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Slough Borough Council

Growing a place of opportunity and ambition

Date of issue: Monday, 18 March 2019

MEETING:	**SLOUGH WELLBEING BOARD** Councillor Pantelic, Lead Member for Health and Social Care (Chair) Dr Jim O'Donnell, East Berkshire Clinical Commissioning Group, Slough Locality (Vice-Chair) Cate Duffy, Director of Children, Learning and Skills Temp. Superintendent Sarah Grahame, Thames Valley Police Lisa Humphreys, Slough Children's Services Trust Ramesh Kukar, Slough CVS Tessa Lindfield, Director of Public Health Councillor Nazir, Lead Member for Corporate Finance & Housing Lloyd Palmer, Royal Berkshire Fire and Rescue Service Colin Pill, Healthwatch Representative David Radbourne, NHS England Raakhi Sharma, Slough Youth Parliament Representative Alan Sinclair, Director of Adults and Communities Josie Wragg, Chief Executive, Slough Borough Council
DATE AND TIME:	TUESDAY, 26TH MARCH, 2019 AT 5.00 PM
VENUE:	VENUS SUITE 2, ST MARTINS PLACE, 51 BATH ROAD, SLOUGH, BERKSHIRE, SL1 3UF
DEMOCRATIC SERVICES OFFICER: (for all enquiries)	NICHOLAS PONTONE 01753 875120

NOTICE OF MEETING

You are requested to attend the above Meeting at the time and date indicated to deal with the business set out in the following agenda.

JOSIE WRAGG
Chief Executive

AGENDA

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AGENDA ITEM	REPORT TITLE	PAGE	WARD
	PART I		
	Apologies for absence.		
CONSTITUTIONAL MATTERS			
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2.	Minutes of the last meeting held on 14th January 2019	1 - 4	-
3.	Action Progress Report	5 - 6	All
ITEMS FOR ACTION / DISCUSSION			
4.	Terms of Reference, Membership and Outcome of January Away Day	7 - 24	All
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THEMED DISCUSSION			
9.	Wider Determinants of Health - Priorities for Slough	95 - 116	All
FORWARD PLANNING			
10.	Forward Work Programme	117 - 122	All
ITEMS FOR INFORMATION			
11.	Slough Prevent Board (Six Month Progress Report)	123 - 128	All

Press and Public

You are welcome to attend this meeting which is open to the press and public, as an observer. You will however be asked to leave before the Committee considers any items in the Part II agenda. Please contact the Democratic Services Officer shown above for further details.

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Slough Wellbeing Board – Meeting held on Monday, 14th January, 2019.

Present:- Councillors Pantelic (Chair) and Nazir, Dr Jim O'Donnell (Vice-Chair), T/Supt Grahame, Ramesh Kukar, Tessa Lindfield, Colin Pill, Alan Sinclair and Josie Wragg

Apologies for Absence:- Cate Duffy, Lisa Humphreys, Lloyd Palmer, David Radbourne and Raakhi Sharma

PART 1

44. Declarations of Interest

Councillor Pantelic declared that she was the Council's outside body representative on Frimley Health NHS Foundation Trust (as a stakeholder governor) and on Berkshire Healthcare NHS Foundation Trust (Council of Governors).

45. Minutes of the last meeting held on 20th November 2018

Resolved – That the minutes of the meeting held on 20th November 2018 be approved as a correct record.

46. Action Progress Report

An Action Progress Report was received that updated the Board on the recently completed and outstanding actions arising from previous meetings.

A number of actions arising from the Away Day discussions held immediately prior to the Board meeting would be taken forward. In particular, it was noted that the Board should review it's terms of reference and membership to ensure that all relevant partners were engaged including SWP, SCAS, Wexham Park Hospital and the education sector.

Resolved –

(a) That the Action Progress Report be noted.

(b) That the SWB Terms of Reference be considered at the next meeting in March 2019.

47. Frimley Health & Care Integrated Care System: Draft Operational Plan 2019/20

The Board received an update on the progress being made to develop a single system Operational Plan for 2019/20 for the Frimley Health & Care Integrated Care System (ICS) and the arrangements being put in place to develop a new operating model for Continuing Health Care and Section 117 aftercare across East Berkshire.

The Chair commented on the importance of aligning the next version of the draft Operational Plan with the key priorities in the recently published NHS Long Term Plan. A delegation from Slough would be visiting Wigan in the near future to learn from their Integrated Care System and an update would be provided to members. Fiona Edwards had had been announced as the new leader for the Frimley Health and Care ICS. She would also continue with her role as Chief Executive of Surrey and Borders Partnership NHS Foundation Trust. It was agreed to invite Ms Edwards to a future of the Board.

The Board discussed various matters relating to the progress of the ICS including the priority given to prevention in the draft Operational Plan, the role of the Alliance Board and the engagement of local authority partners in the ICS. Whilst it was recognised that good progress had been made in a number of areas, more work was needed to ensure that funding followed the agreed priorities such as prevention and tackling health inequalities.

Resolved – That the progress being made in developing a single system Operational Plan for 2019/20 be noted.

48. Slough Clinical Commissioning Group Annual Report 2017/18

The Board received the Slough Clinical Commissioning Group (CCG) Annual Report for 2017/18. This was the final annual report for Slough as an independent CCG following the merger which formed East Berkshire CCG on 1st April 2018.

Dr Jim O'Donnell, Clinical Chair of Slough CCG, summarised the key aspects of the Annual Report which included evidence of improved quality of services to local people resulting in NHS England awarding an 'outstanding' assessment. The rationale for the move to create one CCG for East Berkshire was to build upon the success of developing links between practices, the local population and partners such as Slough Borough Council. Partnership working was a strong theme in the CCGs work, including through the contribution to the development to the Frimley Health & Care Integrated Care System.

The Board welcomed the annual report and commented on the positive work that had been done. Members emphasised the importance of ensuring Slough's view came through strongly in the wider East Berkshire model, particularly in areas such as tackling health inequalities which was a key priority of the Wellbeing Board. Dr O'Donnell confirmed that health inequalities was prioritised in CCG plans and explained some of the areas where significant improvements had been made in outcomes such as stroke services. There was a discussion about how partners could be actively involved in the annual planning of the CCG and it was agreed that there should be engagement in the summer during the commissioning cycle.

At the conclusion of the discussion, the report was noted.

Resolved – That the Slough Clinical Commissioning Group Annual Report 2017/18 be noted.

49. Mental Health: Review of Impact of the #NotAlone Campaign and Shape of the Next Stage of the Campaign

Resolved – That the item be deferred to a future meeting.

50. Forward Work Programme

The Forward Work Programme for future meetings was considered in light of the wider discussions during the earlier SWB Away Day.

Members suggested using some time at future meetings to hear from external speakers that could highlight good practice which could be adopted in Slough. It was agreed that approaches for effective collaboration needed to be tested and that Josie Wragg and Temp. Supt Grahame take forward a focused piece of work on youth violence. A report back would be provided to a future meeting.

Resolved – That the Forward Work Programme be noted.

51. Attendance Report

Resolved – That the Members' Attendance Record be noted.

52. Date of Next Meeting - 26th March 2019, 5pm

The date of the next meeting was confirmed as 26th March 2019 at 5pm.

Chair

(Note: The Meeting opened at 5.00 pm and closed at 5.43 pm)

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Slough Wellbeing Board – Action Progress Report

14th January 2019

No:	Item	Action(s):	For:	Update/Report Back to and date:
3.	Action Progress Report	• Terms of Reference & Membership to be added to agenda for SWB in March	Dean Tyler	March 2019 Completed
4.	Integrated Care System Update	• Invite Fiona Edwards, ICS system leader, to a future meeting of the Board	Chair	Timing TBC
7.	Forward Work Programme	• TS Grahame and Josie Wragg to lead a piece of collaborative work on youth violence and report back to the SWB.	TS Grahame/Josie Wragg	May 2019

20th November 2018

No:	Item	Action(s):	For:	Update/Report Back to and date:
3.	Action Progress Report	• Chair to contact local business organisation about vacant business representative positions	Councillor Pantelic	March 2019

Slough Wellbeing Board – Action Progress Report

26th September 2018

No:	Item	Action(s):	For:	Update/Report Back to and date:
7.	Delivering the next phase of the Leisure Strategy	• Refresh of Leisure Strategy to be considered by the SWB in 2019.	Alison Hibbert	To be added to work programme in 2019 as new Leisure Strategy is developed.

15th November 2017

No:	Item	Action(s):	For:	Update/Report Back to and date:
7.	Themed Discussion- Prevention Strategy	• That further engagement with partners take place in the form of an Innovation Café.	Rebecca Howell Jones/ Fatima Ndanusa	To return to Board- dependant on outcome of workshops
16.	Housing Update: Key Elements and Recent Developments including Key Worker Housing	• Policy to assist key workers (referenced at 6.2 first bullet point) to be circulated to members of the Board if possible.	Colin Moone	Policy still in development, will be circulated once available.

SLOUGH BOROUGH COUNCIL

REPORT TO: Slough Wellbeing Board **DATE:** 26 March 2019

CONTACT OFFICER: Dean Tyler, Service Lead Strategy and Performance Service

(For all Enquiries) (01753) 875847

WARD(S): All

PART I
FOR DISCUSSION

TERMS OF REFERENCE, MEMBERSHIP AND OUTCOME OF JANUARY AWAY DAY

1. Purpose of Report

1.1 To agree terms of reference including membership and next steps following the January Away Day.

2. Recommendation(s)/Proposed Action

2.1 The Board is recommended to:

a) Endorse the terms of reference at Appendix A;
b) Discuss and agree changes to membership;
c) Agree next steps following the Away Day – report at Appendix B.

3. The Slough Joint Wellbeing Strategy, the JSNA and the Council's Five Year Plan

3a. Slough Joint Wellbeing Strategy Priorities

The Slough Wellbeing Strategy 2016-2020 was launched at the Board's partnership conference in September 2016. It explains the role of the Board and how it has set itself an ambition to set strategic direction for partnership working in Slough. The Strategy describes the relationship between the Board and the wider partnership network in Slough and how it hold the 'hold the ring', by coordinating activity to make the best use of resources in achieving common outcomes. The Wellbeing Strategy includes four priorities:

1. Protecting vulnerable children
2. Increasing life expectancy by focusing on inequalities
3. Improving mental health and wellbeing
4. Housing

3b. Joint Strategic Needs Assessment (JSNA)

The priorities in the Wellbeing Strategy are informed by evidence of need contained in the Joint Strategic Needs Assessment.

3c. Council's Five Year Plan Outcomes

The work of the Board and the Wellbeing Strategy contributes to the five priority outcomes in the Council's Five Year Plan:

- Outcome 1: Slough children will grow up to be happy, healthy and successful
- Outcome 2: Our people will be healthier and manage their own care needs
- Outcome 3: Slough will be an attractive place where people choose to live, work and stay
- Outcome 4: Our residents will live in good quality homes
- Outcome 5: slough will attract, retain and grow businesses and investment to provide opportunities for our residents

4. Other Implications

(a) Financial – There are no financial implications directly resulting from the recommendations of this report.
(b) Risk Management - There are no identified risks associated with the proposed actions.
(c) Human Rights Act and Other Legal Implications - There are no direct legal implications. The specific activity in the Wellbeing Strategy and other plans may have legal implications which will be brought to the attention of the Council's Cabinet separately. There are no Human Rights Act Implications.
(d) Equalities Impact Assessment - There is no requirement to complete an Equalities Impact Assessment (EIA) in relation to this report. EIAs will however be completed on individual aspects of any actions produced to sit underneath the Wellbeing Strategy, as required.

5. Summary

This report sets out the Board's Terms of Reference including current membership - the Board may wish to consider extending membership

The Board held an Away Day on 14 January 2019 and an outcomes report is included. This should inform a discussion about next steps for the Board's focus and work programme for the coming year.

6. Supporting Information

6.1 Terms of Reference and membership were last reviewed in July 2018.

6.2 Membership - attempts to date to recruit to the 2 vacant business representatives have proved unsuccessful. The Board should consider how best to attract business representatives and to agree additional representation, for example, from the Department for Work and Pensions.

6.3 Following the annual conference in October 2018 an Away Day was held in January. This reflected discussion at the Board meeting in November 2018 and an intent to further develop collaboration between partners. It was agreed at the Away Day to focus on one or two key issues and use these to strengthen current ways of working. The Away Day also looked at key themes including co-production and co-commissioning and a more focussed approach was felt to be the best approach

to test the extent to which these could be enabled. Members of the Board also travelled to Wigan in February to learn more about the Wigan Deal initiative.

7. Comments of Other Committees

7.1 Members of the Health Scrutiny Panel were invited to the Away Day.

7.2 While not a Committee of the Council, the Health and Social Care Partnership Board will be engaged with next steps following the Away Day.

8. Conclusion and next steps

8.1 Subject to comments the Terms of Reference will be endorsed and actions taken to follow up additional membership.

8.2 Further work will take place to support the Board in taking forward next steps following the Away Day including a focus on one or two key issues and closer collaboration with communities and partners.

9. Appendices

A – Terms of Reference
B – Report of January Away Day

10. Background Papers

None

APPENDIX A

SLOUGH WELLBEING BOARD – TERMS OF REFERENCE, MARCH 2019

1. Purpose and objectives

1.1 The Slough Wellbeing Board (the Board) will carry out the statutory functions of Health and Wellbeing Board as set out in the Health and Social Care Act 2012 and all other relevant statutory provision.

Statutory functions of the Board

1.2 To prepare and publish a Joint Strategic Needs Assessment for Slough.

1.3 To prepare and publish a Joint Health and Wellbeing Strategy for Slough.

1.4 To give its opinion to the East Berkshire Clinical Commissioning Group as to whether their Commissioning Plans adequately reflect the current Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

1.5 To comment on the sections of the East Berkshire Clinical Commissioning Group's Annual Report which describe the extent of their contribution to the delivery of the Joint Health and Wellbeing Strategy.

1.6 To give its opinion, as requested by the NHS Commissioning Board, on East Berkshire Clinical Commissioning Group's level of engagement with the Board, and on the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

1.7 To encourage persons who arrange for the provision of health and/or social care services in the area to work in an integrated manner for the purpose of advancing the health and wellbeing of the area.

1.8 To work with partners to identify opportunities for future joint commissioning.

1.9 To lead on the signing off of the Better Care Fund Plan.

1.10 To publish and maintain a Pharmaceutical Needs Assessment.

1.11 To give its opinion to the Council on whether it is discharging its duty to have regard to any Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy prepared in the exercise of its functions.

1.12 To exercise any Council function which the Council delegates to it.

1.13 To ensure that strategic issues arising from Slough's Adult Safeguarding Board and Local Safeguarding Children's Board inform the work of the Board.

1.14 To receive the annual reports from the Slough's Adult Safeguarding Board and Local Safeguarding Children's Board and ensure that partners respond to issues pertinent to the Board.

Locally agreed objectives of the Board

1.15 To act as the umbrella high level strategic partnership for the Borough, to agree the priorities that will improve the health and wellbeing and reduce the inequalities of the people of Slough.

1.16 To give the public a voice in shaping health and wellbeing services in Slough.

2. Membership

2.1 Board members will be required to represent their organisation with sufficient seniority and influence for decision making. The membership of the Board will consist of:

- The Cabinet Member for Health and Social Care
- The Cabinet Member for Corporate Finance and Housing
- The Chief Executive of Slough Borough Council
- The Chief Executive of Slough Children's Services Trust
- The Director of Adults and Communities
- The Director of Children, Learning and Skills
- The Director for Public Health (Berkshire)
- A representative of East Berkshire's Clinical Commissioning Group
- A representative of Slough Healthwatch
- The Local Police Area Commander
- A representative of the Royal Berkshire Fire and Rescue Service
- Two local business representatives
- A representative of Slough's voluntary and community sector
- A representative of the NHS Acute and Community Sector
- A representative of Slough's Youth Parliament
- Other members appointed by the Board or the Leader of the Council after consultation with the Board

2.2 The two local business representatives will be appointed for a period of two years. No business representative shall be appointed for more than two consecutive terms.

2.3 The Board will keep membership under review and make recommendations to Council as required.

2.4 Membership of the Board will be reviewed annually.

2.5 The Chair of the Board will be required to hold a named delegate list for Board representatives including deputies.

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

2.7 Board members are bound by the same rules as Councillors, including submitting a Register of Interests.

2.8 The following are disqualified from being a Board Member:

a) Any person who is the subject of a bankruptcy restriction order or interim order; and

b) any person who has within five years before the day of being appointed or since his or her appointment has been convicted in the United Kingdom, the Channel Islands or the Isle of Man, of any offence and has had passed on them a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine.

Election of Chair and Vice-Chair

2.9 Each year, the Board will appoint its own Chair and Vice Chair who must be voting members of the Board. In the absence of the Chair or the Vice Chair the Board shall elect a Chair for that meeting from the members present.

Resignation

2.10 Members may resign by giving written notice to the Chair.

Member's roles and responsibilities

2.11 All members of the Board will commit to the following roles, responsibilities and expectations:

a) Commit to attending the majority of meetings;

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

c) Be prepared to represent the Board at stakeholder events and support the agreed consensus view of the Board when speaking on behalf of the Board to other parties;

d) Champion the work of the Board in their wider networks and in community engagement activities;

e) Participate in Board discussion to reflect views of their partner organisations, being sufficiently briefed to be able to make recommendations about future policy developments and service delivery; and

f) Ensure there are communication mechanisms in place within the partner organisations to enable information about the priorities and recommendations of the Board to be effectively disseminated.

3. Working arrangements

3.1 The Slough Wellbeing Board is a committee of the Council and will adhere to the Constitutional requirements of the Council affecting committees unless alternative provision is made within these terms of reference or the law.

3.2 The Board shall schedule meetings at least six times a year.

3.3 The Board will meet in public and comply with the Access to Information procedures.

3.4 The filming/recording of all public meetings is allowed in accordance with the Council's Constitution.

3.5 The Board will hold ad-hoc meetings, workshops and development sessions throughout the year as and where appropriate.

3.6 Decision-making will be achieved through consensus reached amongst those members present. Where a vote is required decisions will be reached through a majority vote of voting members; where the outcome of a vote is impasse the Chair will have the casting vote.

3.7 All members have an equal vote.

3.8 Meetings will be deemed quorate[1] if at least one third of members are present and in no case shall the quorum for the Board be less than 5. If the number of members increases this will need to be reviewed. Where a meeting is inquorate those members in attendance may meet informally but any decisions shall require appropriate ratification at the next quorate meeting of the Board.

3.9 The Board will produce an Annual Report which will be shared with all ember organisations and published on the Council's website.

4. Relationship to other partnership groups

4.1 A network of partnerships groups is already in place which will act as the vehicle for the delivery of the Slough Wellbeing Strategy. The Board will coordinate activity between these and any new groups, to ensure greater clarity of accountability and ownership of agendas. In this respect the Board will 'hold the ring' for the wider partnership network, coordinating activity to make the best use of resources in achieving common outcomes.

4.2 The Board may establish sub groups or Task and Finish groups to help it undertake its statutory and strategic functions.

4.3 The Board may ask for regular reports from the other partnership groups, at least annually, highlighting any areas the Board may be able to support.

4.4 For the avoidance of doubt these groups are not sub committees of the Council.

4.5 The Board will not exercise scrutiny duties around health and adult social care directly. This will remain the role of the Slough Borough Council's Health Scrutiny Panel. Decisions taken and work progressed by Slough Wellbeing Board will be subject to scrutiny by the Council's Health Scrutiny Panel.

5. These terms of reference will be reviewed annually and will require the approval of the full Council.

1 *The Board does not have to comply with Part 4.1 rule 7 of the Council's Constitution.*

SLOUGH WELLBEING BOARD AWAY DAY
14 JANUARY 2019

Purpose

The Away Day was held to bring partners together to:

- Understand the key issues facing Slough
- Identify common priorities
- Develop a One Vision and Plan for Slough to make a difference together

Context

The Slough Wellbeing Strategy 2016-2020 was launched at the Board's partnership conference in September 2016. It explains the role of the Board and how it has set itself an ambition to set strategic direction for partnership working in Slough. The Strategy describes the relationship between the Board and the wider partnership network in Slough and how it 'holds the ring', by coordinating activity to make the best use of resources in achieving common outcomes. The Wellbeing Strategy includes four priorities:

1. Protecting vulnerable children
2. Increasing life expectancy by focusing on inequalities
3. Improving mental health and wellbeing
4. Housing

The priorities in the Wellbeing Strategy are informed by evidence of need contained in the Joint Strategic Needs Assessment.

The Wellbeing Board held its annual conference at The Curve on 4 October 2018 which enabled partners working in Slough from across the public, private and voluntary sectors to:

a) Share success;
b) Understand health inequalities in Slough;
c) Consider how the wider determinants of health impact on delivery of the priorities in the Slough Wellbeing Strategy;
d) Review the role of the Slough Wellbeing Board and wider partnership network to deliver better outcomes for Slough.

The conference was facilitated by Dr Jim O'Donnell and delegates heard from a key note speaker Terry Blair-Stevens from Public Health England. The format of the conference involved a series of world café style table discussions on the key issues facing the town.

The world café style discussions provided delegates with an opportunity to:

- Discuss the impact of the wider determinants of health on delivery of each of the four priorities in the Slough Wellbeing Strategy;
- Share ideas for practical action to tackle the wider determinants and consider what is needed to make this happen e.g. behaviour change;
- Identify what they could offer as an individual, organisation or a partnership; and
- Suggest what needed to be done to mobilise as a partnership to improve health outcomes for Slough.

Delegates made a number of suggestions about how the wider partnership could contribute to tacking health inequalities and target the wider determinants of health. The key themes and issues arising were:

- Partners have access to a significant amount of data which should be shared to help inform future evidence led policy and service design.
- We should play to our strengths and use our successful networks within the voluntary and community sector to increase participation in local communities through the co-production/co-design of services
- There were opportunities to promote the borough's extensive range of leisure centres and parks to improve physical and mental health and wellbeing
- There was recognition that a significant amount of work has been done across the partnership and the wider health system to tackle health inequalities and the wider determinants of health. There is scope to improve how these are promoted to help 'sign-post' residents.

On 20 November the Wellbeing Board discussed the outcomes of the conference and agreed to hold an Away Day on 14 January – see agenda at Annex 1.

Away Day

The Away Day was structured as follows:

- Where are we now?
- Where do we need to get to?
- How do we get there?

Part One – Where are we now

What is the evidence telling us about need?

There are wide inequalities in life expectancy in Slough between our most and least deprived areas, with a difference of 9.2 years for men and 7.0 years for women. People living in the borough's least deprived areas live around 20 years longer and in good health than those in tour most deprived areas. There are significant costs to society associated with not addressing health inequalities - such as:

- productivity losses of around £31-33 billion per year,
- lost taxes and higher welfare payments in the range of £20-32 billion per year and
- NHS healthcare costs associated with inequality are in excess of £5.5 billion per year

The wider determinants of health and wellbeing have an impact on the health of our population.

Other key points raised included:

- **Demography** - specific challenges for certain social & ethnic groups. Need for engagement with all.
- **Deprivation** - impacting multiple areas.
- **Secondary schools** - need to look beyond Early Years.
- **Regional differences** - Slough is an outlier in Berkshire and the South East.
- **Complex needs** - need for further support.
- **Low resident engagement** - low participation - e.g. residents survey.

What are our current priorities as individuals and organisations?

Partners discussed a range of current issues and priorities and in the discussions that followed agreed the following:

- **Holistic view** - need to look at life-cycles, starting early, intergenerational issues, sticking with people through the system. Need for joined-up working.
- **Troubled / priority families** - addressing complex needs.
- **Mental health** - developing shared training / commissioning / work programmes.
- **Intervention** - joining up opportunities.
- Aligning **people & place**.
- **Targets** - need to change mind-sets, target-driven culture can be detrimental.
- **Leisure** - potential success story.

What further evidence can be added to our base to enhance our strategic picture?

- **Prevention** - need to better understand the 'causes of the causes'.
- **Early help** - need evidence of what works
- **Mental health** - need to look at case studies in maternal mental health units - e.g. Swindon, Scotland, Wales.
- **Impact** - evidence on social / financial impact of investment.
- **Migration** - getting at new residents early.
- **Licensing** - how are decisions made / what is the impact?
- **Resident engagement** - evidence of what works, and at what level - e.g. neighbourhoods

Part Two – Where do we need to get to?

This part of the session looked at where we could identify common priorities as a partnership and to reflect on the current 4 priorities in the Slough Wellbeing Strategy.

What is our common purpose and vision for the town?

- **Partnership working and focus on outcomes** - default position.
- **More strategic less operational**
- **Town of opportunity / safety** - developing a launch-pad for all, a place where people are empowered to get on in life, and no one falls through the gaps. People are encouraged to feel they can stay in Slough - positive perceptions.
- **Community cohesion**
- **Eradicating homelessness** - by addressing root causes.
- **Strategic alignment** - one public sector.
- **Tangibility** - residents can see and feel improvements.
- **Early identification / intervention** - spotting red flags.
- **Self-help and community involvement** - actions are commissioned with the communities. Their priorities are reflected.
- **Sustainability** - self-helping, empowered communities.

How can we strengthen our current partnership arrangements to work more collaboratively?

A number of key principles around our ways of working as a partnership were identified to strengthen collaboration:

- **Understanding and collaboration** - knowledge of each other's priorities. Shared messages, understood by the public.
- **Community engagement & co-production**
- **Data** - shared data warehouse?
- **Workforce** - common approach, grown in Slough. Embedding collaboration skills. Engaged staff.
- **Accountability / decisiveness** - having the correct people in the room that can make necessary decisions.
- **Ambition** - what can we achieve over five years? We overstate what we can do one year and understate what we can do in five years.

How can we develop more effective communications between each other and as a place?

- **Mapping** - identifying and sharing available support with partners and the public.
- **Meetings** - more informal meetings to build trust, going beyond board meetings.
- **Feedback** - more information from elected members, patient groups, citizens groups.
- **Earlier notification** of each others plans.

The diagram below summarises key ways in which the Wellbeing Board and wider partnership could strengthen collaboration and focus on shared priorities

A number of barriers to achieving this vision and potential solutions were discussed.

Barriers to achieving the vision			
Poor IT Lack of access to the same information. GDPR	Recruitment and retention of staff. Knowledge gaps	Failing to implement our plans and volume of work.	System complexities
Potential solutions			
Better data sharing and communication. People only having to tell the partnership once. Learning from Milton Keynes - Sup. Int. Grahame to arrange a meeting for partners. Joined-up access. More connected care. Prevention (predictive analytics)	Forming a group to look at collective skills shortages. Building on Slough Academy: • Growing our own talent • Apprenticeships • Engaging the School Network Berkshire apprenticeship service ending in March 2019 - what next? Institutional knowledge - knowing the key people to contact. Developing resilience.	Sticking to our strategic plan. Governance - ensuring there are checks and balances. Focusing on *how* we do things. Promoting culture change in partner organisations. Consultation with other boards. Empowering people to choose the right services. Reducing duplication.	Flexible plans. Clarity of purpose. Clarity over the scale of delivery.

Part Three – How do we get there?

The final part of the Away Day looked at:

- Where are the gaps in our current plans and partnerships?
- What are the challenges to meeting current priorities?
- How could our challenges be resolved via shared, strategic commissioning?

Key challenges included:

- Identifying key partners to work with
- Turnover of staff and building sustainable relationships
- Competing priorities
- Data sharing (e.g. GDPR) and systems that don't 'talk' to each other
- Getting residents voices heard

A key objective when the agenda was set was to investigate how joint working could lead to co-commissioning opportunities. It was agreed that:

- There was a strong appetite to tackle health inequalities in Slough
- Be more strategic and less operational when setting priorities
- Despite a number of problems with health and wellbeing in Slough, there were indications that this was now improving and moving in the right direction
- There was an appetite to increase participation in local communities through the co-production/co-design of services
- Focus on early intervention and prevention
- There were opportunities to promote the borough's extensive range of leisure centres and parks to improve physical and mental health and wellbeing
- There was a range of qualitative data from partners which could be shared to help inform future policy and service design and development
- There were a number of successful national programmes which could be used to reach out to more communities.

The diagram below sets out a vision for co-commissioning:


Spending any extra funding on shared priorities
Prevention
Learning from how its been done in the past
Co-commissioning vision
Evidence-based
• Understanding our population
Understanding the causes of the causes
Partner mapping
• Knowledge of partner organisations & our people.

Next steps

The Wellbeing Board would discuss the outcome of the Away Day at its next meeting in March.

It was agreed that the Away Day had been useful in bringing key partners together and had confirmed the collective appetite for closer working as a partnership network and system to deliver better health and wellbeing outcomes for Slough.

A useful set of principles and areas of focus had been agreed to inform closer collaboration and these are summarised in the diagrams in the report.

The Wellbeing Board would be recommended to consider the outcome of the Away Day and in particular **to identify one or two key issues to focus on over the coming year.**

Resident and community engagement is key to changing traditional ways of working – greater levels of co-design and co-production leading to early intervention and prevention people would pay dividends.

Developing a Slough ‘social movement’ with empowered residents who are increasingly engaging was important to future success and a visit to Wigan to find out more about the ‘Wigan Deal’ was being arranged for 15 February.

The Wellbeing Board would bring greater strategic coherence to the agenda by reviewing governance and ways of working; identifying strategic priorities and revisiting its membership to include key additional partners.

Annex 1 – Away Day agenda

One Slough, One Vision – making a difference together
Arbour Park, Monday 14 January 2019

Purpose

To bring decision makers from across our partnerships together to:

- Understand the key issues facing Slough
- Identify common priorities
- Develop a One Vision and Plan for Slough to make a difference together

9.00 - Welcome - Teas & Coffees & Registration

9.45 - Opening remarks
Councillor Natasa Pantelic, Chair, Slough Wellbeing Board

10.00 - Where are we now?
- *What is the evidence telling us about need?*
- *What are our current priorities as individuals and organisations?*
- *What are the key impacts we make?*
- *Where are we most effective?*

11.15 - Break - Teas & Coffees

11.45 – Where do we need to get to?
- *What is our common purpose and vision for the town?*
- *What are our key shared priorities?*
- *How can we strengthen our current partnership arrangements to work more collaboratively?*
- *How can we develop more effective communications between each other and as a place?*

13.00 - Lunch

14.00 - How do we get there?
- *Where are the gaps in our current plans and partnerships?*
- *What are the challenges to meeting current priorities (trouble shooting)*
- *How could our challenges be resolved via shared, strategic commissioning?*

15.30 - Closing remarks and next steps
Councillor Natasa Pantelic, Chair, Slough Wellbeing Board

16.00 - Informal networking

17.00 – Finish

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SLOUGH BOROUGH COUNCIL

REPORT TO: Slough Wellbeing Board **DATE:** 26th March 2019

CONTACT OFFICER: Alan Sinclair – Director of Adults and Communities
(For all Enquiries) (01753) 875752

WARD(S): All

PART I
FOR COMMENT & CONSIDERATION

FRIMLEY HEALTH AND CARE INTEGRATED CARE SYSTEM UPDATE

1. Purpose of Report

1.1 This report provides the Slough Wellbeing Board with an update on progress being made to deliver the Frimley Health and Care Integrated Care System (ICS).

2. Recommendation(s)/Proposed Action

2.1 The Board is recommended to note the report and the progress being made in developing the ICS and comment on any aspect of the plan.

3. The Slough Joint Wellbeing Strategy, the JSNA and the Five Year Plan

3a. Slough Joint Wellbeing Strategy Priorities

The priorities in the ICS reflect the need to improve the health and wellbeing of the population. The ICS will focus on those priorities that can be delivered across the system and local areas will continue to address their own local priorities. Slough's Joint Strategic Needs Assessment (JSNA) has informed the work of the ICS.

The ICS supports the delivery of several of the current Slough Wellbeing Board's strategic priorities including:

- Protecting vulnerable children and young people
- Improving healthy life expectancy
- Improving mental health and wellbeing

3b. Five Year Plan Outcomes

The ICS will also support the delivery of the following Five Year Plan outcomes:

- Slough children will grow up to be happy, healthy and successful
- Our people will be healthier and manage their own care needs

4. Other Implications

(a) Financial - One of the aims of the ICS is to bring financial balance to the Frimley footprint by 2020 – across health and social care. There is a significant financial pressure facing all parts of the system and the plan will address how these

pressures will be managed. Any future investment from the NHS in local systems will come via the ICS process.

(b) Risk Management - There are no recommendations arising from this report.

(c) Human Rights Act and Other Legal Implications - No legal implications have been identified at this point.

(d) Equalities Impact Assessment - These are being undertaken by service deliverers as ICS programmes become operative.

5. Summary

This report provides the Board with:
a) An update on progress being made to deliver the ICS;
b) An opportunity to ask questions about and/or comment on any aspect of the Plan; and
c) Consider next steps.

6. Supporting Information

6.1 The Frimley footprint has been in operation since October 2016. This has seen the system change from the initial Sustainability and Transformation Programme to an ICS, which became operational in 2018. This involves all health and care providers and commissioners, including Slough Borough Council.

6.2 Given the importance of the matter to healthcare provision in Slough and across the region, this has been a regular agenda item for the Slough Wellbeing Board.

6.3 An update on the Development of the System Operating Plan for 2019/20 is attached at Appendix A which covers:

- February submission of the 2019-20 Operational Plan
- Indicative Local Timeline
- NHS Long Term Plan & Engagement

7. Comments of Other Committees

7.1 The ICS has also been a regular agenda item for the Health Scrutiny Panel. The last meeting to receive an update on progress was held on 21st November 2018.

8. Conclusion

8.1 Given the relative newness of the ICS, Slough Wellbeing Board may wish to use this agenda item to discuss how to contribute to the ongoing consultation. They may also wish to consider how to add value to the implementation of the ICS throughout 2019 – 20 and how they can best contribute to its progress.

8. Appendices Attached

'A' Developing our System Operating Plan 2019-20 – Key Messages Pack

Frimley Health and Care

Developing our System Operating Plan 2019-20

Key Messages Pack

February 2019

ASCOT • BRACKNELL • FARNHAM • MAIDENHEAD • NORTH EAST HAMPSHIRE • SLOUGH • SURREY HEATH • WINDSOR

Introduction

- Local Authorities and local health organisations are working together as the Frimley Health and Care Integrated Care System (ICS) to provide a joined up health, care and wellbeing system
- We will produce a single system Operational Plan for 2019-20 which reflects the development of our Integrated Care System, partnership working and includes our Organisational and Local Place-based Priorities, building upon the 2018-19 ICS Operational Plan
- It is set within a 12 month planning improvement journey which will inform and support delivery of multi-year plans within the context of the NHS Long Term that has recently been published
- We are sharing our planning process with Frimley Health and Care organisations, staff, stakeholders and local communities through regular updates. **December's briefing pack**:
- Thank you for your responses and feedback on our December first draft plan – we have used those comments and suggestions to shape the second draft plan

December briefing pack

During January we have:

- Completed the second draft version of the 2019-20 Frimley Health and Care Operational Plan to enable feedback
- Submitted our January submission to NHS England/Improvement on activity and finance
- Began to engage with stakeholders on our process for developing our response to the NHS Long Term plan

February submission of the 2019-20 Operational Plan

- We have produced our second draft of the plan in preparation for submission of the 2019-20 Frimley Health and Care Operational Plan on 19th February 2019 to NHS England/Improvement
- It describes how we are embedding the work that we started last year across the ICS programmes and builds upon the comments received back from stakeholders on the first draft of the plan that was circulated in November 2018
- This second version includes more on the system's priority aspirations, including details of the ICS programmes outcomes and milestones, and of our local authorities' priorities and work within the programmes
- The system has a challenging financial position and we are also working through our activity and planning assumptions which will be included within the final version of the plan

How you can help us now:

We would appreciate your feedback/comments to inform the final Plan narrative – please see attached:

2019-20 2nd draft Operational Plan

Please would you send any comments/feedback to helen.single@nhs.net (copying in Diane Sheffield – diane.sheffield1@nhs.net) no later than Friday 22nd February

Indicative Local Timeline

DATE	
22 November 2018	**First draft of system plan narrative produced** Circulated to partners and wider stakeholders for review and comments back by **end of December** Includes ICS Board, HWB Boards and Alliance, and internal partners governance structures
November & December	ICS Programmes/enablers begin financial and milestone review First draft system efficiency and demand/capacity plans (activity) developed Second key messages monthly pack shared – including highlights for organisational/local priority plans
14th January 2019*	14th January submission to NHS England/Improvement on activity/ finance
January	**Second draft narrative plan** with milestones shared including any refresh of financial changes in 14th Jan submission. Circulated to partners for review by 8th February and to wider stakeholders with final comments back by **22nd February**
19th February 2019*	DRAFT 19th February system operational plan narrative submission to NHS England/Improvement Contract Heads of Terms/plan alignment discussion at ICS Board
5th March 2019*	Contract/plan alignment submission
19th March 2019 (ICS Board)	**FINAL ICS Operating Plan** endorsed by ICS Board – narrative, financials, activity, capacity assumptions (beds)
By 29th March 2019	**FINAL ICS Operating Plan** approved by Governing Bodies and Trust Boards including approval of 2019/20 budgets
11th April 2019*	**Final system operational plan narrative submission to NHS England/Improvement**

NHS Long Term Plan

- Our 2019-20 Operational Plan is set within a 12 month planning improvement journey which will inform and support delivery of multi-year plans - within the context of the NHS Long Term Plan (published 7 January 2019)
- You can access a copy of the summary document: **https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/**

- Support people to stay well
- Work together with health and care partners for
- Cancer care
- Increase access to mental health services
- Focus on prevention
- Reduce variation
- Improving productivity

NHS Long Term Plan Engagement

- NHS England are also working with Healthwatch England to fund an engagement programme to assist each ICS/STP to develop their Long Term Plans during March-June 2019

- Healthwatch England are funding each local Healthwatch a grant of £2500 to undertake engagement activity to include surveys and focus groups, developed and focussed around local ICS priorities, population needs and engagement requirements

- We are currently working with our local Healthwatch organisations to develop a programme of engagement which meets our local needs, whilst building on existing engagement

- The **Local Government Association** have developed a briefing in January on their response to the Long Term Pan which you may find helpful – please see attached:

LGA January Briefing

Any questions or comments:

If you have any questions about the contents of this pack or any comments on how we could improve it please contact:

georgia.henkun1@nhs.net

And we will get back to you as soon as possible.

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SLOUGH BOROUGH COUNCIL

REPORT TO:	Slough Wellbeing Board
DATE:	26 March 2019
REPORT AUTHORS:	Jo Jefferies, Consultant in Public Health, Public Health Services for Berkshire Nisha Jayatilleke, Screening and Immunisation Lead, NHS England South Paula Jackson, Screening and Immunisation Lead, NHS England South
CONTACT OFFICER: **(For all Enquiries)**	Dr Liz Brutus - Service Lead Public Health (SBC) (01753) 875142
WARD(S):	All

PART I
FOR COMMENT & CONSIDERATION

FIRST ANNUAL REPORT ON IMMUNISATIONS & SCREENING IN SLOUGH

1. Purpose of Report

- To provide a summary of the current commissioning and provider arrangements for immunisations and screening programmes and the organisations involved
- Provide an update on immunisation and screening programme coverage in Slough
- Highlight recent successes and key opportunities to maximise programme coverage and uptake with a view to reducing health inequalities in this area.
- Provide an update on the emerging 'system, place and locality' responses to the Report.

2. Recommendations

The Wellbeing Board is recommended to:

1. Consider the actions being taken to deliver the national programmes for immunisation and screening and their progress in tackling health inequalities in Slough.
2. Review the proposed Local Action Plan in 3 – 6 months to ensure it has actions tailored to the needs of Slough and relevant partners are addressing the relatively lower uptake and health inequalities in both immunisation and screening.
3. Review an Annual Report on Immunisation and Screening from NHS England every year.

3. The Slough Joint Wellbeing Strategy, the JSNA and the Five Year Plan

3a. Slough Joint Wellbeing Strategy Priorities

The current programme is aimed at supporting local residents to improve their health and wellbeing through improved prevention and early detection as provided through the national immunisation and screening programmes. In particular, this work supports the Joint Wellbeing Strategy priorities:

- Protecting vulnerable children
- Increasing life expectancy by focusing on inequalities

Data from the immunisation and screening activities contribute to further developing the base of the Joint Strategic Needs Assessment and understanding the needs and health inequalities of our population..

3b. Five Year Plan Outcomes

The primary outcomes where delivery will be enhanced by the paper are:

- Outcome 1: Slough children will grow up to be happy, healthy and successful
- Outcome 2: Our people will be healthier and manage their own care needs

4. Other Implications

(a) Financial

There are no financial implications directly resulting from the recommendations of this report and outlined activities are within the current budget and resources.

(b) Risk Management - None

There are no identified risks associated with the proposed actions.

(c) Human Rights Act and Other Legal Implications

There are no Human Rights Act implications to the content of this report

(d) Equalities Impact Assessment

The content of this report does not require an Equalities Impact Assessment.

5. Supporting Information

Context

5.1 NHS England is responsible for commissioning screening and immunisation programmes in England. Locally this is co-ordinated and managed across Thames Valley by the Public Health Commissioning team at NHS England, South East under an agreement known as Section 7a.

5.2 Historically, Slough has had some of the lowest uptake of screening and immunisation programmes in the South East of England, contributing to poor health in both adults and children and our health inequalities. Over the last 5 years, there have also been various changes in the organisation of the commissioning and delivery nationally. This combined annual report, for the first time, therefore outlines the picture of immunisations and screening in Slough, their current provision, the challenges and opportunities and future plans.

5.3 Wellbeing Board Members may find it helpful to consider 'The Ten Questions to Consider If You're Scrutinising Local Immunisation Services'[1] which have relevance for both Immunisation and Screening. In view of Slough's focus on health inequalities, Question 10 is particularly relevant. (See Appendix.)

Executive summary of Immunisations and Screening Report

5.4 The full report is in the Appendix but summarised below.

5.5 NHS England has continued to commission the services set out under the Section 7A agreement to a high standard, offering continued protection to the public. Data and evidence demonstrates that public health protection remains world class and we have achieved real success. Increasing access to screening and immunisation programmes, contributes to the wider prevention agenda and the implementation of the Five Year Forward View.

5.6 Some of the recent successes that have benefitted the local population include programmes to increase uptake and improvements to data quality for closer monitoring of progress. Examples include the development of a GP toolkit with tips and advice for primary care colleagues to improve immunisation uptake for their patients. The toolkit is implemented in many practices across Slough. In addition, data on immunisations delivered in primary care are now auto-extracted from the clinical record and entered electronically on the Child Health Information System (CHIS) which is not only more efficient but has also improved the accuracy of the data. The LA, the school immunisation provider and NHS England have worked together to agree how they will address cultural and language barriers to further improve uptake in groups with lower historic vaccination rates.

5.7 As part of the Thames Valley Cancer Alliance GP Quality Improvement Scheme, there are initiatives in place to improve cancer screening coverage as well as the safe mobilisation of the Diabetic Eye Screening programme following a contract review.

5.8 Successful collaborative working has enabled improvements in some outcomes, however there is still opportunity to improve uptake of cancer screening programmes and childrens immunisations, particularly PCV (pneumococcal) booster, second dose MMR, and the Hib/MenC booster. It is important to have a thorough understanding of opportunities and challenges that need to be considered in Slough to be able to support families take up the offer for vaccination and to work collaboratively with stakeholders to improve vaccine uptake.

5.9 There are several new opportunities ahead to implement and embed changes that will further improve screening and immunisation services locally. These include the introduction of a new screening test in the bowel screening programme, incorporating HPV primary screening into the cervical screening programme and a new booster seasonal flu immunisation for people aged 65 and over.

5.10 Governance and reporting arrangements are also being tightened. The Shared Public Health Team is scoping an annual Health Protection Report, drawing together

[1] The Ten Questions to Consider If You're Scrutinising Local Immunisation Services. Centre for Public Scrutiny. 2016. Available at: https://www.cfps.org.uk/10-questions-ask-youre-scrutinising-local-immunisation-services/

key metrics and issues. The Terms of Reference of the Berkshire Health Protection Committee is also under review to ensure the committee fulfils its system assurance role, with partners providing assurance to the Strategic DPH and holding each other to account. In addition, NHS England is revising the quarterly Berkshire screening and immunisation dashboard to improve clarity and enable access for Public Health Consultants in each Local Authority.

5.11 The Report focuses on the commissioning and delivery of the screening and immunisation programmes but we also need to consider the wider determinants of health (including for example, income levels, education and skills, employment, housing and environmental factors). These affect both overall health and wellbeing and decision-making about health.

System / Place / Locality - Emerging responses to the Annual Report

5.12 The Annual Report is already proving to be a useful catalyst for bringing together key organisations and stakeholders who recognise the significant need identified within the Annual Report and to consider the most effective approach to action. The Report has provoked challenge at a System, Place and Locality level.

5.13 *System - Frimley ICS*: With its clear articulation of the challenges on this topic in Slough, there has been some interest within the Frimley ICS to consider this as part of the 'Reducing Variation' clinical workstream. In addition, the low cancer screening uptake undermines the work of the Cancer Workstream.

5.14 Although not specifically raised with the Frimley ICS Board, at a more fundamental level, the particular 'hotspot' of poor immunisation and screening outcomes in Slough challenges the ICS to consider how it is addressing its health inequalities across the footprint and whether it applies 'proportionate universalism' to address the very particular needs of an area (in this case, Slough) even if other areas are not badly affected. ie Providing more resource to improve outcomes where there is greater need.

5.15 *Place – Slough*: An initial meeting for Slough's action plan is being planned to scope the work and agree SMART actions for the coming year. It'll be important to try to map / coordinate the variety of activity that is currently being driven via NHS England and Public Health England, Thames Valley Screening and Immunisation Network, CCG-level, Slough Public Health level and our various front-line providers. A task and finish group will be led by the Slough Public Health Service Lead.

5.16 In addition, Slough Public Health has commissioned a significant piece of research to understand the health beliefs, understanding and 'health ambitions' of Slough residents including their thoughts around immunisations and screening. This will be key information to support planning – the final report is due in early July 2019.

5.17 *Locality – Ward*: It is likely that as we drill down into the detail and examine the very particular challenges at a Ward and neighbourhood level, specific action targeted around certain areas (and facilitated around specific GP practices). We are already in conversation with East Berkshire CCG and GP leaders in Slough around how best

we can start to work together more systematically on this and build on the existing good practice that already exists.

6. Comments of Other Committees

6.1 The Report was considered by the Health Scrutiny Committee on 17 Jan 2019 and by the Health and Care Partnership Board on 29 Jan 2019. In both meetings, the findings were considered and while the recent activities over the last year or so were praised, the overall findings of generally poor uptake of both immunisations and screening were noted to be a concern for Slough. A local action plan was welcomed by both groups.

7. Conclusion

7.1 The national Screening and Immunisation programmes provide important opportunities for protecting health and wellbeing and preventing avoidable disease with cost-effective and evidence-based interventions. However, their uptake also acts as marker of health inequality in certain groups which we must be vigilant to.

7.2 Historically, Slough has had lower than average uptake of both screening and immunisations, reflecting a variety of issues including accessibility, acceptability and availability of interventions delivered by the system as well as individuals' beliefs and understanding of the programmes. Poor uptake of these programmes (and other health improvement activities) is also more likely in individuals and key groups in Slough who already experience the worst health outcomes with associated worsening impact on health inequalities. Social and environmental factors – the wider determinants of health – also affect our population's health and shape their individual health and wellbeing decisions on matters such as taking up invitations for screening and immunisation.

7.3 Through concerted local partnership working, there has been some encouraging progress in recent years however considerable challenges remain across the various immunisation and screening programmes in Slough. These challenges will benefit from the proposed national and local plans being developed and/or currently delivered. The programmes will also benefit from ongoing monitoring of their impact on Slough's health.

7.4 The emerging responses at a Frimley ICS system, place and locality level are being captured and developed in order to create a Slough Local Action Plan under the guidance of a time-limited task and finish group led by the Slough Public Health Service Lead. In particular, these poor immunisation and screening outcomes challenge the Frimley ICS Board on how health inequalities are being tackled across the footprint.

8. Appendices

1. Immunisation and Screening Programmes - an update for Slough. Dec 2018.

2. The Ten Questions to Consider If You're Scrutinising Local Immunisation Services. Centre for Public Scrutiny. 2016

9. Background Papers

None

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TITLE: **Immunisation and Screening Programmes- an update for Slough**

DATE: December 2018

Report By: Jo Jefferies, Consultant in Public Health, Public Health Services for Berkshire
Nisha Jayatilleke, Screening and Immunisation Lead, NHS England South
Paula Jackson, Screening and Immunisation Lead, NHS England South

Purpose of Report:

- To provide a summary of the current commissioning and provider arrangements for immunisations and screening programmes and the organisations involved
- Provide an update on immunisation and screening programme coverage in Slough
- Highlight recent successes and key opportunities to maximise programme coverage and uptake with a view to reducing health inequalities in this area.

Executive Summary

NHS England has continued to commission the services set out under the Section 7A agreement to a high standard, offering continued protection to the public. Data and evidence demonstrates that public health protection remains world class and we have achieved real success. Increasing access to screening and immunisation programmes, contributes to the wider prevention agenda and the implementation of the Five Year Forward View.

Some of the recent successes that have benefitted the local population include programmes to increase uptake and improvements to data quality for closer monitoring of progress. Examples include the development of a GP toolkit with tips and advice for primary care colleagues to improve immunisation uptake for their patients. The toolkit is implemented in many practices across Slough. In addition, data on immunisations delivered in primary care are now auto-extracted from the clinical record and entered electronically on the Child Health Information System (CHIS) which is not only more efficient but has also improved the accuracy of the data. The LA, the school immunisation provider and NHS England have worked together to agree how they willaddress cultural and language barriers to further improve uptake in groups with lower historic vaccination rates. As part of the Thames Valley Cancer Alliance GP Quality Improvement Scheme, there are initiatives in place to improve cancer screening coverage as well as the safe mobilisation of the Diabetic Eye Screening programme following a contract review.

Successful collaborative working has enabled improvements in some outcomes, however there is still opportunity to improve uptake of cancer screening programmes and childrens immunisations, particularly PCV (pneumococcal) booster, second dose MMR, and the Hib/MenC booster. It is important to have a thorough understanding of opportunities and challenges that need to be considered in Slough to be able to support families take up the offer for vaccination and to work collaboratively with stakeholders to improve vaccine uptake.

There are several new opportunities ahead to implement and embed changes that will further improve screening and immunisation services locally. These include the introduction of a new screening test in the bowel screening programme, incorporating HPV primary screening into the cervical screening programme and a new booster seasonal flu immunisation for people aged 65 and over.

Governance and reporting arrangements are also being tightened, The Shared Public Health Team is scoping an annual Health Protection Report, drawing together key metrics and issues. The Terms of Reference of the Berkshire Health Protection Committee is also under review to ensure the committee fulfils its system assurance role, with partners providing assurance to the Strategic DPH and holding each other to account. In addition, NHS England is revising the quarterly Berkshire screening and immunisation dashboard to improve clarity and enable access for public health consultants in each Local Authority.

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Background

Current commissioning and provider arrangements

- NHS England is responsible for commissioning screening & immunisation programmes in England. Locally this is co-ordinated and managed across Thames Valley by the Public Health Commissioning team at NHS England, South East under an agreement known as Section 7a – see
-
- Figure 1 and Figure 2.
- GP Practices are the main providers of childhood immunisation for children under 5 years of age commissioned by NHS England and with a quality duty in CCGs.
- NHS Trusts are the main providers of NHS Screening Programmes
- Currently, the Berkshire Healthcare Foundation Trust School Immunisations Team is commissioned by NHSE to provide school aged immunisations in Berkshire. This is a different service than the School Nursing Services commissioned by Slough Borough Council
- Public Health England South East Health Protection Team is responsible for functions related to health protection reactive work, outbreak management etc. in which immunisations may be offered to protect healthy people who have been exposed to a particular infection.

Figure 1: Public Health and NHS England: Section 7a Operating Model

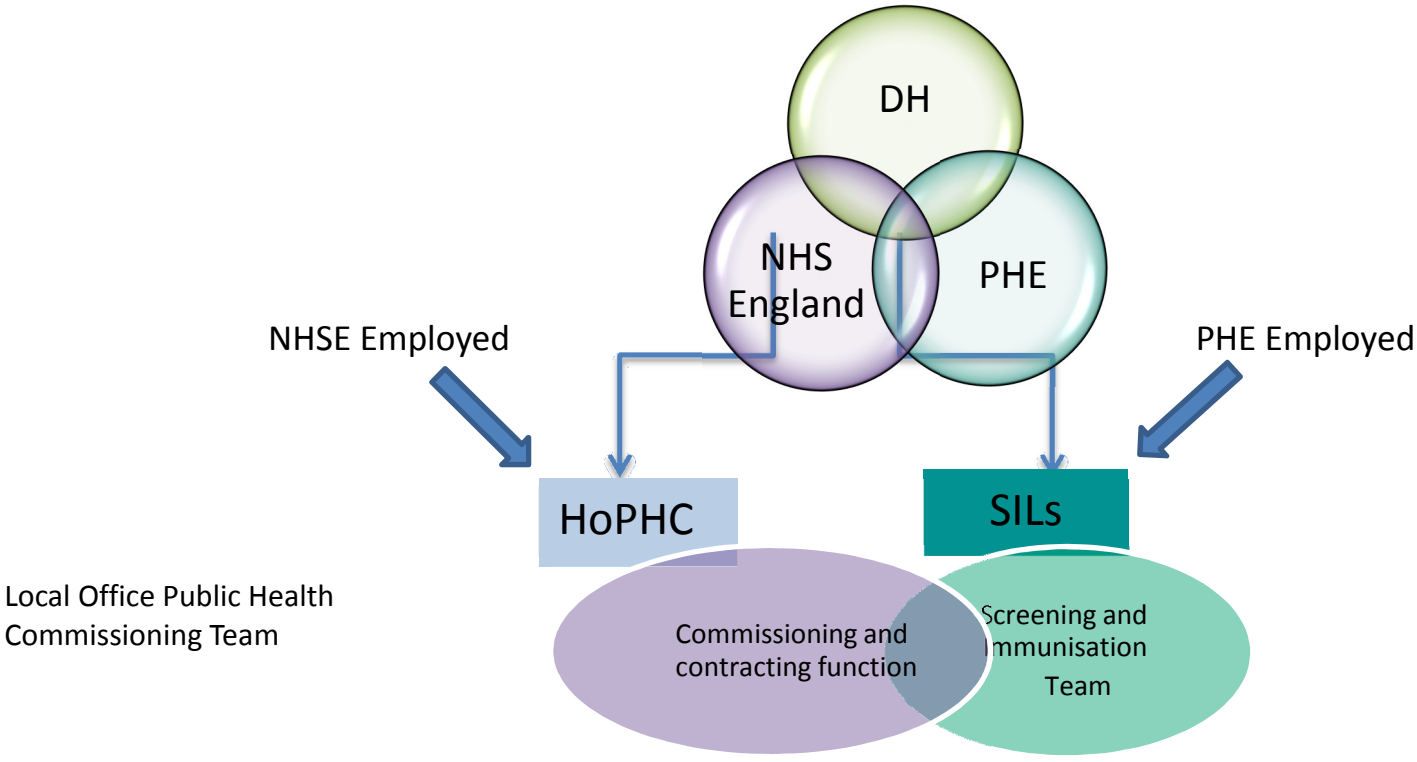
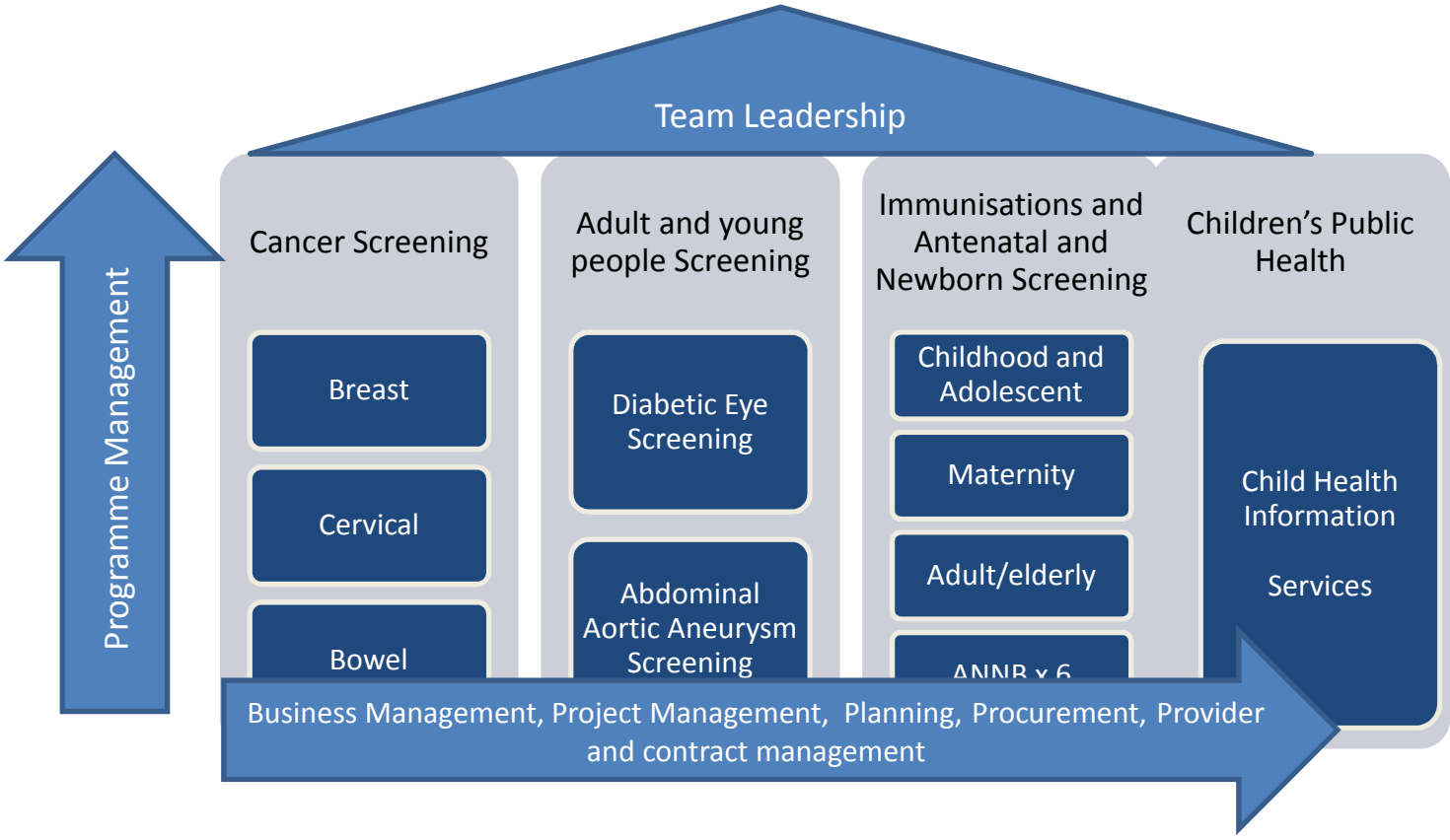


Figure 2: Public Health and NHS England: Section 7a Programme Management



Immunisation programmes

Immunisation is one of the most effective public heath interventions, the World Health Organisation states that "Only clean water (a human right) ranks as highly as vaccination in terms of the greatest impact on health globally". The UK has a well-established and successful immunisation programme offered through the NHS. There is a need to ensure that as many people as possible are taking up the offer of vaccination to protect against disease.

Immunisation is more than the sum of its parts, as increasing the number of immunised people in a population reduces the opportunity for infection to pass from one person to another through the phenomenon known as 'herd immunity'. When an immunisation programme against a disease begins, the number of people catching the disease goes down. As the threat decreases, it's important to keep vaccinating; otherwise the disease can start to spread again. If enough people in a community are vaccinated, it's harder for a disease to pass between people who have not been vaccinated. Herd immunity is particularly important for protecting people who can't get vaccinated because they're too ill or because they're having treatment that damages their immune system.

Childhood immunisation programmes

The UK Childhood Immunisation Schedule covers the recommended immunisations for children and young people aged 0 to 18 years. The schedule comprises the recommended universal or routine immunisations which are offered to all children and young people, as well as selective immunisations which are targeted to children at higher risk from certain diseases. The target of the national immunisation programme is for 95% of children to complete courses of the routine childhood immunisations at appropriate ages.

Table 1: UK Childhood Immunisation Programme as of November 2018

Age	Vaccines offered	Diseases protected against
Eight weeks old	Hexavalent vaccine (DtaP/IPV/Hib/HepB)	Diphtheria, tetanus, pertussis (whooping cough) polio, *Haemophilus influenzae* type B infections and hepatitis B
	MenB	Meningococcal group B infections
	Rotavirus	Rotavirus gastroenteritis
	PCV13	Pneumococcal infections (13 serotypes)
Twelve weeks old	Hexavalent vaccine (DtaP/IPV/Hib/HepB) – dose 2	Diphtheria, tetanus, pertussis (whooping cough) polio, *Haemophilus influenzae* type B infections and hepatitis B
	Rotavirus – dose 2	Rotavirus gastroenteritis
Sixteen weeks old	Hexavalent vaccine (DtaP/IPV/Hib/HepB) – dose 3	Diphtheria, tetanus, pertussis (whooping cough) polio, *Haemophilus influenzae* type B infections and hepatitis B
	MenB – dose 2	Meningococcal group B infections
	PCV13	Pneumococcal infections (13 serotypes)
One year old (on or after the child's first birthday)	Hib/MenC	*Haemophilus influenzae* type B infections and meningococcal group C infections
	PCV13 booster	Pneumococcal infections (13 serotypes)
	MMR	Measles, mumps and Rubella (German measles)
	Men B booster	Meningococcal group B infections
Children aged 2 and 3 and those in schools years reception to year 5*	Nasal flu vaccine (each year from September)	Seasonal influenza
Three years four months old or soon after	DtaP/IPV	Diphtheria, tetanus, pertussis and polio
	MMR – dose 2 (check first dose given)	Measles, mumps and Rubella (German measles)
Girls aged 12 to 13 years old	HPV (two doses, 6 to 24 months apart)	Cervical cancer caused by humans papillomavirus (HPV) types 16 and 18 and genital warts caused by types 6 and 11
Fourteen years old (school year 9)	Td/IPV (check MMR status)	Tetanus, diphtheria and polio
	Men ACWY	Meningococcal groups A, C, W and Y infections

All babies born on or after 1 August 2017 are offered protection against hepatitis B as part of the universal childhood immunisation programme in addition to continued protection against diphtheria, tetanus, pertussis, polio and Hib.The 6-in-1 vaccine (Dtap/IPV/Hib/HepB) is offered at 8, 12 and 16 weeks old. Babies are also vaccinated to protect against rotavirus (a common cause of diarrhoea and sickness, sometimes requiring hospitalisation) and Meningitis B (to protect from infection by meningococcal group B bacteria, which are responsible for more than 90% of meningococcal infections in young children).

Vaccines are offered at age 12-13 months and in the pre-school years including MMR (measles, mumps and rubella) and the pre-school booster. From 1st July 2016, the schedule for MenC vaccination changed. Babies have their first dose of the MenC vaccine at 12-13 months of age through the combination Hib/MenC vaccine. They then receive a booster dose at 13-14 years of age, as part of the MenACWY vaccine. From 1st August 2017 the combined infant vaccination (DTaP/IPV/Hib) changed to include Hepatitis B (DTaP/IPV/Hib/HepB) at 8 weeks, 16 weeks and at the pre-school booster given at 3 years 4 months.

The school-aged immunisation programme is primarily delivered in schools offering HPV to Year 8 or 9 girls as well as the fifth and final dose of tetanus, diphtheria and polio (Td/IPV) vaccine. Teenagers are offered the MenACWY vaccine to protect them against four different causes of meningitis and septicaemia. There is provision made to offer the full immunisation schedule to children who are home schooled or otherwise not in full-time education.

The COVER (Cover of Vaccination Evaluated Rapidly) programme evaluates childhood immunisation in England. PHE in collaboration with other agencies collates UK immunisation coverage data from child health information systems for children aged one, two and five years of age. COVER monitors immunisation coverage data for children in the United Kingdom who reach their first, second or fifth birthday during each evaluation quarter. This information is promptly fed back to local level, creating the opportunity to improve coverage and to detect changes in vaccine coverage quickly.

Immunisation programmes for young people and adults

Although the majority of vaccines in the immunisations programme are offered in childhood with the aim of conferring long lasting immunity, a number of vaccines are offered to young people and adults in order to protect them against infection, these are set out in Table 2.

Table 2: Immunisation programmes for young people and adults

Vaccine	Population offered the vaccine	Infection vaccine aims to prevent
Pneumococcal vaccine	All people aged 65 and over	Pneumococcal disease.

Annual flu vaccine	• People aged 65 and over
	• People aged under 65 in a clinical risk group
	• Pregnant women
	• Carers and household contacts of immunocompromised individuals
	  • Social Care and hospice staff
	  • people living in long-stay residential care homes or other long-stay care facilities
	  • School aged children in reception to year 5
	  • 2 and 3 year old children
		Seasonal influenza

Shingles vaccine	Routine cohort people aged 70 (see details below) The shingles vaccination programme started on 1st September 2013. The programme offers routine vaccinations to people aged 70 years old along with a catch-up immunisation programme for people aged 79 years. Anyone who has previously been eligible remains eligible until their 80th birthday. The link attached shows eligibility for 2018/19: https://www.gov.uk/government/publications/shingles-vaccination-eligibility-poster	Shingles (caused by the varicella-zoster virus which also causes chicken pox) https://www.gov.uk/government/collections/shingles-vaccination-programme
Pertussis Vaccine	All pregnant women	Whooping cough in newborn infants

Additional vaccines are also recommended for people with specific health conditions (see The Routine Immunisation Schedule).

Population Screening

Screening is the process of identifying healthy people who may have an increased chance of a disease or condition. Screening aims to identify the individuals most at risk of a disease so that they can be offered information, further tests and early treatment.

Table 3: NHS National Screening Programmes

Screening Programme	Population offered the screen	Aim of programme
Bowel Cancer (**faecal occult blood test** (FOBT) checks for occult (hidden) blood in the stool. Bowel Scope	Men and women aged 60 to 74 One off test offered at age 55. This programme is currently being rolled out and is not yet available to the entire population	Reduce illness and deaths from bowel cancer Prevent the development of bowel cancer by removing pre-cancerous polyps
Breast Cancer	Women aged 50 -70	Reduce illness and deaths from breast cancer in women aged 50 to 70
Cervical	Women aged 25 to 64	Reduce illness and deaths from cervical cancer in women through identifying pre-cancerous changes
Abdominal Aortic Aneurysm (AAA)	One off test for men in their 65th year	Reduce AAA related deaths among men aged 65 to 74
Diabetic eye screening	All people with type 1 and type 2 diabetes aged 12 or over who are not already under the care of an opthalmologist for diabetic retinopathy	Reduce sight loss due to diabetic retinopathy
Antenatal screening	All pregnant women- Infectious Diseases in Pregnancy screening Sickle cell and thalassaemia Down's, Edwards' and Patau's syndromes Physical abnormalities (mid-pregnancy scan) Eye problems in women with diabetes	Screening tests are offered during pregnancy to try to find any health problems that could affect the woman or the baby. The tests – ultrasound scans, blood tests and a questionnaire – can help make choices about care or treatment during pregnancy or after baby is born. A dating ultrasound scan, offered at around 8 to 14 weeks' pregnancy, is the most accurate way to work out the baby's due date. A mid-pregnancy ultrasound scan, offered around 18 to 21 weeks' pregnancy, looks for physical abnormalities in the baby.
Newborn screening	All Heart, eyes, hips and testes (physical examination) Hearing loss Blood spot	Screening offered so that baby can be given appropriate treatment as quickly as possible if needed

Current Performance- national immunisation programmes

Childhood immunisation programmes

Annual immunisation uptake statistics for children aged up to five years in Slough, compared England uptake for 2016-17 and 2017-18 is shown in Table 4. In Slough, across all indicators except DTaP/IPV booster, there have been improvements from 2016/17 to 2017/18. However uptake of MMR1, Hib/MenC and the PCV booster remains lower than the England figure and below 90%. Uptake of all vaccines by five years has improved in 2017-18 compared with the previous year but remains substantially below target for MMR2, meaning that around 1 in 5 children in Slough are not adequately protected against measles at a time when incidence has increased in England[1]. Some of the improvements are directly due to data quality improvements both at GP practices and within Child Health Information System. As part of the data quality improvement activity, the reporting for DTaP/IPV booster in 2017/18 was standardised to align to national COVER reporting criteria which means only children who received the vaccination between age 3 years and 4 months and 5 years is included.

Table 4: Childhood Immunisation (0-5 years) Uptake 2016-17 and 2017-18

			2016-17 England	2017-18 England	2016-17 Slough	2017-18 Slough
Age 1	DTaP/IPV/Hib	% immunised	**93.4**	**93.1**	**90.8%**	**93.7%**
	PCV	% immunised	**93.5**	**93.1**	**90.8%**	**93.8%**
	Rotavirus (1)	% immunised	**89.6**	**90.1**	**87.9%**	**91.2%**
Age 2	DTaP/IPV/Hib primary	% immunised	**95.1**	**95.1**	**94.1%**	**95.2%**
	MMR 1st dose	% immunised	**91.6**	**91.2**	**84.8%**	**87.1%**
	Hib/ MenC	% immunised	**91.5**	**91.2**	**85.6%**	**87.2%**
	PCV booster	% immunised	**91.5**	**91**	**84.6%**	**87.3%**
Age 5	DTaP/IPV/Hib primary	% immunised	**95.6**	**95.6**	**93.3%**	**97.7%**
	DTaP/IPV booster	% immunised	**86.2**	**85.6**	**77.7%**	**75.1%**
	MMR 1st dose	% immunised	**95**	**94.9**	**91.1%**	**94%**
	MMR 1st and 2nd dose	% immunised	**87.6**	**87.2**	**79.0%**	**81.1%**
	Hib/ MenC booster	% immunised	**92.6**	**92.4**	**90.3%**	**91.4%**

Data Source: NHS Digital (2017 and 2018): Childhood Vaccination Coverage Statistics, England

Prior to Q2 of 2017-18, children who received the vaccination for DTaP/IPV booster from 3 years of age were included in the COVER data. The dip in performance for the DTaP/IPV booster at age 5 years may be explained by the fact NHS England changed the 5 year COVER parameters for DTaP/IPV as of Q2 2017-18 to standardise reporting parameters with national guidance and to align with local practice. The

[1] *Laboratory confirmed cases of measles, rubella and mumps, England: April to June 2018, PHE*

impact of this change was a perceived difference in performance as there were 270 children in Slough who received the vaccination aged between 3 years and 3 years 4 months which would not be included in the COVER parameters. To address this, the CHIS Provider is now sending invitations at age 3 years and 4 months to ensure timely vaccination.

Schools-aged immunisation programme

In England, the recommendation from September 2014 was to offer the first (priming) HPV vaccine dose to females in Year 8 and the second dose 12 months later in Year 9 (aged 13 to 14 years), as this would reduce the number of immunisation sessions required in schools. In Berkshire, the school immunisation Provider, Berkshire Healthcare NHS Foundation Trust, with effect from September 2017- autumn term deliver to this model to facilitate expanded delivery of the seasonal childhood flu programme across most of the autumn term.

The school leaver booster is the fifth dose of tetanus, diphtheria and polio (Td/IPV) vaccine in the routine immunisation schedule and completes the course, providing long-term protection against all three diseases. The Berkshire Healthcare Foundation Trust School Immunisations Team delivers Td/IPV tetanus and diphtheria and polio combined vaccine and (since January 2018) also deliver the MenACWY (meningitis vaccine) to students in school Year 9.

The School Immunisation Team have also been offering a catch up MMR programme to all year 9 students who missed one or more doses as an infant, during 2017-18, 979 students were vaccinated with MMR as part of this programme. The catch up programme is being run alongside the delivery of MenACWY and Td/IPV in secondary schools. This reduces the time students are absent from education and minimise disruption to lessons while improving efficiency and maintaining high uptake. From April 2018, a check is taking place in school year 2 to identify children with incomplete or missing MMR and this will be offered in school.

Table 5: HPV, Men/ACWY and Td/IPV vaccine uptake in school-aged children 2016-17

			England 2016-17	**South East 2016-17**	**Slough 2016-17**
Girls aged 12 to 13 (Year 8)	HPV 1st dose	Cohort	299,198	26,290	1,177
		Number of children immunised	260,959	21,288	1,046
		% immunised	87.2%	81%	88.9%
Girls aged 13 to 14 (Year 9)	HPV 2nd dose	Cohort	289,499	25,697	916
		Number of children immunised	240,590	20,120	834
		% immunised	83.1%	78.3%	91.0%
School Year 9 in 2016/17 (13-14 year olds) born between 1 September 2002 - 31 August 2003)	Td/IPV and Men/ACWY	Number of 13-14 year olds	463,477	52,805	1,976
	Td/IPV	Number of children immunised	384,564	42,751	1,804
		% immunised	83%	81%	91.3%
	Men/ACWY	Number of children immunised	402,942	43,225	1,789
		% immunised	83.6%	81.9%	90.5%

Data source: NHS Digital (2017)

The school-aged immunisation programme for HPV performs similarly or better than England in Slough. In 2017-18 uptake of HPV is approaching the 90% objective in Year 8 and achieved the objective in year 9, comparing well with 83% nationally.

The Trust is changing HPV vaccination delivery schedule to 12 months/ 2 academic terms, HPV 1 was delivered to Year 8 students during summer 2018 and HPV 2 will be delivered to Year 9 students in summer 2019. A few schools will remain on the 6 month schedule, including pupil referral units.

Over the past year, the school nursing team has reported a number of instances of anti-vaccine information being circulated among parents across Berkshire LA areas, primarily through social media. This has the potential to undermine the performance of the service and has been recognised as an area of action by commissioners and local stakeholders.

Young people and adult Immunisation Coverage

Table 5: Shingles Vaccination Coverage, Slough CCG May 2018

	Percent coverage	
	Slough	**England**
Shingles: coverage for routine cohort since 2013	32.2%	41%
Shingles: coverage for the catch up cohort since 2013	35.9%	42%

Data Source: https://www.gov.uk/government/publications/herpes-zoster-shingles-immunisation-programme-2013-to-2014-provisional-vaccine-coverage-data

Table 6: Pneumococcal Vaccination Coverage, all GP registered patients aged 65 and over Slough CCG

	Received the Pneumococcal (PPV) vaccine between 1st April 2017 and 31st March 2018 inclusive
Slough	67.6%
England	69.5%

Data Source: Pneumococcal Vaccine Coverage Monitoring Programme England - data to end March 2018, PHE

Table 7: Annual pre-natal Pertussis Vaccination Coverage, Slough CCG between 2015-16 and 2017-18

	2015-2016	2016-2017	2017-2018
Slough	43%	51.3%*	49.1%*
England	58.2%	66%*	71.9%*

Data Source: Immform /Prenatal Pertussis Vaccine Coverage monitoring programme.
*Please note NOV 2016- No data received from one large IT supplier for Thames Valley and APRIL-JUNE 2017- No data received nationally from IT supplier

Table 8: Seasonal Flu Vaccination Coverage, Slough CCG 2017-18

Eligible group	National Ambition	% uptake Slough	% uptake England
2yr olds	40%	26.3%	42.8 %
3yr olds	40%	28.1%	44.2%
Pregnant women	55%	35.9%	47.2 %
Under 65s at risk	55%	47.5%	48.9 %
65 and over	75%	69.9%	72.6 %
School based programme			
Reception	40%	53.5%	62.6%
Year 1	40%	45.2%	61%
Year 2	40%	46.8%	60.4%
Year 3	40%	43.2%	57.6%
Year 4	40%	42%	55.8%

Data source: Seasonal flu vaccine uptake in gp-patients winter 2017 to 2018 and Seasonal flu vaccine uptake in-children of primary school age winter 2017 to 2018

Current Performance- national screening programmes

Screening data is subject to a time lag as invitees are given a period of time to respond to an invitation in order to improve participation in the programme and maximise uptake. Episodes therefore close some time after an invitation is issued and data is not available until this period has ended, which varies for each programme.

Coverage of screening programmes for young people and adults

Table 9: Cancer Screening Coverage 2017

finition	National Targets		Latest published data		
			Slough	South East	England
BREAST: % of the eligible population (50-70) have been screened in the last 3 years	70%	80%	68.7%	76.9%	75.4%
BOWEL: % of the eligible population (60-74) have been screened in the last 2.5 years	52%	60%	44%	61%	59.6
CERVICAL: % of the eligible population (25-64) have been screened in the last 3.5 /5.5 years	75%	80%	66.4%	73.2%	72%

Data source: Public Health England; Public Health Outcomes Framework
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework

Table 10: Non-Cancer Screening Uptake

Programme	2016/17	
	National	Local
Berkshire Diabetic Eye Screening: Uptake of Routine Screening	82.4%	74.4%
Thames Valley AAA Screening: Proportion of eligible men offered screening who accept the offer	81.1%	79.3%

Data Sources: https://www.gov.uk/government/publications/diabetic-eye-screening-2016-to-2017-data
https://www.gov.uk/government/publications/abdominal-aortic-aneurysm-screening-2016-to-2017-data

Coverage of antenatal and newborn screening programmes

Table 11: Antenatal and newborn screening programmes delivered at Wexham Park (Frimley Hospitals Trust) 2017/18 Q2- 2018/19 Q1

	2017/18 Q2	2017/18 Q3	2017/18 Q4	2018/19 Q1
Infectious Diseases Screening				
HIV testing coverage	100.0	99.8	99.9	99.9
Hep B testing coverage	100.0	99.8	99.9	100.0
Syphilis testing coverage	100.0	99.8	99.9	100.0
Fetal Anomaly Screening				
Fetal anomaly screening(18+0 to 20+6 fetal anomaly ultrasound)-Coverage	100.0	101.4	99.8	100.0
Sickle Cell & Thalessaemia Screening				
Antenatal sickle cell and thalassaemia screening – coverage	100.0	99.8	99.9	100.0
Newborn Bloodspot Screening				
Newborn blood spot screening – coverage	97.9	98.9	98.9	92.6
Newborn blood spot screening – coverage (Movers In)	93.8	93.1	90.5	86.5
Newborn Hearing Screening				
Newborn hearing screening – coverage	99.5	99.3	99.7	99.7
Newborn and Infant Physical Examination Screening				
Newborn and Infant Physical Examination – coverage (newborn)	98.0	98.7	98.8	99.5

Data source: https://www.gov.uk/government/collections/nhs-population-screening-programmes-kpi-reports

Assurance arrangements

NHS England Public Health Commissioning Team provide assurance to the Strategic Director of Public Health through the quarterly Berkshire Health Protection Committee that work is progressing to maintain and improve uptake of immunisations and screening across Berkshire.

The Public Health Consultant in Slough is informed of performance and progress on all immunisation and screening programmes through the sharing of published key screening and immunisations indicators as part of the suite of JSNA data updates prepared by the Shared Public Health Team and of progress on regional initiatives via the monthly Shared Team Highlight Report presented at consultant meetings. The Slough consultant is a key stakeholder in local initiatives to improve uptake. An annual flu report collates data on flu activity and vaccine uptake is provided by the Berkshire Shared Public Health Team.

The Strategic Director of Public Health may seek additional assurance from NHS England or other stakeholders as regards the performance of local health protection programmes, including screening and immunisation.

Recent key Successes

- Immunisation data delivered in primary care are now auto-extracted and entered electronically on Child Health Information System (CHIS), improving efficiency and accuracy of data. NHS England procured a new larger CHIS system across the entirety of Thames valley to reduce variation and issues with children registered around county borders.
- Development of a GP toolkit to improve immunisation uptake with tips and advice for primary care colleagues. The toolkit is implemented in many practices across Slough.
- Joint working between LA, school immunisation providers and NHS England to agree actions to address cultural and language barriers to improve uptake rates.
- Thames Valley Cancer Alliance GP Quality Improvement Scheme; to improve cancer screening coverage.
- There has been a procurement of the diabetic eye screening programme in Berkshire, with the new contract awarded to Health Intelligence. The new provider began offering screening in Q1 2018-19 and patient feedback so far has been positive. Performance data for the new provider will be published next quarter.
- Slough Borough Council Public Health Team launched the #IamVaccinated campaign in 2018. This is the new face of the teams drive to increase vaccination rates within the local community. The campaign focuses on the personal reasons people get vaccinated and aims to dispel myths. It is not vaccine specific, but initially focussed on Flu, HPV and MMR.
- East Berkshire CCG has worked with Macmillan and other key partners to implement the Slough Bowel Cancer Screening Project. This aims to support GP practices to improve uptake and to raise awareness of bowel cancer and its signs and symptoms through community education. To date there have been 67 events and conversations with over 1800 people. 14 out of 16 practices have improved their screening uptake since the project began.

Key Opportunities

- A new test known as FIT (Faecal Immunochemical Test) is being introduced into the national bowel screening programme in April 2019. This test will replace the guaiac faecal occult blood test (gFOBt). The new test is more sensitive and because it is easier for participants to use improves uptake in screening, particularly in deprived groups. This is likely to improve uptake of bowel cancer screening in Slough.
- From December 2019 all cervical smear tests will be tested using HPV primary testing following a national procurement process. Evidence shows that HPV testing is a better way to identify women at risk of developing cervical cancer than cytology (looking at cells under a microscope). The test will increase the number of women correctly identified as being at risk of developing cancer of the cervix. This new service will also alleviate the poor performance nationally to the 14 day turnaround time key performance indicator.
- NHSE commissioned a pilot project from the South Central and West Commissioning Support Unit CHIS to send a letter to parents in Berkshire providing information about the benefits and practicalities about vaccinating their 2 and 3 year old children against flu. It is hoped that this will increase the uptake of the vaccine in this age cohort.

- The 2018/19 seasonal flu programme includes a new booster vaccine for people aged 65 and over. Research indicates that the new adjuvant vaccine (aTIV) is both more clinically and cost-effective than the non adjuvanted vaccines previously offered to this age group. It is anticipated that this will contribute towards reducing flu related morbidity and mortality among older people.

Next Steps

- Key partners will work together to develop a local action plan for Slough to improve uptake of screening and immunisation programmes
- The Shared Public Health Team will scope production of an annual Health Protection Report, drawing together key metrics and issues
- The Terms of Reference of the Berkshire Health Protection Committee are under review reviewed to ensure the committee fulfills itssystem assurance role, with partners providing assurance to the Strategic DPH and holding each other to account
- NHS England are reviewing the presentation of the quarterly Berkshire Screening and Immunisation Dashboard to improve clarity and enable wider sharing to public health consultants in each borough.

Centre for Public Scrutiny

sanofi pasteur MSD
vaccines for life

10 Questions To Ask If You're Scrutinising...
...Local Immunisation Services

Third edition, April 2016

The Centre for Public Scrutiny

The Centre for Public Scrutiny (CfPS), an independent charity, is the leading national organisation for ideas, thinking and the application of policy and practice to promote transparent, inclusive and accountable public services. We support individuals, organisations and communities to put our principles into practice in the design, delivery and monitoring of public services in ways that build knowledge, skills and trust so that effective solutions are identified together by decision-makers, practitioners and service users.

This guide on the scrutiny of immunisation provision is one of a series by CfPS designed to help Health Overview and Scrutiny Committees (HOSCs) carry out their scrutiny work around various health, healthcare and social care topics.

The guide identifies ten key question areas and their detailed questions, which can be used by the HOSC to scope out a wide review or to concentrate on an area of particular interest or bearing; this is important if local needs are to be identified and areas are to provide an effective response.

Other guides in the series include:

- Child and Adolescent Mental Health Services
- Services for people with dementia
- Adult social care
- Reducing unintentional injury in the under 15s
- Preventing cardiovascular disease
- Men's health
- Service for Looked After Children

THIS SCRUTINY GUIDE HAS BEEN PRODUCED AS A COLLABORATION BETWEEN THE CENTRE FOR PUBLIC SCRUTINY AND SANOFI PASTEUR MSD; THE GUIDE WAS COMMISSIONED AND FUNDED BY SANOFI PASTEUR MSD, WHO HAVE CONTRIBUTED TO AND REVIEWED THE CONTENT. THE GUIDE IS PRIMARILY INTENDED FOR HEALTH OVERVIEW AND SCRUTINY COMMITTEE MEMBERS AND ASSOCIATED STAKEHOLDERS.

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CONTENTS

FOREWORD

Asking well-informed questions about immunisation is an essential component of effective scrutiny. This publication provides the material and framework to enable members and officers to explore the complex and multifaceted topic in a clear and accessible way. As the authors have identified, immunisation is one of the great success stories of modern public health with a strong evidence base of successful interventions.

However, there are also specific challenges for the layperson as they engage with some of the more specialist and technical elements. The situation on the ground is increasingly complex with a wide range of approaches to commissioning and provision. At times this can appear inconsistent and liable to change. As a result there is significant variation across the country in terms of uptake and impact. Understanding who holds local responsibility for immunisation is critical. Local authorities are well placed to bring together networks and use their influence and leadership to build stakeholder approaches to mapping and understanding the system.

The immunisation of young children between 0 and 5 years old provides the foundations for lifelong immunity and helps to protect the most vulnerable members of our communities. It is essential that scrutiny committees understand the positive impacts of infant programmes and the reasons for any patterns of low take-up. But it is also important to consider the significance of a life course approach to immunisation for other groups such as young people, adults and older people as well as the broader issues of diversity and health inequalities. Scrutiny offers the opportunity to assess some of the wider, more holistic aspects of immunisation and share learning with other local authority functions in areas such as early years, housing, education and communications. Listening and understanding the experiences of children, young people and families can also ensure that scrutiny reviews take account of local voices and perspectives – placing them at the core of a review.

10 Questions to ask if you're scrutinising local immunisation services will be of great benefit to scrutiny committees, health and wellbeing boards and other local partnerships that want to understand more about the factors that drive effective and inclusive immunisation programmes. The Centre for Public Scrutiny looks forward to seeing how local committees use this resource to lead effective reviews.

Lord Kerslake,
Chair of the Centre for Public Scrutiny

INTRODUCTION

Nowhere has public health achieved more success than in the protection against infectious disease. Over the centuries improved living standards, sanitation, hygiene and nutrition have all been contributory factors. After clean water, vaccination is recognised as one the most effective public health interventions for saving lives and promoting good health. It is seen as the most cost-effective activity undertaken by healthcare professionals and is a critical element of preventive health care around the world. [1]

Immunisation is the process whereby a person is made immune or resistant to an infectious disease. This is achieved through vaccination but also when an individual has the disease naturally. Vaccination is the term used when a vaccine is introduced into the body to invoke an immune response. Vaccines are products developed to immunise against a specific disease. The terms vaccination and immunisation are used interchangeably.

BACKGROUND

In the United Kingdom, vaccine policy is advised by the Joint Committee on Vaccination and Immunisation (JCVI). The success of immunisation policy in the UK relies on vaccines protecting the individual from the specific disease. It is also dependent on achieving high uptake of the vaccines across the population, which thereby minimises the spread of infections. The UK is successful in this and although it is not compulsory for anyone to receive vaccines, the uptake for most vaccinations is high and vaccine-preventable disease is now relatively rare in the UK. The programmes rely on a complex process of policy decision, contract development and implementation to ensure access is equitable. This includes vaccine procurement and appropriate training and support for staff involved.

Vaccines are routinely given across the life course to those at most risk of contracting serious illnesses, including;

- Children between 0 and 5 years of age receive the majority of routine vaccinations.
- School-aged children require certain vaccines; some as boosters which will prolong the longevity of the immunity acquired and some deemed best to be given to teenagers.
- Adults require vaccines depending on age and if they have underlying medical conditions.
- Travellers will also be recommended some vaccines depending on where they are going.
- Some vaccines are recommended for certain occupational groups. This is to protect the individual who is at an increased risk of exposure. It is also to protect the wider public from any subsequent spread of infection.

HOW TO USE THIS GUIDE

This third edition of the guide is intended to be used as a tool to provide local authority councillors and others involved in Health Overview and Scrutiny Committees (HOSCs) and Health and Wellbeing Boards (HWBs), with useful background information about immunisation and a series of questions that may be helpful to consider when scrutinising the effectiveness of local services.

The right to receive the vaccinations that the JCVI recommends under an NHS-provided national immunisation programme is enshrined in the NHS constitution. [2] The effectiveness of the programme is dependent on the uptake of the specific vaccine being high and equitable across the eligible population. This requires close scrutiny of all the elements of the programme and the role of the local authority is to make sure the needs of their population are being met. This scrutiny falls broadly into three main groups:

- Vaccines for children aged 5 and under
- Vaccines for school-aged children
- Vaccines for adults.

This '10 Questions' guide is designed to give an overview of the rationale and policy for immunisation. It provides a basis to discuss the specific issues relating to each of these groups and how to make sure services are equitable across the population so that uptake is maximised.

Immunisation is very effective at reducing the incidence of infectious disease. The graphic below from Public Health England (PHE) demonstrates how once very common and potentially fatal infections are now very rarely seen in the UK following the introduction of vaccination.

Source PHE : https://publichealthmatters.blog.gov.uk/2015/11/12/phe-data-week-immunisation-in-numbers-5-fascinating-facts/

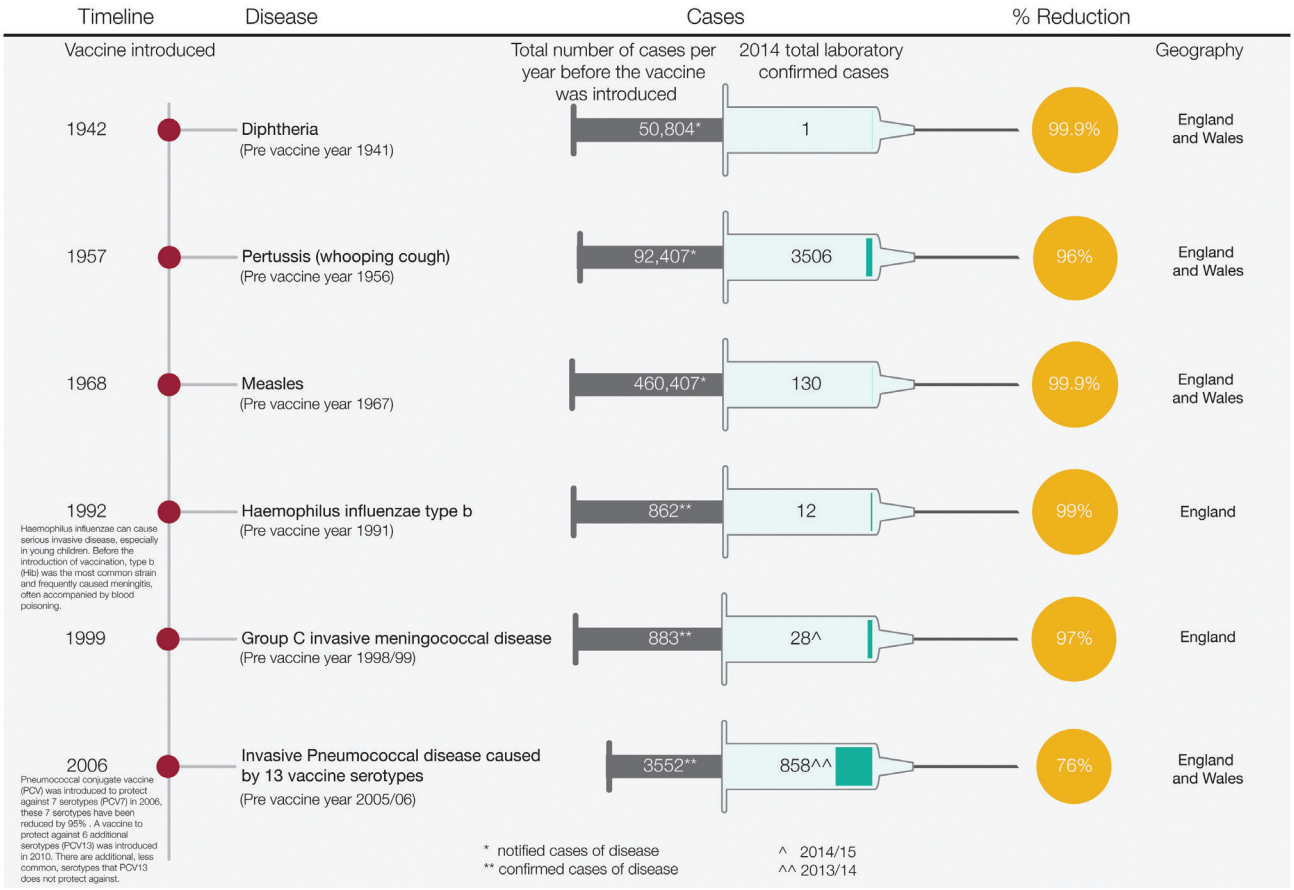


Image reproduced with permission from PHE.

A glossary of technical and medical terms can be found at the end of the document along with a Useful Links section to provide you with further resources should you wish to know more.

10 QUESTIONS TO CONSIDER WHEN SCRUTINISING LOCAL IMMUNISATION SERVICES

These questions are designed to give background and context for HOSCs and HWBs to consider and explore to ensure local immunisation services are effective and responsive.

1. Why is immunisation important and how is policy for vaccination decided in the UK?

Background and policy context

Immunisation is a proven tool for controlling and eliminating infectious diseases and the World Health Organisation (WHO) have estimated it to avert between two and three million deaths globally each year. [3] The primary aim of vaccination is to protect the individual. However, because vaccinated individuals are less likely to be a source of infection to others the risk to those not protected by vaccination being exposed to infection is reduced, this is a concept known as 'herd immunity' (or 'community immunity'). It is, however, important to note that not all diseases can be eradicated. Infections such as tetanus can only be kept at bay by protection of the individual. Tetanus spores are present in soil or manure and can be introduced into the body through a puncture wound, burn or scratch so protection against tetanus is individual.

Vaccine policy in the United Kingdom is advised by the JCVI, whose remit is;

"To advise UK health departments on immunisations for the prevention of infections and/or disease following due consideration of the evidence on the burden of disease, on vaccine safety and efficacy and on the impact and cost effectiveness of immunisation strategies. To consider and identify factors for the successful and effective implementation of immunisation strategies. To identify important knowledge gaps relating to immunisations or immunisation programmes where further research and/or surveillance should be considered."

The JCVI has no statutory responsibility to provide advice to ministers in Scotland or Northern Ireland. However, health departments from these countries may choose to accept the Committee's advice or recommendations. UK health departments are made aware of all JCVI advice through their designated observers who attend JCVI and sub-committee meetings and receive committee papers.

Decisions on the national vaccination programmes are taken after scrutiny of available evidence and literature both published and unpublished, alongside analysis of epidemiological data of disease incidence and consideration of the economic and health benefits of specific vaccinations and the benefit of making changes to the schedule.

The NHS delivery of immunisation programmes is good and uptake rates in the UK are generally very high. The key reasons for this are:

- A right to be immunised, free of charge, is enshrined under the NHS Constitution and as such vaccines for the NHS programme are provided free of charge to patients.
- The COVER programme (Cover of Vaccine Evaluated Rapidly); [4] since 1987 this programme has improved coverage by collecting, analysing and publishing data on vaccine uptake at local level in a consistent way across the country enabling changes in vaccine coverage to be detected quickly.
- The ongoing surveillance of all immunisation programmes to ensure maximum benefit to the individual as well as safety and cost-effectiveness through the JCVI.
- The continued high priority given by the government to the national childhood immunisation programme. With a commitment within NHS England and PHE structures that supports the effective delivery of immunisation programmes.

- Regular updates and information via tripartite (Department of Health (DH), PHE and NHS England) communications.
- Requirements for training and updates at a local level. PHE have developed a core curriculum and national minimum standards as well as a range of training resources. [5] There is a joint RCN and PHE training guidance resource [6] and a framework to asses staff competence in the workplace. [7]
- The regular updating of national policy guidance in the online resource, 'Immunisation against infectious disease' ('The Green Book' [8]).
- Publicity and information materials to support the programmes, including leaflets and factsheets developed by the immunisation team at PHE and made available via NHS Choices and the government website.

Questions to ask/consider?

An effective immunisation programme should encompass key 'Quality Criteria' - these were previously defined by the Health Protection Agency (HPA) in 2012; the HPA is now part of PHE. [9]

1) How is information and advice on changes and amendments to the schedule cascaded to services delivering vaccination?
2) Is immunisation a high priority area locally and does the local Joint Strategic Needs Assessments (JSNA) reflect the importance of maximising immunisation uptake across the life course for adults and children and is it updated to reflect new vaccines added into the national programme?
3) Is vaccination available easily and actively offered to those who need it and the service designed to make sure that every opportunity is taken to make sure those eligible are assessed and offered vaccination appropriately.
4) Are there call and recall systems in place in primary care and are staff alerted to the fact that a patient is due a vaccine?
5) Are there effective documentation and record keeping processes to ensure accurate information is available on population coverage and that the individual has a lifelong record?
6) Are vaccine related incidents reported and managed appropriately and are lessons learnt and disseminated.
7) Are there effective mechanisms to ensure vaccines are transported and stored appropriately so that vaccines given are of optimum quality?
8) Is training available for staff? The vaccine programmes are complex; training and access to support should be available for anyone involved in immunisation. All staff need to know where and how to access this.
9) Is there effective coordination so that all the elements of the immunisation programme are appropriately aligned and accountable?

2. Why is it important to scrutinise immunisation?

Background and policy context

Systematic review of vaccination uptake has been a key requirement for many years, to enable close analysis of pockets of poor uptake in order to support prediction of potential problems and implementation of early measures to mitigate these. The Public Health Outcomes Framework (PHOF), 'Improving outcomes and supporting transparency' [10] includes immunisation coverage rates as a continued outcome measure for reporting with the addition of the requirement to report on the uptake for targeted vaccinations and those given to teenagers and adults in a similar way to routine childhood vaccinations.

The PHOF Data Tool (under Indicator 3.03) enables individual local authorities to "compare and contrast" data, across a spectrum of immunisation indicators, against neighbouring authorities within the region and against an England average. [11]

The NHS England commissioning, Immunisation and Screening National Delivery Framework and Local Operating Model 12 sets out the arrangements for delivery and governance of immunisation and screening programmes and, importantly, who is responsible for the various aspects of immunisation.

NHS England/Public Health England

NHS England local offices are responsible for commissioning the national immunisation services locally and for providing system leadership to all those involved. Each NHS England local office has one or more public health commissioning teams made up of both NHS England-employed staff and public health professionals who are employed by PHE but are "embedded" within NHS England in order to provide public health leadership and expertise for these programmes.

Contracts to provide immunisation services are held with a range of providers;

- General practices for immunisations given in primary care (this includes vaccines given to children up to 5 years old and others)
- Community providers for immunisations that are given in a school setting (for example the childhood flu and the teenage vaccines).
- Contracts may also be held with community pharmacists (for example for flu vaccine) and sometimes with maternity services for the vaccines given to women who are pregnant (whooping cough and flu).

The NHS England teams will offer help and support to immunisation providers as well as monitoring uptake and taking action where uptake could be improved whilst acknowledging that immunisation is also a choice for parents and patients.

NHS England also holds contracts with the local provider of the Child Health Information System (CHIS). The CHIS should keep a record of every child's immunisation status and is the source for the childhood immunisation uptake data.

Clinical commissioning groups (CCGs)

CCGs have a responsibility for the quality of primary care services provided by the general practices within their organisation. CCGs are encouraged to see immunisation uptake rates as a marker for good quality primary care. Many CCGs include measures such as flu immunisation uptake and MMR uptake as quality measures in a "balanced scorecard" approach to quality.

Local Authority Director of Public Health (DPH)

The DPH has an assurance function. They need to assure themselves that the arrangements for immunisation are fit for purpose and are delivering service of high quality. Many local authorities exercise this responsibility via a health protection board as a sub-group of their health and wellbeing board.

Relationships between the local providers and commissioners and the HOSC and HWB are crucial in making sure the links between the various elements are transparent.

Increasingly the discussion about immunisation has expanded to recognise that immunisation is not only important in reducing preventable illness but also in minimising the consequences of infection for those with chronic conditions. For example, seasonal flu immunisation prevents not only excess winter deaths but reduces both hospitalisation and winter pressures on accident and emergency departments and it may, in turn, reduce nursing costs and residential home placements.

Immunisation should not always be a subject of scrutiny in isolation. When HOSCs are considering other topics, immunisation pathways should be included in the review. For example, a scrutiny of local maternity services could include a review of the provision of pertussis vaccination or of hepatitis B immunisation for at-risk neonates and, similarly, a review of support for older or vulnerable adults with long term conditions could consider how well they are protected through seasonal flu immunisation programmes.

Questions to ask/consider?

1) Is it clear who is responsible for commissioning immunisations within the NHS England local office?

2) Are providers of immunisation services (general practices and school-aged immunisation providers) clear who is responsible for commissioning and system management of immunisation services locally?

3) What are the reporting mechanisms within NHS England locally to show that immunisation performance is being given sufficient importance?

4) What systems does the DPH have in place to provide themselves with the assurance they need that immunisation services locally are fit for purpose?

5) Are practice level immunisation rates used by CCGs as a quality measure of general practice in their area?

3. How do you know which vaccines are available on the NHS?

Background and policy context

The routine schedule constantly evolves as research identifies better use of the vaccines currently available and as new vaccines become available. The schedule is developed to ensure that the most cost-effective programme is in place to protect the public from vaccine-preventable illness. Some vaccines are recommended for everyone whereas others are only recommended for those at greatest risk of developing severe disease or at particular risk of infection.

The timeline below shows when vaccines were introduced into the UK schedule.

Source PHE : https://www.gov.uk/government/publications/vaccination-timeline

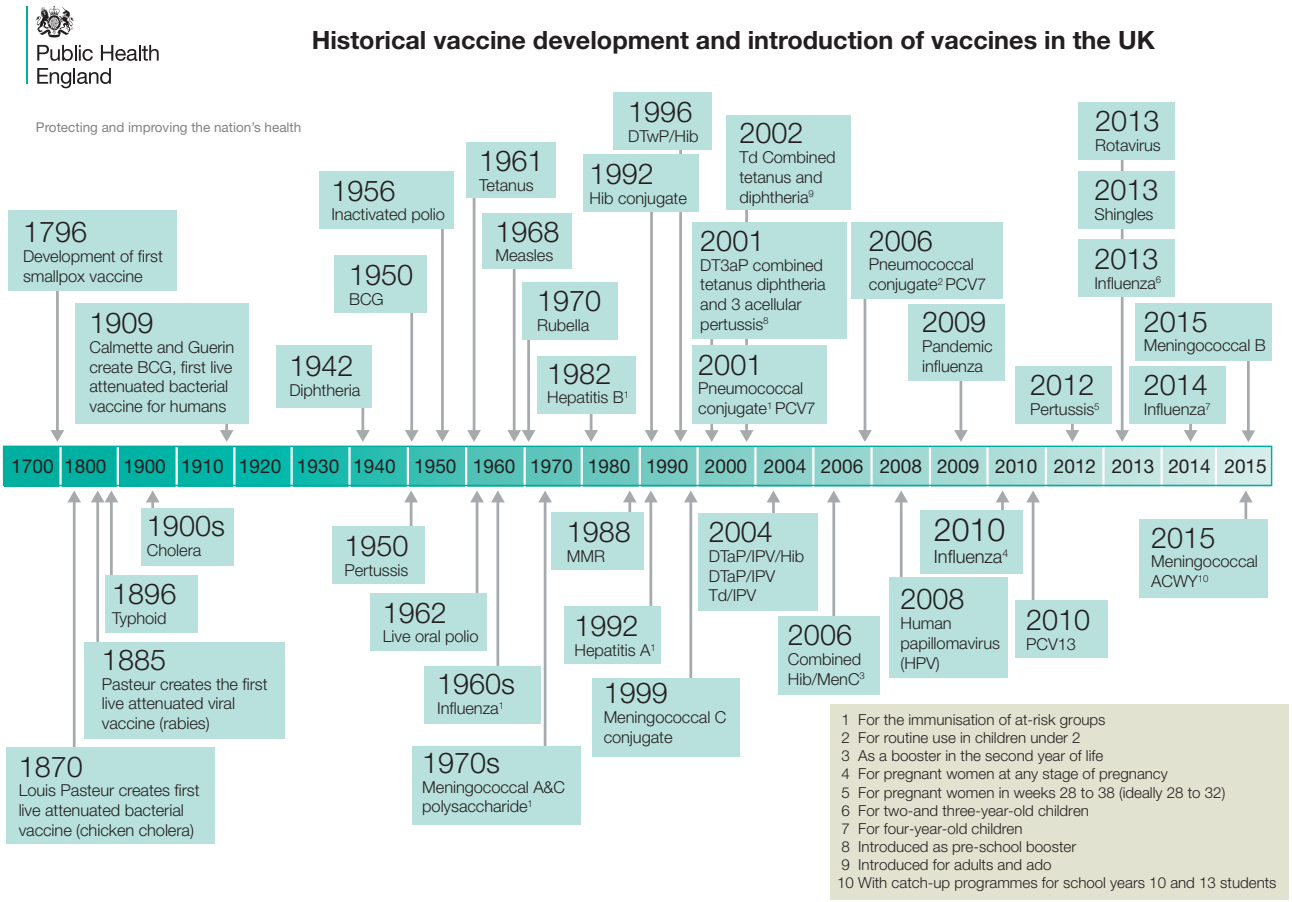


Image reproduced with permission from PHE.

The current complete routine schedule is available from PHE. [13] The detail behind it is presented in the DH publication 'Immunisation against infectious disease', [8] the Green Book which is regularly updated and only available on-line.

Childhood vaccines (under 5 years) are given to protect against the following diseases;

- rotavirus
- diphtheria
- tetanus
- polio
- meningococcal serogroup B (Men B)
- pertussis (whooping cough)
- haemophilus influenzae type b (Hib)

- meningococcal serogroup C (Men C)
- pneumococcal disease
- measles
- mumps
- rubella
- influenza
- hepatitis B } For babies identified as being at risk.
- BCG for tuberculosis } For those in defined high risk groups

School-aged vaccines are given to protect against the following diseases;

- tetanus
- diphtheria
- polio
- meningococcal serogroups ACWY (Men ACWY)
- human papilloma virus (HPV); in girls
- influenza

Adult vaccines are given to protect against the following diseases;

- shingles
- pneumococcal disease
- influenza
- pertussis; vaccine given in pregnancy to protect the new-born infant.

This guidance covers vaccines given as part of national immunisation programmes to protect the public's health. Certain vaccines are given for specific clinical need to those with particular health problems; these are not monitored for uptake as part of wider public health scrutiny.

It is important to note that the schedule will continue to change and evolve with the development of new vaccines and with ongoing evidence from surveillance of diseases. Changes are often widely reported in the press and sometimes cause some anxiety amongst the public and also in staff delivering the services.

The schedule may change to make sure individuals are protected against infections for as long as possible, for example, introducing a booster of pertussis (whopping cough) vaccine to teenagers and changing the schedule for meningococcal vaccination. HPV vaccination for boys may be recommended in due course, if it can be shown to be cost effective. These decisions are for the JCVI to make.

Questions to ask/consider?

1) Are staff locally aware of how to access the current schedule and where to look when things change?

2) Are staff locally aware of the local commissioning arrangements and who to contact for advice and support?

3) Are publicity campaign materials available? These are generally developed nationally and can be useful in raising awareness but there is also a need to ensure that professionals receive appropriate training to promote immunisation and support children, parents and adults taking up the offer to protect themselves.

4. How does your local authority know what the uptake of particular vaccines is in the local population?

Background and policy context

Data is key to understanding how successful local immunisation programmes are in protecting local people from preventable diseases through vaccination.

Different immunisations are reported through different data collection pathways, most of which involve an element of time delay between the immunisation being administered and recorded at a local level and the immunisation being reflected in local authority statistics. Data and reports for England on the coverage of vaccinations offered under the national immunisation programmes are available from PHE. [4]

Immunisation data for seasonal flu is the timeliest, collated via GP practice systems. Routine childhood immunisations are reported through the COVER system. The delay on this can be up to 18 months as the data is extracted based on the age of the child, not the chronology of the immunisation. For example, a child who is appropriately immunised at 12 months old with MMR will not be reflected in the statistics until they reach 24 months and are included in the 2 year old data cohort.

Despite various initiatives over the years there continues to be a wide variation of uptake to immunisation programmes across the country. Every effort should be made to ensure that all those eligible are offered immunisation. Some vaccines continue to be indicated even if they are not given at the ideal time. This would include vaccines such as MMR and tetanus. Some other vaccines may not continue to be indicated if the child has exceeded the aged where the risk is highest. This would apply to rotavirus and to childhood pneumococcal vaccines for example.

Questions to ask /consider?

1) What activities are in place to ensure these figures are increased to meet WHO “aspirational” targets?

The PHOF Data Tool [11] (under Indicator 3.03) enables an individual authority to “compare and contrast” data, across a spectrum of immunisation indicators, against their neighbouring authorities within the region and against an England average. Comparisons with ONS-defined peer authorities can be a very useful way of using this sort of data as this helps to lessen the impact of population factors (such as deprivation) and increase the impact of service differences. The following highlight the key areas to look at.

Children aged 0-5

2) What is the uptake of 2 doses of MMR vaccine in children at 5 years of age? WHO Europe has a regional goal to eliminate measles and rubella disease. [14] To achieve this, there is a recommendation of 95% coverage of two doses of measles-containing vaccine.

3) What are the uptake rates across the programme; 12 months – primary immunisation, 2 years – child immunisation course and 5 years – completed primary immunisations and boosters?

4) How is the local area performing against national standards for childhood immunisation? How well is the area performing both in absolute terms and in comparison to neighbouring/ peer authorities and to national rates?

5) Is practice level data fed back to practices on a regular basis? Do practices know how well they are doing in comparison to national targets and to neighbouring practices?

School-aged children

6) What is the uptake for HPV vaccine and how well is the area performing both in absolute terms and in comparison to neighbouring/peer authorities and to national rates?

7) What is the uptake for the teenage booster vaccine and how well is the area performing both in absolute terms and in comparison to neighbouring/peer authorities and to national rates?

8) What is the uptake for the Meningococcal ACWY vaccine, given as part of the teenage booster, and how does this compare to neighbouring/peer authorities and to national rates?

9) What is the uptake for the influenza vaccine given to school-aged children and how well is the area performing both in absolute terms and in comparison to neighbouring/peer authorities and to national rates?

Adult vaccines

10) What is the uptake locally for the seasonal flu vaccine and how does this compare to neighbouring and/or similar areas?

- in those aged 65 and over,
- in those in clinical at-risk groups,
- in pregnant women,
- in carers in receipt of an allowance
- in local health and social care staff

11) What is the uptake for the adult pneumococcal vaccination and how well is the area performing both in absolute terms and in comparison to neighbouring/peer authorities and to national rates?

12) What is the uptake for the shingles vaccination and how well the area is performing both in absolute terms and in comparison to neighbouring /peer authorities and to national rates?

13) What is the uptake for the pertussis vaccination in pregnancy and how well is the area performing both in absolute terms and in comparison to neighbouring /peer authorities and to national rates.

5. Why and when should children aged 0-5 years receive vaccinations?

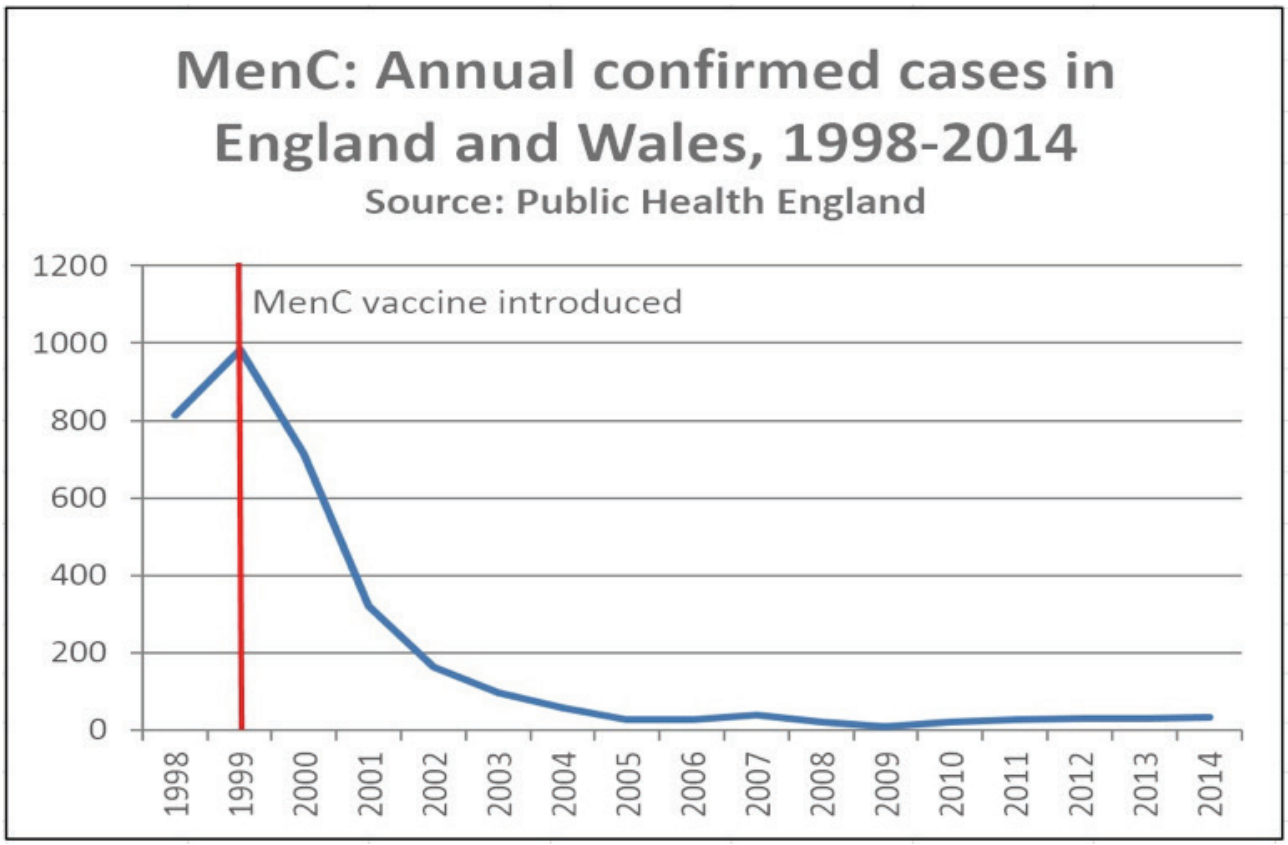
Background and policy context

The childhood immunisation programme in the United Kingdom (UK) protects young people against a wide number of infectious diseases, such as measles, polio, diphtheria and pertussis (whooping cough). What has been forgotten is how, in the past, large numbers of children either died or were left with permanent damage to their health and wellbeing because of these infections and their complications. The success of the immunisation programme can reduce the perception of the severity of these diseases both with the public and amongst health professionals.

The immunisation programme is an essential part of protecting children's health. Low vaccine uptake puts children at risk, particularly in view of recent outbreaks of measles, mumps and pertussis.

As examples, it is worth noting that:

- Before the introduction of MMR vaccine in 1988, approximately 1,200 people across England and Wales were admitted to hospital each year because of mumps. [8]
- Since 2000, the Meningitis C vaccination programme has prevented over 9,000 cases of serious disease and more than 1,000 deaths. There have been only 2 deaths in children and young people under 20 in the last 5 years, compared to 78 deaths the year before the vaccine was introduced. [8]



- Before the introduction of the haemophilus influenzae type b (Hib) vaccination in 1997, one in every 600 children developed Hib meningitis or other serious forms of disease before their fifth birthday. Today, there are only a handful of cases in young children. [8]

Vaccines should be given as soon as a child reaches the age at which the vaccine is indicated. Generally young infants are most at risk and therefore the majority of vaccines are given in infancy and childhood.

The schedule is complex, with boosters and repeat doses recommended during the child's life to complete the programme and maximise protection.

Where children are born in other countries they should be offered relevant vaccinations to bring them into line with the UK schedule as quickly as possible. Wherever possible the vaccines should be given together to minimise the number of appointments the child needs to attend.

Guidance on this is clearly detailed in the Green Book [8] and in a specific PHE resource vaccination of individuals with uncertain or incomplete immunisation status. [15]

Questions to ask/consider?

1) What structure is in place to achieve oversight, monitoring and coordination of services (e.g. a local strategy and/or implementation committee)? Are the responsibilities of those involved clearly defined?

2) What arrangements are in place to provide appropriate, regular reports to the local authority, CCG, Children's Trust Board, HWBs etc. about local providers' performance?

3) Are local immunisation providers aware of new structures, sources of expertise and key contacts?

4) The majority of vaccines at this age are given in primary care, are the mechanisms between primary care and the local CHIS system robust to ensure accurate data transfer so the figures reported are correct?

5) Who is responsible for inviting children for their routine immunisations? If it is general practices do we know that every practice is actively inviting children at the correct time for each vaccine? If invitations come from the child health information system are we sure their registers are complete and that they are calling children at the correct time?

6) Do we know if any practices have waiting lists for routine childhood immunisations?

7) Do the local systems enable opportunistic and catch-up vaccination?

8) Many practices have fixed immunisation clinics, for example, every Tuesday morning. Are practices able to offer appointments at other times if parents are unable to attend the fixed clinic?

6. Why and when should school-aged children receive vaccinations?

Background and policy context

Vaccines given to school-aged children are part of the wider schedule, giving boosters for certain vaccines given first in early childhood and infancy or specific vaccines recommended to be given at this age. The timing of when to give vaccines is often a balance between when the disease is most likely to be contracted and the age when the vaccine would be most effective. Vaccines are given in early childhood to provide timely protection at a time when they are most vulnerable. As the immune system matures through childhood and into teenage years, boosters of vaccines given in early childhood prolong the longevity of the protection, thus ensuring that protection against these infections lasts through to adulthood.

The meningococcal ACWY vaccine which is given alongside the teenage booster for diphtheria, tetanus and polio will enhance the protection against the meningococcal C serotype, from the vaccines given to children in early childhood, and add protection against A, W and Y serotypes. Vaccines are also given to school-aged children because this is the most appropriate age; for example the HPV vaccine which protects against cervical cancer and is given to teenage girls before the age when they are likely to become infected. The influenza vaccine for children is given in primary care settings to those in early childhood and then normally in school as children gets older.

In terms of access it makes sense to give vaccines at a venue where children already are. This helps improve uptake and makes it as easy as possible for individual children to be able to benefit, preventing additional appointments out of school and potential time out from the school day.

It is important that records of vaccines given at school are shared with each child's GP so that their patient records are kept up to date. The information also needs to be recorded on the CHIS system. For vaccines given in primary schools, written parental consent is always sought in advance and vaccines will not be given without this being available. For children in secondary schools written consent is normally sought in advance involving both the parent/guardian and the young person. On occasions, if a young person wishes to receive a vaccine and is considered to be 'Gillick' competent, a vaccine may be given in the absence of parental consent. [16]

The process for school-based vaccination requires close liaison between the service providing the vaccination (often but not always the school nursing service), the schools, parents or guardians and the children or young people themselves.

It needs to consist of a process for advising parents and guardians and the school staff and gaining consent. It requires administration for the vaccination sessions, arranging appropriate times in liaison with the school to avoid for example school examinations. School-based vaccination sessions also need to consider the practicalities of providing a clinical health procedure in school such as maintaining infection control, having a process for transporting vaccines so that they stay at the correct temperature, this normally requires the use of appropriate medical cool boxes. It also needs to consider the disposal of needles and syringes, so having appropriate sharps disposal.

The school-based sessions, as well as at school entry at reception and year 7 or whenever the child joins the school, are good opportunities to check on the child's immunisation history and can serve as a useful reminder to parents or guardians. Similarly school trips can be helpful in checking the child is fully protected. For many vaccines it will still not be too late if the child has previously missed out and parents or guardians can be advised to go to their GP surgery. Given the complexity it may be appropriate, depending on the staff and service available, to think of what other health promotion could be built in around these sessions.

Questions to ask/consider?

1) Are vaccines for school-aged children given in a school setting or by general practice?

2) If not given in school how is the access for children ensured so they do not have to miss too much school. For example, is there provision for evening and weekend clinics?

3) If given in schools, are all schools included (e.g. academies, public schools, independent schools, special schools etc)?

4) Are there any schools that do not allow immunisation sessions within the school? If so, what arrangements are in place to offer the children a service?

5) How are those not at school on the day offered a service, for example those who are sick, are home educated or attend pupil referral centres?

6) If children miss the opportunities in school can these vaccines be given in general practice, if necessary?

7) Are health screens used to check on immunisation history at school entry or for school trips?

8) Do schools use health promotion opportunities on, for example, school admission documentation on which vaccines children should have received with advice on where to go?

9) Do local services support young people to check they are fully immunised before leaving school?

7. Why and when should adults receive vaccinations?

Background and policy context

Immunisation is often seen as the domain of children, however, immunisation should be seen as a necessary intervention across all stages of life, as part of a life course approach.

Analysis from Age UK, [17] demonstrate that the population is ageing rapidly. There are currently approximately 15 million people over 60 years of age and the projections estimate that this will rise to 20 million over 60 by 2020. By 2040, 24.2% of the UK population will be aged 65 or over and the number of people who are over 85 will more than double. Evidence demonstrates that older people are at greater risk of morbidity and mortality from vaccine-preventable diseases. Research from the University of Birmingham has identified several reasons why vaccination is increasingly important within older age groups: [18]

- Older people may be at increased risk of serious illness or death resulting from certain common infections.
- Immune function decreases with age, leading to increased susceptibility to more severe and frequent infections.
- Older people may not have received immunisations in younger years and newer vaccines may not have been available to them when they were children.
- Boosters may be recommended for immunity that decreases with age.

As well as the increase of co-morbidities, increasing frailty and moving to institutional living, where infections are more easily transmitted, may also be contributing factors.

Adults require protection against vaccine-preventable disease when travelling – this increasingly includes those "Visiting Friends and Relatives" (VFR) as well as trips for business or holiday. While many of the vaccines recommended for travel are not covered by the NHS, it does provide an opportunity to make sure adults are up to date with the routine scheduled vaccinations.

The Best Practice Guide 'Vaccination programmes in older people' from the UK British Geriatric Society [19] recommends greater emphasis on vaccination in older people. It is recognised that while the immune response to vaccines is less than in younger people there is good evidence that they can significantly reduce the impact of infectious illnesses and therefore should be actively promoted. There has also been a call for a life course approach to vaccination by the International Longevity Centre UK [20] as an essential part of preventative health care across the population.

There is similar recognition from the EU that the older population is not properly protected from vaccine-preventable disease. [21] The WHO recommends that where national flu vaccination policies exist, strategies should be established and implemented to increase vaccination coverage of all people at high risk, including the elderly and persons with underlying diseases, with the goal of attaining vaccination coverage of the elderly population of at least 75% as well as in those under 65 years of age with clinical risks and for pregnant women and to also encourage healthcare workers to take up the vaccination. [22]

Herpes Zoster (shingles) vaccine is recommended for those aged 70 with a phased 'catch up' so that those up to 79 are offered the vaccine.

Vaccinations offered in pregnancy through the maternal vaccination programme include influenza, given during the flu season as pregnant women are at higher risk of complications that can threaten both mother and baby. Maternal vaccination also helps protect babies during the first few months of life when pertussis (whooping cough) can be a very serious illness.

Some vaccines are recommended for specific occupations to protect the staff but also the public from inadvertent cross infection. These include; health and social care staff, environmental health staff, laboratory technicians etc. These vaccines are the responsibility of the employer to provide and are not part of NHS provision. Apart from monitoring of the uptake for seasonal flu vaccination in health and social care staff, occupational health vaccination is not part of the NHS and as such detailed description of occupational health vaccination is not included in this guidance.

Whilst the UK is well ahead of most countries of the EU, with uptake of seasonal flu vaccination for the over 65 year olds at just below the WHO target of 75%, the uptake in certain groups remains inadequate, for example, frontline health and social care workers (HCW). 4

Questions to ask/consider?

1) What specific measures are in place to ensure that those older people who are living together in settings, such as long-stay residential care homes, are suitably immunised?

2) How are local services delivering immunisation to pregnant women? Are vaccinations available via midwifery services?

3) The Department of Health recommends that every employer has ambitious flu immunisation programmes for frontline health and social care workers to significantly improve upon their uptake; what is the % coverage rate for front line HCW staff in local primary and secondary care settings, and what activities are in place to ensure that this figure is increased? What initiatives are in place to ensure high coverage of HCW flu vaccination uptake?

4) Is there any local data relating to seasonal flu vaccination of frontline social care staff? If yes, how well is the area performing? If not, are there any plans to gather this important data in future?

8. Are sufficient measures being taken to ensure that local people are adequately protected from vaccine-preventable illnesses whilst abroad "Visiting Friends and Relatives" (VFR)?

Background and policy context

Travel, whether for leisure or business purposes or in order to visit friends and relatives, has steadily increased from the 1980s until now. Provision of travel vaccines as part of NHS core responsibilities is limited to diphtheria, polio and tetanus as a combined booster, typhoid, hepatitis A and cholera. [23] Other vaccinations for travel purposes may entail payment and not all primary care providers will wish to provide a service.

There are instances of mandatory vaccination for travellers. For example, Saudi Arabian authorities require those undertaking pilgrimage to Mecca to have certain vaccinations and vaccination against Yellow Fever (YF) is still required for travellers to many YF endemic countries or for entry into other countries for travellers arriving from YF endemic countries. General information on immunisation, travel advice and health risks when travelling overseas, can be found at the NaTHNaC (National Travel Health Network and Centre) website. [24]

Few of the health hazards associated with travel outside the UK are preventable by vaccination, however, those that can be prevented by vaccination can be very serious and potentially fatal.

Attendance for vaccination also offers the opportunity for the practitioner to offer additional travel health advice, particularly around malaria, food and waterborne illness such as salmonella and typhoid as well as HIV and other sexually transmitted diseases.

Questions to ask/consider?

1) Have there been any initiatives to make information available to members of ethnic minority communities about the need to seek health protection advice and services for those VFR travellers?

2) Do all practices actively promote travel advice and vaccination in their surgeries?

3) What means are taken to ensure that comprehensive education and awareness information is made available for those VFR, in order to promote correct messaging and encourage immunisation?

4) Do local pharmacies offer advice on protecting health when travelling abroad?

5) From a wider perspective, how much engagement takes place with religious community leaders to ensure that health protection messages around the benefits of immunisation are properly communicated and in turn cascaded out to their communities?

9. What policies are in place for the two childhood programmes that are offered to specific at-risk groups?

Background and policy context

There are two childhood immunisation programmes that are not universally offered to all but are offered to those at specific risk. These are the programmes for BGC vaccine for tuberculosis (TB) and hepatitis B vaccine to babies born to mothers who are infected with the hepatitis B virus.

BCG vaccine for tuberculosis

BCG vaccine used to be given to all children in their teenage years to help prevent TB in young adults. This strategy was ceased in 2005 due to a continuous decline in TB in the indigenous UK population and was replaced by a targeted approach. BCG should now be offered to the following groups: [8]

- All infants (aged 0 to 12 months) living in areas of the UK where the annual incidence of TB is 40/100,000 or greater
- All infants (aged 0 to 12 months) with a parent or grandparent who was born in a country where the annual incidence of TB is 40/100,000
- Children older than 12 months who have not been previously vaccinated, with a parent or grandparent who was born in a country where the annual incidence of TB is 40/100,000.

BCG is a difficult vaccine to give and most people who give other childhood vaccines are not trained to give BCG vaccine. It is important that staff who do give BCG vaccine are adequately trained in the specific technique.

The vaccine is shown to have varying efficacy. It is most effective at preventing the most severe forms of the disease, such as TB meningitis, in young children and this is the reason it is given in this context. It has limited effect on pulmonary disease which tends to affect older people.

Neonatal hepatitis B vaccine

All women who are pregnant are offered a blood test to see if they are infected with hepatitis B virus. It is not uncommon for people to become chronically infected with the hepatitis B virus and this poses a threat to the baby if the mother is infected in this way. If babies contract hepatitis B from their infected mother then 90% will themselves become chronically infected with the risk of serious liver disease later in life including cirrhosis and liver cancer.

Babies born to mothers who are known to be hepatitis B positive should be offered a course of hepatitis B vaccine with doses given at birth, 1 month, 2 months and 12 months, so four doses in all. The children should also be tested at 12 months to check whether they have become infected with hepatitis B. It is very important that these children receive all four doses of the vaccine in a timely manner. [8]

Questions to ask/consider

1) What BCG policy currently applies in the local authority area and why? Are all neonates offered BCG because it is a high prevalence area or is it offered only to those with a parent or grandparent from a high prevalence country?

2) If it is a targeted approach is there a clear and written pathway describing who assesses the need and who is responsible for giving the vaccine?

3) If eligible babies get discharged from hospital without receiving BCG vaccine what are the follow up and fail-safe processes to ensure that the child is offered the vaccine?

4) What data is available on the number of babies born in the area who are eligible for BCG vaccine and the number of these babies who received a BCG vaccine?

5) Is there a clear and written pathway for identifying babies born to mothers who are hepatitis B positive? Does this clearly identify the necessary communication required between maternity services, health visitors, general practice and child health information departments?

6) Who is responsible for scheduling each immunisation appointment and what are the failsafe procedures to ensure that children are not lost to the system?

7) What data is available on the number of babies born to hepatitis B positive mothers and the completeness of each eligible child's immunisation status?

8) Who is responsible for undertaking the blood test for each eligible child at 12 months and what proportion of these tests are completed?

10. How do you know vaccination is easily accessible to everyone in the population?

Background and policy context

Immunisation provides clear protection for the health of the individual; systematic and unjustified differences in immunisation rates between population groups should be viewed as an avoidable inequality in health.

For most immunisation programmes improving uptake impacts on the herd immunity. Reducing inequalities in uptake therefore also improves the overall effectiveness of immunisation and its health benefits.

There is a moral justification for reaching out to as many of those who can benefit from immunisation as possible. If some groups are systematically 'not reached' then services need to work hard to ensure that their offer is set out, or tailored, in the right way, so that the benefits of immunisation are clearly expressed and understood by the intended recipient groups.

The local JSNA may include case studies of inequalities in vaccinations and immunisations.

NICE guidance, [25] demonstrates the evidence which shows that the following groups are more likely to be at risk of not being fully immunised:

- Those who have missed previous vaccinations (whether as a result of parental choice or otherwise)
- looked-after children
- those with physical or learning disabilities
- children of teenage or lone parents
- those not registered with a GP
- younger children from large families
- children who are hospitalised or have a chronic illness
- those from some minority ethnic groups
- those from non-English speaking families
- vulnerable children, such as those whose families are travellers, asylum seekers or are homeless

Patient reminders and recall systems are also shown to be effective in developed countries such as the UK. [26]

Although population level coverage is presented in the PHOF national benchmarking tool, [7] coverage of vaccinations can be compared to other local authorities. The area statistics are not broken down by important inequalities groups. Therefore, monitoring uptake is not possible but HOSCs should consider how accessible and available the services are across the population.

Infectious diseases contribute to health inequalities. The burden of disease falls disproportionately on disadvantaged groups such as older people, the homeless and the chronically ill. [27] These vulnerable groups are also those most likely to be at risk of not being fully immunised.

The scrutiny needs to focus on what arrangements are there to identify patients who are resident within the area but are not registered with primary care providers. Although most people are registered with primary care providers, there are certain recognised groups who are known to fail to engage with services, including vaccination services. Those groups include the homeless, drug and

alcohol abuse clients, asylum seekers (either through fear of detection if staying illegally or through ignorance/lack of information about access to health services), traveller communities, those with learning difficulties, looked-after children, children excluded from school and young offenders.

Questions to ask/consider?

1) Has an equity audit been undertaken to understand different uptake of immunisation in different population groups?

2) Given the importance of repeated failure to attend immunisation appointments as a warning sign in several high profile child protection cases, how does the local immunisation programme integrate its safeguarding responsibilities around children who repeatedly do not attend immunisation appointments?

3) How are local GPs being encouraged and/or incentivised to achieve higher coverage?

4) How are the local GP practices being monitored and supported to ensure that 'early years' immunisations are optimised?

5) Are opportunities optimised to immunise immigrants from developing countries? And are translated materials or translator access available for immunisation appointments?

6) Is advice about vaccinations available and/or promoted at pharmacies, libraries, community centres, retail outlets, etc. (i.e. places other than those where vaccinations are given)?

7) Is enough being done to ensure people are fully able to access immunisation services? For example, weekend clinics and/or opportunistic services?

8) Is vaccination advised at other opportunities e.g. A&E, Outpatients, Developmental Assessments and Child Health Reviews, so that every opportunity is taken to identify unprotected individuals and advise on vaccination?

9) Can the Scrutiny Committee be reassured that providers;

- regularly review their arrangements to assess who is at increased risk of vaccine-preventable diseases?
- are making efforts to offer appropriate advice and services to the most vulnerable groups?

10) If there are homeless hostels or gypsy and traveller sites in the area, how is the immunisation programme making specific outreach and engagement efforts to provide services in these locations?

11) What arrangements/agreements are in place for dealing with single cases or outbreaks of communicable disease for which vaccination of contacts may be required? Does any agreement/ plan identify resources that can be mobilised, as required?

USEFUL LINKS

Inside Government – Gov.uk website

'The Green Book' ('Immunisation against infectious disease') has the latest information on vaccines and vaccination procedures for all the vaccine-preventable infectious diseases that may occur in the UK.

Available From:
https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

The complete immunisation schedule can be found at:

https://www.gov.uk/government/publications/the-complete-routine-immunisation-schedule

There are also other general and specific resources on vaccination including; training resources, Q&A documents, leaflets and posters.

Available From: https://www.gov.uk/government/collections/immunisation

PHE Vaccine uptake guidance and the latest coverage data

Vaccine coverage data reports for England of vaccinations offered under the national immunisation programme for;

- influenza,
- human papillomavirus (HPV),
- rotavirus,
- pertussis (whooping cough) for pregnant women
- shingles
- COVER data programme which evaluates childhood immunisation in England.

Available from: https://www.gov.uk/government/collections/vaccine-uptake

Health and Social Care Information Centre (HSCIC)

NHS Information Centre (for Health and Social Care) publishes uptake statistics on an annual basis which looks at the number of children who are immunised against childhood diseases by their first, second and fifth birthdays, those people over the age of 65 immunised against influenza and immunisation against tuberculosis (BCG).

Available from: http://www.hscic.gov.uk/searchcatalogue?productid=18810&topics=1%2fPublic+health%2fHealth+protection&sort=Relevance&size=10&page=1#top

Public Health Outcomes Framework

The Public Health Outcomes Framework, part of 'Healthy lives, healthy people: Improving outcomes and supporting transparency' sets out desired outcomes and indicators to provide an understanding of how well local public health is being improved and protected.

Available from: http://www.phoutcomes.info/

The indicators for 'population vaccination coverage' are under the health protection section covers all vaccination programmes across the life course.

Available from: http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000043

The on-line framework is set out as an interactive tool which enables an individual local authority to "compare and contrast" (across a spectrum of immunisation indicators) their performance against their neighbouring authorities within the region and against an England average:

NHS Choices

Set up as a first-line for information for the public and includes a comprehensive section on immunisations recommended across the life course. It includes which vaccinations are offered to all on the NHS, at what age, and the optional vaccinations for those considered at-risk.

Available from:
http://www.nhs.uk/Conditions/vaccinations/Pages/vaccination-schedule-age-checklist.aspx

NICE

PH21; reducing differences in the uptake of immunisations (issued September 2009, reviewed March 2013): Provides guidance on differences in the uptake of immunisations (including targeted vaccines) in people younger than 19 years. The guidance aims to increase immunisation uptake among those aged under 19 years from groups where uptake is low. It also aims to ensure babies born to mothers infected with hepatitis B are immunised.

Available from: http://www.nice.org.uk/PH21

Key Operational Documents

NHS England work closely with the DH in commissioning a number of public health services, including immunisation. Key documents that underpin these services are:

- The NHS Public Health Functions Agreement (Section 7a services), which is the annual agreement between the Secretary of State for Health and NHS England for these services. NHS England has a specific role to commission specific public health services set out in this agreement and DH is the overall steward of the system. The document includes links to specific services agreements for the various programmes
- The Immunisation and Screening National Delivery Framework and Local Operating Model sets out the national, regional, and local operational and governance arrangements for national screening and immunisation programmes in England.

These two documents are available from:
https://www.gov.uk/government/publications/public-health-commissioning-in-the-nhs-2015-to-2016

and https://www.england.nhs.uk/commissioning/pub-hlth-res/

GLOSSARY

Consent: Consent is legally required before a vaccine is given. Where vaccines are given to those under 18 the consent is usually sought from the parent or guardian. However, those aged 16 /17 are generally deemed able to consent without their parents express permission. Younger children can sometimes consent. 'Gillick competent' is the term used in medical law to decide whether a child, of 16 years or younger, is able to consent to his or her own medical treatment, without the need for parental permission or knowledge is (see the NSPCC website for further information on Gillick competence).

Diphtheria: Diphtheria is an upper respiratory tract illness caused by the bacterium Corynebacterium diphtheriae. It is a contagious disease spread by direct physical contact or breathing the aerosolised secretions of infected individuals.

'The Green Book': The Green Book is the popular name for the document 'Immunisation against infectious disease'; this is the policy document on the principles, practices and procedures of immunisation in the UK. The document provides details of the diseases, how they are spread and the history of vaccination. It is only available on line and can be found at: https://www.gov.uk/government/organisations/public-health-england/series/immunisation-against-infectious-disease-the-green-book

Hepatitis A: Hepatitis A is an acute infectious disease of the liver caused by the hepatitis A virus, usually spread through the faecal-oral route; transmitted person-to-person by ingestion of contaminated food or water or through direct contact with an infectious person (The Green Book, section 17).

Hepatitis B: Hepatitis B is an infectious inflammatory illness of the liver caused by the hepatitis B virus (HBV); the virus can be transmitted by exposure to infectious blood or body fluids such as semen and vaginal fluids, and also from mother to child around the time of birth (The Green Book, section 18).

Herd immunity: Herd or community immunity describes a form of immunity that occurs when the immunisation of a significant portion of a population provides a measure of protection for individuals who have not been vaccinated or developed immunity.

Human papillomavirus (HPV): While the majority of the nearly 200 known types of human papillomavirus (HPV) cause no symptoms in most people, some types can cause warts, while others can – in a minority of cases – lead to cancers of the cervix, vulva, vagina, and anus in women or cancers of the anus and penis in men. The virus can also cause head and neck cancers (The Green Book, section 18a).

Immunisation: Immunisation is the process by which an individual's immune system becomes fortified against an agent (known as the antigen).

Immunocompromised: A term used to describe the state in which a person's immune system is weakened or absent. This can be as a result of underlying disease or condition (e.g. HIV/AIDS, pregnancy) or as a result of treatment (e.g. chemotherapy, radiotherapy).

Influenza: Commonly known as flu, a viral infection that affects mainly the nose, throat, airways and, occasionally, the lungs. The influenza virus is transmitted easily from person to person via droplets and small particles produced when infected people cough or sneeze. Influenza tends to spread rapidly in seasonal epidemics

Joint Committee on Vaccination and Immunisation (JCVI): The Joint Committee on Vaccination and Immunisation (JCVI) is an independent expert advisory committee that advises Ministers on matters relating to the provision of vaccination and immunisation services. JCVI gives advice to Ministers based on the best evidence reflecting current good practice and/or expert opinion. The process

involves a robust, transparent, and systematic appraisal of all the available evidence from a wide range of sources. Members of the committee are appointed on merit by the Appointments Commission.

Measles: Measles (sometimes known as English Measles) is a highly contagious infection of the respiratory system caused by a virus, and spread though contact with fluids from an infected person's nose and mouth, either directly or through aerosol transmission.

Meningococcal disease: Caused by the bacterium, neisseria meningitidis, also known as meningococcus, there are 12 known different serotypes of which groups A, B and C account for about 90% of meningococcal disease. Recently there have been increasing numbers of cases attributed to the Y and W135 strains. Many people "carry" meningococci without suffering any harm, but meningococcal disease is uncommon. When it occurs, however, it is very serious and can cause meningitis and/or septicaemia. Even with the best treatment about 10% of cases will die; and a high proportion of the survivors will have long-term damage

Mumps: A viral disease caused by the mumps virus. Before vaccination, it was a common childhood disease worldwide. Painful swelling of the salivary glands (classically the parotid gland) is the most typical presentation a rash may also occur. The symptoms are generally self-limiting and not severe in children but can lead to complications in teenagers and adults.

Pertussis (whooping cough): Is highly contagious bacterial disease caused by Bordetella pertussis. Symptoms are initially mild, and then develop into severe coughing fits, which produce the characteristic high-pitched “whoop” sound in infected babies and children when they inhale air after coughing. The coughing stage lasts for approximately six weeks before subsiding

Poliomyelitis: Often referred to as polio or infantile paralysis, is an acute viral, infectious disease spread from person to person, primarily via the faecal-oral route

Rotavirus: Is highly infectious virus which causes gastroenteritis, characterised with fever and diarrhoea and vomiting. Prior to vaccination nearly all children under five would have at least one episode of rotavirus gastroenteritis.

Rubella: A disease caused by the rubella virus, and often referred to as "German measles". Usually mild symptoms and attacks can pass unnoticed or last one to three days. Children recover more quickly than adults. Infection of the mother by rubella virus during the first 16 weeks pregnancy can disrupt the development of the baby and cause a wide range of significant health problems

Shingles (Herpes zoster): Shingles is caused by the reactivation of the virus that causes chickenpox. Once a person has had chickenpox, the varicella zoster virus (VZV) lies dormant in the nerves and can re-emerge at a later stage as shingles. Shingles, characterized by a rash of blisters, can be very painful but is seldom life-threatening. Shingles is most common in people over age 60 or in those with a weak immune system

Tetanus: Caused by the Clostridium tetani bacteria and often referred to as "lockjaw", tetanus infection generally occurs through wound contamination and often involves a cut or deep puncture wound. As the infection progresses, muscle spasms develop in the jaw (hence the name “lockjaw”) and elsewhere in the body.

Tuberculosis: Tuberculosis (TB) is a contagious bacterial infection which usually attacks the lungs but can also affect other parts of the body. It is spread through the air when people who have an active TB infection cough, sneeze, or otherwise transmit their saliva through the air

Typhoid: A highly contagious bacterial disease transmitted by the ingestion of food or water contaminated with the faeces of an infected person, which contain the bacterium, Salmonella typhii.

Varicella (chickenpox): A highly contagious illness caused by primary infection with varicella zoster virus (VZV). It usually starts with a skin rash mainly on the torso and head and becomes itchy, raw

pockmarks, which mostly heal without scarring. Chickenpox is an airborne disease spread easily through coughing or sneezing of ill individuals or through direct contact with secretions from the rash. There are very limited rationale for vaccination against varicella for chicken pox in the UK.

Visiting Friends and Relatives (VFR): "Visiting Friends and Relatives" or "VFR" travel is travel involving a visit whereby either (or both) the purpose of the trip or the type of accommodation involves visiting friends and/or relatives.

World Health Organization, (WHO): The World Health Organization (WHO) is the directing and coordinating authority for health within the United Nations system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends. In the 21st century, health is a shared responsibility, involving equitable access to essential care and collective defence against transnational threats.

Yellow fever: Yellow fever is an acute viral haemorrhagic disease; the virus is transmitted by the bite of female mosquitoes (the yellow fever mosquito, Aedes aegypti, and other species) and is found in tropical and subtropical areas in South America and Africa, but not in Asia. The only known hosts of the virus are primates and several species of mosquito (The Green Book, section 35).

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SLOUGH BOROUGH COUNCIL

REPORT TO: Slough Wellbeing Board

DATE: 26 March 2019

CONTACT OFFICER: Dr Liz Brutus - Service Lead Public Health (SBC)
(For all Enquiries) (01753) 875142

WARD(S): All

PART I
FOR COMMENT & CONSIDERATION

WIDER DETERMINANTS OF HEALTH – PRIORITIES FOR SLOUGH

1. Purpose of Report

- To further develop and refine the discussion about the wider determinants of health (WDH) which worsen health and wellbeing and health inequalities in Slough. The original paper identifies up to 5 WDH which could be agreed to be prioritised amongst Board partners. (The choice of 3 of these WDH would allow some alignment with the chosen priority areas for the Frimley Integrated Care System (ICS)).

2. Recommendations

The Wellbeing Board is asked to:

1. Consider the 5 priority areas proposed for the wider determinants of health (which are based on the evidence and local data) and agree the priority one(s) to take forward.

3. The Slough Joint Wellbeing Strategy, the JSNA and the Five Year Plan

3a. Slough Joint Wellbeing Strategy Priorities

The current programme is aimed at supporting local residents to improve their health and wellbeing through improved prevention and early detection as provided through the national immunisation and screening programmes. This work supports all four of the Joint Wellbeing Strategy priorities:

1) Protecting vulnerable children
2) Increasing life expectancy by focussing on inequalities
3) Improving mental health and wellbeing
4) Housing

Some nationally prescribed data related to the wider determinants of health already contributes to our Joint Strategic Needs Assessment and identification of priority

areas will enhance that and our understanding of the needs and health inequalities of our population.

3b. **Five Year Plan Outcomes**

The primary outcomes where delivery will be enhanced by the paper are:

- Outcome 1: Slough children will grow up to be happy, healthy and successful
- Outcome 2: Our people will be healthier and manage their own care needs

However, depending on the choice of wider determinants prioritised, this may have direct and indirect impacts on achievement of Outcomes 3, 4 or 5.

Outcome 3: Slough will be an attractive place where people choose to live, work and visit
Outcome 4: Our residents will have access to good quality homes
Outcome 5: Slough will attract, retain and grow businesses and investment to provide jobs and opportunities for our residents.

4. **Other Implications**

(a) Financial
There are no financial implications directly resulting from the recommendations of this report and outlined activities are within the current budget and resources.

(b) Risk Management - None
There are no identified risks associated with the proposed actions.

(c) Human Rights Act and Other Legal Implications
There are no Human Rights Act implications to the content of this report

(d) Equalities Impact Assessment
The content of this report does not require an Equalities Impact Assessment.

5. **Supporting Information**

Context

5.1 The Slough Wellbeing Board has been considering how best to tackle the wider determinants of health (WDH) and where best to prioritise and focus action in order to reduce health inequalities. The Board recognises the various other, sometimes competing, strategic drivers and priorities across member organisations (including the Frimley Health and Care Integrated Care System (ICS)) and its role in building consensus and providing leadership to agree a shared focus of energy and resources for Slough.

5.2 The attached paper outlines the rationale for 5 options for wider determinant topic areas which may have varying appeal to Board members. (There is a more extensive appendix to the original paper which outlines the evidence, local data and some known local activity.) The first three priorities have been proposed at a Frimley 'system' level but recognising Slough's local 'place' priorities, 2 further possible

options - employment and business and serious youth violence have also been proposed. In total, the 5 priority options are:

1. Housing
2. Planning
3. Asset based approach to support community health/wellbeing/resilience:
4. Employment and Business
5. Serious youth violence

5.3 It should be noted that Housing is already one of the Wellbeing Board's chosen strategic priorities.

5.4 The Health and Care Partnership Board considered this paper on Mon 25 Feb 2019 and with the NHS and Slough Borough Council (SBC) colleagues present, were able to agree on a focus around asset based community development. This priority already resonates with a recently proposed partnership between SBC, East Berkshire CCG and Slough CVS with Oasis, a non-governmental organisation (NGO) who specialise in community-embedded work at a national level.

5.5 The asset based community development also chimes with the Council's near-finalised Five Year Plan which includes piloting community development amongst 3 more deprived areas in Slough as part of its work to create 'strong, healthy and attractive' neighbourhoods. From previous discussions at the Wellbeing Board, there would also appear to be potential harmony with other Board Members' existing strategic drivers around building community and shifting the focus towards strengthening communities' capacity to support themselves.

6. Comments of Other Committees

6.1 The paper was considered by the Health and Care Partnership Board on 26 Feb 2019 as outlined in para 5.3. Following discussion, the Board agreed on one priority wider determinant - asset-based community development. A task & finish group is to be convened to consider scoping this work but informed by the Wellbeing Board's selection of priorities.

7. Conclusion

7.1.1 The Wellbeing Board is keen to provide leadership and gain consensus around tackling some of the wider determinants of health with the recognition of their beneficial impact on reducing health inequalities.

7.1.2 Five potential priority wider determinants of health (WDH) which impact health and wellbeing in Slough are proposed. Housing is already a priority of the Wellbeing Board. The first three allow full alignment with Frimley ICS – housing, planning and asset based community development. In addition, employment and business and serious youth violence have been proposed to reflect Slough's particular local needs.

7.1.3 The Board is asked to consider these wider determinants – do they feel like the right ones for Slough; which one(s) will we focus on?

8. Appendices

1. Wider determinants of health: Priorities for Slough paper. Dated 15 Feb 2019.

9. Background Papers

None

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Wider Determinants of Health: Priorities for Slough Health and Care Partnership Board

Aims: This paper aims to propose the next steps for taking forward the Wider Determinants of Health (WDH) in Slough Health & Care Partnership Board, to support similar discussions within Slough Wellbeing Board and to create alignment with proposals within the Frimley Integrated Care System (ICS).

Rationale:

As described in a previous paper to the Board (Aug 2018 – See Appendix 1), the wider determinants of health are important if we are to improve the length and quality of life experience by local people. Wider determinants of health have the biggest impact on health outcomes, with factors such as education, employment and income contributing to 40% of health outcomes (length and quality of life). This is closely followed by health behaviours (30%), such as smoking and alcohol; with access and quality of clinical care only contributing to 20% of outcomes; and the built environment contributing 10% to health outcome.

Public Sector organisations can influence the local environment and make healthy lifestyle choices an easier option, for example good access to green spaces can provide opportunities for people to be physically active. In this way they can support both (1) self-care - the actions that individuals take for themselves to develop, protect, maintain and improve their health and wellbeing; and (2) help to address health inequalities through enabling equal opportunity to lead a healthy life. Therefore, Public Sector organisations have a vital role to play in addressing the wider determinants of health, supporting a good start in life and enabling individuals, families and communities to reach their full potential.

The recently published NHS 10 year plan includes a clear focus on 'prevention, personal responsibility and health inequalities' and supports the way we were already moving towards in Slough. The explicit inclusion of inequality comes at the same time as an increasing national focus on the wider determinants of health, such as poverty, education, employment, social isolation and the environment (Kings Fund, 2018). The plan sets out the role the NHS must play in delivering the wider determinants of health, including improving air quality, in partnership with local government and communities at place.

3 Key priorities for Frimley + Considering 2 extra priorities for Slough:

Public Sector organisations, along with third sector organisations, will play a key role supporting the preventative agenda within both Slough and the Frimley Integrated Care System[1] (ICS). Closer collaboration and partnership working with Health and Social Care Board, will facilitate a more holistic, joined up approach to managing the health and wellbeing of all residents.

In order to provide focus on the wider determinants of health for all stakeholders within the coming year, it is envisaged that within the Frimley ICS, Public Sector organisations will initially concentrate on three priority areas: housing; planning; and an asset based approach to support community health, wellbeing and resilience. However, there is recognition that this will not be to the exclusion of identified opportunities in other areas.

[1] Integrated Care Systems (ICSs) are evolved versions of STP partnerships, working as locally integrated health systems – including commissioners, providers and local authorities - taking on clear, collective responsibility for local resources and population health. Surrey Heartlands is one of 14 ICSs nationally.

In Slough, we should consider whether we would like 2 additional or alternative priority areas; business and employment (given the particular opportunities in Slough to improve health through both workplace health and better jobs and drawing from connections with the Slough Trading Estate) and tackling youth violence (which is increasing in Slough and would require close working with the Safer Slough Board).

Set out below are proposals for how the WDH priorities could be taken forward, using opportunities within existing forums to move the agenda forward across Slough.

Moving forward

Public Sector organisations, along with third sector organisations, will play a key role supporting the preventative agenda across Slough. Closer collaboration and partnership working with Health and Social Care, will facilitate a more holistic, joined up approach to managing the health and wellbeing of all residents.

In order to provide focus on the wider determinants of health for all stakeholders within the Frimley ICS over the coming year, it is envisaged that Public Sector organisations will initially concentrate on three priority areas: housing; planning; and an asset based approach to support community health, wellbeing and resilience. This will not be to the exclusion of identified opportunities in other areas.

1. **Housing** - adoption of recommendations contained within the Kings Fund Housing and Health Paper March 2018[2] which include; housing options to support discharge from hospital; strategic use of NHS estates, considering opportunities for extra care housing; and good quality supported housing to support independent living in the community for people with mental health problems. Slough has a particular problem with rough sleepers.
2. **Planning** - influence the wider determinants of health through the built and natural environments and develop channels to strengthen health and social care input into local infrastructure planning; use of s106 money; opportunities to influence Slough's regeneration and Heathrow Airport developments.
3. **Asset based approach to support community health/wellbeing/resilience** - maximising opportunities to link local assets through more integrated lifestyle services and/or Social Prescribing Model

Two additional possible priority areas in Slough include:

4. **Employment and Business** – Use of Public Sector in Slough as 'anchor institutions' promoting good workplace health, work conditions and inclusive employment; working with large and smaller businesses in Slough with a similar approach; building greater linkage with DWP (JobCentrePlus) to support inclusive employment, close disability gap in Slough and enable fuller employment especially for people with mental health conditions.
5. **Serious youth violence** – In collaboration with the Safer Slough Partnership, use Health and Care Public Sector in Slough to tackle some of the risk factors for serious youth violence including approaches to improving the best start in life; identifying and tackling child poverty; and adequate provision for earlier management of emotional and conduct disorders in 5-16 year olds.

[2] Available at: https://www.kingsfund.org.uk/sites/default/files/2018-03/Housing_and_health_final.pdf

Appendix 2 sets out the rationale for Slough, where activity is already happening in the borough and what the NHS Long Term Plan writes on the issue. Action plans for each priority area could be developed in the coming months in consultation with H&C Partnership partners.

How will we measure impact/progress?

Metrics to measure progress and impact of action will be developed alongside the action plans for each chosen priority area. For overarching metrics, we will use the below indicators to measure long term impact:

- Life expectancy at birth for males and females
- Inequality in healthy life expectancy at birth for males and females

Life expectancy provides a good single measure of how healthy a local population is, with differences in life expectancy one way of showing the extent of health inequalities between groups of people. *Healthy life expectancy* is an estimate of the number of years individuals can expect to live in good or very good health, based on subjective assessment of health. Both are good summary measures of improving health of the local population.

Questions for the Slough Health and Care Partnership Board:

1. There are 5 priority areas presented; which ones should we focus on in Slough?
2. How best can we ensure alignment with the Slough Wellbeing Board?

Way forward
It is recommended that once priority areas have been agreed, we identify leads for each of the chosen areas to work with relevant council and CCG colleagues and develop a brief (1-2 side) scoping document which outlines the opportunities and next steps in more detail.

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Acknowledgement: This paper is based on “Frimley ICS Wider Determinants of Health” written by Helen Atkinson, DPH Surrey County Council (Joint SRO – Frimley ICS Prevention & Selfcare Workstream)

Appendix 1: ‘Tackling Slough’s health inequalities and wider determinants of health: Considerations for Slough Wellbeing Board and Frimley Integrated Care System’ – Aug 2018:

Appendix 2: Table showing summary of rationale, alternative options and what the NHS Long Term Plan says for each of the 5 priority areas.

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Tackling Slough's health inequalities and wider determinants of health: Considerations for Slough Wellbeing Board and Frimley Integrated Care System

Author: Dr Liz Brutus, Consultant in Public Health, Public Health, Slough Borough Council
Date: 31 Jul 2018

Purpose of paper

1. This paper discusses how Slough's Wellbeing Board and Frimley Health and Care Integrated Care System (Frimley ICS) can contribute to tackling health inequalities and targeting the wider determinants of health. Learnings from Slough are likely to have implications for other areas of deprivation and health inequality across the Frimley ICS footprint. The paper attempts to outline the balance of where work is best done – trying to tease out what lends itself to the ICS level in a "do once and share" approach versus the local level.

Background

2. The recent work of PHE South East (PHE SE) presented by Don Sinclair, has highlighted some of the stark differences in the distribution of both life expectancy and certain health conditions, depending on where you live in the ICS footprint (and by proxy, your socioeconomic status). In short, as seen nationally, across the ICS, the better off you are, the better your health and the longer you live. In contrast, the less money you earn, the worse off you are with earlier and more frequent ill health and a shorter life overall.

3. Most health inequalities[1], both across Slough and between Slough and other Frimley ICS areas, have not improved and for many issues, have worsened. As a result we need to refocus our priorities and actions.

4. At present, ward-level health data is not yet routinely presented for the Frimley ICS footprint. However, based on the PHE SE analysis, in this paper, where available, Slough's Britwell & Northborough (B&N) and Bracknell Forest's Warfield Harvest Ride (WFR) wards have been used to illustrate the differences in health outcomes between deprived and affluent areas across the ICS. Frimley ICS consists of some 110 wards, with Slough wards consistently over-represented for being in the lowest quintile of health outcomes – whatever the health condition.

Describing health inequalities in Slough

5. The health inequalities described by PHE SE predominantly demonstrate the differences in health experience by socio-economic deprivation. However, in general, health inequalities can also be seen between ethnic minorities, those living with disability (particularly where there is mental illness or learning disability), people whose sexuality is other than heterosexual and in short, amongst any group where stigma or discrimination is more common. In addition, there may be complex interactions amongst people with more than one such characteristic and/or poor socioeconomic status, whose health outcomes can be particularly poor.

[1] Health inequalities are differences between people or groups due to social, geographical, biological or other factors. These differences have a huge impact because they result in people who are worst off experiencing poorer health and shorter lives. (NICE)

6. There is a social gradient in pretty much any health measure but in Slough, we see these health inequalities across the life course, particularly in:
   - Children's poor early start with persistently high levels of childhood overweight and obesity, low physical activity, poor oral health, low immunisation rates and maternal mental health problems. (This is especially significant as a good start in life can positively disrupt a cumulative cycle of disadvantage and poorer health outcomes over a person's whole life.)
   - Working age adults with:
     - High rates of overweight , obesity and inactivity which, in Slough's population with a large population of people with South Asian heritage, is associated with high rates of diabetes;
     - Higher smoking rates (16.6% in Slough vs eg 11.2% in Windsor and Maidenhead / 10.9% in Surrey). Knock-on effects include the higher rates of smoking-related hospital admissions – 1,847/100,000 in Slough vs 1,051/100,000 in Windsor and Maidenhead, worsening over winter.
     - High rates of un-diagnosed hypertension and chronic obstructive pulmonary disease (COPD) (and to a lesser extent, undiagnosed diabetes and atrial fibrillation) which all contribute to the high rates of emergency adult admissions overall;
     - In particular, we see a 7-fold difference between e.g. B&N and WHR in premature deaths (i.e. under 75s) due to coronary heart disease (CHD). Slough has more than twice the death rate than the England average and this is strongly related to high rates of historically undiagnosed or poorly managed diabetes, hypertension and smoking.
     - In addition, a smaller number of working age people in Slough experience high rates of TB (almost unseen outside of London), late diagnosed HIV, substance misuse and mental health problems which are also important markers of social disadvantage and stigma.
   - Older people in Slough have higher rates of social isolation with more pensioners living alone (42.5% vs 26.3% in WHR and 31.5% in England). Social isolation is associated with both poorer mental and physical health.

Wider determinants of health and their impact on health inequalities

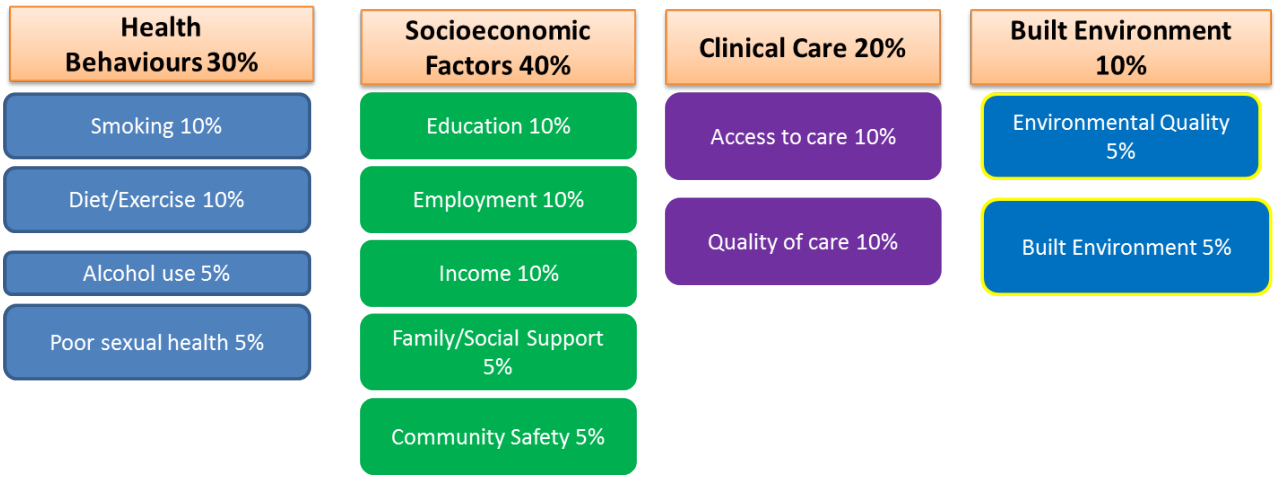
7. Individuals are at the centre of their health and bear responsibility for it and the health behaviour choices they make but this is not the whole story. As can be seen in Figure 1 below, factors outside an individual's control also affect their health – for example, including their access to health care, employment status, their working or educational environment (from whether physical safety is protected through to whether their line manager or head teacher pays attention to employee or student mental wellbeing) and air quality. For example, Slough has considerably higher rates of air pollution than other areas in the Frimley ICS footprint and this has an impact on conditions and associated hospital admissions due to childhood asthma, COPD and CVD.

8. In comparison to most localities in the ICS footprint and despite the number of successful business start-ups, being the most productive town in the UK[2] and attracting new businesses at a faster rate than anywhere else in the UK, Slough's resident population is disproportionately over-represented by low to low-middle-income households. Many of

[2] Centre for Cities, 2017

Slough's population experience high levels of in-work poverty - a barrier for people wanting to take action towards their goals. Around a million workers in England claim benefits each year because their income is so low. The jobs tend to have short-term prospects and few, if any, benefits such as sickness or maternity cover. This can create a cycle where workers move between work and worklessness (known to some as the 'lobster pot'), in which it is hard for people to find the time, energy or money to build their confidence or skills to break out of this cycle.[3]

Figure 1: Factors contributing to overall health outcomes



Source: Robert Wood Johnson Foundation

9. Income deprivation affects 21.3% of B&N's population in comparison to an England average of 14.6% and WHR's 3.0%. Overall income levels also affect basic decisions which affect health. These range from decisions about food (we have seen the rise in foodbank use in Slough and other less affluent areas), quality of housing, home heating, transport and homelessness (both of single people and families). Income also affects more subtle issues such as social engagement and a person's sense of personal control in being able to improve any part of their lives - contributing to a negative cycle of limiting life circumstances.[4] Slough GP data show that patients don't feel confident in managing their own condition which suggests various factors including low sense of personal agency and poor health literacy consistent with a more deprived population.[5]

Why do health inequalities matter to Slough and to the Frimley ICS?

10. Health inequalities matter for a variety of reasons; at a moral level, for their unfairness to the individual and the kind of society we want. However, inequality impacts not just health but crime, educational achievement and social cohesiveness.[6] At an economic level, there is

[3] H Khan et al. Good and Bad Help: How purpose and confidence transform lives. NESTA. 2018. Available at: https://www.nesta.org.uk/report/good-and-bad-help-how-purpose-and-confidence-transform-lives/
[4] R Wilson, C Cornwell et al. Good and Bad Help: How purpose and confidence transforms lives. NESTA. Feb 2018. Available at: https://www.nesta.org.uk/report/good-and-bad-help-how-purpose-and-confidence-transform-lives/
[5] Slough CCG Profile. 2017. Berkshire PH Shared Team Informatics. Available at: http://www.slough.gov.uk/council/joint-strategic-needs-assessment/slough-ccg-profile.aspx
[6] K Pickett, R Wilkinson. The Spirit Level: Why equality is better for everyone. (Allen Lane 2009)

the 'double whammy' of premature ill health and death resulting in lost productivity (and tax revenues) while associated with additional social care, health and welfare costs.

11. Given the proposed financial connectedness of all the organisations and areas within the ICS footprint i.e. 'we're all in it together', we need to look for opportunities to reduce or delay the additional health and social care costs associated with health inequalities above and beyond the well-described challenges associated with an ageing population.

12. Fortunately, ill health and rising care demands are not inevitable results of either age or income. For example, in B&N, healthy life expectancy is 59.1yr whereas in WFR, it's 77.2yr[7] - a huge gap of 18.1yr. It's not age itself that drives ill health but cumulative social and health circumstances - many of which can be prevented or at least delayed through supporting everyone to live and age better. There is an established and growing evidence-base on what can be done. The NHS's Five Year Forward View recognised this and called for a 'radical upgrade in prevention'. (However, recognising the difficulties in delivering prevention more consistently across the NHS, the All Our Health Framework[8] for frontline staff was published in 2018.)

13. One particularly knotty issue which will likely present a political challenge to ICS partners is how these health inequalities are addressed and the level of investment distributed. Marmot[9], whose seminal review of health inequalities for Government in 2010, recommended that action should be taken for all but for those with the most need, more must be done – so-called 'proportionate universalism'. In reality, in order to address the inequalities across the footprint, this will mean that areas of deprivation and greater health inequality including but not limited to wards in Slough, will need higher levels of investment than their wealthier and healthier areas and resident populations.

What's being done in Slough already to tackle health inequalities?

14. Much of the work of Slough Borough Council implicitly addresses the wider determinants of health within the constraints of its central government funding which has been halved over the period 2010/11 to 2017/18.[10]

15. There are ambitious plans for the town's future which include regeneration of the town centre, the arrival of Crossrail and a potential third runway at Heathrow. Alongside investment in transport, housing, schools, community buildings and leisure facilities these developments will bring benefits and opportunities to residents and communities.[11]

16. For example, Slough schools rate highly in working to close the gap in educational attainment between children receiving free school meals (a marker of income deprivation)

[7] ONS life expectancy tool. Available at: https://www.ons.gov.uk/visualisations/dvc479/map/index.html
[8] All Our Health. Available at: https://www.gov.uk/government/publications/all-our-health-about-the-framework/all-our-health-about-the-framework
[9] M Marmot et al. Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England Post-2010. Available at: http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review
[10] https://www.local.gov.uk/parliament/briefings-and-responses/debate-reductions-local-government-funding-house-common
[11] Slough Borough Council. Slough Story. 2017.

and those without FSM and have increasingly high overall attainment for all. There are low levels of NEETs (young people not in employment, education or training).

17. Work on housing, adult education, parks and green space, leisure facilities, support to community groups and community development all contribute to close the gap and in particular, have significant benefits to mental health and wellbeing which, in turn, beget better outcomes in employment, education and other elements of health.

18. Recognising the relationship between non-health factors on improving health, especially in tackling issues such as loneliness and social isolation's damaging effects, the work of Slough's voluntary and community sector is vital. The move towards more social prescribing[12],[13] (largely delivered by the SPACE Consortia[14] (Slough Prevention Alliance Community Engagement)) is promising.

19. Within the limits of the reducing Public Health ring-fenced grant for Slough, there remains a fairly broad programme of preventive work aimed at the individual across the life course and which largely correspond to the health needs identified in Slough within the Joint Strategic Needs Assessment[15]. However, with a shrunken and activity-driven budget, the PH offer probably lacks the required scale for radical change.

20. The Public Health services range from the provision of the 0-19 Service (of health visitors and school nurses), lifestyle behaviour change services across the lifecourse, promoting, for example, healthy eating, greater physical activity, better mental health, smoking cessation, safer reproductive and sexual health and the provision of a substance misuse service.

21. The CCG have been working to 'close the prevalence gap' with earlier diagnosis and tighter management of diseases which both drive unplanned emergency admissions and reflect the strong social gradient of health inequalities. In particular, these include coronary heart disease, diabetes, asthma and COPD – all diseases that are more common (or have worse impact) in less affluent populations.

22. In addition to various East Berkshire CCG programmes of work (including NHSE Right Care) which have looked to reduce the clinical variation across specific health pathways, the Frimley ICS includes the 'Reducing Clinical Variation' workstream with various sub-streams of that including maternity, diabetes and cardiovascular pathways which have particular relevance for Slough residents.

[12] Social prescribing, sometimes referred to as community referral, is a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services. Kings Fund
[13] What is social prescribing? Kings Fund. 2017. Available at: https://www.kingsfund.org.uk/publications/social-prescribing
[14] SPACE. Available at: https://spaceslough.org.uk/
[15] JSNA – Slough 2018. Available at: https://www.slough.gov.uk/council/joint-strategic-needs-assessment/jsna-summary-and-why-we-need-it.aspx

23. Furthermore, the Frimley ICS 'Prevention and Self Care' workstream is working to explore and develop opportunities which help tackle health inequalities such as community asset development.

What is best practice to address health inequalities?

24. There is a bank of evidence and commentary on 'best practice' available about how best to tackle health inequalities (including tackling the wider or social determinants of health). However, it is also recognised that each local system will have its own unique interplay of complex factors and that given this complexity, different interventions have different time scales at which they operate over the short, medium and longer term.

25. This short paper does not intend to cover the detailed evidence but instead highlights PHE's *Reducing health inequalities: system, scale and sustainability*[16] which provides an extensive review of the evidence and tools available.

Conclusion

26. Overall, while there has been fairly good investment in Slough to tackle the deeply entrenched issue of health inequalities and there has been some improvement in health outcomes, the health inequality gap between most wards in the borough and their more affluent neighbours in the ICS has barely changed, and perhaps, even slightly worsened.[17]

27. This suggests that we cannot continue to do things the same way if we want to see a step-change in closing the gap in health outcomes across both Slough and the ICS. Some of this step-change will require a change in culture and explicit decisions about how we work with residents.

28. However, in addition, there are very tangible actions that will need to be driven at pace and scale. This includes relatively greater investment in health and care spending in the more deprived wards in Slough and other areas or population groups with greater need – Marmot's 'proportionate universalism'.

Recommendations

29. Based on key elements of PHE's *Reducing health inequalities: system, scale and sustainability,* Slough Wellbeing Board in collaboration with its Frimley ICS partners, should consider the following:

A. Building understanding and planning change

1) Request access to population health data that matches the ICS footprint from PHE

A huge amount of data exists which provides information across the service user's journey, including for example, information on health and social care service usage and health and wellbeing outcomes. At present, the IT system *Connected Care* is still gathering momentum across the patch and in addition, access to data remains fragmented over different geographical

[16] Reducing health inequalities: system, scale and sustainability . PHE. 2017. Available at: https://www.gov.uk/government/publications/reducing-health-inequalities-in-local-areas

[17] PHE SE (Don Sinclair's slide set) 2018. (Awaiting publication)

levels, analytical teams and limited by various information governance issues. To support a better understanding and monitoring of health inequalities, an early recommendation/request to PHE would be to start presenting data wherever available at the ICS footprint geographical level while still maintaining sufficient granularity to at least ward level.

2) Improve understanding of residents and empower them

a. **Improve understanding of residents and the opportunities and challenges for better health and wellbeing**

In addition to service-related resident engagement, it would be valuable to conduct qualitative work to better understand how residents, particularly those experiencing health inequalities, consider their health and wellbeing and the factors (including use of health services) that affect it. Given the changing demographic in many areas of socioeconomic deprivation, both in Slough and other areas within the Frimley ICS, this should take into consideration important pyscho-social and cultural issues such as health beliefs, health literacy[18,19] and 'superdiversity'[20].

Any qualitative work should be solution-focused with a very practical view on how findings can be rapidly used to improve health and wellbeing eg using behavioural insights such as social marketing to increase uptake of preventive or selfcare-related health care and public health services.

b. Further develop co-production of services

Work more consistently with residents to design and produce services – both to improve the quality and effectiveness of services but also, because it helps empower residents and tackle health inequalities[21].

3) Develop strategy for tackling health inequalities at the appropriate level of action

The initial priority for both Slough Wellbeing Board and Frimley ICS should be on coming to a shared understanding of local health inequalities and in particular, the impact of the wider determinants of health.

Working with residents, we should develop strategy to tackle health inequalities in Slough and the other deprived areas of the ICS, addressing the wider determinants of health, and agreeing the level at which is most effective to act. Through stakeholder engagement, we will need to tease out what issues lend themselves to being dealt with at the ICS level in a "do once and share" approach vs what is best dealt with locally.

[18] 'Health literacy' refers to people having the appropriate skills, knowledge, understanding and confidence to access, understand, evaluate, use and navigate health and social care information and services. (PHE 2015)

[19] Improving health literacy to improve health inequalities. PHE. 2015. Available at: https://www.gov.uk/government/publications/local-action-on-health-inequalities-improving-health-literacy

[20] 'Superdiversity' encompasses the varied patterns of transnational migration, legal statuses, countries of origin, socio-economic statuses, linguistic abilities, cultural and ethnic factors that amalgamate to influence the health and health behaviours of people. (Vertovec 2006).

[21] Co-production catalogue. NESTA. 2013. Available at: https://www.nesta.org.uk/report/co-production-catalogue/

B. Interventions: Individual, Community and Locality levels of action

4) Further develop interventions at an individual level that tackle health inequalities

a. **Scale up provision of individual interventions** (such as developing through the 'Reducing Clinical Variation' workstreams).
For example:

i. **Close the prevalence gap of conditions** with a significant social gradient that drive the burden of ill health in more deprived geographical areas and 'at risk' groups including people with severe mental illness, learning disability and travellers. In particular, these include earlier identification of conditions such as undiagnosed hypertension, depression, COPD or diabetes. Poorly diagnosed conditions with a significant social gradient include learning and behavioural conditions and childhood asthma.

ii. **Scale up provision of healthy behaviour change** amongst the most socially deprived across Slough and the ICS – both in the 'well' population (primary prevention) and those already being treated by health and social care (secondary prevention). Residents at particular risk include people with mental health conditions and learning disability but each locality may have additional groups. Smoking, physical inactivity and obesity remain the most significant of these unhealthy behaviours.

iii. **Scale up provision of social prescribing** as a means of action at the individual 'patient level' to tackle the wider determinants of health.

b. **Scale up Making Every Contact Count (MECC)** (Already part of the Frimley ICS Prevention Workstream)
This supports professionals (including healthcare, social care and voluntary sector) to identify residents most in need of support to improve health and wellbeing and empowers the professional to have those 'healthy conversations'.

5) **Boost Asset-based Community Development** (already part of the ICS Prevention workstream)
Supported by PHE recommendations, this would empower communities from the 'inside out' and support the shift towards greater self-management and in line with Adult Social Care 'strengths-based conversations'.

6) Tackle prioritised wider determinants of health based on the JSNA
It would be helpful to map current work to address wider determinants (recognising that a good deal of this sort of activity is already done by SBC and other local authorities) to identify and prioritise specific gaps and opportunities for joint action with Wellbeing Board and/or ICS partners. Other key players in tackling wider determinants of health include the voluntary and community sector (VCS) as recognised by the Institute for Health Equity and summarised in their related review[22].) Potential and current areas of action for members of the Slough Wellbeing Board are outlined in Table 1 below.

[22] Voluntary sector action on the social determinants of health: evidence review. IHE. 2017. Available at: http://www.instituteofhealthequity.org/resources-reports/voluntary-sector-action-on-the-social-determinants-of-health

Table 1: Key areas of wider determinants of health and how Slough Wellbeing Board members could or already act

Wider determinants of health: **Key areas**	**Potential areas where Slough Wellbeing Board partners could or already act to tackle wider determinants**		
	SBC	**NHS**	**Other Board Partners including VCS, Local Business and other Public Sector**
Sustainable ecosystem	Climate change strategies, recycling, planning and development	Climate change strategies (eg transport and travel policies, procurement), recycling	Climate change strategies, recycling,
Natural environment	Green spaces, parks, air quality and sustainable development	Air quality and sustainable development	Green space volunteering
Built environment	Cycle routes, speed limits, housing, building controls	NHS Estates (planning and development)	Housing (private landlords)
Activities	Benefits advice, homelessness support, play provision, school programmes,	In-house advice on benefits and housing	Youth work provision, play provision
Local economy	Regeneration, business grants, social enterprise, JobCentre Plus collaboration, geographically-appropriate 'living wage' (including supply-chain)	NHS job provision, in-job training and apprenticeships, geographically-appropriate 'living wage' (including supply-chain)	Private sector job provision, work readiness schemes, social enterprise, geographically-appropriate 'living wage' (including supply-chain)
Community	Community development, youth groups, volunteering,	Co-production of services, social prescribing, patient participation groups	Community and voluntary sector groups, volunteering
Lifestyle	Leisure, libraries, licencing, workplace health, other Healthy settings[23] (including Healthy Early Years and Healthy Schools)	Workplace health (which includes 'Healthy Hospital')	Workplace health

Source: Adapted from Wider Determinants of Health: Local Authority Framework. 2017 (Dr Rachel Gill, Consultant in Public Health, Surrey County Council)

[23] 'Healthy Settings' involve a holistic and multi-disciplinary method which integrates action across risk factors. The goal is to maximize disease prevention via a "whole system" approach. (World Health Organisation – Ottawa Charter 1986).

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Appendix 2

Table showing summary of rationale, alternative options and what the NHS Long Term Plan says for each of the 5 priority areas.

Potential priority area	Why focus on this area for Slough?	If not chosen by the Health & Care Partnership Board, how else could this work be achieved?	What the NHS Long Term Plan (NHS LTP) [1] says
Housing	• There were 404 households in temporary accommodation in the borough (Mar 18) - an increase of 8% from the previous quarter. 83 of these households were in bed and breakfasts. • Rough sleeping is increasing. Official estimates put the number of rough sleepers in Slough at 27 (Autumn 2017), but Partners indicate that the real number may be as high as 65-75. • We are missing up to date data, but as of 2011, Slough had the second largest average household size in England and 12.8% of households showed evidence of overcrowding in terms of sleeping space. • Slough's private rented sector is generally worse than other types of tenure across various key indicators including disrepair, fuel poverty and falls hazards. • Despite substantial house-building in the borough, Slough still faces a shortfall on the number of new houses. Identified challenges include scarcity of developable land, potential increases in congestion and the impact on the borough's environment.	Through combination of work: 1. SBC-led Slough Housing Strategy 2. Recently started SBC-CCG partnership work on future use of NHS premises in Slough 3. Rough Sleepers SBC-East Berks CCG-Slough CVS partnership working	NHS LTP - Rough Sleepers: Up to £30 million extra on meeting the needs of rough sleepers, to ensure that the parts of England most affected by rough sleeping will have better access to specialist homelessness NHS mental health support, integrated with existing outreach services. NHS LTP on Housing: Spring 2019 - *Putting Health into Place* guidelines for how local communities should plan and design a healthy built environment. This covers approximately 70,000 homes over the next five years. In 2019/20, NHS England will build on this by working with government to develop a Healthy New Towns Standard, including a Healthy Homes Quality Mark to be awarded to places that meet the high standards and principles that promote health and wellbeing.

[1] The NHS Long Term Plan (NHS LTP). Jan 2019. Available at: https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

Planning	• Slough Borough Council has begun an ambitious programme of regeneration to make the town both an attractive place to live, work and stay; and a place where businesses want to locate and invest. • Various improvements in infrastructure are imminent - including the arrival of Crossrail, the expansion of Heathrow airport and the new Western Rail Link to Heathrow - to promote economic growth. • 'Car use is king' and physical activity levels are some of the lowest in the UK: SBC is developing opportunities to promote the uptake of more sustainable modes of transport through improved cycling infrastructure; the installation of electric vehicle charging points; a new Low Emissions Strategy to improve air quality and a reduction in journey times and gridlock by introducing the A4 Slough Mass Rapid Transit (SMaRT) dedicated bus lane.	Through combination of work: • SBC's work with Heathrow Airport • Slough Urban Renewal programme • Recently started SBC-East Berks CCG partnership work on future use of NHS premises in Slough	NHS LTP - Health & Environment: Through the Healthy New Towns programme, the NHS is playing a leading role in shaping the future of the built environment. In 2019/20, NHS England will build on this by working with government to develop a Healthy New Towns Standard which include local planning guidance to ensure all future developments have a focus on design that support prevention and wellbeing.
Asset based approach to support community health/wellbeing/	• Though it is now quite dated, research from 2013 suggests that community cohesion is, in general, very good in Slough. Six in seven surveyed felt that ethnic difference was respected in their local area and four-fifths agreed that people from different backgrounds get on well together. • In 2017/18, SBC embedded a "Strengths based Conversation" model in our Adult Social Care operational teams and have also sought to link our service users to their local communities to reduce the need for long-term care. • Slough has significantly worse healthy life expectancy (the average number of years a person would expect to live in good health) at birth than the national average - for both men and women.	Through combination of work: • SBC's new Community Development pilots in Chalvey, Foxborough and Trelawney Avenue. • East Berkshire CCG's Oasis project • Frimley ICS (Prevention & Self care Board) Community Asset mapping	

	• Slough residents have reported less overall life satisfaction than residents in nearby boroughs, though this has improved in recent years.		
Employment & Business	• The total number of enterprises in Slough has grown significantly over the last 5 years; Slough is recognised as the 2nd most productive area in the UK. • 79.3% of Slough's population are economically active - higher than the national average of 78.4%. • Both adult and youth employment has been growing steadily since 2011/12 and Slough has a lower percentage of workless households than the national average. • The average gross weekly pay for residents of Slough working full time is £604.60, compared to a regional average of £614.50. In addition, the gross weekly pay for all those who work in Slough working full time is £679.20, a gap of £74.60 per week. This implies that those who are commuting in to the borough are generally in higher paid work. • A comparatively small proportion of Slough's population hold NVQ-recognised qualifications, however the gap between Slough and the whole of Great Britain has decreased markedly over the last decade. • A higher proportion hold 'other' qualifications - which may reflect the large number of non-UK born residents. • Disability-employment gap: Slough data – tbc (National gap: In 2018, 51.3% of people with disabilities were in employment vs 81.4% of people without disabilities – a gap of 30.1%. The gap for people with a mental health condition is generally larger.)	Through work of: • SBC working with *Thames Valley Berkshire LEP*, *Thames Valley Chamber of Commerce, Slough Business Community Partnership* and others to develop the borough's economy and promote growth. • Mental Health Service's 'Recovery College' and IPS Programme to support employment for people with mental health conditions.	NHS LTP - The NHS as an 'anchor institution': As an employer of 1.4 million people, with an annual budget of £114 billion in 2018/19, the health service creates social value in local communities. Some NHS organisations are the largest local employer or procurer of services. NHS LTP: A major factor in maintaining good mental health is stable employment. The Plan sets out how the NHS is improving access to mental health support for people in work and supporting people with severe mental illnesses to seek and retain employment. As the largest employer in England, we are also taking action to improve the mental health and wellbeing of our workforce and setting an example to other employers.

Serious Youth Violence	• Despite good educational results for many young people, Thames Valley Police report a perceived trend in increasing youth and gang violence. (We are currently missing data on the prevalence & causal factors due to small numbers.) • The council continues to worked in close collaboration with the Safer Slough Partnership. • Demand on the Children and Adolescent Mental Health Services (CAMHS) Rapid Response team is increasingly high and demand is outstripping capacity in several areas. • Slough has a high prevalence of domestic abuse, poor parental mental health, substance and alcohol abuse. Further key challenges include; Female Genital Mutilation (FGM), Forced Marriage, Child Sexual Exploitation (CSE) and Child Exploitation (CE), Gangs and Serious Youth Violence. • Slough has a higher reported crime rate than the national average. The total crime rate for Slough increased by 7.5% between 12 months ending March 2018 and 12 months ending June 2018.	Through work of: • Safer Slough Partnership (but there has been interest in working jointly on this issue with the Slough Wellbeing Board.)	NHS LTP: We will invest in additional support for the most vulnerable children and young people in, or at risk of being in, contact with the youth justice system. The development of a high-harm, high risk, high vulnerability trauma-informed service will provide consultation, advice, assessment, treatment and transition into integrated services. This will provide support to, and help to address the complex and challenging needs of vulnerable children and young people.

Slough Wellbeing Board's Work Programme

2019/20

Contact officer: Dean Tyler**,** Service Lead Strategy & Performance, Slough Borough Council

For all enquiries: (01753) 875847

8 May 2019

Subject	Decision requested	Report of	Contributing Officers(s)	Key decision *
Discussion				
Integrated Care System (ICS)	The Board is asked to discuss and comment on recent activity undertaken to deliver the ICS.	Alan Sinclair, Director of Adults & Communities		No
Annual review of Joint Wellbeing Strategy priorities, ways of working (including TOR) and preparation for the 2019 Conference	The Board is asked to endorse the approach being taken to review and agree refreshed priorities for the Strategy and to comment on the early arrangements being made for the 2019 partnership conference.	Dean Tyler, Service Lead Strategy & Performance	Democratic Services	No
Slough Wellbeing Board Annual report for 2018/19	The Board is asked to endorse the final draft of the annual report.	Dean Tyler, Service Lead Strategy & Performance	Chairs of subgroups	No
Report of the Disability task and finish group	The Board is asked to discuss and comment on the report of the task and finish group	Colin Pill, Chair, Disability ask and the finish Group		No
Schools and health. Details to be confirmed.	Details to be confirmed.	Liz Brutus, Service Lead, Public Health/ Tessa Lindfield, Director of Public Health, Berkshire		No
Social mobility and inclusive growth. Details to be confirmed.	Details to be confirmed.	Liz Brutus, Service Lead, Public Health/ Tessa Lindfield, Director of Public Health, Berkshire		No
Workplace health. Details to be confirmed.	Details to be confirmed.	Liz Brutus, Service Lead, Public Health/ Tessa Lindfield, Director of Public Health, Berkshire		No
Forward Work Programme	The Board is asked to discuss and update the Forward Work Plan.	Dean Tyler, Service Lead Strategy & Performance		No

Themed discussion				
Details to be confirmed	Details to be confirmed.			
Information				
Sexual health services: new service update. Details to be confirmed. Possible referral from Health and Social Care Partnership Board.	Details to be confirmed.	Liz Brutus, Service Lead, Public Health/ Tessa Lindfield, Director of Public Health, Berkshire		No
Space Prevention Alliance Community Engagement (SPACE) Annual Report 2018	The Board is asked note the annual report and SPACE's plans for 2019.	Commissioning team and SCVS	Director, Adult Social Care	No
Berkshire Suicide Prevention Strategy and Action Plan update	The Board is asked note the strategy and action plan.	Liz Brutus, Service Lead, Public Health		No

17 July 2019

Subject	Decision requested	Report of	Contributing Officers(s)	Key decision *
Discussion				
Integrated Care System (ICS)	The Board is asked to discuss and comment on recent activity undertaken to deliver the ICS.	Alan Sinclair, Director of Adults & Communities		No
Urgent Care Update	The Board will receive an update on the latest position regarding the review of urgent care services in East Berkshire	EB CCG		No
Forward Work Programme	The Board is asked to discuss and update the Forward Work Plan.	Dean Tyler, Service Lead Strategy & Performance		No

Themed discussion				
Details to be confirmed	Details to be confirmed.			
Information				

Unprogrammed items				
Cold winter deaths	Going to Health and Social Care Partnership Board in January 2019. Opportunity to take the draft plans for 2019/20 to the Board for comment in July 2019	Liz Brutus, Service Lead, Public Health/ Tessa Lindfield, Director of Public Health, Berkshire		
Environmental sustainability: Collaborative paper from Wellbeing Board members. Details to be confirmed.	Details to be confirmed. Possible referral from the Health and Social Care Partnership Board	Liz Brutus, Service Lead, Public Health/ Tessa Lindfield, Director of Public Health, Berkshire		No
Refresh of the Council's Leisure Strategy 2019	To be confirmed.	Alison Hibbert, Leisure Strategy Manager		No
Housing / homelessness as a themed discussion item	To be confirmed	Colin Moone, Service Lead Strategic Housing Services		No
Vulnerable children as a themed discussion item	To be confirmed	Cate Duffy, Director Children, Learning and Skills		No
People on the edge of services: Possible referral from the Health & Social Care Partnership	To be confirmed	Julia Wales, DAAT Manager & Commissioner		No
Social care: the forthcoming Green Paper on older people (England)	To be confirmed	Alan Sinclair, Director of Adults & Communities		No
Refresh of JSNA	To be confirmed	Liz Brutus, Service Lead, Public Health/ Tessa Lindfield, Director of Public Health, Berkshire		No
Tuberculous	To be confirmed	Liz Brutus, Service Lead, Public Health/ Tessa Lindfield, Director of Public Health, Berkshire		No

Low Emissions Strategy	To be confirmed	Liz Brutus Service Lead, Public Health / Jason Newman, Environmental Quality Team Manager		No
Improve the provision and access to green spaces, including new development, allotment etc. to improve residents activity and wellbeing	To be confirmed	Alan Sinclair, Director of Adults & Communities		No
Business and skills – development agenda as a health issue	To be confirmed	Liz Brutus Service Lead, Public Health		No

Criteria

Does the proposed item help the Board to:

1) Deliver one its statutory responsibilities?

2) Deliver agreed priorities / wider strategic outcomes / in the Joint Wellbeing Strategy?

3) Co-ordinate activity across the wider partnership network on a particular issue?

4) Initiate a discussion on a new issue which it could then refer to one of the key partnerships or a Task and Finish Group to explore further?

5) *Respond to changes in national policy that impact on the work of the Board?*

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SLOUGH BOROUGH COUNCIL

REPORT TO: Slough Wellbeing Board **DATE:** 26 March 2019

CONTACT OFFICER: Naheem Bashir, Prevent Coordinator, Slough Borough Council

(For all Enquiries) (01753) 875201

WARD(S): All

PART I
FOR INFORMATION

SLOUGH PREVENT BOARD (SIX MONTH PROGRESS REPORT)

1. Purpose of Report

1.1 To inform Slough Wellbeing Board about the recent work of the Slough Prevent Board, including activity to meet the Prevent Duty created by the Counter Terrorism and Security Act (CTSA) 2015.

2. Recommendation(s)/Proposed Action

2.1 The Board is requested to note the work of the Prevent Board and its Action Plan (at Appendix A).

3. The Slough Joint Wellbeing Strategy, the Joint Strategic Needs Assessment and the Five Year Plan

3a. Slough Joint Wellbeing Strategy Priorities 2016 - 2020

The action plan at Appendix A supports delivery of the following Joint Wellbeing Strategy 2016 – 2020 priority: Protecting vulnerable children and young people.

3b. Joint Strategic Needs Assessment (JSNA)

The Wellbeing Board's Safeguarding Protocol 2016/17 recommends that the Prevent Board will contribute information to the Joint Strategic Needs Assessment as part of its annual update.

3c. Five Year Plan Outcomes 2017 - 2021

The action plan at Appendix A supports delivery against each of the following Five Year Plan outcomes:

Slough Children will grow up to be happy, healthy and successful
Slough will be an attractive place where people choose to live, work and stay

4. Other Implications

(a) Financial - There are no financial implications directly resulting from the recommendation of this report.

(b) Risk Management - There are no risk management implications associated with this report.

(c) Human Rights Act and other legal implications - There are no Human Rights Act implications associated with the proposed action. Following the introduction of the Prevent Duty for local authorities and other parts of the public sector (contained within the Counter-Terrorism and Security Act 2015), the public sector has a key role to play in preventing people from being drawn into terrorism.

(d) Equalities Impact Assessment (EIA) – An EIA is not required for this report.

5. **Summary**

- In order to deliver the Prevent Duty, the Prevent Board is represented by key strategic, statutory and voluntary partners who meet on a quarterly basis to review the Delivery Plan and ensure it is delivering the themes within the Delivery Plan in partnership and supporting the Prevent staff.
- The Prevent Board currently sits under the Slough Wellbeing Board and provides a regular (twice yearly) report to partners on its activities.
- Counter Terrorism Strategy (CONTEST) and Prevent was reviewed following the terrorist attacks in 2017 and the reviewed strategy was published on 4th June 2018.
- This report provides activity undertaken during the last six months.

6. **Supporting Information**

6.1 The updated Action Plan at Appendix A sets out the various ways in which the Prevent Board is ensuring that the Prevent Duty for local authorities and other parts of the public sector is met. Slough Wellbeing Board will note the work to engage local communities, including faith institutions, staff training, and work with schools. The emphasis in all this activity is that it is set within the context of safeguarding.

7. **Comments of Other Committees**

7.1 The Action Plan will be shared with the following partnerships and boards in Slough:

- Slough Local Safeguarding Children's Board (SLSCB)
- Slough Adult Safeguarding Board (SASB)
- Safer Slough Partnership Board (SSPB)

8. **Conclusion**

8.1 The Prevent Board continues to fulfil an important role within Slough to deliver the Prevent Strategy as per the Delivery Plan. The multi-agency panel (Channel panel) continues to meet on a monthly basis to ensure the safeguarding of vulnerable individuals.

9. **Appendices Attached**

‘A’ - Prevent Action Plan

10. **Background Papers**

None

Prevent Delivery Plan 2018/19: 26 March 2019

Action	Progress update/comments

Counter Terrorism Strategy (CONTEST) and Prevent review 2018	• Following the terrorist attacks in 2017 the Government reviewed CONTEST. The updated Counter Terrorism Strategy was published on 4th June 2018 and the changes to the Prevent Strategy is as follows:
	• Prevent is part of the UK's Counter Terrorism Strategy, to safeguard and support those vulnerable to radicalisation and to stop them becoming involved in terrorism or supporting terrorism.
	• The objectives of Prevent are to:
	  ○ Tackle the causes of radicalisation and respond to the ideological challenge of terrorism;
	  ○ Safeguard and support those most at risk of radicalisation through early intervention, identifying them and offering support; and
	  ○ Enable those who have already engaged in terrorism to disengage and rehabilitate.

Agree a programme to engage with faith and other community organisations to raise awareness	• Engagement with all faith institutions and key community contacts has taken place on a regular basis over the past six months. • Key individuals have been invited to meetings/events involving Prevent organised by Prevent Coordinator, as well as, events run by Partner agencies.
Schools training programme to be completed and kept under review	• Ongoing Prevent Awareness sessions to Early Years, Childminders, Primary and Secondary Schools have continued on a regular basis for staff and students. • WRAP product is currently under review by the Home Office, therefore the Prevent Education Officer (PEO) has developed and designed PowerPoint presentations tailored to the needs of the Primary and Secondary Schools, it provides the appropriate support, advice and guidance based upon the review of CONTEST and Prevent. It includes case studies to reflect the work of Prevent in Education and their role of safeguarding young people from extremism and radicalisation. • Improved communication has lead to a better understanding of the referral process. • Global Acts of Unity – Mike Haines delivered 4 sessions (2 x Windsor Forest

Action	Progress update/comments
	College and 2 x St Joseph's School) each session is an hour long. Mike is the brother of David Haines, aid worker who was killed by ISIS; he spoke on the issues of Terrorism, Extremism, Radicalisation, Hate, discrimination and reconciliation. Mike gave an insight of his personal experience, the need for cohesion, unity and challenge those who seek to divide our communities in the UK. Feedback was very positive and young people remained after the session to speak to him. • Provide support to the Prevent Coordinator.
Develop a joint communication plan including: • Consistent messages for all partners • Messages on travel to Syria • Charitable giving • Community's role "what is your contribution to the solution"	• Regular communications and briefings to the SBC Senior Leadership Team and Members are communicated through the Prevent Coordinator. • BBC Radio Berkshire piece on Prevent (18/02). • National key messages on Prevent and travel to conflict zones is communicated through the SBC website, local Press and Twitter. • Advice and guidance on donating safely is available on the SBC website, under 'Charitable Collections'.
Prevent Coordinator	• Engagement with key community individuals takes place on a regular basis. • Information and update provided in relation to Prevent and its implications following the CONTEST review 2018. • Workshop to Raise Awareness of Prevent (WRAP) delivered to Foster Carers and Social Workers (South East Migration Partnership). • Organise community meetings/events to provide a two way dialogue in relation to the Prevent Strategy and Duty. • Provide support to the Prevent Education Officer.

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SLOUGH BOROUGH COUNCIL

REPORT TO: Slough Wellbeing Board **DATE:** 26 March 2019

CONTACT OFFICER: Dean Tyler, Service Lead Strategy and Performance Service

(For all Enquiries) (01753) 875847

WARD(S): All

PART I
FOR INFORMATION

SBC FIVE YEAR PLAN 2019-2024

1. Purpose of Report

1.1 To provide the Wellbeing Board with an update on the review of the Council's Five Year Plan.

2. Recommendation(s)/Proposed Action

2.1 To note the content of the Council's Five Year Plan in the context of the Council's ongoing commitment to partnership working.

3. The Slough Joint Wellbeing Strategy, the JSNA and the Council's Five Year Plan

3a. Slough Joint Wellbeing Strategy Priorities and Joint Strategic Needs Assessment

The Five Year Plan is clear about the Council's ongoing commitment to partnership working. The priority outcomes support the priorities in the Slough Wellbeing Strategy.

3b. Council's Five Year Plan Outcomes

The Five Year Plan is the Council's key strategic plan and has a vision for Slough as 'growing a place of opportunity and ambition.' There are five priority outcomes:

- Outcome 1: Slough children will grow up to be happy, healthy and successful
- Outcome 2: Our people will be healthier and manage their own care needs
- Outcome 3: Slough will be an attractive place where people choose to live, work and stay
- Outcome 4: Our residents will live in good quality homes
- Outcome 5: slough will attract, retain and grow businesses and investment to provide opportunities for our residents

4. Other Implications

(a) Financial – the Five Year Plan is important in determining the priority outcomes against which resources will be allocated. The time frame for the Five Year Plan is

aligned with our medium term financial planning and will roll forward each year, i.e. the new Plan looks ahead for the five years 2019/20 to 2023/24.

(b) Risk Management - There are no identified risks associated with the proposed actions.

(c) Human Rights Act and Other Legal Implications - There are no direct legal implications. The specific activity in the Five Year Plan and other plans may have legal implications which will be brought to the attention of Cabinet separately. There are no Human Rights Act Implications.

(d) Equalities Impact Assessment - There is no requirement to complete an Equalities Impact Assessment (EIA) in relation to this report. EIAs will however be completed on individual aspects of any actions produced to sit underneath the Five Year Plan, as required.

5. Summary

This item provides members with an update on the review of the Council's Five Year Plan. As the Council's strategic plan this is an important document which sets the vision, direction and key priority outcomes for the Council. It also reinforces the Council's ongoing commitment to working in partnership and refers specifically to the Wellbeing Board on page 6.

6. Supporting Information

6.1 The Five Year Plan was launched in 2015 to define the Council's ambition; the opportunities and challenges we face; the role of the Council in meeting these and the priority outcomes against which resources will be allocated.

6.2 The Plan is updated every year and we also produce an Annual Report so that we can check progress.

7. Measuring progress

7.1 We produce an Annual Report of progress with case studies and performance indicators setting out how we are delivering our priority outcomes.

7.2 The refresh of the Five Year Plan includes a summary of the success measures as a Balanced Scorecard of key performance indicators that will be used to keep track of how we are achieving the outcomes.

8. Comments of Other Committees

7.1 The Council's Scrutiny function (including Health Scrutiny Panel) challenges and tracks progress of the outcomes at its meetings throughout the year.

9. Conclusion

9.1 The new Five Year Plan will provide the strategic direction for the Council over the next five years and will enable a clear focus of resources and activity.

10. **Appendices**

A – Five Year Plan 2019/20 – 2-23/24

11. **Background Papers**

None

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Five Year Plan 2019/20 – 2023/24

'Growing a place of opportunity and ambition'

Contents

1. **Leader's Foreword**

The 5 Year Plan sets out the Council Leadership Team's vision for Slough – growing a place of opportunity and ambition – and how we will deliver this by **putting people first**.

As Leader of the Council, my priority is to ensure that the ambitions we have for our town enable Slough residents to access enhanced opportunities, good services and flagship leisure facilities – to help them build good lives for themselves and their families. My colleagues and I are working to grow our town in a sustainable way that delivers quality development and helps our communities to thrive.

This Five Year Plan sets out more detail around our priorities and how we will:

- Increase the supply of housing, particularly affordable quality homes.

- Improve public transport infrastructure, not only will this relieve congestion by encouraging people to use their cars less, it will support our clean air strategy and prevent traffic gridlock from threatening our successful economy.

- Move forward with our 'place-shaping' agenda. This means joining up services, not just within the Council but with our partners too, bringing them closer to people's localities and delivering major regeneration of our neighbourhoods, like Chalvey. In addition we are reshaping our town centre to renew it for another generation.

- Maximise commercial opportunities afforded us by the strength of our local economy – both to protect frontline services and to ensure the Council is dynamic, ambitious and entrepreneurial (like our residents) but also to drive service transformation and improvement including IT and new contact channels for the digital age.

- Deliver an improving public realm and a world-class leisure offer with new state of the art buildings, outdoor gyms and safe public spaces.

Our challenge is to maintain investment in the town, despite the backdrop of funding reductions from central government and uncertainties about political direction nationally and globally. Our strength is that locally our political direction is clear, our commitment unquestionable, our focus on key priorities is relentless, and we have been building the organisational capacity to deliver on our ambitions.

The expansion of Heathrow, the arrival of Crossrail, together with our international reputation as a place for business to invest, mean I am confident in Slough's future and the town as a destination for people from all walks of life to come to live, work, play and stay.

Councillor Cllr James Swindlehurst
Leader, Slough Borough Council

2. **Introduction**

Since joining the Council on 1 October 2018 I have been continually impressed by the hard work and dedication of our staff to improve outcomes for people in Slough.

The Five Year Plan is important in defining the council's vision and ambition; the opportunities and challenges we face; the role of the council in meeting these and the priority outcomes against which resources will be allocated.

The Five Year Plan is also important in explaining how and why the council is changing. To ensure it is always up to date the Five Year Plan is refreshed every year and we also produce an Annual Report so we can check progress.

Opportunities and challenges

The Leader has been clear in his Foreword about our ambitious plans to deliver the best outcomes for the town and its people. By continuing to attract growth and shape and manage Slough the place effectively we can ensure we deliver benefits for local residents.

Our population of around 145,000 is young, growing and dynamic. We need to ensure their future from an early age and education, to local employment opportunities and the availability of housing to meet their needs. People are living longer today than ever before but this adds pressure on local services such as adult social care to meet more complex needs while enabling people to live independently for as long as possible. There are inequalities across our population including household income, living conditions, wellbeing and health. Not all of these issues are within our power to address directly which is why it is important that we make the most of our network of communities and local partners.

Maintaining a strong local economy to generate income from business rates is essential for our budget, particularly as our funding from Government disappears. The success of our economy, with a turnover of around £9 billion, together with our reputation as a place to invest means growth provides a number of opportunities. Inward investment, regeneration and infrastructure improvements will bring real benefits to Slough, from housing and jobs, to better transport, shopping and leisure facilities – and we need to make sure that all of our residents benefit from this.

By the time our grant from Government disappears we will be almost entirely reliant on income from business rates and Council Tax. Developing these twin sources of income and other opportunities is essential to our finances and paying for services.

In this context, being focussed on clear priorities is essential. This is why the Five Year Plan is so important as we will use it to:

- drive the decisions made in the medium and long term financial strategy
- focus on delivery of outcomes by prioritising resources
- provide a basis for discussions with partners about the services they provide
- develop a performance framework to which services and staff will be held accountable

The role of the Council

We will meet the challenges and opportunities we face by:

- demonstrating community leadership

- enabling people to help themselves
- supporting the most vulnerable
- shaping and managing the changing place

Our capacity to provide people with support is under growing pressure as a result of cuts to our funding from central Government together with an increase in demand. 70% of our budget is spent on social care and supporting those members of our community who are most vulnerable.

Our challenge is that we know that we can no longer provide services in the way that we have in the past – we will not be able to provide everyone with everything. We need to rethink and change not only what we do but how we do it. It is brave decisions that we make now that will sustain our ability to provide services in the future.

We believe we can do more to close gaps and reduce inequalities by enabling people to take more responsibility for their own lives, for example, by living healthier lifestyles. We will build on the strengths of our communuties and partnerships to work as 'One Slough'. Wherever possible we will also look to manage future demand for services through targeted intervention and prevention. We will always ensure the most vulnerable in our community know how to get the support they need.

Transformation

The Council has begun to develop and define a transformation programme which will guide our future ways of working as a Council and support the provision of our services. We want to enable independent sustainable communities and support people to prevent demand pressure on the council. We will maximise the use of our assets to maximise our localities offer.
The Transformation Programme will be rolled out at pace over the coming year so that:

- We will be a modern and efficient council that optimises customer service.
- We will have a new culture which embraces change and is fast-paced and dynamic.
- We will use technology to drive improvements to services and our ways of working.
- We will work as One Council and with our partners as One Slough to deliver better outcomes.
- We will pursue commercial and other funding opportunities to maximise benefits for Slough

Our values

We will recruit, retain and develop high quality people who are committed to Slough and supported to do their job. Being clear about our values and behaviours means we can support our staff who want to continue to make a positive difference in their services to improve the lives of people in Slough. Our five **values** are:

- Responsive
- Accountable
- Innovative
- Ambitious
- Empowering

We will use these to drive our behaviours and how we work. We will recruit and manage people by checking how they are performing against these. In addition, and importantly, we have set a series of equality objectives to reduce inequalities and improve outcomes for local people in specific service areas. This is in line with our focus on putting people first as well as ensuring we meet our requirements under the Public Sector Equality Duty (Equality Act 2010). It is important that organisationally these outcomes are owned and are integral to our own work programmes. We must all know the part we play in striving towards achieving these outcomes.

Josie Wragg
Chief Executive

3. **Our priority outcomes – putting people first**

Our communities are at the heart of everything we do. It is our responsibility to ensure that as we change the way we do things, we communicate and engage with people so that they understand what is happening around them and why – and that they are empowered to help us shape and implement out vision for Slough.

Our response to the opportunities and challenges we face is to focus on five priority outcomes to improve the lives of people in Slough. **Resources will primarily be allocated to achieve these outcomes**. Resource allocation will be evidence based – there will need to be a demonstrable, evidenced link between the outcome and the key action.

Our priority outcomes – putting people first

- Slough children will grow up to be happy, healthy and successful
- Our people will be healthier and manage their own care needs
- Slough will be an attractive place where people choose to live, work and stay
- Our residents will live in good quality homes
- Slough will attract, retain and grow businesses and investment to provide opportunities for our residents

These cross cutting outcomes are important in ensuring that we are joining up resources to focus on shared priorities – this approach means we will increasingly be seen to be working as 'One Council'.

Our partners are facing the same twin challenges as the Council – rising demand at a time when resources are diminishing. Like us, they cannot deliver their outcomes without additional support. We will work through the Slough Wellbeing Board to facilitate a wider partnership network across the public, private and voluntary sectors to coordinate action and resources to achieve the best results for Slough.

Many of our priorites cannot be achieved by us as a Council without the support of others. As well as working in partnership with the public and voluntary sectors we will continue to build partnerships with the private sector to attract investment and support delivery. We will work with residents and community groups to build confidence and skills to improve their own lives and communities.

<u>Just a few of the things we have done over the last year:</u>

- Refurbished and expanded our nurseries, creating new early years places.
- Collaborated with Slough Youth Parliament on the Slough Youth Awards, highlighting the success of our young people, and the Women Leading Women event promoting equality for all, celebrating the achievements of Slough women and inspiring future generations.
- Worked closely with local schools to raise awareness about tooth decay, improve oral health education and facilitate supervised brushing.
- Collaborated with Slough Wellbeing Board to encourage small positive changes in lifestyle, tackle social isolation, and promote good mental health through our #BeRealistic, #ReachOut and #NotAlone campaigns.
- Increased the number of people managing their care and support
- Founded a new Town Team to deliver rapid improvements to our town centre.

- Celebrated the 80th anniversary of Slough receiving a Royal Charter and held the successful Slough Half Marathon, Canal Festival, Bonfire night and Festive Fun events.
- Campaigned with the Safer Slough Partnership to combat Modern Slavery and other Hidden Harms.
- Invested in improvements to our existing council stock and developed a new app to help council tenants report and track repairs.
- Prepared to relocate our headquarters, which will bring greater footfall to the town centre and help to support local businesses.
- Become the first town in the country to trial revolutionary green technology which generates electricity from microbes which form around plant roots.
- Continued to make improvements to our highway network and trialled the use of electric buses along the Green Line.

As the council leads the regeneration of our town over the next five years - improving Slough's buildings, spaces and infrastructure - we are determined to maximise the benefits for residents and exploit opportunities to enhance the services we provide.

Case studies:

Wexham School:

Students at Wexham School have now moved in to brand new facilities, created as part of the council's ambitious school places programme - a multi-million pound investment in primary and secondary school buildings, extensions and new schools.

The expansion includes a new 3,000 square metre three storey Woodside Building that houses 29 new classrooms for English, Special Educational Needs (SEN), Humanities and Languages, three of which have dedicated ICT facilities.

The Woodside Building also provides staff workrooms, group rooms, a new student reception and welfare facilities, a new library and a sixth form study centre. The existing library has been converted into two new science laboratories and external landscaped areas will be provided, along with a new staff car park, and improvements to the local highway to complete the site.

Lawrence Smith, headteacher at Wexham School: "We couldn't be happier with our school's new facilities. Feedback from students and teaching staff now using the Woodside Building has been extremely positive. Our new state-of-the-art teaching spaces will be instrumental in helping us build on this year's 'Good' Ofsted report, which stated the school's work to promote pupils' personal development and welfare is outstanding."

Salt Hill Activity Centre:

In June, Salt Hill Activity Centre opened its doors after undergoing a 12 month renovation that has seen the building transformed from a ten-pin bowling alley into a state-of-the-art indoor activity centre.

The new facilities include a six-lane ten-pin bowling alley, trampoline park, soft play, indoor high ropes and caving.

The centre will help the council to achieve our priority outcomes by bringing people together and encouraging greater levels of physical activity amongst our children and young people.

Slough Horticultural Show:

In August, we held Slough's first horticultural show in thirty years in Lascelles Park.

There were competitions for the best home grown produce including vegetables and flowers, and best home made items, including cakes, knitted items and clothing.

There was also a photography competition and classes for children to enter their home grown produce and home made wares.

The event sought to bring residents together, encourage people to get active in their gardens and promote healthier foods.

Holding events such as these will also help us to challenge negative perceptions of Slough, showcase our excellent parks and open spaces, and build a town where families choose to live, work and stay.

Outcome 1: Slough children will grow up to be happy, healthy and successful

Why this is important

- Demand for children's services is increasing in scale and complexity.
- As school populations rise in Slough, there is increased competition for school places.
- Some families remain under pressure with less disposable income, increased use of food banks and overcrowded accommodation which impacts their children.
- While some progress has been made, Slough has high rates of preventable ill health amongst children including obesity, tooth decay and higher levels of hospital admissions for some long-term conditions such as asthma.
- Slough has a higher than average infant mortality rate and an increasing incidence of premature births and low birthweight births.
- Young people in Slough have also raised concerns around knife crime, mental health and homelessness, as well as a desire for equal pay and a curriculum that prepares them better for life.

Our response

We are committed to ensuring Slough is a great place for children to grow up and live happy, healthy and successful lives.

Levels of attainment have continued to improve across all ages, and are above national averages:

- 74% of children achieved a good level of development at Early Years, Foundation Stage.
- At Key Stage 2, 68% of pupils achieved the expected level in reading, writing and maths at key stage 2.
- 56.6% of pupils achieved Grade 5 or above in English and maths GCSEs.

The council has also worked to support more 16 and 17 year olds in education, employment or training, and the borough has seen a substantial improvement over recent years and been recognised as a hotspot by the Social Mobility Commission.

We are determined to continue to build on this progress to ensure that all our young people secure the best outcomes for them.

We are committed to working closely with Slough Youth Parliament to address key areas of concern, and are excited for the role young will play in shaping the future of Slough, as we continue to regenerate our town.

Alongside Slough Children's Services Trust and other partners, we will ensure that vulnerable young people are protected and supported, and we will step up our efforts to improve children and infants' health through early intervention, tackling the root cause of issues.

Our long-term priorities are to:

- Work with our partners to ensure excellent *educational, health and wellbeing* outcomes for children and young people in Slough.
- Reduce the numbers of children looked after and care leavers and young people with *an Education Health and Care Plan* who are not in education, employment or training.
- Support the creation and promotion of pathways to high quality employment, including apprenticeships.

- *Work with partners to further develop our early help and early intervention offer for children and families*.

Outcome 2: Our people will be healthier and manage their own care needs

Why this is important

- We are experiencing increasing demand for health and social care services, at a time when resources are limited.
- Levels of physical activity are poor and Slough has particular challenges around cardiovascular health, obesity, diabetes and other preventable diseases, which cause both premature ill health and shorter lives.
- Though we have made progress over the last year, Slough still has lower than average rates of immunisations and screening.
- Our residents have less overall life satisfaction than in nearby boroughs and higher levels of depression and anxiety, and we know there are also challenges around social isolation.
- There are also inequalities in health, primarily between different areas of the borough and between different ethnic groups, which need to be addressed.

Our response

Central to the council's work over the next five years will be developing an effective, evidence-based, outcome-focussed, preventative approach - this will include understanding what residents think about their health, working with the evidence of what works, and supporting residents and their communities to help themselves and keep as well as possible.

Recognising the strengths of our residents, the power of community and the interdependence between Outcomes to build stronger, healthier and attractive neighbourhoods, we will work together to pilot the right approach for Slough.

Our new co-production group will bring the council together with carers, people who use adult social care and support services, and health and social care staff, to ensure diverse views and ideas are represented in the design and delivery of services, and to make positive changes in the community.

Together with our partners in the public and voluntary sectors, we will continue to enhance our shared Health and Wellbeing Strategy, targeting health inequalities by focussing on the wider determinants of health - such as low household income, poor housing, employment and air quality.

We will also seek to make best use our new state-of-the-art leisure facilities to bring people together and get more people, more active, more often.

Our long-term priorities are to:

- *Enhance our strategic approach to improving the health and wellbeing of our residents through improved prevention and early intervention.*
- *Make best use of our new leisure facilities and get* more people - more active - more often.
- *Improve mental wellbeing and* reduce loneliness and isolation - more people - more connected - and happy.
- Reduce the need for long term social care through improved early help and *effective partnership work.*

Outcome 3: Slough will be an attractive place where people choose to live, work and stay

Why this is important

- Though we have made substantial progress, more needs to be done to enhance the visual appeal of our public realm and challenge stereotypes about Slough.
- We also know that we can do more to improve perceptions around levels of community safety, and Slough has particular challenges around 'hidden harms', such as modern slavery and domestic abuse.
- Slough has pockets of severe, multi-faceted deprivation, with some areas requiring greater levels of intervention and integration.
- Several areas of the borough have poor air quality with a lack of public awareness and understanding of air pollution being identified as a significant barrier to change.
- Recycling rates are also substantially below the national average.

Our response

Slough's greatest strength is its people, a strength which can be seen in our diversity, our community spirit, and our shared determination to create a town that more people are proud to call their home.

Over the next five years, the Safer Slough Partnership will continue to develop our work in tackling key local issues and ensuring that Slough is a safe place, where people feel they have the security to prosper.

We have plans in place to ensure our town centre reflects our ambitions to create a vibrant and attractive location and our parks have been recognised as some of the best in the country.

The implementation of our new Low Emissions Strategy will enhance air quality and we will look to promote greater awareness of the importance of recycling.

We will continue to host our successful programme of events bringing together our different communities, fostering civic pride and welcoming visitors to our town.

2019 will also see work begin on our locality offer - using council facilities to deliver joined-up services in the community alongside our partners.

Our long-term priorities are to:

- Actively manage the impact of new developments and infrastructure so the town centre is a place where people can live, work, shop and enjoy.
- Improve the Slough brand and develop our identity as a *safe* place of opportunity and ambition, co-produced with our communities and partners.
- Improve air quality in the borough with innovative solutions.
- *Encourage greater levels of recycling by raising awareness*.

Outcome 4: Our residents will live in good quality homes

Why this is important

- Space for new housing developments in Slough is severely limited.
- Levels of homelessness and rough sleeping have increased substantially, raising demand for temporary accommodation and social housing, which also impacts the health and the educational attainment of children.
- House prices are comparatively high when compared to average wages in Slough, and median rents are above average for the South East.
- The condition of our housing stock is generally better than national and regional averages, but more needs to be done to improve conditions in the private sector.

Our response

Slough is one of the smallest unitary authorities in the UK, and our growing population and attractive location have led to a significant demand for more housing in the borough.

To meet this challenge we will continue to build new, high quality and affordable homes, enhancing our partnership with Slough Urban Renewal.

In particular the council is committed to increasing the availability of council housing for our residents and we have identified sites to build approximately 500 more council homes over the next 3 years, subject to feasibility and funding.

We will continue to work closely with our partners to take preventative action to support those individuals most at risk of becoming homeless and improve the availability of accommodation through our subsidiary housing company James Elliman Homes.

The council will also look to improve the regulation of private sector housing and develop more effective relationships with landlords.

Our long-term priorities are to:

- Maintain our council housing to a high standard.
- *Deliver new affordable homes for our residents.*
- *Reduce the number of households in temporary accommodation*.
- Drive up standards in the private rented sector.

Outcome 5: Slough will attract, retain and grow businesses and investment to provide opportunities for our residents.

Why this is important

- Slough has high levels of personal car use, leading to congestion and exacerbating issues around air quality.
- The use of public transport is low compared to similar areas, such as Reading.
- Slough's business start up rate is positive, but survival rates beyond five years are low.
- Slough's retail offer is limited, but there is the opportunity to establish alternative uses for the centre of town to accommodate our rising population and create the business vibrancy that Crossrail has potential to bring.
- Though progress has been made in recent years, a comparatively small proportion of Slough's population hold NVQ-recognised qualifications.
- As of 2018, the average gross weekly pay for residents of Slough working full time was £74.60 lower than the average for all those working here, which implies that those commuting in to the borough are generally in higher paid work.
- Although employment levels are good overall, some groups, such as women, remain under-represented in the labour market.

Our response

As a council, we are committed to promoting inclusive economic growth, ensuring that the benefits from the regeneration of our town are shared by all of our residents.

We are well-placed to exploit new transport links and strengthen our growing reputation as a regional economic centre, but know there is more for us to do attract investment and bring more high-quality, well-paid jobs to Slough.

Work on the old library site is now underway and we will soon begin our regeneration of the former Thames Valley University campus, which will provide more retail, office and leisure space, as well as housing.

We will also continue plans to improve our infrastructure - supporting digital development, unshackling the town from congestion, and encouraging a shift towards more sustainable forms of transport.

This approach will enable us to present a comprehensive vision and masterplanning of opportunities, and to encourage and influence high quality design and development throughout the town centre.

Our long-term priorities are to:

- Collaborate on the Heathrow expansion.
- *Have a clear vision and masterplan for the centre of town, regenerating major sites and attracting investors and occupiers.*
- *Encourage modal shift to sustainable forms of transport - including walking, cycling and public transport - reducing traffic congestion and emissions.*
- *Provide residents with opportunities to improve their skills and secure quality jobs*.

4. **The budget –*to be inserted***

5. **Keeping track of progress – balanced scorecard**

It is important that we are able to provide evidence of progress towards achieving better outcomes to improve people's lives.

We have identified a high level set of key performance indicators in the table below. These will form part of our Annual Report of progress against the outcomes. They will also be included in future annual refreshes of the Five Year Plan so that we have a consistent set of key performance measures to report against – whether performance is good or bad - so we can spot trends and tackle issues to get us back on track where needed.

This set of key performance indicators will therefore remain largely constant although there will be minor changes as performance requirements change. For example some of the detailed priorities under outcomes will change as specific actions are delivered and new ones identified. In addition we have a series of statutory returns we provide to Government as well as indicators to measure council tax and business rates collection.

Five Year Plan outcome		**Performance measure**
Outcome 1	Slough children will grow up to be happy, healthy and successful	The percentage attainment gap between all children and bottom 20% at Early Years Foundation Stage
		The percentage gap between disadvantaged pupils and all others at Key Stage 2 in Reading, Writing and Maths
		The gap between disadvantaged children and all others at Key Stage 4 percentage achieving grades 9-5 in English & maths
		Percentage of Child Protection Plans started in the past year that were repeat plans within 2 years
		Percentage of 16 to 17 year olds not in education, employment or training (NEETs)
Outcome 2	Our people will be healthier and manage their own care needs	Number of adults managing their care and support via a direct payment
		Uptake of targeted health checks The percentage of the eligible population aged 40-74 who received a NHS Health Check
		Number of people inactive The percentage of people aged 16 and over who do not participate in at least 30 minutes of sport at moderate intensity at least once a week
Outcome 3	Slough will be an attractive place where people choose to live, work and stay	Level of street cleanliness: Average score for graded inspections of Gateway sites (Grade options from best to worst are: A, A-, B, B-, C, C-, D)
		Crime rates per 1,000 population: All crime (cumulative from April)

Outcome 4	Our residents will live in good quality homes	Number of homeless households accommodated by SBC in temporary accommodation
		Number of permanent dwellings completed in the borough during the year
		Number of licenced mandatory Houses in Multiple Occupation (HMOs)
		Number of empty properties brought back into use (by Council intervention)
Outcome 5	Slough will attract, retain and grow businesses and investment to provide opportunities for our residents	Business rate income: Business rate in year collection (amount & percentage rate accrued)
		Access to employment Proportion of resident population of area aged 16-64 claiming JSA and NI or Universal credits
		Journey times Average journey time from Heart of Slough to M4 J6 (M-F 16:30-18:30)
Corporate health		Percentage of household waste sent for reuse, recycling or composting
		Percentage of municipal waste sent to landfill
		SBC staff survey: Percentage of staff proud to work for the council
		SBC staff survey: Percentage of staff rate working for the council as either good or excellent
		Council tax in year collection (amount & percentage rate accrued)

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SLOUGH BOROUGH COUNCIL

REPORT TO: Slough Wellbeing Board **DATE:** 26th March 2019

CONTACT OFFICER: Colin Moone, Service Lead: Housing Services
(For all Enquiries) (01753) 874057

WARD(S): All

PART I
FOR INFORMATION

HOMELESSNESS & ROUGH SLEEPING UPDATE

1. Purpose of Report

This report provides the Slough Wellbeing Board with an update of the current homelessness and rough sleeping situation in the borough since the last report on 20th November 2018. Homelessness can be wide-ranging so this report concentrates on the rough sleeping element.

2. Recommendation

2.1 The Slough Wellbeing Board is recommended to note this report and

2.2 to further note that there is no indication from government that the Rough Sleeper Initiative money will be available from 2020/21.

3. The Slough Joint Wellbeing Strategy, the JSNA and the Five Year Plan

- The priorities of the Slough Joint Wellbeing Strategy (SJWS) have been taken account of in the production of the draft Homelessness Strategy which, rough sleepers form a part.

3a. Slough Joint Wellbeing Strategy Priorities

Housing is a key determinant of health and wellbeing and it is a priority in the new Wellbeing Strategy. Being homeless can exacerbate a household's housing situation and therefore their health will be affected as a result.

3b. The JSNA

The Housing Strategy Key objectives, identifies homelessness as a key area. A new Homelessness Strategy has been drafted but the Housing Strategy identifies that:

- homelessness and rough sleeping is to be reduced

3c. Five Year Plan Outcomes

The key driver for the Housing Strategy is to deliver Outcome 4 of the 2018 Five Year Plan, "Our residents will have access to good quality homes". This is being refreshed for 2019/20. As homelessness is one of the main routes to accessing accommodation in the borough, this area is really relevant to the outcomes of the Five Year Pan. It also helps to deliver and makes significant contributions to each of the other outcomes:

1) Our children and young people will have the best start in life and opportunities to give them positive lives
2) Our people will become healthier and will manage their own health, care and support needs
3) Slough will be an attractive place where people choose to live, work and visit
4) Our residents will have access to good quality homes
5) Slough will attract, retain and grow businesses and investment to provide jobs and opportunities for our residents

4. **Other Implications**

(a) Financial – Whilst there are no direct financial implications arising from this report, it should be acknowledged that rough sleepers have impacts on budgets across many services, e.g. Health.

(b) Risk Management – Rising homelessness increases the financial risks to the Council.

(c) Human Rights Act and Other Legal Implications – There are no Human Rights Act implications arising from this report.

(d) *Equalities Impact Assessment* - There are no equality issues arising from this *report.*

5**. Summary**

5.1 Rough Sleepers

5.1.1 The Council received £260k for 2018/19 to help with its work with rough sleepers. This work had a slow start but is now fully up and running. Although, because of the slow start, there is a projected underspend this year, the Ministry of Housing have agreed to roll over the under-spend into next year, but to spend on specific initiatives.

5.2 What has progress been this year

- A Team compromising a Co-ordinator and 2 x Outreach Workers employed
- Blocked booked beds for emergency provision brought online
- Floating support provision available
- Winter Night Shelter opened since 11th of December 2018
- London and Slough Run Night Shelter open also
- Provision of a Severe Weather Emergency Provision (SWEP) available since December 2018
- Incentives/rent in advance to access accommodation
- 15 rough sleepers housed into semi-permanent accommodation

5.2.1 The Official Rough Sleeper Count was 29 and a Night Walk, which took place in January 2019, found 25 rough sleepers in various locations. 40% of this cohort were EU Nationals, predominantly polish. These EU Nationals have not exercised their Treaty Rights and therefore are unable to access public funds. The Council does not currently have a solution for these households.

5.3 Day time provision for rough sleepers

5.3.1 There is already a daytime service for single homeless people provided by SHOC for six days a week, from the morning until about 2pm. The Salvation Army provide a drop-in service, most mornings but not all. These services vary in the Offer they provide. SHOC help with benefit advice, help with housing issues, showers, food and clothes etc. The Salvation Army provide food, showers and clothes.

5.3.2 Officers feel that there is no point opening up something similar to what already exists. However, there is a definite need for some alternative provision, which could provide much needed services to rough sleepers, who may feel reluctant to walk into a conventional set-up.

5.3.3 Officers therefore feel that there is an opportunity to provide some additional support for rough sleepers in the day time. This could be a hub with: -

- Volunteers providing refreshments and possibly lunch;
- Befriending services;
- A number of services – Housing, Mental Health, Nurse, Doctor (GP), drugs worker, benefit advisor, etc. n

5.3.4 If this type of provision could be organised, 1 – 2 days would be an appropriate amount of time to provide this, given the existing provision available. Given that the Night Shelter is due to close at the end of March 2019, for the spring/summer, thought needs to go into continuing the service in some guise in order for the gains, with this cohort, not to be lost.

5.3.5 On average, 15 rough sleepers a night are occupying each night shelter. There are still a number of people refusing to use this provision and are still occupying car parks and Tescos, at night, for example. It is estimated that the day time provision for two days would cost in excess of £83k for 2019/20.

5.4 The current work of the team

5.4.1 The role of the team is to: -

- Co-ordinate the work of partners working with rough sleepers
- Move rough sleepers from the streets to appropriate accommodation
- Develop targeted multi agency collaboration
- Develop reconnection services
- Co-ordinate a multi-agency partnership meeting to oversee the work
- Develop and maintain effective relationships with rough sleepers and single homeless households
- Engage entrenched rough sleepers
- Develop individual plans for each person
- Engage agencies, i.e. Police, NHS (mental health, drug and alcohol services etc.), housing providers etc.

5.4.2 For 2019/20, the Council has bid for a second year of Rough Sleeper Initiative money. These are the work areas being asked to be funded: -

- Existing Team £130K
- Landlord Incentives and booked beds £ 92K
- Additional Outreach Worker £ 40K
- Tenancy Sustainment £ 48K
- Extended Winter Accommodation (SWEP) £ 50K
- Resettlement/Reconnection Fund £ 15K
- Contracted part-time drugs worker £ 30K
- Contracted mental health worker £ 30k
- **2018/19 underspend c/f £ 87K**
- **2019/20 final allocation £ 348K**
- **Total £ 435K**

5.4.3 This report informs the Wellbeing Board about progress in this area of work. It also concludes that the Task and Finish Group, which was set up to look at the issues and monitor the initial work for rough sleepers, should cease its monitoring role as this work is now currently embedded.

5.4.4 It must be noted however, that there is no guarantee that this work can be sustained after 2019/20, if the government does not continue funding, which it has given no indication that it will do.

5.5 Challenges for this work going forward

5.5.1 There are a number of challenging issues for this work going forward: -

5.5.1.1 The funding is confirmed for 2019/20 but not beyond. Therefore, officers do not know what the government thinking is beyond next year as initially government had indicated that this would possibly be a two year programme. If there is no early indication that this funding is going to be available beyond 2019/20, Housing Services will seek to put forward a growth bid to at least continue some of the services it sees as essential to sustaining some of the work, which it feels is making a difference;

5.5.1.2 At least 40% of the rough sleeper cohort are EU Nationals, in the main polish men. They are unable to access housing as they cannot receive benefits because of their immigration status. There is therefore no housing solution for them as they cannot pay their housing costs. Officers need to be able to find an imaginative solution to these individuals to stand any chance of actually preventing them from remaining on the streets. The limited conversations with these individuals have indicated that they are not prepared to go back to their country of birth. Officers will continue to engage these rough sleepers to find a solution.

5.5.1.3 The Winter Night Shelter/Extended Severe Weather Emergency Provision (SWEP) located at Serena Hall has been open since 11th December 2018 and is due to close at the end of March 2019. However, with the Night Shelter at the London and Slough Run also closing at this time, there will potentially be over 30 rough sleepers with no night time provision immediately after that, notwithstanding our continued attempts to house them elsewhere.

5.5.1.4 Officers are therefore considering extending the provision of the night shelter at Serena Hall and are looking at the potential for a day time provision, which will then provide a facility going forward for rough sleepers. Costs are therefore being looked at to see how feasible this is and for how long. However, officers feel that closing the provision at the end of March will not be in the Council's interest as well as rough sleepers'.

6. Comments of Other Committees

6.1 There are no comments from any other committees.

7. Conclusion

7.1 The government resources to help with Slough's rough sleeping problem has gone a long way to beginning the processes of removing people off of the streets. The infrastructure is being built and officers have seen some successes in 15 rough sleepers being housed into semi-permanent accommodation.

7.2 Sustaining this into next year and beyond will be the significant challenge of Slough and its partners, particularly as the financial position, in relation to the Rough Sleeper Initiative Grant cannot be relied on after 2019/20.

8. Background Papers

8.1 There are no background papers or appendices to this report.

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SLOUGH WELLBEING BOARD - ATTENDANCE RECORD 2018/19

MEMBER	18/07	26/09	14/11 POST-PONED	20/11/18	14/01	26/03	08/05
Naveed Ahmed	P						
Andrew Bunyan (SCST Interim CEO)	Ap (Sandra Davies - sub)						
Cate Duffy	P	P		Ap	Ap		
Temp Supt Grahame	Ap (CI Spencer – sub)	P		P	P		
Lisa Humphreys		P		Ab	Ap		
Ramesh Kukar	P	Ap		P	P		
Tessa Lindfield	P	Ap		P	P		
Councillor Nazir	P	P		P	P		
Dr Jim O'Donnell	P	Ap		P	P		
Nigel Pallace	Ap	P					
Lloyd Palmer	Ap	P		P	Ap		
Councillor Pantelic	P	P		P	P		
Colin Pill	P	P		Ap	P		
Raakhi Sharma	P	Ap		Ap	Ap		
Alan Sinclair	P	Ap (Liz Brutus – sub)		P	P		
Josie Wragg				P	P		
NHS England representative	Ap	Ap		Ap	Ap		

P = Present Sub = Substitute sent Ap = Apologies given Ab = Absent, no apologies given

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