SLOUGH BOROUGH COUNCIL

REPORT TO: Slough Wellbeing Board **DATE: 26th March 2014**

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PART II

FOR DECISION & CONSIDERATION

Progress report on the Healthy Lives, Healthy People, Healthy Slough strategy

1. Purpose of Report

To update the Wellbeing board on progress under the strategic themes and objectives identified in the attached Health Strategy for 2013-16.

2. Recommendation(s)/Proposed Action

The Wellbeing board is asked to note consultation has taken place to inform the strategy with; the public, with the Health Priority Development Group and with the Corporate Management Team. Significant progress has been made in the first year of this strategy as shown in section 5 and the board is asked to endorse the partnerships work and strategy for 2014-16. The board will also need to note that a performance scorecard view of the reported actions is being developed to underpin the longer term outcomes monitored through the public health outcomes framework.

Since the development of the Health strategy two supporting strategies have been written and approved – the diabetes and physical activity strategies. Both of these report through the Health Priority Development group and it is recommended that the board reviews progress against these at future meetings.

3. The Slough Joint Wellbeing Strategy, the JSNA and the corporate plan

This strategy is based on the emerging wellbeing priorities in the Slough Joint Wellbeing Strategy and will be available on line for local residents to comment on as part of the JSNA and Joint Health and Wellbeing strategic cycle. It supports the following objectives in the corporate plan: deliver high quality services, develop new ways of working, deliver local and national change, achieve value for money.

4. **Other Implications**

(a) Financial

All funding sources required to implement the strategy have been identified in the attached action plan and agreed with the relevant agencies. The main sources of funding are itemised under each key action.

b) Risk Management

Recommendation	Risk/Threat/Opportunity	Mitigation(s)
Ongoing engagement is taking place through the Chance4Change programme to ensure that the community owns the strategy	Community engagement is based on perceptions rather than on fact	A two month consultation with a wide range of community groups was undertaken in July and August of 2013. This has informed this version of the strategy as well as the most recent version of the JSNA 2013. This strategy will be reviewed in a continuous cycle alongside the JSNA, which is now live on the web.
Financial constraints to implementing the strategy are reviewed annually as part of the medium term financial strategy	The public health grant, CCG funding and Big Lottery funding are key sources for implementing this strategy	The Public Health budget, Big Lottery funding and the commissioning plan are aligned to this strategy. There are opportunities to extend the Big Lottery funding if the targets are met by 2015.
Proxy indicators have been identified for this strategy, which are collected by the commissioned services or interventions. These are being monitored by the Health Priority Development Group.	It is not possible to measure the impact of this strategy in terms of the long term public health outcomes due to the multiple influences of other strategies on the wider determinants of health	Outcomes reported to the HPDG are collated from the entire partnership. Quarterly Public Health outcomes are reviewed by the PDG as well as the Wellbeing board.

(b) Human Rights Act and Other Legal Implications

There are no Human Rights Act implications.

(c) Equalities Impact Assessment

The JSNA on which this strategy is based is a full assessment of the impact of the strategy on different age, gender and ethnic groups as well as those with protected characteristics.

(d) Workforce

There are no new workforce implications as all the services identified are already commissioned. Where champions or volunteers are used and expenses can be paid to attend training.

5. Supporting Information

The aim of the Slough Health Strategy is to improve health and wellbeing outcomes and reduce inequalities through the following key objectives i.e:

1. Review and update the needs and priorities in this strategy based on evidence in the Joint Strategic Needs assessment.
2. Use a partnership approach to identify local actions, in areas of need.
3. Develop local mental and physical wellbeing champions and measure the wider impact of joint work on local communities.
4. Promote oral health, healthy eating and physical activity throughout life
5. Increase prevention of, early identification of and management of obesity and diabetes
6. Increase the uptake of the NHS Health checks programme, aimed at people aged 40-74 (to identify people at risk of; heart disease, stroke, diabetes, kidney problems, alcohol problems or dementia).
7. Increase access to health reviews for carers and for those with mental health problems or learning disabilities
8. Reduce the numbers of people smoking and consuming harmful tobacco products.
9. Increase access to high quality self care programmes for people with long-term conditions at risk of poor outcomes.
10. Reduce the rates of hospital admissions for respiratory conditions among young children which can be managed at home.
11. Develop innovative ways of Improving information and care pathways to prevent unnecessary hospital admissions and discharge people early - linking health and social care with the voluntary sector.
12. Prevent the spread of active TB and other communicable diseases.
13. Increase access to family planning services and reduce the late diagnosis of HIV.
14. To support local actions led by NHS England to influence uptake of immunisation, screening and other programmes

The evidenced based actions are organised under strategic themes as follows;

- Prevention
- Early Intervention
- Targeted provision
- Hospital avoidance

Update on Theme 1 – Prevention

1.1 Two local diabetes programmes (Merit and the Diabetes Warwick course) have been rolled out for primary care professionals. Local educational updates are organised by the diabetes specialist nurse and community team who deliver educational updates quarterly and at local GP training sessions. 40 clinicians have participated in diabetes educational updates and a conference was held for the county. 10 Slough practitioners attended this diabetes best practice event and Dr Kesar Sadhra and Dr Nithya Nanda spoke about the work being piloted in Slough. Over 90 Sikh elders with diabetes are regularly attending the Falcon Community Centre to participate in exercise and educational programmes. A local educational programme is being developed in partnership with the Sikh community, Diabetes UK, the diabetes network and the mayor of Slough Borough Council.
An on-line app is being scoped (subject to funding from Public Health England) in the West of Berkshire and will become an on-line resource for Slough residents in 2015.

1.2 Stop Smoking Services have technically over-performed in 2013-14 but the original targets were set too low for Slough. Latest results (Sept 2013) show that the service has delivered 672 four week quitters and 187 twelve week quitters. 69% of these are carbon monoxide validated. CACI estimates indicate that demand exceeds supply as Slough has c.21,000 smokers. CACI estimates Slough has 2300 'high risk' smokers and these will be the focus of commissioned services in 2014-15, including those with mental health problems and young smokers.

1.3 Work on reduction of access to illegal cigarettes is undertaken by the trading standards team. 1115 seizures have taken place in 5 stores and 62 visits made to ensure that premises are compliant. 57 were compliant and the remainder have action plans in place.

1.4 Prevention of exposure to second hand smoke has been limited to date and actions will be built into the commissioning plans for 2014-15.

1.5 A web based directory of local sport and physical activity services has been compiled for the physical activity strategy and published in the Slough Services guide at
http://servicesguide.slough.gov.uk/kb5/slough/services/results.page?cr=1&qt=sport+and+physical+activity&term=&sorttype=relevance

1.6 6 new green gym facilities - called Muga's (multi user game areas) have been developed. Upton Court Park and Mercian Park now have outdoor Gyms.

1.7 Healthy cooking sessions have been very popular in Slough and are delivered through schools as well as through the public health dietetic service and via the New Futures workstream of the Big Lottery funded programme.

The targets for the latter have been increased following a successful launch and two courses have been delivered to date with more planned in the summer. 5 young carers and 14 NEETS. 2 of these have gained employment and one has gained a work placement. This means that two thirds of the Big Lottery targets to June 2015 have already been met. Links will be made to internships being offered in SBC

1.8 Numbers participating in led walks across the borough – numbers of community clubs, number of attendees on specific programmes, data is being collated for the physical activity and sport strategy. This is the area of greatest concern in relation to the Big Lottery targets.

1.9 Healthcheck Data for January 2014 relates to Q3 and can be found at http://www.healthcheck.nhs.uk/interactive_map/south_of_england/thames_valley/?la=Slough&laid=150. 10 out of the 16 GP practices are now delivering Healthchecks compared to 5 in April 2013. The response to this free health check (offered by general practices) to the end of March was 1856/ 3750 who have been offered the check via a GP (a 49.1% uptake rate). 31646 are considered eligible and each year one fifth of these should be offered the check. End of year figures are awaited and the remainder are supplied through the Healthy Hearts service in Slough. The estimated percentage uptake is 80.9% uptake for Q3 compared to 56.4% averaged over the year to date. These figures will be subject to end of year updates as some smaller practices only returned their data in March.

With the support of the central team and NHS England the local public health team have been promoting the uptake of flu vouchers and Table 1 shows the results. These figures will improve next year following changes to the way in which people are invited. The GP returns do not include those that are bought direct from pharmacies or supplied through workplaces.

Table 1 Flu vaccination uptake at the end of January was as follows

	NHS SLOUGH CCG
No. of practices	16
No. of forms completed	16
% of practices responding	100.0
65 and over	69.6
Under 65 (all Patients)	9.1
Under 65 (at-risk only)	52.7
Pregnant and NOT IN a clinical risk group	29.6
Pregnant and IN a clinical risk group	52.9
All Pregnant Women	31.0
Aged 2 and NOT IN a clinical risk group	29.3

Aged 2 and IN a clinical risk group	42.4
All Aged 2	29.6
Aged 3 and NOT IN a clinical risk group	22.8
Aged 3 and IN a clinical risk group	50.7
All Aged 3	23.5

These are not the final year figures and must be viewed with caution. Plans are in place between NHS England and WPH maternity services to offer flu vaccinations to all pregnant women in Q3 2014.

1.10 MMR uptake has been the focus of a great deal of the partners time this year. Uptake at the end of Q1 2013 was 91.9% for MMR1 and 80.3% for MMR2 – audits have revealed a range of reasons include a change of software, the need for consistent read codes, SMS texting and options to drop into clinics if appointment times are not convenient. NHS England has funded a small pilot to ensure that all those aged 10-16 can catch up who have only received 1 dose or those who have not received any dose. The results of this pilot are awaited but the practice manager leading this work has identified a key issue in relation to the coding differences as software has changed and has shown all the other practice managers how to extract and recode the entries. Those who have genuinely not had a single dose are estimated to be X and those who have had only one dose are estimated to be Y. This is a considerable reduction W% from the original gap identified in the audit by NHS England.

1.11 TB completion rates have improved although rates of new cases of TB have increased. Slough's incidence of TB has continued to rise to a peak of 56.7 per 100,000 compared to 15.1 in England. (Public Health Outcomes Framework 2010-2012). The treatment completion rates have continued to improve as 89% completed treatment in 2011 compared to 80% in 2007, as described by the 2013-2014 report into Health Protection Priorities in the Thames Valley. The Chief Medical Officer's target is 85%. The TB new entrant health service has been audited in Q3 and the results of that will inform future decisions by the CCG

1.12 Sources of national PSHE training have been identified and 900 young people in a local academy benefitted from additional PSHE expertise in relation to sexual health

1.13 Long acting contraception rates in local practices were reported as significantly below the England average in the sexual health needs assessment in 2013. Changes to the delivery of services will be needed to increase the rates; this is compared to around 33% of those offered contraception at the Garden Clinic who are fitted with LARC.

1.14 Condom provision – increased access to condoms has been arranged through a range of settings;

- 10 Children Centre's
- GP Surgeries

- Supported Housing Organisations
- 1 College
- Young Peoples Organisations
- 14 GP Surgeries under 3 C's programme (current and to be trained soon)
- 1 HIV Support agency
- Slough Drug Support Agency

Update on theme 2 – Early Intervention

2.1 Local pharmacies have been increasing awareness of bowel cancer screening in a recent campaign in January and the results of this campaign are awaited. Health activists have supported this campaign. The National Bowel Cancer Screening Programme invites men and women aged 60-69 years to be screened for bowel cancer every two years using a faecal occult blood test (FOBt). Those whose FOBt screen is positive will be offered a colonoscopy. The Berkshire programme has also now been extended to include those aged 70-74 years. The latest data from the JSNA reported that 38.5% of people invited for bowel screening in the last 2 years received an adequate screening result (Jul-11 to Jun-13). This information is taken from the GP practices that are based in the Slough Borough locality. Slough's positivity rate was 4.66% for all the bowel cancer screens completed between July 2011 and June 2013.

Cervical cancer screening coverage rates have risen steadily each year and were 73.7% in 2012 against the national average of 78.6% of the eligible population aged 25-74. The results for 2013 will be released in Q2. Results for one practice have improved dramatically following a review of read codes and all practices are exploring options to improve uptake through SMS texting.

Breast cancer screening coverage rates were reported as X% in 2012 against the national average of 73%.

A pilot outreach programme to local mosques, temples and children's centres by trainee GPs increased peoples willingness to take part in cancer screening and the 2013 results are expected in Q3 2014.

2.2 Coverage of Chlamydia screening increased in Q2 to 2001 per 100000 and fell in Q3 to 1512 per 100000. Positivity rates have however remained above 7% and at Q3 were 8.6%. The results in Q2 reflected higher positivity rates and although it is a national screening programme positivity rates are highest when at risk groups are targeted.

Coverage of diabetic eye screening in 2012-13 was 5891 of 7816 out of the 8776 registered patients and uptake was 75.4%. Diabetic eye screening results show a 11.3% increase in coverage since 2011/12 – placing Slough second only to Wokingham (the host area for diabetic eye screening services in Berkshire). Slough had been the lowest performing area in 2011/12. The coverage rate is now classed as at an acceptable level. The work of the diabetes network is extensive and results of 2013-14 are expected to bring Slough up to the 80% target.

2.3 HIV screening in secondary care is the responsibility of the CCG and data has been requested from WPH as there was an agreement in 2013-14 that this would be a quality improvement target.

2.4 Due to the rising trend in obesity in reception and despite good breastfeeding initiation rates a group has been established to design a culturally sensitive weaning programme as poor weaning practices are observed in some groups. The results will be fed into materials for the health visiting service to use and into the Breastfeeding Network national training packs.

Childhood obesity in year 6 remains in line with national averages, The scrutiny panel have investigated a range of interventions being taken locally. In terms of new programmes three schools with 15-20 children in each have signed up in January 2014 to the Lets Get Going programme to reduce childhood obesity – Wexham Court, Iqra School and Parlaunt School. Schools are awaiting a trainer to deliver the programme.

2.5 The rate if early deaths from cardiovascular disease remain high and a key national programme has been introduced to detect cardiovascular problems earlier. The Health Checks programme is being supported by two main providers – general practices and the Healthy Hearts programme. 20 pharmacies were trained in Q1 but the contract was not perceived financially viable so no pharmacy is delivering this under contract from SBC.

2.6 The Big Lottery funded training of mental health first aid champions is being rolled out via Slough CVS. 90 out of the target 180 have completed MHFA and 30/180 have completed domestic abuse training. The target is for the end of June 2015. Sessions are planned in the summer to increase uptake. 15 school assistants have also been trained in MHFA Lite at Foxborough as part of the Place Shaping approach and domestic abuse training will follow in Q3 of the academic year. The ;singing boxes' programme being implemented in ten care homes has received excellent reviews from the Big Lottery and is popular with residents.

2.7 The DAAT team have reviewed the alcohol liaison in reach service at Wexham Park Hospital delivered by Turning Point. Over 600 patients have been seen through the programme in a six month period and around 30% are known to the service. Clear disaggregation of costs are planned as the benficiaries are from all over the UK. A new service will be recommissioned from April 2014. An alcohol strategy is yet to be developed as Slough has been designated an alcohol action area. One of the products of this joint work is the development of a community alcohol partnership. Research has been undertaken to inform the development of a framework (similar to Brighton and Hove) to ensure that new licence applications are viewed against background thresholds of antisocial behaviour, child protection cases involving alcohol and childhood accidents etc

2.8 A quality innovation, productivity and performance (QIPP) plan has been funded by the CCG to start in Q2 2914. This is a Silverstar charity and Public Health joint initiative which will promote diabetes screening in places of worship.

Update on Theme 3 – Targeted Intervention

3.1 Access to evidence based self care programmes is being promoted with Public Health England and local partnerships for children and maternity services in the Thames Valley. Funding confirmation is awaited from PHE that the www.puffell.com platform can be developed to contain a range of decks – Reading and the Berkshire West CCGs are leading on the diabetes deck, Slough Borough Council and Slough CCG is leading on the 0-5 deck for parents, the CAMHS deck and the asthma and viral wheeze deck. Collaboration with air quality experts in the US and in London has already identified opportunities to improve behaviour change for asthma medication uptake, in relation to air quality changes and to check whether the child has an asthma plan.

3.2 The numbers of children in receipt of the ITALK programme is awaited as is the number of families have been supported through the Family Nurse Partnership programme, a targeted service for those with significant vulnerabilities.

3.3 Ward profiles have been created for the JSNA and are available at http://www.slough.gov.uk/council/strategies-plans-and-policies/slough-profile.aspx. Councillors have appreciated the resource and are using these in their consultations with the public

3.4 The numbers of people trained to the middle of March 2014 via the dementia awareness programme (offered by SBC learning and development) is 450 from 70 different organisations.

3.5 All general practices have had access to dementia awareness training – via STEPS and from the memory clinics.

3.6 The numbers of NEETs accessing job seekers allowance in July 2013 was 700 of which 235 had been claiming for six months or more. The New Futures Big Lottery work stream has trained 19 young people since July 2013 and 2 of these have been given employment and 1 has gained work experience. Further courses are planned in the summer of 2014. Data formerly reported through the Raising Participation service needs to be collated to inform the board about the wider opportunities for young people in the town

3.7 Work with care homes on screening for malnutrition is ongoing as part of CQC inspections. A new measure has been identified - number of homes monitoring actions in response to screening**.** This is an area of work to be reported through adult social care.

Update on Theme 4 – Hospital avoidance programmes

4.1 The numbers of practices participating in the GRASP programme and who have a stroke audit action plan is being researched as part of the cardiology workstream, the national sentinel audit for stroke has identified WPH as an outlier and improved stroke care in the community is a key priority

4.2 A pilot COPD comprehensive care programme is underway in one practice where rates are higher. This Innovation Funded programme will report at the end of the year

4.3 The results of winter pressures projects as reported to the CCG operational leadership team in March is that the PACE service is delivering well and there will be a risk share with Buckinghamshire. The uptake of RACC by Slough patients has been 18% and service redesign is underway. It is too early to evaluate the outcomes of the paediatric assessment unit at Upton and the extra 5% appointments have only just commenced. These and the GP acute home visiting service are yet to be evaluated. The extra ambulance cover will be redesigned into core services with South Central Ambulance Services

4.4 The numbers of people admitted to Wexham Park hospital known to the Slough alcohol treatment service in the community was 30% of the 153 Slough residents seen by the service (last extract January 2014). 602 people were seen by the Wexham service from areas all over the country since July 2013. This service will be recommissioned in 2014.

4.5 IPP plans are in place to improve the offer and uptake of the 8 care processes for diabetes care.. Enhanced management of diabetes training has been delivered and detailed plans and mentorship established. A trained specialist nurse is visiting practices and supports in identifying high risk patients and supports in management and a mentorship programme has been established. 15/16 have completed this and an advanced management of diabetes programme will be rolled out in 2014-15. A specialist educational initiative is about insulin initiation and management called Pitstop has been approved. This is a university accredited programme and all prescribers will be offered this programme.

4.6 The total number of service users, aged 65+ in residential care as at 28th Feb 2014 is 204 (61.76% in nursing care and 38.23% in residential care).

4.7 The Better Care fund plans include the following linked key priority aims:

- Encourage independence and self- reliance by building community capacity
- Reduce the proportion of patients falling into crisis and needing admission to hospital or care home
- Increase the proportion of patients who feel supported to manage their long term condition
- Reduce permanent admission to nursing and residential care for over 65s
- Increase number of people (aged 65+) offered reablement following discharge from hospital
- Reduce avoidable hospital admissions

- Maintain the good performance of older people at home 91 days after discharge from hospital care into reablement

4.7.1 These key priority aims will be delivered through the following three BCF programme delivery groups:

- Self Care and Prevention
- Maintaining and recovering independence
- Care Co-ordination

6. Comments of Other Committees

The Health Priority Development Group has worked collaboratively and overseen the content and actions within this strategy. The Health Scrutiny panel was consulted on the content. The CMT members have ensured that the emerging leisure strategy is also linked to this strategy. Local councillors were involved in the community outreach sessions to obtain local views on the wider determinants of health.

7. Conclusion

The board is requested to note the progress being made to deliver the strategy and the work underway under each objective. The board is asked to endorse the strategy for 2014-16.

New Public Health Outcomes indicators published in February 2014 show additional action is now needed to reduce the risk of falls, of fractures and of sight loss due to diabetes and acute macular degeneration. This work together with a renewed focus on stroke care in hospital and community settings could be picked up through the Better Care Fund programme.

Work has progressed within the diabetes and physical activity networks but the board will need to be sighted on those areas that are not yet able to progress within these strategies.

8. Appendices Attached

Healthy Lives Healthy People; a public health strategy for Slough 2013-16.

9. Background Papers

None