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SOUTHEND-ON-SEA BOROUGH COUNCIL

Health & Wellbeing Board

Date: Wednesday, 22nd March, 2017
Time: 5.00 pm
Place: Committee Room 1 - Civic Suite
Contact: Robert Harris

Email: committeesection@southend.gov.uk

AGENDA

1 **Apologies for Absence**

2 **Declarations of Interest**

3 **Questions from Members of the Public**

4 **Minutes of the Meeting held on Wednesday 1st February 2017** (Pages 1 - 4)

******** **Items for Discussion/Decision**

5 **Health Indicators** (Pages 5 - 8)
Report from Policy, Engagement and Communications Team attached.

6 **Annual Public Health Report** (Pages 9 - 78)
Report from the Director of Public Health attached.

7 **Pharmaceutical Needs Assessment (PNA)** (Pages 79 - 90)
Report from the Director of Public Health attached.

8 **Better Care Fund 2017-2019 Plan** (Pages 91 - 176)
Report from the BCF Programme Manager attached.

******** **For Information**

9 **Health & Social Care Integration - The Next Steps** (Pages 177 - 184)
Report from the Programme Manager attached.

******** **A Better Start Governance Board**

10 **A Better Start Governance** (Pages 185 - 212)
ABSS Portfolio Strategy and Plan 2017-2019 attached.

(Additional reports from interim Programme Director to follow)

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SOUTHEND-ON-SEA BOROUGH COUNCIL

Meeting of Health & Wellbeing Board

Date: Wednesday, 1st February, 2017
Place: Committee Room 3 - Civic Suite

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Present: Councillor L Salter (Chair)
Dr J G Lobera (Deputy Chair),
Councillors Callaghan, Lamb and Evans,
Ms M Craig, Mr S Leftley, Ms A Semmence, Mr N Leitch, Ms A Atherton, Ms L Chidgey, Ms A Clare, *Ms L Crabb and Mr A Vowles.

In Attendance: Mr R Harris, Mr R Walters and Councillor Moyies (observer – People Scrutiny Committee Chairman).

Start/End Time: 5.00 - 6.15 pm

723 Welcome and Apologies for Absence

Apologies for absence were received from Councillors Ayling and Willis (no substitutes). Apologies were also received from Mr R Tinlin, Ms S Morris, Dr Chaturvedi, Ms C Panniker, Mr I Stidston and Ms M O'Callaghan (sub: Ms L Crabb).

724 Declarations of Interest

Councillor Salter - Minute 731 (Sustainability & Transformation Plan (STP) Status Briefing – Non-pecuniary interest – husband is Consultant Surgeon at Southend Hospital and holds senior posts at the Hospital; son-in-law is GP; daughter is a doctor at Broomfield Hospital.

725 Questions from Members of the Public

There were no questions from the public at this meeting.

726 Minutes of the Meeting held on Wednesday 7th December, 2017

Resolved:-

That the Minutes of the Meeting held on Wednesday 7th December 2016 be confirmed as a correct record and signed.

727 Locality Approach and Complex Care Co-ordination Service

The Board considered a joint report from the Head of Integrated Care Commissioning and BCF Project Manager which provided a briefing update on the formation of commissioning localities for health and social care in Southend-on-Sea and the commissioning and 'go live' of the Complex Care Coordination service.

The Board asked a number of questions which were responded to by the BCF Project Manager.

Resolved:

1. That the updates on both the locality approach and the complex care coordination service be noted.

728 Integrated Community Health and Social Care Services - The Next Steps

The Board considered a report from the BCF Project Manager which provided an update regarding community health and social care integration and sought approval to explore the opportunities to further integrate community health and social care services.

The Board asked a number of questions which were responded to be the BCF Project Manager.

The Board discussed the provision of mental health and dementia services in the borough. The Board recognised that there was a significant and growing demand for mental health services and that work was underway to address the specific issues for mental health. The Board also noted that the dementia services for Southend had recently been remodelled and was now fully integrated within health and social care services/provision.

Resolved:

That the commissioning of a joint report by Southend-on-Sea Borough Council (SBC), Southend Clinical Commissioning Group (SCCG) and Southend Public Health, which explores the community health and social care integration opportunities and evaluates the options be approved and that the recommendations on the way forward be submitted to a future meeting of the Board for consideration and approval.

729 Inclusion of health related performance measures for Southend Council's Corporate Monthly Performance Report

The Board considered a report from the Council's Team Leader, Policy and Information Management Team, which sought consideration of appropriate health related performance measures for inclusion in the Council's Corporate Monthly Performance Report (MPR) from April 2017.

The Board noted that the Council's Cabinet had agreed that the MPR should include a small basket of indicators which related to areas where the Council does not have lead responsibility or direct control but were important to the Council to achieve its priorities. The Board are therefore asked to consider and agree which performance measures would be the most appropriate for inclusion.

The Board discussed the potential additional performance measures (as set out in paragraph 3.6 of the report) which could be included in the Council's MPR

and stressed that the performance measures must provide added value and clear on the reasons why the information is needed and how it will be used. The Board suggested that the Council's Policy and Information Management Team liaise with the Southend CCG to identify an appropriate list of 4 or 5 basket of indicators.

Resolved:

That the Council's Policy and Information Management officers liaise with the Southend CCG to identify the 4 or 5 additional performance measures which could be included in the Council's MPR and that the proposed basket of indicators be considered at a future meeting of the Board.

730 Southend LSCB and SAB Annual Reports on the Effectiveness of Safeguarding Services 2015-16

The Board considered for information the Local Safeguarding Children Board (LSCB) and Safeguarding Adults Board (SAB) Annual Reports for 2015-16 which provided an assurance statement of the effectiveness of safeguarding services in Southend and identified areas for development for consideration by other strategic and commissioning bodies when reviewing their strategic and business plans for the new financial year 2017-18.

Resolved:

1. That the Board ensures that the areas for development identified in the LSCB and SAB Annual Reports for 2015-16 (appendices 1 and 2) and in sections 3.1 and 3.2 of the report are reflected in the Boards strategic planning for the coming year.

2. That the Schematic of Strategic Leads for Safeguarding and Community Safety Priorities set out in appendix 3 to the report be approved.

731 Sustainability & Transformation Plan (STP) Status Briefing

The Board considered a report from the Programme Director, Mid and South Essex Success Regime, which provided an update on the progress of the Mid and South Essex Success Regime (SR) and Sustainability and Transformation Plan (STP).

Resolved:

1. That the update and continuing opportunities to give views on the STP and developing options for service change be noted.

2. That the Board continues to participate in discussions with the Mid and South Essex SR and STP engagement and consultation programmes, which include stakeholder meetings and meetings of the Southend, Essex and Thurrock Boards.

732 Southend Multi-Agency Risk Assessment Team (MARAT) - Review of Progress

The Board considered a joint report from the external consultant and the Council's Group Manager for Children's Services which provided an update on the progress to date of the Southend Multi Agency Risk Assessment Team (Southend MARAT).

Resolved:

That it be noted that a further review of the progress of the Southend MARAT would be undertaken in April 2017 and that the review would consider the Southend MARAT, Essex MARAT and Thurrock MASH/MARAC processes and would be a joint SET review process.

733 HWB Forward Plan

The Board considered the Board's Forward Plan of activity for the period June 2016 to March 2017.

Resolved:

That the Forward Plan be noted.

734 A Better Start Southend - Strategic Proposition for 2017/18

The Board considered a report from the Interim Programme Director, A Better Start, which set out the strategy and delivery focus for the Better Start Programme for 2017/18. In addition to the report the Board also received the latest financial commitments allocated to support the projects being delivered under the ABSS programme.

The Board asked a number of questions which the Interim Programme Director responded to. The Board welcomed the proposals and emphasised that this was a significant step forward in the delivery of the programme.

Resolved:

1. That the strategic direction and priorities set out in the report be endorsed.

2. That the sign-off of the final version of this proposal (including all financial detail) be delegated to the Partnership Board to meet the Big Lottery Fund's deadline of 3rd February 2017.

3. That the sign-off of the second part of the submission which will set out the detail of the projects to be delivered be delegated to the Partnership Board.

735 Date and time of future meetings

Wednesday 22nd March 2017 at 5pm – Venue to be confirmed.

Chairman: _____

Southend Health & Wellbeing Board

Agenda Item No.

5

Report of the Deputy Chief Executive, People

to

Health & Wellbeing Board

on

22 March 2017

Report prepared by: Tim MacGregor – Team Leader, Policy & Information Management

For information only		For discussion	x	Approval required	

Inclusion of health related performance measures for Southend Council's Corporate Monthly Performance Report

Part 1 (Public Agenda Item)

1. Purpose of Report

1.1. To consider appropriate health related performance measures for inclusion in the Council's Corporate Monthly Performance Report from April 2017.

2. Recommendation

2.1. That the Health & Wellbeing Board consider which health related performance measures should be included in the Council's Monthly Performance Report.

3. Background & Context

3.1 Health and Wellbeing Board on 1 February 2017 considered a report which sought views on appropriate health related performance measures for inclusion in the Council's Corporate Monthly Performance Report (MPR) from April 2017.

3.2 The Board noted that the Council's Cabinet had agreed that the MPR should include a small basket of indicators which related to areas where the Council does not have lead responsibility or direct control but were important to the Council in achieving its priorities. Areas identified were community safety, the local economy and health. The Board were, therefore, asked to consider a basket of (about five) suggested performance measures and to identify the most appropriate for inclusion.

3.3 The Board asked that the Council's Policy and Information Management Team liaise with officers from Southend CCG to have a more considered view on which indicators to include, covering primary and secondary sectors as well as mental health services.

3.4 These discussions have now taken place and as a result the following performance indicators identified as suitable for inclusion:

	Potential Performance Measures	Rationale for inclusion
1	**Referral to treatment** - % of patients referred from GP to hospital treatment within 18 weeks Link for more information and context	National standard, providing a measurement of key area of performance and a key area of public concern. Can be produced monthly and is easy to benchmark.
2	**Cancer treatment** - % patients treated within 62 days of GP urgent suspected cancer referral Link for more information and context	National standard, providing a measurement of key area of performance and a key area of public concern. Can be produced monthly and is easy to benchmark.
3	**A&E** - % of patients attending Southend Hospital A&E, seen, treated and admitted or discharged in under 4 hours (95% target) Link for more information and context	National standard. Provides information relating to the effectiveness of the urgent care system. Can be produced monthly and is easy to benchmark.
4	**Mental health** - Improving Access to Psychological Therapy (IAPT) - % of people with common mental health problems accessing the service and entering treatment in the current year Link for more information and context	Provides an indicator for a priority area for councillors and one of the HWB Strategy ambitions. Can be produced monthly and is easily benchmarked.
5	**Dementia** - % of people diagnosed with dementia against the estimated prevalence. (66.7% national ambition).	Issue of increasing prevalence and concern among the public. Can be produced monthly and is easy to benchmark.
6	**Primary Care** – GP Patient Survey: - Overall experience of the GP surgery (very/fairly good; fairly/very poor; neither good nor poor) Link for more information from survey	Provides residents views on the quality of GP service in the borough. Survey is twice a year, so findings would be updated every 6 months.
7	**Primary care –** GP Patient Survey: - % satisfaction with opening hours Link for more information from survey	Provides residents views on the quality of GP service in the borough. Survey is twice a year so findings would be updated every 6 months.

3.5 As previously reported, these indicators would be in addition to the three public health related indicators already included in the MPR (relating to 4 week smoking quitters; Health Check programme and public health responsibility deal).

3.6 It is suggested that links to each of the performance measures are provided to the latest publically available performance reports to Southend CCG Governing Body (or to appropriate CCG webpage) to provide further commentary and

context to the information.

3.7 It is also suggested that the Board consider the possibility, in future, of including certain locality based performance indicators in the MPR. These could provide useful information for councillors and stimulate discussion around the reasons for variable performance across the borough.

4. Health & Wellbeing Board Priorities / Added Value

How does this item contribute to delivering the;

- *Nine HWB Strategy Ambitions (listed on final page)*
- *Three HWB "Broad Impact Goals" which add value;*
  - *a) Increased physical activity (prevention)*
  - *b) Increased aspiration & opportunity (addressing inequality)*
  - c) *Increased personal responsibility/participation (sustainability)*

4.1 To provide a wider group of councillors with more information in relation to promoting a positive health agenda for Southend, helping them to understand the context, challenges and some of the key issues of the health sector.

4.2 Contributes to Ambitions 3, 6c and 9a.

5. Reasons for Recommendations

5.1. To enable the Health and Wellbeing Board to contribute to the identification of appropriate performance measures for inclusion in the Council's Monthly Performance Report.

6. Financial / Resource Implications

6.1 None specific

7. Legal Implications

7.1. None specific

8. Equality & Diversity

8.1. None specific

9. Background Papers

9.1. Southend Council's Monthly Performance Report

10. Appendices

None

HWB Strategy Priorities

Broad Impact Goals – adding value

a) Increased Physical Activity (prevention)
b) Increased Aspiration and Opportunity (addressing inequality)
c) Increased Personal Responsibility and Participation (sustainability)

Ambition 1. A positive start in life a) Reduce need for children to be in care b) Narrow the education achievement gap c) Improve education provision for 16-19s d) Better support more young carers e) Promote children's mental wellbeing f) Reduce under-18 conception rates g) Support families with significant social challenges	**Ambition 2. Promoting healthy lifestyles** a) Reduce the use of tobacco b) Encourage use of green spaces and seafront c) Promote healthy weight d) Prevention and support for substance & alcohol misuse	**Ambition 3. Improving mental wellbeing** a) A holistic approach to mental and physical wellbeing b) Provide the right support and care at an early stage c) Reduce stigma of mental illness d) Work to prevent suicide and self-harm e) Support parents postnatal
Ambition 4. A safer population a) Safeguard children and vulnerable adults against neglect and abuse b) Support the Domestic Abuse Strategy Group in their work c) Work to prevent unintentional injuries among under 15s	**Ambition 5. Living independently** a) Promote personalised budgets b) Enable supported community living c) People feel informed and empowered in their own care d) Reablement where possible e) People feel supported to live independently for longer	**Ambition 6. Active and healthy ageing** a) Join up health & social care services b) Reduce isolation of older people c) Physical & mental wellbeing d) Support those with long term conditions e) Empower people to be more in control of their care
Ambition 7. Protecting health a) Increase access to health screening b) Increase offer of immunisations c) Infection control to remain a priority for all care providers d) Severe weather plans in place e) Improve food hygiene in the Borough	**Ambition 8. Housing** a) Work together to; ○ Tackle homelessness ○ Deliver health, care & housing in a more joined up way b) Adequate affordable housing c) Adequate specialist housing d) Understand condition and distribution of private sector housing stock, to better focus resources	**Ambition 9. Maximising opportunity** a) Have a joined up view of Southend's health and care needs b) Work together to commission services more effectively c) Tackle health inequality (including improved access to services) d) Promote opportunities to thrive; Education, Employment

Southend Health & Wellbeing Board

Agenda Item No.

6

Report of
Simon Leftley, Deputy Chief Executive (People)
to
Health & Wellbeing Board
on
22nd March 2017

Report prepared by: Andrea Atherton
Director of Public Health

For information only		For discussion	x	Approval required	

The 2016 Annual Report of the Director of Public Health

Part 1 (Public Agenda Item)

1. Purpose of Report

1.1. To present the 2016 Annual Report of the Director of Public Health.

2. Recommendations

2.1. To consider and note the content of the 2016 Annual Report of the Director of Public Health.

2.2. To agree the recommendation to establish a multiagency subgroup of the Southend Health and Wellbeing Board to oversee the development of an action plan to ensure the implementation of the recommendations of the 2016 Annual Report of the Director of Public Health.

3. Background

3.1. The Health and Social Care Act 2012 requires the Director of Public Health to prepare an annual report on the health of the local population. This is an independent report which the local authority is required to publish. The report is an opportunity to focus attention on particular issues that impact on the health and wellbeing of the local population, highlight any concerns and make recommendations for further action.

4. The 2016 Annual Report of the Director of Public Health

4.1 Health protection is the branch of public health concerned with planning for emergencies, protecting the population from communicable diseases and a range of environmental hazards. Health protection also includes the delivery of the national immunisation and screening programmes.

4.2 The transfer of public health into local authorities in April 2013, brought with it new responsibilities for health and health protection. These new health protection duties build on the existing health protection function and statutory powers bestowed on local authorities by various Acts of Parliament, such as the Public Health (Control of Diseases) Act 1984, and associated regulations, and delivered through environmental health, trading standards and regulatory services.

4.3 The Director of Public Health, acting on behalf of their local authority, is responsible for ensuring that plans are in place to protect the health of the local population from threats ranging from relatively minor outbreaks and contaminations to full-scale emergencies. The scope and scale of this work is driven by the health risks in the local area.

4.4 In undertaking this assurance role, the Director of Public Health is expected to provide relevant information, advice as well as challenge to key partners so that threats to health are properly understood and addressed. Public Health England in particular plays a significant role in supporting local authorities with their new health protection responsibilities. Other key partners include NHS England, Clinical Commissioning Groups as well as provider organisations.

4.5 The 2016 Annual Report of the Director of Public Health provides an overview of the following health protection issues:

- Communicable Diseases and Outbreaks
- Immunisation
- Seasonal Influenza
- Tuberculosis
- Sexual Health and Blood Borne Viruses
- Healthcare Associated Infections
- Emergency Preparedness
- Screening

A number of recommendations are made for each of the topic areas for the Council and relevant partners to consider.

5. Health & Wellbeing Board Priorities / Added Value

5.1 The 2016 Annual Report of the Director of Public Health focuses particularly on those areas in Ambition 7: Protecting Health.
The report also recommends that a multiagency subgroup of the Southend Health and Wellbeing Board is established to oversee the development of an action plan to ensure the implementation of the report's recommendations.

6. Reasons for Recommendations

6.1. The Health and Social Care Act 2012 requires Directors of Public Health to prepare an annual report on the health of the local population.

7. Financial / Resource Implications

7.1 There are no financial implications arising directly from the contents of this report.

8. Legal Implications

8.1. There are no legal implications arising directly from this report.

9. Equality & Diversity

9.1. The Annual Public Health Report provides evidence that population health needs are assessed and considered.

10. Background Papers

10.1. Background documents are listed in the Annual Public Health Report.

11. Appendices

11.1. The 2016 Annual Report of the Director of Public Health for Southend.

HWB Strategy Priorities
Broad Impact Goals – adding value

a) Increased Physical Activity (prevention)
b) Increased Aspiration and Opportunity (addressing inequality)
c) Increased Personal Responsibility and Participation (sustainability)

Ambition 1. A positive start in life A. Children in care | B. Education- Narrow the gap | C. Young carers | D. Children's mental wellbeing | E. Teen pregnancy | F. Troubled families	**Ambition 2. Promoting healthy lifestyles** A. Tobacco – reducing use | B. Healthy weight | C. Substance & Alcohol misuse	**Ambition 3. Improving mental wellbeing** A. Holistic: Mental/physical | B. Early intervention | C. Suicide prevention/self-harm | D. Support parents/postnatal
Ambition 4. A safer population A. Safeguarding children and vulnerable adults | B. Domestic abuse | C. Tackling Unintentional injuries among under 15s	**Ambition 5. Living independently** A. Personalised budgets | B. Enabling community living |C. Appropriate accommodation | D. Personal involvement in care | E. Reablement | F. Supported to live independently for longer	**Ambition 6. Active and healthy ageing** A. Integrated health & social care services | B. Reducing isolation | C. Physical & mental wellbeing | D. Long Term conditions– support | E. Personalisation/ Empowerment
Ambition 7. Protecting health A. Increased screening | B. Increased immunisations | C. Infection control | D. Severe weather plans in place | E. Improving food hygiene	**Ambition 8. Housing** A. Partnership approach to; Tackle homelessness | B. Deliver health, care & housing in a more joined up way | C. Adequate affordable housing | D. Adequate specialist housing | E. Strategic understanding of stock and distribution	**Ambition 9. Maximising opportunity** A. Population vs. Organisational based provision | B. Joint commissioning and Integration | C. Tackling health inequality (improved access to services) | D. Opportunities to thrive; Education, Employment

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ANNUAL REPORT

OF THE

DIRECTOR OF PUBLIC HEALTH

2016

Contents

Foreword

The Director of Public Health has a statutory duty to produce an independent report on the health of the local population. This year my annual report focuses on health protection, a branch of public health concerned with planning for emergencies and protecting our population from communicable diseases, as well as minimising the health impact of a range of environmental hazards**.** Health protection also includes the delivery of major programmes such as national immunisation and screening programmes.

When public health transferred into local authorities in April 2013, it brought with it new responsibilities for health and health protection. These new health protection duties build on the existing health protection function and statutory powers bestowed on local authorities by various Acts of Parliament, such as the Public Health (Control of Diseases) Act 1984, and associated regulations, and delivered through environmental health, trading standards and regulatory services.

The Director of Public Health, acting on behalf of their local authority, is responsible for ensuring that plans are in place to protect the health of the local population from threats ranging from relatively minor outbreaks and contaminations to full-scale emergencies. The scope and scale of this work is driven by the health risks in the local area.

In undertaking this assurance role, the Director of Public Health is expected to provide relevant information and advice, as well as challenge to key partners so that threats to health are properly understood and addressed. Public Health England in particular plays a significant role in supporting local authorities with their new health protection responsibilities. Other key partners include NHS England and Clinical Commissioning Groups, as well as provider organisations.

The first part of the report provides an overview of communicable diseases and outbreaks, as well as a more in-depth look at tuberculosis, sexually transmitted infections, blood borne viruses, and healthcare acquired infections. This includes raising awareness of what can be done to prevent their spread and complications.

The important topic of immunisation for the prevention of communicable diseases is explored, with a focus on childhood illnesses and seasonal influenza.

The report covers arrangements for dealing with emergencies relating to issues that threaten public health, including extremes of weather.

The final section covers the various national screening programmes in place to identity those at risk of serious illnesses that may not cause symptoms early on.

I hope that my report will serve to reinforce the important health protection issues for Southend. As in previous years I would welcome your feedback, comments and suggestions.

Dr Andrea Atherton
Director of Public Health

Acknowledgments
I am indebted to many people who have supported and contributed to my report. These include: Margaret Gray, Liesel Park, James Williams, Angela Squires, Erin Brennan-Douglas, Lisa Holloway, Simon D Ford and Sally Watkins.

I would also like to thank:
Dr Smita Kapadia and Caroline Back, Public Health England.
Matt Rangue and Sheila O'Mahony, NHS Southend Clinical Commissioning Group
Dr Pam Hall and Oliver Jackson, NHS England

Executive Summary

The 2016 Annual Public Health Report explores the topic of health protection. This is a branch of public health concerned with planning for emergencies, protecting the population from communicable diseases and a range of environmental hazards, and also includes the delivery of the national immunisation and screening programmes.

Communicable diseases and outbreaks

There has been a statutory requirement to notify cases of certain infectious diseases since the end of the 19th century. More recent regulations have added substances thought to present a significant risk to human health, as well as additional infections to the notification list.

Notifications of infectious disease are sent directly from medical practitioners and laboratories in England to Consultants in Communicable Disease Control based at the Public Health England East of England Centre, who act as the Proper Officer for Southend Borough Council. These notifications are collated and an analysis of national and local disease trends is published weekly by Public Health England.

Populations of local authority areas are too small to show meaningful trends even in the most common infection, as variations in reported cases between years may be real or reflect erratic reporting.

Campylobacter, the most common cause of food poisoning in the UK, was the most commonly reported infection in Southend in 2014 and 2015. Campylobacter is found in the intestinal tract of animals and birds, and people can become infected by eating raw or undercooked meat, particularly chicken; or drinking unpasteurised milk and contaminated water. Transmission may also occur from cooked foods that have been cross-contaminated with the bacteria from raw meat. Salmonella is also an important but less common cause of food poisoning.

Good hygiene in the kitchen when storing and preparing food, particularly raw chicken, and ensuring that food is thoroughly cooked are important in the prevention of food poisoning.

The Regulatory Services Team within the Council is responsible for developing the Annual Southend Official Feed and Food Service Plan, which outlines the inspection programme for the 1788 food premises in Southend.

An outbreak is defined as an incident in which two or more people experiencing a similar illness are linked in time or place. Early recognition of an outbreak is important so that the source can be identified and further action can be taken to prevent further spread or recurrence of the infection.

A significant proportion of outbreaks are handled as part of the routine business of the Public Health England local Health Protection Teams. In some situations it may be necessary to establish an Outbreak Control Team, which includes members of environmental health and public health.

Care homes are a common setting for outbreaks to occur. In 2014 and 2015, care homes in Southend accounted for a significant proportion of reported outbreaks of gastroenteritis and respiratory illness.

Immunisation

After clean water, immunisation is recognised as one of the most effective public health interventions for saving lives and promoting good health.

Although the primary aim of immunisation is to protect the individual who receives the vaccine, when enough people in a community are immunised they are less likely to be a source of infection to unvaccinated individuals - a concept known as “herd immunity”. The World Health Organisation generally recommends vaccination uptake of at least 95% of the eligible population to achieve “herd immunity”.

There is generally good uptake of primary childhood immunisations in Southend, with sufficient uptake to achieve herd immunity for most of the programmes. Uptake of the second dose of MMR (measles, mumps and rubella) vaccine still remains around 5% below the target uptake.

Following a national pertussis (whooping cough) outbreak in 2012, pregnant women were offered pertussis immunisation to protect their babies from birth through the intrauterine transfer of maternal antibodies. Pertussis activity remained high in 2016 and unprotected young infants continue to be at risk. In Southend the monthly uptake of the prenatal pertussis vaccine ranged from between 40.8% and 55.7% between April 2015 and March 2016.

Older people are at greater risk of morbidity and mortality from vaccine-preventable diseases as a consequence of reduced immunity with age, and also as they may not have received immunisations in younger years.

In 2014/15 only 58.4% of eligible people aged 65 years or over in Southend received the pneumococcal vaccine, which is significantly lower than the England average (70.1%). Uptake of shingles vaccine in 2014/15 in 70 year olds was also significantly lower than the England average, at 46.6% compared to 58.3%.

Staff in NHS England local area teams are responsible for commissioning the national immunisation services locally and for providing system leadership, training and support to all those involved, including GPs, community pharmacists and community providers.

Influenza

The influenza virus is highly contagious and is easily passed from person-to-person when an infected person coughs or sneezes. For most healthy individuals, influenza is an unpleasant but usually self-limiting illness. However, for some it can lead to serious complications which may require treatment in hospital and can be life threatening.

Seasonal influenza vaccine is offered to those at higher risk of serious complications including people aged 65 or over, children and adults with an underlying chronic health condition such as respiratory disease, heart disease and diabetes, those with weakened immune systems as well as pregnant women.

Immunisation is also offered to frontline health and social care staff, main carers of older or disabled people and household contacts of immunocompromised people.

Different strains of influenza virus circulate each year, and the vaccine is changed annually based on the strains most likely for the coming influenza season. This means that eligible people need to get a flu jab every year.

The annual influenza immunisation programme is being extended to include vaccination of healthy children from the age of two. These children will generally receive the vaccine as an intranasal spray. From 2016/17, the vaccine will be offered to two, three and four year olds and children in school years 1, 2 and 3. The programme will gradually extend over future years to all primary school aged children.

There is poor uptake of influenza vaccine across virtually all eligible groups at a local level, with only 64.1% (target 75%) of people aged over 65 and 38% (target 55%) under 65 in a clinical risk group in Southend receiving the flu vaccine in 2015/16.

A multiagency Southend Seasonal Flu Oversight Group implemented a range of initiatives to increase uptake of flu vaccine as part of the 2016/17 immunisation programme. Public health continues to commission a service to assist with the management of outbreaks of influenza in care homes.

Tuberculosis

Tuberculosis (TB) is a bacterial infection that can affect almost any part of the body, most commonly the lungs. TB is much less infectious than other respiratory infections, such as influenza.

In some people the initial infection may be eliminated or they may develop latent disease. Latent TB infection (LTBI) may reactivate later in life, particularly if an individual's immune system has become weakened e.g. through HIV or cancer chemotherapy.

At the beginning of the 20th century there were over 117,000 new cases of TB in England every year. This fell to a low of 5086 new cases every year in 1987, the downward trend then reversed until it reached a peak in 2011, (8,280 cases or 15.6 new cases per 100,000 population). There has been a year-on-year decline since then to 5,758 new cases or 10.5 new cases per 100,000 in 2015.

The peak incidence of TB in Southend occurred in 2004-6, and has since continued to decline to a three average rate of 7.5 new cases per 100,000 population in 2013-15.

TB is now a disease that occurs predominantly in specific population subgroups, including communities with connections to higher-prevalence areas of the world and in communities with social risk factors such as homelessness, drug or alcohol misuse and imprisonment.

The East of England TB Control Board, which covers the population of Southend, has comprehensive plans in place to address the key recommendations of the national TB strategy across the region.

Locally a community tuberculosis service provides diagnostic, treatment and screening services, in which all tuberculosis patients are cared for by a multidisciplinary team.

Sexual health and blood borne viruses

Within the population sexual health needs vary according to factors including age, gender, ethnicity and sexuality, with some groups disproportionately at risk of poor sexual health. Intervention programmes to improve sexual health outcomes should be developed based on a robust evidence base and local needs.

Chlamydia is the most common bacterial sexually transmitted infection in England, with rates substantially higher in young adults than any other age group. The National Chlamydia Screening Programme recommends that all sexually active men and women aged under 25 years old are tested for chlamydia every year or on change of sexual partner.

Southend continues to have a significantly better rate of chlamydia screening in 15-24 year olds than the national average. The chlamydia detection rate in Southend is also similar to the England average, but remains below the recommended level to reduce the prevalence of chlamydia in the population.

The diagnostic rate of genital warts and genital herpes in Southend are both similar to the England average, whereas the diagnostic rates of gonorrhoea and syphilis in are both significantly lower than the England average.

HIV remains an important communicable disease in the UK. People living with HIV can expect a near normal life expectancy if they are diagnosed and treated promptly.

The prevalence of HIV in Southend has historically been higher than the national average, although, over time the difference has narrowed. The rate of new HIV diagnosis in Southend has almost halved since 2012, and is now lower than the England average.

HIV testing is integral to the treatment and management of HIV. Knowledge of HIV status increases survival rates, improves quality of life and reduces the risk of HIV transmission. HIV test coverage in Southend is significantly higher than the national coverage.

Late diagnosis of HIV is the most important predictor of morbidity and mortality among those with the infection. Over the last five years there has been a continued

downward trend in the proportion of individuals diagnosed late with HIV in Southend, which is now similar to the England average.

Locally the SHORE (Sexual Health, Outreach, Reproduction and Education) Integrated Sexual Health Service provides comprehensive sexually transmitted infection testing and treatment services and contraceptive services across all its sites. Southend residents are also able to access the online national HIV self-sampling service to request an HIV testing kit.

The hepatitis B and C viruses can be transmitted through contact with the blood or body fluids contaminated with blood. Many people infected with these viruses won't experience any symptoms. Up to 80% of people infected with hepatitis C go on to develop chronic infection, whereas the likelihood of developing chronic hepatitis B infection varies with age. The long term complications of chronic hepatitis B and C infections include cirrhosis of the liver and primary liver cancer.

Transmission of hepatitis B can be prevented through a course of vaccinations. Although there is no vaccine for hepatitis C, it is a potentially curable disease with antiviral therapy.

Specialist drug and alcohol services in Southend prioritise hepatitis B and C interventions within their nurse-led health and wellbeing work. There are close links with the specialist hepatology services and liver nurses to ensure that clients are quickly identified and referred for support and treatment where necessary.

Healthcare Associated Infection

Healthcare associated infections are a range of infections acquired in healthcare settings or as a direct result of healthcare interventions such as medical or surgical treatment. The most common types of healthcare-associated infection are respiratory infections, urinary tract infections and surgical site infections.

Everyone carries large numbers of micro-organisms on their skin or in their bodies, which only become a problem when the person becomes unwell or when the organisms have the opportunity to enter the bloodstream e.g. from an intravenous cannula.

There are national surveillance programme to monitor the numbers of certain infections that occur in healthcare settings, including Staphylococcus aureus, Escherichia coli, Clostridium difficile and surgical site infection. These infections can range from mild to life threatening.

Some strains of Staphylococcus aureus have developed resistance to antibiotics, such as meticillin resistant Staphylococcus aureus (MRSA), and will require different types of antibiotic to treat them.

Numerous interventions aimed at reducing the incidence of healthcare associated infections have been introduced over the last 8 years. These have contributed to a marked decrease in MRSA bacteraemia and Clostridium difficile infection rates in Southend and England over this time.

It is probably impossible to completely eradicate healthcare associated infections. In addition to clean environments, the key interventions that can significantly reduce their incidence include good hand hygiene practices, proper use of invasive medical equipment and prudent use of antibiotics.

The inappropriate use of antibiotics has contributed to the dramatic rise in antibiotic resistance over the last 40 years, and few new antibiotics have been developed. Work is being undertaken at a national level to tackle antimicrobial resistance, directed by a cross-government antimicrobial resistance strategy.

At a local level a multidisciplinary Antimicrobial Resistance Group has been established to develop a local strategy and action plan to slow the development and spread of antimicrobial resistance by tackling overuse and misuse of antibiotics. In addition healthcare professionals and members of the public are being encouraged to become an “Antibiotic Guardian”.

Emergency preparedness

Threats to the public’s health such as outbreaks of disease or severe weather conditions can arise at any time. On occasions these can escalate into a major incident requiring the implementation of special arrangements by one or a number of agencies.

The Civil Contingencies Act 2004 (CCA) was brought in to ensure that the organisations best placed to manage emergency response and recovery are at the heart of civil protection.

The Act divides local responders into two categories. Category 1 responders are those organisations at the core of emergency response, such as the emergency services, local authorities and acute hospitals. They have a range of specific duties around risk assessment, the development of emergency plans and business continuity management arrangements; as well as making information available to the public with the ability to ’warn, inform and advise’ in the event of an emergency.

Category 2 responders include the utilities, transport, the Health and Safety Executive and Clinical Commissioning Groups. They generally support the emergency response through the provision of specialist support, equipment or advice.

The CCA requirement for multi-agency co-operation in emergency preparedness is fulfilled at the local level by the Essex Local Resilience Forum, which brings together Category 1 and 2 responders. The Emergency Planning Lead Officer for Southend Borough Council and the Director of Public Health are both members of the Essex LRF.

There is also an Essex Local Health Resilience Partnership which brings together senior representatives from the health sector across Essex to co-ordinate and support joint working and effective planning of the health emergency response. Their key responsibilities include the production of local sector-wide health plans to

respond to emergencies as well as to contribute to multi-agency emergency planning.

Greater numbers of people are known to die during periods of extreme temperature. In response, Public Health England has developed a Cold Weather Plan and Heatwave Plan, associated with a national Weather Alert service which operates from 1 November to 31 March and from 1 June to 15 September. This uses Met Office data to trigger levels of response from NHS, local government and the public health system and communication of risks to the public when severe cold or hot weather is forecast.

At a local level, Southend Borough Council facilitates the distribution of relevant heatwave and cold weather planning guidance to the relevant non NHS agencies in the community (including education establishments and residential homes) and cascades the Weather Alert Level notifications.

Screening

Screening is the process of identifying apparently healthy people, who may be at increased risk of a disease or condition. They can then be offered information, further tests and appropriate treatment to reduce associated risks or complications arising from the disease or condition.

However, the screening process is not perfect and in every screening programme there are some false positives (wrongly reported as having the condition) and false negatives (wrongly reported as not having the condition). The UK National Screening Committee advises the NHS on which population screening programmes are implemented. There are currently 11 NHS systematic population screening programmes, including 5 young person and adult screening programmes.

England has 3 national cancer screening programmes; breast, cervical and bowel. The NHS Breast Screening Programme aims to find breast cancer at an early stage, often before there are any symptoms. To do this, X-rays are taken of each breast (mammogram) to look for any abnormalities in breast tissue.

Women in England aged 50-70 years are invited for screening every three years. The NHS is currently in the process of trialling extending the programme, offering screening to some women from the age 47 and up to 73 years old.

In Southend the breast screening coverage for women aged 50-70 years in 2015 was 67.9%, which is significantly lower than the England average of 75.4%.

The NHS Cervical Screening Programme aims to prevent cancer by detecting abnormalities in cells of the cervix and referring women for further investigation and potential treatment.

Screening is offered every three years to all women aged 25 to 49 years and every five years to those aged 50 to 64 years. Southend has historically had a low coverage in this screening programme and most recent data (2015) shows that there has been no significant improvement, with coverage currently at 72.6%.

The NHS Bowel Cancer Screening Programme aims to detect bowel cancer at an early stage when treatment is more likely to be effective. A faecal occult blood (FOB) screening kit is offered to men and women aged 60 to 74 every two years. This test detects occult traces of blood in a small stool sample. People with a positive test are referred further tests and treatment, if necessary.

An additional one-off bowel scope screening test is gradually being offered in England to men and women at the age of 55. A bowel scope (a thin, flexible instrument) is used to look inside the lower part of the bowel to find any small polyps which may develop into bowel cancer if left untreated.

The NHS Bowel Cancer Screening Programme has been in place for 10 years, but uptake is still low both nationally and locally. For Southend, in 2015 coverage was 53.7% compared with an England average of 57.1%, against a required target of 75%.

People with diabetes are at risk of a condition called diabetic retinopathy. This condition occurs when diabetes affects small blood vessels, damaging the part of the eye called the retina. The NHS Diabetic Eye Screening Programme offers screening every 12 months to all people with diabetes aged 12 and over. The screening test involves examining and taking photographs of the back of the eyes.

An abdominal aortic aneurysm (AAA) is a dangerous swelling (aneurysm) of the aorta, which is the main blood vessel that runs from the heart, down through the abdomen to the rest of the body. An AAA usually causes no symptoms, but if it bursts it is extremely dangerous and usually fatal. The condition is far commoner in men aged over 65 than in women or younger men.

The NHS Abdominal Aortic Aneurysm (AAA) Screening Programme involves a simple ultrasound scan to measure the abdominal aorta. Once identified AAAs can be monitored or treated, greatly reducing the chances of the aneurysm causing serious problems.

Summary of Recommendations

- Southend Public Health Department should support the Public Health England local Health Protection Team to provide regular updates on the reporting of and management of communicable diseases and outbreaks for staff in primary care and schools.

- Ensure timely sharing of information between Public Health England, Southend Borough Council and Primary Care about outbreaks in healthcare settings, care homes and schools so that prompt action can be taken.

- Every opportunity should be taken to actively promote immunisation uptake in children across Southend. This should include promotion in children's centres and at school entry.

- Work should continue with primary care and midwives to immunise more pregnant women against whooping cough.

- Provide information about immunisations to a broad range of partners who work with older people to enable them to pass on accurate information on the importance of immunisations at appropriate opportunities.

- A review is undertaken of the Southend Seasonal Influenza Action Plan outcomes for 2016/17, and the findings used to inform any changes to the action plan for 2017/18.

- Share best practice of those GPs delivering high rates of seasonal vaccination as part of the 'locality approach' of the South and Mid Essex Sustainable Transformation Plan.

- All health and social care organisations covering Southend should put in place plans to increase staff influenza vaccination uptake to meet the nationally agreed targets.

- Southend University Hospital NHS Foundation Trust to review how to provide additional support to increase uptake of influenza vaccination in at risk groups and specifically pregnant women.

- Training is made available to professionals to raise awareness of TB in vulnerable groups including homeless, drug and alcohol misusers, as well as new migrants from high incidence countries, to ensure prompt referral when TB is suspected.

- The Council collaborates with the East of England TB Control Board and local partners to ensure directly observed therapy (DOT) is available for those people with TB in the most disadvantaged or hard to reach groups.

- The Council supports the East of England TB Control Board and local stakeholders to implement the local plan for latent TB infection testing and treatment services.

- Undertake a review of availability of chlamydia screening in sexual health service venues and community based settings to ensure screening is available in the populations with the highest need based on positivity.

- Raise professional awareness about who to screen and test for HIV to continue the reduction in late diagnosis.

- Continue efforts to reduce stigma and highlight testing opportunities to those at greatest risk of HIV.

- Continue to increase standards and implementation of infection control measures across health and social care services (such as hand washing, use of personal protective equipment, decontamination, sterilisation, and patient isolation).

- Continue to promote the role of Antibiotic Guardian with healthcare professionals and the public.

- Promote public education about appropriate use of antibiotics and the importance of adherence to the prescribed dose and taking the full course of antibiotics.

- The Essex Local Health Resilience Partnership should be asked to prepare an Annual Report and present to the Southend Health & Wellbeing Board and Cabinet to provide assurance to the Council on local health sector emergency preparedness.

- Consideration to be given to the inclusion of information on NHS screening programmes in ‘Making Every Contact Count’ training. This will enable staff from health, the local authority and other organisations to promote screening through routine health promotion messages to residents.

- Increase uptake and decrease inequity in uptake across all the screening programmes by targeting groups and communities who are less likely to access screening.

My final recommendation is:

- Establish a multiagency subgroup of the Southend Health and Wellbeing Board to oversee the development of an action plan to ensure the implementation of the recommendations of this report.

Chapter 1 Communicable Diseases and Outbreaks

1.0 Background

There has been a statutory requirement to notify cases of certain infectious diseases since the end of the 19th century. Regulations which came into force in 2010 take a wider and more flexible approach to hazards, including chemicals, radiation and other environmental hazards. In addition to the specified list of infectious diseases which require notification (Table 1), there is a requirement to notify cases of other infections or substances thought to present a significant risk to human health.

It is the statutory responsibility of the attending medical practitioner to complete a notification certificate or telephone the 'Proper Officer' for the Local Authority on clinical suspicion, without waiting for laboratory confirmation of the diagnosis. For Southend Borough Council and the other local authorities in Essex, the Consultants in Communicable Disease Control at the Public Health England East of England Centre act as their Proper Officers and receive the notifications directly.

All laboratories in England performing a primary diagnostic role must also notify Public Health England when they confirm a notifiable organism. Public Health England collates the notifications and publishes an analysis of local and national trends every week.

Table 1 Notifiable Diseases under the Health Protection (Notifiable) Regulations 2010

Acute encephalitis	Haemolytic uraemic syndrome (HUS)	Rabies
Acute infectious hepatitis		Rubella
Acute meningitis	Infectious bloody diarrhoea	Severe acute respiratory syndrome (SARS)
Acute poliomyelitis	Invasive group A streptococcal disease	Scarlet fever
Anthrax		Smallpox
Botulism	Legionnaires' disease	Tetanus
Brucellosis	Leprosy	Tuberculosis
Cholera	Malaria	Typhus
Diphtheria	Measles	Viral haemorrhagic fever (VHF)
Enteric fever (typhoid or paratyphoid)	Meningococcal septicaemia	Whooping Cough
	Mumps	
Food poisoning	Plague	Yellow Fever

2.0 Incidence of Selected Notifiable Diseases in Southend

The prime purpose of the notifications system is to allow rapid detection of possible outbreaks in order to enable prompt action to be taken to prevent further cases. As cases are notified based on clinical suspicion, not all will subsequently prove to have the disease. In addition, not all cases of infectious disease are notified, as the patient may not seek medical attention, or the doctor may fail to notify.

Populations of local authority areas are too small to show meaningful trends even in the most common infections. Variations in reported cases between years may be

real, or may reflect erratic reporting. All of these factors need to be taken into consideration when reviewing the data in the next section.

Selected notifiable diseases reported to Public Health England for Southend in 2014 and 2015 are shown in Table 2.

Table 2 Selected notifiable diseases reported to Public Health England for Southend and East of England in 2014 & 2015 (crude rate per 100,000 population and number of cases)

Infection	Rate per 100,000 population and (number of cases) 2014		Rate per 100,000 population and (number of cases) 2015	
	Southend	East of England	Southend	East of England
Gastrointestinal				
Campylobacter	111.84 (199)	110.17 (6980)	123.64 (220)	91.29 (5784)
Cryptosporidium	2.81 (5)	6.76 (428)	8.99 (16)	9.75 (618)
E coli 0157	0.00 (<5)	1.12 (71)	1.69 (<5)	0.79 (50)
Giardia	0.00 (<5)	5.93 (376)	2.25 (<5)	6.63 (420)
Salmonellosis	8.99 (16)	9.83 (623)	14.05 (25)	11.10 (703)
Vaccine preventable				
Measles	0.00 (<5)	0.21 (13)	0.00 (<5)	0.06 (<5)
Mumps	3.37 (6)	3.46 (219)	0.56 (<5)	0.98 (62)
Pertussis (whooping cough)	3.93 (7)	5.89 (373)	2.25 (<5)	6.23 (395)
Rubella	0.00 (<5)	0.02 (<5)	0.00 (<5)	0.06 (<5)
Other				
Meningitis (all)	1.12 (<5)	0.95 (60)	1.12 (<5)	1.20 (76)
Meningococcal septicaemia	1.12 (<5)	0.51 (32)	0.56 (<5)	0.55 (35)
Hepatitis B	26.98 (48)	19.29 (1222)	29.22 (52)	22.79 (1444)
Hepatitis C	19.11 (34)	13.31 (843)	13.49 (24)	15.33 (971)

Data sources: Public Health England: HPZone, Second Generation Surveillance System and Enhanced Tuberculosis surveillance. ONS Mid-Year Estimates 2015 used to calculate rates.

2.1 Food Poisoning

Two important bacterial causes of food poisoning are Campylobacter and Salmonella.

Campylobacter

Campylobacter is the most common bacterial cause of food poisoning in the UK and is estimated to make more than 280,000 people ill each year. Campylobacter is found in the intestinal tract of animals and birds. Methods of transmission to humans include the consumption of raw or undercooked meat, particularly chicken, as well as unpasteurised milk and contaminated water. Transmission may also occur from ready to eat foods that have been cross-contaminated with the bacteria from raw meat. It is therefore important to take care to avoid cross contamination by keeping

raw meat separate to cooked and ready to eat foods, and ensuring that hands are thoroughly washed after handling raw meat.

A UK wide survey was undertaken in 2014-15 to determine the levels of Campylobacter on whole fresh retail chickens and their packaging (1). A joint Food Standards Agency and industry target was set up to reduce the prevalence of the most contaminated chickens.

All chickens, regardless of which retail outlet they are bought from, are at risk of being contaminated with Campylobacter, which is why it is important for consumers to handle and cook their chicken safely. Effective cooking will kill any Campylobacter on the chicken.

Chicken is safe as long as consumers follow good kitchen practice:

- **Cover and chill raw chicken**: Cover raw chicken and store on the bottom shelf of the fridge so juices cannot drip on to other foods and contaminate them with food poisoning bacteria such as Campylobacter;
- **Don't wash raw chicken**: Cooking will kill any bacteria present, including Campylobacter, while washing chicken can spread bacteria by splashing;
- **Wash hands and used utensils**: Thoroughly wash and clean all utensils, chopping boards and surfaces used to prepare raw chicken. Wash hands thoroughly with soap and warm water, after handling raw chicken. This helps stop the spread of Campylobacter by avoiding cross contamination.
- **Cook chicken thoroughly**: Make sure chicken is steaming hot all the way through before serving. Cut in to the thickest part of the meat and check that it is steaming hot with no pink meat and that the juices run clear.

Salmonella

Salmonella is found in the intestinal tracts of wild and domestic birds, animals and reptiles. The main route of transmission is through the consumption of contaminated food, particularly meat, raw eggs and dairy produce. This may occur either as a result of contamination of cooked food by raw food, or by the use of insufficiently high temperatures during cooking. Spread can also occur through close contact with infected people or animals.

2.2 What is Being Done Locally?

Measures are being taken to reduce the burden of vaccine preventable diseases, tuberculosis and blood borne viruses. These are discussed in other chapters of this report.

The Food Standards Agency (FSA) requires every local authority to develop and submit an annual food enforcement service plan. The purpose of the plan is to ensure that the highest achievable levels of food control (including food safety, food standards and control of feeds) are maintained, and is the basis on which local authorities are monitored and audited by the FSA.

The Regulatory Services Team within the Council is responsible for developing the Annual Southend Official Feed and Food Service Plan (2). The Service Plan outlines the inspection programme for the 1788 food premises in Southend. Priority for inspections and interventions is given to premises which have been risk assessed as presenting the highest risk in terms of their activity and the conditions at the premises. All high and medium risk category programmed inspections are to be completed within the financial year with appropriate alternative approaches adopted for the remaining inspections. For 2016/17, 964 premises required an official food hygiene intervention. There are also 9 Approved Food Premises in Southend, including the cockle processors, which are inspected annually.

3.0 Responding to Outbreaks

Definition

An outbreak may be defined as:

an incident in which two or more people experiencing a similar illness are linked in time or place

The primary objective in outbreak management is to protect the public's health by identifying the source and implementing control measures to prevent further spread or recurrence of the infection.

A significant proportion of outbreaks are handled as part of the routine business of the Public Health England local Health Protection Teams (3). However, the establishment of an Outbreak Control Team is appropriate when an outbreak is characterised by:

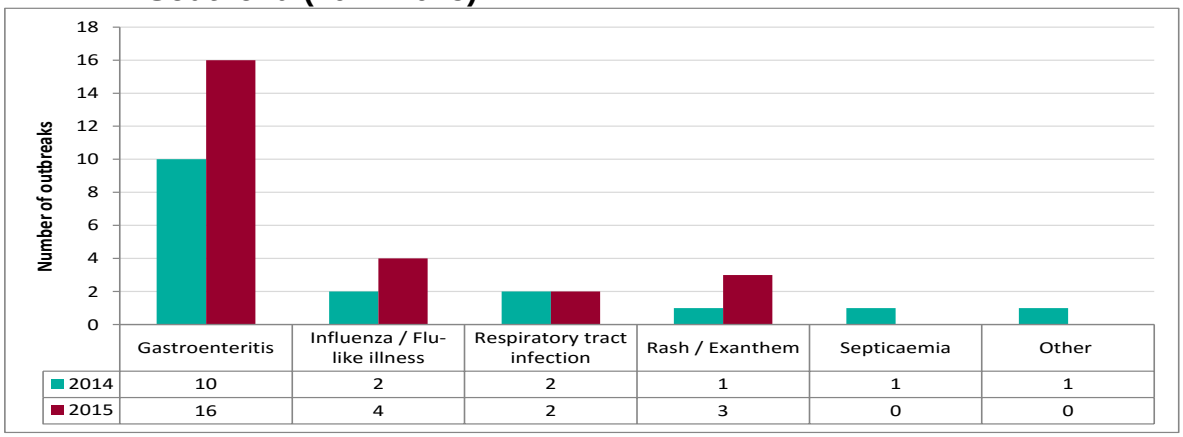
- immediate or continuing significant risk to the health of the population
- one or more cases of serious communicable disease (e.g. diphtheria)
- a large number of cases
- cases identified over a large geographical area suggesting a dispersed source

Membership of an Outbreak Control Team will vary according to the type of outbreak and the incident level. In addition to a local Health Protection Team member, members are likely to include an Environmental Health Officer, the Director of Public Health and a public health microbiologist.

Measures taken to control an outbreak can require a need to urgently mobilise resources. This might include the collection of samples for screening or diagnostic purposes or the provision of vaccines or antibiotic prophylaxis for contacts.

Figure 1 shows the number of outbreaks in Southend by type of infection reported to Public Health England (PHE) East of England in 2014 and 2015. Figure 2 shows the number of outbreaks and type of infection in Southend by setting.

Figure 1 Number of outbreaks reported to PHE East of England in Southend (2014-2015)



	Gastroenteritis	Influenza / Flu-like illness	Respiratory tract infection	Rash / Exanthem	Septicaemia	Other
2014	10	2	2	1	1	1
2015	16	4	2	3	0	0

Figure 2 Number of outbreaks reported to PHE East of England in Southend by year (2014-2015) and setting

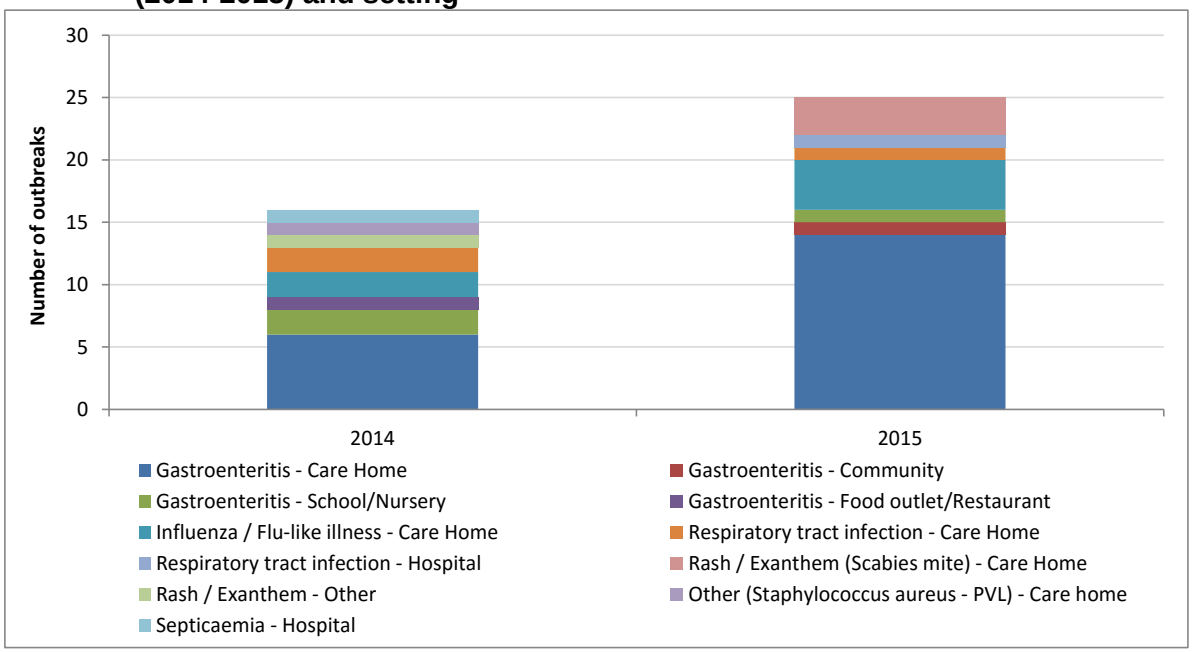


Figure 2 highlights that care homes are a common setting for outbreaks to occur. It is crucial that there are well established procedures for identifying and responding to these outbreaks. The management of outbreaks of influenza in care homes is described in Chapter 3.

4.0 Recommendations

- Southend Public Health Department should support the Public Health England local Health Protection Team to provide regular updates on the reporting of and management of communicable diseases and outbreaks for staff in primary care and schools.

- Ensure timely sharing of information between Public Health England, Southend Borough Council and Primary Care about outbreaks in healthcare settings, care homes and schools so that prompt action can be taken.

Chapter 2 Immunisation

1.0 Background

After clean water, immunisation is recognised as one of the most effective public health interventions for saving lives and promoting good health (1). Due to routine immunisation programmes, we no longer see serious illnesses like smallpox, and polio has almost been eradicated.

Immunisation is the process whereby a person is made immune or resistant to an infectious disease by the administration of a vaccine. Vaccines work by stimulating the body's own immune system to produce antibodies to protect against subsequent infection or disease. Immunisation programmes aim to produce long lasting immunity and have led to a drastic reduction in illness and death from infectious diseases.

Immunity can also be acquired from the transfer of antibodies from immune individuals, such as mothers to their babies across the placenta. However, this 'passive' immunity lasts for only a few weeks or months.

The primary aim of immunisation is to protect the individual who receives the vaccine. If enough people in a community are immunised they are less likely to be a source of infection to unvaccinated individuals. This concept is known as "herd immunity".

The World Health Organisation generally recommends vaccination uptake of at least 95% of the eligible population to achieve "herd immunity".

2.0 The UK Routine Immunisation Schedule

The routine immunisation schedule is based on the advice of the Joint Committee on Vaccination and Immunisation (JCVI) (2). The schedule has changed over time as new vaccines become available.

The aim of the routine immunisation schedule is to provide protection against the following vaccine-preventable infections:

- diphtheria
- tetanus
- pertussis (whooping cough)
- Haemophilus influenza type b (Hib)
- polio
- meningococcal disease (certain serogroups)
- measles
- mumps
- rubella
- pneumococcal disease (certain serotypes)
- human papillomavirus (certain serotypes)
- rotavirus

The immunisation schedule has been designed to provide early protection against infections. Some immunisations are provided very early in life to offer protection against infections that are most dangerous for the very young. Further vaccinations are offered at other points throughout life to provide protection against infections before eligible individuals reach an age when they become at increased risk from those diseases. Table 1 details the routine childhood immunisation schedule as at September 2016 (2).

Table 1 UK Routine Childhood Immunisation Programme (September 2016)

When to immunise	Diseases protected against	Vaccine given
Eight weeks old	Diphtheria, tetanus, pertussis (whooping cough), polio and *Haemophilus influenzae* type b (Hib) Pneumococcal infection Meningococcal group B Rotavirus gastroenteritis	DTaP/IPV/Hib Pneumococcal conjugate vaccine, (PCV) MenB Rotavirus
Twelve weeks old	Diphtheria, tetanus, pertussis, polio and *Haemophilus influenzae* type b (Hib) Rotavirus gastroenteritis	DTaP/IPV/Hib Rotavirus
Sixteen weeks old	Diphtheria, tetanus, pertussis, polio and *Haemophilus influenzae* type b (Hib) Meningococcal group B Pneumococcal infection	DTaP/IPV/Hib MenB PCV
One year old	*Haemophilus influenza* type b (Hib)/ Meningitis C Pneumococcal infection Measles, mumps and rubella Meningococcal B	Hib/MenC booster PCV booster MMR MenB booster
Two to up to seventeen years old	Influenza (each year from September)	Live attenuated influenza vaccine (LAIV)
Three years & four months or soon after	Diphtheria, tetanus, pertussis and polio Measles, mumps and rubella	DTaP/IPV or dTaP/IPV +MMR
Girls aged twelve to thirteen	Cervical cancer caused by human papilloma virus types 16 and 18	HPV (2 doses 6-24 months apart)
Fourteen years old (School Year 9)	Diphtheria, tetanus, polio Meningococcal groups A,C,W and Y	Td/IPV MenACWY

Source: Public Health England (2)

2.0 Monitoring Uptake of Childhood Immunisations

Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable diseases, and is closely correlated with levels of disease. Monitoring vaccine coverage can help to identify possible drops in immunity before levels of disease rise.

The effectiveness of the national childhood routine immunisation programme is monitored by Public Health England, through looking at the percentage of eligible population immunised in the given period. The programme COVER (cover of vaccination evaluated rapidly) data looks specifically at the percentage of the population that has received each vaccination by ages one year, 2 years and 5 years within certain timeframes (i.e. quarter and annual).

Tables 2-4 detail how Southend childhood vaccine uptake rates compare to England and regional rates.

Table 2 Percentage of children immunised by their 1st birthday 2015/16

Area	Diphtheria, Tetanus, Polio, Pertussis, Hib (DtaP/IPV/Hib) (%)	Pneumococcal Disease (PCV) (%)	Rotavirus (%) – 2015/16 data*
Southend	93.8	94.1	90.7
East of England	95.6	95.6	-
England	93.6	93.5	-

Source: COVER data, Public Health England
*Rotavirus data still undergoing evaluation

Table 3 Percentage of children immunised by their 2nd birthday 2015/16

Area	Diphtheria, Tetanus, Polio, Pertussis, Hib (DTaP/IPV/Hib) (%)	MMR (%)	Pneumococcal Disease (PCV) (%)
Southend	95.4	93.0	93.5
East of England	96.4	93.5	93.5
England	95.2	91.9	91.5

Source: COVER data, Public Health England

Table 4 Percentage of children immunised by their 5th birthday 2015/16

Area	Diphtheria, Tetanus, Polio, Pertussis, Hib (DTaP/IPV/Hib) Primary (%)	Diphtheria, Tetanus, Polio, Pertussis, Hib (DTaP/IPV/Hib) Booster (%)	MMR first dose (%)	MMR first and second dose (%)	Hib/ Men C booster (%)
Southend	95.9	91.6	94.8	90.4	93.9
East of England	96.7	90	96.8	91.8	94.4
England	95.6	86.3	94.8	88.2	92.6

Source: COVER data, Public Health England

Uptake of flu immunisation in children in discussed in Chapter 3.

There is generally good uptake of primary childhood immunisations in Southend, with sufficient uptake to achieve herd immunity for most of the programmes. Uptake of the second dose of MMR (measles, mumps and rubella) vaccine, however, still remains an issue and remains around 5% below the target uptake. This has important implications for herd immunity against measles.

Public Health England undertakes surveillance to ensure early detection of increased numbers of cases of infectious diseases. Following an increase in cases of pertussis (whooping cough), including in infants under three months of age who are most vulnerable to severe disease, a national pertussis outbreak was declared in April 2012. This led to a temporary immunisation programme in which pregnant women were offered pertussis immunisation to protect infants from birth, through intra-uterine transfer of maternal antibodies until they can receive the pertussis vaccine at 8 weeks old (3). The reported incidence of pertussis in infants under three months subsequently fell back to levels observed before the 2012 peak. In 2014, this maternal immunisation programme was extended for a further five years (4).

Pertussis activity remains high in 2016 and unprotected young infants continue to be at risk. In Southend the monthly uptake of the prenatal pertussis vaccine ranged from between 40.8% and 55.7% each month between April 2015 and March 2016. GPs, practice nurses, obstetricians and midwives should continue to encourage pregnant women to receive the vaccine.

3.0 Recent Changes to the Childhood Immunisation Programme

A number of changes to the national immunisation programme were made during 2015-16 to reflect the recommendations by the national Joint Committee on Vaccination and Immunisation (JCVI) to improve the overall level of protection against preventable diseases.

The main changes relate to vaccines for meningococcal disease. Meningococcal disease can affect all age groups, but cases increase from birth and peak at five months before declining gradually until 24 months. Cases remain low until 12 years of age and then gradually increase to a smaller peak at 18 years before declining again.

Since September 2015, all infants born from 1 July 2015 became eligible for the meningococcal B vaccine which is administered together with the other primary immunisations at 2 months, 4 months and 12 months.

Due to the success of the MenC programme introduced in 1999, there are now very few cases of invasive meningococcal serogroup C disease. Since July 2016, infants no longer require the MenC vaccine at 12 weeks of age (5). Children will continue to be immunised against MenC via the Hib/MenC vaccine dose given at 12 months of age and the MenACWY conjugate vaccine dose given at around 14 years of age.

Various sub groups of meningococcal disease can spread quickly in areas where people live closely to each other, such as in university halls of residence. Young people aged 25 and under about to start university and have not received MenACWY will also be offered the vaccine.

4.0 Adult Immunisations

Immunisation is often seen as the domain of children, however, immunisation should be seen as a necessary intervention across all stages of life. Evidence demonstrates that older people are at greater risk of morbidity and mortality from vaccine-preventable diseases. The reasons for this include reduced immunity with age leading to increased susceptibility to more severe and frequent infections. In addition they may not have received immunisations in younger years and newer vaccines may not have been available to them when they were children.

Older adults (65 years or older) should be routinely offered a single dose of pneumococcal polysaccharide vaccine, if they have not previously received it. Annual influenza vaccination should also be offered.

Adults aged 70 should also be offered shingles vaccine, with a phased ‘catch up’ so that those up to 79 are offered the vaccine.

Uptake of influenza vaccination is discussed in detail in Chapter 3. In 2014/15 only 58.4% of eligible people aged 65 years or over in Southend received the pneumococcal vaccine, which is significantly lower than the England average (70.1%). Similarly uptake of shingles vaccine in 2014/15 in 70 year olds is also significantly lower than the England average, at 46.6% compared to 58.3%.

5.0 What is Being Done Locally?

NHS England local area teams are responsible for commissioning the national immunisation services locally and for providing system leadership to all those involved.

Contracts to provide immunisation services are held with a range of providers, including general practices for immunisations given in primary care and community providers for immunisations given in a school setting. Contracts are also held with some community pharmacists, for example for flu vaccine.

The local NHS England team offers help and support to immunisation providers and recently commissioned a series of free update sessions aimed at practice nurses across Essex. The aim of these sessions is to help share learning from recent incidents and to provide a round-up of hot topics, general updates and changes to the immunisation schedule.

The Health Protection Team, part of Public Health England, has provided training and update sessions on the pertussis and flu vaccinations for pregnant women for the midwives in Essex.

The local NHS England team lead commissioner for immunisations holds a bimonthly immunisaton oversight meeting attended by public health staff from the three upper tier authorities in Essex.

6.0 Recommendations

- Every opportunity should be taken to actively promote immunisation uptake in children across Southend. This should include promotion in children's centres and at school entry

- Work should continue with primary care and midwives to immunise more pregnant women against whooping cough

- Provide information about immunisations to a broad range of partners who work with older people to enable them to pass on accurate information on the importance of immunisations at appropriate opportunities

Chapter 3 Seasonal Influenza

1.0 Background

Influenza (flu) is an acute viral infection of the respiratory tract. Symptoms frequently include fever, headache, cough, sore throat, extreme fatigue, and aching muscles and joints.

The influenza virus is highly contagious and is easily passed from person-to-person when an infected person coughs or sneezes. Transmission can also occur by touching a contaminated surface e.g. a door handle, and then putting the fingers in the mouth or near the eyes. Even people with mild or minimal symptoms can still infect others.

For most healthy individuals, influenza is an unpleasant but usually self-limiting illness with recovery usually within a week. However, for some it can lead to serious complications such as bronchitis and secondary bacterial pneumonia, which may require treatment in hospital and can be life threatening.

Those at higher risk of serious complications include people aged 65 or over, children and adults with an underlying chronic health condition such as respiratory disease, heart disease and diabetes, those with weakened immune systems as well as pregnant women (1).

Most cases of seasonal influenza in the UK tend to occur during an eight to ten week period during the winter. The timing, extent and severity of this can vary from year to year. In addition to the impact on the health and social care system (2), seasonal influenza can have a significant impact on the wider society through sickness absence amongst the working age population. The latest UK Labour force market survey identified that minor illnesses, including influenza, accounted for 27.4 million lost working days in 2013. This was 30% of all sickness absences and the most common reason for worker absence (3).

2.0 The Influenza Immunisation Programme

The aim of the national influenza immunisation programme is to protect those who are at a higher risk of serious illness or death should they develop influenza. It also helps to reduce transmission of the infection (4).

Seasonal influenza vaccine, or 'flu jab' should be offered, ideally before influenza starts circulating, to those in the following clinical risk groups:

- All those aged 65 or older
- Adults and children (over the age of 6 months) with chronic underlying health problems
    - A chest complaint or breathing difficulties, e.g. severe asthma, chronic bronchitis or emphysema
    - A heart problem
    - A kidney disease
    - Liver disease

  - A neurological disease e.g. multiple sclerosis
  - Diabetes
- Lowered immunity due to disease or treatment e.g. cancer treatment
- All pregnant women

Immunisation is also offered to health and social care staff directly involved in the care of patients/ clients to contribute to the protection of these vulnerable groups and to reduce sickness absence through the winter. It can also be offered to the main carers of older or disabled people and household contacts of immunocompromised people.

As different strains of influenza virus circulate each year, the vaccine formula is changed annually based on the strains most likely for the coming influenza season. This means that eligible people need to get a flu jab every year.

Following advice from the Joint Committee for Vaccination and Immunisation, the annual influenza immunisation programme is being extended to include vaccination of healthy children aged two to less than 17 years old. These children will generally receive the vaccine as an intranasal spray. In addition to preventing a large number of cases of influenza in children, it will also provide indirect protection by reducing transmission of influenza from children to adults and those in the clinical risk groups of any age.

Due to the scale of the programme it is being phased in over a number of years. This began in 2013, with the inclusion of children aged two and three years in the routine programme. There were also seven geographical pilots of primary school aged children, including one in South East Essex covering Southend.

From 2016/17, the intranasal influenza vaccine will be offered to two, three and four year olds and children in school years 1, 2 and 3. In addition, the pilot influenza immunisation programmes in primary schools will be continued. The intent is that the programme will gradually extend over future years to all primary school aged children.

2.1 Uptake of Influenza Vaccine in Southend

NHS England local area teams are responsible for commissioning the national influenza immunisation programme. Contracts to provide influenza immunisation services are held with a range of providers, including general practices for immunisations given in primary care and community providers for immunisations given in a school setting.

The NHS England Essex Area Team undertook an influenza immunisation pilot in 2014/15 with a number of community pharmacists, which evaluated positively. From 2015/16, a national scheme was introduced to enable all community pharmacies to provide flu vaccination to eligible adult patients where they met key criteria.

Influenza immunisation should be offered to 100% of those eligible to receive it. Table 1 shows the percentage uptake of influenza vaccine for each eligible group in 2015 -2016. The range of the lowest and highest uptake by GP practice in Southend

is also provided for people aged over 65, those under 65 in a clinical risk group, and pregnant women.

Table 1 Seasonal Influenza Vaccine Uptake by Eligible Population in Southend compared with England 2015/16

Eligible Population	National Targets 2015/16	Uptake of influenza vaccine in England 2015/16	Uptake of influenza vaccine in Southend 2015/16
Aged 2 years	65%	35.4%	18.8%
Aged 3 years	65%	37.7%	22.1%
Aged 4 years	65%	30.0%	15.7%
Age 5 (School year 1)	Not included	N/A	54.4% (local pilot)
Age 6 (School year 2)	Not included	N/A	52.9% (local pilot)
Age 7 (School year 3)	Not included	N/A	NA
All Pregnant Women	(range 40 to 65%) as per at risk groups)	42.3%	39.2%* (Range 26.7% - 60.6%)
Under 65- at risk	55%	45.1%	38.0%* (Range 23.2% - 63.3%)
65 and over	75%	71%	64.1%* (Range 50.3% - 80.3%)
Health Care Workers	75%	54.6%	SUHFT-59.3% SEPT- 30.1% NELFT-24.7%
Social Care Workers	75%	Data not available	Data not available

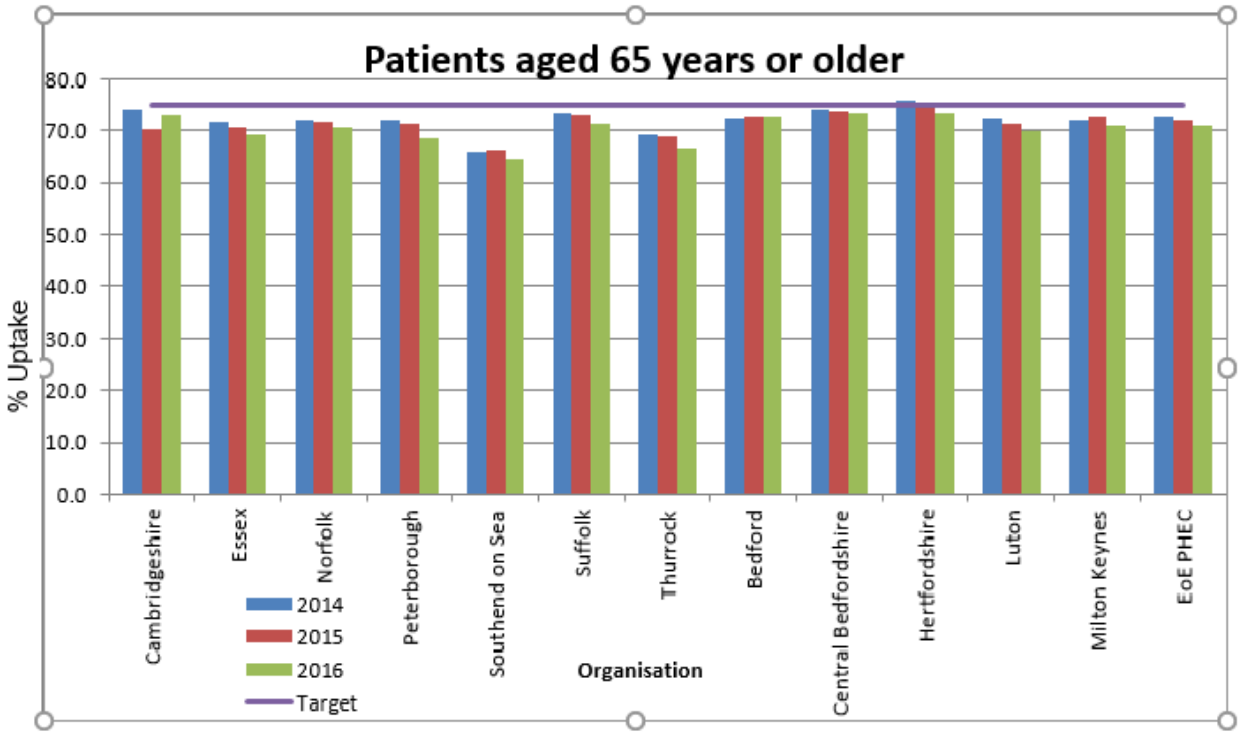
Source: Public Health England Public (PHE) 2016. Influenza Immunisation Vaccine Uptake Monitoring Programme

* The range of the lowest and highest uptake by GP practice in Southend is provided for people aged over 65, those under 65 in a clinical risk group, and pregnant women.

The poor uptake of influenza vaccine across virtually all eligible groups at both a national and a local level is concerning. Figure 1 highlights the continued downward trend of influenza vaccine uptake in persons aged 65 and over in Southend since 2014. This downward trend is generally reflected in the other local authority areas covered by the Public Health East of England Centre.

The exact cause of this downward trend in uptake of influenza vaccine is not known. It is unfortunate that there is often poor public perception of the benefits of influenza immunisation, often fuelled by negative media coverage and general misinformation.

Figure 1 **Trend of influenza vaccine uptake in persons aged 65 and over in Southend compared to the Public Health England East of England Region for 2014 to 2016.**



Source: Public Health England (PHE) 2016. Influenza Immunisation Vaccine Uptake Monitoring Programme

3.0 What is Being Done Locally?

Addressing the impact of seasonal influenza is a priority for the Southend health and care economy. Southend has an older population, with 18.9% of people aged 65 and over compared to the England average of 17.6%. Southend also has more people living with three or more long term conditions compared with England. This means that Southend has more people in the higher risk clinical groups who are more likely to suffer complications from influenza.

The commissioning of the seasonal influenza vaccination programme is undertaken by staff in the NHS England local area teams. The Director of Public Health in local authorities has a challenge and assurance role for local arrangements to ensure access to flu immunisation to improve uptake by eligible populations (5).

Following a review of the 2015/16 seasonal influenza immunisation programme in Southend, initiatives were put in place to increase local uptake. These included the establishment of a multi-agency Seasonal Flu Oversight Group to develop a detailed Southend Seasonal Influenza Action Plan to increase uptake of flu vaccine as part of the 2016/17 immunisation programme.

This group comprised representation from all key stakeholders, including local GPs and Community Pharmacists, Social Care, Public Health England, Southend

University Hospital NHS Foundation Trust, South Essex Partnership NHS Trust and NHS Southend CCG.

To set an example to other employers and increase uptake of flu vaccine amongst its own workforce, the Borough Council commissioned an influenza immunisation programme for all Council front line staff. This programme covered care staff working in council commissioned residential and care homes and staff employed by domiciliary care providers working in Southend. This programme has been commissioned for the 2016/17 season.

The Council also worked closely with NHS Southend CCG and Public Health England to increase uptake of influenza vaccination amongst staff in the top twenty care homes in the borough with the highest rates of patients admitted to hospital as a result of a respiratory condition. This work included a major communications and publicity programme to promote the benefits of flu immunisations as well as challenging the myths and misinformation about the vaccine. A number of face to face workshops and training sessions were also delivered in the community and local care homes.

The Council's Public Health Team has worked closely with NHS Southend to develop a specific plan for outbreaks of influenza in residential and care homes in Southend. When the Public Health England East of England local health protection team is alerted to a number of residents in a home with clinical symptoms suggestive of influenza, nose and throat swabs of those affected are sent off for laboratory confirmation. If the infection is confirmed as influenza, all unaffected residents are offered antiviral prophylaxis and appropriate infection control measures are put in place in the home. Public health commission the service for taking swabs and provision of antivirals, and NHS Southend Clinical Commissioning Group provide the funding for antivirals.

4.0 Recommendations

- A review is undertaken of the Southend Seasonal Influenza Action Plan outcomes for 2016/17 and the findings used to inform any changes to the action plan for 2017/18.

- Share best practice of those GPs delivering high rates of seasonal vaccination as part of the 'locality approach' of the South and Mid Essex Sustainable Transformation Plan

- All health and social care organisations covering Southend should put in place plans to increase staff influenza vaccination uptake to meet the nationally agreed targets

- Southend University Hospital NHS Foundation Trust to review how to provide additional support to increase uptake of influenza vaccination in at risk groups and specifically pregnant women

Chapter 4 Tuberculosis

1.0 Background

Tuberculosis (TB) is caused by infection with the bacteria Mycobacterium tuberculosis and can affect almost any part of the body, most commonly the lungs (1). The disease develops slowly and it may take several months before symptoms appear. Symptoms of TB include persistent cough, possibly with blood stained sputum, fever, weight loss and night sweats, and can be fatal if left untreated.

TB is spread by breathing in airborne droplets when a person with infectious respiratory TB coughs or sneezes. However, TB is much less infectious than other respiratory infections, such as influenza. Prolonged close contact such as living in the same household with an infected person is generally required to transmit the disease.

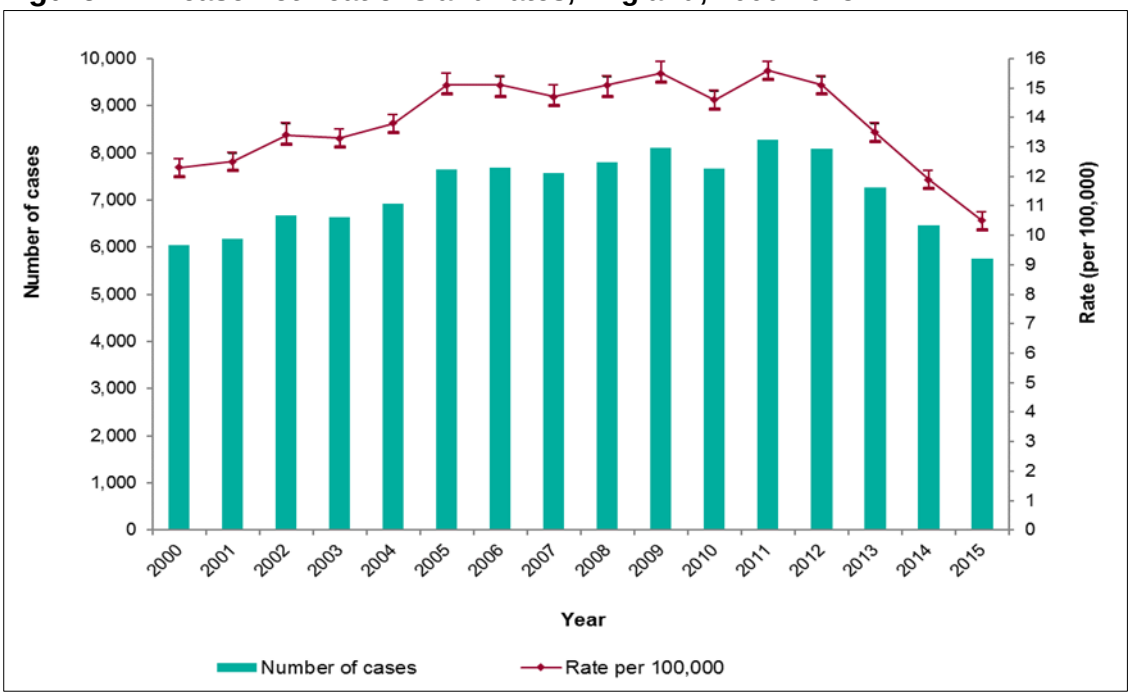
Not everyone who comes into contact with TB gets the disease. In some people the initial infection may be eliminated or they may develop latent disease when the TB bacteria remain in the body but the individual has no symptoms. Latent TB infection (LTBI) may reactivate later in life, particularly if an individual's immune system has become weakened e.g. through HIV, cancer chemotherapy or in old age. Up to 10% of people who have LTBI will develop the disease at some point in their lifetime (2).

At the beginning of the 20th Century there were over 117,000 new cases of TB in England every year. By the 1980s, with better housing and nutrition along with effective treatments, the number of new cases fell to a low of 5,086 in 1987 (1).This trend then reversed with a steady increase in the number of new reported cases, reaching a peak of over 8,280 in 2011 (15.6 new cases per 100,000 population), with the highest numbers concentrated in urban areas, particularly London (3).

Over the past four years there has been a year-on-year decline in the number of new cases of TB in England, down to 5,758 cases (10.5 new cases per 100,000 population) in 2015, a reduction of one third since the peak in 2011. This trend is shown in Figure 1.

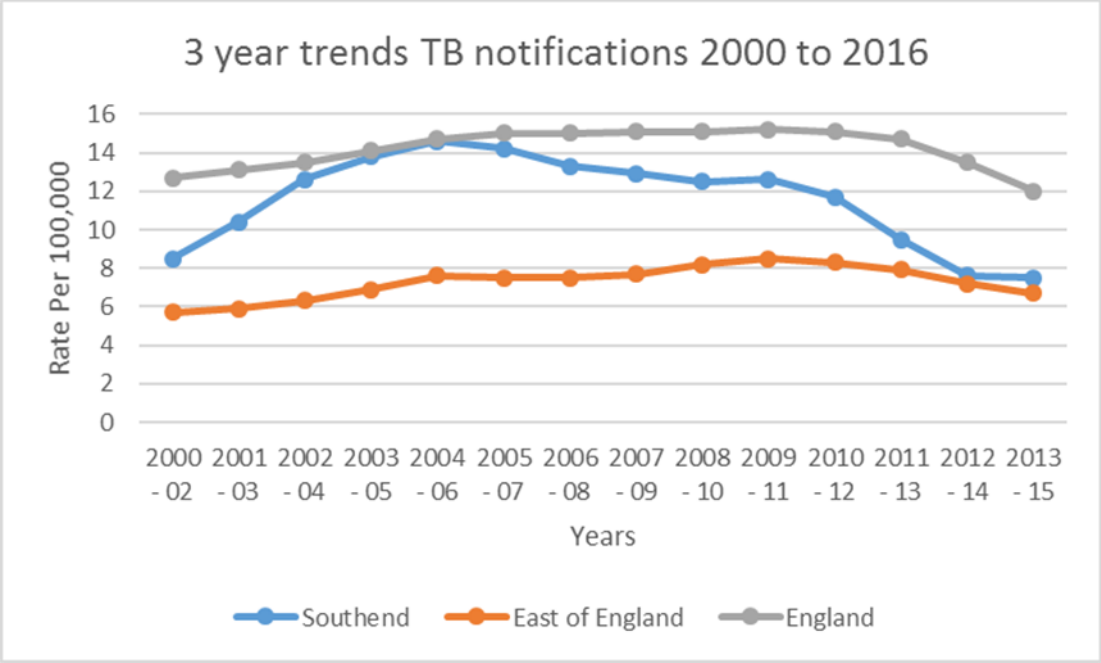
Figure 2 highlights the three yearly trend of TB notifications in Southend from 2000-2 to 2013-15. The peak incidence of TB occurred in 2004-6 and has since continued to decline to a three average rate of 7.5 new cases per 100,000 population in 2013-15.

Figure 1 TB case notifications and rates, England, 2000-2015



Source: Public Health England

Figure 2 Notifications of TB in Southend compared to England and East of England Region (three year average incidence per 100,000, 2000-2 to 2013-15)



Source: Public Health England 2016. TB Strategy Monitoring Indicators (4)

2.0 The Changing Pattern of Tuberculosis

Over the last 50 years TB has changed from a being disease that occurred across all parts of the population to one occurring predominantly in specific population subgroups (1).

Rates of TB are higher in certain communities, mainly by virtue of their connections to higher-prevalence areas of the world. The rate of TB in the non-UK born population is 15 times higher than in the UK born population, and 73% of all TB cases notified in 2015 were born abroad (3). Of these, 60% had been in the country for longer than six years, suggesting latent TB infection may have played a role in these cases.

In other communities, social risk factors such as homelessness, drug or alcohol misuse and imprisonment, are important factors. Despite the recent reduction in overall TB cases, the proportion of cases with at least one social risk factor increased from 9.8% in 2014 to 11.8% in 2015.

2.1 National Initiatives to Tackle Tuberculosis

Although England is considered as a low incidence country for TB, it still has one of the highest rates of TB notifications in Western Europe. To tackle this problem Public Health England in close collaboration with NHS England and a coalition of key stakeholders launched the TB strategy for England 2015-2020 (5). This aims to achieve a year-on-year decrease in TB incidence, and ultimately the elimination of TB as a public health problem in England.

The strategy includes ten key areas of action including the prompt identification of individuals who are infectious and ensuring that they are placed on appropriate treatment; vaccination of high risk groups; maintaining excellent diagnostic services; tackling drug resistant TB; identifying and treating those with latent TB; ensuring contact tracing happens; and workforce planning to deliver these interventions.

The national TB strategy created a national TB Office and seven multiagency TB Control Boards to oversee the implementation of the national strategy.

The UK previously screened migrants from countries with a high incidence of TB at the time of entry into the country. This has since been replaced with a chest x-ray based screening for active pulmonary TB prior to entry to the UK (6).

There are effective treatments for TB and there is now a focus on picking up the disease when it is latent. From 2015, there has been a national roll-out through GP practices of systematically testing and treating eligible new migrants for latent TB infection (7).

The BCG vaccine is most effective against the most severe forms of the TB in children, but less effective in preventing respiratory TB, which is the more common form in adults (1). From 2005, the BCG vaccine has been given to babies and children with a parent or grandparent from a country with a high incidence of TB

(over 40 cases per 100,000), or those who live in an area of the UK where the incidence of TB is high.

3.0 What is Being Done Locally?

The East of England TB Control Board, which covers the population of Essex, has comprehensive plans in place to address the key recommendations of the national TB strategy across the region. A network of local TB Control Boards from across the region, including Southend, link to the regional Board.

Over the past year, the Council has been working with the Essex TB Control Board on a number of initiatives, including the delivery of housing solutions for vulnerable homeless people diagnosed with TB.

The Clinical Commissioning Groups in South Essex commission the community TB service from South Essex Partnership NHS Foundation Trust. The aim of the service is to prevent the spread of TB in the community by providing rapid assessment of those suspected to have active TB and to arrange treatment at the earliest opportunity. All tuberculosis patients are cared for by a multidisciplinary team, and specialist TB nurses follow up and support patients once they are presumed to have TB to ensure medication is taken to completion. The nurses also identify and screen those who have been in contact with the case and provide support to people with TB and their families.

The local drug and alcohol service collaborates with the community TB service to support directly observed therapy (DOT) for people with TB with substance misuse problems. This involves the supervision of the patient by a healthcare worker when taking their medication, leading to better compliance with treatment. The local sexual health services have also been promoting the uptake of TB screening for all those offered HIV testing.

4.0 Recommendations

To continue the downward trend of TB notifications in Southend it is recommended that:

- Training is made available to professionals to raise awareness of TB in vulnerable groups including homeless, drug and alcohol misusers, as well as new migrants from high incidence countries, to ensure prompt referral when TB is suspected.

- The Council collaborates with the East of England TB Control Board and local partners to ensure DOT therapy is available for those people with TB in the most disadvantaged or hard to reach groups

- The Council supports the East of England TB Control Board and local stakeholders to implement the local plan for latent TB infection testing and treatment services

Chapter 5 Sexual Health and Blood Borne Viruses

1.0 Background

Good sexual health is fundamental to the health and wellbeing of individuals. It is underpinned by the provision of high quality, safe and accessible sexual health services and interventions.

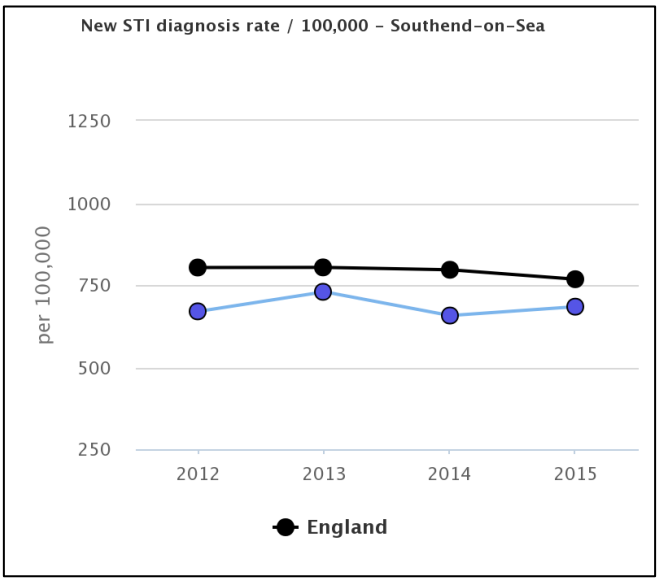
Despite progress in recent years, the UK continues to have high rates of sexual ill health. Within the population sexual health needs vary according to factors including age, gender, ethnicity and sexuality, with some groups disproportionately at risk of poor sexual health. These include young people aged 16-24, men who have sex with men, the 50+ age group, black and minority ethnic groups and other high risk groups such as sex workers and people misusing drugs and/or alcohol (1).
In order to improve sexual health outcomes, intervention programmes should be developed based on a robust evidence base and local needs.

Since April 2013, local authorities in England have been responsible for commissioning the majority of sexual health services, including sexually transmitted infections (STI) testing and treatment, and notification of sexual partners of infected persons (2). Clinical Commissioning Groups and NHS England commission other aspects of sexual health care.

2.0 Sexually Transmitted Infections

Information on the burden of sexually transmitted infections (STIs) in the population is collected from Genitourinary Medicine (GUM) Services, primary care and community services. The rate of new STI diagnoses in Southend remains significantly lower than the national average (Figure 1).

Figure 1 New STI Diagnoses in Southend compared to England average (rate per 100,000 and excluding Chlamydia in under 25's)



Source:PHE Fingertips

2.1 Chlamydia

Chlamydia is the most common bacterial sexually transmitted infection in England, with rates substantially higher in young adults than any other age group

Chlamydia infection is often asymptomatic and if left untreated it can cause a range of complications such as pelvic inflammatory disease, infertility and ectopic pregnancy.

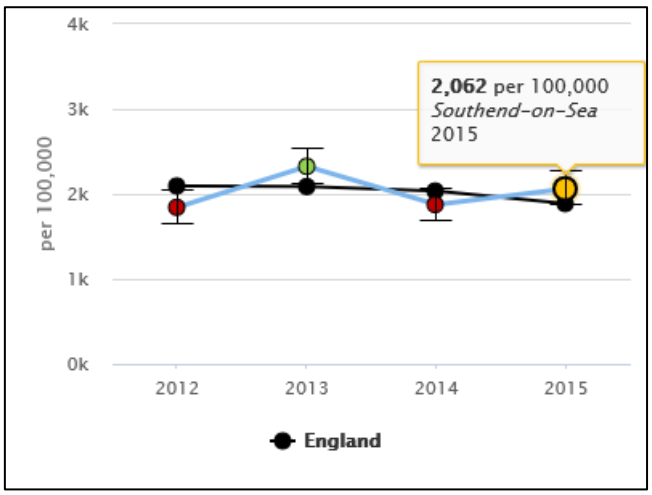
The National Chlamydia Screening Programme (NCSP) recommends that all sexually active under 25 year old men and women are tested for chlamydia every year or on change of sexual partner. By diagnosing and treating asymptomatic chlamydia infections, chlamydia screening can reduce the duration of infection, reduce the risk of developing complications, and reduce transmission (3).

The chlamydia detection rate amongst under 25 year olds is used as a measure of chlamydia control activity, with an increased detection rate being indicative of increased control activity. Public Health England recommends that local authorities should be working towards achieving a detection rate of at least 2,300 per 100,000 population aged 15-24.

Southend continues to have a significantly better rate of chlamydia screening in 15-24 year olds than the national average (23.8% compared to 22.5% in 2015).

Figure 2 highlights that the chlamydia detection rate in Southend is similar to the England average, but remains below the recommended level to reduce the prevalence of chlamydia in the population.

Figure 2 Chlamydia Detection Rate in Southend compared to England (rate per 100,000 aged 15-24, 2012- 2015)



Source:PHE Fingertips

2.2 Other Sexually Transmitted Infections

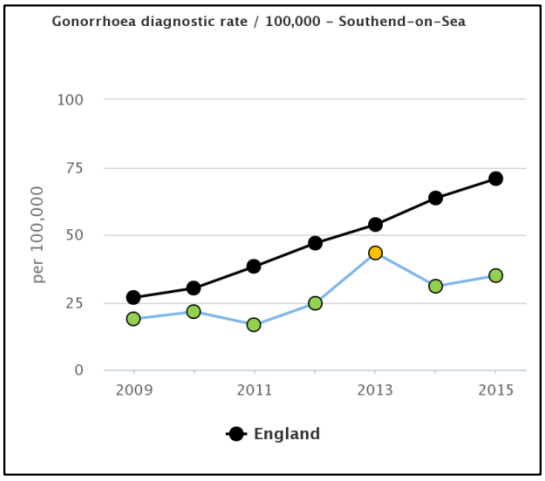
Gonorrhoea

Gonorrhoea is the second most common bacterial sexually transmitted infection in the UK. Diagnoses of gonorrhoea are particularly concentrated in young adults, men who have sex with men and black ethnic minority populations.

Gonorrhoea is often used as a marker for rates of unsafe sexual activity. This is because the majority of cases are diagnosed in genitourinary medicine (GUM) settings, and consequently the number of cases may be a measure of access to sexually transmitted infection treatment. Infection with gonorrhoea is also more likely than chlamydia to result in symptoms.

Rates of gonorrhoea in Southend are significantly lower than the national average (Figure 3).

Figure 3 Gonorrhoea Diagnostic Rate in Southend Compared to England Average (Rate per 100,000 population, 2009-2015)

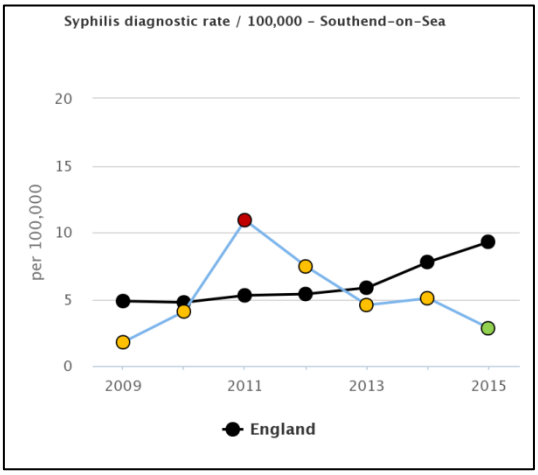


Source: PHE Fingertips

Syphilis

If untreated, syphilis can have serious health implications. These include damage to the internal organs, nervous system, bones and even death. Syphilis is an important public health issue in men who have sex with men (MSM) among whom incidence has increased over the past decade. Figure 4 illustrates the trend in all syphilis diagnoses among people accessing GUM services in Southend. The diagnostic rate has continued to fall since 2011, and is now significantly lower than the national rate (Figure 4).

Figure 4 Syphilis Diagnostic Rate in Southend Compared to England Average (Rate per 100,000 population, 2009-20015)



Source: PHE Fingertips

Genital Warts and Genital Herpes

Genital warts are the result of a viral skin infection caused by the human papilloma virus and genital herpes is caused by herpes simplex virus, types 1 and 2. The diagnostic rate of genital warts and genital herpes in Southend are both similar to the England average.

3.0 Human Immunodeficiency Virus (HIV) and Blood Borne Viruses

Blood-borne viruses (BBVs) are viruses that are carried in the blood and can be transmitted from one person to another. Those infected with a BBV may show little or no symptoms of serious disease, but other infected people may be severely ill.

The most common blood borne viruses are:

- Human immunodeficiency virus
- Hepatitis B
- Hepatitis C

3.1 HIV

Human immunodeficiency virus (HIV) is a virus that attacks the body's immune system, by destroying a type of white blood cell called a T cell (or CD4 cell), weakening the ability to fight infections and disease, including cancer. There is currently no cure for HIV but there is a range of effective treatments.

HIV can be transmitted by unprotected sexual intercourse, shared needle use by injecting drug users, needle stick injuries in healthcare workers as well as mother to child transmission before, during or after (via breast milk from an infected mother) the birth of the child.

HIV remains an important communicable disease in the UK. It is associated with considerable morbidity and mortality, high treatment and care costs. Treatment is available with highly active anti-retroviral therapy, which has led to a substantial reduction in the incidence of AIDS and the numbers of HIV-related deaths (4).

In 2015, there were an estimated 101,200 people living with HIV infection in the UK, equivalent to 1.6 per 1,000 people; 13% were unaware of their infection and at risk of passing on the infection. There were also 6,095 new HIV diagnoses in the UK in 2015, this represents a new diagnosis rate of 11.4 per 100,000 people which is higher than most other countries in western Europe (5).

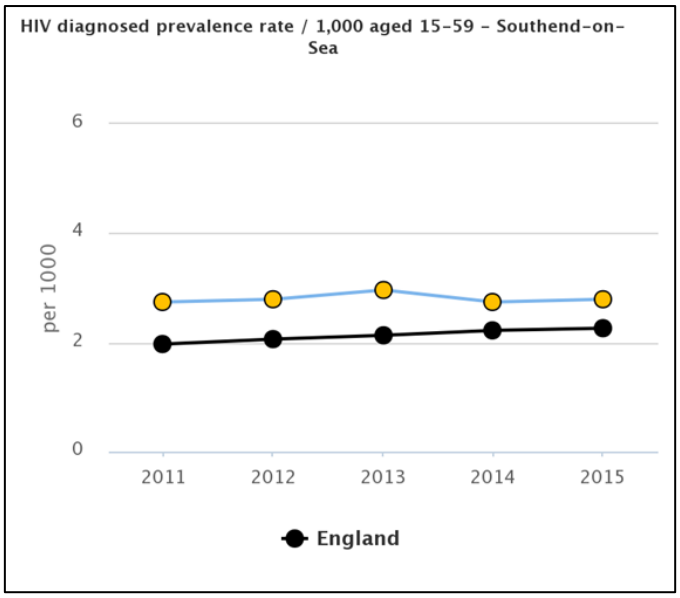
Of those diagnosed in 2015, 71% were aged between 25 and 49 years, and 17% were aged 50 years and over. The number of new cases of HIV reported in gay and bisexual men remains high and accounted for 54% of the new diagnoses in 2015. Of the 39% of the new cases of HIV acquired heterosexually, fewer cases were in people who were born abroad.

People living with HIV can expect a near normal life expectancy if they are diagnosed and treated promptly. A late HIV diagnosis (defined as having a CD4 cell count less than 350/mm3 within three months of diagnosis) can have adverse consequences on the individual including making it more likely the person will have frequent admissions to hospital due to illness and reducing their life expectancy. In 2015, among those with CD4 data available, 39% of adults were diagnosed late.

3.2 HIV in Southend

The prevalence of HIV in Southend has historically been higher than the national average, although, over time the difference has narrowed (Figure 5).

Figure 5 HIV prevalence in Southend compared to England (diagnosed rate per 1000 population aged 15-59 years)

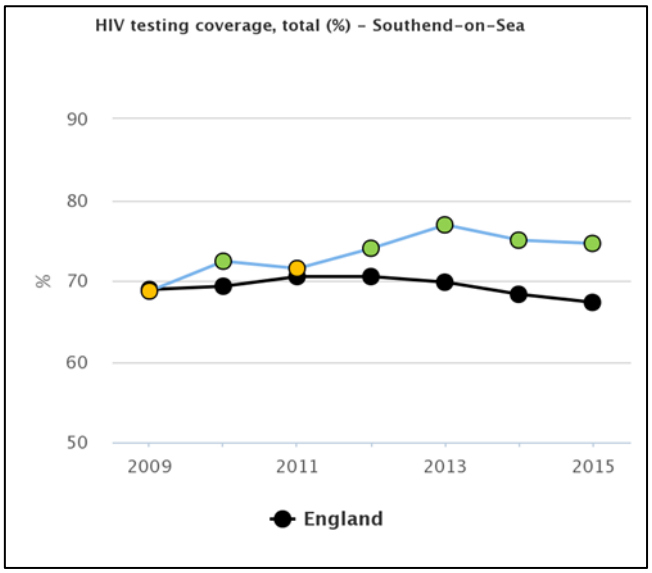


Source: PHE Fingertips

The rate of new HIV diagnosis in Southend has almost halved since 2012. In 2015, there were 8.9 new HIV diagnosis per 100,000 population among people aged 15 and over in Southend, which is lower than England average (12.1 per 100,000 population aged 15+)

HIV testing is integral to the treatment and management of HIV. Knowledge of HIV status increases survival rates, improves quality of life and reduces the risk of HIV transmission. Figure 6 shows that HIV test coverage in Southend is significantly higher than the national coverage. HIV testing coverage data represents the number of people tested for HIV.

Figure 6 HIV testing coverage in Southend compared to England, 2009-15 (% uptake in eligible new attendees to genitourinary medicine clinics)

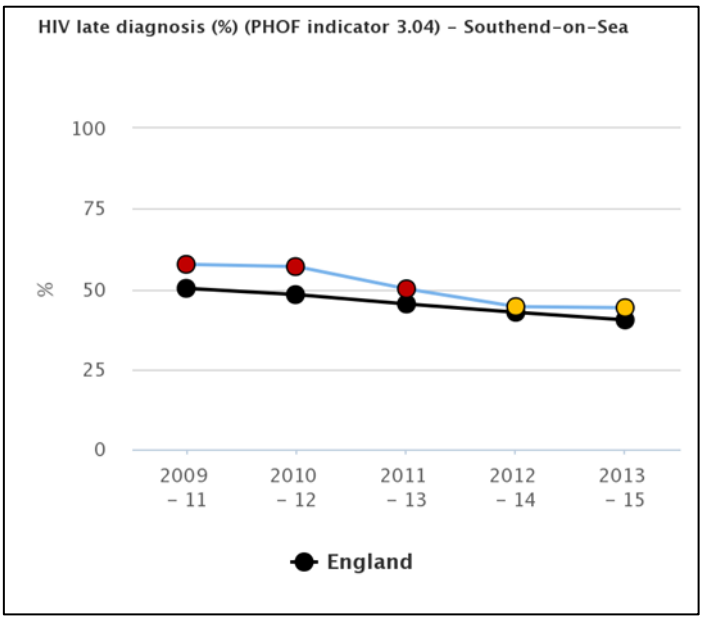


Source: PHE Fingertips

Late diagnosis of HIV is the most important predictor of morbidity and mortality among those with the infection. Those diagnosed late have ten times the risk of death compared to those diagnosed promptly.

Over the last five years there has been a continued downward trend in the proportion of individuals diagnosed late with HIV in Southend, which is now similar to the England average (Figure 7).

Figure 7 HIV late diagnosis in Southend compared to England 2009-15



Source: PHE Fingertips

4.0 Hepatitis B and C

Hepatitis B virus (HBV) replicates in the liver, and is also present at very high levels in the blood of people who are infected. The virus is transmitted by contact with an infected person's blood or body fluids contaminated by blood, and can be spread through sexual transmission, needle stick injuries, tattooing and body piercing, use of contaminated equipment for IV drug use as well as transmission from an infectious mother to her unborn child.

Many people with hepatitis B won't experience any symptoms and the infection will resolve without them realising they had it. In some people the virus persists for six months or more to develop chronic hepatitis B. The risk of chronic infection varies with age, occurring in 90% of those infected perinatally, but is less frequent in those infected as children. About 5% or less of previously healthy people infected as adults become chronically infected (6). The long term complications of chronic hepatitis B infection include liver cirrhosis and hepatocellular carcinoma, the most common type of primary liver cancer.

Hepatitis B is relatively uncommon in the UK and most cases affect people who become infected while growing up in part of the world where the infection is more common, such as Southeast Asia and sub-Saharan Africa.

Transmission of hepatitis B can be prevented through a course of vaccinations. These are offered to those at highest risk of infection: household contacts of people with hepatitis B including the babies of mothers with hepatitis B, injecting drug users and healthcare workers.

The hepatitis C virus (HCV) is also transmitted by contact with an infected person's blood or body fluids contaminated by blood. The routes of transmission are similar to hepatitis B, although transmission through unprotected sexual intercourse is less likely.

Most people with hepatitis C do not experience any symptoms. Unlike hepatitis B, 50-80% of people infected with hepatitis C go on to develop chronic infection. Of these 15% will develop liver cirrhosis and 2- 5% will develop hepatocellular carcinoma every year (7).

About 214,000 people have chronic hepatitis C in the UK, which is equivalent to 0.4% of the adult population. Up to 90% of hepatitis C infections in the UK are acquired through injecting drug use.

Although there is no vaccine for hepatitis C, it is a potentially curable disease. People with chronic hepatitis C infection should be referred to a specialist and considered for antiviral therapy.

5.0 What is Being Done Locally?

5.1 Sexual Health and HIV

Southend-on-Sea Borough Council has commissioned the SHORE (Sexual Health, Outreach, Reproduction and Education) Integrated Sexual Health Service. This is delivered through a collaborative partnership between South Essex Partnership Trust, Southend University Hospital Foundation Trust Hospital and Brook young people's sexual health organisation.

The integrated sexual health service ensures that all aspects of the service are working consistently to national standards and contractual requirements. It includes:

- Contraceptive, sexual health and reproductive health services
- Genitourinary medicine services
- Specialist input for termination of pregnancy service
- Chlamydia screening including online and postal chlamydia testing services, and a data administration service
- Education Based Health Service - delivered in identified secondary schools and further/higher colleges in Southend.
- Management of the chlamydia testing and treatment and Long Acting Reversible Contraception services in primary care general practice settings
- Management of the chlamydia testing and treatment services and Emergency Hormonal Contraception in primary care community pharmacy settings
- Microbiology Services
- The Brook My Life programme: This is a programme that enables individuals and groups of young people to take charge to improve their own health and wellbeing by exploring skills, goal setting and becoming more emotionally resilient.
- Management of a separately commissioned 'Sexual Health Promotion and Community HIV Prevention Service' contract. This is currently contracted to the Terrence Higgins Trust.

SHORE now provides same day HIV testing as part of a four sexually transmitted infections (STI) test offer (HIV, syphilis, chlamydia and gonorrhoea) and full STI screening across all its sites.

The Council has also commissioned the national HIV self-sampling service to deliver online HIV tests since January 2016, to Southend-on-Sea residents through the online kit request service (www.test.hiv). This service is being promoted through the national website and by SHORE and Terrence Higgins Trust with targeted communities and businesses.

5.2 Hepatitis B and C

Specialist drug and alcohol services in Southend prioritise hepatitis B and C interventions within their nurse-led health and wellbeing work. They have developed pathways to specialist hepatology services and are working closely with liver nurses to ensure clients are quickly identified and referred for support where necessary. The most recent data suggests that this work is having an effect, and that the number of patients receiving hepatitis C tests is now greater than the England average.

6.0 Recommendations

- Undertake a review of availability of chlamydia screening in sexual health service venues and community based settings to ensure screening is available in the populations with the highest need, based on positivity.

- Raise professional awareness about who to screen and test for HIV to continue the reduction in late diagnosis.

- Continue efforts to reduce stigma and highlight testing opportunities to those at greatest risk of HIV.

Chapter 6 Healthcare Associated Infection

1.0 Background

Healthcare associated infections are a range of infections acquired in healthcare settings or as a direct result of healthcare interventions such as medical or surgical treatment (1). They occur most frequently in hospitals but can also be acquired in the community (including clinics, care homes and patient's own home); and affect patients, healthcare workers, carers and visitors.

Healthcare associated infection can result in significant harm to those infected; causing illness, delaying recovery, prolonging hospital stay, and may cause serious disability or even death.

2.0 The Scale of the Problem

Approximately, 300,000 patients a year in England are affected by a healthcare-associated infection as a result of care within the NHS (2). The most common types of healthcare-associated infection are respiratory infections (22.8%), urinary tract infections (17.2%) and surgical site infections (15.7%) (3).The cost of healthcare associated infections to the NHS is estimated to be in the region of £1 billion a year (4).

Everyone carries large numbers of micro-organisms on their skin or in their bodies, which only become a problem when the person becomes unwell or when the organisms have the opportunity to enter the bloodstream. People are at a greater risk of getting an infection when

- they are very young or very old,
- they have underlying health conditions e.g. diabetes which can impair their natural immune response
- their treatment involves invasive procedures e.g. urinary catheters or intravenous drips that provide an entry point for infection,
- they have a compromised immune system e.g. patients receiving chemotherapy
- they have a longer length of hospital stay or are in a high-risk area e.g. Intensive Care Unit (2).

3.0 Types of Healthcare Associated Infections

As part of the work to reduce healthcare associated infections, Public Health England runs a national surveillance programme to monitor the numbers of certain infections that occur in healthcare settings.

There are 4 mandatory surveillance programmes:

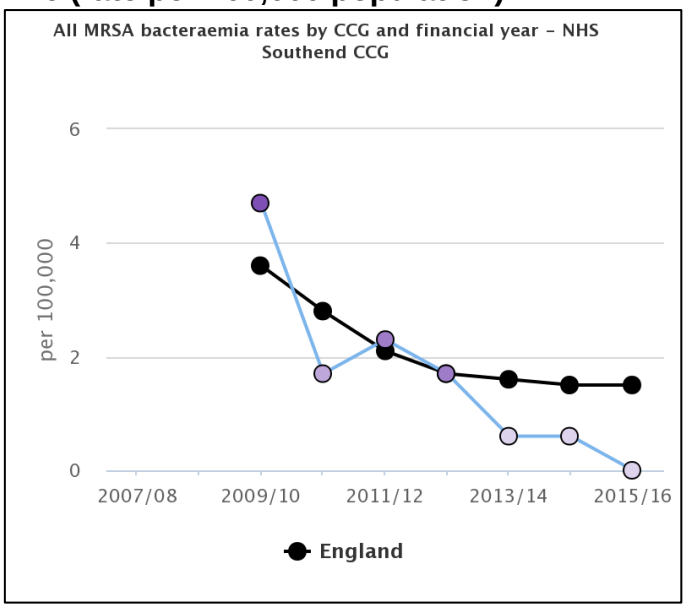
- Staphylococcus aureus (methicillin resistant Staphylococcus aureus or MRSA and methicillin sensitive Staphylococcus aureus or MSSA)
- Escherichia coli
- Clostridium difficile infection
- Surgical site infection

3.1 Staphylococcus aureus

Staphylococcus aureus (S. aureus) is a bacterium that is commonly found on human skin and mucosa without causing any problems. However, if the bacteria enter the body e.g. through a break in the skin or via medical equipment, such as catheters and drips, they can cause health problems ranging from mild to life threatening. These include skin and wound infections, abscesses, joint infections, infections of the heart valves, pneumonia and bacteraemia (blood stream infection).

Most strains of S. aureus are sensitive to commonly used antibiotics, but others have developed resistance, such as methicillin resistant Staphylococcus aureus (MRSA), and will require different types of antibiotic to treat them.

Figure 1 MRSA bacteraemia rates in Southend and England, 2007-16 (rate per 100,000 population)

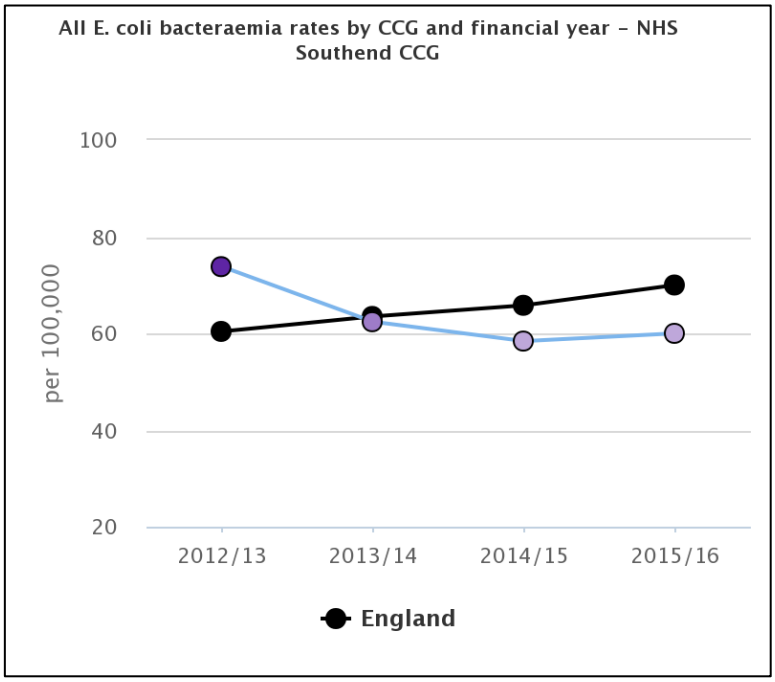


Source: Public Health England

3.2 Escherichia coli

Escherichia coli (E. coli) bacteria are found in the intestines of humans and animals. E. coli bacteria can cause a range of infections including urinary tract infection, intestinal infection and can also spread to the blood causing bacteraemia.
In England there has been a steady rise in the number of cases of E. coli bacteraemia reported over the past 4 years. Southend has not seen the same increase and remains below the England average (Figure 2).

Figure 2 E Coli Bacteraemia rates in Southend and England, 2012 -16 (rate per 100,000 population)



Source: Public Health England

Bacteraemia can be divided into two categories: 'hospital-acquired,' in which positive blood cultures occur more than 2 days after hospital entry; and 'community-onset,' occurring in the community or detected before 2 days of hospitalisation. Surveillance indicates that three quarters of E. coli bacteraemia cases have their onset in the community, so this is the setting where prevention and infection control interventions will have most benefit.

3.3 Clostridium difficile

Clostridium difficile (C. difficile) is a bacterium that is found in people's intestines. It can be found in healthy people (3% of adults) where it causes no symptoms. When people are unwell and treated with antibiotics, this allows C. difficile to grow to take over the gut and causes diarrhoea.

C. difficile infections can range in severity from mild diarrhoea through to severe inflammation of the intestine, but they can usually be treated with another course of antibiotics (5). Infection with C difficile can spread easily to others from contact with a contaminated environment or infected person.

Since 2004 the reporting of C difficile has been mandatory and there has been an overall decrease in the counts and rates of all reported cases since 2007.

NHS England set official guidance for C. difficile infection for NHS organisations in 2016/17, including objectives for maximum number of cases and rates of infection for acute hospitals and NHS commissioners. Table 1 shows the objectives for the local area. A sanction can be applied if hospitals exceed their case objective.

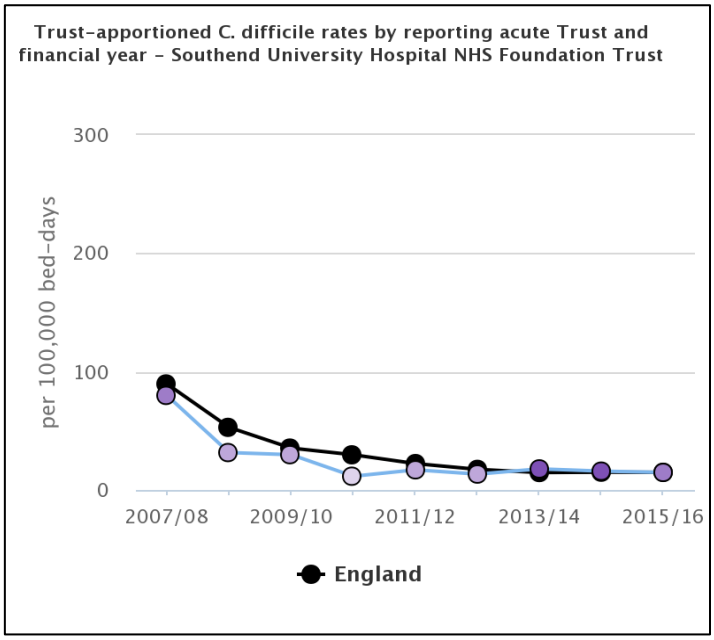
Table 1: Clostridium difficile (CDI) objectives for Southend University Hospital NHS Foundation Trust and NHS Southend Clinical Commissioning Group 2016/17

Organisation	CDI case objective	CDI rate objective
Southend University Hospital NHS Foundation Trust	**30**	**17.3**
NHS Southend Clinical Commissioning Group	**36**	**20.5**

Source: NHS England

Southend University Hospital NHS Foundation Trust has shown the same decrease in rates of C. difficile as has been seen nationally (Figure 3) and is below the expected case maximum.

Figure 3 Trust apportioned C. difficile rates Southend University Hospital Foundation NHS Trust 2007-2016



Source: NHS England

3.4 Surgical Site Infection (SSI)

A surgical site infection is an infection that occurs after surgery in the part of the body where the surgery took place. Surgical site infections can sometimes be relatively minor infections involving the skin only. Other surgical site infections are more serious and can involve tissues under the skin, organs, or implanted material.

4.0 Reducing Healthcare Associated Infections

The Department of Health has made the control and prevention of healthcare associated infections a top priority (6). In addition improving cleanliness and reducing healthcare associated infections is a top tier ‘must do’ target for the NHS (7).

Although it is probably impossible to completely eradicate healthcare associate infections, in addition to clean environments, the key interventions that can significantly reduce their incidence are:

- Good hand hygiene practices
- Proper use of invasive medical equipment e.g. intravascular (IV) lines mechanical ventilation and catheters
- Prudent use of antimicrobials and optimising prescribing practice

4.1 Good Hand Hygiene Practices

The single most cost-effective intervention to prevent the transmission of healthcare associated infection is good hand hygiene, by washing hands with soap and water or using alcohol-based hand rubs before and after patient contact (8).

The *Cleanyourhands* campaign run by the National Patient Safety Agency was associated with increased hospital procurement of both alcohol hand rub and soap, with reduced rates of MRSA bacteremia and C difficile infection (9). This campaign has now been superseded in hospitals by the World Health Organisation’s ‘Save Lives – Clean your hands’ and the ‘Five Moments for hand hygiene.

Sometimes even the best hand washing will not be enough, and there is a need to wear protective equipment such as gloves and an apron.

4.2 Proper Use of Invasive Medical Equipment

Common invasive devices e.g. urinary catheters or intravenous cannulas carry a greater risk of healthcare associated infections. These may result from contamination from the skin during insertion of the device, contamination on staff hands when manipulating the device, or if the device is left in place for prolonged periods.

Strict infection control guidelines govern the use and management of invasive devices, their decontamination and disposal and the frequency with which they are checked and replaced while in use.

4.3 Prudent Use of Antibiotics

Modern medicine relies on antibiotics for preventing and treating serious infections, and their use is an essential component of modern surgery, cancer chemotherapy and organ transplants.

Antibiotic resistance (also known as antimicrobial resistance) occurs when bacteria adapt and become resistant to the medicines used so that they no longer work effectively.

The inappropriate use of antibiotics has contributed to the dramatic rise in antibiotic resistance over the last 40 years, and few new antibiotics have been developed. This has led to increased pressure on existing antibiotics and greater challenges in treating patients (10).

Work is being undertaken at a national level to tackle antimicrobial resistance, directed by a cross-government antimicrobial resistance strategy (11). This focuses activities around improving the knowledge and understanding of antimicrobial resistance, conserving the effectiveness of existing treatments and stimulating the development of new antibiotics, diagnostics and novel therapies

There are also a wide range of national initiatives to improve antibiotic prescribing practice:

- Raising awareness e.g. European Antibiotic Awareness Day' (EAAD) is held in November each year, aimed at health professionals and the public
- Optimising prescribing in primary care via education programmes such as Stemming the Tide of Antibiotic Resistance and Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET). Health Education England has also produced an e-learning module *Reducing Antimicrobial Resistance: An Introduction* aimed at all health and social care staff
- Optimising prescribing in hospitals and antimicrobial stewardship - the introduction of multi-professional specialist teams to monitor prescribing, resistance, and infections, and to supporting prescribers in choice and use of antibiotics (12)
- Measures to reduce the use of some antibiotics (associated with an increased risk of infection) e.g. cephalosporin and quinolone antibiotics
- Funding research

NICE have recently issued guidance on the effective use of antimicrobials (including antibiotics) which aims to change prescribing practice to help slow the emergence of antimicrobial resistance (13).
The change in prescribing practice needs to be coupled with further public campaigns around antibiotics. There is good evidence that these campaigns lead to reduction in use (14).

5.0 What is Being Done Locally?

5.1 Healthcare Associated Infections

Healthcare associated infections have been tackled successfully in recent years in Southend. This has resulted from a wide range of initiatives that have already been launched across the health economy. These include the widespread implementation of the "clean your hands campaign" and the Saving Lives High Impact Interventions initiative which focuses on actions that are known to make a difference, such as good catheter care.

Southend Clinical Commissioning Group (CCG) works closely with Southend University NHS Foundation Trust on infection control issues and audits cases of C difficile and MRSA bacteraemia. All cases of Clostridium difficile and MRSA bacteraemia are reviewed by provider organisations with CCG infection prevention and control input. The CCG Governing Body receives regular updates on healthcare associated infections.

5.2 Antimicrobial Resistance

A multidisciplinary Antimicrobial Resistance Group has been established to develop a strategy and action plan to slow the development and spread of antimicrobial resistance by tackling overuse and misuse of antibiotics.

The Public Health team has highlighted a resource called ‘e-bug’ which has gone out to schools through the local Schools Learning Network. E-bug is a free educational resource for classroom and home use to make learning about micro-organisms, the spread, prevention and treatment of infection, fun and accessible for all students.

All healthcare professionals and members of the public are being encouraged to become an Antibiotic Guardian.

The Southend CCG Medicines Management Team continues to work with prescribers and pharmacists to educate staff, promote good antibiotic prescribing practice and to audit antibiotic prescribing.

The use of delayed prescriptions in primary care for simple non-bacterial infections e.g. sore throats. Prescribers issue an antibiotic prescription but ask the patient to wait 24-48 hours to see if the condition resolves before commencing use. This has been shown to reduce antibiotic usage.

6.0 Recommendations

- Continue to increase standards and implementation of infection control measures across health and social care services (such as hand washing, use of personal protective equipment, decontamination, sterilisation, and patient isolation).

- Continue to promote the role of Antibiotic Guardian with healthcare professionals and the public.

- Promote public education about appropriate use of antibiotics and the importance of adherence to the prescribed dose and taking the full course of antibiotics.

Chapter 7 Emergency Preparedness

1.0 Background

Threats to the public's health such as outbreaks of disease, environmental hazards and severe weather conditions are continually emerging and can arise at any time. On occasions these can escalate into a major incident in a short space of time, requiring the implementation of special arrangements by one or a number of agencies such as the emergency services, the NHS or the local authority.

A key role of the Director of Public Health, acting on behalf of their local authority, is to ensure that plans are in place to protect the health of their population from threats ranging from relatively minor outbreaks to full-scale emergencies (1).

This role involves collaboration with Public Health England, NHS England and other relevant agencies to plan and prepare for, and contribute to a 24/7 response capability to deal quickly and effectively with emergency situations.

2.0 Emergency Preparedness and Planning

The Government is responsible for emergency planning and brought in the Civil Contingencies Act 2004 (CCA) (2) to ensure that the organisations best placed to manage emergency response and recovery are at the heart of civil protection.

The Act defines an emergency as:

- an event or situation which threatens serious damage to human welfare
- an event or situation which threatens serious damage to the environment
- war or terrorism, which threatens serious damage to security

The Act divides local responders into two categories depending on the extent of their involvement in civil protection work, and places a proportionate set of duties on each.

Category 1 responders are those organisations at the core of emergency response (e.g. emergency services, local authorities, acute hospitals, Public Health England and NHS England) and are subject to the full set of civil protection duties.

These duties include the assessment of risk of emergencies occurring and using this to inform contingency planning; putting in place emergency plans and business continuity management arrangements; having arrangements to make information available to the public about civil protection matters as well as the ability to 'warn, inform and advise' public in the event of an emergency

Category 2 responders include the utilities, transport, the Health and Safety Executive and Clinical Commissioning Groups. They generally support the emergency response through the provision of specialist support, equipment or advice.

2.1 What is Being Done Locally?

Essex Local Resilience Forum

The CCA requires multi-agency co-operation in emergency preparedness. At a local level this is fulfilled by the Essex Local Resilience Forum (Essex LRF) which brings together Category 1 and 2 responders. There is also a requirement for the Essex LRF to compile a Community Risk Register based on an assessment of the key risks facing the local community. The Risk Register is then used to inform emergency planning.

To facilitate close partnership working between the organisations that make up the Essex LRF, all of their emergency planning leads meet up for a day every week ("Working on Tuesdays" group) to help prepare and update plans for responding to major emergencies. This group also helps with the preparation and running of multiagency exercises and ensures that any lessons learnt are subsequently incorporated into the relevant plans.

The Emergency Planning Lead Officer for Southend Borough Council and the Director of Public Health are both members of the Essex LRF.

Essex Local Health Resilience Partnership

Local Health Resilience Partnerships (LHRPs) bring together health sector organisations to co-ordinate and support joint working and effective planning of the health emergency response (3). Their key responsibilities include the production of local sector-wide health plans to respond to emergencies as well as to contribute to multi-agency emergency planning. LHRPs are coterminous with LRFs and provide assurance about the ability of the health sector to respond in partnership to emergencies at the LRF level.

LHRPs are not statutory organisations and each constituent organisation remains responsible and accountable for their effective response to emergencies, in line with their statutory duties and obligations.

The Essex Local Health Resilience Partnership is co-chaired by the Director of Public Health for Southend-on-Sea Borough Council and the NHS England Locality Director for Mid and South Essex. The membership includes senior representatives from the health sector across Essex and the Health Protection Team at the Public Health England East of England Centre. All organisations represented on the Essex LHRP have signed a Memorandum of Understanding in relation to dealing with outbreaks involving a multiagency response.

NHS England is responsible for seeking assurance on the preparedness of the NHS in England to respond to an emergency, and that there is resilience in relation to continuing to provide patient care. This process is undertaken on an annual basis via LHRPs, and requires both health commissioners and providers to undertake a self-assessment against relevant NHS Emergency Preparedness, Resilience and Response (EPRR) Core Standards.

In the most recent assurance exercise, NHS Southend Clinical Commissioning Group was assessed as being “fully compliant” across all applicable core EPRR standards and sufficiently ready to respond to an emergency (4). Over the next 12 months Southend Clinical Commissioning Group will be undertaking further work to gain assurance that any providers they commission and any sub-contractors have robust business continuity planning arrangements in place.

On the basis of the self-assessment against the NHS Core Standards for EPRR, Southend University Hospital NHS Foundation Trust’s overall compliance is considered to be “substantially compliant”. Action has been taken to address the four criteria rated as ‘partially compliant’ within the next 6 months (5).

3.0 Extreme Weather and Health

Our climate is changing and evidence suggests that more extreme changes to our climate and extreme weather events can be expected in the future. Changing climate will affect people’s health, both directly and indirectly. Taking appropriate action and preparing for these changes now should lessen their impact.

3.1 Health and cold weather

Greater numbers of people are known to die during the winter months. Cold weather increases the risk of heart attacks, strokes, and respiratory diseases, as well as injuries from slips and falls in the snow or ice. Older people, very young children, and people with serious medical conditions are particularly vulnerable to the effects of cold weather.

The reasons more people die in winter are complex and interlinked with inadequate heating and poorly insulated housing, as well as circulating infectious diseases, particularly flu and norovirus, and the extent of snow and ice.

Excess winter deaths are additional deaths which occur between December and March (December-March) compared to the average number of deaths in non-winter months (August-November and April-July). The Excess Winter Death Index in Southend is similar to the rest of England (6).

Fuel poverty is an important public health issue, and is considered to be the cause of up to 1 in 10 excess winter deaths (7). Currently 9% of households in Southend experience fuel poverty, which is significantly better than the England average (6).

3.2 What is Being Done Locally?

Local action to tackle fuel poverty was covered in detail in my last two annual reports, which are available on the Council’s website.

Every year detailed local multi-agency planning takes place to inform the System Winter Resilience Plan, with the aim of minimising the impact of cold weather on the local population and on health and social care services. This includes a detailed communications plan covering actions to increase uptake of seasonal flu vaccine in eligible groups and a ‘keep warm and well’ campaign for the general public.

As part of the Cold Weather Plan for England (8), a national Cold Weather Alert service operates from 1 November to 31 March. This uses Met Office forecasts and data to trigger levels of response from NHS, local government and the public health system and communication of risks to the public when severe cold weather is forecast.

3.2 Health and Hot Weather

In contrast to deaths associated with cold snaps in winter, the rise in mortality as a result of very warm weather follows very sharply – within one or two days of the temperature rising. This means that by the time a heatwave starts, the window of opportunity for effective action is very short indeed; and therefore advanced planning and preparedness is essential

The Heatwave Plan for England and Heat Health Watch alert system were first developed following the Heatwave in 2003 when there were an estimated 2000 extra deaths in England (9). To support the Plan, the Met Office issues Heatwave Alerts from 1 June to 15 September each year.

3.3 What is Being Done Locally?

At a local level, Southend Borough Council facilitates the planning for the distribution of relevant heatwave planning guidance to the relevant non NHS agencies in the community (including education establishments and residential homes) and cascades the Heat Alert Level notifications. NHS England Midlands and East Regional Team have made similar arrangements for NHS organisations.

4. Recommendation

- The Essex Local Health Resilience Partnership should be asked to prepare an Annual Report and present to the Southend Health & Wellbeing Board and Cabinet to provide assurance to the Council on local health sector emergency preparedness.

Chapter 8 Screening

1.0 Background

Screening is the process of identifying apparently healthy people, but who may be at increased risk of a disease or condition. They can then be offered information, further tests and appropriate treatment to reduce associated risks or complications arising from the disease or condition.

The aim of screening is to identify those who are more likely to be helped than harmed by further tests or treatment to reduce risk. However, the screening process is not perfect and in every screening programme there are some false positives (wrongly reported as having the condition) and false negatives (wrongly reported as not having the condition). Before a screening programme is established there are a number of important criteria that must be met relating to the condition itself, the test, the intervention and the programme (1).

The UK National Screening Committee advises the NHS on which population screening programmes are implemented. Public Health England leads the NHS Screening Programmes and is responsible for quality assurance and monitoring uptake. Commissioning of NHS screening programmes is undertaken by NHS England. The Essex Screening and Immunisation Team based in NHS England East Team commissions the national screening programmes for the population of Southend.

There are currently 11 NHS systematic population screening programmes; six antenatal and newborn, three cancer and two young person and adult (2). This chapter focuses on the cancer and young person and adult screening programmes.

2.0 Cancer Screening

England has 3 national cancer screening programmes; breast, cervical and bowel.

2.1 NHS Breast Screening Programme

Breast cancer is the most common type of cancer in females in the UK and the second most common cause of cancer death in women (3). Approximately 45,000 cases of breast cancer are diagnosed every year, usually in women who are over 50 years of age (3).

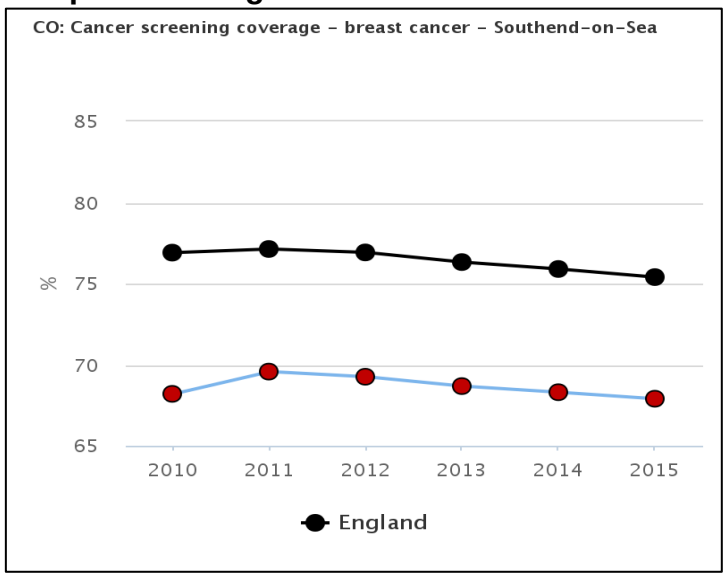
The NHS Breast Screening Programme aims to find breast cancer at an early stage, often before there are any symptoms. To do this, digital scans are taken of each breast (mammogram) to look for any abnormalities in breast tissue. Early detection may mean simpler and more successful treatment.

Women in England aged 50-70 years are invited for screening every three years. Women over 70 can continue to be screened by making an appointment at their local screening unit every three years. The NHS is currently in the process of trialling extending the programme, offering screening to some women aged 47- 49 and 71-73 years.

For the screening programme to be effective, it is important that a substantial proportion of the eligible population participate. The minimum standard is for 70% of women who are invited over a 3-year period to be screened and the target is 80%.

In Southend the breast screening coverage for women aged 50-70 years in 2015 was 67.9%, which is significantly lower than the England average of 75.4% (Figure 1). Breast screening coverage has been decreasing both nationally and locally since 2011. There is a need to increase screening coverage to further improve outcomes and breast cancer survival rates.

Figure 1 Breast Cancer Screening Coverage in Southend Compared to England 2010 -2015 *



Source: Public Health Outcomes Framework
(* % of eligible women screened in previous 3 years)

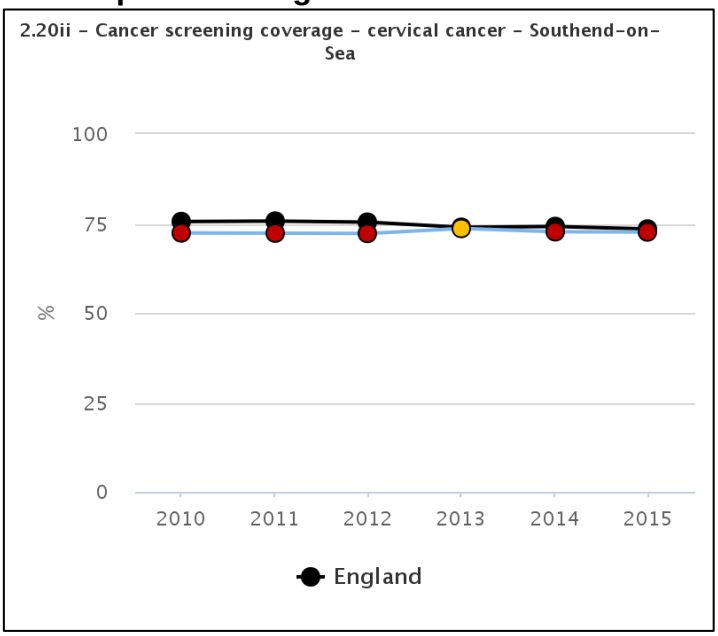
2.2 NHS Cervical Screening Programme

Cervical cancer is the 20th most common cancer in the UK, with around 3,200 new cases per year (3). The NHS Cervical Screening Programme aims to prevent cancer by detecting abnormalities in cells of the cervix and referring women for further investigation and potential treatment. Screening is offered every three years to all women aged 25 to 49 years and every five years to those aged 50 to 64 years.

It is estimated that early detection and successful treatment can prevent up to 75% of cervical cancers from developing (3). Since its introduction, the screening programme has helped half the number of cervical cancer cases, and is estimated to save approximately 4,500 lives per year in England (4).

Southend has historically had a low coverage in this screening programme and most recent data shows that there has been no significant improvement.

Figure 2 **Cervical Screening Coverage in Southend Compared to England 2010 -15 ***



Source: Public Health Outcomes Framework

(*% of eligible women screened adequately within the previous 3.5 or 5.5 years)

2.3 NHS Bowel Cancer Screening Programme

About one in 20 people in the UK will develop bowel cancer during their lifetime. It is the third most common cancer in the UK, and the second leading cause of cancer death (3). The risk of bowel cancer increases with age, with over 80% of bowel cancers arising in people who are 60 or over.

The NHS Bowel Cancer Screening Programme aims to detect bowel cancer at an early stage when treatment is more likely to be effective. Bowel cancer screening also detects polyps, which are not cancers but may develop into cancers over time and can easily be removed.

The NHS offers two types of bowel cancer screening to adults registered with a GP in England:

- A faecal occult blood (FOB) screening kit is offered to men and women aged 60 to 74 every two years. The kit is completed at home and posted to a laboratory for analysis. The FOB test detects occult (hidden) traces of blood in a small stool sample. People who test positive for FOB are referred further tests and, if necessary, treatment.

- An additional one-off test called bowel scope screening is gradually being introduced in England. This is offered to men and women at the age of 55. It involves a doctor or nurse using a sigdmoidoscope (a thin, flexible instrument) to look inside the lower part of the bowel. The aim is to find any small polyps which may develop into bowel cancer if left untreated

The NHS Bowel Cancer Screening Programme has been in place for 10 years, but uptake is still low both nationally and locally. For Southend, in 2015 coverage was 53.7% compared with an England average of 57.1%, against a required target of 75%.

2.4 What is Being Done Locally?

Depending on their area of residence and the breast screening round, women in Southend can access the breast screening programme at one of a number of sites. This can include the Southend University Hospital NHS Foundation Trust site, or the breast screening mobile unit which is placed at a number of venues in Southend.

In view of the falling cervical screening coverage in 25-29 year olds, a social marketing exercise has been undertaken in Essex with a wide range of stakeholders and 25-29 year old women. The findings will be used to inform local work, including a programme of communications targeting younger women.

The South Essex Bowel Cancer Screening Programme centre, which covers eligible men and women of Southend, commenced the bowel scope screening in December 2016, with plans for full implementation by the end of 2018.

3.0 Non-cancer young people and adult screening programmes

3.1 NHS Diabetic Eye Screening Programme

People with diabetes are at risk of a condition called diabetic retinopathy. This condition occurs when diabetes affects small blood vessels, damaging the part of the eye called the retina. Untreated this retinopathy is one of the most common causes of sight loss among people of working age. It may not cause symptoms until it is quite advanced.

The NHS Diabetic Eye Screening Programme aims to reduce the risk of sight loss in people with diabetes through the early detection, appropriate monitoring and referral for treatment of diabetic retinopathy. It offers screening every 12 months to all people with diabetes aged 12 and over. The screening test involves examining the back of the eyes and taking photographs.

The data for screening uptake is at present only available at regional level. The uptake for East of England in 2014/15 (82.4%) is similar to the England average (82.9%).

3.2 NHS Abdominal Aortic Aneurysm Screening Programme

Abdominal aortic aneurysm (AAA) screening is a way of detecting a dangerous swelling (aneurysm) of the aorta – the main blood vessel that runs from the heart, down through the abdomen to the rest of the body The swelling occurs when the wall of the aorta weakens and stretches. What causes this weakness is still unclear, however, smoking and high blood pressure are thought to increase the risk of an aneurysm.

An AAA usually causes no symptoms, but if it bursts it is extremely dangerous and usually fatal. Around 8 out of 10 people with a ruptured AAA either die before they reach hospital or do not survive surgery.

Early detection is important because once identified AAAs can be monitored or treated, greatly reducing the chances of the aneurysm causing serious problems. AAA screening involves a simple ultrasound scan to measure the abdominal aorta.

AAA is far more common in men aged over 65 than it is in women and younger men, so men are invited for screening in the year they turn 65. Men over 65 who have not previously been tested can self-refer for screening.

The NHS Abdominal Aortic Aneurysm (AAA) Screening Programme aims to reduce the number of ruptured AAAs and premature deaths among men aged 65 and over by up to 50% through early detection, follow-on tests and referral for treatment.

The Essex AAA Screening service was launched in May 2013.The uptake for 2015/16 for Essex was 78.8%. This is a promising start for a very new programme, especially as it is aimed only at men and for a condition that is not as widely known about. Data is also available at Clinical Commissioning Group level, and this shows that there is a lower uptake for AAA screening in Southend (75.4%).

3.3 What is Being Done Locally?

As part of the new Essex Diabetic Eye Screening Programme, an Engagement Manager has been recruited who is working with local diabetes support groups to enhance the service and improve access. They are also working with GP practices in the promotion of the service.

The Essex AAA programme is managed by Southend University Hospital NHS Foundation Trust. The programme continues to work with GP practices and local community services to promote the programme and raise awareness among the target age group.

4.0 Recommendations

- Consideration to be given to the inclusion of information on NHS screening programmes in ‘Making Every Contact Count’ training. This will enable staff from health, the local authority and other organisations to promote screening through routine health promotion messages to residents.

- Increase uptake and decrease inequity in uptake across all the screening programmes by targeting groups and communities who are less likely to access screening.

Feedback from Recommendations for 2015

This section highlights some of the initiatives that have taken place in the past year that are linked to the recommendations from the 2015 Annual Public Health Report.

Healthy Early Education and Childcare Settings

- A research report was commissioned by A Better Start Southend looking at childhood obesity. This highlighted a range of issues that contribute to childhood obesity and the associated high impact changes to address them. Children's Centres will be central to the delivery of a number of the initiatives, including peer support for breast feeding, support for the introduction of solid foods including skills for healthy cooking on a low budget, and healthy portion size.

- The appropriate regulations, including a licence from the Medicines and Healthcare Products Regulatory Agency (MHRA), and staff training have been put in place to enable Children's Centres to distribute Healthy Start Vitamins from their premises.

Healthy Schools

- All Southend Schools engage with the Healthy Schools Agenda. There are 42 Southend schools (80%) currently working towards achieving Enhanced Healthy School Status. In July 2016, 12 further schools achieved Enhanced Healthy Schools status.

- A number of primary schools in Southend are now participating in the 'Daily Mile'. This is a simple and free initiative where children take a brisk walk outside in the playground averaging a mile each day.

Healthy Homes

- Southend Council worked with the multi-agency South East Essex System Resilience Group to develop a 'Keep Warm, Keep Well' campaign to promote key messages to the public about how to stay well during winter, including having a flu jab.

- Southend Council continues to promote Southend Energy, an energy partnership between Southend Council and OVO Energy. Southend Energy offers Southend residents offers savings on their energy through competitive tariffs, including much-reduced standing charges and 3% interest reward on all credit balances.

- Southend Council has employed a dedicated public health private sector housing officer. This officer works predominantly with vulnerable older people, supporting them to maintain their properties and take relevant action to address issues that might impact on their physical and mental health. This enables people to stay in their own homes, reducing the likelihood of a placement in a residential or nursing

home. It also helps reduce the emergency hospital admissions, attributable to poor housing conditions.

Healthy Workplaces

- During 2016, over 40 small and medium enterprises signed up to the Southend Public Health Responsibility Deal. Employees have had the opportunity to access a number of initiatives to improve their health and wellbeing, including health checks, various physical activities and workshops on topics such as eating for performance.

- Southend Council has continued to promote the health and wellbeing of its staff through a number of staff health events. This has also included the use of 'step jockey' to prompt greater physical activity by labelling the stairs for 'calorie burn'.

Healthy Southend

- Southend Council declared an Air Quality Management Area in 2016 and is currently in the process of developing an air quality strategy and Air Quality Management Area action plan.

- A Southend Physical Activity Strategy has been developed with an associated comprehensive action plan. This includes actions to promote the use of green spaces and parks in the borough to increase physical activity.

- Fourteen restaurants, cafes and sandwich shops have signed up to Southend Public Health Responsibility Deal and have committed to offering healthy options on their menu.

- The Southend Public Health Responsibility Deal has been promoted to schools via the Healthy Schools Programme, resulting in 12 schools signing up to the Deal.

- A Southend Joint Adult Prevention Strategy has been developed and has identified the key areas for prioritisation of resources across the spectrum of prevention.

- Southend launched its own version of the national "One You" health initiative. This programme is focused on adults and aims to help them live longer healthier lives by addressing negative lifestyle factors.

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Southend Health & Wellbeing Board

Report of Deputy Chief Executive (People)
to
Health and Wellbeing Board
on
22nd March 2017

Agenda Item No. **7**

Report prepared by: James Williams
Deputy Director of Public Health

For information only		For discussion	x	Approval required	

Southend-on-Sea Pharmaceutical Needs Assessment
Executive Councillor- Councillor Lesley Salter

A Part 1 Public Agenda Item

1. Purpose of the Report

1.1 To report on the progress of the refresh of the Southend-on-Sea Pharmaceutical Needs Assessment (PNA).

2. Recommendations

2.1 The Health and Wellbeing Board (HWB) note the timeline for the refresh of the Southend-on-Sea PNA.

2.2 The Health and Wellbeing Board agree the Terms of Reference (ToR) for the Southend Pharmaceutical Needs Assessment Steering Group.

2.3 The Health and Wellbeing Board delegate authority to the Southend Pharmaceutical Needs Assessment Steering Group, to review and advise the HWB on any responses they need to make in relation to 'Consolidated Applications' received by the HWB from NHS England.

3. Background

3.1 The provision of NHS pharmacy services is a controlled market. If someone wants to provide NHS pharmaceutical services, they are required to apply to the NHS to be included on a pharmaceutical list and must prove they are able to meet a pharmaceutical need.

3.2 The National Health Service England (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 (SI 2013 No. 349) set out the system for market entry. Under these Regulations, Health and Wellbeing Boards are responsible for publishing a Pharmaceutical Needs Assessment (PNA). The PNA tells us what pharmaceutical services are currently available and where we are likely to need changes in the future because of demographic or other changes.

3.3 NHS England (the national body responsible for commissioning pharmaceutical services) relies on PNAs to inform decision making, specifically regarding whether existing pharmaceutical services meet local need. The PNA is also used by NHS England to assess applications from applicants who want to modify existing services or deliver new pharmaceutical services within the borough.

3.4 The Southend Health and Wellbeing Board discharged its statutory duty and published its first PNA on the 3rd December 2014. Regulations require the HWB to revise and update the PNA every 3 years, or sooner should any significant changes occur that impact on the configuration or provision of local pharmaceutical services. In order to comply with its statutory duties, the HWB is required to approve an updated PNA by the 6th December 2017. This is the closest date to the 3 year anniversary of the original publication and will enable the HWB to publish the PNA before the 1st April 2018.

3.5 The HWB should note the implications of an amendment to the National Health Service Pharmaceutical Services, Charges and Prescribing Regulations act (S.I. 2016/1077). This amendment came into force on 5th December 2016. It essentially modifies the way in which pharmacies are remunerated for undertaking NHS related activity. It has led to a new regulatory process (an "Excepted Application") termed a 'Consolidated Application'.

3.6 Consolidated Applications enable a provider to submit a proposal to NHS England to close its premises. NHS England are required to notify the HWB of the application and to seek their views on whether this would create a gap in the provision of local pharmaceutical services. NHS England will only grant the application if it considers that no gap in provision will be created. NHS England must refuse any applications by other providers to fill any alleged gap resulting from a closure of premises under a Consolidated Application, until the next revision of the PNA, these are termed 'Unforeseen Benefit Applications'.

3.7 Possible circumstances when a Consolidated Application might be submitted, could be if a large pharmacy chain wishes to close a branch or outlet. Providers can still apply to NHS England to close premises using separate existing procedures, but they would lose any protection from 'Unforeseen Benefit Applications'. This means other providers could apply to NHS England to deliver local pharmaceutical services in that particular locality.

4. Update on the process of the refresh of the Southend-on-Sea PNA

4.1 The HWB previously delegated authority to the Director of Public Health (DPH) to maintain and update the existing PNA. The DPH has initiated this process and established a PNA Steering Group chaired by the Deputy Director of Public

Health. The Terms of Reference and membership of the PNA Steering Group are set out in Appendix 1.

4.2 The PNA Steering Group has developed a project plan and timeline for the completion of the PNA refresh. The PNA Steering Group has compiled a risk and issues log and started to scope the questions and process that will inform the 60 day public consultation process. This consultation is a regulatory requirement. The PNA Steering Group has also initiated the process of engagement with existing providers of pharmaceutical services, prior to the comprehensive needs assessment process that will be undertaken over the coming months.

5.0 Key Issues for the Health and Wellbeing Board

5.1 The HWB should review the Terms of Reference for the PNA Steering Group and determine whether any amendments are required.

5.2 The PNA Steering Group has all relevant professionals and lay representation required, to scrutinise any applications received from NHS England. The HWB should consider whether they are content to delegate the technical process of reviewing and making recommendations to the Board regarding 'Consolidated Applications', to the PNA steering group.

5.3 The HWB should note the timeline for completion of the refreshed PNA. Members will receive regular progress updates at each HWB meeting through to December 6th 2017 when the Board will need to agree the refreshed PNA.

6.0 Health & Wellbeing Board Priorities / Added Value

6.1 Pharmacies are an important part of the healthcare system and contribute to the delivery of a number of Ambitions in the Health and Wellbeing Strategy.

7.0 Reasons for Recommendations

7.1 The PNA is a statutory document. The Health and Wellbeing Board must refresh it in line with prescribed timescales. Delegating authority to the PNA Steering Group to consider 'Consolidated Applications', will enable to HWB to make informed responses to NHS England on any applications that might impact on the ability of local people to access pharmaceutical services in Southend-on-Sea.

8.0 Financial / Resource Implications

8.1 The cost of the development of the Southend PNA will be met from the public health budget.

9.0 Legal Implications

9.1 The relevant statutory framework is referred to in Section 3 of this report.

10.0 Equality & Diversity

10.1 Equality and diversity issues will be taken into account as part of the process of PNA refresh.

11.0 Background Papers

11.1 None.

12.0 Appendices

12.1 Appendix 1 Southend-on-Sea Pharmaceutical Needs Assessment Steering Group Terms of Reference

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HWB Strategy Priorities

Broad Impact Goals – adding value

a) Increased Physical Activity (prevention)
b) Increased Aspiration and Opportunity (addressing inequality)
c) Increased Personal Responsibility and Participation (sustainability)

Ambition 1. A positive start in life A. Children in care | B. Education- Narrow the gap | C. Young carers | D. Children's mental wellbeing | E. Teen pregnancy | F. Troubled families	**Ambition 2. Promoting healthy lifestyles** A. Tobacco – reducing use | B. Healthy weight | C. Substance & Alcohol misuse	**Ambition 3. Improving mental wellbeing** A. Holistic: Mental/physical | B. Early intervention | C. Suicide prevention/self-harm | D. Support parents/postnatal
Ambition 4. A safer population A. Safeguarding children and vulnerable adults | B. Domestic abuse | C. Tackling Unintentional injuries among under 15s	**Ambition 5. Living independently** A. Personalised budgets | B. Enabling community living |C. Appropriate accommodation | D. Personal involvement in care | E. Reablement | F. Supported to live independently for longer	**Ambition 6. Active and healthy ageing** A. Integrated health & social care services | B. Reducing isolation | C. Physical & mental wellbeing | D. Long Term conditions– support | E. Personalisation/ Empowerment
Ambition 7. Protecting health A. Increased screening | B. Increased immunisations | C. Infection control | D. Severe weather plans in place | E. Improving food hygiene	**Ambition 8. Housing** A. Partnership approach to; Tackle homelessness | B. Deliver health, care & housing in a more joined up way | C. Adequate affordable housing | D. Adequate specialist housing | E. Strategic understanding of stock and distribution	**Ambition 9. Maximising opportunity** A. Population vs. Organisational based provision | B. Joint commissioning and Integration | C. Tackling health inequality (improved access to services) | D. Opportunities to thrive; Education, Employment

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Pharmaceutical Needs Assessment Steering Group

Terms of Reference 2017

1. Background

The provision of NHS Pharmaceutical Services is a controlled market. Any pharmacist, dispensing appliance contractor or dispensing doctor (rural areas only), who wishes to provide NHS Pharmaceutical services, must apply to be on the Pharmaceutical List.

The National Health Service England (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 (SI 2013 No. 349) set out the system for market entry. Under the Regulations, Health and Wellbeing Boards are responsible for publishing a Pharmaceutical Needs Assessment (PNA); and NHS England is responsible for considering applications.

A PNA is a document which records the assessment of the need for pharmaceutical services within a specific area. As such, it sets out a statement of the pharmaceutical services which are currently provided, together with when and where these are available to a given population. The PNA is used by NHS England to consider applications to open a new pharmacy, move an existing pharmacy or to provide additional services.

Southend-on-Sea Borough Council published its first PNA under the Regulations in December 2014. The Health and Wellbeing Board has now initiated the process to refresh the PNA; this is in accordance with the Regulations which require a new document to be published every 3 years.

2. Role

The Southend-on-Sea Steering Group (PNA SG) has been established to:

- Oversee and drive the formal process required for the development of a PNA
- Ensure that the published PNA complies with all the requirements set out under the Regulations
- Promote integration of the PNA with other strategies and plans including the Joint Strategic Needs Assessment, the Joint Health & Wellbeing Strategy, the NHS Southend CCG Commissioning Strategy Plan and other relevant strategies including the Sustainability and Transformation Plan
- Establish arrangements to ensure the appropriate maintenance of the PNA, following publication, as required by the Regulations

3. Key Objectives

- Champion the work to develop the PNA with internal and external stakeholders, including patients, service users and the public
- Approve the project plan and timeline
- Drive the project ensuring that key milestones are met
- Ensure that the requirements for the development and content of PNAs are followed and that the appropriate assessments are undertaken, in line with the Regulations
- Review, and agree, the localities which will be used for the basis of the assessment

- Undertake an assessment of the pharmaceutical needs of the population and make recommendations based on this assessment

- Review, and refine if necessary, the criteria for necessary and relevant services and apply these to pharmaceutical services, taking into account stakeholder feedback including views from patients and the public

- To revisit choice and the principles used to determine if this is sufficient

- Determine the impact of changes which have occurred since the current PNA was written, including: changes to the application process which allow consolidation of contracts; the new remuneration arrangements for community pharmacy (which apply from 1 December 2016) and the Pharmacy Access Scheme

- Determine the maps which will be included in the PNA

- Approve the framework for the PNA

- Develop and approve a draft PNA for formal consultation with stakeholders

- Oversee the consultation ensuring that this meets the requirements set out in the Regulations

- Consider and act upon formal responses received during the formal consultation process, making appropriate amendments to the PNA

- Develop and approve a consultation report as required by the Regulations and ensure that this is included within the final PNA

- Submit the final PNA to the Health & Wellbeing Board for approval prior to publication

- Consider and document the processes by which the HWB will discharge its responsibilities in relation to maintaining the PNA; and formally responding to consultations initiated by neighbouring HWBs. This includes making a recommendation on the long term structures required to underpin these responsibilities

- Advise the HWB, if required, when consulted by NHS England in relation to consolidated applications

- Document and manage potential and actual conflicts of interests

4. Governance

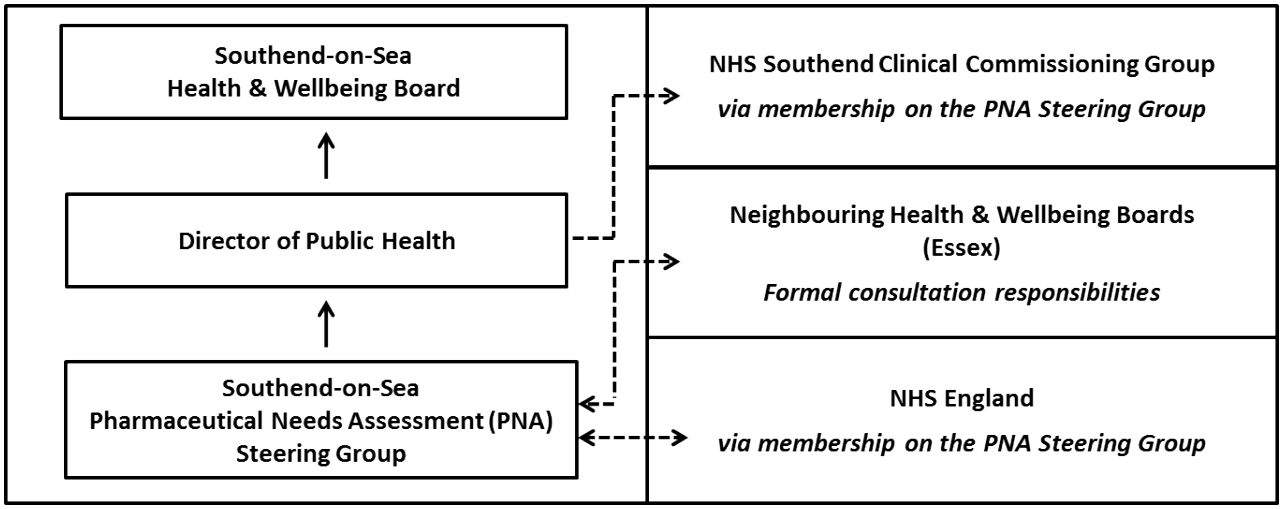
The following Governance arrangements have been established:

- The Southend-on-Sea HWB has delegated responsibility for the development and maintenance of the PNA; and for formally responding to consultations from neighbouring HWBs to Director of Public Health (DPH)

- The Southend-on-Sea PNA SG has been established to support the DPH with the discharge of all functions relating to the PNA. The PNA SG reports to the DPH and is accountable to the HWB through this route

- In addition, the PNA SG will keep the following organisations informed of progress:
    - NHS England via membership on PNA SG
    - NHS Southend CCG via membership on the PNA SG
- The final PNA will be presented to the HWB for approval prior to publication

The diagram below illustrates the accountability and reporting lines between the Southend-on-Sea PNA SG and the various committees and organisations with which it needs to interact with respect to discharging its responsibilities:



5. Meeting Frequency

The PNA SG will meet, either on a face to face basis or virtually (conference call or email discussion), approximately every 4 - 10 weeks, in accordance with the needs of the project plan.

Following publication of the final PNA, the PNA Steering Group will be convened on an 'as required' basis to:

- Fulfil its role in timely maintenance of the PNA
- Advise the HWB, when consulted by NHS England, in relation to consolidated applications

6. Project Management

Webstar Lane Ltd has been commissioned to provide project management support for the development of the PNA.

7. Membership

CORE MEMBERS	
Name	**Role**
James Williams	Chair & Southend-on-Sea BC Lead for the PNA
Karen Samuel-Smith	Essex Local Pharmaceutical Committee

Cathy Pedder	Essex Local Medical Committee
Jane Newman	Chair, Local Professional Network
Sally Watkins	Senior Public Health Intelligence Analyst, Southend-on-Sea BC
Sharon Gray	Contract Manager, NHS England (East)
Georgina Shanley	Primary Care Commissioning Officer, NHS England (East)
Vanessa Lane	PNA Project Manager

EXTENDED / ADVISORY MEMBERS	
Name	**Role**
Simon Williams	Associate Director Medicines Management, NHS Southend CCG
Lois Taylor	Prescribing Advisor, NHS Southend CCG
Mandy O'Calaghan	Healthwatch
Leanne Crabb	Senior Office, specific responsibility for engagement
Suzanne Newman	Senior Consultation and Participation Adviser, Southend-on-Sea BC
Grace Taylor	Engagement Officer – Policy, Engagement & Communication
Evelyn Allen	Director of Pharmacy, Southend University Hospital NHS FT
Louise Crowley	Community Health Services Lead Pharmacist, South Essex Partnership University NHS FT (SEPT)

The PNA SG may co-opt additional support and subject matter expertise as necessary. In carrying out its remit, the PNA SG may interface with a wider range of stakeholders.

8. Quorum

- Chair (or nominated deputy)
- Community Pharmacist (LPC, Pharmacy Local Professional Network or local contractor)
- Two other members
- Webstar Lane Representative

9. Approval

Original Terms of Reference Approved by the Southend-on-Sea Health & Wellbeing Board on 30 January 2014; Membership reviewed and updated by the PNA Steering Group on 11 February 2014

Revised Terms of Reference Approved by the Southend-on-Sea HWB on 22 March 2017

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Southend Health & Wellbeing Board

Agend
Item No

8

Joint Report of
Simon Leftley, Deputy Chief Executive (People), Southend Borough Council;
Ian Stidston, Interim Accountable Officer, Southend CCG

to

Health & Wellbeing Board

on

22 March 2017

Report prepared by:
Nick Faint BCF Programme Lead

For discussion		For information only		Approval required	X

Better Care Fund

2017/19 Plan

Part 1 (Public Agenda Item)

1 Purpose of Report

The purpose of this report is as follows;

1.1 To update members of the Health and Wellbeing Board (HWB) regarding the Better Care Fund (BCF) planning process for 2017/19; and

1.2 To agree delegated authority to the Deputy Chief Executive (People) (Southend-on-Sea Borough Council 'SBC') and the Interim Accountable Officer (Southend Clinical Commissioning Group 'SCCG') in conjunction with the Chair and Vice Chair of HWB to agree the BCF plan and to enable a submission to be made to NHS England in accordance with the planning guidance (not yet published).

2 Recommendations

HWB are asked to;

2.1 note the update for BCF 201/19;

2.2 agree delegated authority to the Deputy Chief Executive (People), SBC and the Interim Accountable Officer SCCG in conjunction with the Chair and Vice Chair of HWB to sign off the final BCF plan for 2017/19 on behalf of HWB; and

2.3 agree to the BCF plan 2017/19 being consulted amongst HWB partners as outlined in section 4.5 – 4.8.

3 Background & Context

3.1 The BCF for 2016/17 was established between SCCG and SBC from 1 April 2016. It is underpinned by a legal Section 75 Agreement between the two organisations that sets out the proposed schemes to be funded, the required flows of income into the pooled budget and the distribution back to the scheme / organisational leads.

3.2 Throughout the course of 2016/17 HWB has reported quarterly BCF activity to NHS England. The most recent return made to NHS England (3 March 2017) continued the theme of reporting that the Southend system continues to operate in challenging financial and operational circumstances but that integrated mitigations and projects are beginning to have an impact, key issues being reported were;

3.2.1 Non-elective admissions are higher than the previous years quarter but the trend is starting to decrease;

3.2.2 Admissions to residential care is stable and is being robustly managed within the context of transforming adult social care;

3.2.3 Delayed Transfers of Care (DToC) presents a significant challenge to both health and social care but is being robustly managed through a programme of DToC transformation; and

3.2.4 Reablement (those still at home 91 days after discharge) is on track and stable.

3.3 The three quarterly returns for 2016/17 are available at Appendix A

4 Southend BCF 2017/19

National

4.1 The policy and technical planning guidance and detailed direction to enable local areas to draft the BCF plans for 2017/19 is not yet published, the date for publication is currently unknown.

4.2 Attached at Appendix B is the most recent published guidance (Dec 2016). Summary points are;

4.2.1 The planning cycle will move from annual to biennial (once every two years) to align with NHS planning requirements;

4.2.2 Local areas will be invited to graduate from BCF which will provide areas with greater autonomy;

4.2.3 National conditions will reduce from eight to three; (1) plans jointly agree; (2) protection of social care; and (3) commissioning of out of hospital services;

4.2.4 Metrics to measure performance will continue to focus on non-elective admissions; admissions to residential care homes; reablement; and DToC;

Local

4.3 Whilst it is difficult to currently plan for BCF 2017/19 without national policy guidance an assurance process has already commenced between SBC and SCCG to review the impact and effectiveness of spend on current integrated services. The outcome of this process will help inform the BCF plan for 2017/19 once guidance has been published.

Timeline

4.4 The timeline is currently unknown.

Consultation and engagement

4.5 A national requirement for the BCF is that HWBs sign off, agree and are engaged in the planning process.

4.6 It is anticipated that following March 2017 HWB planning guidance will be published by NHS England and final / signed of plans will be required to be submitted prior to June 2017 HWB.

4.7 To meet the national requirement outlined in para 4.5 it is proposed that HWB are engaged and consulted with at a senior management level and virtually for Board members of the HWB, specifically;

4.7.1 Via the Locality Transformation Group (LTG) the BCF plan will be developed and the detail reviewed. LTG meets monthly and is attended by SBC, SCCG, SEPT and SUHFT. The group is chaired by the Director of Strategy, Commissioning & Procurement; and

4.7.2 Via virtual circulation of relevant documents, the HWB are distributed with the various planned submissions for review and comment;

4.8 The agreed plan and Section 75 agreement will be brought to the next appropriate HWB following March 2017.

5 Health & Wellbeing Board Priorities / Added Value

5.1 The BCF contributes to delivering HWB Strategy Ambitions in the following ways

5.2 Ambition 5 – Living Independently; through the promotion of prevention and engagement with residents, patients and staff the BCF will actively support individuals living independently.

5.3 Ambition 6 – Active and healthy ageing; through engaging and integrating health and social services within the community the services will be aligned to assisting individuals to age healthily and actively; and

5.4 Ambition 9 – Maximising opportunity; Overarching BCF; Southend is the drive to improve and integrate health and social services. Through initiatives within the BCF we will empower staff to personalize the integrated care individuals receive and residents to have a say in the care they receive.

6 Reasons for Recommendations

6.1 As part of its governance role, HWB has oversight of the Southend BCF 2017/19.

7 Financial / Resource Implications

7.1 None at this stage

8 Legal Implications

8.1 None at this stage

9 Equality & Diversity

9.1 The BCF plan should result in more efficient and effective provision for vulnerable people of all ages.

10 Appendices

Appendix A – Quarterly Returns	
Appendix B – Current planning guidance	

HWB Strategy Ambitions

Ambition 1. A positive start in life A. Children in care | B. Education- Narrow the gap | C. Young carers | D. Children's mental wellbeing | E. Teen pregnancy | F. Troubled families	**Ambition 2. Promoting healthy lifestyles** A. Tobacco – reducing use | B. Healthy weight | C. Substance & Alcohol misuse	**Ambition 3. Improving mental wellbeing** A. Holistic: Mental/physical | B. Early intervention | C. Suicide prevention/self-harm | D. Support parents/postnatal
Ambition 4. A safer population A. Safeguarding children and vulnerable adults | B. Domestic abuse | C. Tackling Unintentional injuries among under 15s	**Ambition 5. Living independently** A. Personalised budgets | B. Enabling community living |C. Appropriate accommodation | D. Personal involvement in care | E. Reablement | F. Supported to live independently for longer	**Ambition 6. Active and healthy ageing** A. Integrated health & social care services | B. Reducing isolation | C. Physical & mental wellbeing | D. Long Term conditions– support | E. Personalisation/ Empowerment
Ambition 7. Protecting health A. Increased screening | B. Increased immunisations | C. Infection control | D. Severe weather plans in place | E. Improving food hygiene	**Ambition 8. Housing** A. Partnership approach to; Tackle homelessness | B. Deliver health, care & housing in a more joined up way | C. Adequate affordable housing | D. Adequate specialist housing | E. Strategic understanding of stock and distribution	**Ambition 9. Maximising opportunity** A. Population vs. Organisational based provision | B. Joint commissioning and Integration | C. Tackling health inequality (improved access to services) | D. Opportunities to thrive; Education, Employment

Quarterly Reporting Template - Guidance

Notes for Completion

The data collection template requires the Health & Wellbeing Board to track through the high level metrics and deliverables from the Health & Wellbeing Board Better Care Fund plan.

The completed return will require sign off by the Health & Wellbeing Board.

A completed return must be submitted to the Better Care Support Team inbox (england.bettercaresupport@nhs.net) by midday on 9th September 2016.

The BCF Q1 Data Collection

This Excel data collection template for Q1 2016-17 focuses on budget arrangements, the national conditions, income and expenditure to and from the fund, and performance on BCF metrics.

To accompany the quarterly data collection Health & Wellbeing Boards are required to provide a written narrative into the final tab to contextualise the information provided in this report and build on comments included elsewhere in the submission. This should include an overview of progress with your BCF plan, the wider integration of health and social care services, and a consideration of any variances against planned performance trajectories or milestones.

Cell Colour Key

Data needs inputting in the cell
Pre-populated cells
Question not relevant to you

Throughout this template cells requiring a numerical input are restricted to values between 0 and 100,000,000.

Content

The data collection template consists of 8 sheets:

Checklist - This contains a matrix of responses to questions within the data collection template.
1) Cover Sheet - this includes basic details and tracks question completion.
2) Budget arrangements - this tracks whether Section 75 agreements are in place for pooling funds.
3) National Conditions - checklist against the national conditions as set out in the BCF Policy Framework 16-17 and BCF planning guidance.
4) Income and Expenditure - this tracks income into, and expenditure from, pooled budgets over the course of the year.
5) Supporting Metrics - this tracks performance against the two national metrics, a DTOC metric, a Non-Elective Admissions metric, locally set metric and locally defined patient experience metric in BCF plans.

6) Additional Measures - additional questions on new metrics that are being developed to measure progress in developing integrated, cooridnated, and person centred care.
7) Narrative - this allows space for the description of overall progress on BCF plan delivery and performance against key indicators.

Checklist

This sheet contains all the validations for each question in the relevant sections.

All validations have been coloured so that if a value does not pass the validation criteria the cell will be Red and contain the word "No" and if they pass validation they will be coloured Green and contain the word "Yes".

1) Cover Sheet

On the cover sheet please enter the following information:

The Health and Well Being Board
Who has completed the report, email and contact number in case any queries arise
Please detail who has signed off the report on behalf of the Health and Well Being Board

Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 7 cells are green should the template be sent to england.bettercaresupport@nhs.net

2) Budget Arrangements

This section requires the Health & Wellbeing Board to confirm if funds have been pooled via a Section 75 agreement. Please answer as at the time of completion.

Have the funds been pooled via a s.75 pooled budget?
If the answer to the above is 'No' please indicate when this will happen

3) National Conditions

This section requires the Health & Wellbeing Board to confirm whether the eight national conditions detailed in the Better Care Fund Policy Framework 16/17 (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/490559/BCF_Policy_Framework_2016-17.pdf) and Better Care Fund Planning Guidance 16/17 (http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/) have been met through the delivery of your plan. Please answer as at the time of completion.

It sets out the eight conditions and requires the Health & Wellbeing Board to confirm 'Yes', 'No' or 'No - In Progress' that these have been met. Should 'No' or 'No - In Progress' be selected, please provide an estimated date when condition will be met, an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed.

Full details of the conditions are detailed at the bottom of the page.

4) Income and Expenditure

This tracks income into, and expenditure from, pooled budgets over the course of the year. This requires provision of the following information:

Planned income into the pooled fund for each quarter of the 2016-17 financial year
Forecasted income into the pooled fund for each quarter of the 2016-17 financial year
Actual income into the pooled fund in Q1 2016-17
Planned expenditure from the pooled fund for each quarter of the 2016-17 financial year
Forecasted expenditure from the pooled fund for each quarter of the 2016-17 financial year
Actual expenditure from the pooled fund in Q1 2016-17

Figures should reflect the position by the end of each quarter. It is expected that the total planned income and planned expenditure figures for 2016-17 should equal the total pooled budget for the Health and Wellbeing Board.

There is also an opportunity to provide a commentary on progress which should include reference to any deviation from plan or amendments to forecasts made since the previous quarter.

5) Supporting Metrics

This tab tracks performance against the two national supporting metrics, a Delayed Transfers of Care metric, a Non-Elective Admissions metric, the locally set metric, and the locally defined patient experience metric submitted in approved BCF plans. In all cases the metrics are set out as defined in the approved plan for the HWB and the following information is required for each metric:

An update on indicative progress against the six metrics for Q1 2016-17
Commentary on progress against each metric

If the information is not available to provide an indication of performance on a measure at this point in time then there is a drop-down option to indicate this. Should a patient experience metric not have been provided in the original BCF plan or previous data returns there is an opportunity to state the metric that you are now using.

6) Additional Measures

This tab includes a handful of new metrics designed with the intention of gathering some detailed intelligence on local progress against some key elements of person-centred, co-ordinated care. Following feedback from colleagues across the system these questions have been modified from those that appeared in the last BCF Quarterly Data Collection Template (Q2 /Q3/Q4 2015-16). Nonetheless, they are still in draft form, and the Department of Health are keen to receive feedback on how they could be improved / any complications caused by the way that they have been posed.

For the question on progress towards instillation of Open APIs, if an Open API is installed and live in a given setting, please state 'Live' in the 'Projected 'go-live' date field.
For the question on use and prevalence of Multi-Disciplinary/Integrated Care Teams please choose your answers based on the proportion of your localities within which Multi-Disciplinary/Integrated Care Teams are in use.

For the PHB metric, areas should include all age groups, as well as those PHBs that form part of a jointly-funded package of care which may be administered by the NHS or by a partner organisation on behalf of the NHS (e.g. local authority). Any jointly funded personal budgets that include NHS funding are automatically counted as a personal health budget. We have expanded this definition following feedback received during the Q3 reporting process, and to align with other existing PHB data collections.

7) Narrative

In this tab HWBs are asked to provide a brief narrative on overall progress, reflecting on performance in Q1 16/17.

Better Care Fund Template Q1 2016/17

Data Collection Question Completion Checklist

1. Cover

Health and Well Being Board	completed by:	e-mail:	contact number:	Who has signed off the report on behalf of the Health and Well Being Board:
Yes	Yes	Yes	Yes	Yes

2. Budget Arrangements

Have funds been pooled via a S.75 pooled budget? If no, date provided?
Yes

3. National Conditions

			7 day services		
	1) Are the plans still jointly agreed?	2) Maintain provision of social care services	3i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	3ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken (Standard 9)?	4i) Is the NHS Number being used as the consistent identifier for health and social care services?
Please Select (Yes, No or No - In Progress)	Yes	Yes	Yes	Yes	Yes
If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	Yes	Yes	Yes	Yes	Yes
If the answer is "No" or "No - In Progress" please provide an explanation as to why the condition was not met within the quarter (in-line with signed off plan) and how this is being addressed?	Yes	Yes	Yes	Yes	Yes

4. I&E (2 parts)

		Q1 2016/17	Q2 2016/17	Q3 2016/17
Income to	Plan	Yes	Yes	Yes
	Forecast	Yes	Yes	Yes
	Actual	Yes		
	Please comment if there is a difference between the annual totals and the pooled fund	Yes		
Expenditure From	Plan	Yes	Yes	Yes
	Forecast	Yes	Yes	Yes
	Actual	Yes		
	Please comment if there is a difference between the annual totals and the pooled fund	Yes		
Commentary on progress against financial plan:		Yes		

5. Supporting Metrics

		Please provide an update on indicative progress against the metric?	Commentary on progress
NEA		Yes	Yes
DTOC		Yes	Yes
Local performance metric		Yes	Yes
Patient experience metric	If no metric, please specify	Yes	Yes
Admissions to residential care		Yes	Yes
Reablement		Yes	Yes

6. Additional Measures

	GP	Hospital	Social Care	Community	Mental health
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes

	To GP	To Hospital	To Social Care	To Community	To Mental health
From GP	Yes	Yes	Yes	Yes	Yes
From Hospital	Yes	Yes	Yes	Yes	Yes
From Social Care	Yes	Yes	Yes	Yes	Yes
From Community	Yes	Yes	Yes	Yes	Yes
From Mental Health	Yes	Yes	Yes	Yes	Yes
From Specialised Palliative	Yes	Yes	Yes	Yes	Yes

	GP	Hospital	Social Care	Community	Mental health
Progress status	Yes	Yes	Yes	Yes	Yes
Projected 'go-live' date (mm/yy)	Yes	Yes	Yes	Yes	Yes

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?
Yes

Total number of PHBs in place at the end of the quarter	Yes
Number of new PHBs put in place during the quarter	Yes
Number of existing PHBs stopped during the quarter	Yes

Of all residents using PHBs at the end of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	Yes

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the non-acute setting?	Yes
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the acute setting?	Yes

7. Narrative

Brief Narrative	Yes

Data sharing			
4ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	4iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	4iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	5) Is there a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional
Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes

Q4 2016/17
Yes
Yes

Yes
Yes

Specialised palliative
Yes
Yes

To Specialised palliative
Yes
Yes
Yes
Yes
Yes
Yes

Specialised palliative
Yes
Yes

Cover

Q1 2016/17	
Health and Well Being Board	**Southend-on-Sea**
completed by:	nick faint
E-Mail:	nickfaint@southend.gov.uk
Contact Number:	01702 212 113
Who has signed off the report on behalf of the Health and Well Being Board:	Clr Lesley Salter, Chair HWB

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

	No. of questions answered
1. Cover	5
2. Budget Arrangements	2
3. National Conditions	36
4. I&E	21
5. Supporting Metrics	13
6. Additional Measures	67
7. Narrative	1

Budget Arrangements

Selected Health and Well Being Board:	Southend-on-Sea

Have the funds been pooled via a s.75 pooled budget?	Yes
If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	

National Conditions

Selected Health and Well Being Board: Southend-on-Sea

The BCF policy framework for 2016-17 and BCF planning guidance sets out eight national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these have been met, as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include an explanation as to why the condition was not met within this quarter (in-line with signed off plan) and how this is being addressed?

Condition (please refer to the detailed definition below)	Please Select ('Yes', 'No' or 'No - In Progress')	If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	If the answer is "No" or "No - In Progress" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:
1) Plans to be jointly agreed	Yes		
2) Maintain provision of social care services	Yes		
3) In respect of 7 Day Services - please confirm:			
i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	Yes		
ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken (Standard 9)?	Yes		
4) In respect of Data Sharing - please confirm:			
i) Is the NHS Number being used as the consistent identifier for health and social care services?	Yes		
ii) Are you pursuing Open APIs (ie system that speak to each other)?	Yes		
iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	Yes		
iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	Yes		
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Yes		
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes		
7) Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care	Yes		
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes		

National conditions - detailed definitions

The BCF policy framework for 2016-17 and BCF planning guidance sets out eight national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with health and social care providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. Furthermore, there should be joint agreement across commissioners and providers as to how the Better Care Fund will contribute to a longer term strategic plan. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences. The Disabled Facilities Grant (DFG) will again be allocated through the Better Care Fund. Local housing authority representatives should therefore be involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing.

2) Maintain provision of social care services

Local areas must include an explanation of how local adult social care services will continue to be supported within their plans in a manner consistent with 2015-16.

The definition of support should be agreed locally. As a minimum, it should maintain in real terms the level of protection as provided through the mandated minimum element of local Better Care Fund agreements of 2015-16. This reflects the real terms increase in the Better Care Fund.

In setting the level of protection for social care localities should be mindful to ensure that any change does not destabilise the local social and health care system as a whole. This will be assessed compared to 2015-16 figures through the regional assurance process.

It should also be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate.

Local areas are asked to confirm how their plans will provide 7-day services (throughout the week, including weekends) across community, primary, mental health, and social care in order:

• To prevent unnecessary non-elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week;
• To support the timely discharge of patients, from acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care. If they are not able to provide such plans, they must explain why.

The 10 clinical standards developed by the NHS Services, Seven Days a Week Forum represent, as a whole, best practice for quality care on every day of the week and provide a useful reference for commissioners (https://www.england.nhs.uk/wp-content/uploads/2013/12/clinical-standards1.pdf).
By 2020 all hospital in-patients admitted through urgent and emergency routes in England will have access to services which comply with at least 4 of these standards on every day of the week, namely Standards 2, 5, 6 and 8. For the Better Care Fund, particular consideration should be given to whether progress is being made against Standard 9. This standard highlights the role of support services in the provision of the next steps in a person's care pathway following admission to hospital, as determined by the daily consultant-led review, and the importance of effective relationships between medical and other health and social care teams.

4) Better data sharing between health and social care, based on the NHS number

The appropriate and lawful sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a consistent identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.

Local areas should:
• confirm that they are using the NHS Number as the consistent identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary security and controls (https://www.england.nhs.uk/wp-content/uploads/2014/05/open-api-policy.pdf; and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA), and if not, when they plan for it to be in place.
• ensure that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights. In line with the recommendations from the National Data Guardian review.

The Information Governance Alliance (IGA) is a group of national health and care organisations (including the Department of Health, NHS England, Public Health England and the Health and Social Care Information Centre) working together to provide a joined up and consistent approach to information governance and provide access to a central repository guidance on data access issues for the health and care system. See - http://systems.hscic.gov.uk/infogov/iga

5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Local areas should identify which proportion of their population will be receiving case management and named care coordinator, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by care coordinators, for example dementia advisors.

6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

The impact of local plans should be agreed with relevant health and social care providers. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. This should complement the planning guidance issued to NHS organisations.

There is agreement that there is much more to be done to ensure mental and physical health are considered equal and better integrated with one another, as well as with other services such as social care. Plans should therefore give due regard to this.

7) Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care

Local areas should agree how they will use their share of the £1 billion that had previously been used to create the payment for performance fund.

This should be achieved in one of the following ways:

- To fund NHS commissioned out-of-hospital services, which may include a wide range of services including social care, as part of their agreed Better Care Fund plan; or

- Local areas can choose to put an appropriate proportion of their share of the £1bn into a local risk-sharing agreement as part of contingency planning in the event of excess activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services including social care (local areas should seek, as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 15-16);

This condition replaces the Payment for Performance scheme included in the 2015-16 Better Care Fund framework.

8) Agreement on local action plan to reduce delayed transfers of care (DTOC)

Given the unacceptable high levels of DTOC currently, the Government is exploring what further action should be taken to address the issue.

As part of this work, under the Better Care Fund, each local area is to develop a local action plan for managing DTOC, including a locally agreed target.

All local areas need to establish their own stretching local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts. This target should be reflected in CCG operational plans. The metric for the target should be the same as the national performance metric (average delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both) per month.

As part of this plan, we want local areas to consider the use of local risk sharing agreements with respect to DTOC, with clear reference to existing guidance and flexibilities. This will be particularly relevant in areas where levels of DTOC are high and rising.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with the relevant acute and community trusts and be able to demonstrate that the plan has been agreed with the providers given the need for close joint working on the DTOC issue.

We would expect plans to:

• Set out clear lines of responsibility, accountabilities, and measures of assurance and monitoring;
• Take account of national guidance, particularly the NHS High Impact Interventions for Urgent and Emergency Care, the NHS England Monthly Delayed Transfers of Care Situation Reports Definition and Guidance, and best practice with regards to reducing DTOC from LGA and ADASS;
• Demonstrate how activities across the whole patient pathway can support improved patient flow and DTOC performance, specifically around admissions avoidance;
• Demonstrate consideration to how all available community capacity within local geographies can be effectively utilised to support safe and effective discharge, with a shared approach to monitoring this capacity;
• Demonstrate how CCGs and Local Authorities are working collaboratively to support sustainable local provider markets, build the right capacity for the needs of the local population, and support the health and care workforce - ideally through joint commissioning and workforce strategies;
• Demonstrate engagement with the independent and voluntary sector providers.

Plan, forecast, and actual figures for total income into, and total expenditure from, the fund for each quarter to year end (in both cases the year-end figures should equal the total pooled fund)

Selected Health and Well Being Board: Southend-on-Sea

Income

Q1 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Total BCF pooled budget for 2016-17 (Rounded)
Please provide, plan, forecast and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	£13,131,049
	Forecast	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	
	Actual*	£3,282,763					
Please comment if one of the following applies: - There is a difference between the planned / forecasted annual totals and the pooled fund - The Q1 actual differs from the Q1 plan and / or Q1 forecast							

Expenditure

Q1 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Total BCF pooled budget for 2016-17 (Rounded)
Please provide, plan, forecast and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	£13,131,049
	Forecast	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	
	Actual*	£3,282,763					
Please comment if one of the following applies: - There is a difference between the planned / forecasted annual totals and the pooled fund - The Q1 actual differs from the Q1 plan and / or Q1 forecast							

Commentary on progress against financial plan:	n/a

Footnotes:

*Actual figures should be based on the best available information held by Health and Wellbeing Boards.
Source: For the pooled fund which is pre-populated, the data is from a quarterly collection previously filled in by the HWB and has been rounded to the nearest whole number.

National and locally defined metrics

Selected Health and Well Being Board:	Southend-on-Sea

Non-Elective Admissions	Reduction in non-elective admissions
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Pressure within the hospital continues. Our plans to reduce non-elective admissions continue to gather momentum through the introduction of the Locality approach, Complex Care Co-ordination service, End of Life pathway redesign and our engagement with the Essex Success Regime.

Delayed Transfers of Care	Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	We have a System agreed plan re DToC that will continue our historically strong performance in managing our system DToC rates. The delivery of the DToC plan is both monitored and managed at a System level. Operational management has an agreed process to excalate. The management teams within both health and social care continue to ensure operational resources are in place to deliver the demanding agreed DToC rates and that the

Local performance metric as described in your approved BCF plan	People with a LTC feeling supported to manage their condition. Numerator and Denominators are not available for Southend
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Our BCF activity is focused on providing an integrated health and social care service for patients with complex care needs. We are planning the configuration of these services and expect for the work to have an impact on this performance metric through 2016 and into 2017. Data for this metric for period July 16 - March 17 will not be available until Sep 17.

Local defined patient experience metric as described in your approved BCF plan	Friends and Family Net promoter score - SUFHT In Patient wards
If no local defined patient experience metric has been specified, please give details of the local defined patient experience metric now being used.	
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Our current performance for Q1 16/17 is 91.2% against a target of 91.7%.

Admissions to residential care	Rate of permanent admissions to residential care per 100,000 population (65+)
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Southend is operating in the context of budget reductions that are set to continue well into 2018. To address these reduced budgets and deliver a more integrated service for our residents Southend on Sea Borough Council is in the process of transforming Adult Social Care. We are, therefore, anticipating, that our residential care admissions will stay at the same levels for 16/17 as they were for 15/16.

Additional Measures

Selected Health and Well Being Board: Southend-on-Sea

Improving Data Sharing: (Measures 1-3)

1. Proposed Measure: Use of NHS number as primary identifier across care settings

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	No	No
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

2. Proposed Measure: Availability of Open APIs across care settings

Please indicate across which settings relevant service-user information is currently being shared digitally (via Open APIs or interim solutions)

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Shared via Open API	Shared via Open API	Not currently shared digitally	Shared via Open API	Shared via Open API	Not currently shared digitally
From Hospital	Shared via Open API	Shared via Open API	Not currently shared digitally	Shared via Open API	Shared via Open API	Not currently shared digitally
From Social Care	Not currently shared digitally	Not currently shared digitally	Shared via Open API	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Community	Shared via Open API	Shared via Open API	Not currently shared digitally	Shared via Open API	Shared via Open API	Not currently shared digitally
From Mental Health	Shared via Open API	Shared via Open API	Not currently shared digitally	Shared via Open API	Shared via Open API	Not currently shared digitally
From Specialised Palliative	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Shared via Open API

In each of the following settings, please indicate progress towards instillation of Open APIs to enable information to be shared with other organisations

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	In development	In development	In development	In development	In development	In development
Projected 'go-live' date (dd/mm/yy)	31/03/17	31/03/17	31/03/17	31/03/17	31/03/17	31/03/17

3. Proposed Measure: Is there a Digital Integrated Care Record pilot currently underway?

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	Pilot being scoped

Other Measures: Measures (4-5)

4. Proposed Measure: Number of Personal Health Budgets per 100,000 population

Total number of PHBs in place at the end of the quarter	24
Rate per 100,000 population	13

Number of new PHBs put in place during the quarter	7
Number of existing PHBs stopped during the quarter	17
Of **all** residents using PHBs at the **end** of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	94%

Population (Mid 2016)	180,589

5. Proposed Measure: Use and prevalence of Multi-Disciplinary/Integrated Care Teams

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **non-acute** setting?	Yes - in some parts of Health and Wellbeing Board area
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **acute** setting?	Yes - throughout the Health and Wellbeing Board area

Footnotes:

Population projections are based on Subnational Population Projections, Interim 2014-based (published May 2016).
http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Q4 15/16 population figures onwards have been updated to the mid-year 2016 estimates as we have moved into the new calendar year.

Narrative

Selected Health and Well Being Board:	Southend-on-Sea

Remaining Characters	31,872

Please provide a brief narrative on overall progress, reflecting on performance in Q1 16/17. Please also make reference to performance across any other relevant areas that are not directly reported on within this template.

Non Elective, residential admissions and DToC

We are delighted that our BCF plan for 2016/17 was approved by NHS England at the end of June 2016. Our plans for 2015/16 were delivered and surpassed as previously submitted in our quarterly returns. For 2016/17 our BCF plan will focus on further reductions in Non Elective admissions, maintaining the performance for residential care admissions achieved in 15/16 against a backdrop of transofrmational change and continuing to deliver strong DToC performance. To achieve these objectives our plans to transform existing services include implementing a Locality approach, commissioning a complex care co-ordination service and engagement with the Essex Success Regime.

Our robust governance structure assures the system that plans are on track and that all partners are engaged.

Income & Expenditure

Income & Expenditure has remained on plan.

Quarterly Reporting Template - Guidance

Notes for Completion

The data collection template requires the Health & Wellbeing Board to track through the high level metrics and deliverables from the Health & Wellbeing Board Better Care Fund plan.

The completed return will require sign off by the Health & Wellbeing Board.

A completed return must be submitted to the Better Care Support Team inbox (england.bettercaresupport@nhs.net) by midday on 25th November 2016

The BCF Q1 Data Collection

This Excel data collection template for Q2 2016-17 focuses on budget arrangements, the national conditions, income and expenditure to and from the fund, and performance on BCF metrics.

To accompany the quarterly data collection Health & Wellbeing Boards are required to provide a written narrative into the final tab to contextualise the information provided in this report and build on comments included elsewhere in the submission. This should include an overview of progress with your BCF plan, the wider integration of health and social care services, and a consideration of any variances against planned performance trajectories or milestones.

Cell Colour Key

Data needs inputting in the cell
Pre-populated cells
Question not relevant to you

Throughout this template cells requiring a numerical input are restricted to values between 0 and 100,000,000.

Content

The data collection template consists of 8 sheets:

Checklist - This contains a matrix of responses to questions within the data collection template.
1) Cover Sheet - this includes basic details and tracks question completion.
2) Budget arrangements - this tracks whether Section 75 agreements are in place for pooling funds.
3) National Conditions - checklist against the national conditions as set out in the BCF Policy Framework 16-17 and BCF planning guidance.
4) Income and Expenditure - this tracks income into, and expenditure from, pooled budgets over the course of the year.
5) Supporting Metrics - this tracks performance against the two national metrics, a DTOC metric, a Non-Elective Admissions metric, locally set metric and locally defined patient experience metric in BCF plans.

6) Additional Measures - additional questions on new metrics that are being developed to measure progress in developing integrated, cooridnated, and person centred care.
7) Narrative - this allows space for the description of overall progress on BCF plan delivery and performance against key indicators.

Checklist

This sheet contains all the validations for each question in the relevant sections.

All validations have been coloured so that if a value does not pass the validation criteria the cell will be Red and contain the word "No" and if they pass validation they will be coloured Green and contain the word "Yes".

1) Cover Sheet

On the cover sheet please enter the following information:

The Health and Well Being Board
Who has completed the report, email and contact number in case any queries arise
Please detail who has signed off the report on behalf of the Health and Well Being Board

Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 7 cells are green should the template be sent to england.bettercaresupport@nhs.net

2) Budget Arrangements

This section requires the Health & Wellbeing Board to confirm if funds have been pooled via a Section 75 agreement. Please answer as at the time of completion.

If it had not been previously stated that the funds had been pooled can you now confirm that they have now?
If the answer to the above is 'No' please indicate when this will happen

3) National Conditions

This section requires the Health & Wellbeing Board to confirm whether the eight national conditions detailed in the Better Care Fund Policy Framework 16/17 (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/490559/BCF_Policy_Framework_2016-17.pdf) and Better Care Fund Planning Guidance 16/17 (http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/) have been met through the delivery of your plan. Please answer as at the time of completion.

It sets out the eight conditions and requires the Health & Wellbeing Board to confirm 'Yes', 'No' or 'No - In Progress' that these have been met. Should 'No' or 'No - In Progress' be selected, please provide an estimated date when condition will be met, an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed.

Full details of the conditions are detailed at the bottom of the page.

4) Income and Expenditure

This tracks income into, and expenditure from, pooled budgets over the course of the year. This requires provision of the following information:

Forecasted income into the pooled fund for each quarter of the 2016-17 financial year
Actual income into the pooled fund in Q1 & Q2 2016-17
Forecasted expenditure from the pooled fund for each quarter of the 2016-17 financial year
Actual expenditure from the pooled fund in Q1 & Q2 2016-17

Figures should reflect the position by the end of each quarter. It is expected that the total planned income and planned expenditure figures for 2016-17 should equal the total pooled budget for the Health and Wellbeing Board.

There is also an opportunity to provide a commentary on progress which should include reference to any deviation from plan or amendments to forecasts made since the previous quarter.

5) Supporting Metrics

This tab tracks performance against the two national supporting metrics, a Delayed Transfers of Care metric, a Non-Elective Admissions metric, the locally set metric, and the locally defined patient experience metric submitted in approved BCF plans. In all cases the metrics are set out as defined in the approved plan for the HWB and the following information is required for each metric:

An update on indicative progress against the six metrics for Q2 2016-17
Commentary on progress against each metric

If the information is not available to provide an indication of performance on a measure at this point in time then there is a drop-down option to indicate this. Should a patient experience metric not have been provided in the original BCF plan or previous data returns there is an opportunity to state the metric that you are now using.

Guidance on accessing CCG based NEA numerator data from SUS via the 'Activity and Planning Report' has been circulated in tandem with this report in order to enable areas to perform their own in year monitoring of NEA data. This guidance document can also be accessed via the embeded object below.

Guide to accessing CCG based NEA data from SUS via

NEA denominator population (All ages) projections are based on Subnational Population Projections, Interim 2014-based (published May 2016) found here:
http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Please note that the Non-Elective Admissions per 100,000 population (All ages) population projections are based on a calendar year.

Delayed Transfers Of Care numerator data for actual performance has been sourced from the monthly DTOC return found here:
http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/

DTOC denominator population (18+) projections are based on Subnational Population Projections, Interim 2014-based (published May 2016) found here:
http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1

Please note that the Delayed Transfers Of Care (delayed days) from hospital per 100,000 population (aged 18+) population projections are based on a calendar year.

Actual and baseline data on Re-ablement and Residential Admissions can be sourced from the annual ASCOF return found here:
http://content.digital.nhs.uk/searchcatalogue?productid=22085&q=ascof
Please note these are annual measures and the latest data for 2015/16 data was published 05/10/2016. Plan data for these metrics in 2016/17 were submitted by HWBs within Submission 4 planning returns and final figures are displayed within the 'Remaining Metrics Enquiry' tab of the Submission 4 report.

6) Additional Measures

This tab includes a handful of new metrics designed with the intention of gathering some detailed intelligence on local progress against some key elements of person-centred, co-ordinated care. Following feedback from colleagues across the system these questions have been modified from those that appeared in last years BCF Quarterly Data Collection Template (Q2/Q3/Q4 2015-16). Nonetheless, they are still in draft form, and the Department of Health are keen to receive feedback on how they could be improved / any complications caused by the way that they have been posed.

For the question on progress towards instillation of Open APIs, if an Open API is installed and live in a given setting, please state 'Live' in the 'Projected 'go-live' date field.
For the question on use and prevalence of Multi-Disciplinary/Integrated Care Teams please choose your answers based on the proportion of your localities within which Multi-Disciplinary/Integrated Care Teams are in use.

For the PHB metric, areas should include all age groups, as well as those PHBs that form part of a jointly-funded package of care which may be administered by the NHS or by a partner organisation on behalf of the NHS (e.g. local authority). Any jointly funded personal budgets that include NHS funding are automatically counted as a personal health budget. We have expanded this definition following feedback received during the Q3 reporting process, and to align with other existing PHB data collections.

7) Narrative

In this tab HWBs are asked to provide a brief narrative on overall progress, reflecting on performance in Q2 16/17.
A recommendation would be to offer a narrative around the stocktake themes as below:
Highlights and successes
What would you consider to be your most significant area of success, or development since the last quarter? What has contributed to this improvement?
Challenges and concerns
Does the information on National Conditions and Supporting metrics point to any issues or areas of improvement? Are there any new anticipated challenges for the coming quarter?
Potential actions and support
What actions could be taken and what support could be offered to address performance challenges and capitalise on successes for subsequent quarters?

Better Care Fund Template Q2 2016/17

Data Collection Question Completion Checklist

1. Cover

Health and Well Being Board	completed by:	e-mail:	contact number:	Who has signed off the report on behalf of the Health and Well Being Board:
Yes	Yes	Yes	Yes	Yes

2. Budget Arrangements

Funds pooled via a S.75 pooled budget? If not previously stated that the funds had been pooled can you confirm that they have now? If no, date provided?
Yes

3. National Conditions

			7 day services		
	1) Are the plans still jointly agreed?	2) Maintain provision of social care services	3i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	3ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken (Standard 9)?	4i) Is the NHS Number being used as the consistent identifier for health and social care services?
Please Select (Yes, No or No - In Progress)	Yes	Yes	Yes	Yes	Yes
If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	Yes	Yes	Yes	Yes	Yes
If the answer is "No" or "No - In Progress" please provide an explanation as to why the condition was not met within the quarter (in-line with signed off plan) and how this is being addressed?	Yes	Yes	Yes	Yes	Yes

4. I&E (2 parts)

		Q1 2016/17	Q2 2016/17	Q3 2016/17
Income to	Forecast	Yes	Yes	Yes
	Actual	Yes	Yes	
	Please comment if there is a difference between the annual totals and the pooled fund	Yes		
Expenditure From	Forecast	Yes	Yes	Yes
	Actual	Yes	Yes	
	Please comment if there is a difference between the annual totals and the pooled fund	Yes		
Commentary on progress against financial plan:		Yes		

5. Supporting Metrics

		Please provide an update on indicative progress against the metric?	Commentary on progress
	NEA	Yes	Yes
	DTOC	Yes	Yes
	Local performance metric	Yes	Yes
If no metric, please specify		Please provide an update on indicative progress against the metric?	Commentary on progress
Patient experience metric	Yes	Yes	Yes
	Admissions to residential care	Yes	Yes
	Reablement	Yes	Yes

6. Additional Measures

	GP	Hospital	Social Care	Community	Mental health
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes

	To GP	To Hospital	To Social Care	To Community	To Mental health
From GP	Yes	Yes	Yes	Yes	Yes
From Hospital	Yes	Yes	Yes	Yes	Yes
From Social Care	Yes	Yes	Yes	Yes	Yes
From Community	Yes	Yes	Yes	Yes	Yes
From Mental Health	Yes	Yes	Yes	Yes	Yes
From Specialised Palliative	Yes	Yes	Yes	Yes	Yes

	GP	Hospital	Social Care	Community	Mental health
Progress status	Yes	Yes	Yes	Yes	Yes
Projected 'go-live' date (mm/yy)	Yes	Yes	Yes	Yes	Yes

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?
Yes

Total number of PHBs in place at the end of the quarter	Yes
Number of new PHBs put in place during the quarter	Yes
Number of existing PHBs stopped during the quarter	Yes
Of all residents using PHBs at the end of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	Yes

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the non-acute setting?	Yes
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the acute setting?	Yes

7. Narrative

Brief Narrative	Yes

Data sharing			
4ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	4iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	4iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	5) Is there a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional
Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes

Q4 2016/17
Yes

Yes

Specialised palliative
Yes
Yes

To Specialised palliative
Yes
Yes
Yes
Yes
Yes
Yes

Specialised palliative
Yes
Yes

Cover

Q2 2016/17	
Health and Well Being Board	**Southend-on-Sea**
completed by:	Nick Faint
E-Mail:	nickfaint@southend.gov.uk
Contact Number:	01702 212 113
Who has signed off the report on behalf of the Health and Well Being Board:	Chair of HWB

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

	No. of questions answered
1. Cover	5
2. Budget Arrangements	1
3. National Conditions	36
4. I&E	15
5. Supporting Metrics	13
6. Additional Measures	67
7. Narrative	1

Budget Arrangements

Selected Health and Well Being Board:	Southend-on-Sea

Have the funds been pooled via a s.75 pooled budget?	Yes
If it had not been previously stated that the funds had been pooled can you confirm that they have now?	
If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	

Footnotes:

Source: For the S.75 pooled budget question, which is pre-populated, the data is from a previous quarterly collection returned by the HWB.

National Conditions

Selected Health and Well Being Board: Southend-on-Sea

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these have been met, as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include an explanation as to why the condition was not met within this quarter (in-line with signed off plan) and how this is being addressed?

Condition (please refer to the detailed definition below)	Q1 Submission Response	Please Select ('Yes', 'No' or 'No - In Progress')	If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	If the answer is "No" or "No - In Progress" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:
1) Plans to be jointly agreed	Yes	Yes		
2) Maintain provision of social care services	Yes	Yes		
3) In respect of 7 Day Services - please confirm:				
i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	Yes	Yes		
ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken (Standard 9)?	Yes	Yes		
4) In respect of Data Sharing - please confirm:				
i) Is the NHS Number being used as the consistent identifier for health and social care services?	Yes	Yes		
ii) Are you pursuing Open APIs (ie system that speak to each other)?	Yes	Yes		
iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	Yes	Yes		
iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	Yes	Yes		
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Yes	Yes		
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes	Yes		
7) Agreement to invest in NHS commissioned out-of-hospital services	Yes	Yes		
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes	Yes		

National conditions - detailed definitions

The BCF policy framework for 2016-17 and BCF planning guidance sets out eight national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissionin

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with health and social care providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. Furthermore, there should be joint agreement across commissioners and providers as to how the Better Car will contribute to a longer term strategic plan. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service consequences. The Disabled Facilities Grant (DFG) will again be allocated through the Better Care Fund. Local housing authority representatives should therefore be involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing.

2) Maintain provision of social care services
Local areas must include an explanation of how local adult social care services will continue to be supported within their plans in a manner consistent with 2015-16.

The definition of support should be agreed locally. As a minimum, it should maintain in real terms the level of protection as provided through the mandated minimum element of local Better Care Fund agreements of 2015-16. This reflects the real terms increase in the Better Care Fund.

In setting the level of protection for social care localities should be mindful to ensure that any change does not destabilise the local social and health care system as a whole. This will be assessed compared to 2015-16 figures through the regional assurance process.

It should also be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate.
Local areas are asked to confirm how their plans will provide 7-day services (throughout the week, including weekends) across community, primary, mental health, and social care in order:

• To prevent unnecessary non-elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week;
• To support the timely discharge of patients, from acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care. If they are not able to provide such plans, they must explain why.

The 10 clinical standards developed by the NHS Services, Seven Days a Week Forum represent, as a whole, best practice for quality care on every day of the week and provide a useful reference for commissioners (https://www.england.nhs.uk/wp-content/uploads/2013/12/clinical-standards1.pdf).
By 2020 all hospital in-patients admitted through urgent and emergency routes in England will have access to services which comply with at least 4 of these standards on every day of the week, namely Standards 2, 5, 6 and 8. For the Better Care Fund, particular consideration should be given to whether progress is being made agains Standard 9. This standard highlights the role of support services in the provision of the next steps in a person's care pathway following admission to hospital, as determined by the daily consultant-led review, and the importance of effective relationships between medical and other health and social care teams.

4) Better data sharing between health and social care, based on the NHS number
The appropriate and lawful sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a consistent identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of informati also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.

Local areas should:
• confirm that they are using the NHS Number as the consistent identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary security and controls (https://www.england.nhs.uk/wp-content/uploads/2014/05/open-api-policy.pdf; and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA), and if not, when they plan for it to be in place.
• ensure that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights. In line with the recommendations from the National Data Guardian review.

The Information Governance Alliance (IGA) is a group of national health and care organisations (including the Department of Health, NHS England, Public Health England and the Health and Social Care Information Centre) working together to provide a joined up and consistent approach to information governance and provide access central repository guidance on data access issues for the health and care system. See - http://systems.hscic.gov.uk/infogov/iga

5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Local areas should identify which proportion of their population will be receiving case management and named care coordinator, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated he social care services, supported by care coordinators, for example dementia advisors.

6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

The impact of local plans should be agreed with relevant health and social care providers. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. This should complement the planning guidance issued to NHS organisations.

There is agreement that there is much more to be done to ensure mental and physical health are considered equal and better integrated with one another, as well as with other services such as social care. Plans should therefore give due regard to this.

7) Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care

Local areas should agree how they will use their share of the £1 billion that had previously been used to create the payment for performance fund.

This should be achieved in one of the following ways:

- To fund NHS commissioned out-of-hospital services, which may include a wide range of services including social care, as part of their agreed Better Care Fund plan; or

- Local areas can choose to put an appropriate proportion of their share of the £1bn into a local risk-sharing agreement as part of contingency planning in the event of excess activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services including social care (local areas should seek, as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 15-16);

This condition replaces the Payment for Performance scheme included in the 2015-16 Better Care Fund framework.

8) Agreement on local action plan to reduce delayed transfers of care (DTOC)
Given the unacceptable high levels of DTOC currently, the Government is exploring what further action should be taken to address the issue.

As part of this work, under the Better Care Fund, each local area is to develop a local action plan for managing DTOC, including a locally agreed target.

All local areas need to establish their own stretching local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts. This target should be reflected in CCG operational plans. The metric for the target should be the same as the national performance metric (average delayed transfers of care (de days) per 100,000 population (attributable to either NHS, social care or both) per month.

As part of this plan, we want local areas to consider the use of local risk sharing agreements with respect to DTOC, with clear reference to existing guidance and flexibilities. This will be particularly relevant in areas where levels of DTOC are high and rising.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with the relevant acute and community trusts and be able to demonstrate that the plan has been agreed with the providers given the need for close joint working on the DTOC issue.

We would expect plans to:

• Set out clear lines of responsibility, accountabilities, and measures of assurance and monitoring;
• Take account of national guidance, particularly the NHS High Impact Interventions for Urgent and Emergency Care, the NHS England Monthly Delayed Transfers of Care Situation Reports Definition and Guidance, and best practice with regards to reducing DTOC from LGA and ADASS;
• Demonstrate how activities across the whole patient pathway can support improved patient flow and DTOC performance, specifically around admissions avoidance;
• Demonstrate consideration to how all available community capacity within local geographies can be effectively utilised to support safe and effective discharge, with a shared approach to monitoring this capacity;
• Demonstrate how CCGs and Local Authorities are working collaboratively to support sustainable local provider markets, build the right capacity for the needs of the local population, and support the health and care workforce - ideally through joint commissioning and workforce strategies;
• Demonstrate engagement with the independent and voluntary sector providers.

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Plan, forecast, and actual figures for total income into, and total expenditure from, the fund for each quarter to year end (in both cases the year-end figures should equal the total pooled fund)

Selected Health and Well Being Board: Southend-on-Sea

Income

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	£13,131,049
	Forecast	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	
	Actual*	£3,282,763					

Q2 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	£13,131,049
	Forecast	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	
	Actual*	£3,282,763	£3,282,762				

Please comment if one of the following applies: - There is a difference between the forecasted annual total and the pooled fund - The Q2 actual differs from the Q2 plan and / or Q2 forecast	

Expenditure

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	£13,131,049
	Forecast	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	
	Actual*	£3,282,763					

Q2 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	£13,131,049
	Forecast	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	
	Actual*	£3,282,763	£3,282,762				

Please comment if one of the following applies: - There is a difference between the forecasted annual total and the pooled fund - The Q2 actual differs from the Q2 plan and / or Q2 forecast	

Commentary on progress against financial plan:	no comment

Footnotes:

*Actual figures should be based on the best available information held by Health and Wellbeing Boards.
Source: For the pooled fund which is pre-populated, the data is from a quarterly collection previously filled in by the HWB. Pre-populated Plan, Forecast and Q1 Actual figures are sourced from the Q1 16/17 return previously submitted by the HWB.

National and locally defined metrics

Selected Health and Well Being Board:	Southend-on-Sea

Non-Elective Admissions	Reduction in non-elective admissions
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	Pressure within the hospital and the system continues. Our plans to reduce non-elective admissions continue to build through the introduction of the Locality approach, Complex Care Co-ordination service, End of Life pathway redesign and our engagement with the Essex Success Regime.

Delayed Transfers of Care	Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	We have a System agreed plan re DToC that will continue our historically strong performance in managing our system DToC rates. The delivery of the DToC plan is both monitored and managed at a System level. Operational management has an agreed process to excalate. The management teams within both health and social care continue to ensure operational resources are in place to deliver the demanding agreed DToC rates and that the

Local performance metric as described in your approved BCF plan	People with a LTC feeling supported to manage their condition. Numerator and Denominators are not available for Southend
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Our BCF activity is focused on providing an integrated health and social care service for patients with complex care needs. We are planning the configuration of these services and expect for the work to have an impact on this performance metric through 2016 and into 2017. Data for this metric for period July 16 - March 17 will not be available until Sep 17.

Local defined patient experience metric as described in your approved BCF plan	Friends and Family Net promoter score - SUFHT In Patient wards
If no local defined patient experience metric has been specified, please give details of the local defined patient experience metric now being used.	
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Our current performance for Q1 16/17 is 93% against a target of 91.7%.

Admissions to residential care	Rate of permanent admissions to residential care per 100,000 population (65+)
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Southend is operating in the context of budget reductions that are set to continue well into 2018. To address these reduced budgets and deliver a more integrated service for our residents Southend on Sea Borough Council is in the process of transforming Adult Social Care. We are, therefore, anticipating, that our residential care admissions will stay at the same levels for 16/17 as they were for 15/16.

Additional Measures

Selected Health and Well Being Board: Southend-on-Sea

Improving Data Sharing: (Measures 1-3)

1. Proposed Measure: Use of NHS number as primary identifier across care settings

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	No	No
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

2. Proposed Measure: Availability of Open APIs across care settings

Please indicate across which settings relevant service-user information is currently being shared digitally (via Open APIs or interim solutions)

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Shared via Open API	Shared via Open API	Not currently shared digitally	Shared via Open API	Shared via Open API	Not currently shared digitally
From Hospital	Shared via Open API	Shared via Open API	Not currently shared digitally	Shared via Open API	Shared via Open API	Not currently shared digitally
From Social Care	Not currently shared digitally	Not currently shared digitally	Shared via Open API	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Community	Shared via Open API	Shared via Open API	Not currently shared digitally	Shared via Open API	Shared via Open API	Not currently shared digitally
From Mental Health	Shared via Open API	Shared via Open API	Not currently shared digitally	Shared via Open API	Shared via Open API	Not currently shared digitally
From Specialised Palliative	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Shared via Open API

In each of the following settings, please indicate progress towards instillation of Open APIs to enable information to be shared with other organisations

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	In development	In development	In development	In development	In development	In development
Projected 'go-live' date (dd/mm/yy)	31/03/17	31/03/17	31/03/17	31/03/17	31/03/17	31/03/17

3. Proposed Measure: Is there a Digital Integrated Care Record pilot currently underway?

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	Pilot being scoped

Other Measures: Measures (4-5)

4. Proposed Measure: Number of Personal Health Budgets per 100,000 population

Total number of PHBs in place at the end of the quarter	24
Rate per 100,000 population	13.3

Number of new PHBs put in place during the quarter	7
Number of existing PHBs stopped during the quarter	17
Of **all** residents using PHBs at the **end** of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	94%

Population (Mid 2016)	180,589

5. Proposed Measure: Use and prevalence of Multi-Disciplinary/Integrated Care Teams

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **non-acute** setting?	Yes - in some parts of Health and Wellbeing Board area
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **acute** setting?	Yes - throughout the Health and Wellbeing Board area

Footnotes:

Population projections are based on Subnational Population Projections, Interim 2014-based (published May 2016).
http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Population figures were updated to the mid-year 2016 estimates as we moved into the new calendar year.

Narrative

Selected Health and Well Being Board: Southend-on-Sea

Remaining Characters	31,872

Please provide a brief narrative on overall progress, reflecting on performance in Q2 16/17. A recommendation would be to offer a narrative around the stocktake themes as below:

Highlights and successes

What would you consider to be your most significant area of success, or development since the last quarter? What has contributed to this improvement?

Challenges and concerns

Does the information on National Conditions and Supporting metrics point to any issues or areas of improvement? Are there any new anticipated challenges for the coming quarter?

Potential actions and support

What actions could be taken and what support could be offered to address performance challenges and capitalise on successes for subsequent quarters?

Non Elective, residential admissions and DToC

We are delighted that our BCF plan for 2016/17 was approved by NHS England at the end of June 2016. Our plans for 2015/16 were delivered and surpassed as previously submitted in our quarterly returns. For 2016/17 our BCF plan will focus on further reductions in Non Elective admissions, maintaining the performance for residential care admissions achieved in 15/16 against a backdrop of transofrmational change and continuing to deliver strong DToC performance. To achieve these objectives our plans to transform existing services include implementing a Locality approach, commissioning a complex care co-ordination service and engagement with the Essex Success Regime.

Our robust governance structure assures the system that plans are on track and that all partners are engaged.

Income & Expenditure

Income & Expenditure has remained on plan.

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Quarterly Reporting Template - Guidance

Notes for Completion

The data collection template requires the Health & Wellbeing Board to track through the high level metrics and deliverables from the Health & Wellbeing Board Better Care Fund plan.

The completed return will require sign off by the Health & Wellbeing Board.

A completed return must be submitted to the Better Care Support Team inbox (england.bettercaresupport@nhs.net) by midday on 3rd March 2017.

The BCF Q3 Data Collection

This Excel data collection template for Q3 2016-17 focuses on budget arrangements, the national conditions, income and expenditure to and from the fund, and performance on BCF metrics.

To accompany the quarterly data collection Health & Wellbeing Boards are required to provide a written narrative into the final tab to contextualise the information provided in this report and build on comments included elsewhere in the submission. This should include an overview of progress with your BCF plan, the wider integration of health and social care services, and a consideration of any variances against planned performance trajectories or milestones.

Cell Colour Key

Data needs inputting in the cell
Pre-populated cells
Question not relevant to you

Throughout this template cells requiring a numerical input are restricted to values between 0 and 100,000,000.

Content

The data collection template consists of 8 sheets:

Checklist - This contains a matrix of responses to questions within the data collection template.
1) Cover Sheet - this includes basic details and tracks question completion.
2) Budget arrangements - this tracks whether Section 75 agreements are in place for pooling funds.
3) National Conditions - checklist against the national conditions as set out in the BCF Policy Framework 16-17 and BCF planning guidance.
4) Income and Expenditure - this tracks income into, and expenditure from, pooled budgets over the course of the year.
5) Supporting Metrics - this tracks performance against the two national metrics, a DTOC metric, a Non-Elective Admissions metric, locally set metric and locally defined patient experience metric in BCF plans.

6) Additional Measures - additional questions on new metrics that are being developed to measure progress in developing integrated, cooridnated, and person centred care.
7) Narrative - this allows space for the description of overall progress on BCF plan delivery and performance against key indicators.

Checklist

This sheet contains all the validations for each question in the relevant sections.

All validations have been coloured so that if a value does not pass the validation criteria the cell will be Red and contain the word "No" and if they pass validation they will be coloured Green and contain the word "Yes".

1) Cover Sheet

On the cover sheet please enter the following information:

The Health and Well Being Board
Who has completed the report, email and contact number in case any queries arise
Please detail who has signed off the report on behalf of the Health and Well Being Board

Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 7 cells are green should the template be sent to england.bettercaresupport@nhs.net

2) Budget Arrangements

This section requires the Health & Wellbeing Board to confirm if funds have been pooled via a Section 75 agreement. Please answer as at the time of completion.

If it had not been previously stated that the funds had been pooled can you now confirm that they have now?
If the answer to the above is 'No' please indicate when this will happen

3) National Conditions

This section requires the Health & Wellbeing Board to confirm whether the eight national conditions detailed in the Better Care Fund Policy Framework 16/17 (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/490559/BCF_Policy_Framework_2016-17.pdf) and Better Care Fund Planning Guidance 16/17 (http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/) have been met through the delivery of your plan. Please answer as at the time of completion.

It sets out the eight conditions and requires the Health & Wellbeing Board to confirm 'Yes', 'No' or 'No - In Progress' that these have been met. Should 'No' or 'No - In Progress' be selected, please provide an estimated date when condition will be met, an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed.

Full details of the conditions are detailed at the bottom of the page.

4) Income and Expenditure

This tracks income into, and expenditure from, pooled budgets over the course of the year. This requires provision of the following information:

Forecasted income into the pooled fund for each quarter of the 2016-17 financial year
Actual income into the pooled fund in Q1, Q2 & Q3 2016-17
Forecasted expenditure from the pooled fund for each quarter of the 2016-17 financial year
Actual expenditure from the pooled fund in Q1, Q2 & Q3 2016-17

Figures should reflect the position by the end of each quarter. It is expected that the total planned income and planned expenditure figures for 2016-17 should equal the total pooled budget for the Health and Wellbeing Board.

There is also an opportunity to provide a commentary on progress which should include reference to any deviation from plan or amendments to forecasts made since the previous quarter.

5) Supporting Metrics

This tab tracks performance against the two national supporting metrics, a Delayed Transfers of Care metric, a Non-Elective Admissions metric, the locally set metric, and the locally defined patient experience metric submitted in approved BCF plans. In all cases the metrics are set out as defined in the approved plan for the HWB and the following information is required for each metric:

An update on indicative progress against the six metrics for Q3 2016-17
Commentary on progress against each metric

If the information is not available to provide an indication of performance on a measure at this point in time then there is a drop-down option to indicate this. Should a patient experience metric not have been provided in the original BCF plan or previous data returns there is an opportunity to state the metric that you are now using.

Guidance on accessing CCG based NEA numerator data from SUS via the 'Activity and Planning Report' has been circulated in tandem with this report in order to enable areas to perform their own in year monitoring of NEA data. This guidance document can also be accessed via the embeded object below.

Guide to accessing CCG based NEA data from SUS via

NEA denominator population (All ages) projections are based on Subnational Population Projections, Interim 2014-based (published May 2016) found here:
http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Please note that the Non-Elective Admissions per 100,000 population (All ages) population projections are based on a calendar year.

Delayed Transfers Of Care numerator data for actual performance has been sourced from the monthly DTOC return found here:
http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/

DTOC denominator population (18+) projections are based on Subnational Population Projections, Interim 2014-based (published May 2016) found here:
http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1

Please note that the Delayed Transfers Of Care (delayed days) from hospital per 100,000 population (aged 18+) population projections are based on a calendar year.

Actual and baseline data on Re-ablement and Residential Admissions can be sourced from the annual ASCOF return found here:
http://content.digital.nhs.uk/searchcatalogue?productid=22085&q=ascof
Please note these are annual measures and the latest data for 2015/16 data was published 05/10/2016. Plan data for these metrics in 2016/17 were submitted by HWBs within Submission 4 planning returns and final figures are displayed within the 'Remaining Metrics Enquiry' tab of the Submission 4 report.

6) Additional Measures

This tab includes a handful of new metrics designed with the intention of gathering some detailed intelligence on local progress against some key elements of person-centred, co-ordinated care. Following feedback from colleagues across the system these questions have been modified from those that appeared in last years BCF Quarterly Data Collection Template (Q2/Q3/Q4 2015-16). Nonetheless, they are still in draft form, and the Department of Health are keen to receive feedback on how they could be improved / any complications caused by the way that they have been posed.

For the question on progress towards instillation of Open APIs, if an Open API is installed and live in a given setting, please state 'Live' in the 'Projected 'go-live' date field.
For the question on use and prevalence of Multi-Disciplinary/Integrated Care Teams please choose your answers based on the proportion of your localities within which Multi-Disciplinary/Integrated Care Teams are in use.

For the PHB metric, areas should include all age groups, as well as those PHBs that form part of a jointly-funded package of care which may be administered by the NHS or by a partner organisation on behalf of the NHS (e.g. local authority). Any jointly funded personal budgets that include NHS funding are automatically counted as a personal health budget. We have expanded this definition following feedback received during the Q3 reporting process, and to align with other existing PHB data collections.

7) Narrative

In this tab HWBs are asked to provide a brief narrative on overall progress, reflecting on performance in Q3 16/17.
A recommendation would be to offer a narrative around the stocktake themes as below:
Highlights and successes
What would you consider to be your most significant area of success, or development since the last quarter? What has contributed to this improvement?
Challenges and concerns
Does the information on National Conditions and Supporting metrics point to any issues or areas of improvement? Are there any new anticipated challenges for the coming quarter?
Potential actions and support
What actions could be taken and what support could be offered to address performance challenges and capitalise on successes for subsequent quarters?

Better Care Fund Template Q3 2016/17

Data Collection Question Completion Checklist

1. Cover

Health and Well Being Board	completed by:	e-mail:	contact number:	Who has signed off the report on behalf of the Health and Well Being Board:
Yes	Yes	Yes	Yes	Yes

2. Budget Arrangements

Funds pooled via a S.75 pooled budget? If not previously stated that the funds had been pooled can you confirm that they have now? If no, date provided?
Yes

3. National Conditions

			7 day services		
	1) Are the plans still jointly agreed?	2) Maintain provision of social care services	3i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	3ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken (Standard 9)?	4i) Is the NHS Number being used as the consistent identifier for health and social care services?
Please Select (Yes, No or No - In Progress)	Yes	Yes	Yes	Yes	Yes
If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	Yes	Yes	Yes	Yes	Yes
If the answer is "No" or "No - In Progress" please provide an explanation as to why the condition was not met within the quarter (in-line with signed off plan) and how this is being addressed?	Yes	Yes	Yes	Yes	Yes

4. I&E

		Q1 2016/17	Q2 2016/17	Q3 2016/17
Income to	Forecast	Yes	Yes	Yes
	Actual	Yes	Yes	Yes
	Please comment if there is a difference between the annual totals and the pooled fund	Yes		
Expenditure From	Forecast	Yes	Yes	Yes
	Actual	Yes	Yes	Yes
	Please comment if there is a difference between the annual totals and the pooled fund	Yes		
Commentary on progress against financial plan:		Yes		

5. Supporting Metrics

		Please provide an update on indicative progress against the metric?	Commentary on progress
	NEA	Yes	Yes
	DTOC	Yes	Yes
	Local performance metric	Yes	Yes
	If no metric, please specify		
Patient experience metric		Yes	Yes
	Admissions to residential care	Yes	Yes
	Reablement	Yes	Yes

6. Additional Measures

	GP	Hospital	Social Care	Community	Mental health
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes

	To GP	To Hospital	To Social Care	To Community	To Mental health
From GP	Yes	Yes	Yes	Yes	Yes
From Hospital	Yes	Yes	Yes	Yes	Yes
From Social Care	Yes	Yes	Yes	Yes	Yes
From Community	Yes	Yes	Yes	Yes	Yes
From Mental Health	Yes	Yes	Yes	Yes	Yes
From Specialised Palliative	Yes	Yes	Yes	Yes	Yes

	GP	Hospital	Social Care	Community	Mental health
Progress status	Yes	Yes	Yes	Yes	Yes
Projected 'go-live' date (mm/yy)	Yes	Yes	Yes	Yes	Yes

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?
Yes

Total number of PHBs in place at the end of the quarter	Yes
Number of new PHBs put in place during the quarter	Yes
Number of existing PHBs stopped during the quarter	Yes
Of all residents using PHBs at the end of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	Yes

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the non-acute setting?	Yes
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the acute setting?	Yes

7. Narrative

Brief Narrative	Yes

Data sharing			
4ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	4iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	4iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	5) Is there a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional
Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes

Q4 2016/17
Yes

Yes

Specialised palliative
Yes
Yes

To Specialised palliative
Yes
Yes
Yes
Yes
Yes
Yes

Specialised palliative
Yes
Yes

Cover

Q3 2016/17	
Health and Well Being Board	**Southend-on-Sea**
Completed by:	Nick Faint
E-Mail:	nickfaint@southend.gov.uk
Contact Number:	01702 212 113
Who has signed off the report on behalf of the Health and Well Being Board:	Cllr Lesley Salter

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

	No. of questions answered
1. Cover	5
2. Budget Arrangements	1
3. National Conditions	36
4. I&E	17
5. Supporting Metrics	13
6. Additional Measures	67
7. Narrative	1

Budget Arrangements

Selected Health and Well Being Board:	Southend-on-Sea

Have the funds been pooled via a s.75 pooled budget?	Yes
If it had not been previously stated that the funds had been pooled can you confirm that they have now?	
If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	

Footnotes:

Source: For the S.75 pooled budget question, which is pre-populated, the data is from a previous quarterly collection returned by the HWB.

National Conditions

Selected Health and Well Being Board: Southend-on-Sea

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these have been met, as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include an explanation as to why the condition was not met within this quarter (in-line with signed off plan) and how this is being addressed?

Condition (please refer to the detailed definition below)	Q1 Submission Response	Q2 Submission Response	Please Select ('Yes', 'No' or 'No - In Progress')	If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	If the answer is "No" or "No - In Progress" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:
1) Plans to be jointly agreed	Yes	Yes	Yes		
2) Maintain provision of social care services	Yes	Yes	Yes		
3) In respect of 7 Day Services - please confirm:					
i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	Yes	Yes	Yes		
ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken (Standard 9)?	Yes	Yes	Yes		
4) In respect of Data Sharing - please confirm:					
i) Is the NHS Number being used as the consistent identifier for health and social care services?	Yes	Yes	Yes		
ii) Are you pursuing Open APIs (ie system that speak to each other)?	Yes	Yes	Yes		
iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	Yes	Yes	Yes		
iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	Yes	Yes	Yes		
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Yes	Yes	Yes		
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes	Yes	Yes		
7) Agreement to invest in NHS commissioned out-of-hospital services	Yes	Yes	Yes		
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes	Yes	Yes		

National conditions - detailed definitions

The BCF policy framework for 2016-17 and BCF planning guidance sets out eight national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with health and social care providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. Furthermore, there should be joint agreement across commissioners and providers as to how the Better Care longer term strategic plan. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequenc Grant (DFG) will again be allocated through the Better Care Fund. Local housing authority representatives should therefore be involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing.

2) Maintain provision of social care services

Local areas must include an explanation of how local adult social care services will continue to be supported within their plans in a manner consistent with 2015-16.

The definition of support should be agreed locally. As a minimum, it should maintain in real terms the level of protection as provided through the mandated minimum element of local Better Care Fund agreements of 2015-16. This reflects the real terms increase in the Better Care Fund.

In setting the level of protection for social care localities should be mindful to ensure that any change does not destabilise the local social and health care system as a whole. This will be assessed compared to 2015-16 figures through the regional assurance process.

It should also be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate.

Local areas are asked to confirm how their plans will provide 7-day services (throughout the week, including weekends) across community, primary, mental health, and social care in order:

- To prevent unnecessary non-elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week;
- To support the timely discharge of patients, from acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care. If they are not able to provide such plans, they must explain why.

The 10 clinical standards developed by the NHS Services, Seven Days a Week Forum represent, as a whole, best practice for quality care on every day of the week and provide a useful reference for commissioners (https://www.england.nhs.uk/wp-content/uploads/2013/12/clinical-standards1.pdf).
By 2020 all hospital in-patients admitted through urgent and emergency routes in England will have access to services which comply with at least 4 of these standards on every day of the week, namely Standards 2, 5, 6 and 8. For the Better Care Fund, particular consideration should be given to whether progress is being made agains standard highlights the role of support services in the provision of the next steps in a person's care pathway following admission to hospital, as determined by the daily consultant-led review, and the importance of effective relationships between medical and other health and social care teams.

4) Better data sharing between health and social care, based on the NHS number

The appropriate and lawful sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a consistent identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of informati right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.

Local areas should:

- confirm that they are using the NHS Number as the consistent identifier for health and care services, and if they are not, when they plan to;
- confirm that they are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary security and controls (https://www.england.nhs.uk/wp-content/uploads/2014/05/open-api-policy.pdf; and
- ensure they have the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA), and if not, when they plan for it to be in place.
- ensure that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights. In line with the recommendations from the National Data Guardian review.

The Information Governance Alliance (IGA) is a group of national health and care organisations (including the Department of Health, NHS England, Public Health England and the Health and Social Care Information Centre) working together to provide a joined up and consistent approach to information governance and provide access guidance on data access issues for the health and care system. See - http://systems.hscic.gov.uk/infogov/iga

5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Local areas should identify which proportion of their population will be receiving case management and named care coordinator, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated he services, supported by care coordinators, for example dementia advisors.

6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

The impact of local plans should be agreed with relevant health and social care providers. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. This should complement the planning guidance issued to NHS organisations.

There is agreement that there is much more to be done to ensure mental and physical health are considered equal and better integrated with one another, as well as with other services such as social care. Plans should therefore give due regard to this.

7) Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care

Local areas should agree how they will use their share of the £1 billion that had previously been used to create the payment for performance fund.

This should be achieved in one of the following ways:

- To fund NHS commissioned out-of-hospital services, which may include a wide range of services including social care, as part of their agreed Better Care Fund plan; or

- Local areas can choose to put an appropriate proportion of their share of the £1bn into a local risk-sharing agreement as part of contingency planning in the event of excess activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services including social care (local areas sho as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 15-16);

This condition replaces the Payment for Performance scheme included in the 2015-16 Better Care Fund framework.

8) Agreement on local action plan to reduce delayed transfers of care (DTOC)
Given the unacceptable high levels of DTOC currently, the Government is exploring what further action should be taken to address the issue.

As part of this work, under the Better Care Fund, each local area is to develop a local action plan for managing DTOC, including a locally agreed target.

All local areas need to establish their own stretching local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts. This target should be reflected in CCG operational plans. The metric for the target should be the same as the national performance metric (average delayed transfers of care (de population (attributable to either NHS, social care or both) per month.

As part of this plan, we want local areas to consider the use of local risk sharing agreements with respect to DTOC, with clear reference to existing guidance and flexibilities. This will be particularly relevant in areas where levels of DTOC are high and rising.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with the relevant acute and community trusts and be able to demonstrate that the plan has been agreed with the providers given the need for close joint working on the DTOC issue.

We would expect plans to:

• Set out clear lines of responsibility, accountabilities, and measures of assurance and monitoring;
• Take account of national guidance, particularly the NHS High Impact Interventions for Urgent and Emergency Care, the NHS England Monthly Delayed Transfers of Care Situation Reports Definition and Guidance, and best practice with regards to reducing DTOC from LGA and ADASS;
• Demonstrate how activities across the whole patient pathway can support improved patient flow and DTOC performance, specifically around admissions avoidance;
• Demonstrate consideration to how all available community capacity within local geographies can be effectively utilised to support safe and effective discharge, with a shared approach to monitoring this capacity;
• Demonstrate how CCGs and Local Authorities are working collaboratively to support sustainable local provider markets, build the right capacity for the needs of the local population, and support the health and care workforce - ideally through joint commissioning and workforce strategies;
• Demonstrate engagement with the independent and voluntary sector providers.

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Plan, forecast, and actual figures for total income into, and total expenditure from, the fund for each quarter to year end (in both cases the year-end figures should equal the total pooled fund)

Selected Health and Well Being Board: Southend-on-Sea

Income

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	£13,131,049
	Forecast	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	
	Actual*	£3,282,763	£3,282,762				

Q3 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	£13,131,049
	Forecast	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	
	Actual*	£3,282,763	£3,282,762	£3,282,762			

Please comment if one of the following applies: - There is a difference between the forecasted annual total and the pooled fund - The Q3 actual differs from the Q3 plan and / or Q3 forecast	

Expenditure

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	£13,131,049
	Forecast	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	
	Actual*	£3,282,763	£3,282,762				

Q3 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	£13,131,049
	Forecast	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	
	Actual*	£3,282,763	£3,282,762	£3,282,762			

Please comment if one of the following applies: - There is a difference between the forecasted annual total and the pooled fund - The Q3 actual differs from the Q3 plan and / or Q3 forecast	

Commentary on progress against financial plan:	nil comment

Footnotes:

*Actual figures should be based on the best available information held by Health and Wellbeing Boards.

Source: For the pooled fund which is pre-populated, the data is from a quarterly collection previously filled in by the HWB. Pre-populated Plan figures are sourced from the Q1 16/17 collection whilst Forecast, Q1 and Q2 Actual figures are sourced from the Q2 16/17 return previously submitted by the HWB.

National and locally defined metrics

Selected Health and Well Being Board:	Southend-on-Sea

Non-Elective Admissions	Reduction in non-elective admissions
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	Pressure within the hospital and the system continues and whilst non-elective admissions (inline with national trends) are higher than 15/16 the trend for 16/17 is declining. This is an indication that our system based plans and commissioned activity are beginning to have an impact and reduce non-elective admissions. We expect for the trend to continue into Q4 16/17.

Delayed Transfers of Care	Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	We have a System agreed plan re DToC that will continue our historically strong performance in managing our system DToC rates. The delivery of the DToC plan is both monitored and managed at a System level. Operational management has an agreed process to escalate. The management teams within both health and social care continue to ensure operational resources are in place to deliver the demanding agreed

Local performance metric as described in your approved BCF plan	People with a LTC feeling supported to manage their condition. Numerator and Denominators are not available for Southend
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Our BCF activity is focused on providing an integrated health and social care service for patients with complex care needs. We are planning the configuration of these services and expect for the work to have an impact on this performance metric through 2017 and beyond. Data for this metric for period July 16 - March 17 will not be available until Sep 17.

Local defined patient experience metric as described in your approved BCF plan	Friends and Family Net promoter score - SUFHT In Patient wards
If no local defined patient experience metric has been specified, please give details of the local defined patient experience metric now being used.	
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Our performance for Q3 16/17 is 92.5% against a target of 91.7%.

Admissions to residential care	Rate of permanent admissions to residential care per 100,000 population (65+)
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Southend is operating in the context of budget reductions that are set to continue well into 2018. To address these reduced budgets and deliver a more integrated service for our residents Southend on Sea Borough Council is in the process of transforming Adult Social Care. We are, therefore, anticipating, that our residential care admissions will stay at the same levels for 16/17 as they were for 15/16.

Additional Measures

Selected Health and Well Being Board: Southend-on-Sea

Improving Data Sharing: (Measures 1-3)

1. Proposed Measure: Use of NHS number as primary identifier across care settings

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	No	No
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

2. Proposed Measure: Availability of Open APIs across care settings

Please indicate across which settings relevant service-user information is currently being shared digitally (via Open APIs or interim solutions)

149	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Shared via Open API	Shared via Open API	Not currently shared digitally	Shared via Open API	Shared via Open API	Not currently shared digitally
From Hospital	Shared via Open API	Shared via Open API	Not currently shared digitally	Shared via Open API	Shared via Open API	Not currently shared digitally
From Social Care	Not currently shared digitally	Not currently shared digitally	Shared via Open API	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Community	Shared via Open API	Shared via Open API	Not currently shared digitally	Shared via Open API	Shared via Open API	Not currently shared digitally
From Mental Health	Shared via Open API	Shared via Open API	Not currently shared digitally	Shared via Open API	Shared via Open API	Not currently shared digitally
From Specialised Palliative	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Shared via Open API

In each of the following settings, please indicate progress towards instillation of Open APIs to enable information to be shared with other organisations

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	In development	In development	In development	In development	In development	In development
Projected 'go-live' date (dd/mm/yy)	31/03/17	31/03/17	31/03/17	31/03/17	31/03/17	31/03/17

3. Proposed Measure: Is there a Digital Integrated Care Record pilot currently underway?

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	Pilot being scoped

Other Measures: Measures (4-5)

4. Proposed Measure: Number of Personal Health Budgets per 100,000 population

Total number of PHBs in place at the end of the quarter	24
Rate per 100,000 population	13.3

Number of new PHBs put in place during the quarter	7
Number of existing PHBs stopped during the quarter	17
Of **all** residents using PHBs at the **end** of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	94%

Population (Mid 2016)	180,589

5. Proposed Measure: Use and prevalence of Multi-Disciplinary/Integrated Care Teams

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **non-acute** setting?	Yes - in some parts of Health and Wellbeing Board area
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **acute** setting?	Yes - throughout the Health and Wellbeing Board area

Footnotes:

Population projections are based on Subnational Population Projections, Interim 2014-based (published May 2016).
http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Population figures were updated to the mid-year 2016 estimates as we moved into the new calendar year.

Narrative

Selected Health and Well Being Board: Southend-on-Sea

Remaining Characters	31,593

Please provide a brief narrative on overall progress, reflecting on performance in Q3 16/17. A recommendation would be to offer a narrative around the stocktake themes as below:

Highlights and successes

What would you consider to be your most significant area of success, or development since the last quarter? What has contributed to this improvement?

Challenges and concerns

Does the information on National Conditions and Supporting metrics point to any issues or areas of improvement? Are there any new anticipated challenges for the coming quarter?

Potential actions and support

What actions could be taken and what support could be offered to address performance challenges and capitalise on successes for subsequent quarters?

Non Elective, residential admissions and DToC

We are delighted that our BCF plan for 2016/17 continues to support and drive our activities to integrate health and social care. Our plans for 2016/17 continues to deliver. As we now enter the planning phase fro 2017 - 2019 our BCF plan will focus on further reductions in Non Elective admissions, maintaining the performance for residential care admissions achieved in the previous 2 years against a backdrop of transofrmational change and continuing to deliver strong DToC performance. To achieve these objectives our plans to transform existing services include implementing a Locality approach, commissioning a complex care co-ordination service and engagement with the Essex Success Regime.

Southend HWB have recently commissioned an options appraisal to evaluate the 'what next' in terms of health and social care integration for Southend. This represents an exciting challenge for our system and one that our system partners are embracing.

Our robust governance structure assures the system that plans are on track and that all partners are engaged.

Income & Expenditure

Income & Expenditure has remained on plan.

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Department of Health | Local Government Association | Department for Communities and Local Government | NHS England

Better Care Fund 2017-19 planning – latest position

December 2016

The Better Care Fund

Introduction

This webinar is intended to give an outline of:

- Better Care Fund (BCF) Policy Framework and Planning Guidance
- The planning template
- Assurance process
- Support

It should enable you to be more prepared when the Framework and Guidance are published.

Please note though

- The Policy Framework and Planning Guidance are not finalised
- Some elements may, therefore change
- We will hold events in the new year to give more details, following publication

Contents

Lessons learnt

Key lessons learnt from the planning processes and ongoing feedback:

What has worked well

- Regional assurance allows a more realistic assessment of the deliverability of plans
- More dialogue among national partners
- Planning process was less bureaucratic in 16/17 than the previous year but could improve further

What could be improved

- The volume of information and national conditions required in the planning process
- Clarity on national conditions and guidance
- Simplification of planning and assurance processes and templates

Policy Framework – current position

Big picture

- More on bigger integration picture
- Description of graduation conditions
- Two year planning cycle 2017-19

Changes to conditions

- Reduction in number of national conditions from 8 to 3:
- Jointly agreed plan
- Social care maintenance
- NHS commissioned out of hospital services

Metrics

- Remain the same as 2016 /17

2017-19 Planning Guidance – Matthew West

Planning - principles

Process

- Two year plans – 2017-2019
- Reduce overall planning burden as far as possible

Plans

- Plans are expected to be evolution of previous versions
- Better Care Plans are part of the wider integration approach and should align, where appropriate to other plans locally, for example STPs or devolution deals.

Planning requirements

Narrative plan

- Vision for health and social care integration
- National conditions
- Evidence based plan – outline template will be provided
- Approach to risk

Funding contributions – via template

- Confirm funding, including in relation to national conditions

Spending plan via template

- Confirm schemes, including amounts, funding source and commissioner

Metrics – via template

- Four national metrics

Narrative plans

Vision

- Local vision for health and social care, including model for integration, how the plan will move services towards a more community based, preventative approach and the role of the BCF in that process

Plan

- A coordinated and integrated plan of action for delivering the vision, supported by evidence

National Conditions

- A clear articulation of how you plan to meet each national condition

Risk

- An agreed approach to risk management, including financial risk management and, where relevant, risk sharing and contingency

National conditions – more detail

Jointly agreed plan

- Agreed by HWB(s)
- All minimum funding requirements met

Social Care maintenance

- Real-terms uplift over the SR period
- Local areas can agree higher contributions from the CCG minimum

NHS commissioned out of hospital services

- Ring-fenced amount for use on NHS commissioned out of hospital services
- Areas are expected to consider holding funds in a contingency if they agree additional targets for NEA above those in the CCG operational plan

Metrics

National metrics

- Non elective Admissions
- Admissions to residential care homes
- Effectiveness of reablement
- Delayed Transfers of Care

Although there is no longer a national condition on Delayed Transfers of Care, they will continue to be measured as in previous years.

Plans should set ambitions for reduction and link these to wider activity plans to reduce DToC

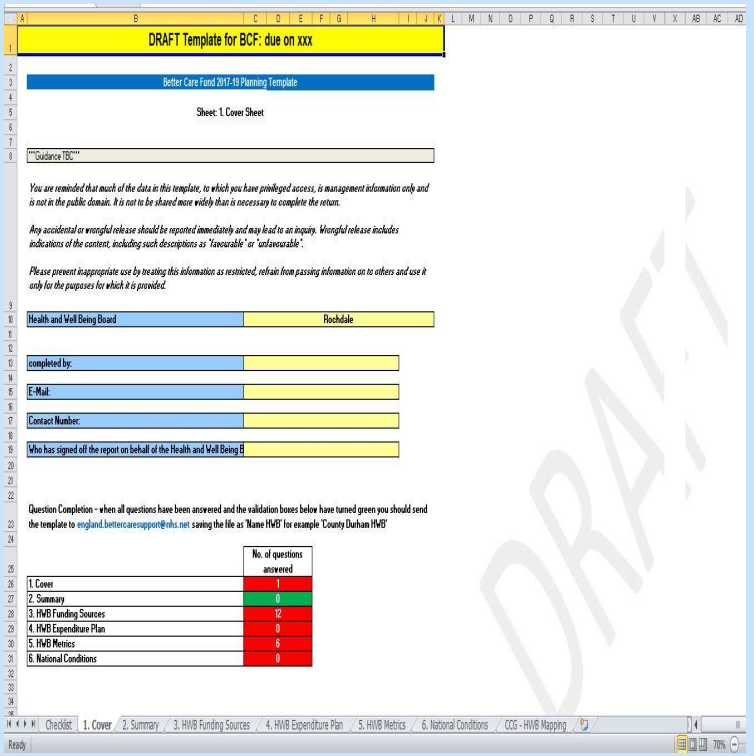
Planning template and assurance- Prashant Mohan

Current draft BCF planning template 2017-19 template structure

The Planning Template follows from the BCF Policy Framework and Planning Guidance to support the consistent capture of key planning requirements and information from each local area to enable an aggregated national view and inform the plan-assurance process.

The overall structure of the template is similar to the 16/17 template:

1. Cover	Local areas identifiers and completion status
2. Summary	Information across tabs summarised for printing and review
3. HWB Funding Sources	Capture all funding contributions to the local area's BCF plan
4. HWB Expenditure Plan	Capture scheme level expenditure and scheme meta-data
5. HWB Metrics	Capture the local area's performance plans to impact the BCF metrics
6. National Conditions	Capture the confirmation of having met the BCF national conditions



Current draft BCF planning template 2017-19 Key changes

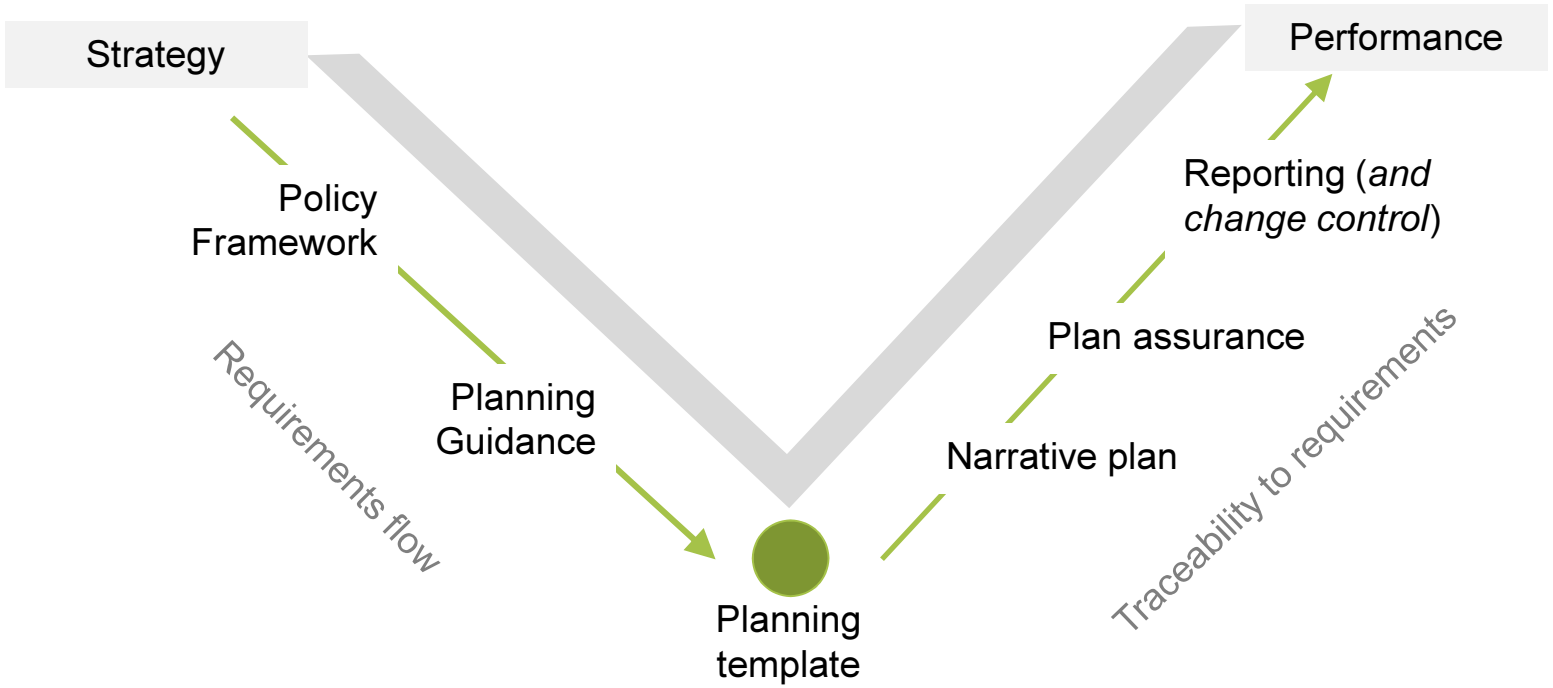
It includes the following design changes, subject to finalisation:

- 2 years of data on a single planning template
- National conditions
- Addition of the new local authority social care grant
- Risk share and contingency fields updated:
  - NEA related contingency or risk share field updated to the summary page
  - Free field on contingency fund excluded
- Social care minimum and uplift from the CCG minimum to be prepopulated on the summary sheet
- Scheme duration field to capture span of a planned scheme across the two years
- Scheme type added: “Supporting discharge”
- Ability to plan Joint source of funding on the ‘Expenditure’ tab
- Ability to print more easily particularly for the ‘Summary’ and ‘Expenditure’ tabs
- ‘Metrics tool’ tab excluded
- Sundry validation and layout improvements based on feedback

Next steps:
Further edits and changes are being incorporated based on subsequent revisions of the 17/19 Policy Framework and Planning Guidance. and other planning template specific feedback.

Draft BCF planning template 2017-19: Informing wider context

The Planning Template is the fundamental building block of the BCF planning data and relies on the accuracy and integrity of the data captured



The planning template informs:

- **subsequent aggregate national analysis for planning**
- **overall assurance of the planning requirements and the plan quality**
- **quarterly and annual BCF reporting and understanding of overall performance**
- **overall insight on the BCF for the national partners and wider system partners including the Treasury**

Assurance – key points

Key points

- Two rounds of assurance
- Shared process across NHS and Local Government
- Plan ratings simplified

First stage process

- First submissions are assured by regional panels
- Moderation will take place at NHS regional level after first stage
- Cross-regional calibration
- Plans are rated ‘compliant’ or ‘not compliant

Second stage process

- All second submissions to be approved by HWB
- Assured by regional panels
- Moderation will take place at NHS regional level after first stage
- Cross-regional calibration
- Plans rated ‘approved’ or ‘not approved’
- If no agreed plan then escalation will commence immediately in order to address issues quickly

Support – Stuart MacLeod

Support offer

The Better Care Support team aims to provide a range of support to help local areas with developing and implementing Better Care Fund plans.

Regional Support Offer – The BCST has devolved funding directly to regions so that bespoke support can be developed.

Better Care Advisors//Multi-Disciplinary Consultancy - Support is being arranged to put in place Better Care Advisor (BCA) and Multi-Disciplinary Consultancy support, to provide hands-on practical support, including project and programme management, analytical expertise, technical support and case study development.

Please liaise with your BCM if you are interested in accessing BCA/MDC support.

Support offer

Better Care Fund Leadership Support - Specific funding for the LGA to provide local areas with leadership support, including:

- Bespoke mentoring to individuals and groups;
- Short, focused and action orientated diagnostic assessments to identify issues and develop action plans to address them;
- Transfer of knowledge and best practice across the care and health systems.

Local areas (both NHS and LA), either individually or in groups, can access this support through their CHIA or BCM.

Thematic Masterclasses and Regional Networking Events – We are working with the Social Care Institute for Excellence (SCIE) to develop a series of events to run from January to March. The Masterclasses will cover key BCF/integration topics such as risk share, DTOC and benefits realisation, while the regional events will help to facilitate networking opportunities. Further details will be confirmed in the near future.

Planning Guidance Roadshow – The BCST are organising Planning Guidance Support Roadshow events and (another) Webinar once the Policy Framework and Planning Guidance have been published.

We hope to be able to offer these events w/c 16 January. Events are likely to take place in London, Birmingham, Leeds and Bristol. Further details will be provided in due course.

Next Steps – Rosie Seymour

Graduation

Key points

- Places will be able to ‘graduate’ from the BCF if they have moved beyond its planning requirements
- There will be a ‘first wave’ to trial the process.

Likely requirements

- Shared commitment and vision for integration by 2020
- A sufficiently mature system for health and social care
- A positive trajectory and/or approach to improving performance on BCF national performance metrics and how graduation will enable the area to accelerate this improvement.
- Pooling above minimum and commitment to greater alignment

Timing

- EOI to be invited soon (possibly ahead of Policy Framework)
- Likely to be from January to April:
  - EOIs setting out proposal and evidence
  - Workshops
  - Graduation panels

Next steps

- Graduation EOIs will be invited in next few weeks

- Policy Framework, Planning Guidance and template are likely to be published in the new year
- Planning Roadshows as soon as possible, following publication

Any Questions?

Contact Us

England.bettercaresupport@nhs.net

Southend Health & Wellbeing Board

Agenda

Item No

9

Joint Report of
Simon Leftley, Deputy Chief Executive (People), Southend Borough Council;
Ian Stidston, Interim Accountable Officer, Southend CCG
Dr Andrea Atherton, Director of Public Health, Southend Borough Council

to

Health & Wellbeing Board

on

22 March 2017

Report prepared by:
Nick Faint BCF Programme Lead

For discussion		For information only	X	Approval required	

Health & Social Care Integration – the next steps

Part 1 (Public Agenda Item)

1 Purpose of Report

The purpose of this report is to;

1.1 provide Health & Wellbeing Board (HWB) members with an update to the report; 'Integrated Community Health and Social Care Services – the next steps' (at appendix 1); and

1.2 provide greater detail in terms of what the opportunities might be in preparation for the options appraisal approved by HWB on 1st February 2017, as requested in the paper at Appendix 1.

2 Recommendations

HWB are asked to;

2.1 note the contents of this report;

3 Background

3.1 A number of factors at a national level, regional and local level are driving the move towards integrated care provision. These are summarised at Appendix 1.

3.2 January 2017 onwards forms a logical point at which to consider potential opportunities for enhanced integration. In December 2016 SCCG and CPR agreed a two-year contract, commencing in April 2017, with the incumbent community health service provider but with a six-month notice period; thus we have the advantages of a stable contract to manage combined with greater flexibility and leverage to make change.

3.3 Proposals in relation to the commissioning of Primary Care which will see SCCG move to fully delegated co-commissioning on 1st April 2017 were recently passed by SCCG whilst CPR are already fully delegated.

3.4 Since HWB on 1st February 2017 and the approval of the paper at Appendix 1, CPR and SCCG have become closer aligned in both direction and organisational form. It has, therefore, become apparent that greater consideration needs to be given to the engagement of CPR in this process.

4 Successes and opportunities for South East Essex (SEE)

Successes

4.1 There are many examples that evidence the success of integration in Southend and across SEE, these include; data sharing; Better Care Fund; Transforming Care Partnership; an integrated commissioning team; Complex Care Co-ordination Service; the Locality approach; Mental Health strategy; and the Single Point of Referral. Each of these are summarised at Appendix 1.

Opportunities

4.2 To support NHS England's 5 Year Forward View approach the Essex Success Regime (ESR) has highlighted the requirement for local health and care economies to join up and address problems systematically, rather than in isolation. Whilst the direction of travel for ESR is focused on acute service reconfiguration there is an underlying assumption that community based integrated health and social care will provide the platform for the changes required within the acute services.

4.3 There have been many national studies carried out by numerous organisations examining the opportunities for local health and social care systems to integrate their services. The studies have reviewed the opportunities from patient, economic, financial and organisational perspectives.

4.4 With the planned closer working between SCCG, CPR and SBC it is imperative that key stakeholders are fully engaged in realising any potential opportunities. Whilst CPR have, to this point, not been fully engaged in the process an opportunity now exists for CPR to become more so.

4.5 The summary of opportunities below in table 1 are intended to represent examples of how patients and organisations might benefit from a greater integrated SEE health and social care system. The list highlights a few key areas but is by no means an exhaustive list;

Table 1: Summary of opportunities

Area	Potential Opportunity	Example
Admission Avoidance (in support of prevention and independence)	Process to support a system in avoiding unnecessary admissions to both hospital and care homes. This could include closer working relationships with intermediate care, Falls prevention services, long terms conditions management, complex care co-ordination, loneliness services etc.	A multi-professional front-door team at A&E of East Lancashire Hospitals NHS Trust consisting of District nursing, Social services staff, Step-up and Step-down pathways, occupational therapy and physiotherapy deflected 100 to 120 admissions per month in 2015, plus a similar number from their equivalent Acute Medical Unit.
Discharge from Hospital (to avoid unnecessary residential placements and support hospital flow)	Process for residential care placement involves active discussion of all potential options at an MDT – not just scheduling	An integrated MDT model in Kent delivered a 36% reduction in short-term bed placements and 34 in long-term bed placements by reviewing and assessing patients discharged from hospital and identifying preferable pathways that could deliver better outcomes, supporting independence and prevention and lower costs.
Avoiding unnecessary health and social care services	Through closer integrated working and alignment of contracting opportunities reablement and domiciliary care contracts could delivery integrated health and social care outcomes	Southend Borough council is currently re-procuring services
Continuing Healthcare	Integrated Procurement of Continuing Healthcare and Local Authority Beds	An integrated procurement of Continuing Healthcare and Local Authority Beds in Sunderland has resulted in the same rates being offered and at a lower rate.
Workforce - nursing	Review of district nurse activity and potential for service user, voluntary sector or existing care workers to undertake enhanced role as part of broader development of localities	A review of registered nurse time by the Local Government Association across five sites demonstrated that significant time was spent on low-level wounds, diabetes (e.g. insulin injections) and medication management. There is the opportunity for registered nurses to have oversight to these activities empowering the service user, their family or care workers to administer.

Workforce – allied health professionals	Integration of Allied Health Professionals such as Speech and Language Therapy, Occupational Therapy, Physiotherapy - with health and local authority.	Torbay health and social care system have developed a single occupational therapy service between the health and the LA. They have introduced a zone management structure which is multidisciplinary.
Child Health	School Nursing and Health Visitors, Children's Community Health Services and Community Paediatrics.	A recently published evidence review from Southend's Public Health Team showed that whilst reporting of outcomes across different studies is often inconsistent in the literature, positive results have been achieved for health and education integration programmes in the United States, integrating pre-school services in Canada, and interagency hubs in Australia.
Integration of Public Health	Closer working relationships to; (a) deliver aligned and integrated services; and (b) produce integrated health and social care data analysis	
Back office	Business intelligence, communications and human resources.	Successes in this regard have been reported by Monitor and NHS Improvement and featured at the Commissioning Show.
Contract Strategies	For local authority and health users, community equipment, wheelchairs, assistive technology, and other technology.	In Suffolk, the two CCGs went to procurement jointly with the County Council for an equipment service that went began operating in 2015. Previously the County Council had spot purchased at increasing cost. This was an opportunity for the new provider and CCG to streamline the catalogue and promote health and independence.

5 The agreed process

5.1 On 1st February 2017 Southend HWB approved the commissioning of a joint report that would explore the integration opportunities within the Southend footprint, consider the options and make a recommendation to HWB for discussion and approval. The report may also want to consider expanding the scope and boundaries to include CPR in order that any future joint (with CPR) commissioning arrangements may be considered.

5.2 It is important that the report produced is independent and unconflicted from any SEE organisational pressure.

5.3 Through BCF an application has been made for support to deliver the requested report. The application was approved. The support from BCF will be in the form of a senior resource to work with Southend to produce the report and ensure that the individual organisations aspirations and concerns are addressed through the process.

5.4 To drive the production of the report and work with any allocated resource from BCF it has been agreed that SCCG, CPRCCG and SBC will jointly contribute £10K to procure an independent organisation to draft the report. This will cover the production and presentation of the report for HWB to consider at an agreed date. Any shortfall will be met by the Pioneer programme.

6 Summary

6.1 With recent changes at a national, regional and local level there is a significant opportunity for SEE health and social care system partners to consider the next steps for community health and care integration. Partners have agreed to robustly consider the opportunities and present a jointly agreed options appraisal to HWB at a date TBC during 2017.

6.2 This paper presents a number of examples regarding further integration and a proposal which will allow the options appraisal to be produced.

7 Health & Wellbeing Board Priorities / Added Value

7.1 Health and Social Care integration contributes to delivering HWB Strategy Ambitions in the following ways

7.2 Ambition 5 – Living Independently; through the promotion of prevention and engagement with residents, patients and staff the integration will actively support individuals living independently.

7.3 Ambition 6 – Active and healthy ageing; through engaging and integrating health and social services within the community the services will be aligned to assisting individuals to age healthily and actively; and

7.4 Ambition 9 – Maximising opportunity; Integration; Southend is the drive to improve and integrate health and social services. Through initiatives within the Southend we will empower staff to personalize the integrated care individuals receive and residents to have a say in the care they receive.

8 Reasons for Recommendations

8.1 As part of its governance role, HWB has oversight for health and social care integration.

9 Financial / Resource Implications

9.1 None at this stage

10 Legal Implications

10.1 None at this stage

11 Equality & Diversity

11.1 Integration should result in more efficient and effective provision for vulnerable people of all ages.

12 Appendices

Appendix 1 - Health and Wellbeing Board report, dated 1st February 2017

170120 Integration Report_The Next Ste

HWB Strategy Ambitions

Ambition 1. A positive start in life A. Children in care | B. Education- Narrow the gap | C. Young carers | D. Children's mental wellbeing | E. Teen pregnancy | F. Troubled families	**Ambition 2. Promoting healthy lifestyles** A. Tobacco – reducing use | B. Healthy weight | C. Substance & Alcohol misuse	**Ambition 3. Improving mental wellbeing** A. Holistic: Mental/physical | B. Early intervention | C. Suicide prevention/self-harm | D. Support parents/postnatal
Ambition 4. A safer population A. Safeguarding children and vulnerable adults | B. Domestic abuse | C. Tackling Unintentional injuries among under 15s	**Ambition 5. Living independently** A. Personalised budgets | B. Enabling community living |C. Appropriate accommodation | D. Personal involvement in care | E. Reablement | F. Supported to live independently for longer	**Ambition 6. Active and healthy ageing** A. Integrated health & social care services | B. Reducing isolation | C. Physical & mental wellbeing | D. Long Term conditions– support | E. Personalisation/ Empowerment
Ambition 7. Protecting health A. Increased screening | B. Increased immunisations | C. Infection control | D. Severe weather plans in place | E. Improving food hygiene	**Ambition 8. Housing** A. Partnership approach to; Tackle homelessness | B. Deliver health, care & housing in a more joined up way | C. Adequate affordable housing | D. Adequate specialist housing | E. Strategic understanding of stock and distribution	**Ambition 9. Maximising opportunity** A. Population vs. Organisational based provision | B. Joint commissioning and Integration | C. Tackling health inequality (improved access to services) | D. Opportunities to thrive; Education, Employment

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10

A Better Start Southend 2017-2019 Portfolio Strategy & Delivery Plan

February 2017

Prepared on behalf of the Partnership Board by the Better Start Programme Office.

LOTTERY FUNDED

A Better Start Southend
2017-2019 Portfolio Strategy & Delivery Plan,
v12

Approval process

Date	Governance	Version	Status
24/01/17	Partnership Board	DRAFT V 09	Approved with additions & amendments
01/02/17	Health & Wellbeing Board	DRAFT V10	Approved with additions from V11
03/02/17	Programme Director	FINAL V12	Signed off

Contents

Introduction

We know that infant and maternal health play a central role in supporting all other aspects of child development. We also know that there is an urgent need to address diet, nutrition and levels of maternal and childhood obesity in Southend, particularly in the Better Start wards. That's why, going forward, *A Better Start Southend* will focus its efforts on improving maternal and infant diet and nutrition outcomes. This document sets out an overview of our ambitions for the coming 12 months.

As we move forward, we will build upon the previous work of the Better Start team – in particular, the effective governance and project development processes put in place following the recent programme review. This, alongside a renewed emphasis on genuine co-production with the local community, will ensure we have a solid platform to deliver *A Better Start* over the long term. Crucially, we are now also able to draw on the experience and expertise of a committed Partnership Board whose members have shaped each stage of the development of this submission.

By focusing on diet and nutrition we will be able to take full advantage of the existing strengths of Southend's public health infrastructure and the strong appetite to deliver change. Our programme of work – as set out in our twin submission documents – will allow us to support the efforts of our partners, develop new projects and approaches, learn from our shared experiences, and build something that will benefit Southend, both now and in the future.

Neil Leitch

Chair, Better Start Southend Partnership Board

Background & purpose of this document

This submission sets out the rationale and evidence for the A Better Start Southend (ABSS) partnership focusing on improving diet & nutrition outcomes for children in the six Better Start wards in Southend throughout 2017-18. And for selecting the following research and development projects for implementation in 2017-18:

- Infant feeding (supporting responsive feeding whether breastfeeding, mixed feeding or formula feeding depending on maternal choice; the introduction of solid food)
- Joined up services and co-production around all services for children aged 0-4 in ABSS wards.

The document sets proposals for the coming 12 months within the context of a two-year strategy to align our work with the Theory of Change and with key Better Start programme milestones at 2019. This focus has been determined and agreed by the programme's Partnership Board, with reference to an agreed set of core principles which will underpin the work (see Appendix 1). Nominated colleagues from each of the Partner organisations, with community engagement, service delivery and subject matter expertise, were tasked with drawing up the strategy with support from the ABSS programme team. (Members of this group are listed at Appendix 2).

The submission has been structured around five core areas for assessment by the Big Lottery Fund (BLF):

1. Portfolio Level Overview
2. Service design of specific interventions
3. Implementation and delivery timetable
4. Communications and Marketing
5. Equalities

Following agreement with the Big Lottery, the submission is being made in two parts. This initial document deals with the strategic portfolio overview; the remaining elements will be addressed in a second document due for submission in mid-February 2017.

The submission will be assessed by the BLF programme team for fit with ABS programme criteria overall, governance and management, value for money and eligibility. In addition, it will be assessed by Chris Cuthbert, Director of Development for A Better Start based on the following:

1. Overall coherence of the proposed package of work: how well does the proposed portfolio / package of work fit together to meet local need and fit with A Better Start aims, outcomes and approach?
2. Delivery planning of the proposed work package: is it realistic and deliverable?
3. Individual service (or 'project' planning): is the project planning well enough thought through to ensure quality implementation and successful delivery?

Rationale for focusing on Diet & Nutrition

A Better Start Southend will concentrate its efforts on improving outcomes in the area of diet and nutrition. Research commissioned by ABSS in 2016[1] indicates that this is an area of particular need in Southend, with indicators above the national average in obesity rates in our target wards and a food environment which is not conducive to healthy eating, and fast food outlets per capita amongst the highest in the country (see section 2 below).

The Better Start Southend Partnership Board has taken the decision to concentrate on this area of work for the period 2017-19, believing that targeting improvements in maternal and infant nutrition will directly impact on developmental outcomes for Southend's children on a number of related areas. The Board feels that developing projects to target this outcome:

- builds on existing core strengths in planning, cross-system working and delivery which are already evident in Southend (see section 3 below)
- offers opportunities to reach our target audience through the combined efforts of public health and early years settings
- offers practical support to local families where the need for intervention is clear
- will help to build the evidence base around interventions
- offers opportunities to link improvements in diet and nutritional standards with the programme's wider ambitions to address social and emotional development and communications and language skills.

The Partnership Board suggests that this is considered as a 2-year strategy covering the period 2017-19 in order to align with the ABSS Theory of Change and key Better Start programme milestones at 2019.

1. Achieving the A Better Start outcomes

The primary focus for the programme's portfolio of activity for 2017-19 will be improving diet and nutrition outcomes for pregnant women, babies and children up to the age of four.

Specific outcomes as set out in the ABSS Theory of Change are that by 2019, in our six ABS wards:

- More children will be healthier as more mothers will initiate and sustain breastfeeding.
- More children will have reduced risk of illness such as diarrhoea and vomiting and respiratory infections.

The diet and nutrition work stream also contributes to the outcomes for social and emotional development and language and communication:

Breastfeeding promotes normal oral-facial development and improves the coordination of the mouth, lips, tongue, and jaw muscles required for speech. In addition, breastfed babies are less likely to get glue ear at a young age which can cause temporary deafness. If a child is unable to hear speech sounds and words clearly, he or she will be unable to copy them which may delay speech and language development.

Breastfeeding and the skin-to-skin contact involved releases the hormones serotonin and oxytocin in both the mother and baby, which encourages good attachment and a strong emotional bond between them. Closeness and responsiveness with the baby during infant feeding helps build a loving relationship which leads to better social and emotional development and stability. Stimulation promotes the development of neural connections, and positive healthy interactions reduce the impact of illness. The protection buffers the brain from the negative impact of stress.

[1] The ABSS PACEC Childhood Obesity Study (Sept 2016)

Before babies and toddlers develop language, they develop an understanding of how language and communication works. They engage in the turn-taking of conversation. During feeding and other interactions mother and baby learn how to interpret and respond to non-verbal cues such as facial expression and gestures which are a vital prerequisite for developing language and communication. The concept of mind-mindedness, which refers to parents' ability or willingness to represent their children's likely thoughts and feelings is related to important developmental outcomes.

Embedding healthy eating and social communication as part of family meals right from the start of life influences children's social and emotional development, as well as their weight and health into adulthood.

As such, breastfeeding has a key preventive role in improving school readiness which is core to our theory of change.

Baseline data and targets for evidencing progress in delivering these outcomes is outlined in information set out as Appendix 3:

- ABSS Key Developmental Outcomes table version 0.8
- Cross Site Common Outcomes Framework (London School of Economics)
- Public Health Outcomes Framework

2. Meeting local needs and priorities

Wider policy context:
Healthy Lives Healthy People (2011) detailed the government's strategy for delivering life-style driven public health challenges. The paper described obesity as "probably the most widespread threat to health and wellbeing" in England. The emphasis on diet, nutrition and, particularly, obesity in children has subsequently been a constant feature of the policy landscape. As recently as 25 January 2017 the Royal College of Paediatrics and Child Health launched a report on the *State of Child Health in the UK.* The report includes a list of 25 measures of the health of UK children, including obesity, breastfeeding rates and smoking in pregnancy, providing an "across the board" snapshot of child health and wellbeing in the UK. The report highlights the impact of deprivation on child health.[2]

Locally, the 2015 Annual Public Health Report highlighted that a fifth of 4-5 year olds and a third of 10-11 year olds in Southend are overweight or obese (2013/14 data from the National Child Measurement Programme). The Report also highlighted aspects of the environment of the borough which may impact on population levels of overweight and obesity, including access to green spaces and that Southend has a fast food-rich environment.

In March 2016 a Childhood Obesity Task and Finish Group established by the Southend Health & Wellbeing Board commissioned an evidence-based review of childhood obesity prevention and access to healthy food for local children aged 0-4 and their families. The report's authors were tasked with delivering:

- Proposals for a locally focused set of strategic interventions.
- A robust delivery plan and proposals for evaluation.
- Baseline data and a set of system wide indicators.
- The strategic interventions to be implemented as a pilot in the six wards aligned to A Better Start Southend, with their impact subsequently evaluated and considered for roll out across Southend.

[2] http://www.rcpch.ac.uk/state-of-child-health/report-in-a-glance

The resulting report (*Better Start Southend: Childhood Obesity Prevention*) highlighted that five of the top six wards ranked in order of childhood obesity rates were Better Start wards, with National Child Measurement data showing around 10% of reception-age children (4–5 year olds) were obese as of 2014. These numbers are higher than the average for the east of England (8.4%) and England as a whole (9.4%). The target wards were also found to feature higher levels of deprivation, more lone parents and higher levels of child poverty. The food environment, known to contribute to childhood obesity, was not found to be conducive to healthy eating strategies, with the number of fast food outlets per capita among the highest in the country (22nd among English local authorities and 2nd in east England).

The report's authors made 5 recommendations; in October 2016 the Executive Board approved this as the framework for improving diet and nutrition outcomes:

1. **Breastfeeding**: expand **breastfeeding peer support** services as well as services supporting the **introduction of solids**. This should include drop-in services and, where resources are available, home visits. Breastfeeding promotion is one of six high impact areas outlined in the Early Years' Commissioning Guidelines. The evidence reviewed (in this report) supports the idea that breastfeeding is a protective factor against childhood obesity, and there is latent demand for related services throughout the borough. Peer support has also been found and evidenced to be a protective factor in that women are significantly influenced by their social networks in terms of infant feeding decisions.

2. **Joined up services**: provide training and advice to GPs locally to improve **signposting for childhood obesity-related services**, particularly health visiting and Children's Centres, promoting preventive approaches in addition to clinical provision including early intervention.

3. **Healthy Cooking and the promotion of Cook 4 Life**: ensure consistent support for cooking classes that support healthy eating across the Borough, with an emphasis on budget / low cost and convenient cooking. Promote new smartphone technology providing recipe and sugar content information such as the Change4Life Sugar Smart and Smart Recipe smartphone apps.

4. **Shopping and the food environment**: ensure complete availability of **healthy start vouchers** across all wards within the Borough, with visible promotion in Children's Centres. Consider including promotion of healthy start vouchers (i.e. signs in participating retailers) as part of the Public Health Responsibility Deal.

5. **Engagement**: develop a strategy and key actions to engage hard-to-reach and minority groups, particularly those with a different food culture. This should build on the work of the local partners with strong knowledge of the challenges of engaging hard-to-reach groups.

For 2017/18 the focus of diet and nutrition interventions will be on:

- Infant feeding (breastfeeding; responsive bottle feeding and hygiene where breastfeeding may not be possible and support with bottle-feeding is required; the introduction of solid food) [Recommendation 1]
- Joined up services and co-production around all services for children aged 0-4 in ABSS wards [Recommendations 2 and 5].

3. Building on and incorporating local skills and strengths

Local context:
Better Start Southend's focus on diet and nutrition builds on an emerging approach to preventive health measures which is already becoming established in Southend and which has the support of all key stakeholders in the Borough.

The Childhood Obesity Prevention Report sets out this joined-up approach to the provision of health care services, highlighting a developing approach focusing on integrated, evidence-based health intervention services, with cross-system efforts already being made to reduce childhood obesity rates. In particular it notes the Southend CCG Strategic Plan (2014-19) designed to develop prevention-led activities for families and children from conception through to pre-school age and which sets out an integrated five year vision for a system-wide approach to transforming services. The Plan's strategic objectives include:

- System objective 2 – 'encourage and support local people to make healthier choices'
- System objective 3 – 'reduce the health gap between the most and least wealthy'

In addition, the Children and Young People's Plan 2016-17 developed by the Success For All Children Group[3] identifies improved levels of breastfeeding and obesity as two areas to focus on as part of an overall preventative approach. The next iteration of this work, the Children's Services Integration Strategy (the Children and Young People's Plan for 2017-18) will set out a vision for a more integrated model of service delivery, underpinned by co-production and delivered through a set of over-arching principles which closely echo the founding principles of A Better Start, seeking to:

- Create a sustainable mix of integration across the partnership
- Develop the culture and capacity for change
- Create an integrated assessment process
- Introduce co-location of services and multi-disciplinary teams
- Remove communication barriers between professionals and improve information sharing, signposting and synergy between services
- Use innovative customer contact technology – channel shift and community resilience building

A local infant feeding policy (2012) has been jointly written by Maternity and health visiting services and has been produced in accordance with the UNICEF Baby Friendly Initiative (BFI) guidance on writing an infant feeding policy. Southend University Hospital NHS Foundation Trust and South Essex Partnership NHS Foundation Trust (SEPT) are committed to implementing UNICEF BFI standards and have achieved Level 2 and Level 3 accreditation respectively. Southend Neo-Natal Unit has achieved Level 2 of the UNICEF standards and is working towards full accreditation, one of the first such units in the country to do so. As part of the commitment to promoting breastfeeding across the ABSS wards, local Children's Centres have enrolled in the UNICEF programme. This is being supported in those centres operating in the ABSS wards, with a view to achieving the initial Level 1 accreditation by the end of 2017.

Finally, The Health & Wellbeing Board's strategic plan for improving health outcomes in Southend outlines the key priorities for improving health and wellbeing for all of the Borough's residents, bringing together the Board's key partners (NHS, public health, and children's services) to plan appropriate services for Southend residents. The strategy outlines nine ambitions, including:

- Ambition 2: Promoting healthy lifestyles: The Board notes … the dangers of childhood obesity and the risks for later life. The strategy cites findings from the National Childhood Measurement

[3] The Success for All Children Group is the Children's Trust in Southend, supporting the Health and Wellbeing Board. The group features the CCG, SAVS, Foundation Trust SEPT as well as local education and policy stakeholders who also form the core of the Better Start Partnership.

Programme showing that 8.3% (156) of 4-5 year olds in the local authority area were classified as obese. The Board pledges to increase green spaces and work with families on early preventative interventions.

Membership of national networks:
The Pre-school Learning Alliance is a core member of the Early Years Nutrition Partnership (EYNP) which provides 'hands-on' help for early years settings, and is thus well-placed to draw on the Partnership's expertise and good practice. EYNP's approach is delivered by a network of nutrition professionals (registered nutritionists and dieticians) with experience in the early years who work alongside local settings to improve their practice, supporting them on their journey to improve and enhance their whole setting approach.

Current assets and existing activity:
Changes in services for child / pregnant mothers' nutrition form part of an enhanced maternity- to-age 3 pathway which links 'Preparation for Birth and Beyond' and '0-5 years Healthy Child Programme' (two year old health development checks) with the 'Early Years Foundation Progress Check'.

A key goal of A Better Start Southend is to enhance this maternity to age 3 pathway, creating a more personal and joined up service underlined by improvements in information sharing. Work is underway to map all of the touch-points along this pathway at which it will be possible for a range of professional practitioners from health and early years settings to intervene to influence behaviour among target audience groups. An infant feeding steering group has been set up bringing together practitioners in public health and early years provision to direct our combined efforts in this work.

There are a number of projects in the existing ABSS portfolio which directly impact on diet and nutrition; others reflect and reinforce work in this area (for a list of current projects and their alignment with this outcome please see Appendix 4). Key parts of the existing diet and nutrition portfolio include:

- **Baby Buddy & Small Wonders:** An interactive, customisable app that guides families through pregnancy and the first six months of a baby's life. It has been designed to deliver best-practice advice to mums to enable the best possible start in life and to support maternal health and wellbeing. The Baby Buddy app provides direct advice and guidance on infant feeding, as well as signposting to local support services. It also provides antenatal dietary advice to support good nutrition throughout pregnancy
- **HENRY:** HENRY (Health, Exercise and Nutrition for the Really Young) is an evidence-based programme aimed at developing lifelong positive approaches to food, nutrition and physical well-being. Typical topics covered include the preparation, cooking and storing of healthy meals / snacks for the whole family, portion sizes / controls, dealing with 'fussy' eating phases and the importance of establishing positive food behaviours / routines in the home.
- **Family Nurse Partnership (FNP):** An intensive programme of support offered to first-time vulnerable teenage mums-to-be / mothers delivered via a network of specially-trained nurse practitioners. The nurses offer intensive 1:1 support over a number of weeks to improve pregnancy outcomes, child health and development and parents' economic and life outcomes by supporting the mums-to-be to develop appropriate skills and the ability to access and engage with support networks, linking with other key local services / agencies where needed. One of the early focuses of the FNP national pilot was to improve the rates of breastfeeding initiation and continuation from birth through to 6-8 weeks as a minimum. The adapted programme in Southend will continue to pursue this aim, as well as develop appropriate links / professional development of staff to enable accessible support services for diet and nutrition advice and information within the ABSS wards.
- **Breastfeeding Support drop in service:** A weekly drop in advice service has been started, based in Southend's central library, as an informal opportunity for mothers to seek professional advice.

- **Crèche Services:** The crèche services project takes the provision of childcare services a step further by having a workforce trained in additional support to reflect the range of services offered via ABSS, e.g. providing direct support, advice and signposting services to parents, reinforcing the behaviours intended by other programmes within the portfolio, linking with other professionals where appropriate. The crèche services programme will provide proactive and targeted support for a range of subjects, including advice under the infant feeding programme (breastfeeding support, advice on safe preparation and demand-led bottle feeding, healthy snacks, portion sizes etc).

To support delivery of the primary focus of improving diet and nutrition outcomes for pregnant women, babies and children up to the age of four, baseline and current monthly data have now been established in respect of three key indicators. Data relating to breastfeeding initiation in the first 48 hours after birth and breastfeeding at 6-8 weeks both support monitoring of the delivery of the short-term objective 'More children will be healthier as more mothers will initiate and sustain breastfeeding'; and data relating to the birth weight of children born within the Borough supports the medium-term objective 'Mothers have good nutrition and healthy lifestyles in pregnancy.' Comparison data for the ABSS target wards and other wards within the Borough allow the relative differences to be tracked on a cumulative monthly basis over the course of the programme's portfolio of activity.

Additional activity to support breastfeeding underway in Southend

Antenatal care

- Midwives offer infant feeding advice as part of antenatal conversations. This includes encouraging parents to connect with their baby, the benefits of skin contact and responding to baby's needs; how closeness, love and comfort can help baby's brain to develop and the value of breastfeeding as protection, comfort and food. Health Visitors offer advice at antenatal contact and additional written information as required or requested. In accordance with UNICEF Baby Friendly Initiative standards this includes discussions on skin to skin contact and the value of breastfeeding/ breastmilk. Community midwifery services offer parent education classes to couples which includes basic breastfeeding management and how to get breastfeeding off to a good start.
- Pregnant women with a medical history which could impact feeding are referred to the infant feeding team for specialist advice during the antenatal period. Southend University Hospital has an antenatal colostrum harvesting service for pregnant women with diabetes as part of the Maternal Medicine antenatal clinic; this service is also offered to pregnant women with more complex medical issues i.e. previous breast surgery, hypoplastic breasts.
- All pregnant women have the opportunity to discuss feeding and caring for their baby with a member of the health visiting team. Mothers can be signposted to support groups at Blenheim and Hamstel Children's Centre for additional peer support and further exploration of feeding choices. National helplines and approved websites are shared whenever a contact is made and whenever this is appropriate or asked for. Information and links to approved websites are available on both SEPT (South Essex Partnership University NHS Foundation Trust) and the Southend Information Point (SHIP) websites.

Healthy child programme delivery

- Mothers are supported by midwives and a feeding assessment made within the first ten days. Health visitors offer care and will carry out a feeding assessment as part of the new birth offer. A formal breastfeeding assessment using the UNICEF tool is carried out at the 'birth visit' (10–14 days) to ensure effective feeding and well-being of mother and baby.
- For those mothers who require additional support for more complex breastfeeding challenges, a referral to the Infant Feeding Advisor Maternity Services can be made.
- Mothers can be signposted to support groups at Blenheim and Hamstel Children's Centre for additional peer support. Further feeding assessment is carried out as part of the universal contact at

6 – 8 weeks and additional support offered as above. Midwifery support is offered from Infant feeding advisers and by the midwifery service as part of the universal offer up to 28 days.

Peer support

- According to NICE guidance, peer support breastfeeding schemes should "be integrated with other elements of care for women requiring support for breastfeeding". It is important to link any proposals for peer support into the local context for maternity service, health visiting, the Healthy Child Programme and national and local performance indicators. Peer support sessions are run at Hamstel and Blenheim Children's Centres in Southend.

DELTA Parenting Programme

The Developing Everyone's Learning and Thinking Abilities (DELTA) parenting programme is delivered locally through Children's Centres to promote both the holistic development of children and their parent's self-esteem in order to enhance the parent/carer and child relationship. DELTA operates on a multidisciplinary basis using a "Parents as Partners" model. The aim was to investigate the effects that mothers might have on their children's development by stimulating them through talking, listening and sharing books following the mother's attendance at a parenting programme. Broad positive gains were reported—maternal attitudes changed, as they felt they were sensitised to the natural learning opportunities in the home. Additionally, when fathers were involved significant higher gains were reported.

Health Visiting team	Location	Frequency
Central Southend	Centre Place/ Summercourt	5 week course every 7 weeks
West Southend	Little Treasures	5 week course except school holidays
South Southend	Friars/ Hamstel/ Temple Sutton	5 week course except school holidays

Local Authority Services

A range of statutory and other services are already working with the Better Start programme in Southend, including the Early Help team, which is actively engaged in delivery of one of the ABSS Communications and Language projects. Other services will be aligned through the emerging localities model, which, whilst not exactly co-terminus with the Better Start wards, offers an opportunity to tailor resource to target areas of the Borough.

4. Leverage and in-kind support from partnership, community and other key stakeholders

At its meeting on 24 January 2017 the strategic partners of the Partnership Board renewed their commitment to making resource contributions to the programme and to setting up the Bank. Partners are committed to the creation of a Bank, pooling resources to deliver the agreed outcomes of the Better Start partnership and to upscale projects into business as usual as the evidence base emerges. Partners agreed to the principle of aligning statutory services and making a commitment, where appropriate, to place non-statutory funds at the disposal of the Partnership Board (whilst acknowledging the statutory duties and governance of the partnership organisations). Leverage to the programme to date has been received in terms of other services and resources and, given the current financial climate, this is likely to be the continuing pattern.

Provision potentially available for Leverage includes the non-statutory elements of Children's Centres and Early Years services, Midwifery and Health Visiting, and communication and language services.

As part of the logic model and service design that will form the second part of this submission, Partners will indicate what leverage they are contributing to each intervention (in terms of restricted funding, unrestricted funding, existing and continuing services, and/or other services and resources).

5. Providing a platform for the future

Programme management and governance

Following the review of governance arrangements carried out in 2016, with the involvement of the local community, the programme now operates within a robust governance structure placing strategic partners at the heart of decision making and guaranteeing a voice for members of the local community through the co-production arrangements and training outlined below. (For more information about the governance structure please see section 6)

Programme delivery

The programme team has developed an “end to end” process for identifying, developing and commissioning projects for the programme and is developing a set of standard approaches for service design and evaluation. The focus on delivery around a smaller set of projects offers an opportunity to test and embed this approach thoroughly over the coming 12 months.

The following diagram shows the full process from initial research and idea generation through to implementation. The new projects proposed in part 2 of this submission are currently at *Phase 4 – Drafting outline proposals*; *Phase 5 - First stage sign-off* will be by the Partnership Board at its meeting on 15 February 2017. Completion of this process for these projects will take a minimum of a further five to six months (see next page).

	Phase	M1	M2	M3	M4	M5	M6	M7	M8	M9	
1	Research										
2	Identifying priorities and scope										
3	Idea generation										
4	Drafting outline proposals										
5	First stage sign off										
6	Initial service design										
7	Final sign off										
8	Tender process										
9	Project set up										

Implement, monitor and evaluate

1	Research	This is an ongoing process. High quality research will describe current needs and inform the types of projects and initiatives that will be commissioned through the programme.
2	Identifying priorities and scope	The workstream development groups will consider the research and identify current priorities and scope of potential initiatives.
3	Idea generation	Those priorities and scope will be fed into community channels where specific ideas will be generated. It is possible at this stage, that an individual from the community, or an organisation has come up with an idea. In this case research will take place after the event.
4	Drafting outline proposals	The ward forums will consider the ideas and draft up outline proposals for initiatives, the best of which, will be put forward.
5	First stage sign off	The development groups will act as the formal decision making group on which proposals to take forward for service design.
6	Initial service design	The initial service design for a project will be carried out by a task and finish group.
7	Final sign off	The partnership board will consider and formally sign off the proposals that have been through the initial service design process.
8	Tender process	Projects above the non-competitive threshold will be opened up to providers through a tendering process.
9	Project set up	The project management office will work with the provider to set the service up and ensure all the relevant governance is wrapped around it.

Co-production

Co-production with parents is a core principal of ABSS and it has been important for the partnership that we build on local expertise and knowledge in this area. We have engaged Southend Association for the Voluntary Sector (SAVS) to develop the co-production strategy and build the platform for developing and delivering our parent engagement and co-production model. By July 2017, it will provide the platform to continuously develop parents to take part in ABSS in whatever way they choose. Our approach is being developed in line with findings from our recent work on enhancing the Healthy Child Programme, focusing on delivery with parents. It embeds opportunities for parents and staff to become volunteer ABSS Champions and link into the wider volunteering and employment opportunities for parents as their children get older.

We know from engagement with parents over the past two years that mothers, fathers and carers are a huge asset for A Better Start in Southend. Recent parent focus groups facilitated by colleagues from the South London and Maudsley NHS Consortium Trust, as part of their work on the Enhanced Healthy Child programme – reportedly the most successful focus groups across the five sites – have confirmed that this is still the case. Our co-production strategy is key to supporting and developing self-organising groups of parents and carers, to maximise and build on what people can do for themselves to improve outcomes for their children[4].

A work plan giving the timeframes for developing engagement in each ward is included overleaf and includes work to deliver the following elements:

- **Parent Forums:** Starting in Victoria and Kursaal Wards parents who want to be involved or who would benefit from being involved in ABSS have been identified with the aim of building an initial group to be taken through an informal Introduction to Volunteering session and encouraged to take up Parent Champion training or Volunteer Preparation training. SAVS is bringing the parents together to develop Parent Forums at times and frequencies agreed with them and with Terms of Reference to be developed in partnership with each group. The ambition is that Parent Champions will ultimately chair the Forums.

- **Parent Champion Training:** A 4-week Parent Champion training course has been developed in collaboration with parents who have been involved with ABSS previously. The aim of the Parent Champion training is to inform, empower and support parents to participate fully in the various governance levels of ABSS. They will lead the Parent Forums, share leadership of the Ward forums and play an active role in other elements of the programme including the Partnership Board and Health and Wellbeing Board (HWB), supporting an original intention for the HWB, that it be a true collaboration between professional practitioners, elected representatives in Southend and members of the local community. The on-going support to sustain this will be provided by a combination of SAVS and peer support and in the longer term by previous Parent Champions who will act as peer volunteer mentors.

- **Ward Forums/Panels:** We are mapping the activities taking place in each ward to identify volunteering opportunities, community groups and community leaders in order to develop the ward forums. Forums will be developed alongside the training of the Parent Champions, development of the Innovation Fund and volunteer training to ensure parents are fully equipped to participate. As part of the mapping process, all ABSS volunteering opportunities will be registered with SAVS who will develop new opportunities where a need is identified.

- **Volunteer Training programme:** In partnership with parents, SAVS has developed a Volunteer Preparation course that will be run over 4 sessions, looking at all aspects of volunteering and

[4] A Better Start: Enhanced Healthy Child Programme, Strands 1-3 Report (January 2017), South London and Maudsley NHS Trust Consortium

encouraging parents to review their own skills and aspirations, build their confidence and equip them to volunteer. These parents will be part of the Parents Forum and will volunteer in different ways, for example, through Timebanking activities with other parents.

- **Innovation fund operating in wards and parent forums:** SAVS are co-producing the Innovation Grant process alongside parents, devising a process that is simple, easy to access but sufficiently robust to meet the programme's requirements. This work is underway, with a view to ideas being submitted and funds allocated from April 2017 via the Ward Forums.

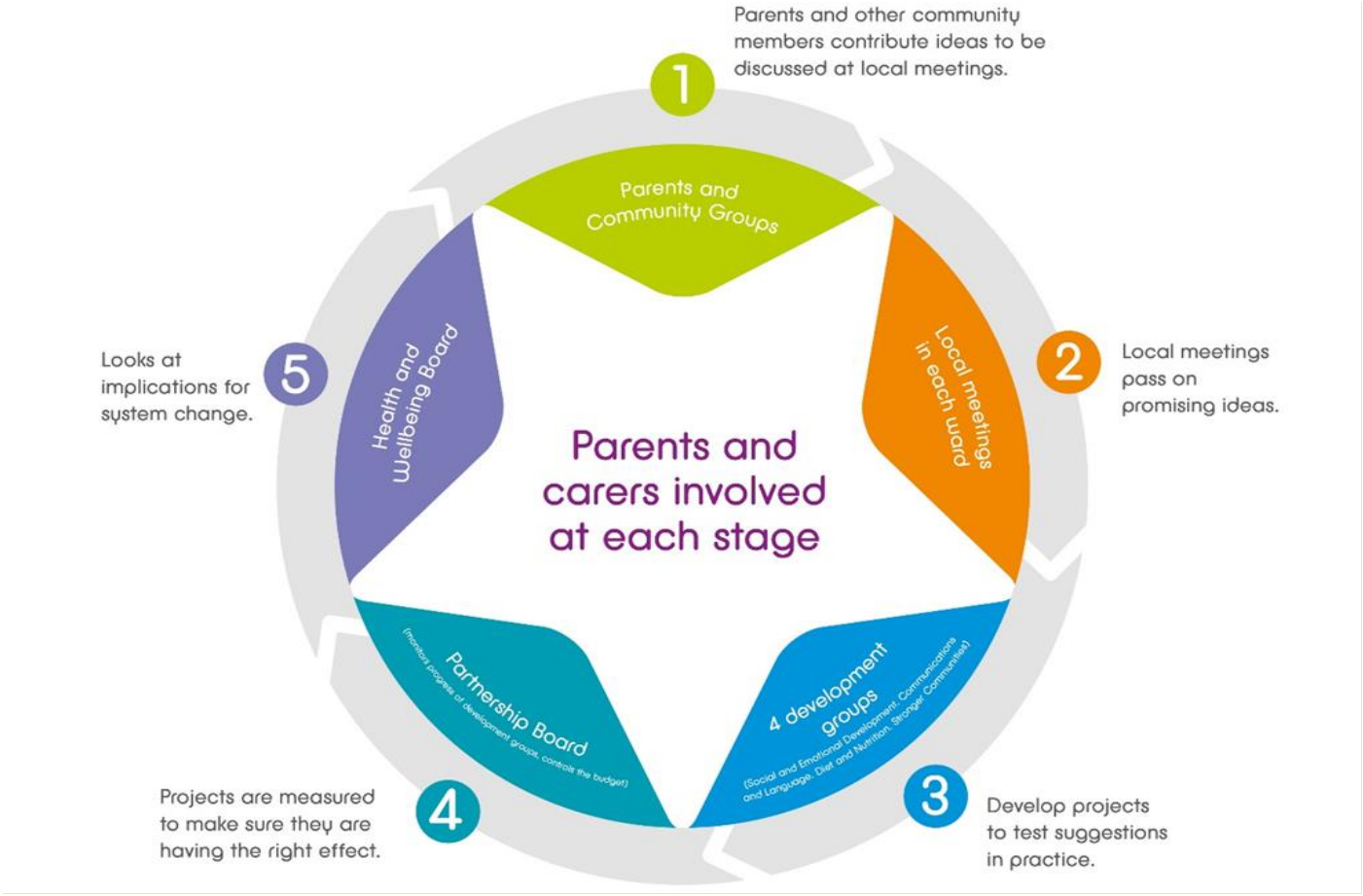
- **Monitoring and Evaluation:** Every element of the co-production and engagement process will be tested along the way and learning will be recorded to ensure the strength of the approach.

In order to secure the platform for co-production, as well as developing parents we need to develop a different culture throughout the system, preparing those involved to operate effectively without feeling threatened. This means we will also be training and developing staff and councillors and improving the culture of how meetings are set up and run in order to encourage participation. The partners recognise that without addressing the business side, co-production of service design and development and decision making will never be effective and so are committed to bringing about the changes required.

Work Stream	Dec	Jan	Feb	Mar	Apr	May	June
Evaluation	Indicators Set (M&E)		Ongoing Monitoring & Evaluation				Final Evaluation
Identifying & Supporting Groups		Kursaal & Victoria (K&V)		Milton & Westborough (M&W)		Shoebury & West Shoebury (S&WS)	
	Ongoing support through informal groups						
Volunteer (Vol) Training	Training Developed		K&V		M&W		S&WS
Vol Opportunity Mapping	Mapping in all six wards						
Vol Opportunity Pathway			Opportunities and pathway developed and included in training				
Parent Champions	Training Developed		K&V Training		M&W Training		S&SW Training
Parent involvement in Governance				Parent champions help develop governance protocols			
				Parent champions attending meetings			
Development of Ward Forums	Mapping to identify forum members from each ward						
				Ward Panel First Meeting (K&W)	Ward Panel First Meeting (M&W)		Ward Panel First Meeting (S&WS)
Idea Development & Implementation	Informal ideas explored with parents.			Presentation of Initial Ideas to Ward Panels at their first meetings (K&V - March), (M&W - April), (S&WS – June onwards)			
Strategy Development	Research		First draft			Review based on evaluation of pilot.	

6. Governance arrangements and costs 2017-19

The strengthened framework that came out of the 2016 governance review comprises 5 levels as follows.



Costs to deliver the governance structure outlined above are estimated as:

Meeting	Frequency	Costs
Health & Wellbeing Board	Quarterly	No direct costs but will incur proportion of staff time
Partnership Board	Monthly Apr-Jun Bi-monthly thereafter	£2450: Average of £325 per meeting, monthly then bi-monthly £630: Assume travel costs for 6 attendees @£15/trip **Total cost £3080**
Finance & Risk Board	Quarterly	£80: held in-house – refreshments only £160: Assume 2 attendees travel by rail **Total cost £240**
Development Groups	Dependent on outcome of Ward meetings & projects progressed	Suggest a provision of £2000 to cover potential meetings, development and testing? (£500/qtr) **Total cost £2000**
Local meetings/Focus Groups in Each Ward	Being Coordinated through SAVS	To pilot the coproduction model through test and learn and develop for up scaling (SAVS objective) **Total cost £23,300**
Parents and Community Groups	Being Coordinated through SAVS	
All Governance Meetings	Variable	Crèche to enable parent engagement and attendance **TBA**

Additional Governance Costs

Governance Secretariat: £12,000 - this assumes 40% of full time position is spent on Governance
Partnership Board Development Costs: £12,000 – estimate for external consultants/coach
Professional fees: £2000 – provision for compliance advice
Innovation Fund: £50,000

Total estimated cost for 2017/18: £104,620 (+ crèche costs)

7. Existing financial commitments 2017-19

The original Better Start bid set out an ambitious transformation programme for Southend and in 2015-16 the programme launched a large number of projects, many of which have delivered real benefits to local people. They did not however deliver a coherent, sustainable programme and as a result, the then Executive Board initiated a review of all projects in the portfolio over the summer of 2016. The outcome of this review was that some projects were halted and others were paused. We now have a portfolio of activity that is making good progress in delivering our BIG 3 outcomes and which has been further reviewed and re-aligned with the 2017-18 focus on diet and nutrition.

From the list of projects committed for delivery (below): at April 2017 there will be 15 projects in the portfolio; at April 2018, there will be 12 projects in the portfolio; and at April 2019 there will be 3 (see Appendix 4) which will continue in delivery alongside activity on Infant Feeding, joined up services and co-production.

Projected Costs by Project	£		£		£		
	2017-18		2018-19		2019-20		Project end date
ID002./3: EPEC Baby and Us / EPEC Being a Parent	63001		-		-		Jul-17
ID002./3: EPEC Baby and Us / EPEC Being a Parent			-		-		Jul-17
ID028: Infant Feeding Programme	35392		-		-		Aug-17
ID011: Baby Buddy & Small Wonders	96859		-		-		Mar-18
ID025: HENRY - Parenting Programme	129097		30399		-		Jun-18
ID040: Crèche Services	90507		90507		-		Jul-18
ID050: Family Nurse Partnership (ADAPT)	394050		204310		-		Jul-18
ID005: Building Bridges	100000		134500		-		Feb-19
ID044: Workforce Development	72052		137724		-		Feb-19
ID022: Fathers Reading Every Day (FRED)	50000		129747		-		Mar-19
ID019: Southend Early Autism Support	37280		50141		-		Mar-19
ID048: Family Focussed GPs	81750		100574		-		Mar-19

ID020/1: Let's Talk to Your Baby / Help me to Talk (ELKAN)	335734		335734		96524		Jun-19
ID036: ABSS Work Skills Project	3900		3900		36461		Oct-19
ID051: Enhanced Healthy Child Programme	47552		47552		12675		Dec-19
ID049: Perinatal Mental Health	TBC		TBC		TBC		TBC
Total Costs	**1,537,174**		**1,265,088**		**145,660**		

In addition, the programme has a number of other financial commitments:

Cross-site marketing and communications campaign directed by Big Lottery Fund, due for implementation from October 2017.	**100,000**
Cross-site workforce development campaign	**40,000**
National evaluation (for detail see below)	**TBC**

National Evaluation

There are two distinct approaches to the National Evaluation of A Better Start a cohort study and an implementation (process) study. Together they will assess the overall impact of A Better Start, and form part of the way that the sites governance is formed. Both will require resources to be provided:

1. **Cohort study**

The overall aim of the independent research evaluation by the Warwick Consortium is to provide **robust research evidence about the impact and cost-effectiveness of the overall ABS programme.** It will focus on the first three years of life, identifying what interventions work for whom and under what circumstances. The data will be matched against 15 comparative non ABS sites.

Its focus is on answering the following questions:

1. How quickly do we find improvements in outcomes, and how sustainable are these over time?
2. How does this compare with families in other areas not supported by Big Lottery's investment?
3. Is the programme investment worthwhile?
4. How much does it cost to run the programme, including the initial set up and over time?
5. How cost effective are different approaches in terms of the outcome achieved?

Before running the longitudinal study, the consortium will run a **small pilot in all intervention areas** (along with 5 comparison areas) to test its recruitment and early data collection methods. This will start in 2016.

Resource	**Resource Requirement**
Southend University Hospital NHS Foundation Trust	Antenatal Recruitment for pilot study (starts 2016) (n = 50)
Southend University Hospital NHS Foundation Trust	Antenatal Recruitment (n = 577)
ABSS Data, Research and Evidence Group	Support e.g. trajectory monitoring

2. **Implementation (process) Study**

The overall aim of the implementation/process evaluation is to provide data that will enable identification of the factors in terms of the key practice and systems lessons that are necessary for wider replication and taking to scale.

Resource	**Resource Requirement**

ABSS Programme Office	Coordination of partner interviews and evidence
ABSS Service Information Questionnaires	ABSS Service Design and Research Lead
ABSS Data, Research and Evidence Group	Cross Site Consultation
ABSS Data, Research and Evidence Group	Overall data dashboard – consultation and on-going data transmission

8. Risk register

Risk Description	Risk Impact (1-4)
There is insufficient time to deliver and evaluate improvement in D&N outcomes by March 2018, given the time required to design, commission and deliver projects and evidence impact (test and learn, evaluation etc).	3
Partners may be asked to make financial decisions on continuing or halting portfolio projects before adequate evidence can be gathered as to their worth.	3
Continuity of approach may be challenged with new CEOs at the Borough Council, NHS Hospital Trust and Southend CCG due to take up posts this year.	3
Partners may not provide type and levels of leverage sufficient to meet the Big Lottery Fund's expectations.	3
Programme may not meet BLF's success criteria at the end of 2017-18 which are not yet confirmed.	4

IMPACT (grade 1 to 4)			
1 - Negligible	**2 - Marginal**	**3 - Serious**	**4 - Critical**

Appendix 1 A Better Start Southend Principles, Values, Objectives

A Better Start offers a once in a generation opportunity to make a real difference to the future of all of Southend on Sea's children, particularly those in the most disadvantaged parts of our community[5]. We will do this by delivering activity based around the core principles, values and objectives set out below.

Core principles (defined in the bid preparation and refined throughout the remediation phase in 2016)

1. Child-centred
2. Co-designed and co-produced with parents and the local community
3. Focused on prevention and early intervention
4. Based on a rigorous test and learn approach
5. Evidence-based
6. Designed to produce long-term, sustainable change

Principles, values & objectives set by the Partnership Board on 09 January 2017

No.	Principle, values, objectives	Source
1.	The focus will be on the ABSS Diet & Nutrition outcome using activities which will also improve Communication & Language and Social & Emotional outcomes (e.g. jaw development and swallowing).	ABSS Theory of Change
2.	Priorities for the next 2 years will be shaped by the recommendations in the Better Start: Childhood Obesity Prevention review approved by the Exec Board on 31/10/16: For 2017/18: recs 1, 2 and 5; for 2018/19: recs 1 to 5.	A Better Start: Childhood Obesity Prevention (PACEC) Sept 2016
3.	The Healthy Child Programme is the spine for aligning delivery (and we should define what this means).	N/A
4.	All cross-system touchpoints with pregnant women and families with small children should be maximised including hospital (in – patient, out-patient, A&E); Health Visitors; Midwives, GP surgeries, Children's Centres, Early Years settings, social housing and private landlords, voluntary sector organisations, faith groups.	Success For All Children
5	Formal / primary signposting services and opportunities should be joined up and optimised. Secondary cross-system inspection and check points, e.g. property inspections and housing officer visits, children's settings inspections, Health Visitor checks should be utilised and coordinated.	Cross-system Partnership intelligence
6	Existing projects in the portfolio should be aligned to the strategy and plan. FNP and FNP Adapt should be strategically integrated and aligned.	ABSS Programme Portfolio and delivery partners
7.	A workforce development strategy and plan to support delivery of the strategy and plan should be included.	N/A
8.	The strategy should align with the emerging Southend Children's Integrated Services Strategy.	JenniNaish@southend.gov.uk
9.	Delivery should be in all six wards.	ABSS programme objectives
10.	The strategy and plan should reflect and reinforce the conceptual approach of the Early Years Nutrition Partnership (EYNP) to tailor support to the demographic of each particular setting and community in which it operates.	http://www.eynpartnership.org

[5] Southend on Sea Better Start Strategy, February 2014

Appendix 2 Task and Finish Group Membership

Partnership colleagues

- **CCG**: Ross Gerrie, Commissioning Manager Children, Young People and Maternity Services
- **Pre-school Learning Alliance**: Michael Freeston, Director of Quality Improvement
- **Pre-school Learning Alliance**: Annie Denny, Diet & Nutrition Specialist Advisor
- **SAVS**: Maureen Longley, Chair
- **SEPT**: Debbie Payne, Professional Lead Health Visiting; Morag Strycharczyk, Clinical Service Manager; Gill O'Connor, Breast Feeding Specialist, Joanne Page, Principal Paediatric Speech and Language Therapist
- **Southend Borough Council**, **Early Years**: Elaine Hammans, Early Years Group Manager
- **Southend Borough Council, Public Health**: Margaret Gray, Head of Public Health
- **Southend NHS Hospital Trust**: Colleen Begg – Head of Midwifery and Gynaecology
- **Southend NHS Hospital Trust:** Lesley Overy, Deputy Head of Midwifery and Gynecology

ABSS programme team

- **Alison Clare**, interim Programme Director
- **Gary May**, interim Programme Manager
- **Penny Neu,** interim Strategic Comms Lead
- **Arlene Perry,** temp Business Support Manager
- **Tim Jarvis,** interim Finance Manager
- **Rachel Wood,** Service Design & Research Lead
- **James Boxer**, interim Project Manager
- **James Bowell**, interim Project Manager
- **Laura Needham**, temp Senior Admin Officer

Appendix 3 Diet & Nutrition Outcomes, Measures, Baseline data and Targets

By 2019, children in our ABSS wards will have improved outcomes for diet and nutrition:

Outcome	Indicator or Measure	Baseline 2014 in ABSS wards	Target 2019 in ABSS wards
More children will be healthier as more mothers will initiate and sustain breastfeeding	Southend Child Health Profile 2014 (Public Health England) 25. Breastfeeding Initiation % 2014-2105 Southend Child Health Profile 2014 (Public Health England) 26. Breastfeeding prevalence (6-8 weeks) % 2014-2015	Not available (only held at PCT level) Not available (only held at PCT level)	73.9% 47.2%
More children will have reduced risk of illness such as diarrhoea and vomiting and respiratory infections	Hospital Episode Statistics (HES) Hospital admissions for children less than12 months for gastrointestinal and respiratory infections	TBC	TBC

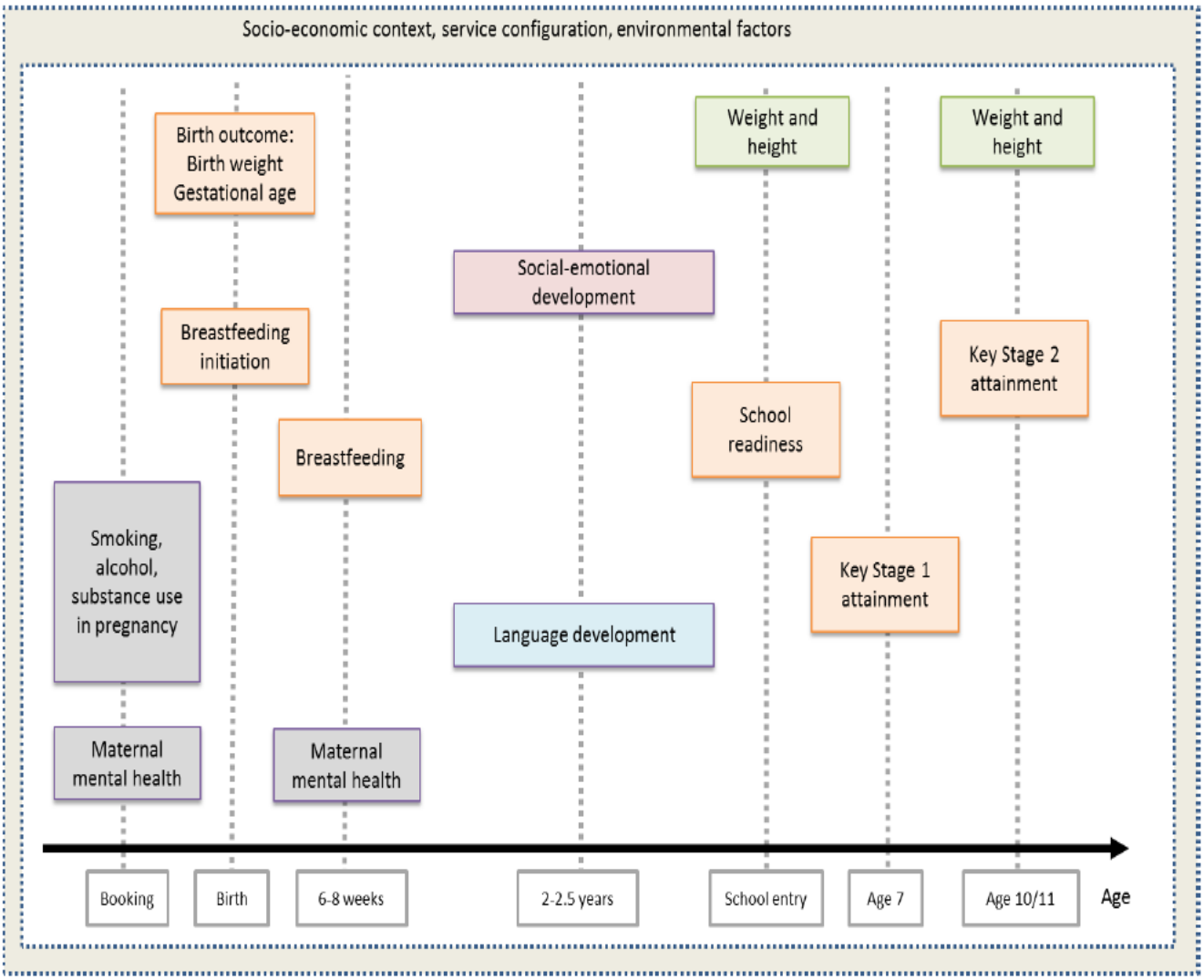
London School of Economics – Common Outcomes Framework

Bonin, E-M, Matosevic, T and Beecham, J (2016) 'A Better Start' Common Outcomes Framework Final Report

To complement the National Evaluation of ABS led by the Warwick Consortium, The Big Lottery Fund commissioned the PSSRU at the London School of Economics to support the ABS partnerships in their work on population level outcomes and indicators with the aim of developing a Common Outcomes Framework (COF). This is intended to allow the ABS sites to track their outcomes locally, as well as comparing trends across sites, and to national level data where these are available.

The common core outcomes are as follows:

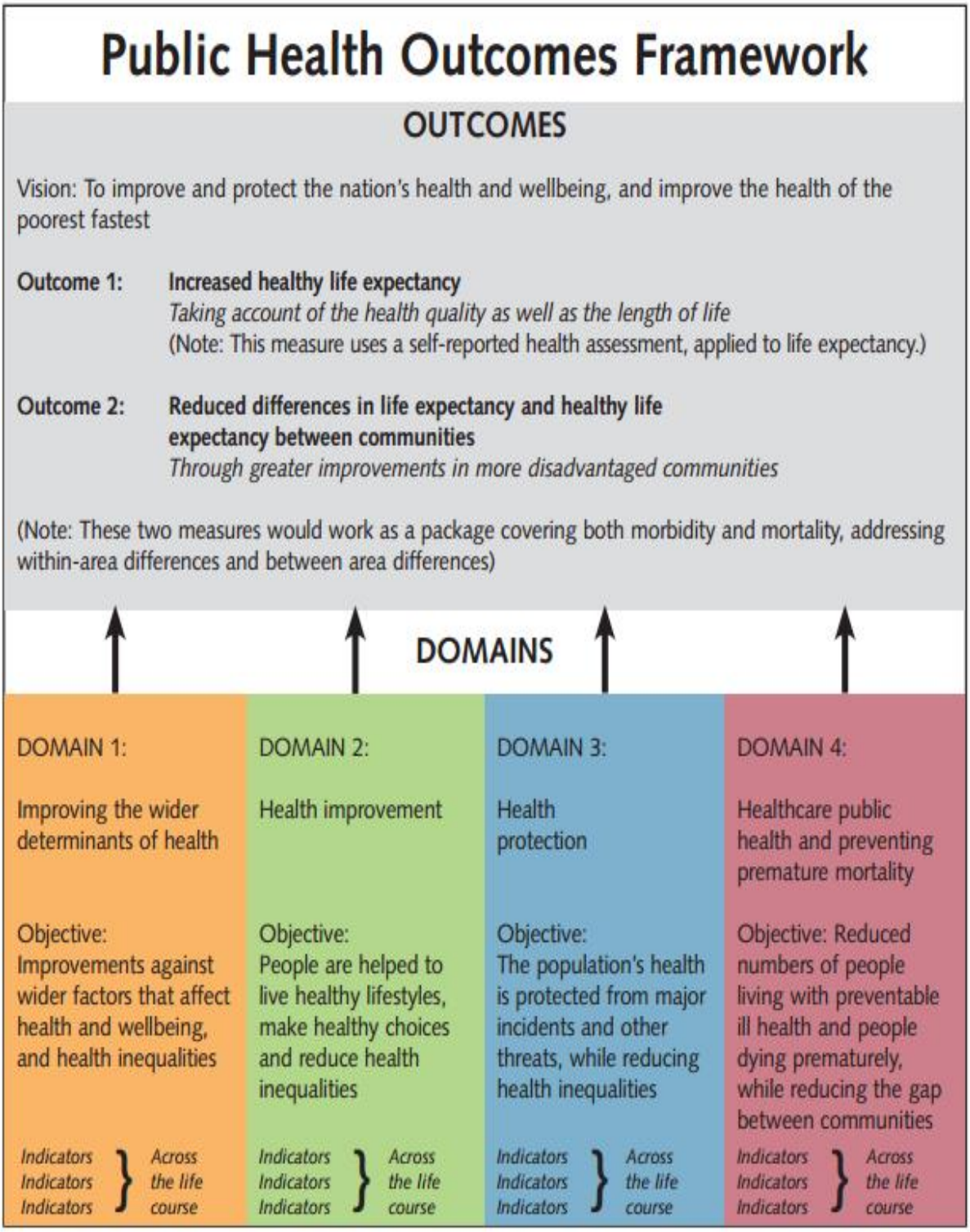
Figure 10: ABS COF – Common Core of outcomes



Public Health Framework

https://www.gov.uk/government/collections/public-health-outcomes-framework

The framework "Healthy People: Improving Outcomes and Supporting Transparency" sets out the vision for Public Health, desired outcomes and the indicators that are used to understand how public health is being improved and protected.



Appendix 4 Existing Projects in the ABSS portfolio to 2020

Current projects & links to Diet & Nutrition:	
Project	**How does this project link to and improve the diet and nutrition outcomes?**
ID002/3 EPEC Baby and Us / Being a Parent To support parents to provide nurturing and loving family environments, which provide enriched learning opportunities with clear guidance, boundaries and support through peer led parenting programmes for parents and carers of babies. This is further developed through a peer-led universal primary prevention parenting follow-on programme (Being A Parent) for mothers and fathers of children aged 2 to 4 years to improve parent-child relationships and interactions; reduce child disruptive behaviour and other problems; and increase participants' confidence in their parenting abilities.	The provider is committed to delivering a range of advice and support topics, and will be supporting the delivery of the D&N portfolio through linking with other services, delivering bite-sized 'taster' sessions of other interventions (such as HENRY) and demonstrating how good eating habits and approaches to sugar intake etc. can be used to reinforce good behaviours. They will be measured against some specific diet and nutrition metrics as well as the existing social and emotional outcomes they are working to.
ID028 Infant Feeding Programme (IFP) The IFP is the umbrella programme of activities that drive the core of the D & N portfolio, and all related activities sit underneath this programme. One of the core components of the IFP is the rollout of the UNICEF 'Baby Friendly' accreditation.	"Infant feeding" covers the whole range of diet and nutrition in the early phases of a child's life, incorporating breastfeeding, demand-led bottle feeding (where breastfeeding has not been established) through to the introduction of solids. This programme is designed to create a pathway from birth through to early childhood that provides the children and their families with the best possible start in life, and a lifelong understanding of the importance of good nutrition and eating habits.
ID011 Baby Buddy & Small Wonders An interactive, customisable app that guides families through pregnancy and the first six months of your baby's life. It has been designed to deliver best-practice advice to mums to enable the best possible start in life and to support maternal health and wellbeing.	The Baby Buddy app provides direct advice and guidance on infant feeding, as well as signposting to local support services. The app also provides ante and post-natal dietary advice to support good nutrition throughout pregnancy.
ID025 HENRY Parenting Programme HENRY (Health, Exercise and Nutrition for the Really Young) is a parenting programme aimed at developing lifelong positive approaches to food, nutrition and physical well-being. Typical topics covered include the preparation, cooking and storing of healthy meals / snacks for the whole family, portion sizes / controls, dealing with 'fussy' eating phases and the importance of establishing positive food behaviours / routines in the home.	The HENRY programme sits as a core element of the D&N portfolio, addressing cooking skills and nutritional education / behaviours as a central theme of the intervention.

ID040 Crèche Services The provision of suitably qualified members of staff of the Professional Association for Childcare and Early Years (PACEY) to deliver Crèche Development Services on behalf of the Pre-School Learning Alliance (PSLA) / A Better Start Southend (ABS). The Crèche services project takes the provision of childcare services a step further by having a workforce trained in additional support (that reflects the range of services offered via ABSS) to provide direct support, advice and signposting services to parents and reinforcing the learning / behaviours intended by other programmes within the portfolio, linking with other professionals where appropriate.	The crèche services programme will be able to provide proactive and targeted support (e.g. where issues are observed / potential opportunities to provide advice and support) for a range of subjects, including advice under the infant feeding programme (breastfeeding support, advice on safe preparation and demand-led bottle feeding, healthy snacks, portion sizes etc).
ID050 Family Nurse Partnership (FNP) An intensive programme of support offered to first-time vulnerable teenage mums-to-be / mothers delivered via a network of specially-trained nurse practitioners. The nurses offer intensive, 1:1 support over a number of weeks to improve pregnancy outcomes, improve child health and development and improve parents' economic and life outcomes through supporting the mums-to-be to develop appropriate skills and the ability to access and engage with their support networks, linking with other key local services / agencies where needed.	One of the early focuses of the FNP national pilot was to improve the rates of breastfeeding initiation and continuation from birth through to 6-8 weeks as a minimum. The adapted programme in ABSS will continue to pursue this aim, as well as develop appropriate links / professional development of staff to enable accessible support services for diet and nutrition advice and information within the ABSS wards. Support and advice is also provided for introducing solids and nutritious family foods.
ID005 Building Bridges Family support services for families that are de-escalating from higher tiers of need; this is a preventative service which aims to support families and prevent return to more formal methods of statutory support.	Nutritionists to function as part of the core delivery of this service to explain how people can consume healthy foods in a way that is economically viable for them and their children. Families and their children will be educated and signposted to relevant information advice and guidance. Courses / group sessions on diet and nutrition will also feature as part of the model.
ID044 Workforce Development The creation of a series of interventions and system-change initiatives to identify and upskill core, shared competencies across the whole spectrum of the workforce (paid professionals and volunteers) who are engaged with our target cohort of children and families. By up skilling the workforce, we will be reducing the incidence of conflicting advice, developing best practice across professional boundaries and improving the breadth and quality of services / advice delivered to children, parents and families	In the mapping of core competencies across the workforce, common approaches to diet and nutrition / infant feeding will be a core component. One of the early initiatives under the workforce development approaches is the UNICEF 'Baby Friendly' initiative, which delivers core training to all staff in children's settings (hospitals, neo-natal units, children's centres through to GP surgeries etc.). In addition to whole-workforce training, the system-change elements are embedded through a series of workshops and development of bespoke policies and practices within each establishment / setting.

ID022 FRED (Father's reading every day) A group based intervention in which fathers are given the skills to read to their children in order to: • Support fathers with skills to encourage communication and attachment with their child and as part of the Inclusion agenda • Support fathers as part of the Inclusion agenda with on-going Social and Emotional benefits • Assist children with Age and Stage / Readiness for school attainment	The messages that fathers receive as part of the process include messaging about breastfeeding, engagement in early care of children – including feeding and the impact dads have on infant and maternal obesity. In terms of the development of father-inclusive practice across ABS in Southend, the Fatherhood Institute are testing the impacts of giving very early messages to dads via health professionals about breastfeeding, nutrition and parental dietary change.
ID019 – SEAS (Southend Early Autism Support) This project supports and signposts families with a child / children with autism to provide them with coping strategies to better understand and respond to their child's day-to-day behaviours in a supportive and appropriate way.	This is a discrete project with no clear and obvious link to the diet and nutrition outcomes in the strategy.
ID048 Family focused GPs An integrated approach to delivering primary care services for children aged between 0-4 and their families through increased, dedicated provision for primary care services and a multi-disciplinary team of professionals wrapped around the family.	The service makes a commitment to educate its health workers in issues of diet and nutrition, ensuring practitioners promote new approaches, are up to date and use the correct terminology. The practitioners have knowledge of and will signpost towards relevant diet and nutrition services. Some hours of community nutritionists will be built into the core delivery of the multi-disciplinary approach. The UNICEF baby friendly initiative links strongly with this project and will support continuation of breastfeeding.
ID 020/1 Let's Talk programmes A preventative, group based approach to communication and language development for families and children aged between 0-4: • Supporting parents with skills to encourage communication and attachment with their child • Improving parents understanding of how speech is developed in the really young so they can communicate more effectively with their child Building relationships with parents of young children and enable the completion of an early assessment of communication in order to identify need.	The Let's Talk programme will focus on oral motor development and number of general motor skills and behavioural changes which, while not specific to feeding, play an important part in the development of an infant's eating habits. Through their close links with statutory SLT service the Let's Talk practitioners will aim to; increase the number of early assessments for infant feeding issues, increase referrals to the dysphagia service and increase general access to infant feeding related information advice and guidance.

ID036 ABSS Workskills project A collaboration between ABSS and Southend Borough Council's economic development team, to improve parental employability, increase the local capacity of enterprises to deliver local opportunities to ABSS cohorts. This will lead to increasing rates of sustained employment and a reduction in the numbers of children growing up in poverty within the target wards and exposure to known risk factors for childhood obesity.	The ABSS workskills project supports the wider message that families and their children need to be fit and healthy in order to be productive in life. The project promotes solutions to diet and nutrition related issues to increase numbers of people going into voluntary roles, full time work and training and education opportunities.
ID051 Enhanced Healthy Child Programme The Healthy Child Programme (HCP) for the early life stages focuses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting. The enhanced HCP is the additional early intervention and prevention public health programme that lies at the heart of our universal service for children and families. at a crucial stage of life, the HCP's universal reach provides an invaluable opportunity to identify families that are in need of additional support and children who are at risk of poor outcomes.	This is a national initiative. The Framework For Action identifies eating behaviour and nutrition among its strategic themes. The national guidance - (http://www.noo.org.uk/uploads/doc/vid_4865_rudolf_TacklingObesity1_210110.pdf) sets out the links that are being made between the EHCP and diet and nutrition more generally.
ID049 Perinatal Mental Health This project aims to support mothers at risk of developing and suffering from issues related to perinatal mental health. While the project is not directly commissioned through the ABSS funding, there are clear links between the programme and the perinatal mental health model. ABSS will assist in the development of the project to ensure it is aligned with the ABSS outcomes.	The ABSS programme team will be working with colleagues in the Perinatal mental health project to identify where this project can reflect, link in with and contribute to the delivery of the diet and nutrition outcomes in this strategy.