility of creating cardio-respiratory ward capacity at Loughborough	Kate Shields	TBA	Freed up acute ward capacity	No. acute hospital beds operational	7. Closed	This will not take place due to clinical suitability, however further actions are being explored.
Flow	2.5 To maximise availablilty/flexibility of safely staffed bed capacity	2.5.2 - Identify opportunities to deliver UHL activity away from the 3 acute sites	Review potential for re-comissioning space on wards used for non-clinical purposes	Darryn Kerr	04/12/2015	Physical potential to create additional bed capacity	Number of acute hospital beds	6. Complete and regular review	In the last month additional gastro, oncology and paediatric beds have been opened. A further piece of work is taking place to open additional beds and we are also confiming required bed capacity for 16/17. It is worth noting that ability to open additional beds is dependent on access to increased staffing levels.
Flow	2.5 To maximise availablilty/flexibility of safely staffed bed capacity	2.5.3 - Improve utilisation of all available and appropriate beds	Improve process for early outlying by sending out an early outlying plan with the bed state on Friday afternoon (4:30/6pm)	Julie Dixon	11/11/2015	Improved flow out of the ED	Reduced time from decision to admit to patients leaving ED	6. Complete and regular review	Outlying plan is circulated every Friday. Work is ongoing to improve process. Data request made to confirm effectiveness of process and to monitor impact on patient outcomes and surgical activity.
Flow	2.6 To speed up and bring forward (time of day) the discharge process	2.6.1 - Additional assistant capacity to support Drs in non-clinical activity	Advanced HCAs x7 on wards with highest daily discharges to support flow, admin and junior Drs in making patients ready	Julie Dixon	w/c 07/12/2015	Reduced time from decision to discharge to patients being made ready	Patients discharged by time of day	6. Complete and regular review	Trialling additional discharge coordinator on base wards with highest turnover. There is little evidence atm discharges have increased as a result.
Flow	2.6 To speed up and bring forward (time of day) the discharge process	2.6.2 - Improve utilisation of the discharge lounge between 8am and 12pm.	Review current processes and approach to utilisation of the discharge lounge	Julie Dixon	18/12/2015	Increased utilisation of the discharge lounge between 8am and 12pm Freed up acute ward capacity	Increased utilisation of the discharge lounge Patients discharged by time of day	6. Complete and regular review	Driven increased discharges to the discharge lounge on oncology and day wards by visiting outlying patients, and encouraging staff to use the discharge lounge Designed a 'meet me in the discharge lounge' project for patients. Data not available to ascertain benefit of project - awaiting information before deciding to pursue additional initiatives

Group	Objective	Action area	Delivery description & detail	Senior accountable lead	Delivery date	Expected impact	Activity Monitoring	Delivery Status	Progress to date
Flow	2.7 To ensure that the hospital responds appropriately to capacity pressures in ED	2.7.1 - Co-ordinated escalation response between ED. AMU and CDU to share risk appropriately across the areas in the safest possible way	Design and implement an escalation policy for CDU as part of the whole hospital response to improve flow through department	Sam Leak	~~01/09/2015~~ 31/01/2016	Reduced number of diverts from AMU/CDU Reduced occupancy in CDU/ED	Evidence of escalation plans being enacted in line with policy	4. On track	Initial meeting between CDU and ED has taken place. AMU and ED meeting being scheduled. Existing escalation plans on CDU and AMU are being reviewed. **Update on 05/01:** Escalation policy updated and to be circulated.
Flow	2.7 To ensure that the hospital responds appropriately to capacity pressures in ED	2.7.1 - Co-ordinated escalation response between ED. AMU and CDU to share risk appropriately across the areas in the safest possible way	Coordinated escalation process to be implemented in the ED	Richard Mitchell	19/12/2015			5. Complete	**Update on 05/01**: Implemented - please see Urgent Care policy agreed with Urgent Care Board
Flow	2.7 To ensure that the hospital responds appropriately to capacity pressures in ED	2.7.1 - Co-ordinated escalation response between ED. AMU and CDU to share risk appropriately across the areas in the safest possible way	Agree and implement escalation response between AMU and ED	Richard Mitchell	19/12/2015			5. Complete	**Update on 05/01:** Implemented - please see Urgent Care policy agreed with Urgent Care Board
Flow	2.8 To ensure that patients who do not require an admission are directed to ambulatory services where possible	2.8.1 - Implement RCT of acute physicians reviewing ED admitting decisions	Agree process for trialling + expected benefits	Ian Lawrence	~~16/12/2015~~ 25/12/2015	Reduction in admissions	Reduced admission rate from ED	5. Complete	Finalising plans **Update on 16/12:** Ian to action **Update on 05/01** - Trialled w/c 28/12 with following results: Deferred admission (discharges home) use of ambulatory pathways (particularly Acute Medical Clinic) Expedited admissions (ACB from Resus/Assessment Bay), direct admissions to SSU/speciality base wards (thus bypassing AMU/AFU) This should be continued and further actions will be added to deliver this sustainability.
Flow	2.8 To ensure that patients who do not require an admission are directed to ambulatory services where possible	2.8.2 - Increase capacity on AMU for GP access	Utilise space on UCC for ambulatory patients to increase capacity for GP direct admisisons	Lee Walker	16/01/2015	Reduced occupancy in ED	Increased number of patients going through AAU	4. On track	Steering group set up, IT and Estates work scoped. Business case for temporary additional staff completed. **Update on 05/01** Updated Version of business case will be discussed at revenue committee in January.
Flow	2.8 To ensure that patients who do not require an admission are directed to ambulatory services where possible	2.8.3 - Work with CDU to develop ambulatory clinic to streamline flow through department	Stream patients at triage who are likely to be ambulatory into separate area to facilitate rapid turnaround	Sam Leak	14/12/2015	Reduced CDU Occupancy	Increased propotion of patients with LoS on CDU of > 6 hours CDU Occupancy	6. Complete and regular review	Streaming service launched on 14/12 with comms to all CDU staff and patient information posters. Full implementation will be complete by March once all staff in post.
Outflow	3.1 To increase community 'step-down' capacity	3.1.1 - Phased increase of Intensive Community Support (ICS) capacity	Implement additional 16 ICS beds; Oct 16 Dec 16 Jan 8 Feb 40 (subject to successful staffing recruitment) Mar 50 (subject to successful staffing recruitment)	Rachel Bilsborough (LPT)	w/c 30/11/2015	Increase of alternatives to acute hospital admission	No. ICS beds operational	4. On track	Additional December capacity opened in line with plan
Outflow	3.2 To optimise use of existing community services capacity	3.2.3 - Additional Primary Care Co-ordinators to expedite identification of patients suitable for discharge to community services	LRI x2 additional to start by 21 Dec	Nikki Beacher (LPT)	21/12/2015	More patients identified as suitable for discharge to community services earlier in LOS	No. patients identified for earlier discharge	4. On track	Recruitment commenced
Outflow	3.2 To optimise use of existing community services capacity	3.2.4- Additional Primary Care Co-ordinators to expedite identification of patients suitable for discharge to community services	Additional recruitment to take full complement to 7 (inc. Glenfield)	Nikki Beacher (LPT)	31/01/2016	More patients identified as suitable for discharge to community services earlier in LOS		4. On track	Staffing for GGH and LRI are in place as per the plan
Outflow	3.3 To maintain DTOC rates at current low levels	3.3.1 - Maintaining daily multi-disciplinary partnership approach	Maintaining daily bed management and DTOC calls	Sarah Prema (City CCG) /Tracy Yole (LLR Urgent Care)	Ongoing	DTOC not being rate limiting factor in discharge flow	DTOC rate to be maintained <2%	4. On track	Current DTOC position remains low at 1.72%

APPENDIX 3

University Hospitals of Leicester NHS NHS Trust

East Midlands Ambulance Service NHS NHS Trust

Overview and Scrutiny Committee

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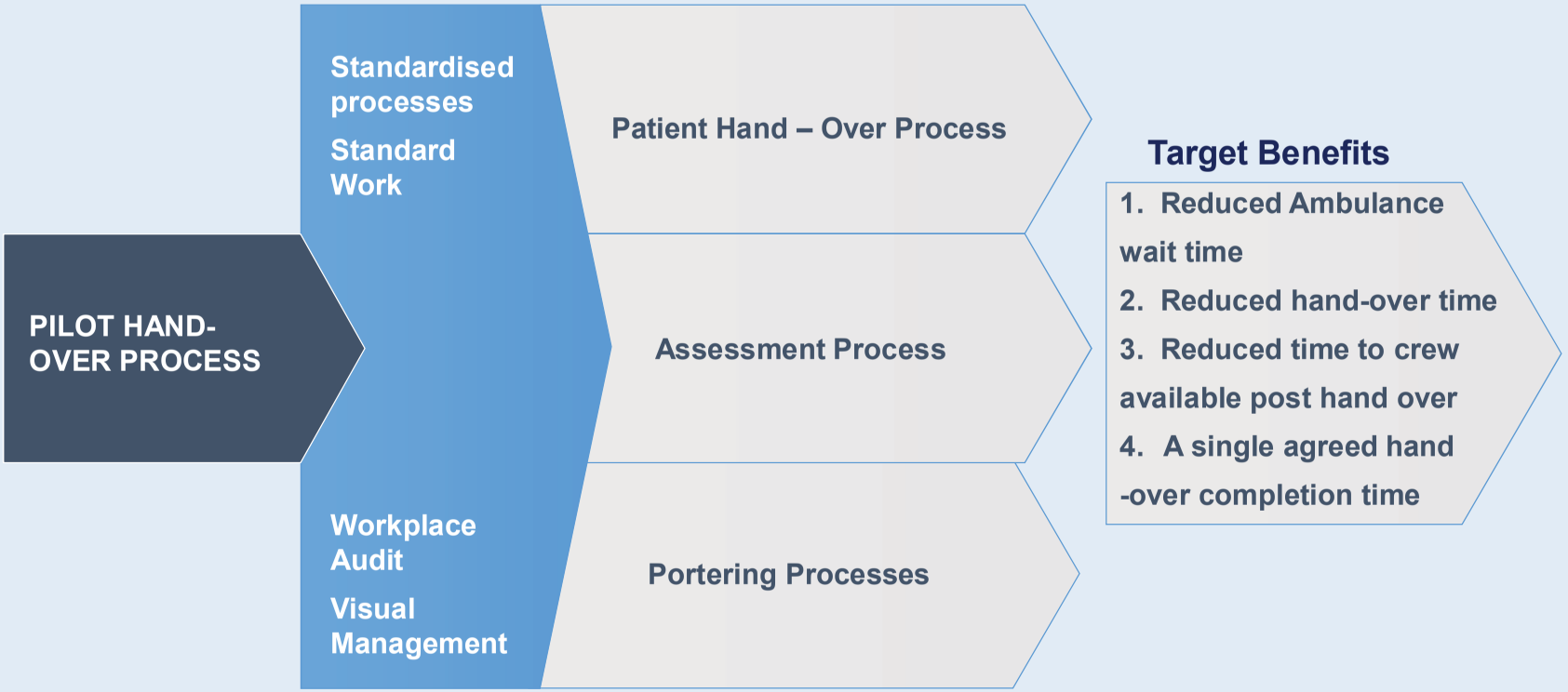
Follow us at: @EMASNHSTrust

Unipart Process Design & Pilot

New Processes designed by the EMAS and UHL Teams



East Midlands Ambulance Service NHS Trust

University Hospitals of Leicester NHS Trust

Unipart Measured Benefits in Pilot Week (7th – 11th December)

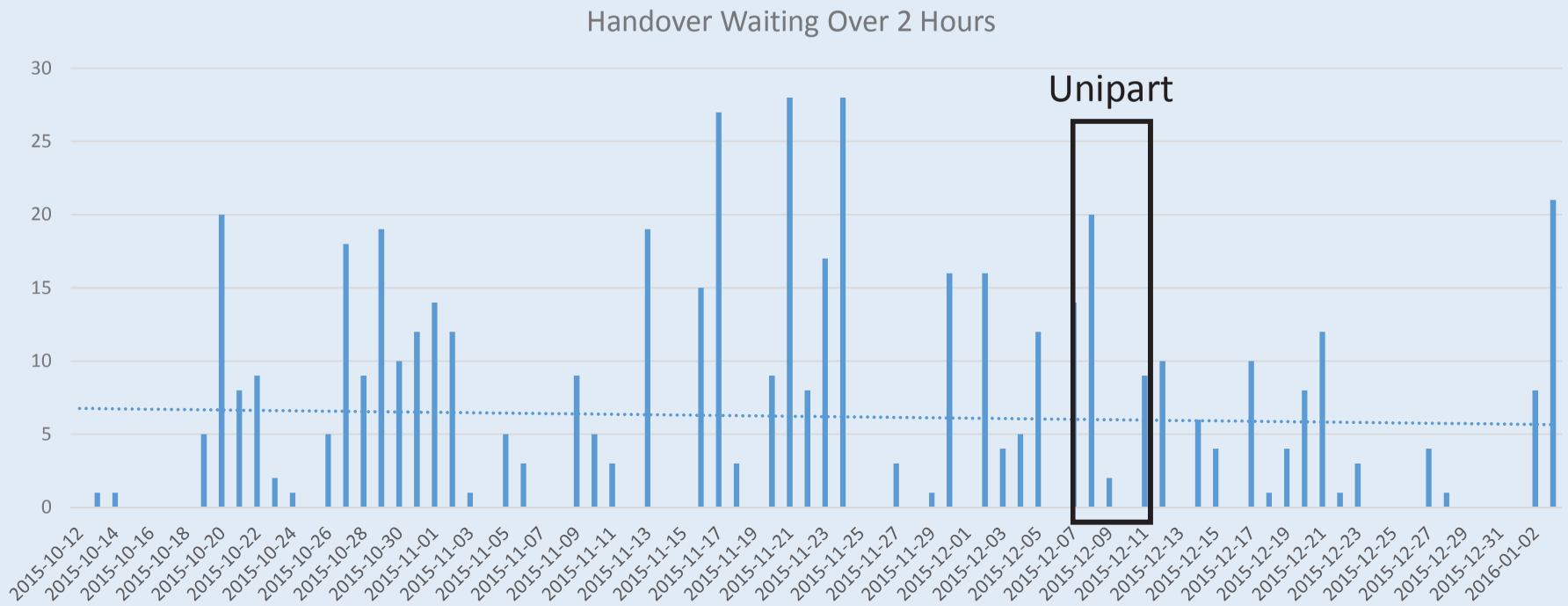
Delivered Benefits

- Patient Hand–Over Process
- Assessment Process
- Portering Processes

1. Reductions in Ambulance waiting time
   - 23% Pre Hand-Over
   - 31% 1-2 Hour Wait
   - 32% Over 2 Hours
2. 14% Reduction in lost hours.
3. 74 Patient redirections to other pathways
4. Improved EMAS response achievements:
   - R1 16% R2 6% R19 5%
5. 10% reduction in Assessment Bay demand
6. Reduction in Majors demand (observed improvement but not measured)

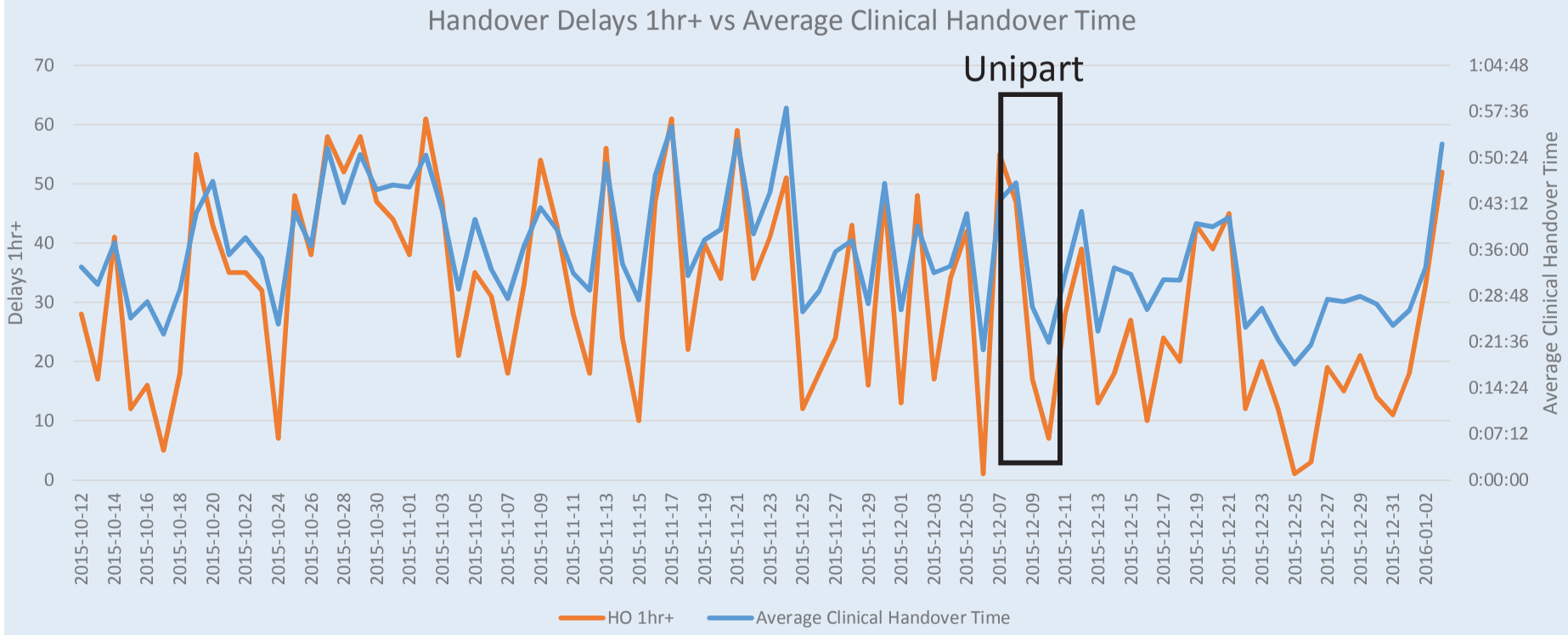
LRI ED Handover Performance October > December

- Data is presented from 12/10/15 (Initial Handover Summit) to 03/01/16
- Unipart Facilitated 'Week' – 7th December > 11th December



LRI ED Handover Performance October > December

- Data is presented from 12/10/15 (Initial Handover Summit) to 03/01/16
- Unipart Facilitated 'Week' – 7th December > 11th December

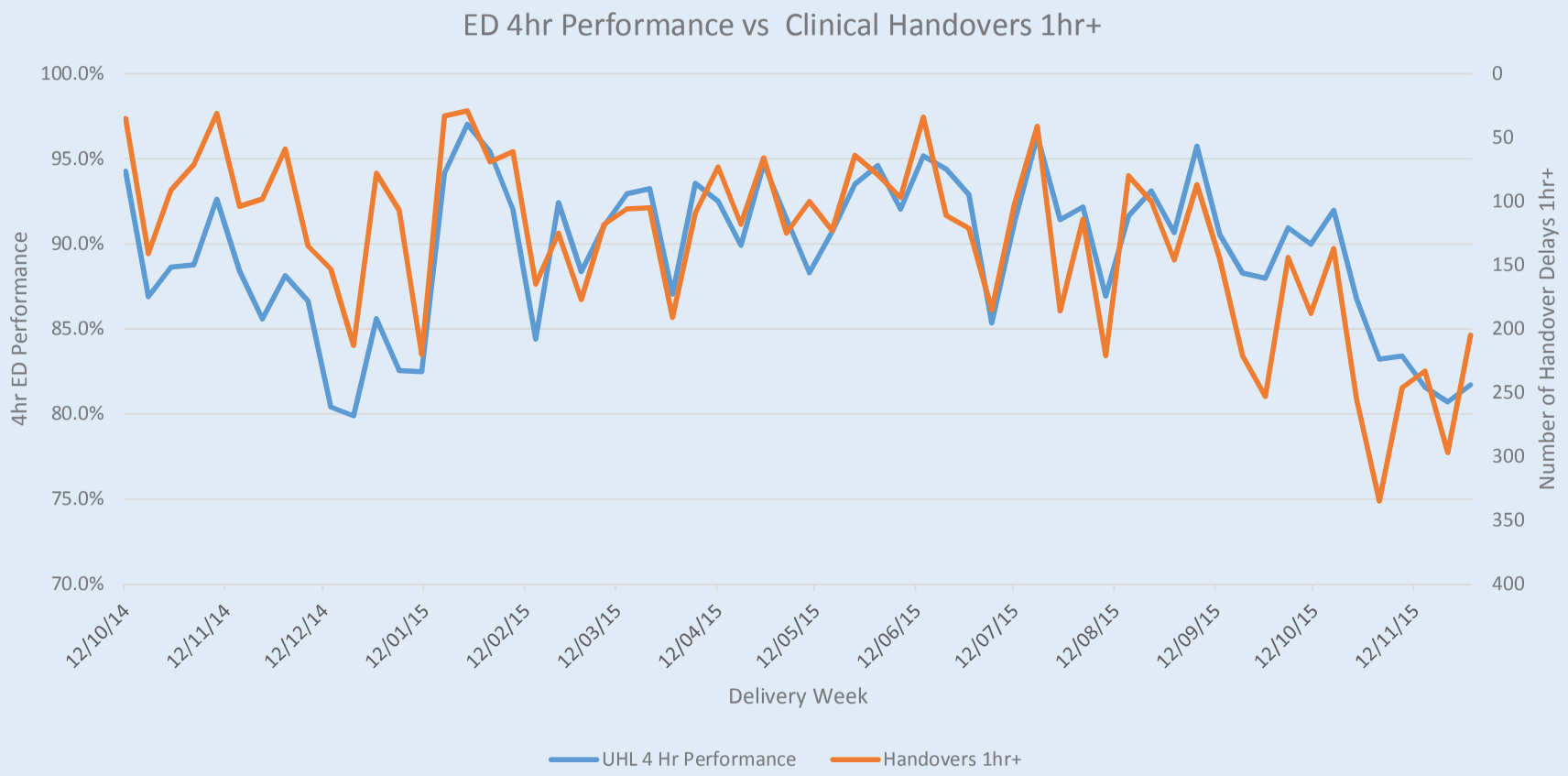


East Midlands Ambulance Service NHS Trust

University Hospitals of Leicester NHS Trust

Handovers – November 2015

Leicester Royal Infirmary 4hr ED Target vs Handovers 1hr+



East Midlands Ambulance Service NHS Trust

University Hospitals of Leicester NHS Trust

Handover Turnarounds – Actions Taken in Leicestershire

- Direct conversations with UHL
- Escalation via letters to all SRGs/Chief Execs
- Escalation Handover Summit Leicestershire
- Escalation to NHS E
- Escalation to TDA
- Escalation to East Midlands UEC Network
- Chairs/ Chief Execs meeting with UHL
- 48 hour Exec to Exec calls Leicester
- HALO deployment
- Cohorting roles and space at LRI
- Comfort rounds for patients
- Staff Welfare & Support
- Unipart LRI Handover Improvement Work
- 'EMAS cars' approach to relieve staff
- CQC Inspection of LRI Dec 2015
- Subsequent sanctions imposed to improve
- Joint TDA & NHS England Risk Summit (18th Dec)
- Next planned Risk Summit 1st February 2016

Handover Turnarounds – Patient Safety

- EMAS patient safety action plan, monitored through EMAS Intensive Support Board pulls together all the current actions being undertaking to ensure that patient safety is monitored and risks identified and mitigated across the Trust especially in periods of high demand.
- Real time reporting of clinical risk due to high demand within EMAS through the Clinical Risk index.
- An agreed Clinical Protocol to ensure the continued clinical assessment of patients whilst waiting to be handed over to the Emergency Department. This incorporates the patients waiting in a corridor or holding in the back of an ambulance, staffed by UHL
- An agreed comfort round document that monitors care given to ensure that patients are hydrated, offered nutrition, are warm enough, can use toileting facilities, are protected where possible from pressure damage and are treated with dignity and respect.
- When continuous pressure at ED is observed and is not resolving, and there is an increase in patient safety concerns and operational concerns a series of measures will be taken, which include:
- Regular teleconferencing between Executive Directors to agree further actions.
- Agree senior clinical presence on site to ensure an effective and efficient working relationship between the emergency department and the ambulance crews to ensure patient and staff welfare.

Agenda Item 10

Leicestershire Partnership NHS
NHS Trust

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 20 JANUARY 2016

REPORT OF LEICESTERSHIRE PARTNERSHIP NHS TRUST

UPDATE OF PROGRESS OF ACTIONS RELATED TO THE CARE QUALITY COMMISSION INSPECTION AT LEICESTERSHIRE PARTNERSHIP NHS TRUST

Executive Summary

1. Leicestershire Partnership NHS Trust (LPT) had a statuary inspection of its services carried out by the Care Quality Commission (CQC) in March 2015. LPT provides integrated Mental Health, Learning Disabilities and Community Health Services for a population of approximately 1 million in Leicester, Leicestershire and Rutland. It provides a wide range of physical and mental health services covering the whole life span, such as school nursing, health visiting, community hospitals, community nursing services, end of life care, mental health services for older persons, IAPT, acute mental health wards, community paediatricians and DIANA nursing services.

2. The final report of the CQC inspection was received by the Trust on 2 July 2015 followed by a Quality Summit on 7 July 2015. The report was published on 10 July 2015. Overall the Trust has been rated as 'requires improvement' with three of the five inspection domains (effective, responsive and well led domains) rated as requiring improvement, one (safe) as inadequate and one (caring) as good. The Health Overview and Scrutiny Committee received a paper on 9 September 2015 describing the process of review, the themes from the report and the immediate actions that were taken as a result of the report. It also received details on the governance processes for the Trust Board to receive assurance on the delivery of the required actions. This report provides an update on actions along with more details of the progress of actions related to Bradegate Mental Health Unit as requested by the last committee.

Background

3. Leicestershire Partnership NHS Trust received an overall requires improvement rating. The main themes arising from the final report were
   (a) Safer staffing and the use of temporary staff;
   (b) Physical environment – seclusion, ward layout, line of sight, single sex accommodation, general maintenance;
   (c) Mental Health Act (MHA)/Mental Capacity Act (MCA) compliance;

(d) Patient safety – ligature points, restrictive practice, seclusion, learning lessons in Child and Adolescent Mental Health Service (CAMHS);
(e) Demand and Capacity – Adult Mental Health (AMH), CAMHS, Community therapies;
(f) Workforce – engagement, morale, appraisal, mandatory training.

4. The Trust received a total of 80 Requirement Notices. A Requirement Notice is issued by the CQC as part of the range of statutory enforcement powers available to the CQC. Requirement Notices are the lowest form of enforcement action the CQC may issue to a health and social care provider it regulates. Requirement Notices are also referred to in the CQC reports and in this paper as 'Must-Do's'.

5. In response to this a comprehensive action plan was developed and submitted to the CQC during August 2015. This plan encompassed the initial concerns raised by the CQC immediately following the inspection in March 2015. There are 38 specific actions that are required covering the 80 Must-Do's. These were the important actions for the Trust to take forward in a reasonably urgent timeframe, to ensure that its services are safe, responsive, caring, well led and effective.

6. Although it was anticipated that most actions will be complete within a six month timeframe, there were a number of actions related to the environment, provision of the mixed sex accommodation on three wards and seclusion at the Bradgate Unit which may exceed the six month timescale.

7. LPT's approach to continuous quality improvement, has already been described in both our clinical strategy and quality strategy but the Trust needs to see this move forward at pace creating the right culture, involving:-

(a) Listening continuously to our users which include patients, their families and carers;
(b) Working in an integrated manner improving the coordination of care and delivery of service;
(c) Staff working together in high performing multidisciplinary teams to deliver the right care for service users at the right time and place;
(d) Enhancing the power of front line clinicians to innovate and improve the care continually.

Progress Since the Last Update

8. Significant achievements

- Mental Health Act: LPT has significantly improved policy, process and training in relation to the Mental Health Act (MHA). It has introduced a medical scrutiny, trained the qualified nurses on scrutiny of all documents at the point of admission, introduced an electronic monitoring tool on the use of MHA within all our inpatient areas, made it

easy to access all mental health related papers in the Electronic Patient Record system (RiO) and developed service level and ward level champions to lead the continuous quality improvement in this area.

- Medication Management arrangement on the wards have been strengthened. New systems for recording and escalating drug fridge temperatures are in place and LPT has ensured greater security of drug storage and prescription stationary.

- The wards at the Bradgate Unit have been transformed to provide single-sex wards and eliminate the potential for mixed-sex sleeping accommodation breaches.

- An Access to Treatment Policy and a Performance Management and Accountability Framework has been developed to continually monitor and improve patient experience and waiting times across all directorates.

9. Significant Challenges

- Environmental works to remove ligature points and modify seclusion facilities in mental health inpatient settings are ongoing however a number of operational challenges to maintaining patient safety during building works have lengthened the initial predicted timescales. Further details are provided in Appendix 1.

- Although LPT has been successful in recruiting more staff, like many other NHS employers the Trust faces continued challenge in the recruitment and retention of clinical staff. Many of the staff recruited are newly qualified nurses requiring a period of preceptorship before taking on full duties. The Service reviews staffing vacancies, turnover, recruitment and sickness and there is a weekly meeting to review ward rotas to ensure safe staffing levels are maintained through the use of internal bank staff and where appropriate agency staff. There is an escalation process in place to ensure the Executive Team is aware of staffing concerns promptly.

- LPT has made progress in its ability to evidence effective supervision, appraisal and training of its workforce. However a number of actions still need to be taken to ensure appropriate recording of supervision and appraisal.

- Development of an appropriate end-of-life policy and care pathway has not been completed as hoped, as LPT is working with the multi-agency work stream to develop an integrated approach. This work however is progressing.

Conclusion

10. Despite a number of challenges including staffing and limited resources, LPT has made significant progress in most areas identified as requiring improvement by CQC. The Trust is meeting with the CQC inspectors to discuss the progress so far and future plans on 8 January 2016. The strengthened leadership on continuous quality

improvement, continuing to listen to patients and strengthened governance will keep this improvement a continuous process and sustainable.

Officer to contact

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Appendix 1

How is LPT doing with the CQC Action Plan at the Bradgate Unit?

Areas of improvement:

Action: We will implement robust and consistent daily checks regarding temperature recording, expiration date checking and signing in and out process and a clear escalation process

Progress: New fridge thermometers have been purchased and local monitoring has demonstrated that temperatures are being monitored and where temperatures have exceeded the recommended levels the appropriate escalation process has occurred.

Action: We will review the 3 wards at The Bradgate Unit that deliver mixed sex accommodation in shared environments (Aston/ Ashby and Bosworth) and designate wards as single sex as part of Inpatient Pathway Review (patient/ care consultation included).

Progress: On the 19th November 2015 the 3 wards were designated as single sex and the unit wards were then designated as: Watermead and Beaumont – mixed sex (fully meeting the Department of Health guidance), Heather, Ashby and Aston as female wards and Thornton and Bosworth as male wards. Initially Aston was designated as a female ward based on bed demands over the months preceding this change. In the days after this change bed demands for the unit remained high, with the increase being from males therefore despite considering patient moves Aston became a mixed ward again. Patients are provided with same sex sleeping areas but the toilet and washing/bathing facilities are off a central corridor, which is considered a breach of guidance. Due to continuing bed demands this ward has been unable to return to same sex. During the admission process consideration to the placement of patients on mixed sex wards takes place, for example known issues with domestic abuse etc. The appropriateness of placements is reviewed during ward rounds regularly.

Action: Review of all Trust Seclusion facilities against MHA/ AIMS standards and report regarding required changes to meet compliance and develop a work plan to address requirements

Progress: All seclusion facilities at the Unit have been reviewed and there is a Trust wide programme to address areas of improvement required. In the interim all seclusion rooms at the Unit are being fitted with two way communication and increased observation via CCTV.

Action: The Trust must review the provision of staffing in the multidisciplinary teams, specifically in relation to psychological input

Progress: There is currently a full time senior clinical psychologist working across the unit. She has spent 2 weeks on each ward scoping the ward culture and needs of the service users and staff training / support. This has been undertaken to look at the requirements for psychological interventions across the Bradgate Mental Health Unit. Training on psychological interventions for the ward staff including nurses and doctors are ongoing and the feedback is good. Further work ongoing to improve Psychological therapies available to patients and are forming part of commissioning intentions for 16/17.

Action: The MHA process and paperwork will be reviewed and integrated into the Inpatient care processes; including systems for compliance monitoring.

Progress: There has been a comprehensive monitoring system put in place since April 2015; recently this has become electronic to aide analysis but has showed an overall improvement in the recording and compliance with Mental Health Act paperwork and the involvement of patients in their care related to detention.

Environmental improvements have been a focus as we work to reducing ligature and safety risks for our acute inpatients.

Progress: We have carried out the immediate remedial ligatures works as identified by the visit. We now conduct quarterly safety walk-rounds with highlighted issues actioned with support from the estates team on a regular basis. The remaining Belvoir ward bathrooms works are scheduled for March 2016. The Herschel Prins Unit ligature programme will begin in January 2016 and planned to take approximately 33 weeks. All the garden perimeter fences are being replaced alongside the installation of anti-climb (works commenced October 2015) to reduce absconsion risk and improve safety.

Patient feedback on their experiences.

Progress: There are monthly community meetings (patient forums) on all wards facilitated by a user/ carer representative. This gives the patients the opportunity to talk about the ward environment, food or any other issues they have. In January 2016 this will also be used as an opportunity to ask patients nearing discharge to complete the Friends and Family Test (FFT). To ensure we gain as much feedback as possible the FFT is also going to offered during the ward reviews prior to discharge in an electronic form on iPads.

January 2016

HEALTH OVERVIEW AND SCRUTINY COMMITTEE
20 JANUARY 2016

REPORT OF THE CHIEF EXECUTIVE AND GEM COMMISSIONING SUPPORT PERFORMANCE SERVICE

HEALTH PERFORMANCE UPDATE

Purpose of Report

1. The purpose of the report is to provide the Health Overview and Scrutiny Committee with an update on performance against current performance priorities set out in the Health and Wellbeing Strategy, Better Care Fund (BCF) Plan and Commissioner Performance Frameworks, based on the latest available data.

Background

2. The Committee currently receives a joint report on performance from the County Council's Chief Executive's Department and the Greater East Midlands (GEM) Commissioning Support Performance Service. This report encompasses:

   (a) Performance against key metrics and priorities set out in the Better Care Fund plan;
   (b) An update on key provider performance issues and performance priorities identified in Clinical Commissioning Group Plans; and
   (c) Latest public health outcomes framework data (PHOF).

Better Care Fund and Integration Projects

3. The dashboard attached as Appendix A summarises current performance against the indicators and targets within the BCF Plan and the impacts of the supporting projects, particularly related to avoiding emergency admissions.

Admissions to Care and Nursing Homes

4. Avoiding permanent placements in residential care homes is a good indication of delaying dependency. Research suggests where possible people prefer to stay in their own home rather than move into residential care. Latest figures forecast that there will be 625.8 permanent admissions to either residential or nursing care of people aged 65 and over per 100,000 population this year, as compared to 710.5 at the 2014/15 year end. This is forecast to meet the BCF target of 670.39.

Older People at Home 91 Days After Discharge

5. A key measure in the BCF is the Adult Social Care Outcomes Framework (ASCOF) metric which demonstrates the proportion of people discharged from hospital via reablement services that are still living at home 91 days later. For those people discharged between June 2015 and August 2015 the figure was 82% against the BCF target of 82.1% and is currently rated Green, with just one person short of the target. The 2014/15 year end figure of 83.5% was above the BCF target.

Delayed Transfers of Care (DToC)

6. The BCF metric is based on delayed days through the month and cumulatively for each quarter against a set of quarterly targets. The quarterly BCF target for Q3 of 2015/16 is 350.79 delayed days per 100,000 population. The number of days delayed was significantly down in October compared to other months in 2015/16 and is currently meeting the third quarter target. An alternative method of monitoring DToCs is a snapshot of people delayed on the last Thursday of each month. This is the method used in the national ASCOF. For Adult Social Care a target has been agreed that the average of these snapshots across the 12 months should not be higher than 8.6. Based on the final Thursday of October there was only one delay attributable to Adult Social Care, a similar position to September and within the target.

Emergency Admissions

7. Data for the period January to October 2015 shows an increase from a rate of 735 non-elective admissions per 100,000 population in September to 770 in October. Against a target to reduce non-elective admissions to 56,273 by December 2015, the health and social care economy in Leicestershire is forecast to underperform by 2,662. The total of 58,935 non-elective admissions will be made by patients residing in Leicestershire, despite a variety of actions, including the introduction of four emergency admissions avoidance schemes.

8. Appendix A shows the total number of avoided admissions that the four BCF emergency admission avoidance schemes have achieved against the performance target so far. In the last month, it has been realised that figures for one of the admissions avoidance schemes (the Single Point of Assessment (SPA) rapid response falls service provided by LPT) have been overstated.

9. The action plan to improve performance against the four emergency admissions schemes has been comprehensively reviewed and revised and is actively being implemented. In addition, a review of the planned trajectories for 2016 is currently underway and proposed revised trajectories (such as the impact of recent changes to seven day working in primary care schemes) are being considered as part of the refresh of the BCF plan.

Patient Experience

10. The BCF metric covering patient/service user experience is derived from a GP survey asking patients whether they have sufficient support from local services/agencies to help manage their long term condition. The aggregated data for July to September 2014 and January to March 2015 shows that 61.6% respondents to the survey, reported they have received enough support from local services/organisations to help manage their long-term condition(s). This is a drop in performance from 64.2% in 2013/14. Delivery of the improvement is therefore rated Amber at this stage.

Emergency Admissions and Injuries Due To Falls

11. The methodology used by Public Health England to calculate the published version of this metric has now been established and local figures since April 2015 have been calculated. Since then the crude rate has varied from 120 per 100,000 to 171 per 100,000. The figure for October is 157 per 100,000. The target for March 2016 is 140.47 and this area is therefore rated Red at this stage.

Integration Project Delivery

12. Within the current BCF scheme delivery progress updates a number of issues have been noted and these are set out below.

Scheme	**Commentary**
Integrating Leicestershire, Leicester and Rutland (LLR) points of access	Following project mobilisation work has now started on the business case for potential access point integration. The project governance is currently being aligned to the urgent care vanguard to ensure that clarity regarding the scope and reporting of both projects is in place.
New services	Enhanced Clinical Care at the Loughborough Urgent Care Centre and Frailty Tracker Nurses are now operational. Data is yet to flow correctly but work is on-going to rectify that.
Care and Health Trak	The vanguard project is concerned with improving the way that patients access urgent care across LLR. The data that we have incorporated into the new Care and Health Trak system to date does not contain all of the information that is needed to do this effectively. It is proposed that the project is expanded to include NHS 111 and out of hours data. Pi Ltd have proposed that they will incorporate these two datasets for free in 2015/16, with an ongoing small charge thereafter.

Provider and Clinical Commissioning Groups (CCGs) Dashboard - Appendix B

13. Attached as Appendix B is a dashboard that summarises information on provider and CCGs performance. The Everyone Counts Dashboard sets out the rights and pledges that patients are entitled to through the NHS. The indicators within the

dashboard are reported at CCGs level. Data reported at provider level does differ, and delivery actions indicate where this is a risk. The report highlights Amber and Red issues on an exception basis.

University Hospitals of Leicester (UHL) Emergency Department 4 Hour Waiting Time

14. 4 hour performance was recorded at 85% in December, and 89% for the full year to date. The national target being 95%. This is primarily driven by record Emergency Department attendances and emergency admissions, but has also been contributed to by staffing issues. Work has started on building a larger Emergency Department to meet demand. This is due to be completed by December 2016. A full action plan on this issue is being monitored by the Urgent Care Board.

Ambulance Response Times, Handovers between UHL Emergency Department and Ambulance and Ambulance Crew Clear

15. An eight-week action plan has been agreed to speed up (reduce) the time it takes for East Midlands Ambulance Service (EMAS) crews to pass patients to Accident and Emergency staff at Leicester Royal Infirmary (LRI). Difficulties continue in accessing beds from the Emergency Department leading to congestion in the assessment area and delays in ambulance handover. Proposals include:
    - Improving processes at Accident and Emergency (A&E) and in the assessment bays;
    - Improving the flow of patients through the hospital and making every effort to reduce numbers attending A&E;
    - Attempting to speed up discharge processes; and
    - Continued work to tell patients the importance of getting medical help before their condition worsens and ends up being an emergency.

Cancelled Operations - Non Re-admitted in 28 Days

16. This issue was highlighted as a risk for November due to the increased emergency pressures. List over-runs form a significant risk to ‘On the Day’ performance. There is on-going work to address paediatric ward bed unavailability due to staff shortages and reduced elective activity. The availability of beds is monitored daily and interventions made where necessary. A review of staffing for Intensive Therapy Unit (ITU) is taking place to ensure that there is best use of staff to maintain beds.

Pressure Ulcers (Grade 2)

17. There was a high number of avoidable Grade 2 pressure ulcers in August and September but improvement was seen in October. The overall number is within the trajectory collectively, as the trend is down for Grade 3 ulcers. This is attributed to earlier detection contributing to the increased number of Grade 2 ulcers, which is positive.

Never Events

18. A patient suffering post-operative delirium managed to manoeuvre out of a top opening window at Leicester General Hospital falling onto a hard surface and sustaining fractures. A full survey of windows across UHL has been commissioned. This will enable the trust to identify where further modification to reduce risk may be required. Clinical colleagues are being asked to further advise where patients at risk of post-operative delirium may be located.

52 Week Waiters (incomplete at UHL) - Orthodontic Patients - Service Commissioned by NHS England.

19. The service is now closed to new referrals with some clinical exceptions. Funding has been secured from NHS England for two full time equivalent locums to clear the backlog. So far recruitment attempts have been unsuccessful. Recommendations from the Serious Untoward Incident (SUI) report included a clearly defined Standard Operating Procedure to be put in place for the administration of planned waiting lists and that all administrative and clinical staff running outpatient clinics should have referral to treatment e-learning training. UHL are exploring capacity for Orthodontic patients within both community and acute providers within the local area. A small number of patients have agreed to transfer their care to Northampton General Hospital or local community providers.

Diagnostic Waiting Times

20. The Trust is working with a number of Independent Sector providers to obtain extra capacity. The Trust will also be part of an initiative around securing extra capacity within the Independent Sector and other NHS Trusts for endoscopy. UHL has submitted its requirements for this process but so far has obtained no extra capacity via this route. The extra capacity is complemented by a robust action plan aimed at addressing general performance issues in Gastroenterology, with particular focus on ensuring that all lists are fully booked and efforts to improve Cancer performance via access to Endoscopy tests.

Cancer

21. *2 Week Wait* - UHL is working intensively with the Endoscopy Department to address the current underperformance. More broadly the Trust is working with CCGs to improve the quality of 2 week wait referrals, specifically in relation to the correct process, use of appropriate clinical criteria, and preparation of patients for the urgency of appointments.

22. *31 day wait* - the Cancer Action Plan aims to address the step-down of patients from Intensive Care in order to pull cancer patients through the system more quickly. It also includes significant investment in more clinical staff, including a nurse specialist in urology and consultants in head and neck and dermatology. This additional capacity will impact positively on performance; however while the recruitment processes are underway staff recruitment has been problematic with a shortage of appropriate candidates.

23. *62 day wait* - efforts to improve 31 day and 2 week wait performance will help to improve the 62 day position. Improvements in endoscopy will significantly help performance in lower/upper gastrointestinal (GI). Additionally the appointment of three service managers with responsibility for managing cancer pathways in UHL's worst performing tumour sites will provide the key focus required; all are now in post.

Improved Access to Psychological Therapies

24. West Leicestershire Clinical Commissioning Group (WLCCG) has now achieved the year to date performance target of 15% for access to psychological therapies. This will continue to be monitored to ensure it remains on track. East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG) performance has improved too, although remains under the national target. Actions to improve performance include a pathway review being undertaken to ensure appropriate patients are referred to the service and patients are discharged in a timely manner. The take-up of self-referrals should increase as a result of engagement with GPs, community venues and adult social services. Waiting times continue to be under target, however there has been some improvement in recent months, as a result of the service now being fully staffed.

Unplanned Hospitalisation and Emergency Re-Admissions

25. UHL's readmission rate has increased during 2015/16 and when compared with other Trusts. A Readmissions Review has now been completed. This highlighted a need for better identification of patients at risk of readmission in order to inform discharge planning and community follow up and support. Work is underway to confirm which 'tool' would be most appropriate for UHL to use and how this would link with the Integrated Community Response Service (ICRS).

Estimated Diagnosis Rate of People with Dementia

26. The national toolkit has been run in the top ten practices in West Leicestershire based on list size and the number of allocated Care Homes. A GP newsletter article is to be published highlighting the Dementia Quality Toolkit and other hints and tips to help support practices to increase dementia diagnosis. For East Leicestershire and Rutland actions include regular dementia communications to practice dementia leads, and included in the GP Bulletin a Care Planning workshop facilitated by Sir Alistair Burns, and Dementia Education for primary care clinicians and practice staff.

Incidence of Health Associated Infection Clostridium Difficile (C.DIFF) – West Leicestershire Only

27. A review of the community and acute positive C.DIFF cases is undertaken to support best practice and identify lapses in care. This includes a discussion relating to different treatment options and a review of current medication. Issues identified are discussed with the GP at the time. Any lessons learnt from these reviews are fed back and discussed with the prescribing lead and medicines management team on a monthly basis. Themes from UHL cases are fed back to the Quality Contracting team for discussion through the contract review process,

as appropriate. All GP prescribers have agreed to undertake an antibiotic/Proton Pump Inhibitor (PPI) prescribing audit as one of their quality audits for 2015/16.

Public Health and Prevention Priorities Dashboard - Appendix C

28. Appendix C to this report is a dashboard summarising performance against key strategic health and wellbeing priorities. The priorities include Better Public Health, Better Physical Health, and improving Children and Young People's Health. Data has been updated for a number of indicators, the following provides an overview by exception.

Child Obesity

29. Results show that for excess weight for children in reception, the overall prevalence in England was 21.9%and 20.2 %. in Leicestershire. For year six excess weight, the prevalence in England was 33.2% and 29.9% in Leicestershire . For the County these results are a small improvement compared to 2013/14. The County remains in the top performing quartile of all authorities.

30. The work commissioned by the Public Health Department to encourage children to move more and to encourage healthy eating, as well as the support we offer families through programmes such as our Family Lifestyle Clubs seems to be paying off. As well as helping children to be healthier now, this will also pay dividends in the future in reduced health care costs for the NHS. However continuing improvement in this area is still a priority.

Child Oral Health

31. A survey of the oral health of five year olds was conducted in 2012 and published in autumn 2013. This identifies the prevalence and severity of dental decay by measuring the number of decayed, missing and filled teeth, this report identified the oral health of 5 year olds as an issue. Data from the more recent Oral Survey of 3 year olds shows Leicestershire children to have a significantly higher percentage of decayed, missing or filled teeth compared to the national average. The figure in Leicestershire is 18.6% compared to 12% nationally. A separate report on actions to tackle this has been presented to the Committee on 9 September 2015.

Recommendations

32. The Committee is asked to:

    a) note the performance summary, issues identified this quarter and actions planned in response to improve performance; and

    b) comment on any recommendations or other issues with regard to the report.

List of Appendices

Appendix A - Better Care Fund Summary Dashboard

Appendix B - Provider and CCG Performance Summary Dashboard

Appendix C – Public Health Summary Dashboard

Background papers

Leicestershire Partnership Trust Board Papers can be found at the following link: http://ow.ly/WKdpb

University Hospitals Leicester Trust Board meetings can be found at the following link:
http://ow.ly/WKdsw

Oral Health of Five Year Olds can be found at the following link: http://ow.ly/WUdmR

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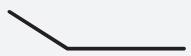
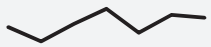
	Metric	Target	Current Data	Trend	RAG	Commentary
Better Care Fund Overarching Metrics	♦ METRIC 1: Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population, per year	670.39	625.8		G	The current data shows an estimate of the full year figure for 2015/16. At 625.8 admissions per 100,000, this is forecast to meet the target.
	♦ METRIC 2: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	82.01%	82.0%		G	The target relates to hospital discharges between October and December 2015 followed by accommodation location between January and March 2016. The measure is monitored on a rolling period with the current performance relating to hospital discharges between Jun and Aug 2015 and accommodation location between September and November 2015.
	♦ METRIC 3: Delayed transfers of care from hospital per 100,000 population, average monthly rate per quarter	350.79	186.80		G	BCF DToCs targets are quarterly and 350.79 covers the 15-16 Q3 period Oct-Dec '15. The target shown is for March 2016. The Q3 performance is the average of Oct-Dec '15, however only October performance is currently available. Delayed days is significantly lower than other months in 2015/16 and is currently meeting the Q3 target.
	♦ METRIC 4: Total non-elective admissions into hospital (general and acute), per 100,000 population, average monthly rate per quarter	717.44	770.47		R	Target shown is pay for performance target of 717.44 for December 2015. March 2016 target is 656.16. Current data shows the October 2015 rate.
	♦ METRIC 5: Patient / service user experience. Patients satisfied with support to manage long term health conditions	66.80%	61.6%		A	Current data contains aggregated data collected from Jul-Sept 2014 and Jan-Mar 2015, results published in July 15. Target is for March 2016.
	♦ METRIC 6: Emergency admissions for injuries due to falls in people aged 65 and over per 100,000 population, per month	140.47	157.00		R	Current data shows October's monthly figure per 100,000 popn. Target is for March 2016. The methodology used by PHE to calculate this metric has now been identified and local figures calculated since April 2015. Since then the rate has varied from 119.8 per 100,000 to 171.3 per 100,000.

Metric Supporting	Scheme Details	P4P Target	Current Month Target	Current Month Data	Cumulative Target	Cumulative Data	Commentary
♦ METRIC 4: Total non-elective admissions into hospital (general and acute), per 100,000 population, average monthly rate per quarter	♦ Rapid Response Falls Service ♦ 7 Day Working Primary Care ♦ Rapid Assessment for Older Persons Unit ♦ Integrated Health and Care Crisis Response	2041 (Dec 15)	174	**108**	1867	**1,452**	Current month data is for November 2015, cumulative data is January to November 2015

APPENDIX A

		Indicator	Latest Data	Data Period	Trend	DOT	RAG	Indicator	Latest Data	Data Period	Trend	DOT	RAG
UHL	Patient Experience	♦ Friends & Family Test Score - in-patients	96.0%	YTD Oct 15			G	♦ Friends & Family Test Score - A&E	96.0%	YTD Oct 15			G
		♦ Friends & Family Test Score - Maternity	95.0%	YTD Oct 15			G						
	ED Waiting Times	♦ UHL Emergency Dept. Waiting Time < 4 Hours	89.5%	YTD Dec 15			R	♦ 12 Hour Trolley Waits	0	YTD Oct 15	LOW		G
		♦ Emergency Dept. Handovers between UHL ED & Ambulance > 30 mins	21.4%	YTD Oct 15	LOW		R	♦ Emergency Dept. Handovers between UHL ED & Ambulance > 1 Hour	11.4%	YTD Oct 15	LOW		R
	DTOC	♦ UHL Delayed Transfers of Care - no. of patients as a % of occupied bed days	1.6%	YTD Dec 15	LOW		G						
	Hospital Quality	♦ Cancelled Operations - non re-admitted in 28 days	98.3%	YTD Oct 15			R	♦ Cancelled operations- Cancelled for a second time	0	YTD Oct 15	LOW		G
		♦ Pressure Ulcers (Grade 2)	60	YTD Oct 15	LOW		A	♦ Pressure Ulcers (Avoidable Grade 3 & 4)	14	YTD Oct 15	LOW		G
		♦ Mixed Sex Accommodation	0	YTD Oct 15	LOW		G	♦ Safety Thermometer (% No Harms)	94.1%	YTD Oct 15			G
		♦ Never Events	1	YTD Oct 15	LOW		R	♦ 52 Week waiters (incomplete)	260	Orthodontics Oct 15	LOW		R
ALL PROVIDERS	Referral to Treatment	♦ 18 Week Referral to Treatment Admitted (All Providers) (WLCCG)	90.2%	YTD Sept 15			G	♦ 18 Week Referral to Treatment Admitted (All Providers) (ELRCCG)	90.7%	YTD Sept 15			G
		♦ 18 Week Referral to Treatment Non Admitted (All Providers) (WLCCG)	95.5%	YTD Sept 15			G	♦ 18 Week Referral to Treatment Non Admitted (All Providers) (ELRCCG)	95.5%	YTD Sept 15			G
		♦ 18 Week Referral to Treatment Incomplete (All Providers) (WLCCG)	95.6%	YTD Sept 15			G	♦ 18 Week Referral to Treatment Incomplete (All Providers) (ELRCCG)	95.6%	YTD Sept 15			G
	Diagnostic Waiting Time	♦ Diagnostic Waiting Times < 6 weeks (All Providers) (WLCCG)	94.5%	YTD Sept 15			R	♦ Diagnostic Waiting Times < 6 weeks (All Providers) (ELRCCG)	93.4%	YTD Sept 15			R
	Cancer Wait Times	♦ Cancer 2 week wait (WLCCG)	90.0%	YTD Oct 15			A	♦ Cancer 2 week wait (EL&RCCG)	90.0%	YTD Oct 15			A
		♦ Cancer 2 week wait Breast symptoms (WLCCG)	95.7%	YTD Oct 15			G	♦ Cancer 2 week wait Breast symptoms (EL&RCCG)	96.4%	YTD Oct 15			G
		♦ Cancer 31 day (WLCCG)	95.6%	YTD Oct 15			A	♦ Cancer 31 day (EL&RCCG)	96.1%	YTD Oct 15			G
		♦ Cancer 31 day surgery (WLCCG)	91.5%	YTD Oct 15			A	♦ Cancer 31 day surgery (EL&RCCG)	86.0%	YTD Oct 15			R
		♦ Cancer 31 day anti cancer drug (WLCCG)	99.1%	YTD Oct 15			G	♦ Cancer 31 day anti cancer drug (EL&RCCG)	100.0%	YTD Oct 15			G
		♦ Cancer 31 day radiotherapy (WLCCG)	94.1%	YTD Oct 15			G	♦ Cancer 31 day radiotherapy (EL&RCCG)	95.7%	YTD Oct 15			G
		♦ Cancer 62 day (WLCCG)	79.8%	YTD Oct 15			R	♦ Cancer 62 day (EL&RCCG)	77.0%	YTD Oct 15			R
		♦ Cancer 62 day - from screening service (WLCCG)	92.8%	YTD Oct 15			G	♦ Cancer 62 day - from screening service (EL&RCCG)	93.6%	YTD Oct 15			G
		♦ Cancer 62 day - consultant upgrade (WLCCG)	88.9%	YTD Oct 15			R	♦ Cancer 62 day - consultant upgrade (EL&RCCG)	100.0%	YTD Oct 15			G

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		Indicator	Latest Data	Data Period	Trend	DOT	RAG	Indicator	Latest Data	Data Period	Trend	DOT	RAG
EMAS	East Midlands Ambulance Service	♦ Ambulance Response Times Cat A Red 1 (8 minutes) conditions life threatening & most time critical (WLCCG)	63.7%	YTD Nov 15			R	♦ Ambulance Response Times Cat A Red 1 (8 minutes) conditions life threatening & most time critical (ELRCCG)	59.9%	YTD Nov 15			R
		♦ Ambulance Response Times Cat A Red 2 (8 minutes) conditions life threatening & most time critical, less so than Red 1 (WLCCG)	58.1%	YTD Nov 15			R	♦ Ambulance Response Times Cat A Red 2 (8 minutes) conditions life threatening & most time critical, less so than Red 1 (ELRCCG)	52.3%	YTD Nov 15			R
		♦ Ambulance Response Times Cat A - ambulance arriving at the scene within 19 minutes (WLCCG)	85.9%	YTD Nov 15			R	♦ Ambulance Response Times Cat A - ambulance arriving at the scene within 19 minutes (ELRCCG)	81.1%	YTD Nov 15			R
		♦ Ambulance Response Times Cat A Red 1 (8 minutes) conditions life threatening & most time critical	71.8%	YTD Nov 15			A	♦ Ambulance Response Times Cat A Red 2 (8 minutes) conditions life threatening & most time critical, less so than Red 1	67.0%	YTD Nov 15			R
		♦ Ambulance Response Times Cat A - ambulance arriving at the scene within 19 minutes	90.3%	YTD Nov 15			A						
		♦ Emergency Dept. Ambulance Crew Clear > 30mins	3.3%	YTD Nov 15	LOW		R	♦ Emergency Dept. Ambulance Crew Clear > 60 mins	0.7%	YTD Nov 15			R
IAPT	Mental Health	♦ Psychological Therapies - % of people who enter the service (WLCCG)	15.0%	YTD Oct 15			G	♦ Psychological Therapies - % of people who enter the service (EL&RCCG)	14.1%	YTD Oct 15	LOW		A
		♦ Psychological Therapies- Recovery rate (WLCCG)	50.0%	YTD Oct 15			G	♦ Psychological Therapies- Recovery rate (EL&RCCG)	55.0%	YTD Oct 15	LOW		G
		♦ Pyschological Therapies - 6 week waits (WLCCG)	37.0%	YTD Oct 15			R	♦ Pyschological Therapies - 6 week waits (EL&RCCG)	44.0%	YTD Oct 15			R
		♦ Psychological Therapies- 18 week waits (WLCCG)	95.0%	YTD Oct 15			G	♦ Psychological Therapies- 18 week waits (EL&RCCG)	96.0%	YTD Oct 15			G
LPT	Mental Health	♦ % Delayed Patients (DToC) - Mental Health	6.4%	(YTD Oct 15)	LOW		G	♦ Occupancy Rate - Mental Health	89.6%	(YTD Oct 15)			A
		♦ Average Length of Stay - Mental Health	51	(Oct 15)	LOW			♦ Median Length of Stay - Mental Health	27	(YTD Oct 15)	LOW		
		♦ % of patients under adult mental illness on CPA who were followed up within 7 days of discharge from psychiatric in-patient care (WLCCG)	95.0%	YTD Oct 15			G	♦ % of patients under adult mental illness on CPA who were followed up within 7 days of discharge from psychiatric in-patient care (ELRCCG)	96%	YTD Oct 15			G
		♦ Early intervention in Psychosis - % newly diagnosed cases against commissioner contract	118.2%	(YTD Oct 15)			G						
	Community & Other	♦ % Delayed Patients (DToC) - Community	1.1%	(YTD Oct 15)	LOW		G	♦ Occupancy Rate - Community	90.8%	(YTD Oct 15)			A
		♦ Average Length of Stay - Community Hospital rehab wards	0.159	(YTD Oct 15)	LOW			♦ % Admissions Gate Kept	98.0%	(YTD Oct 15)			G
		♦ Total number of Home Treatment episodes carried out by Crisis Resolution team year to date	1194	(YTD Oct 15)			G	♦ Patient experience of community mental health services					
	Quality - Safe Care	♦ Never Events	0	(YTD Oct 15)	LOW		G	♦ Patients safety incidents reporting	4224	14/15			G
		♦ STEIS - SI actions plans implemented within timescales	95.2%	(YTD Oct 15)			A	♦ Compliance with hygiene code			LOW		G
		♦ MRSA Bacteraemia Cases - Community	0	(YTD Oct 15)	LOW		G	♦ Clostridium Difficile (C Diff) Cases	4	(YTD Oct 15)	LOW		G

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CLINICAL COMMISSIONING GROUP

	Indicator	WL CCG Latest Data	WL CCG Data Period	WL CCG Trend	WL CCG DOT	WL CCG RAG	EL&R CCG Latest Data	EL&R CCG Data Period	EL&R CCG Trend	EL&R CCG DOT	EL&R CCG RAG
DOMAIN 1	♦ 1 year survival from all cancers	67.4	2011		→	G	70.2	2011		→	G
	♦ 1 year survival from breast, lung and colorectal cancer	68.4	2011		→	G	69.6	2011		→	G
	♦ Potential years of life lost (PYLL) from causes considered amenable to healthcare	1764.2	2014	LOW	→	A	1978.7	2014	LOW	→	R
DOMAIN 2	♦ Unplanned Hospitalisation for chronic ambulatory care sensitive conditions (adults) per 100,000 population	744	YTD Oct 15	LOW	↓	R	762.49	YTD Oct15	LOW	↑	R
	♦ Unplanned Hospitalisation for asthma, diabetes and epilepsy in under 19s per 100,000 population (WLCCG)	137	YTD Oct 15	LOW	↓	R	191.39	YTD Oct15	LOW	↓	R
	♦ Health-related quality of life for people with long term conditions	74.6	2014/15		→	R	75.5	2014/15		→	A
	♦ Estimated diagnosis rate of people with dementia	61.4%	01/11/15		→	R	59.1%	01/11/2015		→	R
	♦ Proportion of people feeling supported to manage their own condition	62.1%	2014/15		→	R	65.1%	2014/15		→	R
	♦ Employment of people with long term conditions (difference between England population and people with LTC)	10.9%	Leics Apr 15-June 15	LOW	→	G	10.9%	Leics Apr 15-June 15	LOW	→	G
	♦ Health-related quality of life for carers	0.814	2014/15		→	G	0.830	(2014/15)		→	A
	♦ Employment of people with mental illness (difference between England population and people with mental illness)	30%	Leics Apr 15-June 15	LOW	↓	R	30%	Leics Apr 15-June 15	LOW	↓	R
DOMAIN 3	♦ Emergency Admissions for acute conditions that should not usually require hospital admission	1063	YTD Oct 15	LOW	→	R	1111.07	YTD Oct 15	LOW	↑	R
	♦ Rate of emergency admissions within 30 days of discharge	1544	YTD Oct 15	LOW	↓	R	1648	YTD Oct 15	LOW	↑	R
	♦ Emergency Admissions for children with Lower Respiratory Tract Infections (LRTI) per 100,000 population	113	YTD Oct 15	LOW	↓	G	129	YTD Oct 15	LOW	→	G
	♦ Proportion of people 65 and over offered rehabilitation following discharge from acute or community hospital										
DOMAIN 4	♦ Overall experience of NHS Dental Service	86.0%	(Jul 14 - Mar 15)		→	G	83.0%	Jul 14 - Mar 15		→	A
	♦ Access to GP Services	73.0%	(Jul 14 - Mar 15)		→	R	72.0%	Jul 14 - Mar 15		→	R
	♦ Access to NHS Dental Services	95.0%	(Jul 14 - Mar 15)		→	G	95.0%	Jul 14 - Mar 15		→	A
DOMAIN 5	♦ Incidence of health associated infection MRSA	0	YTD Nov 15	LOW	→	G	0	FOT to Nov 15	LOW	→	G
	♦ Incidence of health associated infection CDIFF	107	FOT to Nov 15	LOW	↓	R	75	YTD Nov 15	LOW	→	G
PRIMARY CARE	♦ Satisfaction with the quality of consultation at a GP Practice	431	Jul 14 - Mar 15		→	A	440	Jul 14 - Mar 15		→	A
	♦ Satisfaction with the overall care received at Surgery	85.1%	Jul 14 - Mar 15		→	G	85.0%	Jul 14 - Mar 15		→	R

	Indicator	Latest Data	Data Period	Trend	DOT	RAG	Indicator	Latest Data	Data Period	Trend	DOT	RAG
PUBLIC HEALTH	Slope index of inequality in life expectancy at birth (Males) (Leics) (PHOF 0.2iii)	**6.20**	2011-13	LOW	↓	G	% of adults classified as overweight or obese (Leics) (PHOF 2.12)	**64.7%**	2012-14	LOW		A
	Slope index of inequality in life expectancy at birth (Females) (Leics) (PHOF 0.2iii)	**5.00**	2011-13	LOW	↑	A	% successful completion of drug treatment - opiate users (PHOF 2.15i)	**9.3%**	Jul-05		↑	A
	Life expectancy at birth (Males) (Leics) (PHOF 0.1ii)	**80.20**	2011-13		↑	G	% successful completion of drug treatment - non-opiate users (PHOF 2.15ii)	**40.2%**	Jul-05		↑	A
	Life expectancy at birth(Females) (Leics) (PHOF 0.1ii)	**84.10**	2011-13		↑	A	Admissions to hospital for alcohol related causes (rate per 100,000) (Leics) (PHOF 2.18)	**595.00**	Q2 2015/16. Cover	LOW	↓	A
	Take up of the NHS Health Check Programme – by those eligible (2.22iv)	**46.6%**	2014/15		↓	A	Chlamydia diagnoses (rate per 100,000 15-24 year olds) (Leics) (PHOF 3.02ii)	**1616**	Jul-05		↑	A
	Under 75 mortality rate from all cardiovascular diseases (Persons per 100,000) (Leics) (PHOF 4.04i)	**64.00**	2012-14	LOW	↑	G	People presenting with HIV at a late stage of infection - % of presentations (Leics) (PHOF 3.04)	**40.5%**	2012-14	LOW	↑	G
	Under 75 mortality rate from respiratory disease (Persons per 100,000) (Leics) (PHOF 4.07i)	**23.30**	2012-14	LOW	↑	G	Under 18 conceptions (rate per 1,000) (Leics) (PHOF 2.04)	**20.90**	2013	LOW	↑	G
	Under 75 mortality rate from cancer (Persons per 100,000) (Leics) (PHOF 4.05i)	**128.40**	2012-14	LOW	↑	G	Prevalence of smoking among persons aged 18 years and over (Leics) (PHOF 2.14)	**17.0%**	2014	LOW	→	A
	Under 75 mortality rate from all liver disease (Persons per 100,000) (Leics) (PHOF 4.06i)	**13.50**	2012/14	LOW	↑	G	Number of self-reported 4 week smoking quitters (Leics)	**1453**	Q2 2015/16		↑	A
	% of eligible women screened - breast cancer (Leics) (PHOF 2.20i)	**83.5%**	2015		→	G	% of women smoking at time of delivery (Leics) (PHOF 2.03)	**10.3%**	2014/15	LOW	↑	G
	% of eligible women screened - cervical cancer (Leics) (PHOF 2.20ii)	**77.9%**	2015		↓	G						
PHYSICAL HEALTH	% of physically active children - participation in more than 3hrs a week of community sport only	**42.5%**	2014/15		↓	G	% of physically inactive adults (Leics) (PHOF 2.13ii)	**24.8%**	2014	LOW	↑	G
	% of physically active children - participation in more than 3hrs a week of curriculum sport only	**53.4%**	2014/15		↓	G	% of adults participating in one or more sports a week for 30 minutes or more (Leics)	**38.2%**	Apr 14 - Mar 15		↑	G
	% of physically active adults (PHOF 2.13i)	**59.9%**	2014		↑	G						
CYP HEALTH	% of mothers initiating breastfeeding (PHOF 2.02i)	**74.4%**	2014/15		↑	A	% of children with excess weight - 4-5 year olds (Leics) (PHOF 2.06i)	**20.8%**	2013/14	LOW	↑	A
	% of mothers breastfeeding at 6-8 weeks (PHOF 2.02ii)	**47.2%**	2014/15		↑	A	% of children with excess weight - 10-11 year olds (Leics) (PHOF 2.06ii)	**30.1%**	2013/14	LOW	↑	G
	% children aged 5 years with one or more decayed, missing or filled teeth (PHOF 4.02)	**37.1%**	2012	LOW		R	Infant Mortality (PHOF 4.01)	**3.60**	2011-13	LOW	→	A

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APPENDIX C

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Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 20 JANURAY 2016

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

SEXUAL HEALTH NEEDS ASSESSMENT AND DRAFT LEICESTERSHIRE SEXUAL HEALTH STRATEGY 2016-19

Purpose of report

1. The purpose of this report is to inform the Health Overview and Scrutiny Committee of the draft sexual health needs assessment and strategy and gain its views on the proposed future direction for sexual health services across Leicestershire. Formal consultation on these documents will commence mid-January 2016.

Policy Framework and Previous Decisions

2. The Health and Social Care Act 2012 has created fragmentation across the Leicester, Leicestershire and Rutland sexual health system with three main commissioners (local authorities, CCGs, and NHS England) across the pathway. National guidance suggests the need to take a patient-centred, systematic approach to sexual health commissioning. With key commissioners facing financial pressures, there is a need to develop strong collaborative approaches across commissioning organisations to 'pull the system back together' and ensure seamless, high quality, evidence based services are available to the local population.

3. The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 (made under the National Health Services Act 2006) require upper tier local authorities to arrange for the provision of specific services, including sexual health. Local authorities are required to provide:

> *"open access sexual health services for everyone present in their area, covering; free sexually transmitted infections (STI) testing and treatment, and notification of sexual partners of infected persons; and free contraception, and reasonable access to all methods of contraception"*[1].

4. The Cabinet approved the development and consultation of the draft sexual health strategy in December 2015. The final strategy will be submitted to the Cabinet on 19 April 2016 for final approval.

5. The Cabinet has also previously considered the sexual health commissioning decisions as part of the wider Public Health Procurement Plan 2013-14 to 2014-15 in October 2013.

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1 DH (2013) Commissioning Sexual Health Services and Interventions: Best Practice Guidance for Local Authorities. Department of Health, London.

6. The draft strategy looks to build on elements of the Health and Wellbeing Strategy, Community Strategy and Prevention target operating model.

Background

7. The sexual health needs of the population are evolving. Over the past few decades there have been significant changes in relationships and how people live their lives including personal attitudes and beliefs, social norms, peer pressure, confidence and self-esteem, misuse of drugs and alcohol, coercion and abuse.

8. Although sexual relationships are essentially private matters, good sexual health is important to individuals and to society. The World Health Organisation (WHO), 2002 defines sexual health as *'… **a state of physical, emotional, mental and social well-being in relation to sexuality**.'*

9. Sexual ill health can affect all parts of society – often when it is least expected. Investment in sexual health not only improves the overall health of the population, it is also cost effective. The consequences of poor sexual health cost the NHS in 2010 an estimated £193 million in unintended pregnancies and in 2012-13 approximately £630million in HIV treatment and care. National evidence also suggests that:

   - Every one pound invested in contraception saves £11.09 in averted negative outcomes;
   - An increase in long acting reversible contraception (LARC) usage could save £102million;
   - Increasing HIV testing among men who have sex with men and black African communities in England would prevent 3,500 cases of HIV transmission within five years and save £18million in treatment costs per year.

10. A comprehensive Leicestershire and Rutland Sexual Health Needs Assessment (SHNA) was completed in Autumn 2015. The executive summary is attached as Appendix A. It confirms that good progress has been made on key sexual health indicators and on improving sexual health outcomes across Leicestershire and Rutland. However, Leicestershire has an ageing and increasing population and sexual health services must respond. It is therefore important to consider how services evolve to meet these changing needs across the life course.

11. The proposed Sexual Health Strategy uses the latest evidence from the SHNA to take stock of progress made so far and provides key strategic priorities for the next three years to further improve sexual health services across Leicestershire.

Proposed Strategy

12. The draft Leicestershire Sexual Health Strategy 2016-19 is attached to this report (Appendix B). This document outlines the eight key priorities for improving sexual health services and population outcomes across Leicestershire. These are briefly set out below:

(i). **Coordinated approach to sexual health commissioning and partnership work.** Streamlining commissioning intentions across the system to ensure seamless patient pathways, improved quality of service and identify cost efficiencies across the system;

(ii). **Develop a highly skilled local workforce.** Leicestershire has previously experienced recruitment problems within the service. It is therefore important, to develop both the specialist and non-specialist workforce, to make sexual health services in Leicestershire an attractive place to work and progress;

(iii). **Strengthen the role of primary care.** General practices deliver the majority of contraception across Leicestershire, however, demand is significantly increasing in the specialist service. Hence, there is a need to further equip the primary care workforce to deliver more uncomplicated sexual health services in the future;

(iv). **Coordinated, consistent sexual health communications.** Consistent communications have a greater impact on the population, therefore services and commissioners will develop communication approaches in partnership to ensure these have the greatest effect on population attitudes and access to sexual health services;

(v). **Support schools to deliver high quality Relationships and Sex Education (RSE).** High quality RSE is critical in empowering young people to have informed, consenting, positive relationships. Further work will be completed to build on the current Leicestershire RSE toolkit;

(vi). **Utilise new technologies to support sexual health delivery.** Leicestershire is a rural county, therefore sexual health services need to utilise the latest technologies to increase access to the population. This includes developing a risk assessed, full STI (Sexually Transmitted Infection) screen and utilising communication advances in the service delivery, advertisements and partner notification. New sexual health interventions will also be reviewed and implemented as appropriate;

(vii). **Increase access to sexual health improvement and HIV prevention to at- risk groups.** Men who have sex with men, sex workers and black African communities are at greater risk of poor sexual health. Therefore access to HIV home and community testing will be investigated and targeted to these at risk populations;

(viii). **Increase links between sexual violence and sexual health services.** In recent years there has been an increasing national impetus on sexual violence including child sexual exploitation and female genital mutilation. Sexual health services therefore need to further embed the sexual violence prevention agenda within their services.

13. The Strategy is arranged into six key sections, including an introduction, current sexual health progress, cross cutting themes, the strategic approach, key activities to deliver the approach and defining how the strategy will be performance monitored. Full details are given in Appendix B.

Consultation

14. A widespread stakeholder consultation on the draft Strategy will formally commence for eight weeks from mid-January 2016. Consultation will include presenting at key stakeholder meetings (including local providers, Clinical Commissioning Groups (CCGs) and NHS England) and an online survey. Results will be analysed and used to inform a final version of the Strategy to be presented to the Cabinet for approval in April 2016.

Resource Implications

15. The results of the SHNA and draft Strategy propose changes to current sexual health prioritises, commissioning intentions and service provision (including health promotion, RSE, contraception and STI screening and treatment). Specific service implications include:

- Working with local CCGs and NHS England commissioners to reduce fragmentation across the system. Developing a bi-annual sexual health commissioners meeting;
- Increasing the role of primary care in delivering uncomplicated sexual health services (in particular contraception);
- Reduction in opportunistic chlamydia screening and conversion into a full online STI screening service;
- More focused approach to teenage pregnancy including embedding support into core services and increasing the age of support for teenage parents into education, employment and training to 21 years;
- Providing parity across Leicester, Leicestershire and Rutland (LLR) for young people's sexual health services including development of an LLR C-Card (condom distribution scheme) and increasing access into the core integrated sexual health service;
- Increased focus on groups at high risk of poor sexual health, especially men who have sex with men. Converting support for sex workers from health promotion into more clinical sexual health services.

16. Specific services commissioned by Leicestershire County Council that will be affected by this Strategy are highlighted in Appendix C.

Timetable for Decisions

17. Following Cabinet's approval in December 2015, consultation will commence in mid-January 2016 for a period of eight weeks.

18. The draft Strategy will also be considered by the Health and Wellbeing Board on 10 March 2016. The outcome of the consultation together with the final draft of the Strategy for approval will be presented to the Cabinet on 19 April 2016.

Conclusions

19. A significant amount of work has been done through the SHNA to understand Leicestershire's current and future sexual health needs, both regarding the demand and supply of such services. The results of this assessment have been used to develop the

draft Sexual Health Strategy on a needs basis. The draft strategy prioritises the next stage of sexual health commissioning required to meet the evolving needs of the population of Leicestershire. Implementation of the Strategy intends to build on wider County Council priorities including increased focus on prevention (for example by RSE and condom distribution), and supporting communities (by implementing new technologies and increased general practice access), to deliver high quality, cost effective sexual health system, whilst also delivering some cost efficiencies as part of the MTFS. Progress will be monitored by the Director of Public Health and this will be regularly communicated to key stakeholders via sexual health clinical networks and commissioning meetings.

20. Subject to approval by the Cabinet, the Director of Public Health will use the draft Strategy to inform and support commissioning decisions that will need to be taken prior to April 2016, in order that these can be implemented from April 2016 onwards.

Background papers

Report to the Cabinet on 11 December 2015 – Sexual Health Needs Assessment and Draft Leicestershire Sexual Health Strategy 2016-19. http://ow.ly/WWsGh

Report to the Cabinet on 15 October 2013- Public Health procurement plan 2013/14-14/15. http://politics.leics.gov.uk/Published/C00000135/M00003635/AI00035918/$PublicHealthProcurementPlan201314to201415.docA.ps.pdf]

Public Health England. Making It Work – A guide to whole system commissioning for sexual health, reproductive health and HIV. (2014). http://ow.ly/WWsSw

Department of Health. A Framework for Sexual Health Improvement in England. 1–56 (2013). http://ow.ly/WWsXR

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List of Appendices

Appendix A Leicestershire and Rutland Sexual Health Needs Assessment, Executive Summary, October 2015;

Appendix B Draft Leicestershire Sexual Health Strategy 2016-19;

Appendix C Leicestershire County Council Commissioned Sexual Health Services.

Relevant Impact Assessments

Equality and Human Rights Implications

21. A number of at risk groups have been specifically reviewed as part of the SHNA and a key recommendation has been to ensure all sexual health services regularly complete an equality impact assessment.

22. As part of the development of the final Strategy an Equality Human Rights Impact Assessment (EHRIA) will be undertaken to identify equality issues which need to be taken into account. The outcome of the assessment will be reported back to the Cabinet prior to finalising and publishing the strategy.

Crime and Disorder Implications

23. The SHNA has considered the sexual health implications that result from sexual violence. This includes links to domestic abuse, child sexual exploitation(see full SHNA for details).

Partnership Working and associated issues

24. The draft Strategy has been informed by the Leicestershire SHNA which included engagement with specific service user groups and a stakeholder visioning event in July 2015.

25. A key theme of the strategy is to develop a systematic approach to sexual health commissioning. Therefore the strategy has implications for all sexual health commissioners including local authorities, CCGs, and NHS England. Further consultation will be completed with these stakeholders as part of the consultation. This will include presenting the SHNA and strategy to appropriate stakeholder meetings before the strategy is finalised.

Risk Assessment

26. The Sexual Health Strategy aims to reduce a number of current risks identified by the SHNA and wider sexual health system. These risks include:

- Increased demand and cost for the integrated sexual health service;
- Lack of engagement by stakeholders, including CCGs, NHS England and Health Education East Midlands (HEEM), could result in fragmented commissioning of services;
- Potential changes to service delivery due to the implementation of new models of work could result in changes to service providers, causing staff to leave and temporary reductions in access or quality of services;

Budget reductions to Public Health Grant, wider local authority (in particular children and young people's services) and the wider health and social care system could result in loss or restrictions to services, which may lead to increased rates of sexually transmitted infections and unplanned pregnancies.

Appendix A

Leicestershire and Rutland Sexual Health Needs Assessment

Executive Summary

October 2015

Vivienne Robbins, Janet Hutchins,

Katie Phillips and Natalie Greasley

Leicestershire County Council

Rutland County Council

Executive Summary

1. Introduction

The sexual health needs of the population are evolving. Over the past few decades there have been significant changes in relationships, and how people live their lives including personal attitudes and beliefs, social norms, peer pressure, confidence and self-esteem, misuse of drugs and alcohol, coercion and abuse.

Although sexual relationships are essentially private matters, good sexual health is important to individuals and to society. WHO, 2002 defines sexual health as;

*'… **a state of physical, emotional, mental and social well-being in relation to sexuality**.'(Page 5, WHO, 2002)*[1]

Sexual ill health can affect all parts of society – often when it is least expected. Investment in sexual health not only improves the overall health of the population, it is also cost effective. The consequences of poor sexual health cost the NHS an estimated £193m in unintended pregnancies in 2010 and approximately £630m in HIV treatment and care in 2012/13. Evidence also suggests that;

- For every one pound invested in contraception saves £11.09 in averted negative outcomes
- An increase in long acting reversible contraception (LARC) usage could save £102 million and
- Increasing HIV testing among Men who have sex with Men (MSM) and black Africans in England would prevent 3,500 cases of HIV transmission within five years and save £18million in treatment costs per year[2],[3].

There have been unprecedented changes to the sexual health system since the implementation of the Health and Social Care Act 2012. This has created fragmentation across the sexual health system with three main commissioners (local authorities, Clinical Commissioning Groups (CCGs) and NHS England.) National guidance suggests the need to take a patient-centred, systematic approach to sexual health commissioning around patient pathways. With key commissioners facing financial pressures, there is a need to develop strong collaborative approaches across commissioning organisations to 'pull the system back together' and ensure seamless, high quality, evidence based services are available to the local population.

2. Methodology

This Leicestershire and Rutland sexual health needs assessment triangulates national and local policy with quantitative and qualitative data to understand the needs, demands and supply of sexual health services across Leicestershire and

Rutland. The needs assessment has been split into chapters to ease navigation through the document. These are

- Demography
- High risk groups
- Sexually transmitted infections (STIs)
- HIV
- Sexual and reproductive health
- Sexual violence
- Engagement
- Conclusion
- Recommendations

The results will be used to inform the future direction for sexual health commissioning across Leicestershire and Rutland.

3. Demography of Leicestershire and Rutland

- Leicestershire and Rutland (LCR) have older populations than the England average. They are expected to increase 9.5% and 6.8% by 2028 respectively, with greatest increases seen in people aged over 75years and internal migrants.[4]

- The main ethnic group across LCR is White with 91% in Leicestershire and 97% in Rutland.[5]

- Nationally 1.6% of the population define themselves as gay, lesbian or bisexual, this equates to over 10,000 people in Leicestershire and 600 in Rutland. Men are twice as likely as women to declare themselves gay or bisexual.[6]

- Overall Leicestershire and Rutland are very affluent counties with over half of the population living in both Oadby and Wigston borough and Rutland living in the least deprived 20% of areas in the country. However there are still pockets of severe deprivation, in particular areas of Charnwood and North West Leicestershire.[7]

Implications for sexual health services

- Evidence shows that sexual health needs are greatest in young adults and often reduce with age. LCR has an aging population, meaning there may be less need for contraception than the England average. However there have been significant increases in numbers of over 45's presenting with STIs across LCR (59% increase between 2010-2014[8]). With the advances in treatment, HIV has become more of a long term condition with many people living with HIV into older age. Therefore the sexual health needs across the life course must be considered including those of the older population which may entail increased demand in psychosexual, HIV treatment and HIV social care services. Services also need to

be equitable to meet the needs of different vulnerable groups. For example evidence shows that black ethnic minority (BME) groups and men who have sex with men (MSM) are at higher risk of STIs and HIV. Although proportions of these populations are not high across LCR, they are groups with high levels of sexual health service need, meaning that culturally appropriate, targeted services are required.

- There is a social gradient indicating that those living in the most deprived areas of LCR experience the poorest health (including sexual health) outcomes and are at greater risk of teenage pregnancy. Hence service location need to take into account deprivation and groups of high risk of poor sexual health. This includes support for teenage parents who are at significantly higher risk of not being in education, employment and training.

4. Groups at high risk of poor sexual health

- Leicestershire and Rutland have lower estimated prevalence of opiate and/or crack cocaine users aged 15-64, alcohol hospital admission rates and deaths due to alcohol specific conditions than the England average.

- As of September 2015 there are sex workers operating in 6 sauna/parlours and at least 5 flats known to Police services in Leicestershire. Street work has also been indicated in Loughborough. Sex workers are at greater risk of sexual violence and poor sexual health and outcomes. Evidence suggest that men paying for sex are the bridging population for STIs, hence further work is needed to ensure that sex workers and men who pay for sex have access to condoms and regular STI screening.

- At least one in four people will experience a mental health problem at some point in their life. In 2013/14 0.7% of the LCR population is diagnosed with a mental health condition. This is significantly lower percentage than the England average (0.9%).[9] Poor mental health can be both a cause and effect of poor sexual health in particular the impact of stigma and discrimination, and mental health support following sexual violence or termination of pregnancy.

- In 2012, an estimated 11.6% of 16-64 year olds in Leicestershire and 12.0% of 16-64 year olds in Rutland had a moderate to severe physical disability. Both areas have a higher prevalence than the nationally (11.1%).[10] National data suggests that people with physical disabilities are more likely to experience forced vaginal and anal intercourse, report greater than 10 sexual partners over a lifetime and identify themselves as other than heterosexual than people without disabilities.[11] These activities contribute to people with disabilities experiencing increased rates of STIs, unintended pregnancies, and sexual violence than those without disabilities.[12]

- In 2013/14 0.4% (2,140) of the Leicestershire and 0.4% (122) of the Rutland population aged 18years and above were registered with a learning disability.[9]

- In 2013/14, 430 households in Leicestershire and 27 in Rutland were categorised as statutory homeless. Both counties have significantly lower than the national rates of homelessness acceptances.[13] Homeless people are at increased risk of STIs and unwanted pregnancies and can come under pressure to exchange sex for food, shelter, drugs and money.

- The 2013/14 rate of looked after children rate in Leicestershire 33.8 per 10,000 was significantly better than then national average 59.8 per 10,000 population. Rutland's rate was 45.1 per 10,000 was similar to the national average.[13] Young people who are looked after are recognised as being vulnerable to risk taking behaviour[14] including early and unprotected sexual activity, self-harming, misusing illegal and/or volatile substances and alcohol. This makes this group particularly at risk of teenage pregnancy.

Implications for sexual health services

- There are a number of vulnerable groups (including those that misuse substances, sex workers, homeless, those with mental health, learning or physical disabilities, children with child protection plans or that are looked after and homeless) that are more likely to participate in risk taking sexual behaviour and consequently have poorer sexual health outcomes than the general population. Each group has diverse requirements and therefore sexual health services should regularly complete an equalities impact assessment to review how they are meeting the diverse needs of these populations. Interventions may include targeted services (for example to MSM) or tailored information (for people with learning disabilities or English as a second language). Pathways between services that address risk taking behaviours (sexual health, mental health and substance misuse) should also be further developed across service providers to address the root cause of risk taking behaviours.

5. Sexually Transmitted Infections (STIs)

- In 2014, there were 3,667 new STIs diagnosed in residents of Leicestershire (49% male and 51% female), a rate of 554.3 per 100,000 residents. In residents of Rutland, there were 193 new STIs diagnosed (62% male and 38% female), a rate of 515.9 per 100,000 residents. These rates were significantly better than the national rate of 796.1 per 100,000 population.[15]

- Across LCR the highest rate of STI diagnoses were in the 20-24 age band., followed by 15-19 age band in Leicestershire (and England), and 25-34 year age band for Rutland.[15]

- All districts in Leicestershire and Rutland have a STI new diagnosis (excluding chlamydia under 25years and prisons) rate significantly better than the national average. Charnwood has the highest rate of new STIs and Melton, the lowest.[16]

- Chlamydia, followed by genital warts, were the most prevalent STIs in 2014. From 2012 the rate of genital warts in Rutland was higher (although not significantly) than the national average.[16]

- High rates of gonorrhoea and syphilis in a population reflects high levels of risky sexual behaviour. The rate of gonorrhoea diagnoses in Leicestershire is lower than the national average. However there has been a year on year increase in the rate of gonorrhoea diagnoses over time. It is hypothesised that this increase is due to more sensitive tests and additional screening of extra-genital sites in MSM.

- Syphilis has the lowest rate of new STIs both nationally and locally. In Leicestershire, increases were seen between 2009 and 2012, but the latest data for 2014, shows the local rate has declined to lowest rate since recording began. The rate in Rutland fluctuates due to small numbers.[16]

- The rate of genital herpes nationally and in Leicestershire has increased year on year since 2009, although Leicestershire and Rutland rates have remained continuously lower than the national rate. Rutland rates fluctuate due to small numbers involved.[16]

- Re-infection with a new STI within 12 months is a marker of persistent risky behaviour. This measure varies cross districts. It was higher than the national average for women in Oadby & Wigston (7.8%) and for men in Blaby, Charnwood and Oadby & Wigston (10.6%) in 2014. Men were more likely than women to be re-infected with gonorrhoea. Harborough district had the highest percentage of reinfection for men with gonorrhoea at 16.7%, which is twice the national average.[17]

- Nationally, young people aged 15-24 years, MSM and black Caribbean ethnic groups have been shown to have higher rates of new STIs.

- There has been an increase in the proportion of new STIs among MSM from 8.6% (n=108) in 2010 to 10.9% (n=180) in 2013 for Leicestershire and 5.5% (n=6) to 7.6% (n=8) in Rutland over the same time period. Chlamydia and gonorrhoea and syphilis diagnosis is higher in MSM as compared to heterosexual men, where chlamydia and genital warts was the most dominant.[17]

- The majority of STI diagnosis across LCR is found in the White population. The Black ethnic group is overrepresented in terms of STI diagnoses while the Asian groups are underrepresented.[17]

Chlamydia screening

- In 2014 Leicestershire and Rutland screened a significantly worse percentage of 15-24 year olds for chlamydia (22.1% and 18.9% respectively) than the national average (23.9%). The chlamydia diagnosis rate for 15-24 year olds in Leicestershire was 1,616 per 100,000 population and 1,390 per 100,000 for Rutland which are both significantly lower than the national average of 1,978 per 100,000 population. In terms of percentage positivity both Leicestershire and Rutland had lower positivity than the national percentage of 8.3% at 7.3% and 7.8% respectively.[16]

- Nationally and across LCR males age 20-24 years have the highest percentage of tests with a positive result, followed by females aged 15-19 years. Chlamydia detection rates are higher in females than males aged 15-24 years. This distinction is particularly marked in Rutland where the rate for males is 888 per 100,000 aged 15-24 years, whereas the female rate is 2,054 per 100,000 females aged 15-24 years. Interestingly positivity rates from the Integrated Sexual Health Service (ISHS) are higher in males than females across LCR.[13]

- In Leicestershire, the highest percentage of 15-24 year olds tested for chlamydia were in GPs, followed by GUM clinics and then other locations. In Rutland highest percentage of tests occurred in other locations, GPs and GUM.[8]

- In Leicestershire in 2014, the highest percentage positivity was found in GUM clinics (9.6%) followed community sexual health services (9.4%). In Rutland, community sexual health services has the highest percentage positivity (17.0%) followed by GUM clinics (11.3%). It must be noted that these high positivity percentages are likely to fluctuate due to smaller numbers involved.[8]

GUM access overall

- In 2014, there were 14,702 first time attendees from Leicestershire attending any sexual health clinic in England, of these 44% were male. This is an increase in first time attendees from 14,122 in 2013. For Rutland residents, there were 684 first time attendees in 2014 and 63% of these attendees were male.[8]

- In 2014, the age group most frequently attending for a sexual health screen was 20-24 age band for Leicestershire and 25-34 for Rutland. This could indicate problems of access for younger people or reflect the population profile.[8]

- 14% of attendees were homosexual/bisexual males and less than 1 % of women were homosexual or bisexual.[8]

- There was an increase in Leicestershire women and decrease in men attending for a sexual health screen in 2014. This could be a consequence of the new ISHS model. For Rutland the opposite pattern was seen.[8]

Leicester, Leicestershire and Rutland (LLR) integrated sexual health service (ISHS)

- The new LLR integrated sexual health service model commenced from 1 January 2014 with two new hub site locations (St Peter's and Loughborough) and five additional spokes (4 in Leicestershire and 1 in Rutland). Hub opening hours have increased to 9am-8pm Monday to Friday and Saturday mornings, (spoke sites are sessional). The change of clinic sites and establishment of the new service may have impacted on activity levels in 2014 as the new service established new locations. However there was an overall increase in attendances for GUM purposes to LLR sexual health sites by 800 patients for Leicestershire and 44 for Rutland.

- In 2014 there were 18,496 attendances to the LLR ISHS by Leicestershire and 354 by Rutland residents for both GUM and contraceptive services. 83% of the patients attending the Leicestershire clinics were residents of Leicestershire, 1.9% were residents in Rutland and 7% lived in Leicester City. 31% of St Peter's (Leicester City hub) attendees were residents in the County. The new service has doubled the number of attendances by Leicestershire residents to the county sites and decreased the percentage use of GUM clinics outside of LLR by 1% in Leicestershire and by 10% in Rutland between 2013 and 2014.In Rutland in 2014, Loughborough Health Centre had the highest counts of patients attending a GUM, followed by Edith Cavell in Peterborough.[18]

- The highest user age band was in the 15-24 age group. The majority of attendances were female; 65% for Leicestershire and 73% for Rutland. This is likely to be reflective of attendances for contraceptive services. [18]

- The majority of attendees were of white ethnicity which is reflective of the local population.

- The percentage of male attendees identifying as homosexual or bisexual was 14.2% for Leicestershire and 13.8% for Rutland.[18]

- In Leicestershire approximately half of the population live less than a 10 minute drive from an ISHS site and 6.5% have more than a 20 minute drive. The variation across Leicestershire is wide. 27% of the Harborough population have a drive of 20-30 minutes. Melton is the only district with 7.1% of the population needing to drive more than 30 minutes to an ISHS site. In Rutland 40% of the population live less than a 10 minute drive from an ISHS site and 19% have a drive of 20-30 minutes. However the Rutland clinic site is sessional and has limited capacity.[19]

Implications for sexual health

- Overall LCR experiences lower than rates of STI diagnosis than the England average. Chlamydia is the most common STI across LCR, followed by genital warts. Although lower than the national rates, there has been year on year increases in gonorrhoea and genital herpes across Leicestershire. This may be due to increased access to STI testing or increases in STI prevalence across LCR.

- Oadby & Wigston, Blaby, Charnwood have been identified as areas of higher STI reinfection within 12 months and Harborough reinfection percentage for men with gonorrhoea specifically was twice the national average. Therefore additional priority to STI prevention and contract tracing may be beneficial in these districts, in particular with men.

- Young people aged 15-24 years, MSM and black Caribbean ethnic groups have been shown to have higher rates of new STIs across LCR, which is aligned with the national picture. Increases in have been seen in the proportion of STIs diagnosed in MSM across LCR. This may be due to increased uptake of STI screening or higher STI prevalence. Either way targeted work must be maintained with MSM due to the high level of sexual health need.

- LCR does not perform well against the national average for Chlamydia screening in 15-24 year olds. This has been particularly apparent since changes have occurred in the national data collection from 2012. However comparator local authorities perform similarly to LCR, which may indicate that the overall prevalence of chlamydia is lower than the national average. Either way chlamydia screening is a useful tool in normalising STI screening with young adults, therefore opportunistic screening should be increased in core sexual health services.

- Increases in GUM attendance by Leicestershire and Rutland residents has been seen locally and overall (including out of area contacts). This may reflect increased access due to the new LLR ISHS, increased awareness of STI screening, but also reflects the increased STI need across LCR. Slightly older populations (25-29year olds) are most frequently accessing the ISHS from Rutland as compared to Leicestershire (20-24year olds) which may reflect reduced access or the demography of the population. In 2014 there was an increase in women and decrease in men accessing sexual health services locally. The opposite was seen in Rutland, where reductions in women's access were seen. This may be due to changes in the ISHS service model. Therefore further work is needed to increase sexual health access to high risk groups (including MSM), female and younger populations in Rutland and male populations in Leicestershire.

- Rural access is a particular difficulty for areas of LCR due to limited access to some hub and spoke sites via public transport. The use of clinics outside of LLR by Leicestershire and particularly by Rutland residents reflects access issues as some residents may choose to go to other open access sexual health services perhaps closer to workplaces and colleges. The new ISHS has reduced out of area GUM access by 1% in Leicestershire and 10% in Rutland between 2013 and 2014. Increasing accessibility to local services and providing alternative local sexual health service provision such as general practice and pharmacy may continue to reduce use of out of area services.

6. Human Immunodeficiency Virus (HIV)

- In 2013 the HIV diagnosis prevalence in was 0.71 and 0.73 per 1,000 population aged 15-59 years for Leicestershire and Rutland respectively. This is significantly lower than England average of 2.1 per 1,000 population aged 15-59 years. All districts have significantly lower HIV diagnosis rates than nationally, with the highest diagnosis rate in Oadby & Wigston and lowest in Melton. The highest numbers of people living with HIV are in Charnwood district followed by Blaby.[16]

- HIV prevalence rates across LCR have increased over time. This is largely due to increased life expectancy as treatment has improved to make HIV a long term condition.

- In 2013 there were 305 adults received HIV related care in Leicestershire, 216 male and 89 female. 64% were white and 25% black African ethnicity. [20] The likely route of infection was 43% sex between men and 50% sex between men and women. There were 16 new diagnoses, an increase on 2012 and the majority had acquired via sex between men.[20]

- In 2013 there were 15 adults received HIV related care in Rutland, 66% male and 33% female. 53% were white and 40% black African ethnicity. The likely route of infection was approximately 53% sex between men and 47% sex between men and women. There were no new diagnoses in 2013.[20]

- In 2011-13 49% of HIV patients in Leicestershire were diagnosed at a later stage of infection, this is higher than the England overall percentage of 45%. In Rutland 67% of HIV patients were diagnosed at a late stage, most of these being heterosexual. [13]

- The uptake of HIV testing at GUM clinics was higher for Leicestershire (88.5%) and similar for Rutland (79.4%) than in England (80%). Uptake by men in Rutland was lower than the England average.[16]

- Community based testing is available for some groups in Leicestershire and Rutland. Home testing and home sampling HIV tests are now legally

available and a home sampling pilot targeting MSM and black African communities is due to commence across LCR in late 2015.

Implications for sexual health

- There is significantly lower HIV diagnosis rates across LCR compared to the national rate. However HIV prevalence overall is increasing locally and nationally largely due to increased life expectancy as treatment has improved to make HIV a long term condition. There are implications for health and social care providers as the HIV positive group increases in number and becomes an aging population with changing health needs.
- Early HIV diagnosis is important to improve health outcomes for the individual, reduce risk of onward transmission and lower treatment and care costs. Leicestershire and Rutland both have higher late HIV diagnosis rates than the England average. This is particularly apparent in heterosexual transmission. Therefore further work is needed to educate the heterosexual population about HIV and increase access and uptake of HIV testing, for example in Rutland males accessing GUM. Referral pathways between sexual health and HIV services must also be reviewed to ensure there are seamless pathways which prevent unnecessary delay between diagnosis and treatment Commissioning of alternative HIV testing methods such as home testing and home sampling are important options to consider for increasing HIV testing to high risk groups including MSM and black African communities. The implications of the PROUD study on pre-exposure prophylaxis should also be considered to reduce HIV transmission to specific high risk groups.

7. Sexual Reproductive Health

Contraception

- It is estimated that on average, women have a 30 year time period in which they will need to avert an unintended pregnancy.
- Contraception is cost saving, with £11 saving for every £1 spent. NICE guidance identifies that LARC methods such as contraceptive injections, implants, the intrauterine system (IUS) or intrauterine device (IUD) are more effective at preventing pregnancy than user dependent methods(e.g. oral contraception, condom).
- Contraception is available from specialist open access sexual health services and from general practice. It is estimated that 80% of contraception is delivered through general practice (GP).

- In 2013, 5164 Leicestershire and 193 Rutland residents attended specialist sexual health services for contraception.[17]
- In specialist contraceptive services across LCR, user dependent methods of contraception (UDM) were most frequently prescribed for all ages except for the 35-44 year age group, who were most frequently prescribed LARC methods. . In 2013, similar or lower proportions of LARC were prescribed overall compared to the England average in all age groups except for the 35 year plus age group in Leicestershire and the 18-19 and 25-34 year age groups in Rutland.[17]
- For Leicestershire residents, LARC represents 40% of contraceptive provision from specialist sexual health services and 16% from general practice. For Rutland residents, LARC represents 46% of contraceptive provision from specialist sexual health services and 15% from general practice.[17]
- LCR has a higher rate of LARC prescribing from primary care compared to the national average. The rates in 2013 were 61.5 per 1,000 women aged 15-44 years for Leicestershire, 76.1 for Rutland and 52.7 for England. There has been a small increase in the proportion of LARC delivered across LCR in primary care between 2013 and 2014.[16]
- 79 practices provide contraceptive implant fitting and activity levels vary across practices. 3 practices provided more than 75 implant fits in 2014/15. Activity across LCR in 2014/15 was 2491 implant insertions and 1903 implant removals.
- 78 practices provide inter uterine devices/ systems (IUD/S) fitting and activity levels vary across practices. 4 practices provided more than 100 IUD/S fits in 2014/15. 2472 IUD/S fits were completed in GP across LCR in 2014/15.
- Retention of LARC methods is an important factor. LARC methods are cost effective even at one year's use compared to user dependent methods such as the contraceptive pill. Retention rates are difficult to calculate as women may attend different services for fits and for removal.
- The IUS is also used for non-contraceptive purposes e.g. control of heavy menstrual bleeding. This is the commissioning responsibility of Clinical Commissioning Groups. The number of fits for this purpose is difficult to determine from available data sources.
- Approximately 60% of practitioners delivering LARC services currently hold national FRSH Letters of Competence. Ongoing training is required to maintain competencies of practitioners to provide IUD/S and SDI in primary care..

Emergency Contraception

- It is important to access emergency contraception (EC) as early as possible after unprotected sex or contraceptive failure so good access to local services is important.
- There are different types of EC available. There are two types of Emergency Hormonal Contraception (EHC), LNG and UPA (EHC) and also Cu IUD.
- All forms of EC are available from the ISHS and General Practice. EHC (LNG) is available from 84 pharmacies in Leicestershire, 5 pharmacies in Rutland and from some school nurse clinics.
- In 2013, 173 women in Leicestershire and Rutland accessed EC from Sexual Health Services, the 20-35 year age group were the highest users.[17]
- In 2014-15 there were 2573 EHC consultations in LCR Pharmacies. The highest uptake being in the Loughborough locality, reflective of the high student population. The majority of users were in the 19-24 age group. The most frequently stated reasons for accessing EHC were split condom (almost 50%) and no contraception used (40%). The number of patients referred on to sexual health services for further sexual health/contraceptive advice increased between 2013-14 and 2014-15.[21]

Psychosexual services

- In Leicestershire there were 101 referrals for psychosexual services in 2014 and 83 from April to September in 2015. There have been no referrals for residents of Rutland.
- The Natsal-3 sexual attitudes and lifestyles in Britain survey (2010-12) indicated 51% of men and 42% of women surveyed experienced one of more sexual difficulties lasting more than three months in the past year, including lack of interest in having sex, feeling anxious during sex, pain during sex, vaginal dryness and problems getting or keeping an erection.[22]

Teenage Pregnancy

- In 2013, the under 18 conception rate per 1,000 female aged 15 to 17 years was 20.9 in Leicestershire and 9.2 in Rutland, while in England the rate was 24.3. Between 1998 and 2013, Leicestershire achieved a 45.0% reduction in the under 18 conception rate and in Rutland a 45.6% reduction. Nationally the rate reduced by 47.9% throughout this time.[16]
- In 2013, of those females who conceived under the age of 18, the proportion of those leading to abortion in Leicestershire was 56.1%, higher than the national percentage of 51.1%. No data is available for Rutland due to small numbers.[16]

- There are district variations in teenage pregnancy rates. The district level data in Leicestershire and Rutland is open to fluctuations due to the small numbers involved so three year aggregates have been used to smooth any instability. Between 2011-2013, the highest rate in Leicestershire was seen in Hinckley and Bosworth (24.8 per 1,000 population) and the lowest in Harborough (18.6 per 1,000 population). Three districts in Leicestershire saw an increase in their conception rate between 2010-12 and 2011-13. Blaby increased from 21.0 per 1,000 15-17 aged females in 2010-12 to 23.2 per 1,000 in 2011-13, while Harborough increased from 17.9 to 18.6 per 1,000 aged 15-17 females. All other districts decreased their rate over this time period. In Rutland, the rate of under 18 conceptions has remained consistently lower compared to all Leicestershire districts over time. Rutland saw an increase in their conception rate 11.7 per 1,000 15-17 aged females in 2010-12 to 12.3 per 1,000 in 2011-13.[23]

- Five districts in Leicestershire have a higher percentage of abortions in under 18year olds than the national average, with only the percentage in Charnwood and Melton being lower. Since 2008-10, Rutland has witnessed a year on year decrease in the percentage leading to abortions from 50.0% in 2008-10 to 30.0% in 2011-13.[23]

- In March 2015, over half (54%) of the teenage parents in Leicestershire were not in education, employment or training.[24]

Abortion

- Nationally an estimated one in six of pregnancies were unplanned, two in six were ambivalent and three in six were planned. This gives an annual prevalence estimate for unplanned pregnancy of 1.5%. Pregnancies in women aged 16–19 years were most commonly unplanned (45.2%) however, most greatest proportion of unplanned pregnancies were in women aged 20–34 years (62.4%).[25]

- There were 1,439 abortions for Leicestershire residents and 55 for Rutland residents in 2014.[26]

- In 2014 the abortion rates for Leicestershire was 11.9 per 1,000 female population and 9.5 per 1,000 female population for Rutland. Both are significantly better than England average of 16.5 per 1,000 female.[26]

- The highest abortion rate was for the 20-24 year population. Note this is different to Leicester City where the highest abortion rate is in the 25-29year olds.[26]

- In 2014, 20.9% of women in Leicestershire and 21.4% in Rutland had had a previous abortion, while in England the proportion was higher at 27.0%. This increases to 42.8% for Leicestershire and 37% for Rutland in the over 25 age group, however this is aligned with the England proportion at 45.6%.[26]

- In 2014 72.6% of Leicestershire women accessing abortion were under 10 weeks gestation at time of procedure. This was an improvement from 2013 but is below the England average of 80.4%. Rutland figure was 85.2%.[26]
- In 2014 Leicestershire 16% of women accessed abortion procedure at 13 weeks or more gestation. This was twice the England figure of 8%. Rutland was similar to National average at 9%.[26]
- In 2014, 53% of abortions in Leicestershire, approximately a third in Rutland and approximately half in England were surgical procedures.[26]
- There are two providers of abortion services commissioned for LLR population. There is limited local availability of procedures over 12 weeks. Self-referral is not available for both providers.

Implications for sexual health

- Contraception is a cost effective intervention for the whole of society. LARC is shown to be the most cost effective method available. Across LCR LARC prescribing rates are above the national average for primary care, however contribute to a lower proportion of total contraception use. Therefore additional work is needed to maintain the level of GP provision and increase the proportion of LARC procedures completed in the ISHS, in particular in the under 35year old age group. This will include working with GPs to increase the proportion of LARC fitters accredited via the national Letter of Competence and to undertake an audit to gain a better understanding of how long LARC devices are being retained by women.
- It is important to maintain easy access to EC to allow women to access services as soon as possible after they have had unprotected sex. There is good access to EC across LCR provided by the ISHS, GP and local pharmacy. Consideration should be given to new forms of EHC such as UPA (which has a longer effective window) and ensuring women accessing EHC are referred in contraceptive services to establish a longer term contraceptive regime (in particular LARC).
- The Natsal-3 sexual attitudes and lifestyles in Britain survey (2010-12) indicated 51% of men and 42% of women surveyed experienced sexual difficulties lasting more than three months in the past year.**Error! Bookmark not defined.** Hence there is likely to be some unmet demand for psychosexual services across LCR. With an aging population, this demand is likely to increase. Therefore commissioners should consider increasing awareness of the existing service and increasing the activity levels in the future. Discussions are also needed with the local CCGs to identify services for patients with sex addiction.
- The under 18year conception rate continues to fall across LCR. However there is

variation in rates across districts. The proportion of under 18 conceptions leading to abortion is higher in Leicestershire than the England average. This suggests that there are still significant numbers of young people who continue to take risks and not use contraception despite not wanting to become pregnant. Therefore continued easy access to relationships and sex education and community based sexual health services is important to maintain and improve current progress. Training around teenage pregnancy and related issues is important to ensure a high quality children's workforce who feel competent to discuss a range of issues and support young people's access of health services.

- Over 50% of Leicestershire teenage parents are not currently accessing education, employment or training. This will impact on their lifelong opportunities, which will impact on the health and wellbeing of both themselves and their child. Therefore a co-ordinated response to the support of young parents is important to ensure a range of needs are addressed.

- Leicestershire and Rutland both have lower abortion rates than the national average. However a fifth of women had previously had an abortion and a greater proportion of women are accessing services at a stage of later gestation, which reduces their choice of procedure and increases risk of complications and healthcare costs. There is also limited local availability for procedures over 12 weeks across LCR and self-referral is only available in one provider. Therefore additional work is needed to increase access to local abortion services and ensure that all abortion patients are supported to establish a long term contraceptive plan to avoid repeat abortions.

8. Sexual Abuse

- In 2013/14, there were 475 reported sexual offences in Leicestershire and 14 in Rutland. In this year, the rate of sexual offences in Leicestershire was 0.72 per 1,000 population and in Rutland the rate was 0.38 per 1,000 population. Both these rates are lower than the national rate of 1.01 per 1,000 population. Since 2011/12, the rate for sexual offences in Leicestershire has increased year on year, while the rate for Rutland has decreased year on year.[13]

- In Leicestershire domestic abuse is estimated to cost £66m a year in public services and economic output cost, with an estimated at a further £113.8m for emotional and personal costs.

- Every year around 7,600 incidents of domestic abuse are reported to the police in Leicestershire. In 2013/14 over 1,250 referrals were made to domestic abuse specialist support services. Of these approximately 1,100 children were in families that received support from domestic abuse services and over 300 in families referred to a Multi-Agency Risk Assessment Conference define in 2013/14.

- Natsal-3 found that 1 in 10 women and 1 in 71 men said they had experienced non-volitional sex since age 13 (median age for males was 16 and for females was 18). People with poorer physical, mental and sexual health, including treatment for depression or another mental health condition in the past year, a long-term illness or disability, and a lower sexual function score were more likely to report non-volitional sex.[27]

- In 2014, the estimated numbers of people the adult population aged 18-64 who report having been sexually abused during their childhood was 32,080 females and 13,972 males in Leicestershire and 735 females and 1,600 males in Rutland. These numbers are estimated to remain stable in Leicestershire and decrease slightly in Rutland over the next fifteen years.[28]

- Over the past three years referrals to the LLR Child Sexual Exploitation (CSE) team have increased from 54 in 2012/13 to 165 in 2014/15. Prevention, identification and support for victims of CSE remains a key priority for sexual health services.

Implications for sexual health services

- Domestic abuse is a widespread issue and can take place in a range of relationships. There is a lack of understanding around what constitutes domestic abuse. The national coverage on historic abuse and current approaches to raise awareness about CSE are likely to lead to lead to increases in the number of victims coming forward and seeking help. It is therefore important that staff who work in sexual health services are aware of the prevalence of domestic abuse and CSE and are equipped to ask appropriate questions when seeing patients to allow disclosures to be made and appropriate referral onto specialist services.

9. Engagement

- As part of this SHNA a range of stakeholders and service users have been consulted. This includes 2 sexual health stakeholder events consulting over 100 stakeholders and 7 focus groups consulting with 94 people from May to September 2015. Specific LCR groups that were engaged included the Leicestershire Young Parent Forum, Coalville Young Parents Group, Families at Boulter Crescent in Wigston, the Angels and Monsters Group in Braunstone Town, New Futures Project, Trade Sexual Health Project, Oakham Youth Group, and Learning Difficulties and Disabilities (LDD) Partnership Group . Additional feedback was also provided from local services including the POP text.

- LLR historical research findings on HIV prevention services, Relationships and Education, young people's knowledge, attitudes and experience of sexual health and access to LARC and have also been summarised.
- National data and local engagement work highlighted the critical exploration of relationships in both Relationships and Sex Education (RSE) and in the delivery sexual health services.
- There continues to be a lot of confusion over how contraceptive methods work and myths about their reliability and use.
- Services need to take account of the role the media plays in influencing decisions about sex and relationships and make attempts to counter negative or unhelpful overt messages with positive ones e.g. promotion of consent, how to access confidential services and what a healthy relationship looks like.
- Service users value the importance of having local, community based sexual health provision.
- Service providers and users both highlighted gaps in information about the sexual health services that are available, how they can be accessed and how complaints can be raised.
- Additional messages from local stakeholders and professional included the need to clarify the sexual prioritises and commissioning responsibilities across the system to develop a truly integrated LLR sexual health system. Particular feedback was gained on the need to provide equitable and timely access to services, develop the wider sexual health workforce (including primary care) and develop seamless pathways across organisations and services.

Implications for sexual health

- National data and local engagement work highlighted the critical exploration of relationships in both RSE and in the delivery sexual health services. With the impact of social media, evolving sexual practices and a reducing age of first sex, promotion of consensual, informed and respectful relationships is important to balance against other messages.
- Services need to take account of the role the media plays in influencing decisions about sex and relationships and make attempts to counter negative or unhelpful overt messages with positive ones e.g. promotion of consent, how to access confidential services and what a healthy relationship looks like.
- Service users value the importance of having local, community based sexual health provision. Service providers and users both highlighted gaps in information about the sexual health services that are available, how they can be accessed

and how complaints can be raised. Clear and consistent information is required to ensure practitioners and service users know which services they can access and how they do this.

- Despite there being a wider choice of contraception available, there continues to be a lot of confusion over how contraceptive methods work and myths about their reliability and use. Messages about relationships and sex (in school and beyond) need to include clear and concise information about contraceptive methods. In order to promote the LARC methods it is important that the benefits and implications of these methods are understood and communicated to the women who choice to use them.
- From the perspective of Sexual Health Service Providers, key priorities to address are clarifying the priorities for sexual health delivery, commissioner and provider roles and responsibilities, integrating sexual health services across the system and further development of the wider sexual health workforce (including primary care and school nursing). Areas which both providers and service users highlighted including wanting more equitable and timely provision across LLR, wanting easier access in to services, seamless patient pathways, prioritising education on relationships and sex and ensuring clear information about local services.

10. Conclusion

Overall Leicestershire and Rutland (LCR) is meeting the majority of the sexual health needs of their local populations. This is evidenced by continuing lower rates for all STIs (including HIV), under 18 conceptions and sexual abuse than the England average. (Summarised in Appendix 1 and 2.) Nevertheless absolute numbers of some STIs (including gonorrhoea) and patient led demand is increasing across LCR. This is consistent with the national picture, where more people are accessing specialist sexual health services. However locally this is also likely to be linked to the improved access created by the new integrated sexual health service and community based contracts, which have increased numbers and proportions of residents accessing local services across LCR. STI screening and contraception uptake are part of a prevention approach to enable people to maintain good sexual health. Further work is on-going to establish high quality relationships and sex education across all secondary schools; this supports young people to develop positive, healthy relationships.

Each section above (demography, high risk groups, STIs, HIV, sexual reproductive health, sexual violence and engagement) provides specific implications for sexual health services following the review of evidence of need. When triangulating these sections together key areas for improvement across LCR include bringing together the sexual health commissioning system, prioritising prevention and access to vulnerable groups (including young people, men who have sex followed by sex

workers, black African communities and people with physical disabilities) and developing the sexual health workforce (including non-specialist provision such as primary care, school nursing and substance misuse). The recommendations from this triangulation are set out below. These will be translated into a sexual health strategy for Leicestershire and Rutland and reported to local authority departmental management teams, Health and Wellbeing Boards, health scrutiny, Cabinet and other appropriate meetings for approval and implementation.

Key strengths of the needs assessment include the breadth and depth of validated quantitative national data sources that deliver reliable accurate data on service utilisation. This is a good reflection of need for conception and STIs that have symptoms, however is less effective for symptomless or latent STIs such as chlamydia and HIV. Although recent media interest may increase presentation, there is also likely to be underreporting for psychosexual issues and sexual abuse including FGM and CSE. High quality information on specific vulnerable groups (e.g. sex workers, MSM, FGM etc.) was difficult to ascertain. Due to small numbers in many indicators (especially for Rutland) numbers can fluctuate widely across years, making trends more difficult to interpret. There were also different time lags in data sources which must be considered when comparing sections. Qualitative feedback with nearly 200 people was also completed as part of the needs assessment to add additional local detail and identify themes from the results, however fully validated thematic analysis using NVivo was not completed. The consultation with representatives from services was undertaken at a time of year that made it difficult for certain sectors to be involved e.g. teachers and representatives from education and the service user consultation was quite targeted being mainly with individuals under 25. Wider consultation with the general population would provide a broader perspective of views and this will be completed as part of the consultation on the needs assessment and strategy. Results from the needs assessment may be similar to that seen in other affluent counties across England, however is less generalisable to more urban cities.

The LCR sexual health needs assessment provides commissioners with a clear evidence base on sexual health need, supply and demand. With increasing and aging populations, changing sexual health needs across LCR and increasing pressure on public sector budgets. It is therefore necessary to evolve innovative integrated service models to meet this demand within constrained budgets across the local health and social care system.

11. Recommendations

The following section summarises the key recommendations for sexual health commissioners and service providers across LCR;

11.1 Sexual Health Commissioners

1. **Development of a sexual health strategy for Leicestershire and Rutland**. Ensure that this engages and integrates the whole sexual health system, has clearly defined priorities, roles and responsibilities and considers sexual health across the life course.

2. **Explore co-commissioning opportunities to integrate sexual health patient pathways across commissioning organisations.** For example, with CCGs for primary care, menorrhagia, sex addiction, abortion services and NHS England for HIV services (including the implications of the PROUD study). Also consider how sexual health services can be further integrated into other local authority services such as substance misuse, school nursing, health visiting and social services (for HIV positive patients).

3. **Monitor demand for psychosexual services** and potentially increase provision as awareness and need increases with an aging population.

4. **Identify service provision to support people with sex addiction**. Work with CCG mental health commissioners to consider appropriate access to treatment for sex addiction across LCR.

5. **Development of an LLR sexual health marketing and communications strategy** to promote consistent brands and messages about healthy relationships, reducing stigma and how to access services. Additional service promotion is needed to target groups and areas at higher risk of poor sexual health including young people, MSM, sex workers, black African communities and Charnwood, Oadby and Wigston. The implications of late HIV diagnosis should be raised with the heterosexual population.

6. **Assess the cost effectiveness of UPA emergency hormonal contraception** by completing a cost benefit analysis of increasing access to UPA locally. This should then inform future emergency contraception provision across LCR.

7. **Undertake an audit of LARC retention rates in primary care and ISHS** to ascertain how well informed women are of the implications of these methods and how long women are retaining them for. This should focus particularly on younger women aged 15-34years.

8. Consider **locality priorities to address the differing trends in teenage pregnancy** across the 7 Districts in Leicestershire and in Rutland.

9. Additional work is needed with the police to **understand the causes of the increases in sexual offences** in Leicestershire and interventions to help reduce these offences.

11.2 Sexual health services

10. **Equality impact assessment should be completed in all sexual health services** to ensure the services are meeting the needs of whole population including those with protected characteristics as determined in the 2010 Equality Act. Particular attentions should be placed on sexual orientation, BME (including Asian populations that have under representative STI diagnosis), English not as a first language and people with learning and physical disabilities.

11. **Investigate the current barriers to accessing sexual health services from General Practice**, in particular by young people, LGBT and Sex Workers.

12. **Increase chlamydia screening as part of the core ISHS** (i.e. GUM and CSHS) due to high positivity rates and prioritise opportunistic screening to sources of highest positivity such as preventex postal kits.

13. Explore more **innovative models of ISHS service delivery to improve access particularly in more rural areas** including Melton and Rutland .e.g. implementing virtual clinics, online testing etc. Priority should be given to increasing access to sexual health screening to men across Leicestershire and women and those aged 20-24years in Rutland.

14. **Improvements are needed to the appointment booking system for ISHS**. The service should continue to offer both appointments and drop-in appointment options.

15. **Develop effective and efficient pathways between sexual health services and domestic abuse, substance misuse and mental health** services to address the root causes of the risk taking behaviour.

16. **Ensure sex workers and men who pay for sex have access to condoms and regular STI screening** to reduce bridging of STIs into the wider population.

17. **Increase access to community and home based HIV testing for specific groups at higher risk of HIV** (MSM, sex workers, young people, African heritage.) This includes developing robust protocols and pathways for local HIV testing to ensure rapid access to support and treatment for people with reactive test results. Attention should also be given to increasing HIV testing within ISHS for men in Rutland.

18. **Health and social care providers should consider future needs of HIV positive population.** This includes implications of an ageing HIV population and assurance for patients that confidentiality is maintained as the group of care providers extends beyond specialist HIV care providers.

19. **Maintain good access to emergency contraception**, particularly for young people and Asian women. Improve pathways between emergency contraception providers and other sexual health services to ensure longer term sexual health needs are met.

20. **Improve information and access to range of contraception methods to young women aged 15- 25years**, including LARC. This includes reviewing the current model of LARC delivery in primary care to reduce the proportion of women using user defined methods through GPs and ensuring community provision is available for young people.

21. **Increase access to abortion services by developing a single point of access for LLR** (including self-referral) to improve the proportion of women accessing services under 10 weeks gestation. Consideration is also needed to improve local access to abortion services over 12 weeks gestation.

22. **Review of the specialist teenage pregnancy and community midwifery service pathways** to identify opportunities for further integration with sexual health services and to determine the extent to which they are meeting current need.

23. **Review the support needs of teenage parents and mothers in particular those aged 19-21** to ensure that they can positively progress into education, employment and training at a point that is timely for them and their families.

24. **All sexual health services should support the LLR CSE strategy.** Consultation with the CSE Team and if possible, victims of CSE needs to explore to what extent the current SHS offer meets the needs of this vulnerable cohort

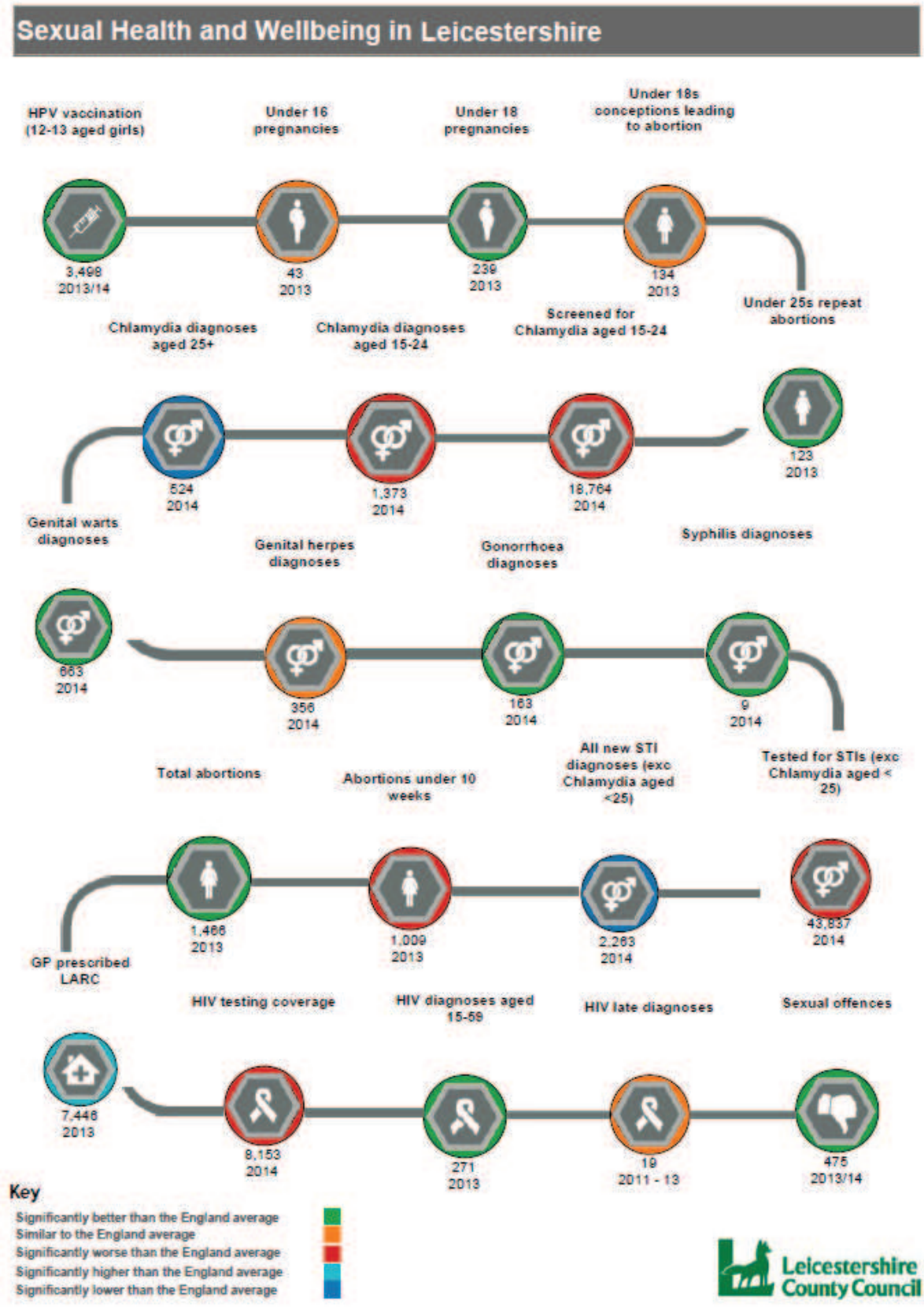
11.3 Training

25. **Complete a sexual health training assessment to develop a workforce plan** to improve all levels of sexual health competencies across LCR. LARC provision and primary care is a key priority for this plan.

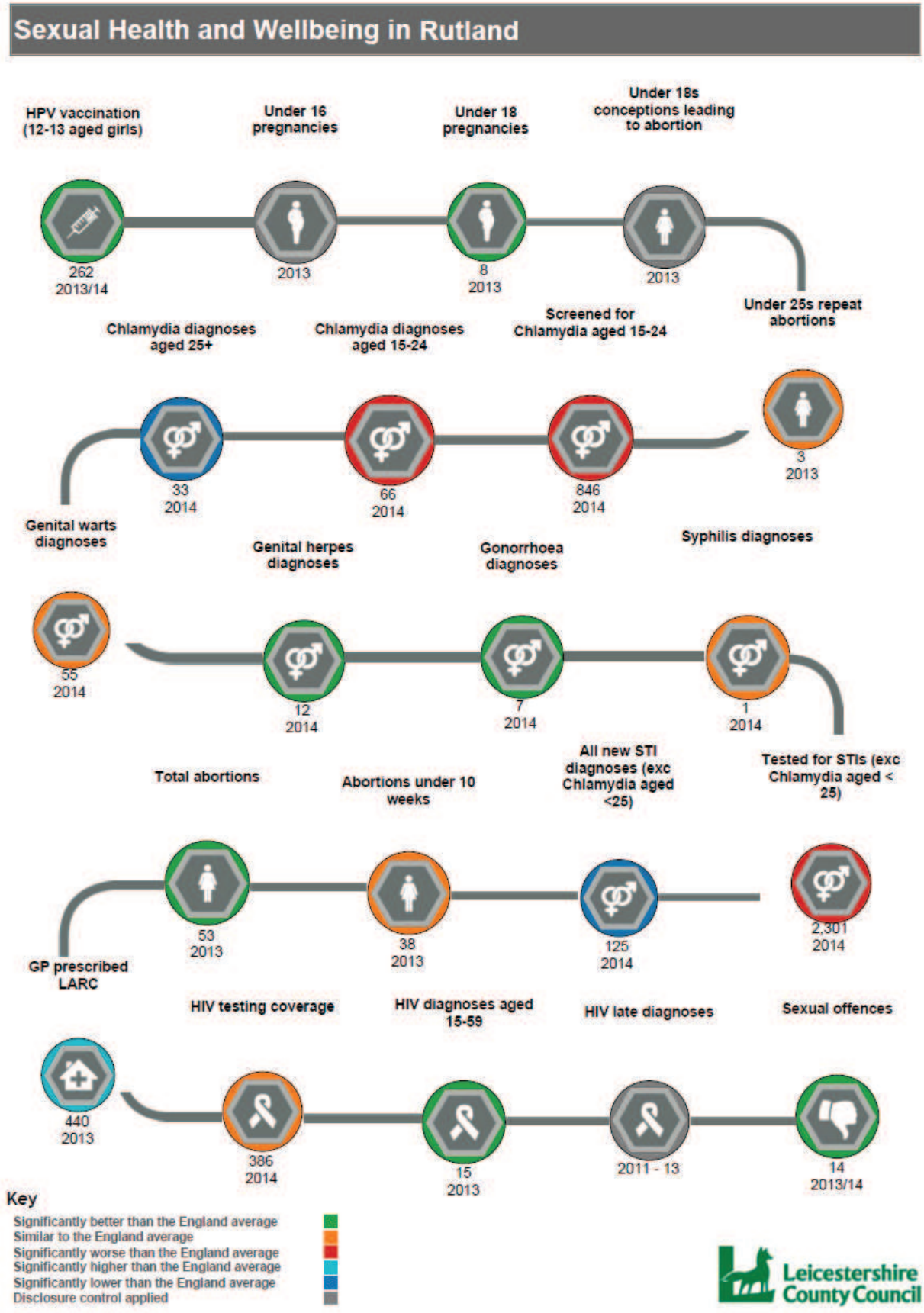
26. **Ensure high quality RSE training/ provision is delivered across LCR** to ensure young people can make informed choices about their sexual health. Materials should give greater emphasis on healthy relationships, consent, domestic abuse, how to seek help, all contraceptive methods and the links between alcohol and risk taking sexual behaviour.

27. **CSE and domestic abuse training should be accessed by key staff from all sexual health providers** to ensure that practitioners can identify and understand local support pathways available.

Appendix 1 Summary of sexual health indicators across Leicestershire (Data as of October 2015)



Appendix 2 Summary of sexual health indicators across Rutland (Data as of October 2015)



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Appendix B

Leicestershire County Council

Leicestershire Sexual Health Strategy

2016-2019

Introduction

The sexual health needs of the population are evolving. Over the past few decades there have been significant changes in relationships, and how people live their lives including personal attitudes and beliefs, social norms, peer pressure, confidence and self-esteem, misuse of drugs and alcohol, coercion and abuse.

Although sexual relationships are essentially private matters, good sexual health is important to individuals and to society. WHO, 2002 defines sexual health as;

*'… **a state of physical, emotional, mental and social well-being in relation to sexuality**.'(Page 5, WHO, 2002)*[i]

Sexual ill health can affect all parts of society – often when it is least expected. Investment in sexual health not only improves the overall health of the population, it is also cost effective. The consequences of poor sexual health cost the NHS an estimated £193m in unintended pregnancies in 2010 and approximately £630m in HIV treatment and care in 2012/13. Evidence also suggests that[ii],[iii];

- For every one pound invested in contraception saves £11.09 in averted negative outcomes
- An increase in long acting reversible contraception (LARC) usage could save £102 million and
- Increasing HIV testing among Men who have sex with Men (MSM) and black Africans in England would prevent 3,500 cases of HIV transmission within five years and save £18million in treatment costs per year.

In terms of improving sexual health outcomes, we have made good progress across Leicestershire. We have been one of the first areas in the county to have a fully integrated sexual health service, which addresses both the sexual health and reproductive needs of patients in one visit and we perform well against many of the key sexual health indicators. However Leicestershire has an ageing and increasing populations and it is important that we consider the changing sexual health needs across the life course.

There have also been unprecedented changes to the sexual health system since the implementation of the Health and Social Care Act 2012. This has created fragmentation across the sexual health system with three main commissioners (local authorities, Clinical Commissioning Groups (CCGs) and NHS England.) National guidance suggests the need to take a patient-centred, systematic approach to sexual health commissioning around patient pathways. With key commissioners facing financial pressures, there is a need to develop strong collaborative approaches across commissioning organisations to 'pull the system back together' and ensure seamless, high quality, evidence based services are available to the local population. This strategy takes stock of progress made so far and provides key strategic priorities for the next three years to further improve sexual health services across Leicestershire and Rutland.

Ernie White CC, Lead Member for Health

Current sexual health progress across Leicestershire and Rutland

As discussed there have been significant changes to the public health commissioning arrangements since the implementation of the Health and Social Care Act, including sexual health services. Local authorities have a statutory responsibility to provide open access sexual health services, which is a substantial proportion of the public health grant. With significant cost pressures to the public health grant in 2015/16 and predicted financial challenges over the next few years, it is important to the ensure the highest quality, evidence based services are commissioned to respond to the needs of the local population. To inform this work a Leicestershire and Rutland Sexual Health Needs Assessment was completed in autumn 2015. The key headlines from this needs assessment are;

Demography of Leicestershire and Rutland

Evidence shows that sexual health needs are greatest in young adults and often reduce with age. Leicestershire has an aging populations, meaning there may be less need for contraception than the England average. However there have been significant increases in numbers of over 45's presenting with STIs across Leicestershire and Rutland (59% increase between 2010-2014). With the advances in treatment, HIV has become more of a long term condition with many people living with HIV into older age. Those living in the most deprived areas of Leicestershire experience the poorest health (including sexual health) outcomes and are at greater risk of teenage pregnancy.

Groups at high risk of poor sexual health

Young people, men who have sex with men (MSM), black African heritage are amongst groups that are more likely to participate in risk taking sexual behaviour and consequently have poorer sexual health outcomes than the general population across Leicestershire . Each group has diverse requirements and therefore sexual health services need to review how they are meeting the needs of these populations. Pathways between services that address risk taking behaviours (sexual health, mental health and substance misuse) should also be further developed across service providers to address the root cause of risk taking behaviours.

Sexually Transmitted Infections (STIs)

Overall LCR experiences lower than rates of STI diagnosis than the England average. Chlamydia is the most common STI across Leicestershire, followed by genital warts. Although lower than the national rates, there has been year on year increases in gonorrhoea and genital herpes across Leicestershire. This may be due to increased access to STI testing or increases in STI prevalence across the counties. Certain districts have been identified as areas having higher rates of STI re-infection within 12 months. Therefore an additional priority of STI prevention and contract tracing may be beneficial in these districts, in particular with men. Young people aged 15-24 years, MSM and black Caribbean ethnic groups have been shown to have higher rates of new STIs across Leicestershire, which is aligned with the national picture. Increases have been seen in the proportion of STIs diagnosed in MSM across LCR. Leicestershire dos not perform well against the national average for Chlamydia screening in 15-24 year olds. However comparator local authorities perform similarly, which may indicate that the overall prevalence of chlamydia is lower than the national average. Chlamydia screening is a useful tool in normalising STI screening with young adults; therefore opportunistic screening should be increased in core sexual health services.

Increases in GUM attendance by Leicestershire and Rutland residents has been seen locally and overall (including out of area contacts). This may reflect increased access due to the new LLR integrated sexual health service (ISHS), increased awareness of STI screening, but also reflects the increased STI need across Leicestershire. Rural access is a particular difficulty for areas of LCR. The new ISHS has reduced out of area GUM access by 1% in Leicestershire and 10% in Rutland between 2013 and 2014. Increasing accessibility to local services and providing alternative local sexual health service provision such as general practice and pharmacy may continue to reduce use of out of area services.

Human Immunodeficiency Virus (HIV)

There are significantly lower HIV diagnosis rates across Leicestershire as compared to the national rate. However HIV prevalence overall is increasing locally and nationally as treatment has improved to make HIV a long term condition. There are implications for health and social care providers as the HIV positive group increases in number and becomes an aging population with changing health needs. Early HIV diagnosis is important to improve health outcomes for the individual, reduce the risk of onward transmission and lower treatment and care costs. Leicestershire and Rutland both have higher late HIV diagnosis rates than the England average therefore increasing access to HIV testing to at risk groups maintain a priority.

Sexual Reproductive Health

Contraception is a cost effective intervention for the whole of society. Long acting reversible contraception (LARC such as coils, implants) is shown to be the most cost effective method available. Across Leicestershire and Rutland LARC prescribing rates are above the national average for primary care, however user dependent methods (such as the combined pill, condoms) remain most widely used. Therefore additional work is needed to maintain high levels of LARC uptake and retention. There is good access to emergency contraception across LCR provided by the ISHS, GP and local pharmacy. Consideration should be given to new forms of emergency hormone contraception (EHC or the morning after pill) such as ulipristal acetate (which has a longer effective window) and ensuring women accessing EHC are referred in contraceptive services to establish a longer term contraceptive regime.

The Natsal-3 sexual attitudes and lifestyles in Britain survey (2010-12) indicated 51% of men and 42% of women surveyed experienced sexual difficulties lasting more than three months in the past year[iv]. Hence there is likely to be some unmet demand for psychosexual services across Leicestershire. With an aging population, this demand is likely to increase. Discussions are also needed with the local CCGs to identify services for patients with sex addiction.

The under 18year conception rate continues to fall across Leicestershire, however there is variation in rates across districts. The proportion of under 18 conceptions leading to abortion is higher in Leicestershire than the England average. This suggests that there are still significant numbers of young people who continue to take risks and not use contraception despite not wanting to become pregnant. Therefore continued easy access to relationships and sex education and community based sexual health services is important to maintain and improve current progress. Over 50% of Leicestershire teenage parents are not currently accessing education, employment or training. A co-

ordinated response to the support of young parents is important to ensure a range of needs are addressed.

Leicestershire and Rutland both have lower abortion rates than the national average. However a fifth of women had previously had an abortion and a in Leicestershire a greater proportion of women are accessing services at a stage of later gestation than the national average, which reduces their choice of procedure and increases risk of complications and healthcare costs. There is also limited local availability for procedures over 12 weeks across LCR and self-referral is only available in one provider. Work is needed to increase access to local abortion services and ensure that all abortion patients are supported to establish a long term contraceptive plan to avoid repeat abortions.

Sexual Abuse

Domestic abuse is a widespread issue and can take place in a range of relationships. There is a lack of understanding around what constitutes domestic abuse and signs of CSE. It is important that staff who work in sexual health services are equipped to ask appropriate questions when seeing patients to allow disclosures to be made and appropriate referral onto specialist services.

Engagement

National data and local engagement work highlighted the critical exploration of relationships in both RSE and in the delivery sexual health services. With the impact of social media, evolving sexual practices and a reducing age of first sex, promotion of consensual, informed and respectful relationships is important to balance against other messages. Service users value the importance of having local, community based sexual health provision. Service providers and users both highlighted gaps in information about the sexual health services that are available, how they can be accessed and how complaints can be raised. From the perspective of sexual health service providers, identified key priorities to address areas clarifying the strategy priorities for sexual health delivery across LLR, commissioner and provider roles and responsibilities, integrating sexual health services across the system and further development of the wider sexual health workforce (including primary care and school nursing). Areas which both providers and service users highlighted including wanting more equitable and timely provision across LLR, wanting easier access in to services, seamless patient pathways, prioritising education on relationships and sex and ensuring clear information about local services.

The results and recommendations for the needs assessment have provided a clear evidence base and rational for the strategic priorities and mission described below.

Our Mission: Empowering the population of Leicestershire to make informed, positive choices about their relationships and sexual health.

Mike Sandys, Director of Public Health

Read more

For additional information on the sexual health needs across Leicestershire and Rutland please see the full needs assessment at XXX.

For further information on the overall needs of Leicestershire please see the respective Joint Strategic Needs Assessments at XXX.

Cross cutting themes

The overall aim of this strategy is to empower the Leicestershire population to have informed, positive relationships that result in reduced rates of unwanted pregnancy and sexually transmitted infections (STIs) including HIV. To achieve this vision there are a number of cross cutting themes that arose from the sexual health needs assessment. These themes should be considered across all strategic priorities and include;

- **Empowerment-** We want the local population to be well informed and empowered to make individual choices around their sexual health. This may range for information on relationships, contraception, STIs, HIV and consent to accessing local services.

- **Patient centred, integrated pathways-** Sexual health pathways must be centred on the patient and not organisational or commissioning boundaries. This creates opportunities for more integrated, joint working across the sexual health system.

- **Equitable –**Services need to available to all, but proportionate to need. The Marmot Review[v] states that to truly reduce health inequalities 'actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage.' This approach is needed to sexual health services to ensure they are available to the whole population but equitable to those of greatest need. This may include targeting the most deprived wards across Leicestershire and Rutland, but also targeting groups at highest risk of poor sexual health such as young people, men who have sex with men, sex workers and black African communities.

- **Prevention focused-** Prevention is better than cure and the evidence suggests that preventative approaches to sexual health are clinically and cost effective[ii, iii]. In times of financial pressures, a focus of prevention is needed to manage demand for services that treat unplanned pregnancies and STIs in the future.

- **Life course approach-** Leicestershire has an increasing but aging populations. Although evidence shows that sexual health needs are greatest in young adults and often reduce with age, there have been significant increases in numbers of over 45's presenting with STIs locally. Other considerations include the advances in anti-retroviral medication that has significantly increased the life expectancy and overall numbers of people living with HIV. This has translated HIV into a long term condition, bringing with it the need to consider the increasing demands of HIV treatment and social care services.

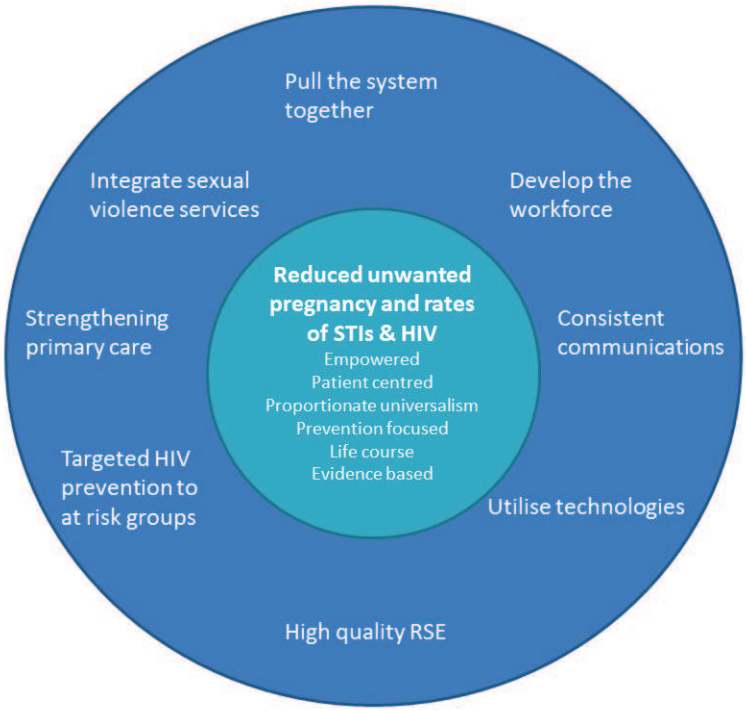
- **Evidence based-** The sexual health needs assessment will be the key resource to ensure services are commissioned to meet the local sexual health needs. All sexual health services must be commissioned using the latest national evidence and standards including National Institute for Health and Care Excellence (NICE), British HIV Association (BHIVA) and British Association for Sexual Health & HIV (BASHH). This will be supplemented with local evaluations to allow more innovative approaches to be piloted across Leicestershire.

Our strategic approach

Across Leicester, Leicestershire and Rutland we want to deliver the highest quality, efficient sexual health system across the East Midlands/ England. This includes developing innovative ways to increase universal access to sexual health services across urban and rural locations, targeting groups at risk of poor sexual health (i.e. young people, men who have sex with men, sex workers, and black African communities.) To achieve this there are eight key themes to the strategy (Figure 1). These will be described in further detail below using the following structure;

- Where are we now?
- What do we want to achieve?
- How will we get there?

Figure 1 Summary of the key sexual health priorities across Leicestershire and Rutland



1. Coordinated approach to sexual health commissioning and partnership work

Where are we now?

Due to the implications of the health and social care act sexual health commissioning has become fragmented across local authority, clinical commissioning groups and NHS England. This has made navigating patient pathways more complex and created gaps in some services. Further work is needed to integrate sexual health commissioning intentions across all sexual health commissioners to ensure the sexual health system is responding to the needs of the local population.

What do we want to achieve?

- Joined up sexual health commissioning including joint procurements and co-commissioning of services across organisational boundaries
- Seamless sexual health patient pathways including services supporting victims of sexual violence.

How will we get there?

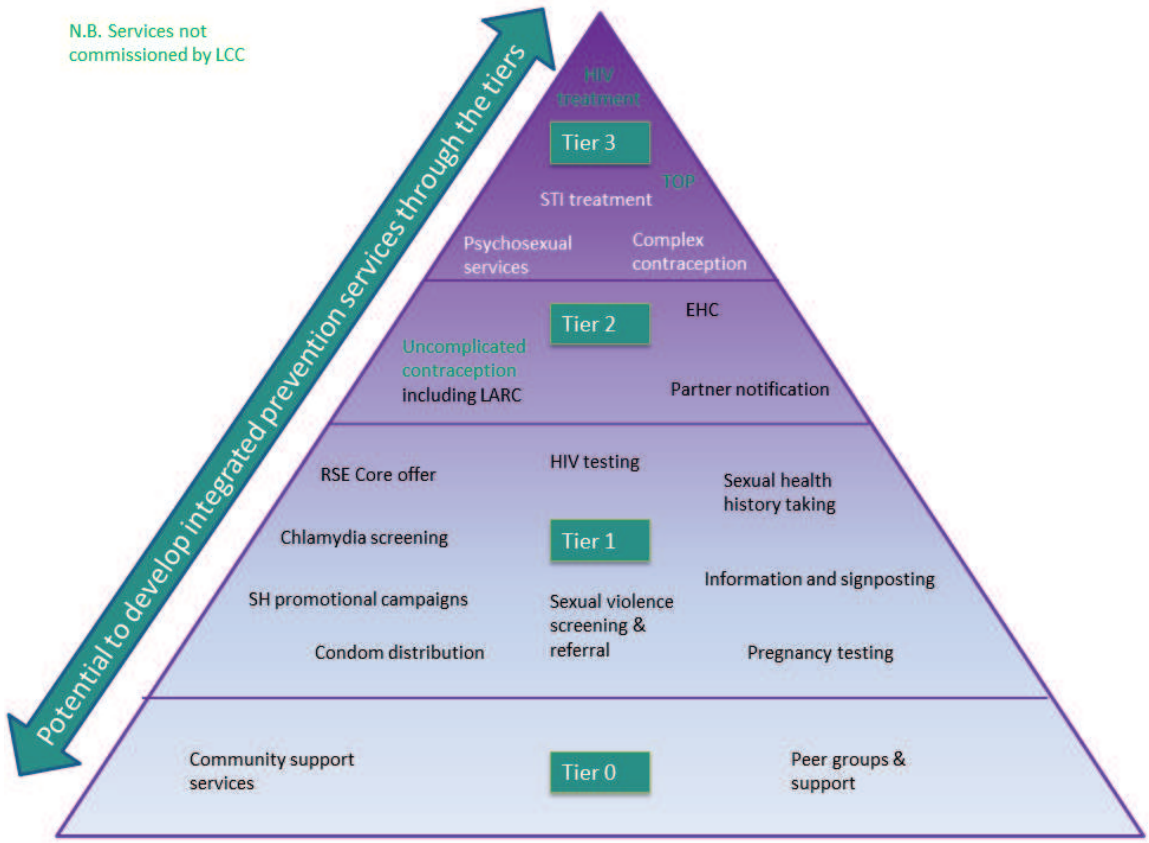
- An agreed, endorsed Leicestershire and Rutland strategic approach to commissioning and delivery of sexual health services over the next 3 years. This will be aligned with Leicester City.
- Establish a biannual Leicester, Leicestershire and Rutland sexual health commissioners meeting to review progress on the sexual health strategic approach, share sexual health commissioning intentions and discuss the implications of these on the wider system.
- Explore co-commissioning opportunities for heavy menstrual bleeding (menorrhagia), sex addiction and cervical cytology services. Review the future possibilities of a centralised booking for abortion services, local abortion services for over 12weeks gestation and integrating HIV services into the integrated sexual health service.

2. Develop a highly skilled local workforce

Where are we now?

Across LLR we have a highly skilled sexual health workforce ranging across all levels of sexual health prevention (Figure 2), from those working in the specialist integrated sexual health service, to primary care to those working in less traditional setting such as education, youth services etc. However sexual health services locally are struggling to recruit individuals with the correct integrated sexual health skills and increasing numbers of patients are unnecessarily being referred to the specialist service. There is also a need to develop the non-core sexual health workforce to effectively embed sexual health services into children's, substance misuse, mental health etc services.

Figure 2: Tiers of sexual health workforce training.



What do we want to achieve?

- A highly skilled, sustainable sexual health workforce across all levels of sexual health service.
- Personal development opportunities to make sexual health across LLR an attractive place to work.
- Key sexual health messages, referral and signposting integrated into other non-core services.

How will we get there?

- Complete a LLR sexual health training assessment.
- Develop a tiered approach to sexual health training across LLR in collaboration with Health Education East Midlands. Prioritises for action include upskilling primary care, safeguarding and sexual violence.
- Review the current delivery model for young people's sexual health services across Leicestershire and Rutland. This includes increasing young people's access to the main integrated sexual health service and embedding a consistent condom distribution approach across LLR.

- Integrate sexual health services more effectively into non-core services e.g. substance misuse, school nursing, health visiting and midwifery.

3. Strengthen the role of primary care

Where are we now?

General practice is the largest provider and most frequently chosen first point of contact for those with sexual health concerns and contraceptive needs [ii]. In Leicestershire we have higher than national rates of long acting reversible contraception (LARC) prescribing in general practice, suggesting patients like the convenience of accessing their local GP for sexual and reproductive health services. However LARC rates are lower than the national average in under 35year olds and user dependant methods are still the most popular form of contraception overall. With the integrated sexual health service seeing significant increases in demand for contraceptive appointments, we need to increase the capacity and expertise of primary care to deliver sexual health services across Leicestershire and Rutland.

What do we want to achieve?

- To increase access to sexual health services in primary care across Leicestershire and Rutland.
- Highly skilled primary care workforce with an expertise in sexual health.
- Revised case-mix at the integrated sexual health services to ensure increased access to the specialist service for complex contraception and STI treatment.

How will we get there?

- See sexual health training priority. A specific focus will be placed on upskilling the primary care workforce on sexual health.
- Review the current delivery model for long acting reversible contraception in primary care. For example, explore a federation/ locality commissioning approach and utilising the Faculty of Sexual Reproductive Health letters of competence.
- Review options to increase delivery of less complex sexual health services through primary care. Promote the use of primary care to patients accessing the integrated sexual health service. For example encouraging repeat oral contraceptive pill consultations to take place in local general practices to release capacity within the integrated sexual health service for more complex needs.
- Undertake cost benefit analysis of increasing access to ulipristal acetate emergency hormonal contraception via pharmacy schemes locally.

4. Coordinated, consistent sexual health communications

Where are we now?

There are a number of sexual health providers and commissioners currently delivering a range of communication materials to the local population about accessing sexual health services, relationships, contraception, STI and HIV testing and treatment. However there is currently little alignment across these communications which can be confusing to the local population and reduce the effectiveness of the campaign.

What do we want to achieve?

- Shared vision about communications.
- Clear, consistent sexual health communication messages across LLR.
- Easily identifiable, coordinated LLR communications approach that utilises local insight and service identities, whilst providing greater opportunities to link into national campaigns.
- Communication approach embedded into relationships and sex education training and delivery.

How will we get there?

- Review the LLR sexual health communication group ownership, attendance and terms of reference to coordinate and review LLR sexual health communications approach.
- Review the membership and ownership of the LLR sexual health communication group. Develop terms of reference for this group to clarify their role in developing a strategic and coordinated approach for all LLR sexual health communications.
- Utilise sexual health contracts to ensure consistent, effective LLR sexual health communications.

5. Support schools to deliver high quality relationships and sex education (RSE)

Where are we now?

Across Leicestershire and Rutland all schools are offered training on a locally developed relationships and sex education (RSE) toolkit. Training equips teachers to confidently deliver RSE lessons covering relationships, consent and the law, contraception and STIs etc. Further work is needed to embed this more sustainably into the wider personal, social, health and economic education curriculum, the Healthy Schools programme, and further education colleges as well as wider youth settings and other children's services.

What do we want to achieve?

- Empower young people to make positive choices about their relationships and sexual health.
- Along term, sustainable model to delivering high quality RSE in all schools and young people's settings.

How will we get there?

- Review the current offers of RSE training and support across Leicestershire and Rutland including strengthening links into wider personal, social, health and economic education and Healthy Schools (Leicestershire only) programme.
- Develop and implement a coordinated RSE training and support offer which meets the needs of schools, further education colleges and other young people's settings. This includes bringing RSE training together across Leicestershire and Rutland.
- Develop a process to audit the quality and consistency of RSE delivery across schools and colleges.
- Utilise the Leicestershire and Rutland RSE group to drive these improvements.
- Review the current support offer for young parents and opportunities to increase the numbers of young mothers in education, employment and training. Explore how support for young parents can be embedded within the wider children and young people's workforce (including Supporting Leicestershire's Families and the children's centre programme).

6. Utilise new technologies to support sexual health delivery

Where are we now?

Across LLR we already use a range of technologies to increase access to sexual health testing, including online chlamydia screening, test not talk at the integrated sexual health service, and use of social media to target information to priority groups such as Men who have sex with men. However there are further opportunities to increase access to services, especially to rural populations and improve efficiency savings by utilising additional technologies including marketing of services, online STI testing, virtual clinics and contact tracing.

What do we want to achieve?

- Increase access to sexual health services and appointment booking.
- Improved access to STI and HIV testing.
- Innovative approaches to delivering the most cost effective sexual health service including contact tracing, text, online, telephone and virtual consultations.
- Increased online presence for sexual health communications.
- Embed the latest evidence based, clinically and cost effective sexual health interventions into local service provision.

How will we get there?

- Establish full asymptomatic online STI testing using online risk assessments and postal screening kits. This includes decommissioning opportunistic chlamydia screening and converting the remaining chlamydia screening programme into a more widely accessible online full STI screening service.

- Implementation of the community and home HIV testing kits, including participating into the national HIV home kit procurement and building this into the online STI screening service mentioned above.

- Review the integrated sexual health service model to see how technology could improve access and reduce infrastructure costs of the service. For example exploring virtual clinics or telephone consultations for less complex sexual health needs.

- Utilise social media, online dating sites etc. to engage service users, advertise services to specific groups and increase the effectiveness of partner notification.

- Review the clinical and cost effectiveness evidence of new sexual health interventions including emergency hormonal contraception, self-injectable contraception and pre-exposure prophylaxis for groups at very high risk of HIV. Review whether these should be commissioned across Leicestershire and Rutland in the future.

7. Increase access to sexual health improvement and HIV prevention to at risk groups

Where are we now?

Across LLR there are a number of voluntary sector organisations that deliver key HIV prevention and testing options for groups at higher risk of STIs and HIV including men who have sex with men, sex workers and black African communities. Results from the Leicestershire and Rutland sexual health needs assessment identified an increased proportion of STI diagnosis and high levels of HIV in these groups (in particular men to have sex with men.) Advances have also been seen in HIV home and community testing and pre-exposure prophylaxis in high risk groups (following the PROUD study.) Hence commissioning decisions will need to be made as to whether these interventions are implemented locally.

What do we want to achieve?

- Reduction of STIs in at risk groups

- Reduced HIV transmission and new diagnoses

- Lower proportions of late HIV diagnosis

- Increased access to HIV testing to at risk groups

How will we get there?

- Review commissioning and delivery protocols of home and community HIV testing for at risk groups.

- Maintain outreach clinics from integrated sexual health service to target at risk groups. For example, focus on increasing access to clinical sexual health services for sex workers and men who have sex with men.
- Considering the implications of PROUD study and pre-exposure prophylaxis to high risk groups (such as men who have sex with men and high numbers of sexual partners.)
- Regular equality impact assessment for all sexual health services.
- Consider the sexual health implications of changing patterns of legal & illegal substance use by men who have sex with men locally.

8. Increase links between sexual violence and sexual health services

Where are we now?

In recent years there has been increasing national impetus on sexual violence including child sexual exploitation and female genital mutilation. The sexual health needs assessment provided some assessment of needs and implications for services, however further work is needed to truly embed the sexual violence prevention agenda within sexual health services.

What do we want to achieve?

- Sexual violence to become an integral part of the wider sexual health system.
- Sexual health services are able to effectively respond to sexual violence needs of the population.
- Ensure sexual health and violence is considered in the commissioning of sexual and reproductive health services including sexual assault referral centre, maternity services etc.

How will we get there?

- Sexual health services to attend Local Safeguarding Children Board training on safeguarding, domestic abuse and child sexual exploitation.
- Maintain sexual violence as a key theme of the sexual health action plan.
- Increased sexual health across the community safety agenda including targeted work with victims of domestic abuse and sex workers.
- Utilise the LLR sexual health commissioners meeting to highlight sexual violence implications for services.

Key activities to deliver this approach

To ensure the strategic approach is delivered we will;

- **Develop new ways of working** across the sexual health system. This includes developing a Leicester, Leicestershire and Rutland sexual health commissioners meeting to ensure all

commissioning intentions are aligned and task and finish groups to progress key elements of the strategic approach.

- **Keep partners informed** of progress. We will develop a detailed action plan which will be regularly reviewed and updated to track progress. Progress updates will be provided to the sexual health clinical network, commissioners meetings and directorate management teams.

- **Monitor performance** through implementation of the action plan and development of a sexual health dashboard. These will be easily accessible for all partners to view.

How will we know we have made a difference?

The key indicators to assess whether this strategy has made a difference are presented in the Public Health England Sexual and Reproductive Health Profiles. (Available online at http://fingertips.phe.org.uk/profile/sexualhealth). These include rates of specific STIs, HIV and unplanned pregnancies. This will be supplemented with local sexual health dashboards and further indicators will be developed as part of the detailed action plan. All data will be split by local authority area. Information will be collated and triangulated with local sexual health provider performance to produce an annual progress update against the action plan and how this has translated to improved sexual health outcomes across Leicestershire and Rutland.

References

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[iv] Mercer, C. H. et al. Changes in sexual attitudes and lifestyles in Britain through the life course and over time: Findings from the National Surveys of Sexual Attitudes and Lifestyles (Natsal). Lancet 382, 1781–1794 (2013)

[v] The Marmot Review. Fair Society, Healthy Lives. (2010).

Appendix C

Appendix C Leicestershire County Council Commissioned Sexual Health Services

Service	What does the service offer?
Sexual Health Service (Provided by: Staffordshire & Stoke on Trent NHS Partnership Trust)	• Genito-urinary medicine, including sexually transmitted infection testing and treatment • Contraceptive and reproductive health services • Emergency hormonal contraception • Chlamydia screening programme (for 15-24 year olds) • Specific young people's services for under 25's (Choices) • Outreach and health promotion • Psychosexual counselling
Leicestershire AIDS Support Services (LASS)	LASS provide sexual health promotion and HIV prevention services for: • People living with and affected by HIV • People of black African heritage What does the service offer? • Health promotion • Outreach • 1 to 1 support • Community based HIV testing • Training for organisations relating to HIV issues and stigma
Trade Sexual Health	Trade Sexual Health provide sexual health promotion and HIV prevention services for men who have sex with men (MSM) What does the service offer? • Health promotion • Outreach • 1 to 1 support • Community based HIV testing • Training for organisations relating to sexual health issues, stigma and MSM
New Futures	New Futures provide sexual health promotion and HIV prevention services for sex workers What does the service offer? • Health promotion • Outreach • 1 to 1 support • Community based HIV testing • Training for organisations relating to sexual health issues, stigma and sex workers
Sexual health services in General Practices (additional to GP core services)	• Opportunistic chlamydia screening (15-24 year olds) • Interuterine device and contraceptive implant fitting in primary care • Emergency hormonal contraception
Pharmacies	Many pharmacies offer: • Emergency hormonal contraception (EHC) • Chlamydia screening Free for those under 25

Untapped Me C.I.C	Supports and delivers initiatives linked to supporting young families (parents under 20). • Provides information and support to young families through the www.parentsunder20.co.uk and www.becomingdad.co.uk websites and associated social media accounts • Develops a range of resources, within input from volunteer young parents (to-be), to support vulnerable young families across Leicestershire • Provides support and training to partner organisations to improve their engagement with and support of young families • Assists in the development of support pathways for young parents to ensure their engagement with appropriate services and a reduction in negative outcomes • Works with agencies across the county to improve access to training, education and employment opportunities for young parents.
Leicestershire and Rutland Community Safer Sex Project	• Supports the delivery of community based sexual health services to ensure easy access by young people • Provides training for practitioners who deliver services and relationships and sex education (RSE) to young people • Delivers POP, a county wide text message advice service for young people
Relate Leicestershire	Post termination counselling for women and men aged under 18 who live in Leicestershire.