Leicestershire County Council

Meeting: **Health Overview and Scrutiny Committee**

Date/Time: **Wednesday, 3 June 2020 at 2.00 pm**

Location: **Skype Video link**

Contact: **Mr. E. Walters (0116 3052583)**

Email: **Euan.Walters@leics.gov.uk**

Membership

Dr. R. K. A. Feltham CC (Chairman)

Mr. T. Barkley CC	Dr. S. Hill CC
Mr. D. C. Bill MBE CC	Mr. J. Morgan CC
Mr. T. Gillard CC	Mrs B. Seaton CC
Mrs. A. J. Hack CC	Mrs. M. Wright CC

Please note: The Health Overview and Scrutiny Committee meeting on Wednesday 3 June 2020 at 2:00pm will not be open to the public in line with Government advice on public gatherings.

This meeting will be filmed for live or subsequent broadcast via YouTube:
https://www.youtube.com/channel/UCWFpwBLs6MnUzG0WjejrQtQ

AGENDA

Item		Report by	
1.	Minutes of the meeting held on 4 March 2020.		(Pages 3 - 8)
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 in respect of items on the agenda.		

Democratic Services ◦ Chief Executive's Department ◦ Leicestershire County Council ◦ County Hall
Glenfield ◦ Leicestershire ◦ LE3 8RA ◦ Tel: 0116 232 3232 ◦ Email: democracy@leics.gov.uk

www.twitter.com/leicsdemocracy www.http://www.leicestershire.gov.u

6.	Declarations of the Party Whip in accordance with Overview and Scrutiny Procedure Rule 16.		
7.	Presentation of Petitions under Standing Order 36.		
8.	Leicestershire Sexual Health Strategy 2020-2023.	Director of Public Health	(Pages 9 - 28)
9.	Health Performance Update 2019/20.	Chief Executive	(Pages 29 - 52)
10.	Date of next meeting.		

The next meeting of the Committee is scheduled to take place on 9 September 2020 at 2:00pm.

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

QUESTIONING BY MEMBERS OF OVERVIEW AND SCRUTINY

The ability to ask good, pertinent questions lies at the heart of successful and effective scrutiny. To support members with this, a range of resources, including guides to questioning, are available via the Centre for Public Scrutiny website www.cfps.org.uk.

The following questions have been agreed by Scrutiny members as a good starting point for developing questions:-

- Who was consulted and what were they consulted on? What is the process for and quality of the consultation?
- How have the voices of local people and frontline staff been heard?
- What does success look like?
- What is the history of the service and what will be different this time?
- What happens once the money is spent?
- If the service model is changing, has the previous service model been evaluated?
- What evaluation arrangements are in place – will there be an annual review?

This page is intentionally left blank

Agenda Item 1

Minutes of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Glenfield on Wednesday, 4 March 2020.

PRESENT

Dr. R. K. A. Feltham CC (in the Chair)

Mr. T. Barkley CC
Mr. I. E. G. Bentley CC
Mr. D. C. Bill MBE CC
Mrs. A. J. Hack CC
Dr. S. Hill CC
Mr. J. Morgan CC
Mrs B. Seaton CC
Mrs. M. Wright CC

In attendance
Mr. L. Breckon CC, Cabinet Lead Member for Health and Wellbeing.
Micheal Smith, Manager, Healthwatch Leicester and Leicestershire.
Jane Green, Contract Manager – Dentistry and Optometry, NHS England and NHS Improvement – Midlands (minute 60 refers).
Tom Bailey, Senior Primary Care Contracts Manager, NHS England and NHS Improvement – Midlands (minute 60 refers).
Andy Williams, Chief Executive, Leicester, Leicestershire and Rutland Clinical Commissioning Groups (minutes 61 and 62 refer).
Spencer Gay, Chief Finance Officer, West Leicestershire CCG (minute 62 refers).

53. Minutes of the previous meeting.

The minutes of the meeting held on 15 January 2020 were taken as read, confirmed and signed.

54. Question Time.

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

55. Questions asked by members.

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

56. Urgent items.

There were no urgent items for consideration.

57. Declarations of interest.

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

No declarations were made.

58. Declarations of the Party Whip.

There were no declarations of the party whip in accordance with Overview and Scrutiny Procedure Rule 16.

59. Presentation of Petitions under Standing Order 35.

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

60. Dental Commissioning.

The Committee considered a report of NHS England and NHS Improvement – Midlands which provided an overview of NHS dental services commissioned in Leicester, Leicestershire and Rutland, and updated on the challenges and commissioning intentions to improve NHS dental services and oral health of the local population. A copy of the report, marked 'Agenda Item 8', is filed with these minutes.

The Committee welcomed Jane Green, Contract Manager – Dentistry and Optometry, and Tom Bailey, Senior Primary Care Contracts Manager both from NHS England and NHS Improvement – Midlands to the meeting for this item.

Arising from discussions the following points were noted:

(i) Nationally, 50% of the population accessed NHS dentistry services, though the percentage varied for individual localities. Prevention work was a priority for NHS England and work was taking place to engage with those people that did not visit the dentist unless they had a specific problem. The Starting Well pilot had taken place in Leicester City due to its poor record on oral health but the pilot had not covered the rest of Leicestershire whereas the Healthy Teeth, Happy Smiles programme covered the county as well and had been supported by the Council's Public Health Department, as had work on providing fluoride varnish for children.

(ii) There were areas of Leicestershire which did not have good access to dentist services, and it was not uncommon that NHS practices would close in some localities and be replaced with private dentist practices leaving no NHS provision. The levels of access to dental services across Leicestershire could change throughout the year depending on capacity. Conversations were taking place with Healthwatch and the Leicestershire County Council Public Health Department to ascertain what measures could be taken to tackle the problem but ultimately it was down to contractors and providers where services were located. NHS England agreed that after the meeting members would be provided with details of the distribution of NHS dental contracts across the County.

(iii) Concerns were raised that many patients were not aware that since April 2006 they were no longer registered to a dental practice and were only attached to a dental practice when they were in an active course of treatment. Patients might not be aware that if they could not get an appointment at their nearest practice they could go to other practices to receive services. This issue was explained on the NHS website but it was acknowledged by NHS England that more needed to be done to publicise the situation.

(iv) There were orthodontic providers available in Leicestershire and pathways to those providers were accessible from primary care. However, there was a national recruitment problem and there could be very long waits for patients to access these services. Work was taking place with University Hospitals of Leicester NHS Trust (UHL) to address the issue and UHL was due to produce a business case for reopening the waiting list for orthodontic treatment.

(v) Concern was raised that it was not always clear to patients what they were being charged for when they received treatment at a dental practice. Reassurance was given that patients could apply under the low income scheme and get treatment at a reduced rate.

(vi) NHS England were holding conversations regarding where dental services fitted into Integrated Care Systems with the hope that they could become a more integral part of the system.

(vii) Ensuring that military personnel had access to dental treatment was part of NHS England's national remit.

RESOLVED:

(a) That the overview of the NHS dental services commissioned in Leicester, Leicestershire and Rutland, and the update on the challenges and commissioning intentions to improve NHS dental services be noted;

(b) That NHS England and NHS Improvement – Midlands be requested to give consideration to how they can better inform the public that patients are no longer registered to a dental practice and are only attached to a dental practice when they are in an active course of treatment.

61. Single Strategic Commissioner for Leicester, Leicestershire and Rutland.

The Committee considered a report of Leicester, Leicestershire and Rutland Clinical Commissioning Groups which provided an update on the options for forming a single strategic commissioner for Leicester, Leicestershire and Rutland. A copy of the report, marked 'Agenda Item 9', is filed with these minutes.

The Committee welcomed Andy Williams, Chief Executive, Leicester, Leicestershire and Rutland Clinical Commissioning Groups to the meeting for this item.

Arising from discussions the following points were noted:

(i) The Integrated Care System for Leicester, Leicestershire and Rutland (LLR) would be based around three levels of activation; System, Place and Neighbourhood. The three CCGs were not able to operate at System level therefore they were not fit for purpose, and instead there needed to be a single strategic Commissioner with a mandate to commission services for the whole of LLR. The Place level was equivalent to the area covered by upper tier local authorities and the work at that level would involve more joined up working regarding the wider determinants of health. Whilst there was potential for the footprint covered by local authorities to change as a result of local government reorganisation, it was still felt by the CCGs that the three levels of activation were appropriate. Organisational change was not the aim of the proposals though it would be a consequence.

(ii) A secondary benefit of moving to a Single Strategic Commissioner was that money could be saved by eradicating the duplication of Governance Boards and other work streams.

(iii) Health services in LLR worked on an internal market system which meant that all secondary care services were automatically funded whether they were needed or not, whereas there was more flexibility regarding the funding for primary care services. It was preferable that there was more flexibility regarding the funding for secondary care services so that decisions could be made regarding which of those services were required and therefore it was hoped to move to a planned economy mechanism.

(iv) Some Patient Care Networks (PCNs) were not contiguous with county boundaries and some areas were covered by more than one PCN which was not efficient. However, the CCGs had limited control over GP Practices and whilst they could incentivise GP Practices to take particular actions and had advised them to organise themselves around places where people live, they could not force them to do so. The current configuration of PCNs reflected relations between practices. Where there was more than one PCN in an area, the CCGs would support them to work together to ensure coherence.

(v) Some health services were provided by external organisations and it was not intended to move away from this model entirely as the independent and voluntary sector performed well in certain areas and added value above that which could be provided by the NHS.

RESOLVED:

(a) That the update on the options for forming a single strategic commissioner for Leicester, Leicestershire and Rutland be welcomed;

(b) That the option to form one new Clinical Commissioning Group for Leicester, Leicestershire and Rutland be supported.

62. <u>2019/20 Quality, Innovation, Productivity and Prevention Programme Update.</u>

The Committee considered a report of West Leicestershire CCG and East Leicestershire and Rutland CCG which provided an update on the 2019/20 Quality, Innovation, Productivity and Prevention (QIPP) programme for West Leicestershire CCG and East Leicestershire and Rutland CCG.

The Committee welcomed Spencer Gay, Chief Finance Officer, West Leicestershire CCG to the meeting for this item along with Andy Williams, Chief Executive, Leicester, Leicestershire and Rutland Clinical Commissioning Groups.

Arising from discussions the following points were noted:

(i) The QIPP programme was not only intended to produce savings but improve quality and efficiency as well. Monitoring the financial situation gave a sense of whether processes were working efficiently and where improvements needed to be made.

(ii) The QIPP targets set for 2019-20 had been very challenging and cost pressures had grown during the year which placed additional pressure on the Clinical Commissioning Groups'(CCGs) finances. It was intended that the savings target for 2020-21 would be more realistic.

(iii) The deficit for WLCCG and ELRCCG was not significantly different to that faced by CCGs in other parts of the country although the system as a whole, including providers, was more of an outlier. The CCG's gap would be mitigated by delivery of £28m from the financial recovery plan. Negotiations would be taking place between the CCGs and NHS England/Improvement regarding the budget for 2020-21 but it was not expected that the budget would be cut.

(iv) In order to improve the CCGs' financial position partnership working would need to take place and conversations needed to be had between CCGs and providers to ensure that the best value for money was obtained. Restructuring the CCGs by having a Single Strategic Commissioner would lead to better joint working between CCG colleagues and other partners. Governance systems would be strengthened and there would be better oversight.

RESOLVED:

That the update on the 2019/20 Quality, Innovation, Productivity and Prevention programme for West Leicestershire CCG and East Leicestershire CCG be noted with concern.

63. <u>Leicestershire Suicide Prevention Strategy and Action Plan 2020.</u>

The Committee considered a report of the Director of Public Health which asked for feedback on the draft Suicide Prevention Action Plan for Leicestershire 2020-2023. A copy of the report, marked 'Agenda Item 11', is filed with these minutes.

Arising from discussions the following points were noted:

(i) The services provided by the Samaritans were a core part of the Suicide Prevention Action Plan and the Start a Conversation website signposted people to the Samaritans phone number.

(ii) Whilst mental health problems were common, suicide was comparatively rare, and it could be difficult to identify genuine risks. There were differences between males and females with regards to the suicide methods most used. Women were more likely to self-harm but they tended to use less violent methods of committing suicide than men. Suicide attempts by drug overdose were less likely to be fatal whereas hanging was more common.

(iii) Concerns were raised that patients with long term physical disabilities were liable to suffer from mental health problems and there was insufficient mental health support for these people. It was noted that the Improving Access to Psychological Therapies (IAPT) service was being re-procured, with greater resource directed at supporting those with long term conditions. The Director of Public Health agreed to ensure that the interface between mental and physical health was being addressed and report back to the Committee at a later date.

(iv) In response to a suggestion from a member the Director of Public Health agreed to consider whether support could be provided to students at Loughborough College in relation to mental health and suicide, though he stated that it was not possible to engage with every institution in Leicestershire.

(v) The Cabinet Lead Member emphasised that once a suicide had taken place a large number of people that knew the deceased would be affected and the suicide bereavement support service that became operational in October 2019 had proved that it had the capacity to meet demand and would benefit from further publicity.

RESOLVED:

(a) That the draft Suicide Prevention Action Plan for Leicestershire 2020-2023 be supported;

(b) That the comments now made be submitted to the Cabinet for consideration at its meeting on 22 May 2020.

64. Date of next meeting.

RESOLVED:

It was noted that the next meeting of the Committee would be held on 3 June 2020 at 2:00pm.

2.00 - 3.55 pm
04 March 2020

CHAIRMAN

Agenda Item 8

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 3rd JUNE 2020

REPORT OF LEICESTERSHIRE COUNTY COUNCIL PUBLIC HEALTH

LEICESTERSHIRE SEXUAL HEALTH STRATEGY 2020-23

Purpose of report

1. The purpose of this report is to consult the Health Overview and Scrutiny Committee on the County Council's draft Sexual Health Strategy for 2020- 2023.

2. The report also includes an overview of sexual health locally as evidenced in the Joint Strategic Needs Assessment chapter on sexual health.

Policy Framework and Previous Decisions

3. In April 2013 Public Health transferred from the NHS into local government, which took on the statutory responsibility for commissioning almost all sexual health services for their local populations.

4. The priorities in the draft Leicestershire Sexual Health Strategy build on the stability of the integrated sexual health service with its strong partnership work that was developed through the 2016-2019 strategy and focuses on sexual health improvement, leadership and policy in Leicestershire. Its five key priorities align with Leicestershire County Council's Strategic Plan 2018-22 which aims to be 'Working together for the benefit of everyone', in particular, the wellbeing and opportunity objective which states that people need to be enabled to take control of their own health and wellbeing throughout their lives and for the Council to support the population to stay well through prevention and early intervention.

Background

5. Sexual and reproductive health is not just about preventing disease or infection. It also means promoting good sexual health in a wider context, including relationships, sexuality and sexual rights. This is a key theme for The Sexual Health Strategy for 2020-23.

6. The previous sexual health strategy 2016-2019 focused on pulling together what was then a fragmented system. This was achieved, and the 2020-23 Strategy builds on the stability of the integrated sexual health service and focuses on sexual health improvement, leadership and policy in Leicestershire.

Sexual Health Locally

7. Nationally and locally, the burden of Sexually Transmitted Infections (STIs) continues to be greatest in young people (aged 15-24). Men who have sex with men (MSM), specific Black and minority ethnic groups, vulnerable people (including Looked After Children (LAC)), those with physical and learning disabilities and those who had adverse childhood experiences, are all at greater risk of STIs. Reinfection rates of STIs, particularly in women, are an issue in some areas of the County.

8. Generally, the diagnosed prevalence rate of HIV is lower than nationally but testing coverage in Leicestershire is significantly worse than England overall. Late diagnosis is a key factor in HIV related morbidity and premature mortality. Local authorities were due to commission, from April 2020, the provision of PrEP (pre exposure prophylactic) an antiviral medication that, when taken appropriately, is a highly effective way of preventing HIV transmission The commissioning of PrEP by local authorities has been delayed due to Covid-19, with no start date as yet. The medication will be paid for by the NHS and the Council has also set aside funding to support delivery.

9. The total abortion rate in Leicestershire has increased significantly over the past six years, reflecting the national pattern. In Leicestershire the rate of abortions in over 25s has increased since 2014, but the rate remains below the national rate.

Leicestershire Sexual Health Strategy 2020-23

10. The draft Leicestershire Sexual Health Strategy 2020-23 is appended to this report. It considers the achievements made thus far and outlines five key priorities for the next three years to further improve sexual health outcomes for Leicestershire's residents. The priorities, which are underpinned by the results and recommendations from the JSNA chapter, which was completed in September 2019, which can be found at: **www.lsr-online.org/uploads/jsna-sexual-health.pdf** The five priorities are:

    - Informed choice around sexual and reproductive health - This includes: communicating clear, consistent sexual health messages across LLR; ensuring delivery of Relationships and Sex Education (RSE) in schools and running targeted sexual health campaigns.
    - Flexible, accessible services for all - Significant work has already been done to improve services and reduced fragmentation across the system. The sexual health services and workforce will look to ensure that groups at specific high risk of poor sexual health have access to high quality equitable services across the county.
    - Fulfilling reproductive intentions - Support Leicestershire residents to have the best opportunity to have children at a time and place in life that they choose and reduce the risk of unplanned pregnancy and STIs.
    - Reduce the impact of health inequalities on sexual and reproductive health - Work with partners both within the council and externally to build a strong local economy to promote opportunities for communities to thrive and, support people to take control of their health and wellbeing.
    - Working with partners to maintain a strategic approach to sexual health improvement - The Council will ensure good joint working with other sexual

health commissioners including joint procurements and co-commissioning of services across organisational boundaries where possible.

Covid-19

11. There is no doubt that the impact of Covid-19 will affect wider health issues for people including their sexual health This may be as a result of the changed access to services during the crisis – mostly delivered via video and telephone link with online provision of contraception and some STI treatment – or through an increase in health inequalities. The Strategy will look to address the changes in people's circumstances and also to promote what which new methods of service delivery have worked well. It will be essential to provide clear communications about the delivery of services as the Council moves into a recovery phase, so that residents are informed and able to make decisions about their sexual health.

Consultation

12. The Strategy is subject to an eight week consultation which began on the 1st April 2020. While face to face meetings have not been possible the consultation has been delivered via email to key stakeholders, social media posts, and articles in local newsletters. Specifically, consultation has been sought with East and West Clinical Commissioning Groups, all 7 District and Borough councils, the integrated sexual health service, University Hospitals Leicester (UHL), Public Health England (PHE), Healthwatch, Turning Point, Voluntary Action Leicestershire (VAL), Leicestershire Aids Support Service (LASS), Trade, Sexual Assault Referral Centre, Chair of Secondary Head Group, Chair of Primary Heads and various schools through the PSHE network, Parish Councils, Leicestershire County Council members and all internal departments. The Strategy has also been shared with Leicester City and Rutland Councils via the integrated sexual health board.

13. The report is being presented to members of the Health Overview and Scrutiny Committee in order for them to comment on the draft Strategy. It is anticipated that the final draft of the Strategy will be presented to Leicestershire County Council's Cabinet for approval on 23 June 2020.

Recommendation

14. It is recommended that members of the Health and Scrutiny Committee comment on the draft Leicestershire Sexual Health Strategy 2020 – 23.

Circulation under the Local Issues Alert Procedure

15. None. The Strategy is county wide.

Officers to Contact

Mike Sandys, Director of Public Health
Tel: 0116 305 4259 email: mike.sandys@leics.gov.uk

Claire Laurent, Consultant in Public Health
Tel 0116 305 4243 email: Claire.laurent@leics.gov.uk

Appendix

Draft Sexual Health Strategy

Relevant Impact Assessments

Equality and Human Rights Implications

As the implementation of the new Strategy would not result in major changes to services, an EHIRA screening exercise identified that a full assessment was not required. The Council will, however, keep in mind that the Covid-19 crisis may have substantially affected resident's sexual health and will therefore reassess whether a full EHIRA might be required in the next 12 months.

Leicestershire County Council

Leicestershire Sexual Health Strategy

2020-2023

DRAFT

Foreword

Sexual and reproductive ill-health can affect anyone – often when it is least expected. An unplanned pregnancy or diagnosis of a complex sexually transmitted infection (STI), (such as HIV) can have a significant impact physically and mentally, sometimes with knock on effects of stigma resulting in discrimination and further impact on education, employment, housing and social care needs.

Achieving good sexual health is complex and the sexual health needs of the population continue to evolve. Over the past few decades there have been significant changes in dating and relationships, and how people live their sexual lives including personal attitudes and beliefs, social norms, peer pressure, confidence and self-esteem, misuse of new drugs and alcohol, coercion and abuse. This has led to changes in risk taking behaviour such as increased average number of sexual partners, expansion of heterosexual repertoires and chemsex. Services must adapt to these changing needs to ensure the best outcomes for our local population.

This Strategy sets out our priorities up to 2023 for what we can do as a council to support good sexual health across Leicestershire.

Delivery of this strategy will require significant partnership working with the NHS and other organisations. I look forward to supporting this collaborative effort to meet our strategic vision and objectives.

Mr Lee Breckon,
Lead Member for Health and Wellbeing

Introduction

Since the implementation of the 2016-2019 Sexual Health Strategy, we have significantly improved services and reduced fragmentation in service delivery across Leicester, Leicestershire and Rutland (LLR). Examples include re-commissioning of an integrated sexual health service, embedding new technologies such as online STI testing and developing contractual agreements to allow patients to access cervical screening and coils across providers. As a result, we have made good progress against many sexual health indicators when compared nationally and to our local comparator authorities. We will continue to adapt and respond to the changing national context, to a growing population and to expanding sexual health needs to ensure the best outcomes for Leicestershire's population.

This strategy takes stock of achievements made thus far and outlines the key priorities for the next 3 years to further improve sexual health outcomes for Leicestershire's residents. These priorities align with Leicestershire County Council's Strategic Plan 2018-22 which aims to be 'Working together for the benefit of everyone.' The outcomes include:

- **Strong economy:** Leicestershire's economy is growing and resilient so that people and businesses can fulfil their potential.
- **Wellbeing and opportunity:** The people of Leicestershire have the opportunities and support they need to take control of their health and wellbeing.
- **Keeping people safe:** People in Leicestershire are safe and protected from harm.
- **Great communities:** Leicestershire communities are thriving and integrated places where people help and support each other and take pride in their local area.
- **Affordable and quality homes:** Leicestershire has a choice of quality homes that people can afford.

Amid a number of changes and unknowns, including the implications of the NHS Long Term Plan, a forthcoming national Sexual and Reproductive Health strategy and uncertainty of Public Health Grant funding, this strategy focuses on the opportunities and challenges that are on the horizon.

These include working with evolving primary care networks whilst developing a sexual health improvement approach that considers the wider determinants of poor sexual health across Leicestershire.

This strategy has been developed using an evidence based approach driven through the Leicestershire Sexual Health Joint Strategic Needs Assessment chapter published in September 2019. This included a review of the current national and local sexual health outcomes, services, evidence base and evaluation of the Leicestershire Sexual Health Strategy 2016-2019. The recommendations in this strategy reflect those findings. The Sexual Health JSNA can be found here:

www.lsr-online.org/uploads/jsna-sexual-health.pdf

Good sexual health is important both 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]

Investment in sexual and reproductive 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. [2 3 4])

Supporting young people to develop safe, healthy relationships and prevent unplanned pregnancy is key to enabling them to fulfil their aspirations and potential.

At a strategic level, getting prevention right:

- is integral to safeguarding, emotional health and wellbeing and early help
- integrates with chlamydia screening and STI prevention
- maximises cost effectiveness of sexual and reproductive health services
- reduces future demand on health and social services

Teenage mothers are more likely than other young people to not be in education, employment or training; and by the age of 30-years, are 22% more likely to be living in poverty than mothers giving birth aged 24-years or over. For every teenage mother who gets back into education, employment or training saves agencies £4500 a year.[5]

Teenage mothers are also more likely to need and receive targeted support than older parents. Children born to teenage mothers have a 63% higher risk of living in poverty. For every child prevented from going into care; social services would save an average £65k a year.[5]

The total cost savings of unplanned pregnancy across the public sector, including healthcare and non-healthcare settings, the return on investment for every £1.00 spent is £4.64 over a four year period, and £9.00 over 10 years. Evidence also suggests that £1.00 investment in contraception saves £11.09 in averted outcomes (NHS savings) £1.00 invested in LARC saves £13.42 in averted outcomes (NHS savings).[6]

- For every one pound invested in contraception saves £11.09 in averted negative outcomes
- £1 invested in LARC methods of contraception saves £13.42 in averted outcomes

Insights into the current picture of sexual health in Leicestershire

Sexually transmitted infections

While Leicestershire reflects national trends for sexually transmitted infections (STIs), for instance rates of syphilis are increasing nationally and locally, its rates for STIs remains lower compared to the England average. In 2018, overall 3,603 new STIs were diagnosed in residents of Leicestershire, a rate of 522 per 100,000 residents (compared to 784 per 100,000 in England). Nationally and locally, the burden of STIs continues to be greatest in young people (aged 15-24). Men who have sex with men (MSM), specific Black and minority ethnic groups, vulnerable people (including Looked After Children (LAC), those with physical and learning disabilities and those who had adverse childhood experience, are all at greater risk of STIs. Reinfection rates of STIs, particularly in women, are an issue in some areas of the county.

Chlamydia detection rates in Leicestershire are lower than the national average (1,703 per 100,000 population compared to the England average of 1,975 per 100,000 population). Therefore, it will be part of the strategic plan to increase the detection rate. We are awaiting a review of the national chlamydia screening programme which is due to report soon.

HIV transmission, late diagnosis

Since 2011, the HIV diagnosed prevalence rate in Leicestershire has remained lower than the national benchmark of a rate less than 2 per 1,000 population. However, over the last five years, both nationally and locally the trend has significantly increased over time, while HIV testing coverage for Leicestershire has remained significantly worse than England for the last four years.

Late diagnosis is the most important predictor of HIV-related morbidity and short-term mortality. Although numbers of late diagnoses are comparatively small in Leicestershire, this is a concerning trend that needs to be addressed through good information about testing for both residents and health professionals and, good access to HIV testing at sexual health clinics.

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. Poor sexual health is also linked to broader health inequalities, with higher rates of STIs transmission found in the most deprived areas of Leicestershire.

Termination of pregnancy

The total abortion rate in Leicestershire has increased significantly over the past six years, reflecting the national pattern. In Leicestershire the rate of abortions in over 25s has increased since 2014, but the rate remains below the national rate.

Teenage pregnancy

Since the introduction of the Teenage Pregnancy Strategy in 1999, England has achieved a 61.8% reduction in the under-18 conception rate between 1998 and 2017 whereas Leicestershire has achieved a higher decrease, at 67.6% reduction. This equates to ten consecutive years that the rate of teenage pregnancies both nationally and locally has decreased. The latest data shows in 2017 the under-18 conception rate per 1,000 females aged 15-17-years was 12.3 per 1,000 females aged 15-17-years, significantly better than the England rate of 17.8 per 1,000 females aged 15-17-years. This equates to 135 under 18 conceptions in Leicestershire in 2017. [7]

Vision

Our strategic vision for good sexual health in Leicestershire is for:

"The people of Leicestershire to make informed, positive choices about their reproductive and sexual health to reduce unplanned pregnancies and sexually transmitted infections (including HIV)."

The 2016-2019 Sexual Health Strategy made significant progress in pulling the 'system' together, including a range of procurements and contractual agreements to ensure that the highest quality, evidence based services are built around the individual rather than organisational structures.

Now that these strong building blocks are in place, the 2020-23 strategy will focus on sexual health improvement, leadership and policy in Leicestershire.

This will allow for further progress to be made, whilst acknowledging the changing commissioning landscape, development of the integrated care system and its impact on partners. Combining this approach with the results and recommendations from the JSNA chapter has provided a clear evidence base and rationale for the strategic priorities and helped shaped the vision below.

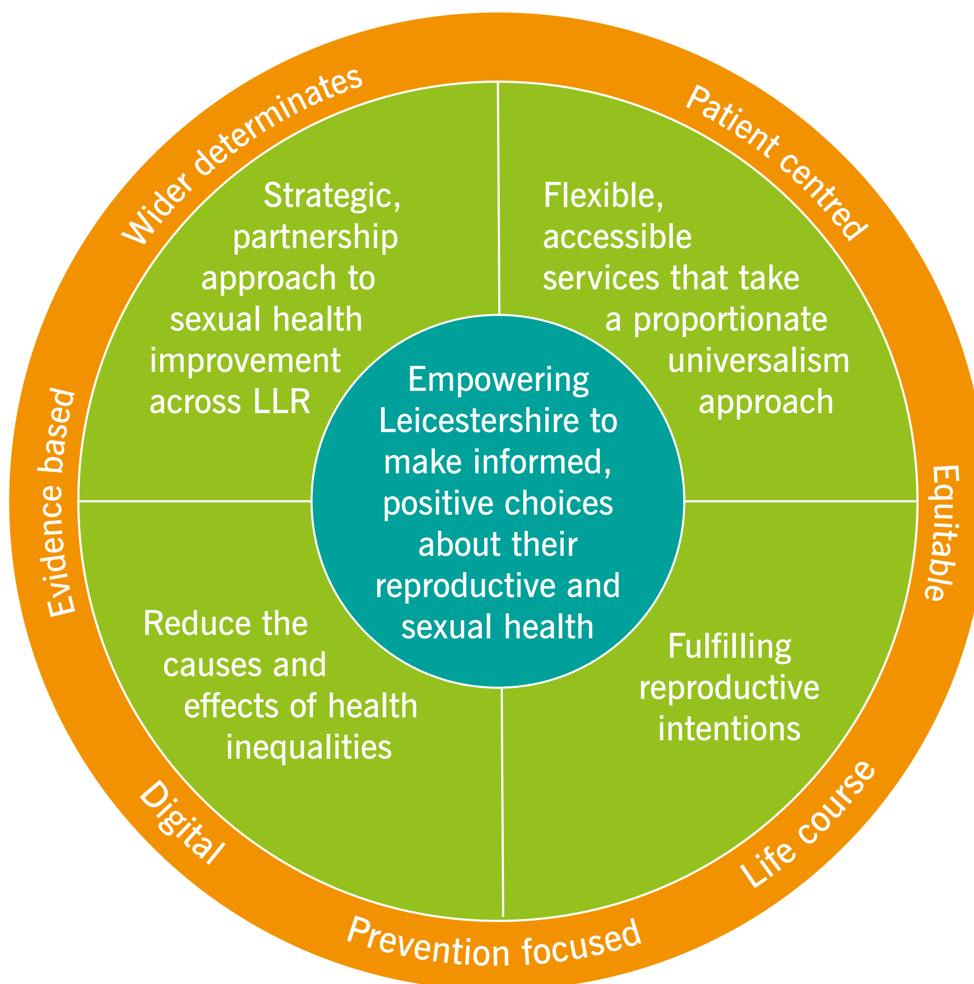
Our strategic approach:

What does good sexual and reproductive health look like across Leicestershire?

The previous Leicestershire Sexual Health Strategy 2016-19 was specifically commissioning focused, to 'pull the system back together' following the fragmentation of services in the 2013 Health and Social Care Act. Much of this work has now been implemented including developing section 75's for intrauterine devices for menorrhagia, NHS England commissioning cervical cytology from the sexual health service, re-commissioning of the LLR Integrated sexual health service (ISHS) and moving the city centre hub into a more accessible, purpose-built facility within the Haymarket. Therefore, the 2020-23 strategy looks at sexual and reproductive health into a policy and leadership role across Leicestershire, while acknowledging there are still commissioning intentions to be discharged.

The key question that this strategy aims to answer is 'What does good sexual and reproductive health look like across Leicestershire?' Figure 1 below, summarises the key priorities to answer this question.

Figure 1 Summary of the key sexual health priorities across Leicestershire



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?

Priority 1:
Informed, empowered choice around sexual and reproductive health

Where are we now?

There are a variety of ways in which we engage with the people of Leicestershire to support them in making informed, empowered choices about their sexual and reproductive health. This can range from delivery of Relationships and Sex Education (RSE) in schools, to information about the services available, to targeted sexual health campaigns. However, we know that relationships, attitudes and sexual practices have evolved, including the use of dating apps, increasing average numbers of sexual partners and varying sexual repertoire. Therefore, we must also adapt how we communicate with the local population so they can make informed, safe choices about their sexual and reproductive health. The introduction of statutory RSE in all primary and secondary schools from September 2020 will also present another avenue for providing information.

What do we want to achieve?

- Informed, empowered population that can make positive choices about their sexual and reproductive health and personal relationships.
- A sustainable model for delivering high quality, effective RSE (including relationships, sexual and reproductive health over the life course) across all schools and young people's settings.
- Clear, consistent sexual health communication messages across LLR, that make use of national campaigns as appropriate.
- Targeted health promotion campaigns for groups at high risk of poor sexual and reproductive health using behavioural insights methodologies.

How will we get there?

- Complete a behavioural insights piece of work including qualitative insight with young people to determine where to focus future efforts and resources to inform and empower them to make positive choices about their relationships, sexual and reproductive health. This will include use of social media approaches to communication campaigns and gathering information.
- Inform public health actions with behavioural change theory to enable women (specifically those aged over 25 in whom the abortion rate is rising) to make informed contraception choices that include Long Acting reversible Contraception (LARC).
- Support further education colleges and other young people's settings to embed high quality RSE as part of the wider personal, social, health and economic education for statutory implementation by September 2020. This will include fully making use of the links with the Healthy Schools programme, RSE toolkit, RSE training offer and links to the Leicestershire and Rutland RSE group.
- Evaluate the current RSE offer and its impact. Develop this into a regular audit process to assess the quality and consistency of RSE delivery across schools and colleges. Specifically review the relationships and sex education received by looked after children, children with learning and physical disabilities.
- Consider what RSE material is available to support parents to discuss RSE with their children including Speak Easy courses for those particularly at risk including foster carers, teenage mothers and those accessing social care.
- Utilise sexual health contracts to ensure consistent, effective sexual health communications between providers and service users.
- Targeted health promotion campaigns using behavioural insights for specific at risk groups and in relation to STI re-infection rates particularly in Charnwood and Oadby and Wigston. This will include mapping all projects across Leicestershire that aim to increase access to sexual health improvement and HIV prevention for high risk groups.
- Engage with patient and public groups, through consultation on the 2020-2023 strategy, to understand the stigma they may feel around sexual health and, develop a communication strategy, with partners, to reduce that stigma and, in turn reduce health inequalities.
- Improved access and uptake to sexual and reproductive health self-care including information, advice and guidance, and access to online services as appropriate.

Priority 2:

Flexible, accessible services for all based on proportionate universalism

Where are we now?

Across Leicestershire there is a comprehensive sexual and reproductive service offer that is delivered through general practice, the LLR Integrated Sexual Health Service, pharmacy, University Hospitals Leicester and the voluntary and community sector. Significant work has been completed to improve services and reduce fragmentation across the LLR system, however there is still work to be done. There are changing sexual and reproductive health needs across the population, including increasing rates of syphilis and drug resistant gonorrhoea, increasing risk taking behaviour such as ChemSex, evolving demands of patients and introduction of new technologies such as pre-exposure prophylaxis (PrEP) for HIV.

Within this context there are groups at specific high risk of poor sexual health (young people, men who have sex with men (MSM), specific Black and minority ethnic groups, vulnerable people (including Looked After Children, those physical and learning disabilities and those who had adverse childhood experience) and there are shortages in specialist sexual health staff and competencies across the system. The sexual health services and workforce must therefore consider how it provides an equitable, high quality service across Leicestershire, while remaining flexible and adaptable to meet these specific and changing population needs.

What do we want to achieve?

- High quality, clinically and cost-effective services for all that proportionately target specific high risk groups (proportionate universalism). For example, those who are homeless will need greater support and focused information to access sexual health services than those who are housed.
- Skilled, flexible sexual and reproductive health workforce that is able to recruit and retain high quality staff that can adapt to local need.

How will we get there?

- Review the new model of ISHS delivery (in particular the digital offer) in relation to access to STI testing and diagnoses, including HIV, and how these meet the specific needs of the whole population and at risk groups through case mix review.
- Implement Public Health England (PHE) syphilis action plan as appropriate for Leicestershire including increased frequency of STI testing for high risk MSM, improved partner notification, antenatal testing, targeted health promotion. Support PHE enhanced surveillance for gonorrhea resistance, targeted health promotion and communication to GP.
- Improve data quality of HIV testing coverage and uptake in ISHS, especially in MSM. Develop a process for case review of late HIV diagnoses to enable learning from missed diagnosis opportunities.
- Improve chlamydia detection rates by increasing the proportion of young people screened for chlamydia.
- Ensure services meet the sexual health needs of young people, including looked after children, by reviewing the latest trends in their attitudes, beliefs and access to sexual health and reproductive health services. This will include exploring the reductions in demand for emergency hormone contraception in under 25's, C-card in under 19's and standard contraceptive appointments in the sexual health service.
- Utilise contracts to ensure homelessness services and domestic abuse services support and signpost their clients to sexual health services and provide follow up support as appropriate.
- Further strengthen the links between sexual health and substance misuse services with relation to Chemsex services and health promotion as part of the substance misuse re-procurement.
- Consider the use of digital online services for oral and emergency hormone contraception in primary care.
- Targeted interventions in the teenage pregnancy hotspots including Coalville, Copt Oak, Anstey, Rothley, Sileby, Wigston and South Wigston. Complete a health equity audit and review annual practice performance in order to inform and improve uptake of cervical cytology Review the model of cervical cytology following a national review, including self testing options for Human Papillomavirus (HPV).
- Consider longer term commissioning arrangements for Hepatitis A vaccination in MSM.
- Drive an increase in the uptake of LARC utilising the development of primary care networks to review of the model of delivery of LARC in primary care, exploring opportunities for greater inter-practice referrals and equity of access across the county.
- Review progress in delivering the recommendations of the training needs assessment specifically for the specialist workforce. When appropriate, consider a follow up assessment to measure impact and ensure the training and development pathway has been fully established across Leicestershire and Rutland.
- Work with Health Education East Midlands to consider the long term workforce implications to deliver sexual and reproductive health across the system. In particular the specialist medical sexual health workforce and primary care capacity to deliver LARC.
- Understand the level of existing knowledge and competence to deliver effective sexual health messages in order to develop a coordinated and consistent approach across primary and community based staff to support referral and signposting to more specialised services

Priority 3:
Fulfilling reproductive intentions.

Where are we now?

Choosing to have children and the timing and size of that family unit is down to each individual and/or couple. The Third National Survey of Sexual Attitudes and Lifestyles (NATSAL-3)[8], carried out in Britain in 2010-12, found that 16.2% of all pregnancies in the year before the study interview were unplanned, with 21.2% in 16 to 19 year olds, but higher numbers in 20 to 34 year olds. Of the unplanned pregnancies 42% ended in an abortion, 32% miscarriage and 25% went on to a full term pregnancy which may become wanted or potentially link into social care. Poor sexual health can affect fertility or lead to problems such as pelvic inflammatory disease and risk of ectopic pregnancy. People are choosing to start families later in life, with the latest evidence suggesting the average first time mother is now aged 29 years old. Increasing age of the mother is also associated with increased risk of infertility. Infertility can have a significant impact on the physical and mental health of the individual, couple and family. Both unplanned pregnancy and infertility can cause financial, housing and relationship pressures and impact on existing children. There are also considerations around fostering and adoption that need to link into children's social care services. In Leicestershire we would like to support individuals and couples to be in the best socially and financially secure position and in good physical and mental health when considering starting a family.

What do we want to achieve?

- Support Leicestershire residents to have the best opportunity to have children at a time and place in life that they choose.

How will we get there?

- Deliver other elements of the sexual health strategy to reduce likelihood of unplanned pregnancy and STIs.
- Strength the abortion pathway by completing the PHE abortion pathway review to inform future commissioning model and action plans to reduce the increasing trend in abortions.
- Review the reproductive pathway, strengthening the delivery of LARC in maternity and abortion services, especially for those at high risk of repeat unplanned pregnancies to ensure that women have more control over when they chose to become pregnant in the future.
- Embed MECC Plus into sexual health services to ensure women can access prevention services to support improvement in their overall health and wellbeing before conception (for example, stop smoking service, maternal obesity and supplement preparation.)
- Review the infertility pathway ensuring a prevention focus, linking back to actions in priority one.

Priority 4:

Reduce the impact of health inequalities on sexual and reproductive health

Where are we now?

Poor sexual health is closely linked to health inequalities, which are avoidable and unfair differences in health status between groups of people or communities. They are the result of a wide range of determinants, from genetics to income, to ethnicity, to where you live and other social factors, including behavioural risks such as smoking, which all impact on peoples' health and can drive poor health

To bring about real change and reduce the inequalities that can often lead to poor sexual health outcomes we need to reduce the impact of local structural influences such as economics, education and employment. This includes working with partners internally on Leicestershire County Council's Strategic Plan 2018-22 which aims to work together for the benefit of everyone, building a strong local economy to promote opportunities to enable communities to thrive and support people to take control of their health and wellbeing.

What do we want to achieve?

- Reduce the causes and impact of health inequalities and the wider determinants in society on sexual and reproductive health.
- Clear links between the Leicestershire Sexual Health Strategy and Leicestershire County Council's Strategic Plan 2018-22.

How will we get there?

- Complete PHE's Teenage Pregnancy Self Assessment toolkit to identify gaps and actions needed to improve the outcomes of young parents.
- Repeat the Equality & Human Rights Impact Assessment (EHRIA) as part of the 2020-2023 strategy development and one year after the commencement of the ISHS contract to assess whether reductions in barriers to access STI and HIV testing have been achieved and what further action is needed.
- Utilise the contractual arrangements with the homelessness service and the domestic violence service to refer people into sexual health services as appropriate and provide support to access treatment.
- Link with partners across departments and organisations to improve signposting and support to sexual health services, thereby improving access.
- Review Leicestershire County Council's Strategic Plan 2018-22 and implementation plan to develop key objectives within the appropriate workstreams that will tackle other specific wider determinants that affect sexual health. This includes high risk groups (teenage parents, safeguarding, looked after children, social care, youth offending, learning and physical disabilities.
- Consider sexual and reproductive health implications for Leicestershire County Council's workforce Health and Wellbeing strategy and action plan.
- Work with CCGs and primary care networks to be aware of the inequalities in sexual health that can impact on people's health and together develop action plans that can reduce these
- Link into place based strategies and approaches to reduce health inequalities including links to integrated neighbourhood teams and primary care network development.
- Consider how health and care services may need to meet the future demands of an aging HIV population. For example, linking into work on multimorbidity and integrated neighbourhood teams.
- Prioritise the reduction of STIs in at risk groups such as: young people aged between 15-24, men who have sex with men (MSM), specific Black and minority ethnic groups, vulnerable people (including Looked After Children (LAC), those with physical and learning disabilities and those who had adverse childhood experiences).

Priority 5:
Working with partners to maintain a strategic approach to sexual health improvement.

Where are we now?

As a result of the 2012 Health and Social Care Act, sexual health commissioning became fragmented across local authority, clinical commissioning groups and NHS England. Significant progress has been made in the previous 2016-2019 Sexual Health Strategy to 'pull the system together', including a range of procurements and contractual agreements to ensure the highest quality, evidence based services are built around the individual and not organisational structures (including a section 75 agreement for Intrauterine System (IUS) for menorrhagia, commissioning of cervical cytology from the sexual health service, recommissioning of the ISHS and community based services delivery in primary care.) However, there are still efficiencies to be made in some pathways (abortion, psychosexual and HIV) and new services such as PrEP and Hepatitis A vaccination for MSM that are likely to need commissioning across the system. National guidance from the NHS Long Term Plan has also suggested the need for further joint or co-commissioning with the NHS in the future.

What do we want to achieve?

- Good joint working with other sexual health commissioners including joint procurements and co-commissioning of services across organisational boundaries where possible.
- Seamless sexual health patient pathways built around the patient.

How will we get there?

- An agreed Leicestershire strategic approach to commissioning and delivery of sexual health services over the next 3 years.
- Review biannual LLR sexual health commissioner's terms of reference to ensure they are fit for purpose and meet the needs of all commissioning partners across LLR. This should include consideration of co-commissioning models of sexual health, use of partners data and the role of workforce leads, such as Health Education East Midlands.
- Explore joint and co-commissioning opportunities for Sexual and Reproductive Health services across LLR including abortion, PrEP, HIV.
- Join up and coordinate sexual health communications and information sharing with partners across LLR, including NHS and VSCE colleagues. Consider leadership approach needed to drive this agenda.
- Jointly review the national sexual health strategy and PHE Sexual and Reproductive action plan due to be published imminently and develop LLR plan/ commissioning intentions in collaboration with partners.
- Consider developing further indicators for future sexual health strategy dashboards that inform strategic commissioning decisions and ensure a focus on outcome improvements.
- Work with NHS England to review PrEP trial progress/ findings to inform future commissioning approaches.

Key activities to deliver this approach

To ensure the strategic approach is delivered we will;

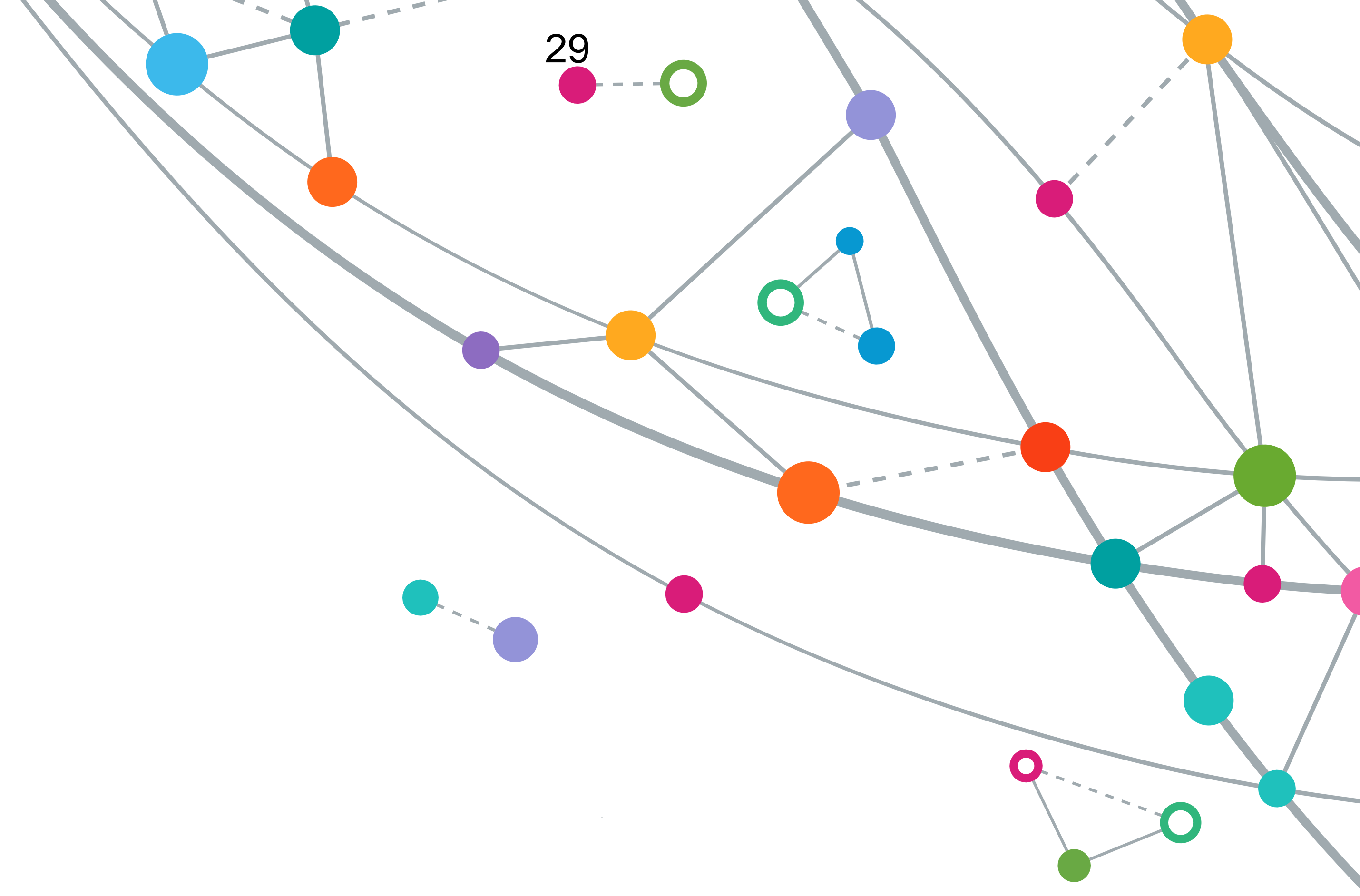
- **Work with partners** across the LLR sexual health system. This includes revising the LLR Sexual Health Commissioners meeting to ensure all commissioning intentions are aligned and task and finish groups to progress key elements of the strategic approach.
- **Keep partners informed** of progress. 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 is supplemented with local sexual health tableau dashboards and further indicators will be developed as part of the detailed action plan. All data will be split by local authority area and compared to local comparator local authorities. 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. This report is then presented annually to the Public Health Departmental Management Team and quarterly to the Sexual Health Strategy Implementation Group.

Scrutiny performance reports and the developing health and wellbeing place based dashboard also offer an opportunity to evaluate effectiveness at a local level.

Our ambition is to see a reduction in health inequalities in sexual health through an improvement in access to services especially for those experiencing homelessness, substance misuse or domestic violence; improved access to contraceptive and sexual health services for all, including in primary care; an increase in the uptake of LARC, especially among women over 25 and, fewer late diagnoses of HIV due to greater awareness among the public and health professionals of testing and access to PrEP.



References

1 WHO. Defining sexual health. Report of a technical consultation on sexual health, 28-31 January 2002. (2002).

2 Department of Health. A Framework for Sexual Health Improvement in England. 1–56 (2013).

3 Public Health England. Making It Work – A guide to whole system commissioning for sexual health, reproductive health and HIV. (2014).

4 Teenage Pregnancy: the evidence http://teenagepregnancyassociates.co.uk/tpa-evidence.pdf (2011)

5 Public Health England (2018). Health matters: reproductive health and pregnancy planning. Available at: https://www.gov.uk/government/publications/health-matters-reproductive-health-and-pregnancy-planning/health-matters-reproductive-health-and-pregnancy-planning.

6 Public Health England (2019). Health Economics: evidence review. Available at: https://www.gov.uk/government/publications/health-economics-evidence-resource

7 Public Health England. Sexual and Reproductive Health Profiles (2018). At https://fingertips.phe.org.uk/profile/SEXUALHEALTH

8 Wellings K et al (2013) The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3) **Lancet; 382: 1807–16**

T0976

Agenda Item 9

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 3 JUNE 2020

REPORT OF THE CHIEF EXECUTIVE AND CCG PERFORMANCE SERVICE

HEALTH PERFORMANCE UPDATE - 2019/20

Purpose of Report

1. The purpose of the report is to provide the Committee with an update on health performance in Leicestershire and Rutland for 2019/20 based on the available data at May 2020.

Background

2. The Committee has, as of recent years, received a joint report on health performance from the County Council's Chief Executive's Department and the CCG Commissioning Support Performance Service. The report aims to provide an overview of performance issues on which the Committee might wish to seek further reports and information, inform discussions and check against other reports coming forward.

NHS Oversight Framework

3. At a national level the health performance reporting model is influenced by the NHS Oversight Framework, issued in August 2019. The Framework summarises the interim approach to oversight for 2019/20 and work that was to be done during 2019/20 for a new integrated approach from 2020/21. The interim Framework has informed reporting related to CCG performance set out later in this report.

4. There are also still a wide range of separate clinical and regulatory standards that apply to individual services and providers. The Public Health Outcomes Framework (PHOF) sets out metrics on which to help assess public health performance and there is a separate framework for other health services. Adult social care outcomes are covered by the Adult Social Care Outcomes Framework (ASCOF) and the Better Care Fund is subject to separate guidance.

Changes to Performance Reporting Framework

5. As well as changes brought about by the new Oversight Framework a number of changes have been made to the way performance is reported to the Committee in recent times to reflect comments at previous meetings, including inclusion of a wider range of cancer metrics and Never Events and Serious incidents related to University Hospitals of Leicester NHS Trust (UHL). The overall framework will continue to evolve to take account of the above developments as well as any particular areas that the Committee might wish to see included.

6. The following 4 areas therefore form the basis of reporting to this committee: -

   a. Some contextual information related to coronavirus and Covid-19 locally;
   b. Clinical Commissioning Group (CCG) performance for both West Leicestershire and East Leicestershire and Rutland CCGs;
   c. Quality - UHL Never Events/Serious Incidents;
   d. An update on wider Leicestershire public health outcome metrics and performance; and
   e. Performance against metrics/targets set out in the Better Care Fund plan and in relation to adult care and integration.

Corona Virus and Covid-19 Contextual Intelligence

7. Due to the impact and prioritisation of the Covid-19 response, usual data collection and reporting have been paused in a number of areas. Some elements of national data collection and release, such as around delayed transfers of care, were put on hold to help providers focus on tackling the immediate coronavirus emergency, so previous data is not able to be reported in a small number of areas. For example, as a result of the Covid-19 response, there have been no further updates to the NHS Oversight Framework Dashboard, from end February and online data files have not be updated.

8. The national data in this report was therefore last updated in February 2020, so Appendix 2 has been updated to this point, which doesn't include or reflect impact from coronavirus. In a number of cases, though, metrics have been updated through local data. The report is therefore not, at this point, a complete 2019/20 out-turn position due to national reporting being paused. It must also be noted that this report represents performance during 2019/20 financial year only. Therefore, the impact of COVID-19 has not been significantly recognised in the data within this report given the impact occurring largely in the mid-March period onwards.

9. Business intelligence services have been redirected significantly to help the NHS, Local Resilience Forum, County Council and other agencies to better understand and help manage the response to the pandemic, including creating a

range of new analysis, intelligence sources, statistics, management reporting, system modelling and surveys. These range from covid-19 cases, deaths, excess deaths, bed capacity and modelling, health and care provider intelligence, testing, body storage and crematoria capacity, shielding of vulnerable individuals and vulnerable children's school attendance. Consideration is being given to holding a meeting of the Leicestershire, Leicester and Rutland (Joint) Health Overview and Scrutiny Committee meeting in July 2020 to consider the local health service response and impact of COVID-19, which will be able to draw on relevant elements of this intelligence.

10. In the meantime, attached as Appendix 1 are two dashboards showing the wider context of Covid-19 in Leicestershire including death occurrences by cause, district and place of death. Also, the percentage of deaths in Leicestershire by super-output area. At the time of writing Leicestershire has had a lower rate of deaths per 100,000 population than in many areas of the country, with the exception of parts of the south-west which have experienced the lowest rates. Admissions and discharges have been generally lower than were initially predicted at UHL and UHL has been able to operate within ventilator capacity. There has been an average of around 140 patients at UHL at the time of writing, down from a peak of 204.

CCG Performance Dashboard - Appendix 2

11. NHS England and NHS Improvement's (NHSE/I) NHS Oversight Framework (OF) 2019/20 was introduced at the end of August 2019. There is a greater emphasis on system performance, alongside the contribution of individual healthcare providers and commissioners to system goals. The specific dataset for 2019/20 broadly reflects previous provider and commissioner oversight and assessment priorities. The 2019/20 framework is based on 5 areas of assurance: -

    1. New service models;
    2. Preventing ill health and reducing inequalities;
    3. Quality of care and outcomes;
    4. Leadership & workforce; and
    5. Finance and use of resources.

12. Due to the impact and prioritisation of the CovidD-19 response, data collection and reporting has been paused by NHSE/I. As a result, there has been no further updates to the NHS Oversight Framework Dashboard, from the last publication in February 2020, and online data files have not been updated.

13. The full dashboard, as published in February by NHSE/I, showing CCG performance across all 5 domains, is reported in Appendix 2 for West

Leicestershire and East Leicestershire and Rutland CCGs and mirrors the overall format of the 2019/20 Oversight Framework.

14. The following table provides an explanation for the key Constitutional indicators not being achieved. 2019/20 data has been provided in the table. Details of local actions in place in relation to these metrics are also shown.

NHS Constitution metric and explanation of metric	2019/20 Performance	Local actions in place/supporting information
Cancer 62 days of referral to treatment The indicator is a core delivery indicator that spans the whole pathway from referral to first treatment covering the length of time from urgent GP referral, first outpatient appointment, decision to treat and finally first definitive treatment. Shorter waiting times can help to ease patient anxiety and, at best, can lead to earlier diagnosis, quicker treatment, a lower risk of complications, an enhanced patient experience and improved cancer outcomes.	**National Target >85%** **ELR (All Providers);** 75% **WL (All Providers);** 75% **UHL (All patients);** 74%	The Covid-19 pandemic has meant that UHL has made some changes to the cancer pathways. These changes are in line with national recommendations to ensure that patients are safe and receive the time critical cancer treatments they require. There are governance systems in place to: 1) Oversee the service changes that are being implemented with dialogue to understand the decision-making processes undertaken; 2) Review patients daily to ensure the patients with the highest clinical need are operated on the following day. The Trust recovery plan for radiotherapy was to send patients for part of their treatment to Northampton General Hospital, however due to the Covid-19 restrictions the clinical team have decided this is no longer appropriate. There has however been a change to radiotherapy treatment which will provide additional capacity and recovery (staff availability dependent). Any patient who is more at risk of coming into hospital due to Covid-19 versus the risk of delaying their cancer treatment has had their pathway paused. These patients are under constant review by the clinical teams.
A&E admission, transfer, discharge within 4 hours A&E waiting times form part of the NHS Constitution. This measure aims to encourage providers to improve health	**National Target >95%** **UHL A&E + UCC's;** 79% **UHL ED only;** 69%	At the end of March, the Strategic Health Executive approved a number of temporary changes to UEC services in order to manage and reduce unnecessary patient flow into the Acute setting. It also helped to consolidate the clinical workforce to divert to the services with the most demand. The approved temporary changes and/or moves include temporary closures of five

outcomes and patient experience of A&E. The standard relates to patients being admitted, transferred or discharged within 4 hours of their arrival at an A&E department.	**LLR Urgent Care; Centres only** 99%	peripheral Urgent Care sites in ELR CCG, two GP extended access sites in WL CCG and two of the Healthcare Hubs in LC CCG. A report was presented to the April Collaborative Commissioning Committee to summarise the LLR service changes arising out of the response to Covid-19 within Acute, Urgent & Emergency Care. It should be noted that this is an evolving picture, with providers managing the implications of Covid in conjunction with system partners.
18 Week Referral to Treatment (RTT) The NHS Constitution sets out that patients can expect to start consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions if they want this and it is clinically appropriate. 19/20 National Target >92% of patients to start treatment with 18 weeks from referral In 2019/20 the national ambition is also that the Waiting List should be sustained at March 2019 levels in March 2020.	**National Target >92%** **ELR (All Providers);** 78% 20,860 patients waiting at the end of March 2019 20,883 patients waiting at the end of March 2020 **WL (All Providers);** 78% 24,383 patients waiting at the end of March 2019 24,421patients waiting at the end of March 2020 **UHL (All Patients);** 76% 64,506 patients waiting at the end of March 2019 64,559 patients waiting at the end of March 2020	RTT waiting list size at UHL has increased as a result of the winter pressures, and this trend has also been observed at other acute providers. The system agreement to close an orthopaedic ward and convert the nursing workforce to support medical admissions over January-March 2020 affected the waiting list size. In addition to the orthopaedic capacity reduction, UHL have also reduced the volumes of booked surgery in ENT, General Surgery, Maxillo-facial, Paediatric Surgery and Paediatric ENT Surgery due to ongoing bed pressures. UHL had successfully avoided 52 week RTT breaches for over a year, however with the winter pressures, reduced elective capacity and impact of Covid-19, the risk of reportable breaches had increased. CCG and UHL teams are working jointly to estimate the likely impact of Covid-19 and the cancellation of all elective operations on RTT waiting list size and 52-week breach numbers. The UHL teams are stratifying patients by clinical need to ensure that emergency and cancer treatments are prioritised during this time.

Other Cancer Metrics

15. The 2019/20 performance for the Cancer Wait Metrics is set out below: -

Metric	Level	Period	Target	East Leicestershire and Rutland CCG	West Leicestershire CCG
Cancer Waiting Times					
The percentage of patients first seen by a specialist within two weeks when urgently referred by their GP or dentist with suspected cancer	CCG	19/20	93%	92.6%	92.8%
Two week wait standard for patients referred with 'breast symptoms' not currently covered by two week waits for suspected breast cancer	CCG	19/20	93%	94.6%	93.5%
The percentage of patients receiving their first definitive treatment within one month (31 days) of a decision to treat (as a proxy for diagnosis) for cancer	CCG	19/20	96%	95.1%	95.0%
31-Day Standard for Subsequent Cancer Treatments where the treatment function is (Surgery)	CCG	19/20	94%	87.8%	85.4%
31-Day Standard for Subsequent Cancer Treatments (Drug Treatments)	CCG	19/20	98%	99.4%	99.9%
31-Day Standard for Subsequent Cancer Treatments where the treatment function is (Radiotherapy)	CCG	19/20	94%	88.3%	87.6%
The % of patients receiving their first definitive treatment for cancer within two months (62 days) of GP or dentist urgent referral for suspected cancer	CCG	19/20	85%	74.9%	75.0%
Percentage of patients receiving first definitive treatment following referral from an NHS Cancer Screening Service within 62 days.	CCG	19/20	90%	84.5%	84.6%
% of patients treated for cancer who were not originally referred via an urgent GP/GDP referral for suspected cancer, but have been seen by a clinician who suspects cancer, who has upgraded their priority.	CCG	19/20	No national standard	80.3%	79.5%

UHL Never Events

16. There have been 2 never events in 2019/20 at UHL, in June 2019 and September 2019, which have been previously reported to the Committee.

Areas of Improvement

17. There are several areas which are worth commenting on, that have shown improvement in recent months;

- Both CCGs achieved the national target for Cancer Two Week Waits each month from December 2019 to March 2020 and also achieved the Two Week Wait Cancer Symptomatic Breast standard in at least 8 months of the 2019/20 financial year.
- Pressure ulcers - there were zero Grade 4 Pressure Ulcers reported during 2019/20 at UHL.
- Delayed transfers of care - remain within the tolerance levels at UHL.
- Dementia diagnosis - both CCGs continue to meet the national standard of over 66.7% of an expected prevalence of over 65s having a dementia diagnosis.
- The number of Mental Health Out of Area Placements (OAPs) continues to reduce. The national aim is that there will be no Out of Area Placements by the end of March 2021.

Future Reporting

18. From 2020/21, the metrics for oversight and assessment purposes will include the headline measures described in the new NHS Long Term Plan Implementation Framework (https://www.longtermplan.nhs.uk/implementation-framework/), against which the success of the NHS will be assessed. These Long-Term Plan measures will be used as the cornerstone of the mandate and planning guidance for the NHS for the next five years.

19. As such the format of assurance reporting is likely to change. Wherever possible this will be mirrored in future reports to CCGs and the Health Overview and Scrutiny Committee.

Public Health Outcomes Performance – Appendix 3

20. Appendix 3 sets out current performance against a range of outcomes set in the performance framework for public health. The Framework contains 38 indicators related to public health priorities and delivery. The dashboard sets out, in relation to each indicator, the statistical significance compared to the overall England position or relevant service benchmark where appropriate. A rag rating of 'green' shows those that are performing better than the England value or benchmark and 'red' worse than England value or benchmark.

21. Analysis shows that of the comparable indicators, 20 are green, 11 amber and 3 red. There are 4 indicators that are not suitable for comparison or have no national data. Of the 20 green indicators, the following indicators, under 18 conceptions, smoking status at time of delivery and Bowel Cancer Screening have shown significant improvement over the last few years. There are no significant changes for child excess weight in 4-5 year olds and for child excess weight in 10-11 years, successful completion of drug treatment by opiate users, cervical cancer screening coverage (aged 25 to 49) and New STI diagnoses. Breast cancer screening coverage and cervical cancer screening coverage (aged 50 to 64) has shown a trend of worsening performance.

22. Of the 11 indicators that are amber, no indicators have shown significant improvement or significantly worsened, whereas there are no significant changes for successful completion of drug treatment for non-opiate users. The remaining 10 indicators don't have a trend that can be calculated.

23. The three red indicators include – percentage of adults classified as overweight or obese which shows Leicestershire is ranked 11th out of 16 of the CIPFA nearest neighbours (1 being the best); Take up of NHS health checks, Leicestershire ranked 13th out of 16 and Chlamydia detection rate Leicestershire ranked 9th out of 16.

Further work is underway to progress improvement across the range of indicator areas. Further consideration will be given to actions to tackle these areas as part of Health and Wellbeing Strategy implementation and the public health service plan development process.

24. HIV late diagnosis (%) for 2016-18 for Leicestershire has no value presented as the data is supressed due to disclosure issues. Self-reported wellbeing-people with a low worthwhile score, for Leicestershire has no value presented due to data quality reasons.

Better Care Fund (BCF) and Adult Care Health/Integration Performance

25. BCF planning guidance, released in July 2017, reduced the number of BCF metrics from six to four. The guidance contained a requirement for all areas to reduce the number of delayed transfers of care (DToCs).

26. A refresh to the BCF Policy Framework for 2019/20 was published in April 2019. The BCF guidance was published in July 2019 along with final financial allocations. There was an expectation that the target for delayed transfers for end of September 2018 would be maintained or exceeded thereafter. A review of other BCF outcome metrics has been carried out and these have been updated accordingly.

27. The four BCF outcome metrics for 2019/20 remain the same as in previous years. The **non-elective admissions** target is based on the CCG operating plans. As in previous years this includes a small percentage of bordering CCGs. The target for the Leicestershire BCF plan is to achieve no more than 72,313 non-elective admissions during 2019/20.

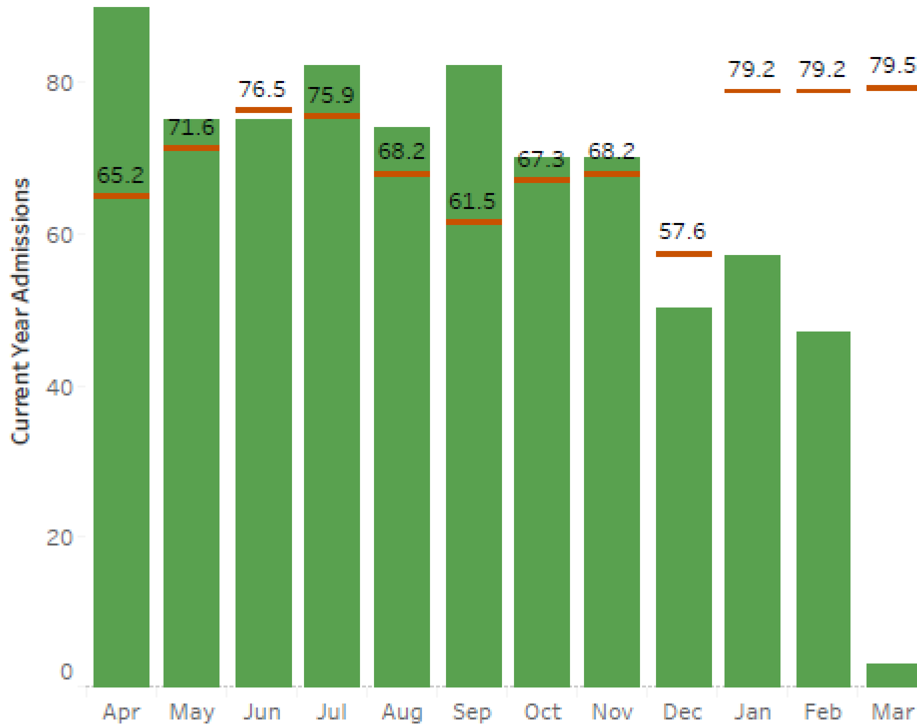
28. The **delayed transfers of care (DTOC)** target has been set by NHS England. The national target remains to achieve below 4,000 delays per day across England. For Leicestershire, the DTOC target is to achieve no more than 42.8 delays per day. Which equates to 7.88 average days delayed per day per 100,000 population.

29. The two BCF social care metrics were refreshed during the main BCF refresh process. The target for the number of **permanent admissions of older people (aged 65 and over) into residential and nursing care homes** is for fewer than 850 admissions during 2019/20. The target for the **proportion of older people who were still at home 91 days after discharge** has been set at 88%.

Metric 1: Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population, per year

30. The BCF target for permanent admissions to care for those aged 65+ during 2019/20 is a maximum of 850 admissions. There were 775 permanent residential admissions between April 2019 and 11 March 2020. The current full year forecast of

858 is predicted, a full year variance of +8. Performance is RAG-rated amber and would be just worse than 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

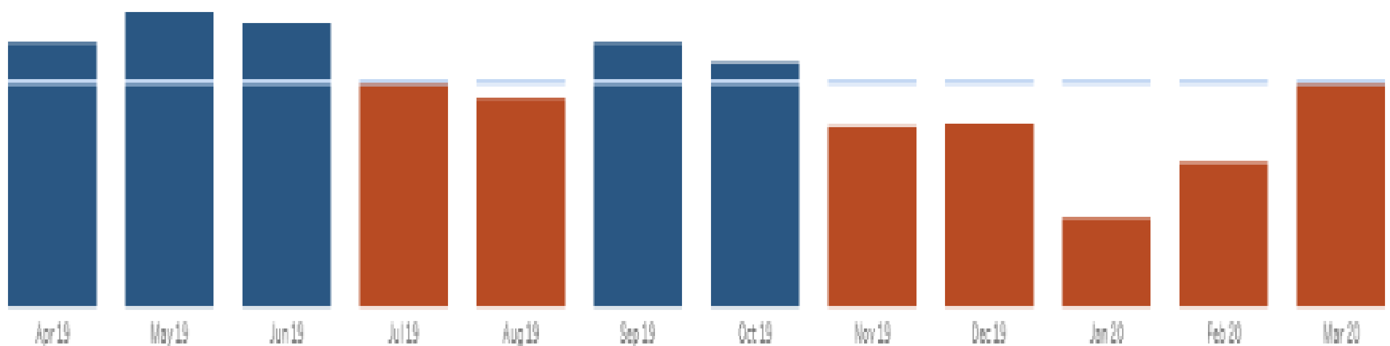
31. For hospital discharges between October 2019 and December 2019, 87.9% of people discharged from hospital into reablement/rehabilitation services were still at home after 91 days. This is just below the 2019/20 target of 88%. Performance is RAG-rated amber and is statistically similar to the target.

ASCOF2B - Proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement / rehabilitation services.

Hospital Discharges	Nov 2018 to Jan 2019	Dec 2018 to Feb 2019	Jan 2019 to Mar 2019	Feb 2019 to Apr 2019	Mar 2019 to May 2019	Apr 2019 to June 2019	May 2019 to July 2019	June 2019 to Aug 2019	July 2019 to Sep 2019	Aug 2019 to Oct 2019	Sep 2019 to Nov 2019	Oct 2019 to Dec 2019
Number of older people discharged from acute or community hospitals to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home	571	582	581	553	546	542	560	544	569	568	595	572

Living at home 91 days later	Feb 2019 to Apr 2019	Mar 2019 to May 2019	Apr 2019 to June 2019	May 2019 to July 2019	June 2019 to Aug 2019	July 2019 to Sep 2019	Aug 2019 to Oct 2019	Sep 2019 to Nov 2019	Oct 2019 to Dec 2019	Nov 2019 to Jan 2020	Dec 2019 to Feb 2020	Jan 2020 to Mar 2020
Of those above, those who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital	510	526	523	486	477	484	496	470	492	472	506	503

ASCOF2B - Monthly Results

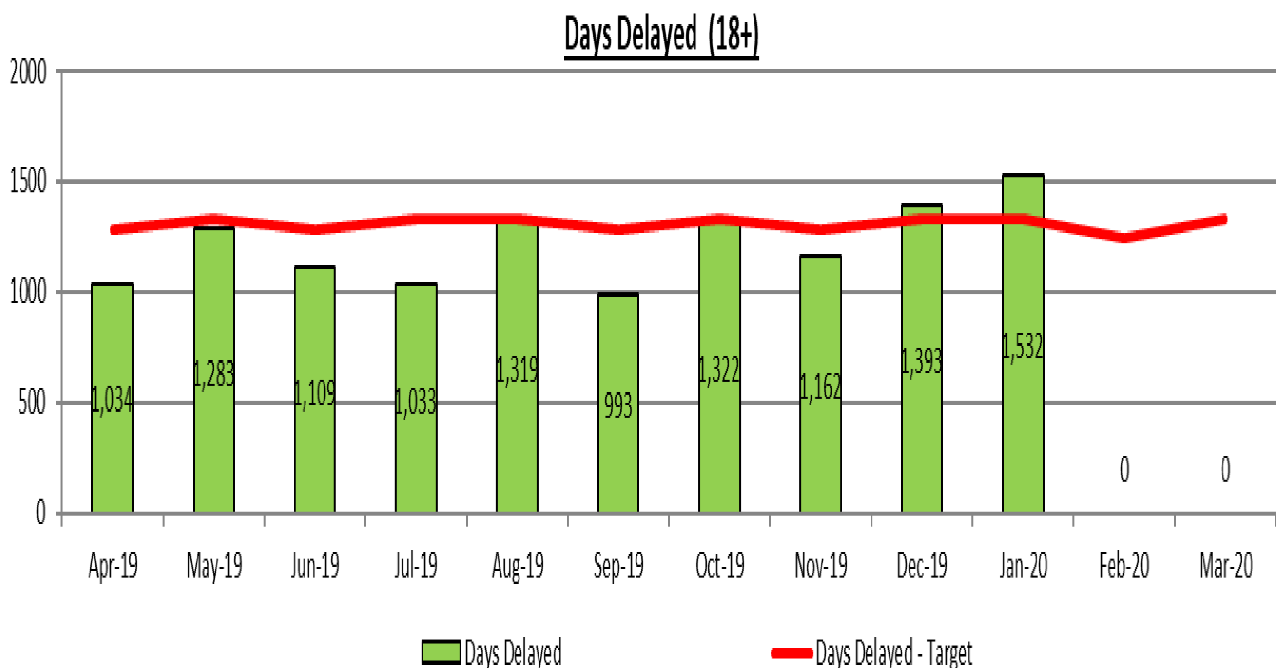


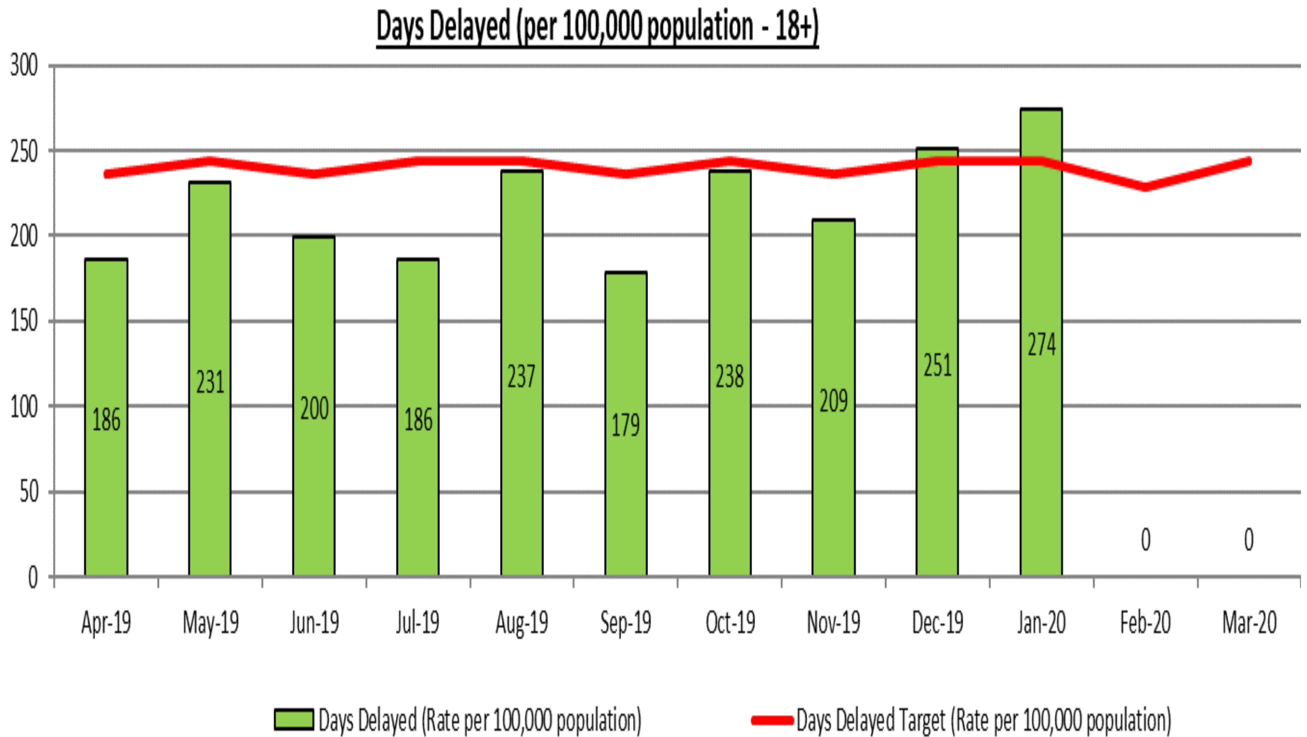
Metric 3: Delayed transfers of care from hospital per 100,000 population

32. The Government's mandate to the NHS for 2018-19 has set an overall ambition for reducing delays to around 4,000 hospital beds occupied by patients delayed without discharge by September 2018. For Leicestershire this equated to DTOCs not exceeding 7.88 in every 100,000 population per day. This target is to be maintained during 2019-20.

33. Overall there were 12,180 days lost to delayed transfers of care in Leicestershire between April and January 2020; a 13% increase on the same period last year. For delays attributable to adult social care there were 1,847 days delayed an increase on the same period last year. With UHL down but both Leicestershire Partnership NHS Trust (LPT) and out of county significantly higher.

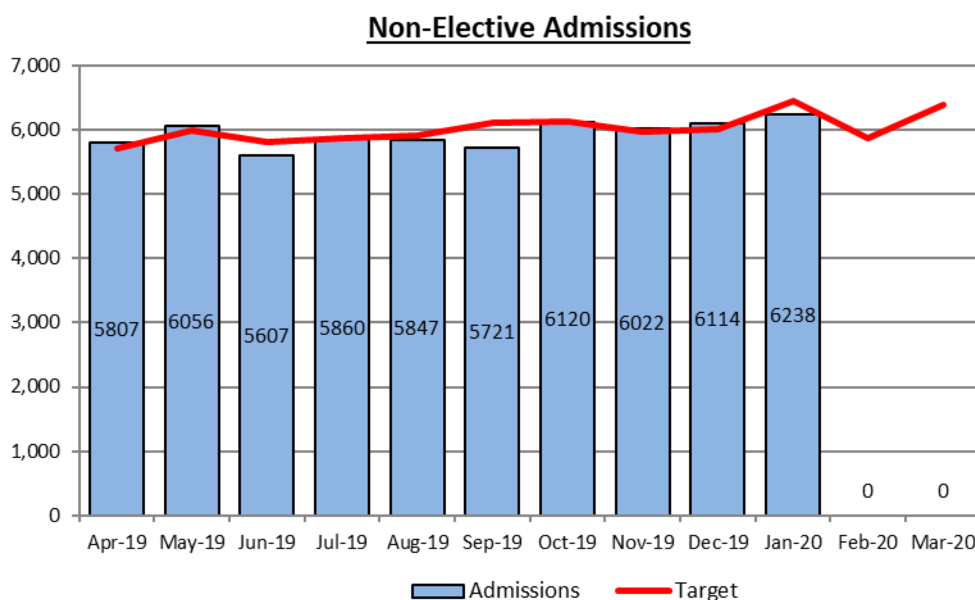
34. All requests for home care and adult care/nursing home placements have continued to be met during the covid-19 epidemic. Less than 9% of home care providers were unable to pick up new packages of care. At the time of writing there was sufficient capacity in the care home sector with over 500 (10%) care home beds available. All LLR, health and social care partners have been working together to establish the safest pathways for all residents for discharge using a range of options with patient safety as the paramount principle.

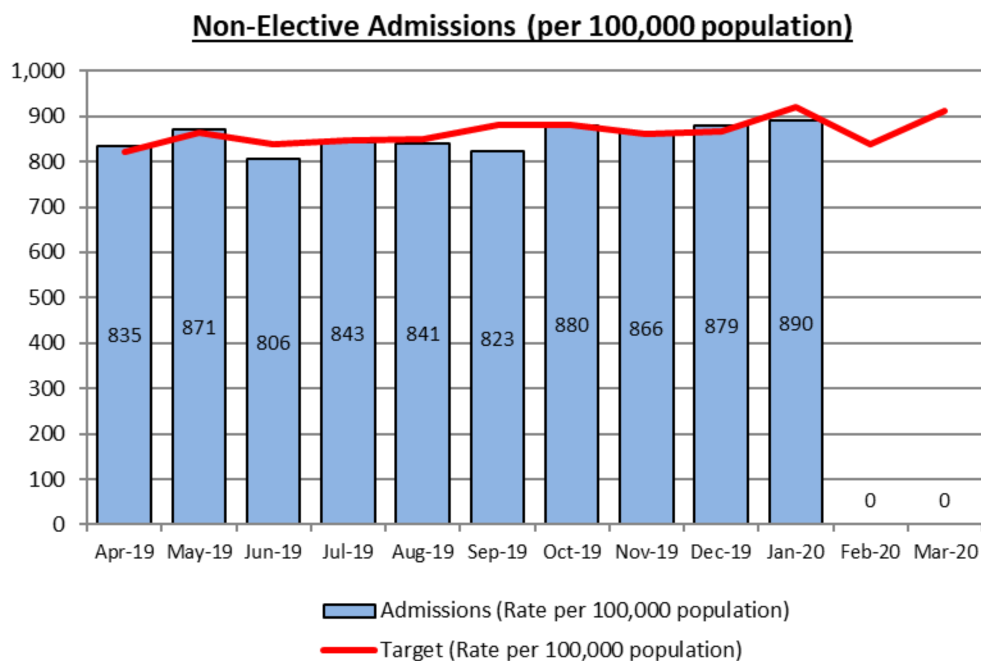




Metric 4: Total non-elective admissions into hospital (general and acute), per 100,000 population, per month

35. Secondary User Statistics data for April 2019 to January 2020 shows 59,392 non-elective admissions. This is a variance of -652 against a month 10 target of 60,044. The target has been achieved in 6 out of 10 months. A full year forecast of 71,661 has been predicted and rag rated green. Non-elective admissions are prominent within 65+ adults at 49.6% compared with 38.5% for 18-64 and 11.9% for children.





List of Appendices

Appendix 1 – Coronavirus and Covid-19 Contextual Information
Appendix 2 – CCG Oversight Framework Dashboard
Appendix 3 – Public Heath Performance Dashboard

Background papers

University Hospitals Leicester Trust Board meetings can be found at the following link:
http://www.leicestershospitals.nhs.uk/aboutus/our-structure-and-people/board-of-directors/board-meeting-dates/

Officers to Contact

Kate Allardyce - NHS Midlands and Lancashire Commissioning Support Unit
Kate.allardyce@nhs.net Tel: 0121 61 10112

Philippa Crane – BCF Lead Intelligence Analyst
Philippa.Crane@leics.gov.uk

Natalie Davison - Public Health Intelligence Business Partner
Natalie.Davison@leics.gov.uk

Andy Brown – Operational BI and Performance Team, Leicestershire County Council
Andy.brown@leics.gov.uk Tel 0116 305 6096

This page is intentionally left blank

ONS Deaths from Covid-19 up to Week 19 2020

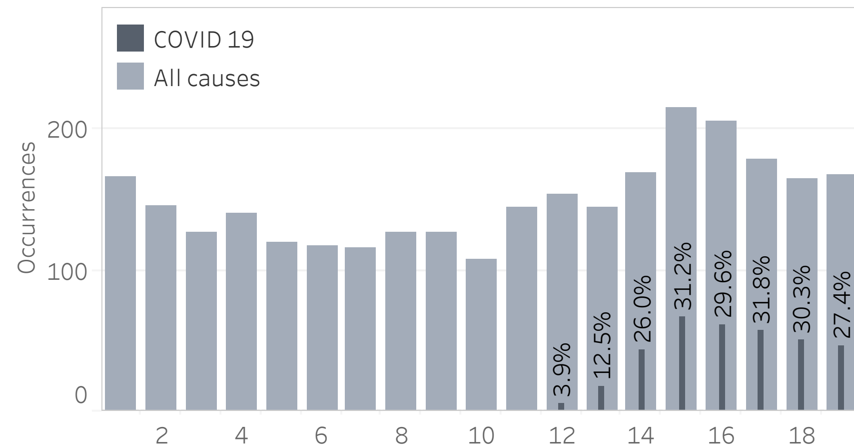
Area
Leicestershire

Recording of Death
Occurrences

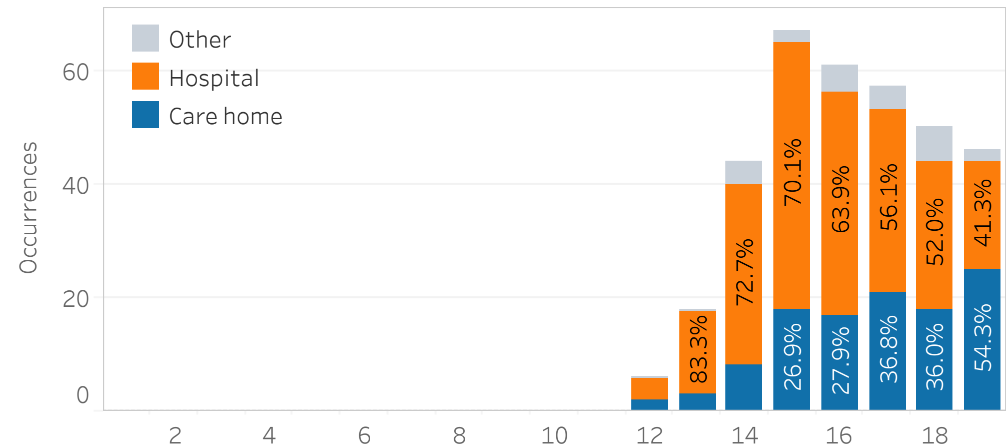
Cumulative Death Occurrences from Covid-19

	Hospital	Care home	Home	Hospice	Elsewhere	Other communal ..	Grand Total
Blaby	28	13	2	1	0	0	**44**
Charnwood	45	27	2	2	0	0	**76**
Harborough	29	15	2	0	0	0	**46**
Hinckley and Bosworth	40	23	3	3	0	0	**69**
Melton	9	10	1	0	0	0	**20**
North West Leicestershire	34	13	5	0	0	0	**52**
Oadby and Wigston	29	11	0	0	0	2	**42**
Leicester	145	37	5	1	2	6	**196**
Leicestershire	214	112	15	6	0	2	**349**
Rutland	6	1	2	1	0	0	**10**

Weekly Death Occurrences in Leicestershire by Cause



Covid-19 Weekly Death Occurrences in Leicestershire by Place of Death

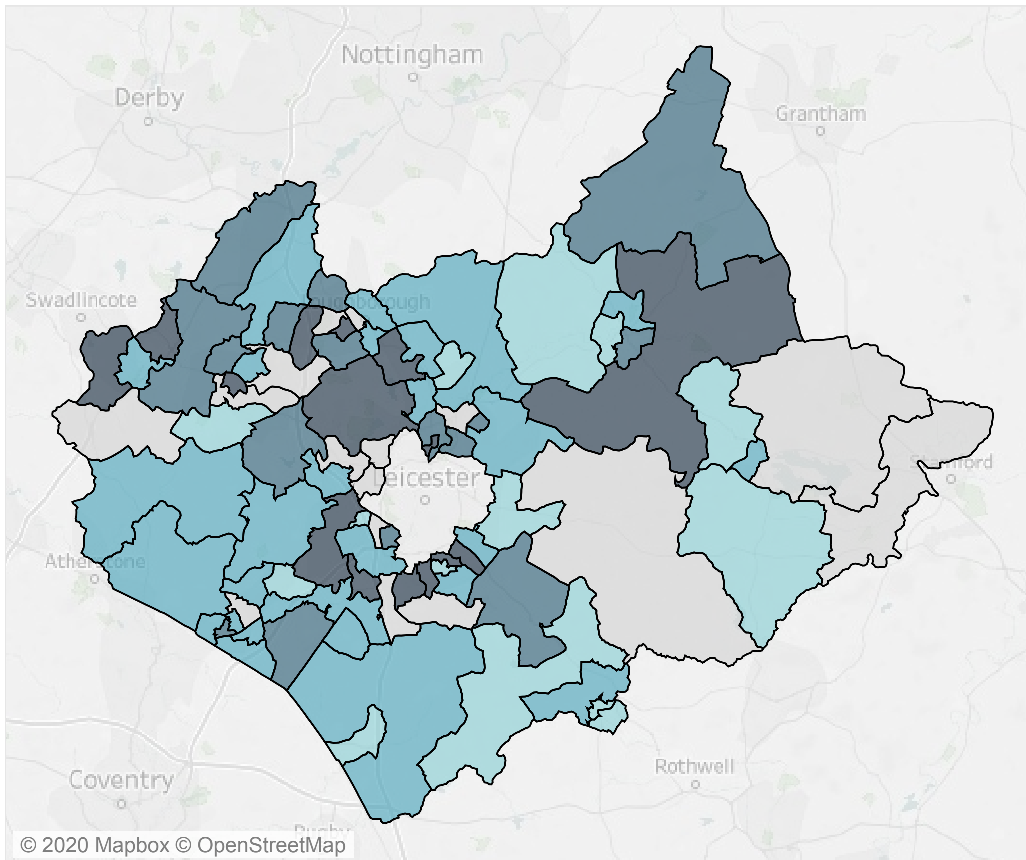


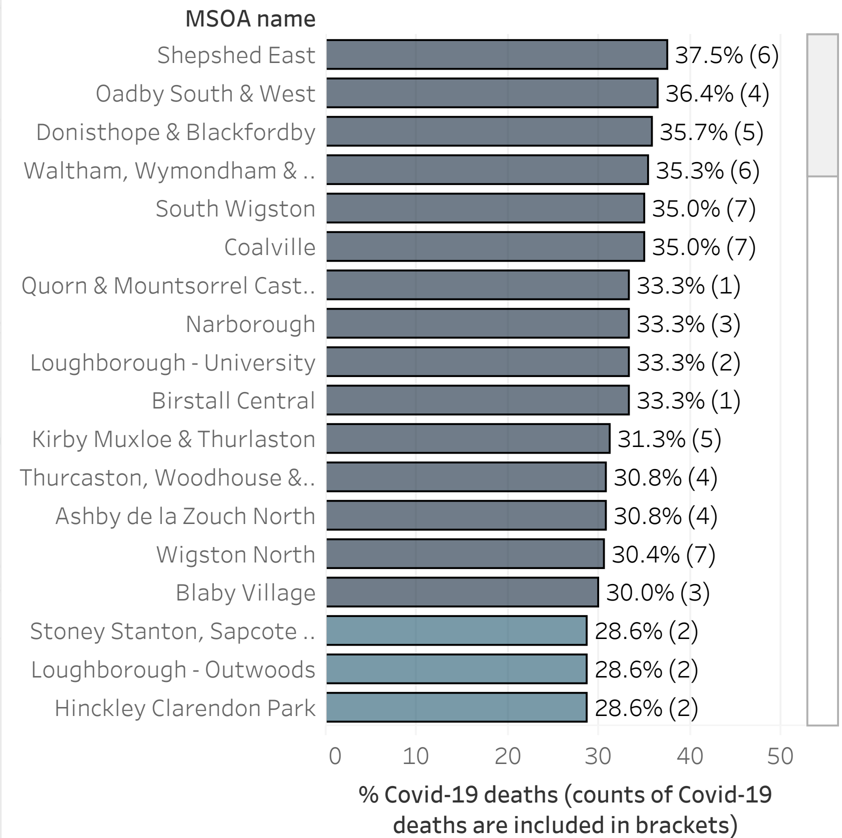
Source: Office for National Statistics licensed under the Open Government Licence

Produced by Strategic Business Intelligence, Leicestershire County Council, May 2020

This page is intentionally left blank

Percentage of deaths from Covid-19 by Middle Layer Super Output Area, Leicestershire and Rutland, deaths occurring between 1st March 2020 and 17th April 2020





0% 1-9% 10-19% 20-29% 30% and above

Source: Office for National Statistics licensed under the Open Government Licence.

Produced by the Strategic Business Intelligence Team, LCC, 2020.

This page is intentionally left blank

CCG Performance Dashboard Appendix 2

The following statement has been provided by NHSE/I in relation to national reporting of the NHS Oversight Framework.

Due to the impact and prioritisation of the COVID-19 response, data collection and reporting has now been paused. As a result, there will be no further updates to the NHS Oversight Framework Dashboard until further notice and online data files will not be updated.

Therefore the data provided within this Appendix was last updated in February 20. There is a significant time delay in reporting a large number of these metrics.

Bandings

- Highest performing quartile
- Interquartile range
- Lowest performing quartile

New service models

IndNameFull	Period	04V: NHS West Leicestershire CCG	03W: NHS East Leicestershire and Rutland CCG
105b: Personal health budgets	19-20 Q2	51	58
127b: Emergency admissions for urgent care sensitive conditions	19-20 Q2	2364	2125
127e: Delayed transfers of care per 100,000 population	2019 12	7.7	7.7
127f: Population use of hospital beds following emergency admission	19-20 Q2	1110	1058
128b: Patient experience of GP services	2019	82.75%	81.70%
130a: Achievement of clinical standards in the delivery of 7 day services	2017-18	3	2
131a: Percentage of NHS Continuing Healthcare full assessments taking place in an acute hospital setting	19-20 Q2	3.85%	3.57%
144a: Utilisation of the NHS e-referral service to enable choice at first routine elective referral	2019 07	100.00%	99.93%

Preventing ill health and reducing inequalities

IndNameFull	Period	04V: NHS West Leicestershire CCG	03W: NHS East Leicestershire and Rutland CCG
102a: Percentage of children aged 10-11 classified as overweight or obese	2015-16 to 2017-18	32.56%	29.45%
104a: Injuries from falls in people aged 65 and over	19-20 Q2	1886	1712
106a: Inequality in unplanned hospitalisation for chronic ambulatory care sensitive and urgent care sensitive conditions	19-20 Q2	2024	2459
107a: Antimicrobial resistance: appropriate prescribing of antibiotics in primary care	2019 11	0.942	0.943
107b: Antimicrobial resistance: appropriate prescribing of broad spectrum antibiotics in primary care	2019 11	9.49%	9.95%
125d: Maternal smoking at delivery	19-20 Q2	10.42%	7.89%
123g: Proportion of people on GP severe mental illness register receiving physical health checks	19-20 Q2	29.0%	25.7%

Quality of care and outcomes

IndNameFull	Period	04V: NHS West Leicestershire CCG	03W: NHS East Leicestershire and Rutland CCG
103a: Diabetes patients that have achieved all the NICE recommended treatment targets: three (HbA1c, cholesterol and blood pressure) for ad..	2018-19	38.44%	40.07%
103b: People with diabetes diagnosed less than a year who attend a structured education course	2017-18 (2016 cohort)	7.28%	11.47%
105c: Percentage of deaths with three or more emergency admissions in last three months of life	2017	9.16%	8.99%
108a: The proportion of carers with a long term condition who feel supported to manage their condition	2019	52.8%	52.0%
121a: Provision of high quality care: hospital	19-20 Q1	54	54
121b: Provision of high quality care: primary medical services	19-20 Q1	65	66
122a: Cancers diagnosed at early stage	2017	51.00%	52.05%
122b: People with urgent GP referral having first definitive treatment for cancer within 62 days of referral	19-20 Q2	75.93%	77.50%
122c: One-year survival from all cancers	2017	72.60%	73.80%
122d: Cancer patient experience	2018	8.7	8.7
123a: Improving Access to Psychological Therapies – recovery	19-20 Q2	47.06%	44.35%

Quality of care and outcomes (continued)

IndNameFull	Period	04V: NHS West Leicestershire CCG	03W: NHS East Leicestershire and Rutland CCG
123b: Improving Access to Psychological Therapies – access	19-20 Q1	4.20%	4.02%
123c: People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral	2019 09	78.85%	65.00%
123f: Mental health out of area placements	2019 11	126	52
123g: Proportion of people on GP severe mental illness register receiving physical health checks	19-20 Q2	29.0%	25.7%
123j: Ensuring the quality of mental health data submitted to NHS Digital is robust (DQMI)	2019 10	92.95%	92.79%
124a: Reliance on specialist inpatient care for people with a learning disability and/or autism	19-20 Q2	53	53
124b: Proportion of people with a learning disability on the GP register receiving an annual health check	2019-20		
124c: Completeness of the GP learning disability register	2018-19	0.41%	0.39%
125a: Neonatal mortality and stillbirths	2017	3.26	3.36
125b: Women's experience of maternity services	2018	80.6	83.0
125c: Choices in maternity services	2018	55.9	60.9
126a: Estimated diagnosis rate for people with dementia	2020 01	70.44%	67.99%
126b: Dementia care planning and post-diagnostic support	2018-19	74.92%	71.51%
129a: Patients waiting 18 weeks or less from referral to hospital treatment	2019 12	82.67%	81.83%
129b: Overall size of the waiting list	2019 12	25386	20975
129c: Patients waiting over 52 weeks for treatment	2019 12	0	1
132a: Evidence that sepsis awareness raising amongst healthcare professionals has been prioritised by the CCG	2018	Amber	Amber
133a: Percentage of patients waiting 6 weeks or more for a diagnostic test	2019 12	1.04%	1.49%
134a: Evidence based interventions	19-20 Q2	Amber	Amber

Leadership & workforce

IndNameFull	Period	04V: NHS West Leicestershire CCG	03W: NHS East Leicestershire and Rutland CCG
128d: Primary care workforce	2019 03	1.07	1.31
162a: Probity and corporate governance	19-20 Q2	Fully compliant	Fully compliant
163a: Staff engagement index	2018	3.59	3.77
163b: Progress against the Workforce Race Equality Standard	2018	0.17	0.17
164a: Effectiveness of working relationships in the local system	2018-19	64.6	67.3
165a: Quality of CCG leadership	19-20 Q2	Amber	Amber
166a: Compliance with statutory guidance on patient and public participation in commissioning health and care	2018	Green	Green

Finance and use of resources

IndNameFull	Period	04V: NHS West Leicestershire CCG	03W: NHS East Leicestershire and Rutland CCG
109a: Reducing the rate of low priority prescribing	19-20 Q2	Amber	Amber
123i: Delivery of the mental health investment standard	19-20 Q2	Green	Green
141b: In-year financial performance	19-20 Q2	Red	Red
145a: Expenditure in areas with identified scope for improvement	19-20 Q2	Red	Amber

Public Health and Prevention Indicators in Leicestershire

Prevention	Indicator		Time Period	Polarity	Value	NN Rank	England	DoT	RAG
	A01a - Healthy life expectancy at birth	(F)	2016 - 18	High	63.9	13/16	63.9	Cannot be calculated	Similar
		(M)	2016 - 18	High	63.8	13/16	63.4	Cannot be calculated	Similar
All	A01b - Life expectancy at birth	(F)	2016 - 18	High	84.2	5/16	83.2	Cannot be calculated	Better
		(M)	2016 - 18	High	80.7	6/16	79.6	Cannot be calculated	Better
	A02a - Inequality in life expectancy at birth	(F)	2016 - 18	Low	5.0	6/16	7.5	Cannot be calculated	Not compared
		(M)	2016 - 18	Low	6.3	3/16	9.5	Cannot be calculated	Not compared
	2.02ii - Breastfeeding prevalence at 6-8 weeks after birth - current method	(P)	2018/19	High	47.1	10/13	46.2	Cannot be calculated	Similar
	B16 - Utilisation of outdoor space for exercise/health reasons	(P)	Mar15 - Feb 16	High	20.8	3/16	17.9	Cannot be calculated	Similar
	C02a - Under 18s conception rate / 1,000	(F)	2018	Low	12.2	4/16	16.7	Decreasing and getting better	Better
	C06 - Smoking status at time of delivery	(F)	2018/19	Low	8.5	2/16	10.6	Decreasing and getting better	Better
	C09a - Reception: Prevalence of overweight (including obesity)	(P)	2018/19	Low	19.6	4/16	22.6	No significant change	Better
	C09b - Year 6: Prevalence of overweight (including obesity)	(P)	2018/19	Low	30.0	4/16	34.3	No significant change	Better
Primary	C16 - Percentage of adults (aged 18+) classified as overweight or obese	(P)	2018/19	Low	64.5	11/16	62.3	Cannot be calculated	Worse
	C17a - Percentage of physically active adults	(P)	2018/19	High	68.3	9/16	67.2	Cannot be calculated	Similar
	C17b - Percentage of physically inactive adults	(P)	2018/19	Low	19.5	8/16	21.4	Cannot be calculated	Better
	C18 - Smoking Prevalence in adults (18+) - current smokers (APS)	(P)	2018	Low	13.2	9/16	14.4	Cannot be calculated	Similar
	C28b - Self-reported wellbeing - people with a low worthwhile score	(P)	2018/19	Low	Null	Null	3.6	Cannot be calculated	Not compared
	E02 - Percentage of 5 year olds with experience of visually obvious dental decay	(P)	2019/20	Low	18.2	9/15	23.4	Cannot be calculated	Better
	C21 - Admission episodes for alcohol-related conditions (Narrow)	(P)	2018/19	Low	587.8	5/16	663.7	Cannot be calculated	Better
	E01 - Infant mortality rate	(P)	2016 - 18	Low	3.5	10/16	3.9	Cannot be calculated	Similar
	E04a - Under 75 mortality rate from all cardiovascular diseases	(P)	2016 - 18	Low	61.1	9/16	71.7	Cannot be calculated	Better
	E05a - Under 75 mortality rate from cancer	(P)	2016 - 18	Low	120.7	7/16	132.3	Cannot be calculated	Better
	E06a - Under 75 mortality rate from liver disease	(P)	2016 - 18	Low	14.3	5/16	18.5	Cannot be calculated	Better
Primary/Secondary	E07a - Under 75 mortality rate from respiratory disease	(P)	2016 - 18	Low	26.7	6/16	34.7	Cannot be calculated	Better
	E10 - Suicide rate	(P)	2016 - 18	Low	8.3	3/16	9.6	Cannot be calculated	Better
	E14 - Excess winter deaths index	(P)	Aug 2017 - Jul 2018	Low	27.9	3/16	30.1	Cannot be calculated	Similar
	E14 - Excess winter deaths index (age 85+)	(P)	Aug 2017 - Jul 2018	Low	44.9	13/16	41.1	Cannot be calculated	Similar
	C19a - Successful completion of drug treatment - opiate users	(P)	2018	High	8.2	3/16	5.8	No significant change	Better
	C19b - Successful completion of drug treatment - non-opiate users	(P)	2018	High	38.6	5/16	34.4	No significant change	Similar
	C22 - Estimated diabetes diagnosis rate	(P)	2018	High	79.4	6/16	78.0	Cannot be calculated	Similar
	C24a - Cancer screening coverage - breast cancer	(F)	2019	High	77.9	7/16	74.5	Decreasing and getting worse	Better
	C24b - Cancer screening coverage - cervical cancer (aged 25 to 49 years old)	(F)	2019	High	76.6	4/16	69.8	No significant change	Better
	C24c - Cancer screening coverage - cervical cancer (aged 50 to 64 years old)	(F)	2019	High	79.5	3/16	76.2	Decreasing and getting worse	Better
Secondary	C24d - Cancer screening coverage - bowel cancer	(P)	2019	High	64.6	3/16	60.1	Increasing and getting better	Better
	C26b - Cumul % of the eligible population (40-74 yrs) offered and received a Health Check	(P)	2014/15 - 18/19	High	42.8	13/16	48.1	Cannot be calculated	Worse
	D02a - Chlamydia detection rate / 100,000 aged 15-24	(P)	2018	High	1,702.7	9/16	1,974..	No significant change	Worse
	D02b - New STI diagnoses (exc chlamydia aged <25) / 100,000	(P)	2018	Low	486.7	4/16	850.6	No significant change	Better
	D07 - HIV late diagnosis (%)	(P)	2016 - 18	Low	Null	Null	42.5	Cannot be calculated	Not compared

Statistical Significance compared to England or Benchmark: Better; Similar; Not compared; Worse

Direction of Travel: Decreasing; Decreasing and getting better; Decreasing and getting worse; Increasing; Increasing and getting better; Increasing and getting worse; No significant change; Cannot be calculated

Nearest Neighbour Rank: 1 is calculated as the best (or lowest when no polarity is applied)

Source: PHE, May 2020

This page is intentionally left blank