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Date of issue: Wednesday, 8 January 2020

MEETING:	**HEALTH SCRUTINY PANEL** (Councillors A Sandhu (Chair), Smith (Vice Chair), Ali, Begum, Gahir, N Holledge, Mohammad, Qaseem and Rasib) **NON-VOTING CO-OPTED MEMBERS** Healthwatch Representative – Colin Pill Buckinghamshire Health and Adult Social Care Select Committee Representative - vacancy
DATE AND TIME:	THURSDAY, 16TH JANUARY, 2020 AT 6.30 PM
VENUE:	COUNCIL CHAMBER - OBSERVATORY HOUSE, 25 WINDSOR ROAD, SL1 2EL
DEMOCRATIC SERVICES OFFICER: **(for all enquiries)**	JANINE JENKINSON 01753 875018

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

PART I

AGENDA ITEM	REPORT TITLE	PAGE	WARD
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CONSTITUTIONAL MATTERS			
1.	Declarations of Interest	-	-

All Members who believe they have a Disclosable Pecuniary or other Interest in any matter to be considered at the meeting must declare that interest and, having regard to the circumstances described in Section 4 paragraph 4.6 of the Councillors' Code of Conduct, leave the meeting while the matter is discussed.

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SCRUTINY ISSUES			
3.	Member Questions *(An opportunity for Panel Members to ask questions of the relevant Director/ Assistant Director, relating to pertinent, topical issues affecting their Directorate – maximum of 10 minutes allocated).*	-	-
4.	First Annual Report on Immunisations and Screening in Slough	9 - 68	All
5.	Adult Social Care Strategy and Budget	69 - 98	All
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ITEMS FOR INFORMATION			
7.	Update on the Activity of the Slough Wellbeing Board	99 - 120	All
8.	Health Scrutiny Panel - Work Programme 2019/20	121 - 124	-
9.	Members' Attendance Record	125 - 126	-
10.	Date of Next Meeting - 23rd March 2020	-	-

Press and Public

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Health Scrutiny Panel – Meeting held on Wednesday, 20th November, 2019.

Present:- Councillors A Sandhu (Chair), Smith (Vice-Chair), Ali, Begum, Gahir, Mohammad and Qaseem

Apologies for Absence:- Councillors N Holledge and Rasib and Colin Pill, Chair of Healthwatch Slough Board

PART I

29. Declarations of Interest

Councillor Mohammad declared that she worked in a General Practitioners Medical Centre. She remained in the Council Chamber throughout the meeting.

29. Declarations of Interest

Councillor Mohammad declared that she worked in a General Practitioners Medical Centre. She remained in the Council Chamber throughout the meeting.

30. Minutes of the Last Meeting held on 15th October 2019

Resolved - That the minutes of the meeting held on 15th October 2019 be approved as a correct record.

31. Member Questions

None had been received.

32. Frimley Health and Care System Winter Planning 2019/20

Mr Ben Cox, Commissioning and Service Improvement Manager (NHS East Berkshire Clinical Commissioning Group), provided a presentation regarding the winter planning arrangements for the Frimley Health and Care system, which included details of system planning, implementation, governance and resilience arrangements during 2019/10.

Each year the Frimley Integrated Care System (ICS) had built on the excellent work carried out as part of the Urgent and Emergency Care Delivery Plan to ensure all system partners were prepared to meet the varied challenges over the winter period. The lessons learnt from the previous year were incorporated into the winter plan to ensure a robust Winter Planning Framework was in place.

Following the conclusion of the presentation, the Chair invited Members to comment and ask questions.

The Panel raised the following points:

- A Member asked what arrangements were in place to mitigate any impacts of Brexit. In response, the Panel was provided assurance that plans were in place for all eventualities.
- Referring to the presentation slide –'Supporting the Delivery of Elective and Emergency Care – Our Focus', the Panel noted that an area of focus was to 'reduce the number of beds occupied by long-stay patients by 25%'. A Member asked about the number of beds at Wexham Park Hospital. It was advised that there were approximately 580 beds. The 25% reduction referred to in the slide related to patients who had been in hospital for 25 days or more. Work was undertaken to identify the reasons for long-term hospital stays to ensure the right provision for patients was in place.
- A Member asked how many health care professionals received a flu vaccine. It was explained that the flu jab was offered to all employees, and approximately 35% of the Social Care Team took up the offer. However, this figure did not include the number of staff that may have chosen to get the vaccine elsewhere.
- In relation to waiting times, a Member asked what the average ambulance 'hand over time' was and the average length of wait in the Accident and Emergency (A&E) department. It was reported that waiting times were based on the level of demand. The target ambulance hand over time was 30 minutes; the average wait in A&E was 280 minutes. The use of Walk-in Centres and nurse navigators had been employed as part of the 2018/19 pilot; however these now formed part of the 'business as usual' winter planning.
- It was noted that a comprehensive communication campaign had been launched to inform members of the public of the options available, other than attending A&E. Including, promoting the use of 111 services and Walk-in Centres. School assemblies had been held to inform seven and eight year olds about the importance of the 'right care, right place, and right time'. The Panel was informed that people were able to make direct bookings to attend an appointment at a Walk-in Centre; and centres were open every day from 8am – 8pm.
- To reach a wide audience it was suggested that the Frimley ICS Communication Plan be shared with community and religious centres.
- A Member queried what plans were in place to mitigate the impacts of severe weather. It was explained that robust business continuity plans were in place to ensure staff could access their place of work. Where appropriate, flexible working arrangements, and facilities such as video conferencing could be used. Where it was crucial for staff to be on site, 4x4 vehicles were deployed to help transport staff.
- A Member asked if data was available to demonstrate the positive impact of children receiving the flu vaccine. The Commissioning and Service Improvement Manager agreed to circulate last year's data to the Panel following the meeting.
- In relation to the role of nurse navigators, a Member asked if consideration had been given to locating GPs in the A&E department to

alleviate some pressure. It was explained that the use of nurse navigators was felt to be the most appropriate option.

- Discussion took place regarding the Government announcement that 16,000 extra GP appointments across East Berkshire would be created through the Primary Care Network Model. It was explained that this equated to 22 additional appointments per week, per GP surgery. The Commissioning and Service Improvement Manager agreed to share with the Panel, the document identifying the relevant GP surgeries in Slough.

On behalf of the Panel, the Chair thanked the Commissioning and Service Improvement Manager for the presentation and report.

Resolved –

(a) That the report and presentation be noted.

(b) That the Commissioning and Service Improvement Manager be requested to share with the Panel the document identifying the GP surgeries in Slough offering additional patient appointments.

(c) That the Commissioning and Service Improvement Manager be requested to circulate last year's flu vaccine data to the Panel.

33. Annual Director of Public Health Report 2019 Berkshire - A Good Place to Work

The Service Lead Public Health introduced the report that summarised the Annual Director of Public Health Report (ADPHR) 2019: Berkshire – A Good Place to Work, which focussed on workplace health and wellbeing.

The Director of Public Health had a statutory responsibility to produce an ADPHR. The report aimed to inform residents of health issues in their community, inspire action and guide decision makers' priorities, and ultimately reduce local health inequalities.

This year the report focussed on work and health. The topic had been selected due to the strong relationship between work, health and the opportunities in workplaces to take action to improve health and wellbeing.

Evidence showed that 'good work' improved health and wellbeing, by connecting people, providing a stable income, social interaction and a sense of identity and purpose. Unemployment was associated with an increased risk of poorer health, including limiting long-term illness, heart disease, poor mental health and health harming behaviour.

The relationship between work and health was symbiotic: good work was good for people's health, and people in the best health were more productive and good for business. The benefit of improving workplace health extended beyond the individual worker. For an employer, a healthy resilient workforce

took fewer sick absences, had better productivity and longer careers before retiring. From an economic and wider societal view, an unhealthy workforce could lead to increased healthcare costs, increased informal caregiving, increased long-term sickness and a loss in productivity.

The key messages of the report were:

- The workplace was an ideal venue for improving health. Workplace health was a win:win for population health, employees and employers.
- Berkshire had relatively high levels of employment; and the top industries were professional, scientific and technical, information and communication. Berkshire had a higher proportion of people in managerial and professional positions than the average in the England.
- There was evidence that improving the health of the workforce assisted productivity. Workplaces were changing and there was a need to adapt approaches to meet the needs of flexible employees and freelancers.
- Evidence showed that engaged and committed organisational leadership, working closely with employees was critical for success.
- Access to good work was easier for some – employment rates varied depending on gender, ethnicity and disability.
- Evidence showed that people in Slough had significantly more years of life in poor health than the national average.

Following the conclusion of the presentation, the Chair invited Members to comment and ask questions.

During the course of a wide-ranging discussion, the following points were raised:

- A Member asked what was being done to discourage people from smoking and vaping. The Service Lead Public Health explained that smokers were being encouraged to vape rather than smoke. Evidence indicated that vaping was 95% less harmful than cigarette smoking.
- Concern was raised that people in Slough had significantly more years of life in poor health compared to the rest of Berkshire. A Member queried why this was the case. It was explained that the causes of this were complex and related to lifestyle choices, income, education, housing and factors such as air pollution and the built environment.
- A Member stressed the importance of promoting the Council's leisure facilities, and ensuring that usage was affordable for residents. The Service Lead Public Health reported that the Health Beliefs and Physical Activity Research project had indicated that one of the barriers preventing people from using the leisure facilities was the perception that gyms were for 'lycra-clad, perfect looking people'. To tackle this, a

marketing campaign depicting imagines of 'everyday' people was being rolled out.

- It was noted that cancer was one of the most common causes of illness and death in Berkshire. A Member asked why this was the case. It was explained that smoking was the single biggest cause of preventable diseases.
- A Member requested some comparator information regarding the numbers of people in Slough and nationally living with disabilities.
- Referring to the information provided in the presentation slides, a Member queried why musculoskeletal disorders were so high in Berkshire. It was explained that increasingly people were working in sedentary jobs, and sitting for prolonged periods had a detrimental impact on people's health. It was explained that the Council promoted 'active movement' to employees, for example encouraging staff to stand up from their desks every 20 minutes.
- It was reported that Slough Wellbeing Board had adopted workplace health as one of its key priorities. The Council's Public Health Team had recently recruited a person to promote work place health and potentially complete a national accreditation scheme. The Panel agreed that regular updates from the Slough Wellbeing Board would be welcome.

On behalf of the Panel, the Chair thanked the Service Lead Public Health for presenting the report.

Resolved –

(a) That the Annual Director of Public Health Report 2019: Berkshire – A Good Place to Work be noted.

(b) That regular update reports from the Slough Wellbeing Board be provided to the Health Scrutiny Panel.

(c) That the Service Lead Public Health be requested to circulate to the Panel comparator data regarding the numbers of people in Slough and nationally living with disabilities.

34. Disability Task and Finish Group Implementation Update

The Panel was provided with an information report regarding the steps that had been taken to implement the recommendations of the Disability Task and Finish Group.

(At this point in the meeting Councillor Gahir declared that he was a taxi driver. He remained in the Council Chamber during the discussion in relation to the report)

Dr Elena Gaddes, Policy Insight Analyst explained that whilst the report had been provided for information, if Members wished to raise any questions she would relay these to the report author and subsequently provide a response to the Panel.

Members raised the following queries:

- What progress had been made to remove obstructions on pathways? In addition, it was requested the details of the pathways that had been cleared to be reported back to the Panel.
- Referring to the target column, set out in Appendix A of the report. A Member asked for a clear definition of the time periods referred to as 'short-term', 'medium-term', 'long-term' and 'on-going'.
- A Member asked how many disabled people had been enabled by the Council to remain living in their own homes. The Policy Insight Analyst agreed to request this information from the Adult Social Care Team and report back to the Panel.
- Referring to the 'next steps' listed on page 75 of the report, 'officers will review disabled parking borough-wide and conduct a statutory consultation on more disabled parking around shopping areas' – a Member asked for further details about when the review would commence and the projected number of additional disabled car parking spaces that would be provided in future.

Members requested that a further report and presentation be provided to the Health Scrutiny Panel.

Resolved -

(a) That the report and information set out in Appendix A be noted.

(b) That a presentation and report addressing the queries set out above and detailing the implementation of the Disability Task and Finish Group recommendations be provided at the Health Scrutiny Panel meeting on 23rd March 2020.

35. Health Scrutiny Panel - Work Programme 2019/20

16th January 2020

- **Immunisation and Screening Annual Report and Local Update** – Members requested that regional and national comparator data be included in the report.

- **New Data Observatory and Website for Public Health** – Dr Brutus agreed to circulate to the Panel the web link to the new public health

website. The item would be removed from the list of items for the 16th January 2020 meeting and rescheduled later in the year.

23rd March 2020

- **Disability Task and Finish Group – Implementation Progress –** Members requested that rather than the 'information only' report scheduled, a full report and presentation be provided to the Panel.

Resolved – That subject to the amendments detailed above, the Forward Work Programme be agreed.

36. Members' Attendance Record

Resolved - That the details of the Members' Attendance Record be noted.

37. Date of Next Meeting - 16th January 2020

Resolved – That the date of the next meeting was confirmed as 16th January 2020.

Chair

(Note: The meeting opened at 6.30 pm and closed at 8.05 pm)

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SLOUGH BOROUGH COUNCIL

REPORT TO:	Health Scrutiny Panel
DATE:	16 January 2020
REPORT AUTHORS:	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 AND SCREENING IN SLOUGH

1. Purpose of Report

- To provide an update on the national screening and immunisation programmes in Slough following a presentation to Slough Health Scrutiny Panel in January 2019.
- Provide an update on current commissioning arrangements and 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.

2. Recommendations

The Panel is recommended to:

(a) Consider the actions being taken to deliver the national programmes for immunisation and screening and their progress in tackling health inequalities in Slough.
(b) Request an update on progress of the Slough Local Action Plans for Immunisations and Screening annually (ideally mid-year eg June to complement this annual NHSE/NHSI Update) and ensure the actions are addressing the relatively lower uptake and health inequalities in both immunisation and screening in Slough.
(c) Request an Annual Report on Immunisation and Screening from NHSE /NHSI for January 2021.

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. This second combined annual report from NHSE/NHSI follows up from their report in Jan 2019 and outlines the picture of immunisations and screening in Slough – in particular highlighting the achievements this year, further opportunities and future plans.

5.3 Panel 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 (NHS E) 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 demonstrate 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 Slough Borough Council ('the LA'), the school immunisation provider and NHS England have worked together to agree how they will address cultural and language barriers to improve uptake further 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.

5.7 Successful collaborative working has enabled improvements in some outcomes; however, there is still opportunity to improve uptake of cancer screening programmes and children's 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.

6. Comments of Other Committees

6.1 This paper, 'Immunisation and Screening Programmes - an update for Slough' (Dec 2019) has not yet been seen by other committees. However, the original paper, 'Annual Report on Immunisations and Screening in Slough – Jan 2019' was presented to both the Slough Wellbeing Board and Slough Health & Care Partnership Board who welcomed the recommendations for a Local Action Plan. In 2019, the focus has been on immunisations (rather than screening) and various updates on the progress of the Local Immunisations Action Plan have been provided to the Health Scrutiny Committee and Slough Wellbeing Board over the year.

[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/

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 particularly in Slough where uptake of both immunisation and screening are still below regional and England average levels. – 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.

7.2 Over the last year, a large amount of work has been achieved by the various partners involved in commissioning, providing and reviewing immunisations and screening for Slough residents as detailed in the report. There has been a steady improvement in almost all areas although we know there is still more to do.

7.3 The strength of the Slough Immunisation Partnership has been that to complement smoother immunisation provision and data reporting, we are considering how we can work around the other factors that affect residents' decision-making and uptake of immunisations. This includes understanding residents' opinions and the impact of the social and environmental factors – the wider determinants of health - including for example, income levels, culture and language, education and skills, employment, housing and environmental factors. In 2020, we will pull together a similar local partnership to consider the most effective ways to improve screening uptake locally.

8. Appendices

A - Immunisation and Screening Programmes - an update for Slough. Dec 2019.

B - The Ten Questions To Ask If You're Scrutinising Local Immunisation Services. Centre for Public Scrutiny. 2016

9. Background Papers

Health Scrutiny 17.01.2019. Immunisation and Screening Programmes - an update for Slough. Dec 2018.

Health Scrutiny 27.06.2019. Update on the Slough Local Action Plan for Immunisations.

Slough Wellbeing Board 13.11.2019. Update On Immunisations and the Slough Local Action

Appendix A

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

DATE: December 2019

Report By: Public Health Commissioning Team- NHS England & NHS Improvement - South East
Nisha Jayatilleke, Screening and Immunisation Lead
Paula Jackson, Screening and Immunisation Lead

Purpose of Report:

- To provide an update on the national screening and immunisation programmes in Slough following a presentation to Slough Health Scrutiny Panel in January 2019.
- Provide an update on current commissioning arrangements and 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 (NHS E) 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 demonstrate 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 Slough Borough Council ('the LA'), the school immunisation provider and NHS England have worked together to agree how they will address cultural and language barriers to improve uptake further 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.

Successful collaborative working has enabled improvements in some outcomes; however, there is still opportunity to improve uptake of cancer screening programmes and children's 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.

Recent nationally-driven quality improvements 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, more effective seasonal flu vaccination programme and the extension of the HPV vaccination programme to all children aged 12 and 13 years of age by rolling the programme to offer boys the vaccination.

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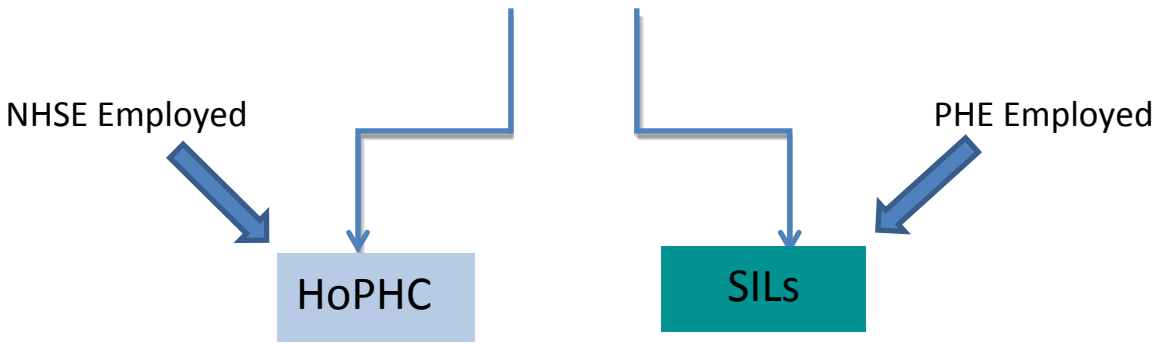
Background

Current commissioning and provider arrangements

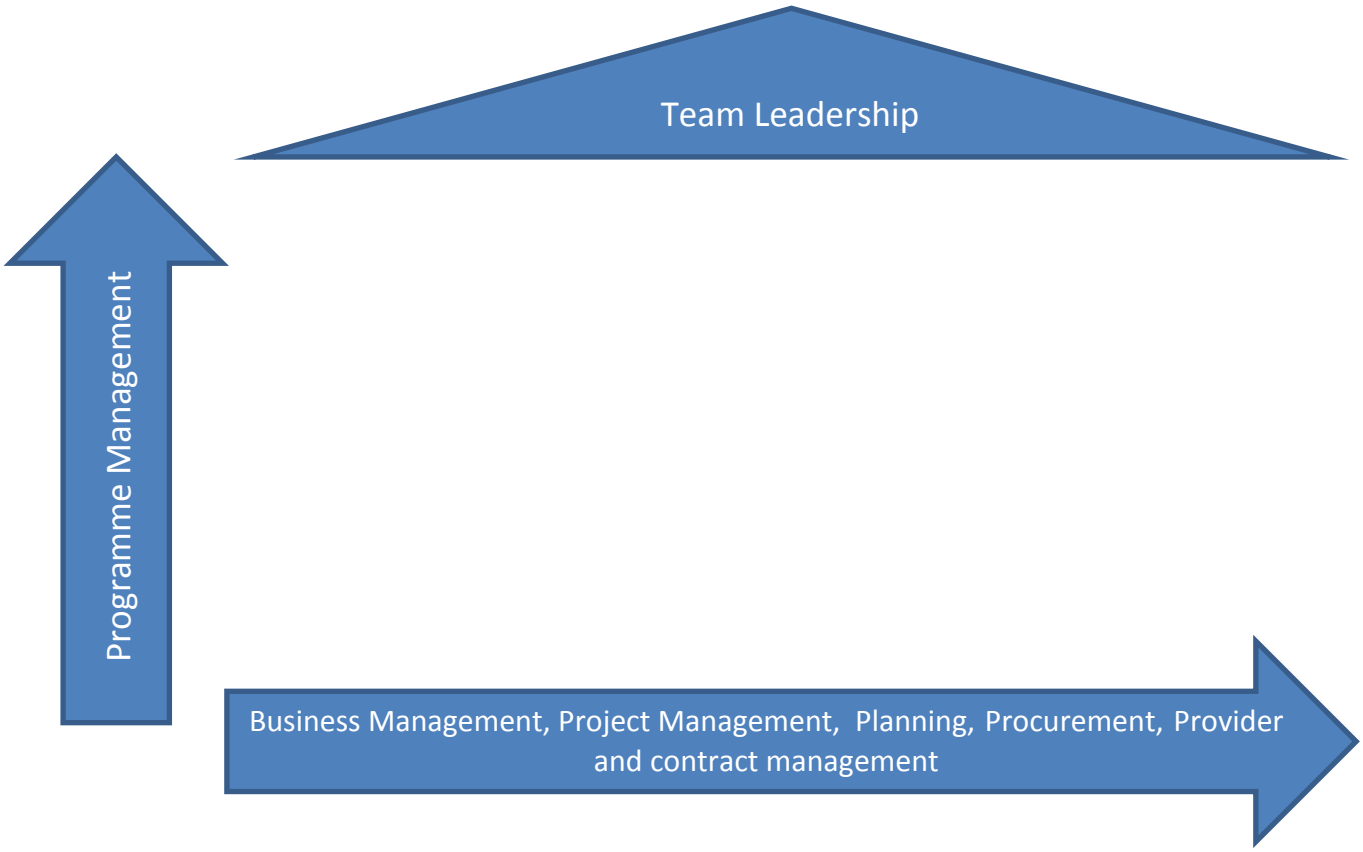
- NHS England is responsible for commissioning screening & immunisation programmes in England. Locally this is co-ordinated and managed across Thames Valley by the Public Health Commissioning team at NHS England & NHS Improvement- South East under an agreement known as Section 7a – see
-
- Figure **1** 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 Screening Programmes are provided by Frimley Hospitals Trust and Health Intelligence.
- 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.
- Child Health Information System (CHIS) is commissioned by NHS England from NHS South, Central and West Commissioning Support Unit.
- Public Health England (PHE) 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



Local Office Public Health Commissioning Team

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



Immunisation programmes

Immunisation is one of the most effective public heath interventions. 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. With high levels of uptake herd immunity can be achieved which 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 complete routine immunisation schedule is published online (available at- https://www.gov.uk/government/publications/the-complete-

routine-immunisation-schedule). The schedule is updated based on scientific evidence reviewed by the Joint Committee for Vaccinations and Immunisation. For example, from September 2019, the human papillomavirus (HPV) immunisation programme was extended. The programme is now offered to boys and girls aged twelve to thirteen years of age. Another new development is that all infants born on or after 1 January 2020 will be offered the updated schedule, (referred to as a 1 + 1 PCV schedule).

Local immunisation providers continue to participate in the COVER (Cover of Vaccination Evaluated Rapidly) programme which 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 also set out in the complete 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 1: NHS National Screening Programmes

Screening Programme	Population offered the screen	Aim of programme
Bowel Cancer (Faecal Immunochemical Test (FIT)) 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 Some women between the ages of 47-50 and 70-73 will also be invited as part of a national age extension trial. This does not affect their invites between the ages of 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	Screening for infectious diseases (hepatitis B, HIV and syphilis) Screening for inherited conditions (sickle cell, thalassaemia and other haemoglobin disorders) Screening for Down's syndrome, Edwards' syndrome and Patau's syndrome Screening for 11 physical	Screening tests are offered during pregnancy to try to find any health conditions that could affect the woman or her baby/ babies. For the woman, the tests can help make choices about further tests and care or treatment during pregnancy or after baby is born.

	conditions (20-week scan) Eye problems in women with diabetes	
Newborn screening	Newborn physical examination Newborn hearing Newborn 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 from2016-17 and 2018-19 is shown in Table 2. 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 2: Childhood Immunisation (0-5 years) Uptake 2016-17 and 2018-19

			2018-19 England	2016-17 Slough	2017-18 Slough	2018-19 Slough
Age 1	DTaP/IPV/Hib	% immunised	**92.1%**	**90.8%**	**93.7%**	**91.8%**
	PCV	% immunised	**92.85**	**90.8%**	**93.8%**	**92.8%**
	Rotavirus (1)	% immunised	**89.7%**	**87.9%**	**91.2%**	**87.8%**
Age 2	DTaP/IPV/Hib primary	% immunised	**94.2%**	**94.1%**	**95.2%**	**94.3%**
	MMR 1st dose	% immunised	**90.3%**	**84.8%**	**87.1%**	**88.4%**
	Hib/ MenC	% immunised	**90.4%**	**85.6%**	**87.2%**	**88.9%**
	PCV booster	% immunised	**90.2%**	**84.6%**	**87.3%**	**88.7%**
Age 5	DTaP/IPV/Hib primary	% immunised	**95%**	**93.3%**	**97.7%**	**95.3%**
	DTaP/IPV booster	% immunised	**84.8%**	**77.7%**	**75.1%**	**75.8%**
	MMR 1st dose	% immunised	**94.5%**	**91.1%**	**94%**	**93.9%**
	MMR 1st and 2nd dose	% immunised	**86.4%**	**79.0%**	**81.1%**	**83.7%**
	Hib/ MenC booster	% immunised	**92.2%**	**90.3%**	**91.4%**	**91.6%**

Data Source: NHS Digital (2017 and 2019): 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. To address this, the CHIS Provider is now sending invitations at age 3 years and 4 months to ensure timely vaccination.

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

Schools-aged immunisation programme

Girls aged twelve to thirteen years have been offered HPV vaccination from September 2014.The vaccine is now being offered to boys, in addition to girls, as part of the routine school aged schedule in England as of 1st September 2019.The majority of the vaccinations occur in the Spring term along side the HPV girls vaccination programme.

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 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 3:HPV, Men/ACWY and Td/IPV vaccine uptake in school-aged children 2017-18

			England 2017-18	**South East 2017-18**	**Slough 2017-18**
Girls aged 12 to 13 (Year 8)	HPV 1st dose	Cohort	306,940	22,866	1,030
		Number of children immunised	266,785	20,826	884
		% immunised	86.9%	91.1%	85.8%
Girls aged 13 to 14 (Year 9)	HPV 2nd dose	Cohort	300,464	22615	1,177
		Number of children immunised	251,919	20,402	1,044
		% immunised	83.8%	90.2%	88.7%%
School Year 9 in 2017/18 (13-14 year olds) born between 1 September 2003 - 31 August 2004	Td/IPV and Men/ACWY	Number of 13-14 year olds	567,140	46,148	2,005
	Td/IPV	Number of children immunised	484,943	40,953	1,805
		% immunised	85.5%	88.7%	90.0%
	Men/ACWY	Number of children immunised	489,071	41,405	1,816
		% immunised	86.2%	89.7%	90.6%

Data source: https://www.gov.uk/government/statistics/hpv-vaccine-coverage-annual-report-for-2017-to-2018; https://www.gov.uk/government/publications/school-leaver-booster-tdipv-vaccine-coverage-estimates; https://www.gov.uk/government/publications/meningococcal-acwy-immunisation-programme-vaccine-coverage-estimates

NHS England continue to work with stakeholders to improve uptake. The school immunisation 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 as well as nationally by NHS England.

Young people and adult Immunisation Coverage

Table 4: Shingles Vaccination Coverage, Slough LA June 2019

	Percent coverage	
	Slough	**England**
Shingles: coverage for routine cohort since 2013	32.7%	31.9%
Shingles: coverage for the catch up cohort since 2013	36%	32.8%

Data Source: ImmForm website: Registered Patient GP practice data. Shingles Immunisation Vaccine Uptake Monitoring Programme Public Health England. Date of latest data extraction 09/07/2019 available at https://www.gov.uk/government/publications/herpes-zoster-shingles-immunisation-programme-2013-to-2014-provisional-vaccine-coverage-data

Table 5: Pneumococcal Vaccination Coverage, all GP registered patients aged 65 and over Slough CCG

	2016-17	2017-18	2018-19
Slough	69.5%	67.6%	67%
England	69.8%	69.5%	69.2%

Data Source: https://www.gov.uk/government/publications/pneumococcal-polysaccharide-vaccine-ppv-vaccine-coverage-estimates

Table 6: Annual pre-natal Pertussis Vaccination Coverage, Slough CCG between 2016-17 and 2018-19

	2016-2017	2017-2018	2018-2019
Slough	51.3%*	49.1%*	49.3%
England	66%*	71.9%*	69.8%

Data Source: Immform /Prenatal Pertussis Vaccine Coverage monitoring programme.
APRIL-JUNE 2017- No data received nationally from IT supplier

Table 7: Seasonal Flu Vaccination Coverage, Slough CCG 2018-19

Eligible group	National Ambition	% Uptake Slough	% uptake England
2yr olds	48%	34.5%	43.8%
3yr olds	48%	37.9%	45.9%
Pregnant women	55%	38.2%	45.2
Under 65s at risk	55%	46.9%	48.0
65 and over	75%	68.0%	72.0
School based programme			
Reception	65%	47.1 %	64.3%
Year 1	65%	46.7%	63.6%
Year 2	65%	45.2%	61.5%
Year 3	65%	44.9%	60.4%
Year 4	65%	42.9%	58,3%
Year 5	65%	42.1%	56.5%

Data source:
https://www.gov.uk/government/statistics/seasonal-flu-vaccine-uptake-in-gp-patients-winter-2018-to-2019
Seasonal influenza vaccine uptake in children of primary school age: winter season 2018 to 2019

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 8: Cancer Screening Coverage 2018-19

Programme	National Targets		Latest published data		
			Slough	South East	England
BREAST (31st March 2018): % Coverage , women aged 53-70 screened within 3 years	70%	80%	68%	76%	75%
BOWEL: % of the eligible population (60-74) have been screened in the last 2.5 years	52%	60%	44.1%	60.8%	59
CERVICAL: (31st March 2019) % of the eligible population (25-64) have been screened in the last 3.5 /5.5 years	75%	80%	66%	73%	72%

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

Table 9: Non-Cancer Screening Uptake

Programme: Diabetic Eye Screening: Uptake of Routine Screening	2018-19			
	Q1	Q2	**Q3**	**Q4**
National	83	83	83.1	81.9
Berkshire Diabetic Eye Screening:	76.6	81.9	83.9	No data

Data Source:
https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2017-to-2018

Table 10: Abdominal Aortic Aneurysm Screening Uptake

	2018	
	National	**Slough**
Thames Valley AAA Screening: Proportion of eligible men offered screening who accept the offer	80.8%	75.9%

Data Source:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework

Coverage of antenatal and newborn screening programmes

Table 11: Antenatal and newborn screening programmes delivered at Wexham Park (Frimley Hospitals Trust) 2018/19 Q2- 2019/20 Q1

ANTENATAL AND NEWBORN SCREENING	STANDARDS AND BENCHMARKING							
	National Standards			2018-19				2019-20
	KPI	Acceptable	Achievable	Q1	Q2	Q3	Q4	Q1
Infectious Diseases Screening								
HIV testing coverage	ID1		≥ 90%	99.9	99.8	100.0	100.0	99.9
Timely referral of hepatitis B positive women for specialist assessment	ID2	>70%	≥ 90%	100.0	100.0	100.0	100.0	100.0
	ID2	D:	N:					
Hep B testing coverage	ID3	≥ 95%	≥ 99%	100.0	99.9	100.0	100.0	99.9
Syphilis testing coverage	ID4	≥ 95%	≥ 99%	100.0	99.9	100.0	100.0	99.9
Fetal Anomaly Screening								
Down's (anomaly) syndrome screening – completion of laboratory request forms	FA1	≥ 97%	100%	99.4	99.2	99.1	98.7	98.6
Fetal anomaly screening(18+0 to 20+6 fetal anomaly ultrasound)-Coverage	FA2	≥ 90%	≥ 95%	100.0	99.8	100.0	99.9	99.9
Down's ,Edwards and Patau's syndrome-Coverage	FA3							
Sickle Cell & Thalessaemia Screening								
Antenatal sickle cell and thalassaemia screening – coverage	ST1	>95%	≥ 99%	100.0	99.9	100.0	100.0	99.9
Antenatal sickle cell and thalassaemia screening – timeliness of test	ST2	>50%	≥ 75%	45.7	52.9		46.5	42.8
Antenatal sickle cell and thalassaemia screening – completion of FOQ	ST3	>90%	≥ 95%	100.0	100.0	100.0	99.0	100.0
Antenatal sickle cell and thalassaemia screening-timely offer of PND to at risk women	ST4a			100.0	No couples	50.0	0.0	100.0
Antenatal sickle cell and thalassaemia screening-timely offer of PND to at risk couples	ST4b			0 couples	50.0	100.0	No cases	0.0
Newborn Key Performance Indicators								
Newborn Bloodspot Screening								
Newborn blood spot screening – coverage	NB1	≥ 95%	≥ 99.9%	92.6	93.5	94.4	98.2	97.4
Newborn blood spot screening – avoidable repeat tests	NB2	>2.0%	≤ 1.0%	1.4	2.7	1.9	1.5	1.7
Newborn blood spot screening – coverage (Movers In)	NB4	≥ 95%	>99.9%	86.5	72.2	72.0	83.6	85.8
	NB4	D:	N:	109 of 126	109 of 151	116 of 161	133 of 159	109 of 127
Newborn Hearing Screening								
Newborn hearing screening – coverage	NH1	≥ 98%	≥ 99.5%	99.7	99.0	99.8	100.0	99.9
Newborn hearing – timely assessment for screen referrals	NH2	>90%	≥ 95%	85.7	75.0	100.0	100.0	100.0
	NH2	D:	N:	12 of 14	6 of 8	9 of 9	9 of 9	15 of 15
Newborn and Infant Physical Examination Screening								
Newborn and Infant Physical Examination – coverage (newborn)	NP1	≥ 95%	≥ 99.5%	99.5	99.1	99.2	99.1	99.3
Newborn and Infant Physical Examination – timely assessment of DDH	NP2	≥ 95%	≥ 99.5%	100.0	No cases	100.0	0.0	No cases

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

- During 2019, we have had more opportunities to work together and identify more areas of work that can lead to improved uptake. This includes shared learning opportunities such as the immunisation conference that was hosted by Slough Borough Council Public Health team.

- 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. Improved accuracy of data means that CHIS can properly identify unimmunised/under-immunised children and target follow up invitations correctly. In addition to general commissioning of CHIS, local practices have received support from a dedicated clinical staff member from CHIS to help implement good practice specifically commissioned by the public health commissioning team.

- There is ongoing joint working between LA, school immunisation providers and NHS England to agree actions to address cultural and language barriers to improve uptake rates. For example, in 2018-19, there have been outreach immunisation clinics in conjunction with the local fire service in the local town centre increasing the opportunity to offer school aged children the flu vaccine.

- Thames Valley Cancer Alliance, a strategic partnership tasked with delivering the national cancer strategy in Thames Valley. A key deliverable of the alliance is to improve early diagnosis of cancer through increasing cancer screening uptake. East Berkshire CCG has played an important in development of working with working with the Screening and Immunisations Team on a GP Quality Improvement Scheme in primary care to improve cancer screening uptake. An additional initiative is now in place to target and improve uptake among people with a learning disability.

- Diabetic Eye Screening (DES): uptake of DES in Berkshire has steadily improved since April 2018. The programme is currently meeting all of its key performance indicators. The service analyses uptake data at GP practice level to identify variation and where uptake is suboptimal the programme manager will visit individual practices to discuss actions that they can take to improve uptake. A dedicated engagement officer (vacant post at time of writing) works with primary care and key stakeholders such as patient groups to promote the service and raise awareness of the importance of eye screening for people living with diabetes. Patient feedback on the service is overwhelmingly positive.

- The Thames Valley AAA has taken steps to improve access and uptake of AAA screening in Slough by working with local faith groups to understand the needs of populations who have historically been less likely to take up the offer of screening. As a result, the programme has recently revised its local screening clinics times to provide better access to men in the Muslim community

- Replacement of the Faecal Occult Blood Test (gFOBt) with the Faecal Immunochemical Test in the Bowel Screening Programme in June 2019 has resulted in increased uptake. This test is also more sensitive and easier to use. Trial data demonstrated that the greatest increase in uptake was seen in those groups previously less likely to participate and therefore contributes to a reduction in inequalities.

- The extension of HPV immunisation programme to enable boys aged 12 to 13 years of age to be vaccinated has been successfully implemented.

- Slough Borough Council Public Health Team launched the #IamVaccinated campaign in 2018. This is the new face of the team's 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.

Key Opportunities

- 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.

- In 2018, NHS E 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. Uptake data indicate a marked improvement in uptake in this cohort and this was thus extended to incorporate the whole of the Thames Valley.

- Continue to work with local public health team from Slough Borough Council to understand population needs and work together to identify ways to empower decision to take up offer of screening and immunisation programmes.

- The 2019/20 seasonal flu programme included a new vaccine - a quadrivalent vaccine QIVc (cell-based cultured on mammalian cells). QIVc is suitable for use both in those aged 18 to 64 years and in those aged 65 years and over.

- The Screening and Immunisations team in Thames Valley has recently met with the Slough LA Public Health Team to discuss development of a local action plan to increase screening uptake and reduce local inequalities. This was informed by a briefing paper from the Screening and Immunisations Team which covered relevant national and local evidence and data, recent activity undertaken to increase uptake of cancer screening by East Berkshire CCG and recommendations for specific actions to be taken in Slough. The action plan will now be taken forward for finalisation by the Slough LA Public Health Team with implementation support from Screening and Immunisations team members.

Next Steps

- Key partners will work together to progress local action plans for Slough to improve uptake and reduce inequalities in screening and immunisation programmes building on recent successes.

- 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 achieves its system 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.

- NHS England will seek to work with the emerging Primary Care Networks to ensure that their work to improve access, engage better with local communities and work with the most vulnerable includes a focus on improving uptake of screening and immunisations

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Centre for Public Scrutiny

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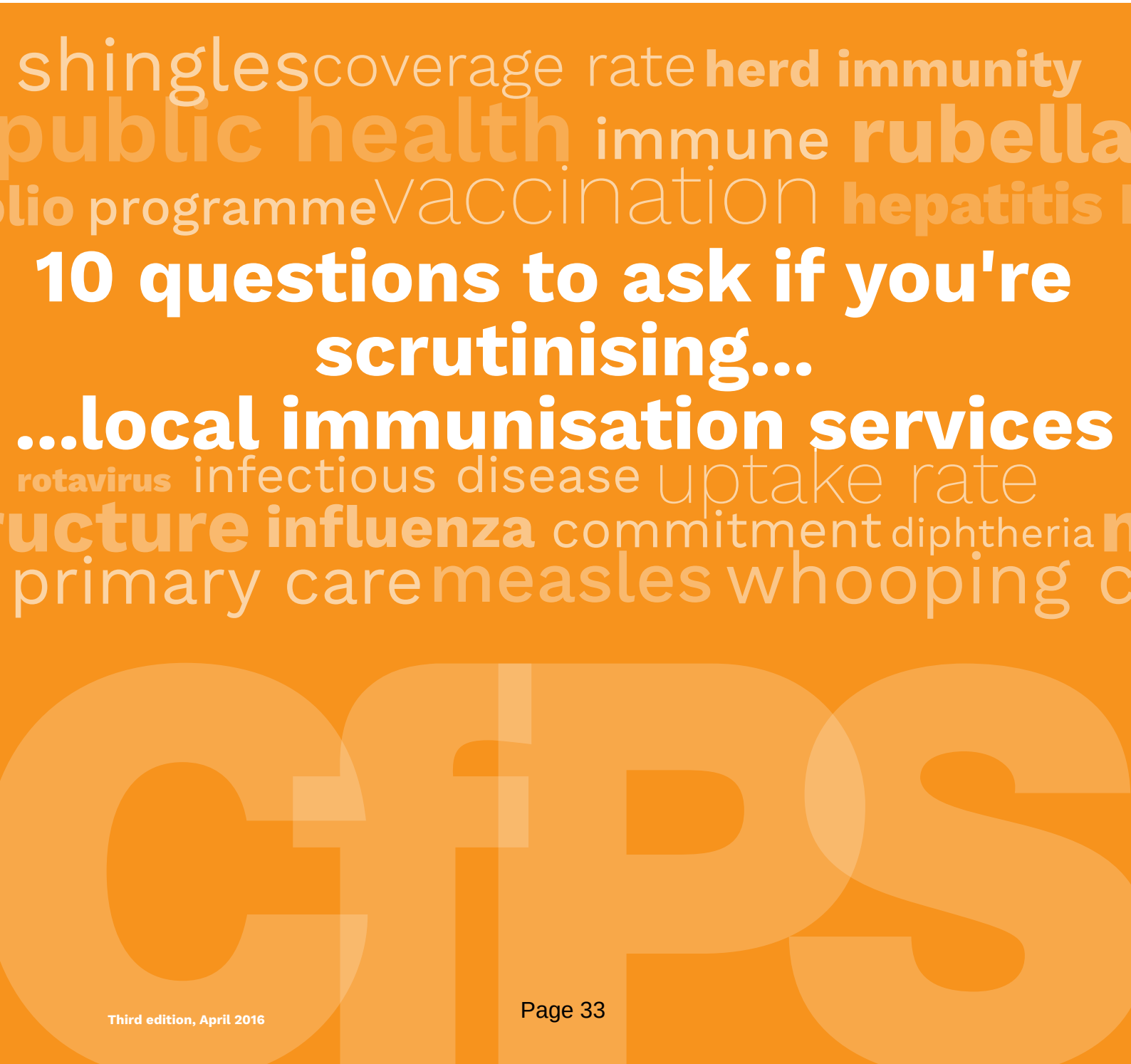
vaccines for life

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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Dr Pratibha Datta

Dr Peter English

Dr Roy Fey

Judith Moreton

Marie Price

Johan van Wijgerden

Dr Justin Varney

David Buck

Dr Peter Skolar

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/

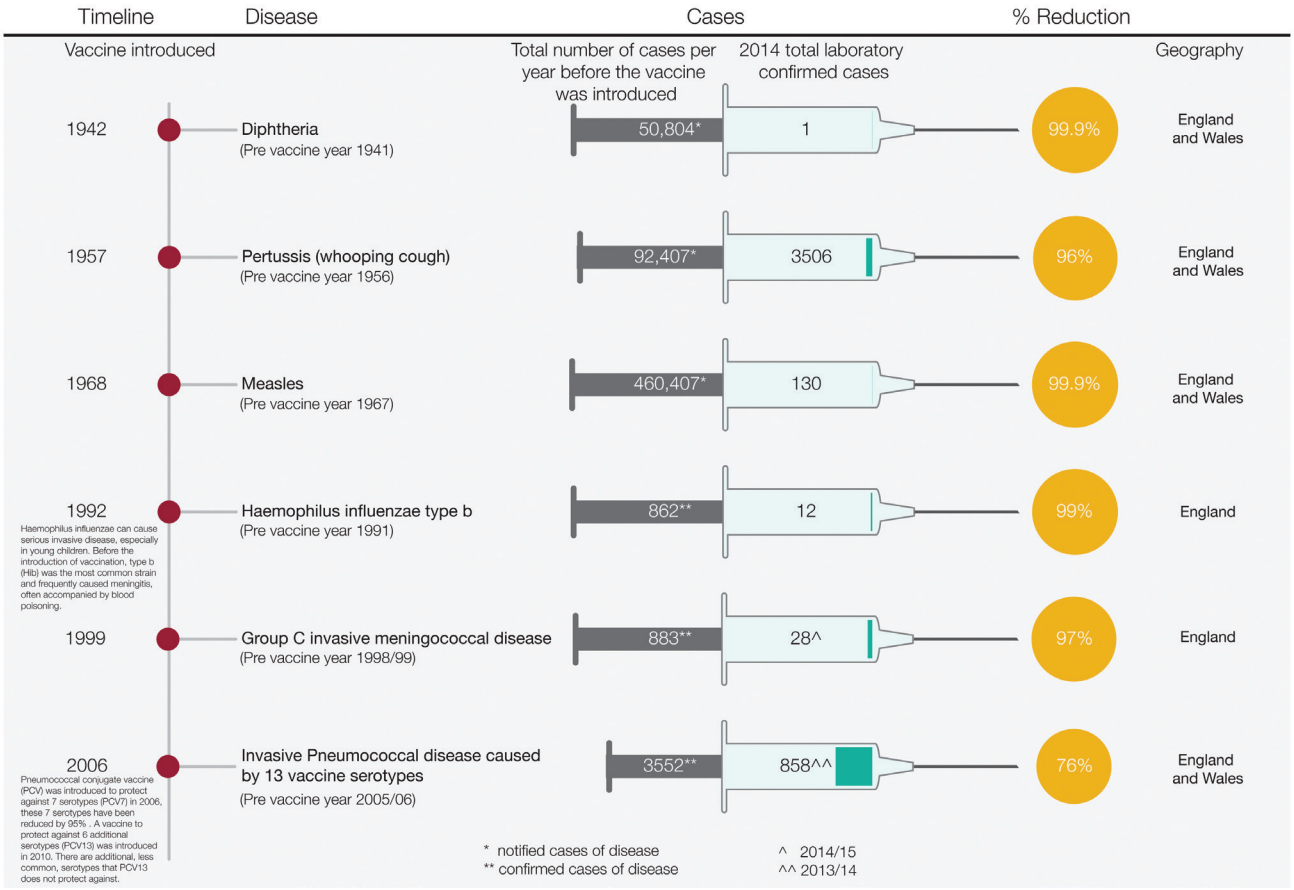


Image reproduced with permission from PHE.

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

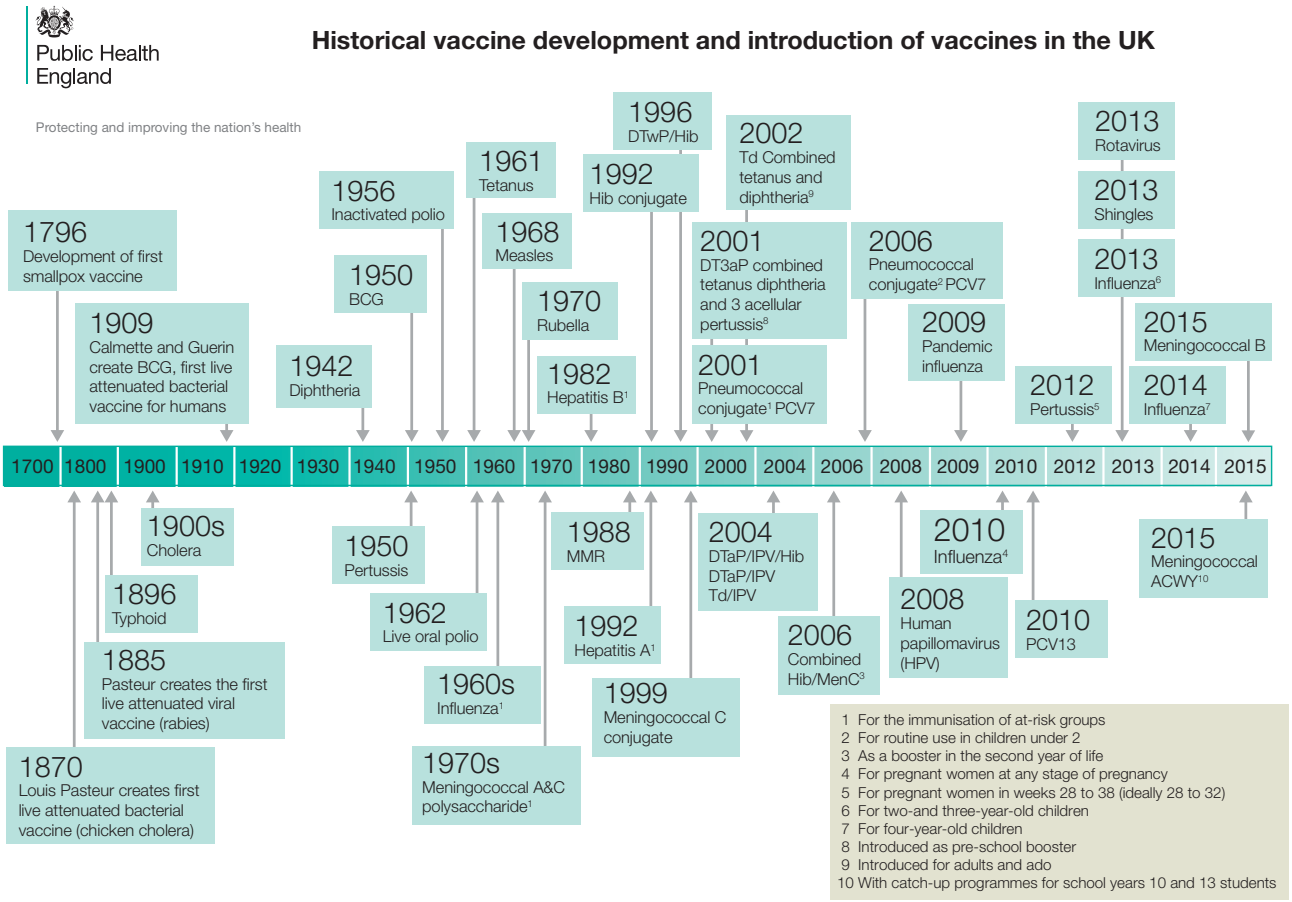


Image reproduced with permission from PHE.

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?

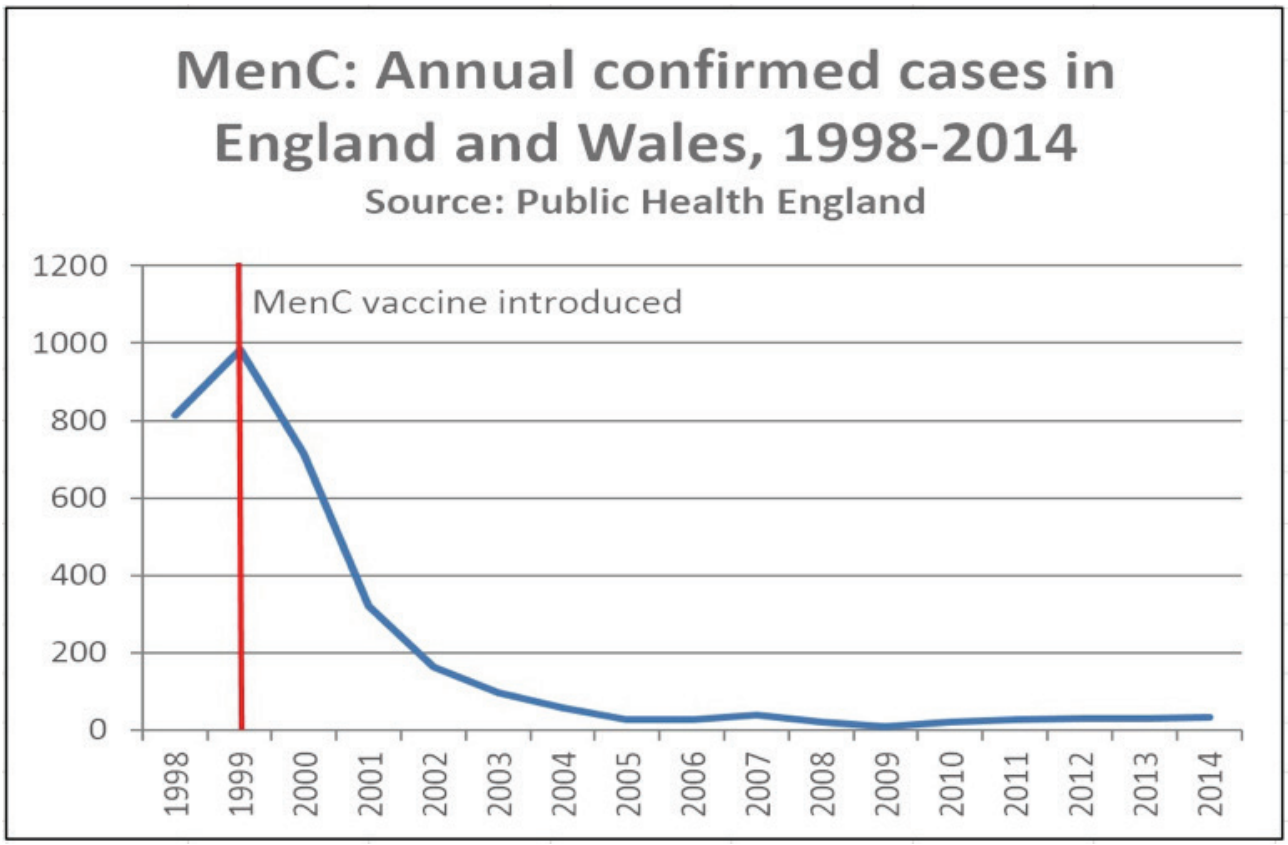
Background and policy context

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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Local Government House Smith Square London SW1P 3HZ
telephone **020 7187 7362** email **info@cfps.org.uk** twitter **@cfpscrutiny**

SLOUGH BOROUGH COUNCIL

REPORT TO: Health Scrutiny Panel

DATE: 16th January 2020

CONTACT OFFICER: Alan Sinclair, Director Adults and Communities

(For all Enquiries) 01753 875752

WARD(S): All

PART I

FOR COMMENT & CONSIDERATION

ADULT SOCIAL CARE STRATEGY AND BUDGET

1. Purpose of Report

To update members of the Health Scrutiny Panel on the delivery of the Adult Social Care Strategy, the expected outturn for 2019/20 and the proposed budget for Adult Social Services in Slough in 2020/2021. The report also provides the Panel with the requested update on proposed fees and charges across a range of adults and communities services.

2. Recommendation(s)/Proposed Action

The Panel is requested to note the report and comment on the financial position facing Adult Social Care Services in Slough.

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

Adult Social Care Services in Slough are particularly focused on meeting Outcome Two of the five priority outcomes in the Council's Five Year Plan:

- Our people will be healthier and manage their own care needs

The work of Adult Social Care Services in Slough also strives to address some of the priority outcomes of the current Slough Wellbeing Strategy (2016-2020).

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

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.

5. Supporting Information

5.1 Adult Social Care Strategy

Slough Adult Social Care aims to improve the outcomes of our residents and their carers by enabling people to do more for themselves, focusing on people's strengths even at points of crisis in their lives, by connecting them to their interests and communities and a network of wellbeing, care and support services.

Our strategic aims are to support Slough residents with adult social care needs and their carers, to enable people to:

- Maintain their health and wellbeing.
- Manage their own care and support needs.
- Live independently in their own homes for as long as possible.
- Have control over the support they receive.
- Avoid hospital admission unless clinically necessary.
- Be safe.

For full details on the current Adult Social Care Strategy, please see Appendix 1 of this report.

Over the last year, some key achievements in delivering the Strategy are:

- An increase in numbers of people managing their own care and support needs through a direct payment. Slough now scores in the top 25% of all Adult Social Care Services nationally in this measure.
- Continued good performance in supporting people to remain living independently at home.
- Continued good performance in supporting people home in a timely way after a hospital admission, with our rates much better than the national average.
- The continued success of Slough's Mental Health Services. These services are ranked amongst the highest nationally for several measures, and were shortlisted for the national 'Innovation in Health' award for their approach to treating mental health.

5.2 Current Financial Position of Slough Adults and Communities

The forecast outturn for Adult Social Care is approximately a £1million overspend, which is 3% of the total net budget. The main reasons for this expected overspend are:

- An increasing number of people needing support.
- An increase in the complexity of people's needs – especially of those people who are already known to social care.
- Increases in prices, mostly due to the increase in the living wage.

Nationally, we know that most, if not all, of the councils who provide social care services are facing similar pressures. We are currently waiting for an announcement from the new government with proposals for the sustainable future funding of adult social care. In the meantime, one-off funding has been provided to all councils, and without this funding the financial position in Slough would be significantly worse.

5.3 **Adult Social Care Proposed Savings and Growth 2020/2021**

Areas of savings and growth for the next financial year have now been proposed. These figures are still draft until the medium term financial plan is agreed by Cabinet and Council. In the next financial year, the adult social care budget is expected to grow by £1.297million, offset by £0.350million in savings. This growth is primarily due to demographic changes and the increasing need for social care services.

The savings for social care were already agreed as part of the 2019/20 medium term financial plan and are not new savings. These are:

- Year 2 of the re-commissioning of the floating support service - £100,000.
- Year 2 of the commissioning of mental health supported accommodation services at Hope House - £100,000.
- Personalisation – increasing the number of people managing their own care and support services - £150,000.

5.4 **Adult Social Care Proposed Fees and Charges for 2020/2021**

For Adult Social Care, charges are statutorily set, and will only increase by the rate of inflation.

5.5 **Slough Leisure Offer - Proposed Fees and Charges for 2020/2021**

The Panel had specifically requested an update on the leisure services fees and charges.

Slough's residents are some of the most inactive in the country but over the last year we have seen a turn in this tide of inactivity, with a recent 3.4% drop in our levels of inactivity amongst our residents (16+) as measured by the Sport England 'Active Lives Survey'.

The recent 'Health Beliefs Survey' carried out in 2019 indicates that our residents know the importance of keeping physically active for their overall health and wellbeing. However they state that time constraints, cost and a lack of information on what is available in the town deter them from being more active.

Slough residents are fortunate to have one of the most comprehensive and affordable leisure 'offers' in the region, along with modern, flagship leisure facilities. In addition to this there are a number of budget gyms and sports clubs situated in the borough offering an alternative programme for those who want a different offer from the traditional leisure centre programme.

Over the last five years sports facilities in parks and open spaces across the borough have seen significant investment including the installation of twenty six green gyms, seven new multi use games areas (MUGAs) a skate park, a parkour park, seven artificial cricket wickets, four cricket practice nets and a network of dedicated walking tracks. All these facilities are free to use.

The Active Slough team offer a comprehensive and affordable activity programme of over 90 sessions a week to people of all ages and abilities, in accessible venues across the borough. 30% of these sessions are free. An average of 1,250 participants engage with the Active Slough programme every week, covering tots, juniors, teens, adults and seniors.

Leisure Centre Prices

Everyone Active was awarded a ten year 'concessions services' contract in June 2017 to operate the council's leisure facilities. The new contract offers the council a far more favourable financial package, with the council able to recoup some of the investment it has made in its award winning leisure facilities, with an estimated saving to the council of over £10 million over the next ten years.

The new leisure centres (Langley and The Centre) have exceeded usage and membership targets set by the operator and to date and current projections for total usage in 2019 / 20 are estimated to be in excess of 1.2 million.

The current prices (2019), which were approved by the Councils Leisure Strategy Board, for the use of the leisure centres have been benchmarked against neighbouring authorities including Windsor and Maidenhead, Bracknell, Ealing and Brent.

Slough's leisure centre prices remain some of the lowest in the area e.g. an adult swim costs £5.75 in Slough compared to £7.10 in the neighbouring borough of Windsor and Maidenhead.

A new proposed price list will be presented to the Council for agreement in February 2020 for introduction in April 2020 and is likely to be current inflation levels.

6. Comments of Other Committees

None

7. Conclusion

This report has outlined the current financial position of Adult Social Care in Slough, and the proposed budget and charges for the next financial year. Nationally and locally there is and will be increasing pressure on adult social services to meet the increasing needs of older and disabled people. The immediate national challenge is to provide certainty regarding the funding available to social care over the next few years rather than the reliance of in year one off funding. The reality is that over the last ten years, adult social care has fared worse than most other parts of the public sector. The £7.7 billion of savings that have been delivered by the adult social care system nationally over the last decade, for Slough this has been savings of nearly £8m over the last 5 years, has shown the strain that people and the system have been under.

8. **Appendices Attached**

Appendix 1 - Slough Adult Social Care Strategy 2018-2021.

9. **Background Papers**

None

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Slough
Adult Social Care Strategy

2018-2021

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Slough Borough Council

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Foreword

The landscape for the delivery of Adult Social Care services has changed dramatically over the past few years. The legislative changes introduced by the Care Act 2014 and its principle duties in relation to wellbeing and prevention, coupled with continued reductions in central government funding and increased client demand has required all Local Authority Adult Social Care departments to fundamentally review how public services need to be directly and indirectly delivered.

The future sustainability of social care is dependent on service users and their carers, families and personal support networks being properly equipped and supported to arrange and manage more of their care with less reliance on direct support from the council.

To respond to the changing landscape, the Adult Social Care Strategy for Slough provides a vision that focuses on people's strengths even at points of crisis in their lives, by connecting them to their interests, communities and a network of wellbeing, care and support services.

The strategy is based on our six strategic priorities: Prevention, Information and Advice, Personalised Outcomes, Building Community Capacity, Workforce Development and Quality and Integration. Focussing our actions and efforts on these key areas for action will allow us over the next three years to strengthen and improve the support and care that we provide to service users and their carers.

Central to the strategy is that we will support individuals to live as independently as possible, and recognise their rights and choices about what is right for them, and make sure that they are safeguarded where necessary. We want to make sure that, wherever possible, service users in Slough are supported to stay or return to their own home, so that they can maintain important relationships with family, friends and continue to actively be a part of their own community.

We successfully implemented the changes required by the Care Act, increased support to carers, and improved our information, advice and guidance offer. Placing the person at the centre of care has allowed the council to achieve better outcomes for residents as well as change services to reflect local need. Through this strategy, we aim to continue to work with our partners to provide support and care based on individual circumstances.

As a council, Adult Social Care will continue to work in partnership with public health, the Clinical Commissioning Groups (CCG), the Acute and Community Health Trusts and voluntary and community organisations to deliver the strategy, including the pooling of resources to enable a more joined up and cost effective approach for the delivery of our services.

The main drive for integrating social care with health and social care provides an opportunity to deliver in partnership, to meet the health and wellbeing needs of local residents, carers and their families. These arrangements will remove duplication and provide better outcomes in a more cost effective way. Adult social care in Slough will be a key a partner in the delivery of the Frimley Health and Integrated Care System Partnership.

Alan Sinclair
Director Adults and Communities

1. Introduction

Slough Adult Social Care has adopted the overarching principle of the Care Act 2014, which is to promote the wellbeing of its service users. The Act introduced major changes for local authorities in how we deliver care and support for adults with care needs and carers. The Act and statutory guiding principles are:

- Clearer and fairer care and support to both service users and carers.
- Improved physical, mental and emotional wellbeing of both the person needing care and their carer.
- Preventing and delaying the need for care and support.
- Putting people in control of their lives.
- Improved and more personalised approaches to safeguarding for both the carer and the cared for person.

2. Our vision

To improve the outcomes of our residents and their carers by enabling people to do more for themselves, focusing on people's strengths even at points of crisis in their lives, by connecting them to their interests and communities and a network of wellbeing, care and support services.

3. Our strategic aims

This strategy sets out our plans to transform the way the council will support Slough residents with adult social care needs and their carers, to enable people to:

- Maintain their health and wellbeing.
- Manage their own care and support needs.
- Live independently in their own homes for as long as possible.
- Have control over the support they receive.
- Avoid hospital admission unless clinically necessary.
- Be safe.

4. Context

The landscape for the delivery of Adult Social Care services has changed dramatically over the past few years with the main influences being:

- The implementation of the Care Act (2014) which has introduced new duties and responsibilities for Local Authorities especially in relation to wellbeing and prevention.
- Increasing demographic pressures from a growing and ageing population who are living longer, but often with a range of long-term health problems.
- Changing public expectations about the role and contribution of the council in supporting people if they have a disability or when they become ill or frail.
- Outcome 2 of Slough Borough Council's 5 year Plan provides that: "Our people will become healthier and will manage their own health, care and support needs".
- Further integration between health and social care to build a joined up health and care system.

- As part of joint Integrated Care System (ICS), there needs to be agreement about how to deal with whole population needs and whole systems recognising the true value of social care in prevention and reducing demand for acute hospital services.
- There has been an increase in Better Care Fund (BCF) funding to improve the wellbeing outcomes of the people.
- We are required to make savings of £7.9 million over a four year period to 2019.
- Provider pressures on the care system are increasing. Providing adequate adult social care poses a significant public service challenge without any easy answers. The need for care is rising while public spending is falling, and there is unmet need.
- Recent projections suggest that there would be an average annual increase of between 5.4 percent and 7.9 percent of adults with learning disabilities requiring care between 2009 and 2026.
- The government's Green Paper on the long-term funding of social care.

The Association of Directors of Adult Social Services (ADASS) states that we must continue work to build a 'joined up' model of care which includes:

A strong model of health and social care delivery

That has:

- Good information and advice to enable those who can to look after themselves and to have access to the right help at the right time.
- A focus on prevention to reduce and delay the need for more formal care.
- Recognition that we need to build supportive relationships and resilient communities.
- Services that rehabilitate after illness and support independence.
- Services that are personalised and address mental and physical wellbeing.
- Services that value and support unpaid carers, recognising their needs.

A model where quality matters

- We must all continue to focus on the quality of care, so that people are treated with dignity and can trust that they will be safe from harm.

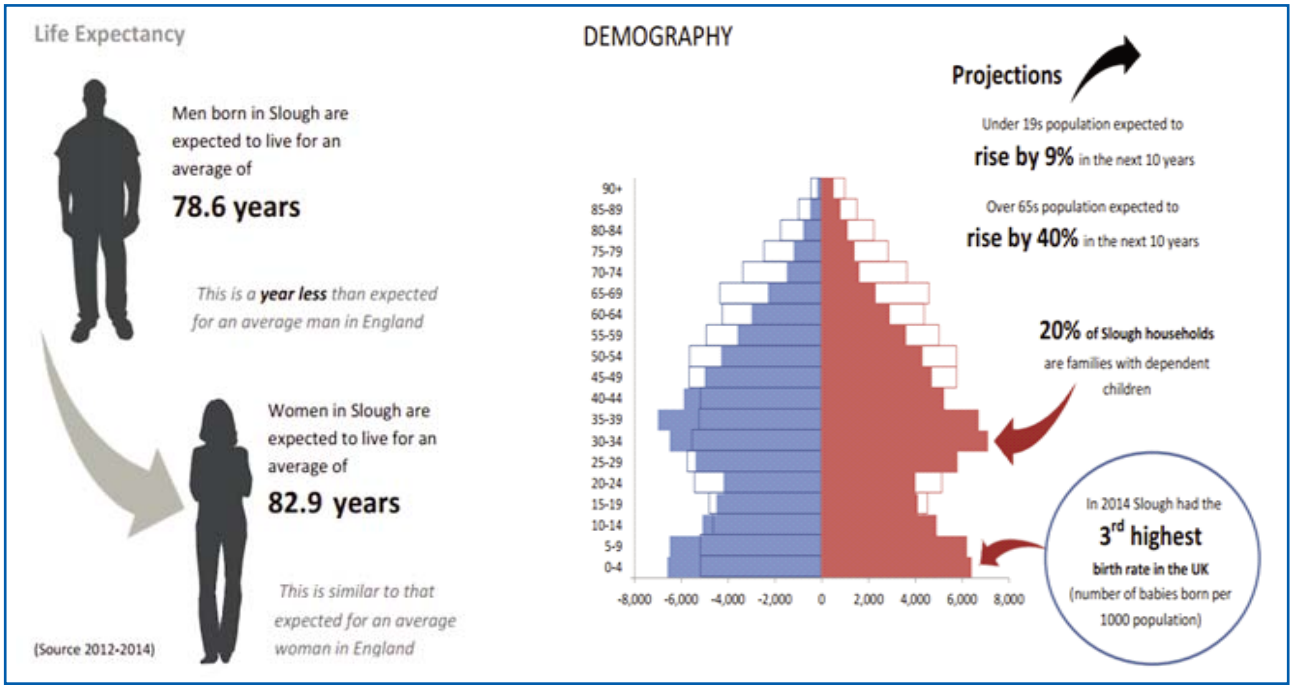
A sustainable workforce

- Good quality social care requires well trained and committed staff that are valued by their employers and by wider society. We must continue to promote social care, making it more attractive as a career.

The model of care as outlined by ADASS has been reflected in the design of the local adult social care transformation programme.

5. Slough story

The total projected population of Slough in 2016 is estimated to be 147,181, an increase of 1,447 on the previous year (or just less than 1%). The projected population comprises of 74,326 (50.5%) males, 72.855 (49.5%) female, 41,406 (28%) children (those aged less than 18) as well as 91,544 (62%) of 'working age' (those aged 18 to 64) and 14,231 (10%) 'older people' (aged 65 or above).



Our population is therefore young, dynamic and growing.

Slough has a long history of ethnic and cultural diversity that has created a place that is truly unique and valued by those who live and work here. 45% of our population is white or white British, 40% is Asian or Asian British and 15 % Black or black British, mixed race or other.

Slough has a number of neighbourhoods that include households facing multiple challenges, for example, with no adults in employment, low incomes, children living in poverty and poor quality housing. These factors can lead to inequalities in health and wellbeing. The Index of Multiple Deprivation (IMD) ranks Slough 78th of 152 upper tier local authorities in terms of deprivation in England.

Life expectancy varies between wards with men expected to live on average until 78.6 while women are expected to live until 82.9. The number of older people in the borough is increasing and people will live longer but with poorer health. Around 19,000 adults in Slough have a limiting long term illness or disability and around 3,000 are economically inactive due to a long term sickness. 62% of Slough's adults are excessively overweight and 25% are obese. Diabetes, cardiovascular disease, strokes, chronic respiratory disease and cancer are the biggest causes of death in Slough and account for much of the inequalities in life expectancy within the borough.

According to Office for National Statistics (ONS) population projections, between 2010 and 2030, the numbers of assessments of younger adults with disability are projected to rise by 11.8%; the numbers of users of local authority home care services would rise by 17.7%; the numbers of users of day care services by 22.4%; the number of younger adults in local authority funded residential and nursing care would need to rise by 25.1%; and the numbers of recipients of Disability Leaving Allowance DLA care (all groups including those without disability) would rise by 10.0%.

This is resulting in the need for care rising at the time when we are seeing public spending is falling due to central government cutting local authority funding, and there is unmet need.

6. Performance data

According to measures from the Adult Social Care Outcomes Framework (ASCOF) results for 2016/17, Slough has improved its performance (in direct value terms) on 10 of the 26 indicators. Slough achieved the Upper quartile performance on three indicators, second quartile performance on six indicators, third quartile performance on nine indicators and lowest quartile on eight indicators. The Outcomes Framework report summarises Slough's performance against the other 151 English councils with Social Services Responsibilities ('CSSRs') for the 22 ASCOF indicators with published results this year.

6.1 What we are doing well

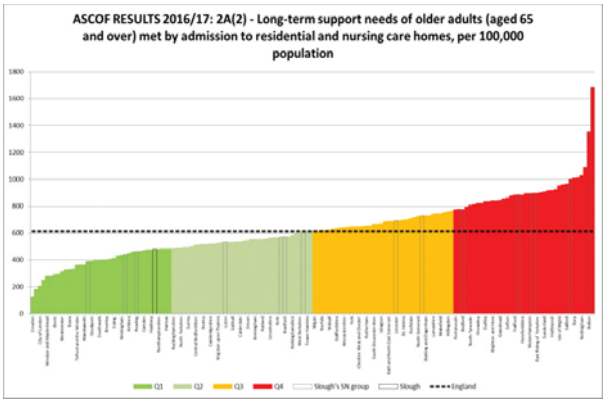
Domain 1G: The proportion of adults with a learning disability who live in their own home or with family.

Domain IG is intended to improve outcomes for adults with a learning disability by demonstrating the proportion in 'stable and appropriate' accommodation. The nature of accommodation for these people has a strong impact on both their safety and overall quality of life, and the risk of social exclusion.

Slough's value of 84.5% places us in the lower end of the top quartile, and this is an improvement from the previous year (81.6%). The all-England position is for 76.2% of LD service users to be living in their own, or their family, home. Note that much of the local improvement in the past year has resulted from the re-designation of residential homes to supported living placements.

There is significant variation in outcome value amongst different areas: a minimum of 33.2% (Bromley) rising to a maximum of 96.2% in Oldham or 100% in the Isles of Scilly (this latter likely to result from very small numbers of people, perhaps only one).

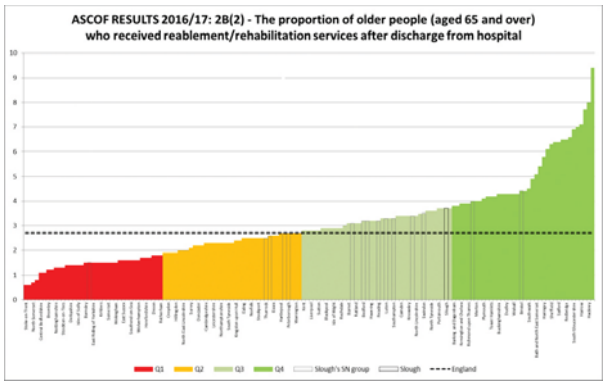
2A(2): Long-term support needs of older adults (aged 65 and over) met by admission to residential and nursing care homes, expressed as a rate per 100,000 local population of that age.



Domain 2A (2) is also known as "new permanent admissions to care homes", and measures local progress in avoiding permanent placements in residential or nursing care homes. As research has shown, people prefer to stay in their own home rather than move into a care home wherever possible. Areas with effective community-based support services are expected to see a lower level of supported care home admissions.

Slough's outcome of 477.8 per 100,000 relates to 68 individuals who were admitted to care homes during 2016/17 keeps Slough in the top quartile, well below the all-England position of 610.7 per 100,000. Slough generally fares very well at supporting people to stay at home.

Domain 2B (2): The proportion of older people who were offered reablement services following discharge from hospital. (The measure is closely linked with measure 2B(1): **The proportion of older people (those aged 65 or older) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services**. Reablement is an effective way of providing short-term support to people in crisis to enable them to regain their independence (wholly or substantially) and therefore minimise their need for ongoing support and dependence on public services.



2B (1): Slough has for several years performed very highly on this measure, within the upper quartile. Though our value this year has fallen (87.4%), this still places us within the upper end of the second quartile, above the all-England position of 82.5%.

2B (2): Slough's value of 3.7% places us within the upper half of the upper quartile, thereby showing that we have achieved a very effective 'reach' for our reablement support service.

Domain 2C (2): Delayed transfers of care from hospital which are attributable to adult social care, per 100,000 local adult population. (Linked to indicator 2C (1): **Delayed transfers of care from hospital, per 100,000 local adult population.)**

For all the delayed transfers of care established through the monthly DToC Situation Reports and counted in measure 2C (1), hospitals decide and categorise whether the delay is attributable wholly to health services, wholly to social care services, or partially attributable to both.

Slough has been attributed as responsible for 11.6 per 100,000. This means that out of every 10,000 adults living in Slough who were discharged from hospital in the period, 11.6 were delayed, or remained in a hospital bed beyond the point that they had been determined as medically fit to leave.

Slough's value is within the second quartile, with far fewer delayed discharges locally than the all-England position of 14.9. However, the proportion of such delays has increased since the previous year (it was 8.4 in 2015/16).

This measure therefore indicates that local services - of which the council is one part - are working fairly effectively to address this issue, although there is still room for further improvement.

Domain 2D: The proportion of new clients who received a short-term service during the year where the sequel to service was either no ongoing support, or support of a lower level.

This monitors the success of providing short-term services to people in response to their social care needs, providing 'reablement' type support and restoring them to independence following a short-term deterioration or crisis.

Slough is doing very well under this measure, with 88% of such service provision resulting in the supported person either no ongoing support or support at a lower level. We are placed in the upper quartile; however this is a reduction from the previous year (96%).

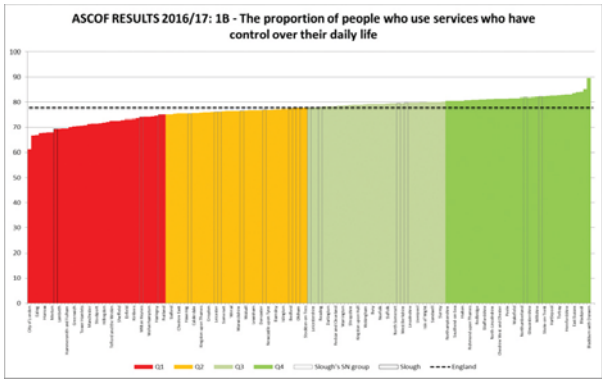
6.2 Where we need to improve

1A: Social care related quality of life score (out of 24).

This indicator gives an overarching view of the quality of life of users of social care, and is a composite measure based on responses to eight questions in the annual Adult Social Care Users survey.

Slough's value of 18.7 places us within the lowest quartile, but above four of our fifteen direct statistical neighbours. Value represents minimal improvement over the previous year, however, Slough has consistently performed in lowest quartile.

1B: The proportion of people who use services who say that they have control over their daily life.



A key aim in delivering care and support that is more personalised, and better controlled by the service users, is that the support provided more closely matches the needs and wishes of the individual.

Slough's value of 69.2 places us within the lowest quartile, and below all of our fifteen direct statistical neighbours. The value achieved is slightly down on that achieved in the previous year (71.2). slough has consistently performed lowest on this quartile.

1D: Carer-reported quality of life

This measure gives an overarching view of the quality of life of carers based on responses to the Survey of Adult Carers in England. The higher the score, the better is the carer-reported quality of life. The maximum quality of life score is 12.

Slough's value of 6.9 places us in the lowest quartile, below all of our statistical neighbours, and only seven other councils reporting the same or lower.

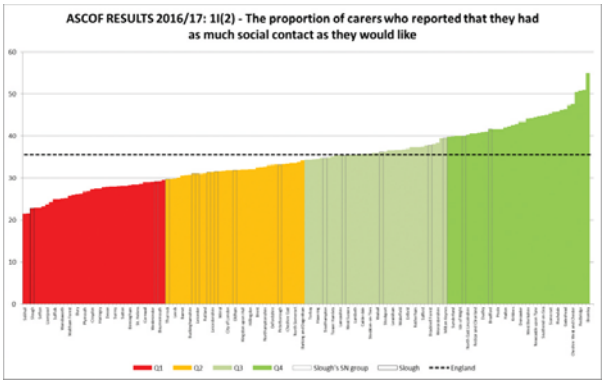
Note the small variation between council values - from a minimum of 6.8 (Sefton) to a maximum of 8.9 (Hartlepool). Slough had a score that was similar to the England average in the previous year the survey was conducted, but has dropped to the lower level of the fourth quartile.

Domain 1I (1): The proportion of people who use services who reported that they had as much social contact as they would like.

This measure draws on self-reported levels of social contact as an indicator for social isolation as there is a clear link between loneliness and poor mental and physical health.

Slough's value of 41.7% places us at the top end of the lowest quartile, with only four of our statistical neighbours reporting a lower proportion. At the other end of the distribution, Southampton reports 52.9% of users stating they have adequate levels of social contact. Across England as a whole, 45.4% of survey respondents were happy with the level of social contact they had.

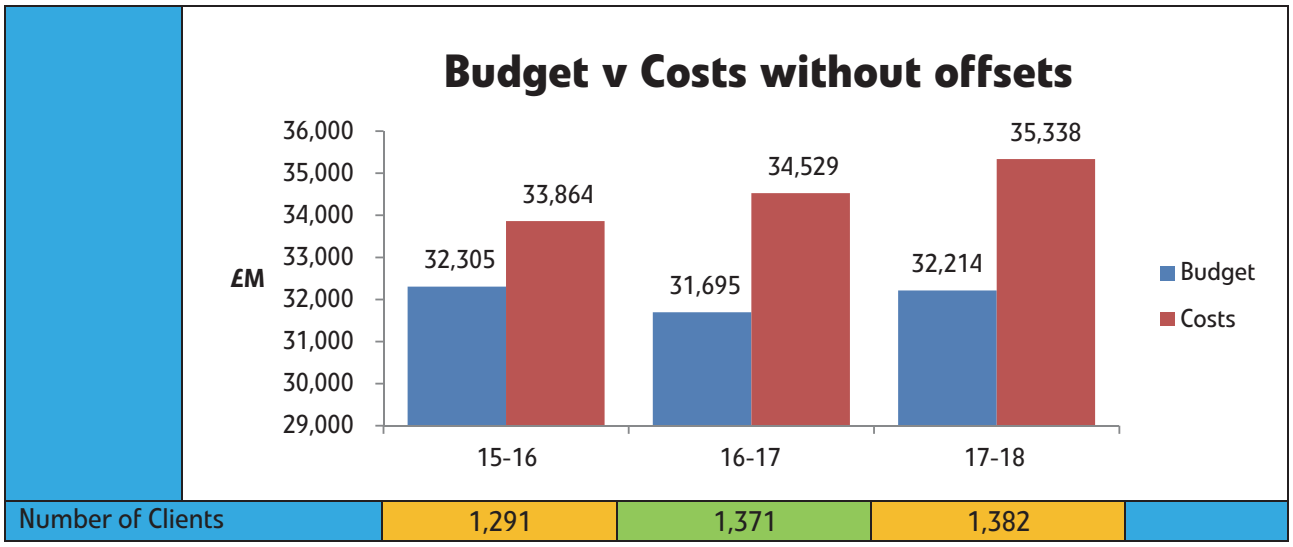
1I (2): The proportion of carers who use services who reported that they had as much social contact as they would like.



This measure derives from a survey of social care users. There is a clear link between loneliness and poor mental and physical health. This measure draws on self-reported levels of social contact as an indicator for social isolation.

Slough's value of 22.7% keeps us in the lowest quartile, with only two other councils reporting a lower proportion.

7. Adult Social Care budget



The adult social care budget has been facing increasing pressures over the last three years with increasing demand, increasing prices and a reducing budget.

There have been an increasing number of clients entering the social care system, from 1,291 in 2015-2016 to an estimated 1,382 clients in 2017-2018; while at the same time ASC is expected to make savings to its budget.

Service	Revised Full Year Budget	Outturn	Total Outturn	Variance
Safeguarding and Governance	305	289	289	-16
ASC Management	1,105	-2,072	-2,072	-3,177
Directly Provided Services	2,005	2,184	2,184	179
Mental Health Services	3,854	4,186	4,186	332
Learning Disability Services	8,813	9,279	9,279	466
North Locality	3,425	4,512	4,512	1,087
South Locality	3,255	3,906	3,906	651
East Locality	4,171	5,570	5,570	1,399
Reablement	1,135	611	611	-524
Care Group Commissioning	3,667	3,355	3,355	-312
Total ASC	**31,735**	**31,819**	**31,819**	**85**

The variance for 2017-18 shows that the Adult Social Care is focussed to overspend by over £3 million.

The position for Slough Borough Council is not significantly different than other councils with responsibility for adult social care. The Association of Directors of Adults Social Services (ADASS) in its annual budget survey published in July 2016 identified the standstill shortfall for all councils for social care of £1 billion for 2017/18. Local councils are facing increasing demand for social care. ADASS estimates £4 billion a year in demographic pressures plus increasing costs, with the national living wage cost alone being £612 million this year. Since 2010 councils have been making savings of approximately £1 billion a year as the government revenue support grant to councils has been reducing.

The 2017 ADASS budget survey published in June 2017 shows a total spend on ASC nationally of £14.19 billion on a net budget of £13.82 billion, a 3% overspend compared to a Slough ASC overspend of 2%. Planned savings for 2017/18 nationally are £824 million, 5% of the net ASC budgets and 27% of total council savings. This compares with Slough planned ASC savings of 4% against the net ASC budget and 10% of council planned savings.

ADASS Directors confidence in delivering these savings is only 31% despite additional national funding and this reduces to 8% for 2018/19.

The national budget statements over the last eighteen months have provided adult social care with additional one off funding each year from 2017/18 to 2019/20. This funding is allocated through the Better Care Fund and requires an agreement with the local NHS on how this funding will be used. The total nationally for 2017/18 is £1 billion. For Slough this improved Better Care Fund allocation is: £2.173 million for 2017/18; £2.862 million for 2018/19 and £3.327 million for 2019/20.

Without this additional funding Slough adult social care would have to make this equivalent level of saving each year in its budget to ensure the adult social care budget is balanced.

After March 2020 there is no guarantee of any further additional national funding so there is a significant risk that the budget for adult social care will need to be reduced by £3.327 million at this point although there will be a further national review of adult social care funding as confirmed in the spring budget.

8. Our priorities

In line with Care Act 2014, Slough Borough Council's Five Year Plan and in order to achieve our strategic aims, the strategy focuses on 6 main areas of delivery in order to effect meaningful and long term change:

8.1 Prevention

Our prevention strategy brings to the fore the best practice to reduce, delay and prevent demand, providing targeted support to people before they reach crisis point. The strategy seeks to understand how best to:

- Promote a person's independence, through the use of a strengths based conversation
- Prevent or delay the person's deterioration
- Proactively engage the public in planning for their care and support and
- Reduce the overall burden on the provision of more costly intrusive public services.

There is a monitoring process for the Prevention Strategy and its action plans will be reviewed every year to identify gaps in pathways and services, which in turn will support decision makers.

8.1.1. Outcomes

- Staff and partners involved in the delivery of care and support apply a strengths based approach in their work with our clients.
- Get Active Slough: a Leisure Strategy, which outlines the plans for encouraging physical activity, to make sure that this is adopted as a habit for life for all, making "more people, more active, more often".

8.2 Information and advice

A partnership pan Slough Information and Advice plan will be developed to deliver the priorities in the prevention strategy, to make sure that people understand how local government, health care and voluntary support services work so they can access the care, support and funding options available to them.

A database of frontline Care Providers, Voluntary and Community Sector will be established and maintained from which information will be available on request. This database will allow information to be accessed easily and so make the decisions about the types of care and support more transparent.

Our strategic aims for the provision of information and advice are:

1. Create a single point of reference for comprehensive access to information and advice on local services, preventing the gaps our citizens fall into.
2. Shift from a passive and generalised provision of information at the point of crisis to a proactive, person-centred delivery of information and advice that will empower residents to plan for future care needs.
3. Create an information and advice quality assurance framework based on the Think Local Act Personal (TLAP) principles to ensure that the information and advice provision is fit for purpose.
4. Re-train staff in frontline facing roles on the importance of accurate and consistent information and advice and update the content for them to use.
5. Analyse the information and advice customer journey, contacts made with providers, and requests for information and advice to identify hard to reach people, those that have complex lives, and opportunities for early intervention.
6. Outline plans to manage, publicise and deliver information and advice services and content related to adult social care centrally within the organisation, in cooperation with our partners, and in alignment with existing non-contractual community resources.
7. Deliver content in a cohesive manner and in a format or via a delivery mechanism that is appropriate for people individually.

8. Reassess delivery channels and redesign the business process in order to maximise the success of our contacts with the public be that face to face or digital.

8.2.1. Outcomes

- People are well informed and have more choice and control over their care.
- Customers have access to accurate information which enables them to make more informed choices about their care and support requirements.
- People can assess their options quickly.
- Information and advice is of high quality, clear, accurate and up-to-date.
- There is additional support for those that need it.
- At the time of their first contact with an information and advice provider people are correctly signposted to other sources of information and advice that match their needs and unique situation.

8.3 Personalised outcomes

As a department we will continue to moving away from a case management model of social work that previously focussed on deficiency and dependency towards one that focuses on people, their interests and skills, the resources found in the communities that our clients want to live in and their circles of support.

This emphasis on a strengths based approach in our work will ensure that people can make an informed choice over the quality of the services that they might require while also providing a real choice of services to Residents of Slough.

8.3.1. Outcomes

- The majority of care is purchased directly by customers using a direct payment rather than contracted and managed by the council.
- Reduced numbers of people supported in care homes.
- People are supported to be as independent as possible and when they became ill get the right treatment and help so they recover quickly and can get on with their lives.
- Self-service technology will be used to provide self-service.
- People with long term conditions are supported by suitable housing which is safe, warm and resource efficient allowing access to appropriate prevention services including adaptations to stay well and maintain their independence.
- People with mental health, learning or physical vulnerabilities, whether in childhood, adulthood, or in older age have choice of access to suitable or specialist accommodation, maintain their independence and report a better quality of life.

8.4 Building community capacity

Given the recognised financial challenges, the issues facing Slough Borough Council over the long term future cannot be tackled in isolation. There is a need to build the capacity of the voluntary and community sector to enable it to play a full and effective role in the development and delivery of local services. The council will support the delivery of a sustainable and effective voluntary and community sector to address the needs of local communities.

8.4.1 Outcomes

- Care is well coordinated and seamless.
- More people directly manage their own care and have the information and tools to do this independently with minimal input from the council.
- We will work to involve the people who use our services - for example in helping us to identify and change the things that do not make a positive difference to them.
- Where they choose to, people will be involved in helping us to identify and change the things that do not make a positive difference to them.

8.5 Workforce development and quality

A skilled and available workforce is one of the key aims of the Slough 5 year plan. At national level there is an increasing risk to the ability to maintain standards in the social care system from a rapidly decreasing and aging social care workforce and an increasing number of people locally that have multiple long term conditions, who are living longer lives with greater health and social care needs.

Working with our strategic partners, informal carers, personal assistants, community groups, volunteers as well as paid care home workers, social care workers in the Borough we will develop an integrated local area workforce strategy. The strategy will be implemented through a focussed plan that will bring long term and sustained change to address recruitment, retention, capacity and competency issues in the care and support sector of Slough. This will help to make sure that both the internal and external workforce will be fit for purpose and able to manage the breadth of work required to support our residents, with either complex health and social care needs or those requiring coordinated support to access low level preventative services. The strategy will review both the internal and external workforce to make sure that we are able to deal with the changing and growing demands facing the care economy in the next 5 years. This will also direct the service towards one that focuses on the development of preventative services and those services that offer choice and value for self-funding clients and those with direct payments.

Shortages in suitable staff have led to dependence on expensive agency staff with consequential impact on budgets and the quality of the workforce. In order to manage supply and demand and the associated costs of using agency staff, there is a need to work together across the South East region and look at a collaborative approach to support this supply and demand, to make sure that we have a high quality agency workforce.

As part of that commitment, at the end of every assignment a reference will be provided to the Agency for the next employer. Adopting a common minimum standard for referencing would help prevent 'recycling' of poor quality permanent and agency workers. We will use end of placement reviews with adequate information passed back to the agency workers and the agency supplier to determine any development requirements or to cease placing the worker to help to address quality issues.

Slough Borough Council is committed to ensuring that we have safe and high quality care and support services in place. The Care Quality Commission's (CQC) fundamental standards and ratings system sets the benchmark for the quality of care people should expect from their provider. We expect to commission services from providers are judged by CQC as either 'good' or 'outstanding'.

The Commissioning Team is giving a sharper focus to the quality function. Our Supplier Relationship Team is enabling us to implement more effective contract monitoring and support. We embarked on a programme of support with all our providers which focus on improved quality, making sure that it is embedded within all aspects of delivery. The team is also supporting the sharing of innovation as well as promote high quality provision locally.

The intention is that we will embed process and utilise resources more effectively for both the council and providers. The appointment of a Quality Assurance Manager will support the work including co-production of a new Quality Assurance Framework with providers. This will help will keep the focus on standards, consistent and proportionate monitoring. Providers that do not meet requirements will be reviewed closely through our robust care governance processes. We will continue to ensure regular provider forums are in place in order to ensure partners are kept informed about changes in national and local policy, local commissioning intentions, market analysis, quality standards, and procurement arrangements and promote dialogue and network opportunities.

8.5.1 Outcomes

- Staff are trusted and supported to make consistent and fair decisions.
- Staff are technology enabled and are able to spend more time working with our customers.
- Care is provided safely by well trained multi-disciplinary teams.
- Partners are aware of the quality of the agency staff being referred to them.

8.6 Integration

There is a wider recognition that residents access services across geographic boundaries and will often have a combination of health and social care needs. Consequently these services need to be designed, commissioned and delivered so that they are agile enough to meet the personal outcomes that residents have as is feasibly possible.

As a result, the council has made progress to integrate services with our health partners, including the pooling of budgets to enable a more joined up and cost effective approach. The main drive for integration with health provides an opportunity to deliver in partnership, the health and wellbeing needs of local residents, carers and their families. The arrangements this will remove duplication and provide better outcomes in a cost effective way. Local residents will receive a cohesive service and will be supported to have maximum choice and control over how they receive the services.

The council is also working with the NHS through new proposals called Integrated Care System (ICS). These are place-based and built around the needs of the local population.

The Better Care Fund (BCF) is another integrated programme spanning both the council and the NHS, which seeks to join-up health and care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible. The BCF has been created to improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support, and providing them integrated health and social care services, resulting in an improved experience and better quality of life.

8.6.1 Outcomes

- Reduce avoidable emergency admissions to hospital.
- Improve patient and user experience of health and social care services.
- Encourage independence and self- reliance by building community.
- Reduce the proportion of patients falling into crisis and needing admission to hospital or a care home.
- Increase the proportion of patients who feel supported to manage their long term conditions.
- Improve mortality and morbidity statistics for CVD, respiratory, stroke and heart failure.
- Reduce permanent admission to nursing and residential care for over 65s.
- Maintain the good performance of older people at home 91 days after discharge from hospital care into reablement.
- Reduce delayed transfers of care.
- Reduce avoidable hospital admissions for children and adults.
- Increase number of people with a health and social care personal budget.
- Increase number of people (aged 65+) offered reablement following discharge from hospital.
- Ensure all patients have a choice of place of death.
- Provide more support within the community for self-care and prevention initiatives for children and young people.
- Increase access to self-care for people with mental and physical health problems.
- Safeguard and support vulnerable adults and children in our communities.

9. How is this going to happen

Governance within Slough Adult Social Care covers all aspects of the service that has a direct or indirect impact on the delivery of the agreed priorities to service users. The following components are interrelated and form a framework of the Governance.

9.1 Outcome 2 (Five Year Plan)

Outcome 2 of Slough's Five Year Plan provides that "Our people will be healthier and manage their own care needs"

We will achieve this through target those individuals most at risk of poor health and wellbeing outcomes to take up health checks. Through the Preventative Strategy, we will enable our residents to become more able to support themselves and build capacity within the community to enable a focus on supporting more people to manage their own health, care and support needs. We will empower residents to live independent and healthy lives, and make sure that people are at the centre of the adult safeguarding process and are supported to manage any risks.

9.2 Partnership working

Adult Social Care in Slough concentrate on achieving the nationally set criteria for partnership working, which are: to reduce health inequalities; to improve wellbeing by tackling the wider determinants of health; and to drive collaboration, integration of local services and joint commissioning. We will continue to work in partnership with public health, the NHS Clinical Commissioning Group (CCG) and voluntary and community organisations to deliver our health partners, including the pooling of budgets to enable a more joined up and cost effective approach. The main drive for integration with health provides an opportunity to deliver in partnership, the health and wellbeing needs of local residents, carers and their families. The arrangements this will remove duplication and provide better outcomes in a cost effective way.

9.3 ASC transformation

Through the transformation programme, we will coordinate and direct the Department's service plans to implement a range of projects that will transform our activities which can be too narrowly focused on traditional models of residential and domiciliary care and that manage care at the point of crisis towards a model of care and support that works with partners internally in the council, with Health and Voluntary sector and with the service users themselves.

We will, through the programme: manage the complex organisational dependencies; communicate with senior stakeholders the importance of realising the benefits of the programme; manage the council's exposure to risk and financial deficit.

9.4 Co-production

The model would inform the future programme of Community development and engagement work. Through "One Slough" approach, we will work with communities in Slough with a view of developing skills and knowledge so that residents are better placed to flourish from the wide range of opportunities available in Slough as well as being equipped to better meet some of their own needs.

This will incorporate three main projects under a single community development programme, these are:

Community Hubs
Building based assets from which our priorities can be achieved

Community Development
Making sure that there is better coordination and integration of our direct work with communities to improve community resilience

Integrated Community Working
Where the council, NHS and voluntary sector staff would work in a multi-disciplinary environments in order to maximise early intervention solutions for the citizens of Slough

9.5 Commissioning model

We will use our internal Commissioning model to identifying the needs of our communities and develop policies and service plans, to meet those needs in the most appropriate and cost effective way. Through the Commissioning Strategy, we will work with public health and Slough CCG will work to fund voluntary and community organisations to deliver health, social care and wellbeing outcomes for vulnerable adults living in Slough. We will continue to use an outcome based approach to purchase services from voluntary and community organisations, which will enable us to enhance the capacity of individuals and the wider community to provide personalised preventative support that builds on people's strengths and assets to reduce the demand on social and health care services.

9.6 Integrated Care System (ICS)

The Frimley Health and Integrated Care System Plan (ICS) is one of 44 plans in the country set up to deliver health's Five Year Forward View it covers a population of 750,000 residents through nine councils (county, borough and district, which include Slough). It sets out how social care and health services delivered by councils and health authorities will become a more integrated system fit for the future.

The plan runs from 2016 to 2021 and we will build on the work already taking place to transform health and care provision in the region, through its stated priorities.

9.7 Better Care Fund BCF

Through the Better Care Fund programme, we will aim to improve, both directly and indirectly, the wellbeing outcomes of the people of Slough against all the priorities of the BCF strategy but especially the Health priority.

10. Appendix 1: The expected benefits and outcomes from our plans

Domain	Project Delivering	Business Change and Outcomes	Programme Outcome
Workforce Dev and Quality	Care and Support Workforce Development	• A highly skilled and innovative workforce • Integrated skills sets to allow staff to manage complex user and patient needs • Improved career and professional opportunities within an innovative and dynamic working environment	• Increased staff satisfaction, expertise and empowerment
	Mobile and Flexible Working	• Remote and mobile working introduced, staff able to work in new collaborative ways with residents and partner agencies	• Service will be digitally optimised
	Management Information Systems	• Increase staff ability to manage performance and financial activity • Market place development through open data • Commissioners can meet the complex health and social care needs of the population as a whole	• Service will be digitally optimised
Community Capacity	VCS Outcomes Based Contract	• Early support to help them maintain their independence • Community volunteering is attractive in Slough • Develop Slough's community based care and support system • Promote and build the community networks needed to support people in their own communities	• Enable people to do more for themselves • Social capital in the community is realised
	Asset Based Community Development	• Connect residents, local organisations and informal community groups to build strong circles of support • Empower communities to drive the process themselves by identifying and mobilizing existing, but often unrecognised community assets • Promote and build the community networks needed to support people in their own communities	• Build community capital and resilience • Co-produce outcomes and service
Personalised Outcomes	Online Citizen Portals (FA, Carers and Slough Citizens)	• The balance of choice and control is shifted towards the service user by enabling them to have a greater control of their outcomes • More people able to manage their own health and care and to plan ahead • Re-focus of staff resources towards other frontline activities, and more complex cases	• Service will be digitally optimised
	Carers	• Embedding the duties of the CA 2014, by helping carers avoid developing support needs, maintaining independence and promoting their wellbeing	• Enable people to do more for themselves
	Direct Payments	• Increase choice and control for Slough resident by increasing the opportunities to employ a PA and manage finances more easily	• Enable people to do more for themselves

Domain	Project Delivering	Business Change and Outcomes	Programme Outcome
Information and Advice	Information and Advice Strategy	• Offer appropriate information and advice to all local people about the help that is available to help them stay independent, safe and well • Information and advice is targeted to key user/ patient groups for a higher return on the intervention • Residents are able to successful navigate the complex health and social care system	• Enable people to do more for themselves
Integration	Multi-disciplinary/ Hub Working	• Integration of delivery models with partners, VSO, providers and borough council services • Expanded whole systems operating models	• A highly skilled and innovative workforce, that work to whole systems
	Continuing Health Care	• Increased staff awareness of CHC options • Increase in the quality of CHC assessments	• Enable people to attain their outcomes
Prevention	Strength Based Conversations	• Implementation new operating model: placed based social work using strength based conversations • Partnership are developed between individuals, communities, the voluntary and private sectors, the NHS and Slough Borough Council • Shift the balance of personalised care in community settings • Social care options are more flexible and responsive to user needs • Existing budgets are optimised to transform outcomes for local communities	• Enable people to do more for themselves
	Wellbeing and Prevention Strategy	• Cross agency partnership developed to focus staff on a key set of prevention enabling projects	• The right information, at the right place, at the right time
	Making Every Connect Count	• Optimise the professional interactions with people and support them to make positive changes to their physical and mental health and wellbeing • Promote much earlier signposting opportunities through a network of trained MECC frontline staff across the council and local partners	• Improve people's life chances • Implement a whole system prevention approach

11. Appendix 2: ASC Strategies and Plans

Commissioning Strategy for Adult Social Care 2010	Identifies the commissioning priorities for adult social care. Based on strategic commissioning principles and best practice it proposes specific actions to transform social care and the range of services commissioned.
Joint Carers Commissioning Strategy.pdf	Updates and sets out how carers will be supported by SBC and CCG. It incorporates changes introduced in the Care Act and Children and Families Act.
Slough carers strategy 2016-21 final.pdf	Supports and encourage people to take responsibility for their own health and wellbeing are central to these changes.
Slough's Joint Autism Strategy 2014-17	Supports key priorities outlined within the national strategy, and responds to the needs of local people with autism and their families to help improve their lives.
Learning Disability Plan 2016-2019.pdf	Looks at continuous improvement and development of services for people with learning disabilities to enable them to live their lives in the way they choose.
ASC-VSO Partnership Strategy 2015-2020.pdf	Sets out SBC, Public Health and CCG partnership working to fund voluntary organisations to deliver wellbeing outcomes for vulnerable adults living in Slough.
Mental Health Strategy (including the Crisis Care Concordant) (Strategy)	Slough adopted the World Health Organisation list of interventions that can be cost effective within 0-5 years - the lifetime of the mental health and wellbeing elements of Slough Wellbeing strategy, these include: Healthy employment programmes; Resilience building; violence prevention, prevention of postnatal depression, family support projects, mental health in the workplace, psychosocial groups for older people, parenting programmes, depression prevention, Behaviour change, restriction of alcohol.
Supported Accommodation Strategy 2011-2016.pdf	The strategy address the needs of a wide range of vulnerable people for accommodation, housing and support, including those already in receipt of Adult Social Care, Children's Services and/or Housing services.
Adult Safeguarding Policy - in Care Act	Looks at preventing harm and reduce the risk of abuse or neglect to adults with care and support needs through safeguarding individuals.
Prevention Strategy 2017-2022 (Under development)	• To prevent: people with no health or care support needs from developing them. • To Reduce: people with health or care support needs from the risk of developing further needs. • To delay: and minimising further deterioration to individuals with existing health and care support needs; through services, facilities or resources that we have available.

Information and Advice Strategy (In Development)	The strategy outlines how SBC will deliver a service that ensures people experience streamlined access to information and advice that is relevant and helpful to their current situation.
Market Position Statement/Strategy (Under development)	External
Slough 5 Year Plan: 2017-2021	The purpose of the Five Year Plan is to do three things: • To set out our vision • To be clear about our priority outcomes • To explain how we will do this.
Slough Sustainable Transformation Plan	Sets out a vision for better health, better patient care and improved efficiency. The plan sets out how this will be achieved locally and how services will evolve and become more sustainable over the next five years.
Slough CCG Plan: 2017	Aims at improving outcomes in cancers, maternity, gastro-intestinal, neurology, trauma and injury, diabetes, dementia and learning disability. Also looks at opportunities to spend money more wisely in: neurology, respiratory, genital-urinary, gastro-intestinal and endocrine.
Slough Wellbeing Strategy: 2016-2020	The Strategy is focussed on four key priorities to improve the health and wellbeing of the people in Slough.

This document can be made available on audio tape, braille or in large print, and is also available on the website where it can easily be viewed in large print.

Slough Adult Social Care Strategy 2018-2021

If you would like assistance with the translation of the information in this document, please ask an English speaking person to request this by calling 01753 xxxxxx.

यदि आप इस दस्तावेज में दी गई जानकारी के अनुवाद किए जाने की सहायता चाहते हैं तो कृपया किसी अंग्रेजी भाषी व्यक्ति से यह अनुरोध करने के लिए 01753 xxxxxx पर बात करके कहें.

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SLOUGH BOROUGH COUNCIL

REPORT TO: Health Scrutiny Panel

DATE: 16th January 2020

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

(For all Enquiries) (01753) 875847

WARD(S): All.

PART I

INFORMATION

UPDATE ON THE ACTIVITY OF THE SLOUGH WELLBEING BOARD

1. **Purpose of Report**

To provide an update to members of the Health Scrutiny Panel on the activity of the Slough Wellbeing Board over the last 12 months.

2. **Recommendation(s)/Proposed Action**

The Panel is requested to note the report.

3. **The Slough Joint Wellbeing Strategy, the JSNA and the 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 Slough Wellbeing 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 can '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

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.

5. Supporting Information

5.1 The activity of the Slough Wellbeing Board was last reported to the Health Scrutiny Panel in October 2018. This report provides information on the work of the Board over the last 12 months.

5.2. The purpose of the Slough Wellbeing Board is to:

- Improve health and wellbeing
- Reduce gaps in life expectancy across Slough Borough Council
- Focus on the wider determinants of health, such as education and training, housing, the economy and employment.
- Commission better, more integrated and efficient health and social care services.

5.3 The Board held the following sessions to further its development and strengthen partnership working across Slough and the wider region – the most recent session in October looked at reviewing priorities for a new strategy for 2020:

- Partnership Conference – October 2018
- Away Day – January 2019
- Development session – October 2019

5.4 The Board has worked to address its priorities as follows:

- Receiving the first annual report on immunisations and screening in Slough.
- Updates from Frimley Health and Care Integrated Care System.
- Receiving a report from Thames Valley Police on their drug diversion programme, that seeks to take a "community resolution" approach to minor drug offences. A task and finish group was established in this area, to explore the opportunities of this approach.
- Receiving a report from the Slough Prevent Board.
- Receiving a report on Homelessness and Rough Sleeping.

- Receiving feedback from the Wigan visit made by the Slough delegation.
- Receiving updates from Sexual Health Services.
- Receiving recommendations from the Disability Task and Finish Group.
- Receiving an update from the Safeguarding Executive Board.
- Receiving a report from the Pause Programme.
- Receiving a report about Health Beliefs and Physical Activity Research.
- Viewing the Frimley Health and Care ICS Draft Operational Plan, and the survey and findings that supported this.
- Viewing the CCG Annual Report
- Viewing the annual reports of both the Slough Adult Safeguarding Board and the Slough Local Safeguarding Children Board
- Receiving an update on oral Health in Slough's Children.
- Receiving an update on homelessness and rough sleeping.
- Receiving a report on the campaigns – Be realistic, Reachout and Notalone.

5.5 The Wellbeing Board's Annual Report for 2018/19 is attached at Appendix A and provides full details of the work of the Board.

6 Comments of Other Committees

None.

7. Conclusion

The Slough Wellbeing Board has been involved in a range of work over the last 12 months. This report provides an update on this work to the Health Scrutiny Panel.

8. Appendices Attached

A - Slough Wellbeing Board Annual Report 2018-19

9. Background Papers

None.

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Slough Wellbeing Board

Annual Report

2018-19

Contents

Foreword

Welcome to the Annual Report of the Slough Wellbeing Board for May 2018 to April 2019.

The Board brings together Slough Borough Council, Slough's Clinical Commissioning Group, HealthWatch Slough, Thames Valley Police, the Royal Berkshire Fire and Rescue Service and the voluntary and community sector with a shared focus on improving the health and wellbeing in Slough, tackling health inequalities and focusing on prevention.

Our main focus as a Board is to make a difference to the lives of Slough residents and this year we have run three very visible and well received campaigns. In 2018 we launched our first social media campaign with #BeRealisitic, a campaign that emphasises small incremental and realistic changes to diet and lifestyle can go along way to improving people's health and quality of life. The #ReachOut campaign was launched to assist people reaching out if they are feeling alone in Slough to find support and connection. We also launched the #NotAlone campaign where we held events and provided resources for people who are experiencing any mental health challenges.

The Board also held its annual partnership conference where we discussed how we can deliver better health and wellbeing outcomes for Slough. Building on the success of our partnership conference, we also held an away day with our partners to identify our common priorities and develop one vision and plan for Slough. The ideas generated at the away day have been insightful and will be used in the upcoming year as we find new and smarter ways to work together.

A useful set of principles and areas of focus were agreed to inform closer collaboration. The Wellbeing Board welcomed and considered the outcomes of the away day, in particular to identify one or two key issues to focus on over the coming year.

I hope this report gives you a valuable insight into the role of the Wellbeing Board and highlights the quality of the joint partnership work during the year. Our main focus as a Board is to make a difference to the lives of Slough residents.

I would like to thank my Vice Chair Jim O'Donnell for his support and leadership throughout the year. I would like also like to thank all of the Board's members and the wider partnership and other partners who have contributed to our work over the past year.

Councillor Natasa Pantelic
Chair of Slough Wellbeing Board

The Slough Health and Wellbeing Context

According to the Public Health England Health Profile for Slough, published in July 2018, the health of people in Slough is varied compared with the England average. About 15% (5,200) of children live in low income families. Life expectancy for men is lower than the England average. Life expectancy is 7.7 years lower for men and 4.0 years lower for women in the most deprived areas of Slough than in the least deprived areas.

People that are socio-economic deprived experience greater challenges to their health than those who are better off. Health inequalities can also be seen in ethnic minorities, those living with disabilities (particularly where there is mental illness or learning disability), LGBTI people and amongst groups where stigma or discrimination is more common.

Children's Health

The Public Health England profile identified:

- In Year 6, 26.0% (543) of children are classified as obese, worse than the average for England.
- The rate of alcohol-specific hospital stays among those under 18 is 16, better than the average for England. This represents 7 stays per year.
- Levels of teenage pregnancy, breastfeeding initiation and smoking at time of delivery are better than the England average.

The challenge for Slough is working with persistently high levels of overweight children 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.

Adult's Health

The Public Health England profile identified:

- The rate of alcohol-related harm hospital stays is 591. This represents 711 stays per year. The rate of self harm hospital stays is 146, better than the average for England. This represents 219 stays per year.
- Estimated levels of adult physical activity are worse than the England average.
- The rate of TB is worse than average.
- The rate of sexually transmitted infections is better than average.
- Rates of violent crime and early deaths from cardiovascular diseases are worse than average.

The Wellbeing Board has identified that Slough has an issue with working age adults with that are overweight, obese and inactive. As a result of this, there is a large population with South Asian heritage that are at risk diabetes.

The smoking rate is high compared to other areas (16.6% in Slough vs 11.2% in Windsor and Maidenhead / 10.9% in Surrey). The 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).

Slough also has 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.

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.

The Slough Wellbeing Board

The Slough Wellbeing Board was formally established as a statutory committee of the council in April 2013; in accordance with the legislation passed in the Health and Social Care Act 2012.

The purpose of the Slough Wellbeing Board is to:
- Improve health and wellbeing
- Reduce gaps in life expectancy across Slough
- Focus on the wider determinants of health, such as education and training, housing, the economy and employment and
- Commission better, more integrated and efficient health and social care services.

The Slough Wellbeing Board has a commitment to openness and transparency in the way that the Board carries out its work and is accountable to local people. This includes a commitment to annually review progress against the Board's ambition to reduce health inequalities and improve health and wellbeing outcomes across the town.

This annual report sets out a review of the Wellbeing Board's progress over the last year and sets the context for the work of the Board during the year ahead.

The Board has a series of statutory responsibilities duties which are set out at Appendix 1.

Membership
The current membership of the Board (as of April 2019) is:
- Slough Borough Council
- NHS
- Slough Clinical Commissioning Group
- Slough Children's Services Trust
- Healthwatch Slough
- Thames Valley Police
- Royal Berkshire Fire and Rescue Service
- Slough Council for Voluntary Service
- Business sector
- Slough Youth Parliament

Decision making
The Board is subject to the same openness and transparency rules as other committees of the council. All meetings are held in public and all of its agendas, reports and decisions are available to view on the council's website. The Board is also subject to scrutiny through the council's Health Scrutiny Panel.

Sharing Information
The Board has an Overarching Information Sharing Protocol, which is updated annually, to ensure information between member organisations is shared consistently and securely.

How the Wellbeing Board works with the key partnership groups in Slough

The Board works closely with the following:
- Health and Social Care Partnership Board
- Safer Slough Partnership
- Slough Local Safeguarding Children's Board

- Slough Adult Safeguarding Board
- Joint Parenting Panel
- Early Help Partnership Board
- Special Educational Needs and Disabilities (SEND) Partnership Board

Each of these partnerships contributes to the delivery of various aspects of the Slough Wellbeing Strategy. Updates on their work have been included in the 'Wellbeing Strategy Priorities' section of this report.

The Wellbeing Strategy 2016 – 2020 explains there is a wider partnership network operating across the town which the Board is seeking to better coordinate. The Board has a Protocol between it and the council's Health Scrutiny Panel and Healthwatch Slough. It sets out the respective roles and statutory responsibilities of each of these bodies and provides a framework for handling key issues and information between them in light of their individual functions.

Highlights of the Wellbeing Board 2018-19

Partnership Conference – October 2018
The 2018 annual partnership conference focused on tackling inequalities across Slough to improve health and wellbeing outcomes for our population.

The purpose of the conference was to:
- Share success;
- Understand health inequalities in Slough;
- Consider how the wider determinants of health impact on delivery of the priorities in the Slough Wellbeing Strategy;
- Review the role of the Slough Wellbeing Board and wider partnership network to deliver better outcomes for Slough.

Members gave their feedback on some of the key themes which came through from the event which included the need to communicate effectively to help partners and other organisations in Slough be well informed; ensure the governance arrangements were in place to improve the connections between operational activity; and the importance of being able to measure and track the progress of long term interventions.

Away Day – January 2019
Following up from the outcomes of the Partnership Conference, the Wellbeing Board and its partners held an away day in January to:
- Understand the key issues facing Slough
- Identify common priorities
- Develop a One Vision and Plan for Slough to make a difference together

The away day was useful in bringing key partners together and had confirmed the collective desire 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 were agreed to inform closer collaboration. The Wellbeing Board welcomed and considered the outcomes of the away day, in particular to identify one or two key issues to focus on over the coming year.

Priorities in the Wellbeing Strategy 2016-2020

The section below sets out highlights of the work undertaken against the four priorities of the Wellbeing Strategy 2016 – 2020.

<u>Priority 1 – Protecting vulnerable children</u>

The Board looked at a range of issues that helped protect vulnerable children. Specifically the Board looked at oral health in children and immunisation and screening in Slough. Both of these areas cover both Priority 1 – Protecting vulnerable children, and Priority 2 – Increasing Life Expectancy by focusing on inequalities.

The Board also reviewed the annual report of the Slough Local Safeguarding Children's Board for 2018-19. A major development for the Safeguarding Children Board in this period was the establishment of the Slough Safeguarding Executive Board where senior managers from the core agencies, Slough Borough Council, Thames Valley Police and the Clinical Commissioning Group to ensure common and coordinated approaches.

Oral Health
Oral health was an important 'marker' of health inequality and was linked to deprivation. There was particular concern about oral health of children in Slough with 41.5% of children having one or more decayed teeth compared to 23.3% in England.

The levels of decay were higher than would be expected taking into account Slough's deprivation and there were therefore other factors such as culture and language which influenced the position. The Council was taking action to address the issues and the evidence indicated that the greatest impact would be by focusing on oral health in children.

The Board noted the current oral health initiatives which included the oral health promotion project provided by Oxford Health NHS Foundation Trust; "Starting Well" initiative; Active Movement; and the Healthy Early Years and Healthy Schools coordinators. The "Starting Well" scheme had received £85,000 from NHS England and initially linked six schools in the most deprived wards with local dental practices. There were open days for families and it was considered that investing early would deliver long term results. It was hoped that funding could be secured for a further year and that the work could be embedded.

Priority 2 – Increasing life expectancy by focusing on inequalities

As discussed above, the Board did review a range of issues that cover both vulnerable children and health inequalities.

Frimley Health and Care Integrated Care System (ICS)
Local Authorities and local health organisations are working together as the Frimley ICS to provide a joined up health, care and wellbeing system. The Board received regular updates on the progress being made to deliver Frimley ICS' system operating plan.

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. The coordinated operational system will assist in tackling health inequalities.

Tackling Slough's Health Inequalities and Wider Determinants of Health
Slough Borough Council introduced a report on health inequalities in Slough and how wider social factors affected health. The wider determinants of health were a key theme at the partnership conference on 4 October and the Board hoped it would be a focus of the Frimley Health and Care Integrated Care System (ICS).

The Board welcomed the presentation and agreed that addressing issues relating to the wider determinants of health was central to the work of health and wellbeing boards. The issue was health inequalities and the wider determinants of health were also the focus of the 2018 Partnership Conference and the Away Day in January 2019.

Leisure Strategy
In September, the Board received an update on the 2014 Leisure Strategy. This was a five year strategy aimed at improving the health of the people of Slough by providing them with a wider range of physical and social activities. The Board was pleased to note that the four key priorities of the strategy had been delivered.

- A new core leisure offer by investing in new and refurbished facilities: £62m had been invested in Arbour Park, the Ice Arena, Salt Hill Activity Centre and Langley Leisure Centre refurbishments and the new leisure centre on Farnham Road. The capital programme had been delivered on time and budget.

- A network of free and accessible facilities in neighbourhood parks and open spaces: 18 new green gyms and trim trails in local parks, six new and refurbished multi-use games areas, a parkour park and cricket facilities had been provided.
- A comprehensive programme of accessible opportunities for residents to participate in regular physical activity: The 'Get Active' programme offered over 80 sport and physical activity sessions weekly had been delivered. The evidence showed this programme was particularly effective in engaging females, children and people aged between 25- 44 years old.
- Procure a new leisure operator to manage the new core leisure facilities: Everyone Active had been contracted to manage and operate Slough Wellbeing Board - 26.09.18 four of the new Council leisure facilities with an estimated saving to the Council of over £15m in the next ten years. The provider indicated that there had been circa 60,000 additional visits to Montem Leisure Centre compared to 2017/18.

In 2019-20 the Board will be asked to contribute to the development of the new Leisure Strategy for the next five years.

First Annual Report on Immunisation and Screening in Slough

In March 2019, the board received the Annual Report on Immunisation and Screening in Slough. 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.

The aim of the annual report is to outlines the picture of immunisations and screening in Slough, their current provision, the challenges and opportunities and future plans. The findings in the report will be used to assist the Wellbeing Board in 2019-20 in reducing health inequalities.

The report highlighted some recent successes that have benefitted the local population include programmes to increase uptake and improvements to data quality for closer monitoring of progress. A GP toolkit has been developed with tips and advice for primary care colleagues to improve immunisation uptake for their patients. The toolkit is implemented in many practices across Slough.

Data on immunisations delivered in primary care are now auto-extracted from the clinical record and entered electronically on the Child Health Information System which is not only more efficient but has also improved the accuracy of the data. Slough Borough Council, 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.

The 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.

Priority 3 – Improving mental health and wellbeing

In 2018-19, the board placed considerable focus on mental health and wellbeing campaigns through social media campaigns and events.

#BeRealistic

The board's first social media campaign #BeRealistic focused on obesity. The aim of the campaign is to improve the health and wellbeing of Slough residents by encouraging small

positive changes in lifestyle and achieving and maintaining a healthy weight. The message was promoted by creating a webpage on the Slough website (www.slough.gov.uk/berealistic), social media campaigns via Twitter and Facebook and linking the campaign to all related events.

#ReachOut
The aim of this campaign is to improve the health and wellbeing of Slough residents by encouraging people to 'reach out' and seek help and support if they are feeling lonely or socially isolated; as well as offer advice to people wanting to help those who are lonely or isolated. Loneliness is a bigger problem than simply an emotional experience. It is seen by many as one of the largest health concerns we face and affects all local services.

The official #ReachOut launch took place on 1 August 2018 at the Salt Hill Park Playday. The event was an ideal opportunity to incorporate the ideas of reducing social isolation and loneliness in the borough with a social event for the whole family.

It was very well attended, with numerous stallholders from the voluntary and statutory sector including Thames Valley Police, Royal Berkshire Fire and Rescue Service, The Curve, Healthwatch Slough and groups including Aik Saath and Home-Start Slough, who have received Red Cross funding to reduce loneliness amongst new mothers.

#NotAlone
Building on the #ReachOut campaign the #NotAlone campaign was launched on Mental Health Day October 2018 to remind the community they are 'not alone' and they can seek support and help if they are experiencing mental health issues. The campaign signposts people to organisations and charities that can offer assistance or advice. Or if someone thinks they know someone who needs assistance, they can use this information to pass on.

A number of events have been held in Slough, bringing people together with diverse backgrounds to share their experience and find common ground. The events have been well attended and SBC has had direct face to face contact with around 640 people from different groups across the community. A number of useful resources have been added to the website and a Twitter campaign has been running along side the #NotAlone campaign.

Priority 4 – Housing

The Board received information about the work of the newly established Homelessness and Rough Sleeping Task and Finish Group.

The Board also considered a report about the current homelessness and rough sleeping situation in the borough. The report included the draft 'Single homeless and rough sleeping reduction plan' which was part of the Homelessness Prevention Action Plan 2018-2023.

The Wellbeing Board set up a Task and Finish Group to oversee Slough's approach to rough sleepers and to ensure that the partnership is fully engaging sufficiently to support the work which the Council and the voluntary sector are doing.

In November 2018, the Board received a report that provided an update on the following issues:

- Recent activity to tackle rough sleeping across Slough
- The strategy that is being developed to help prevent people from becoming homeless in the first place;
- Information on the 2018 Winter offer for rough sleepers
- Other work underlay that is connected to rough sleeping.

Statutory Responsibilities

Joint Strategic Needs Assessment (JSNA)
The Board has a statutory responsibility to undertake a Joint Strategic Needs Assessment (JSNA) for the town. The JSNA is an assessment of the current and future health and social care needs of Slough's population and the factors affecting their health, wellbeing, and social care needs. It brings together information from different sources and partners to create a shared evidence base, which supports service planning, decision-making, and delivery.

The JSNA presents key headlines from the most recent analysis of the data and includes population change, population groups, wider determinants of health (employment, housing, education, environment), health conditions and causes of death, lifestyles and service use. Supporting this information are ward profiles and links to Slough's Clinical Commissioning Groups profiles for those who require more detail.

A summary document is also produced each year drawing attention to key facts and figures, and highlighting priority issues for Slough. The JSNA is a continuous process and is updated as additional information becomes available, to support evidence-based commissioning and highlight gaps and areas for future work. A refresh of the JSNA is currently underway and will be published later this year.

Joint Wellbeing Strategy
The 2016-20 Strategy was developed following a review of the 2013-2016 Strategy and after a renewal of the borough's JSNA in 2016. It is being used to prioritise and underpin the work of the Board and its four priorities for the town are:

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

Pharmaceutical Needs Assessment (PNA)
The Board has a statutory responsibility to undertake a Pharmaceutical Needs Assessment (PNA) every three years. The PNA aims to review the current pharmaceutical services for Slough and identify any gaps in provision through assessment, consultation and analysis of current and future local need.

Integration / Partnership Working
Throughout 2018/19 the Board has continued to oversee the development and delivery of a number of ambitious plans for local health and social care integration which underpin the town's health and wellbeing ambitions for the next five years.

These plans have provided the Board with a unique opportunity to drive forward its health and social care integration aspirations.

Frimley Health and Care Sustainability and Transformation Partnership
During the year, the board received updates from the Frimley Health and Care Integrated Care System and its progress in developing a single system Operating Plan for 2019/20.

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. While 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.

Better Care Fund

In July 2018 the Board received and considered the summary of the Better Care Fund programme activity and outturn position for 2017-18.

The Better Care Fund programme is developed and managed between the local authority and CCG together with other delivery partners aims to improve, both directly and indirectly, the wellbeing outcomes for the people of Slough in the areas of:

- Increasing life expectancy by focussing on inequalities and
- Improving mental health and wellbeing.

Overall the activities within the BCF programme have continued to support and invest in areas of integrated care between NHS and adult social care services in Slough where they deliver better outcomes for residents and demonstrate effective use of funding by keeping people well and in the community, avoiding non-elective admissions to hospital where possible and supporting people home quickly if they go to hospital.

Safeguarding

The Board reviewed the Slough Adult Safeguarding Board and Slough Local Safeguarding Children's Board annual reports for 2017-18.

The Board discussed the proposed multi-agency safeguarding partnership arrangements in Slough which would further strengthen the links between the two bodies as it was recognised that there was significant commonality of membership, processes and core safeguarding issues. While the two boards would remain separate as statutory boards, it was proposed that their meetings would be coordinated, there would be a single safeguarding business plan and shared sub-groups. The Board was very supportive of the principle of improving the joint working between the two boards.

Conclusion

This annual report summarises the work of the board to improve health and wellbeing outcomes for people living in Slough throughout 2018/19. The approach is one founded on strong partnership working and an understanding that the challenges facing health and social care are too great for any single organisation to tackle alone.

Members of the board are committed to working together to ensure Slough has the right strategic plans and partnership arrangements to face these challenges.

During the course of 2019-20 the board will continue to review and strengthen its partnership structures and governance arrangements to build on the work that has been done to date to improve the health and wellbeing of local people.

The board will use the findings of this Annual Report to review progress against the priorities in the Wellbeing Strategy and check that these remain the right areas of focus for the year ahead. It will refresh these priorities and the Strategy where appropriate if the data and local context suggest that this is necessary.

The Slough Wellbeing Board will also consult on any changes that are required and will invite input from partners and stakeholders.

Appendix 1 – Statutory Responsibilities

The Wellbeing Board has the following statutory responsibilities (as set out in the Health and Social Care Act 2012):

- To prepare and publish a Joint Strategic Needs Assessment (JSNA) of the health needs of the people of Slough.
- To prepare and publish a Joint Health and Wellbeing Strategy (JHWS) for Slough.
- To give its opinion to the Slough Clinical Commissioning Group (the CCG) as to whether their Commissioning Plans adequately reflect the current JSNA and JHWS.
- To comment on sections of the CCG's Annual Report which describe the extent of the CCG's contribution to the delivery of the JHWS.
- To give its opinion, when requested by the NHS Commissioning Board, on the CCG's level of engagement with the Board, and on the JSNA and the JHWS.
- To encourage integrated partnership working between organisations that plan and deliver health and/or social care services for local people in the area.
- To work with partners to identify opportunities for future joint commissioning.
- To lead on the signing off of the Better Care Fund Plan (BCF).
- To publish and maintain a Pharmaceutical Needs Assessment (PNA).
- To give its opinion to the council on whether it is discharging its duty to have regard to any JSNA and JHWS prepared in the exercise of its functions.
- To ensure that strategic issues arising from Slough's Adult Safeguarding Board and Local Safeguarding Children's Board inform the work of the Board.
- 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.
- To exercise any council function which the council delegates to it.

Appendix 2 – Members of Slough Wellbeing Board 2018/19

- Councillor Natasa Pantelic (Chair) SBC Lead Member for Health and Social Care
- Dr Jim O'Donnell (Vice-Chair) East Berkshire Clinical Commissioning Group, Slough Locality
- Cate Duffy, Director of Children, Learning and Skills, SBC
- Superintendent Sarah Grahame, Thames Valley Police
- Lisa Humphreys, Slough Children's Services Trust
- Ramesh Kukar, Slough Community and Voluntary Sector
- Tessa Lindfield, Director of Public Health
- Councillor Mohammed Nazir, SBC Lead Member for Corporate Finance & Housing
- Lloyd Palmer, Royal Berkshire Fire and Rescue Service
- Colin Pill, Slough Healthwatch
- David Radbourne, NHS England
- Raakhi Sharma, Slough Youth Parliament
- Alan Sinclair, Director of Adults & Communities, SBC
- Josie Wragg, Chief Executive, Slough Borough Council

Appendix 3

WELLBEING BOARD WORK PROGRAMME 2018/19

9 May 2018
Items for Action/Discussion • Feedback on the #BeRealistic campaign • Draft SWB Annual Report for 2017/18 Themed Discussion • Interim Director of Public Health's Annual Report 2017/18 (Draft): The natural environment
18 July 2018
Items for Action/Discussion • Frimley Health and Care Integrated Care System • #BeRealistic Campaign Update • #Reach Out Campaign: Progress Report • Refreshed Terms of Reference and Update on the Recruitment of Two Business Representatives • Arrangements for the 2018 Partnership Conference
26 September 2018
Items for Action/Discussion • Integrated Care System Update • Refresh of Local Transformation Plan of the Children and Young People Mental Health and Wellbeing (East Berkshire) • Tackling Slough's Health Inequalities and Wider Determinants of Health • Delivering the Next Phase of the Leisure Strategy

20 November 2018
Items for Action/Discussion • Integrated Care Systems (ICS) Update and Findings of the 'Your views matter: the big conversation' survey • Annual Reports of the Slough Adult Safeguarding Board and Slough Local Safeguarding Children Board • Oral Health in Slough's Children • Outcome of 2018 partnership conference
14 January 2019
Items for Action/Discussion • Frimley Health and Care Integrated Care System: Draft Operational Plan 2019/20 • Slough Clinical Commissioning Group Annual Report 2019/20 Themed Discussion • Mental Health: Review of Impact of the #NotAlone Campaign and Shape of the Next Stage of the Campaign
26 March 2019
Items for Action/Discussion • Terms of Reference, Membership and Outcome of January Away Day • Frimley Heath and Care Integrated Care System Update • Thames Valley Police – Drug Diversion Programme • First Annual Report on Immunisation and Screening in Slough • Director of Public Health's Annual Report 2018/19 Themed Discussion • Wider Determinants of Health – Priorities for Slough

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SLOUGH BOROUGH COUNCIL

REPORT TO: Health Scrutiny Panel

DATE: 16th January 2020

CONTACT OFFICER: Ellie Gaddes, Policy Insight Analyst
(For all Enquiries) (01753) 875657

WARDS: All

PART I
FOR COMMENT AND CONSIDERATION

HEALTH SCRUTINY PANEL - WORK PROGRAMME 2019/20

1. Purpose of Report

For the Health Scrutiny Panel to discuss the Work Programme for 2019/20.

2. Recommendations/Proposed Action

That the Panel review the Work Programme and potential items listed for inclusion.

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

3.1 The Council's decision-making and the effective scrutiny of it underpins the delivery of all the Joint Slough Wellbeing Strategy priorities. The Health Scrutiny Panel, along with the Overview & Scrutiny Committee and other Scrutiny panels combine to meet the local authority's statutory requirement to provide public transparency and accountability, ensuring the best outcomes for the residents of Slough.

3.2 The work of the Health Scrutiny Panel also reflects the following priorities of the Five Year Plan:

- Our people will become healthier and will manage their own health, care and support needs.
- Our children and young people will have the best start in life and opportunities to give them positive lives

4. Supporting Information

4.1 The current Work Programme is based on the discussions of the Health Scrutiny Panel at previous meetings, looking at requests for consideration of issues from officers and issues that have been brought to the attention of Members outside of the Panel's meetings.

4.2 The Work Programme is a flexible document which will be continually open to review throughout the municipal year.

4.3 At the meeting in September 2019, it was agreed to restrict the agenda for each meeting to two substantive items, with any further reports taken as information-only items.

5. Conclusion

This report is intended to provide the Health Scrutiny Panel with the opportunity to review its upcoming Work Programme and make any amendments it feels are required.

6. Appendices Attached

A - Work Programme for 2019/20 Municipal Year

7. Background Papers

None.

Appendix A

Health Scrutiny Panel Work Programme 2019/20

Task and finish Group / Visits
Meeting Date
23 March 2020
• Slough Safeguarding Adults Board Annual Report • Air Quality Report • Adult Social Care Local Account 2019-20 • Disability Task and Finish Group - Implementation Progress

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MEMBERS' ATTENDANCE RECORD 2019/20

HEALTH SCRUTINY PANEL

COUNCILLOR	27/06/19	10/09/19	15/10/19	20/11/19	16/01/20	23/03/20
Ali	P	P	P	P		
Begum	P	P	P	P		
Gahir	P*	P	P	P		
N Holledge	P	P	P	Ap		
Mohammad	P	P*	P	P		
Qaseem	P	Ab	P	P		
Rasib	P	P	P	Ap		
A Sandhu	P	P	P	P		
Smith	P	P	P	P		
Colin Pill - Healthwatch Representative	P	Ap	P	Ap		

P = Present for whole meeting
P* = Present for part of meeting
Ap = Apologies given
Ab = Absent, no apologies given

(Ext - Extraordinary)

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