SHADOW HEALTH AND WELLBEING BOARD AGENDA

HARTLEPOOL BOROUGH COUNCIL

23 April 2012

at 1.00 p.m.

Boardroom, 1st Floor Hart Building,
at the University Hospital of Hartlepool
Holdforth Road, Hartlepool
(Access from main entrance and follow the directional signs)

MEMBERS: SHADOW HEALTH AND WELLBEING BOARD
Voting Members (statutory members)
Directly Elected Mayor, Executive Members of the Local Authority, Chief Executive of Local Authority, Representative of Clinical Commissioning Group, Chief Executive/Director of the PCT (transitional arrangements until 2013), Director of Public Health, Director of Child and Adult Social Services, HealthWatch Board Member, Representative of the NHS Commissioning Board, Patient Representative.
Non-Voting Members (non-statutory members)
Director of Regeneration and Neighbourhoods, North Tees and Hartlepool NHS Foundation Trust, Tees Esk and Wear Valley NHS Trust, Voluntary Sector Representative(s), North East Ambulance NHS Trust, Cleveland Fire Authority.

1. **APOLOGIES FOR ABSENCE**

2. **TO RECEIVE ANY DECLARATIONS OF INTEREST**

3. **MINUTES**

   3.1 To confirm the minutes of the meeting held on 27 February 2012 *(attached)*

4. **MATTERS ARISING FROM MINUTES**

5. **ITEM FOR INFORMATION**

   5.1 Draft Hartlepool Joint Health and Wellbeing Strategy 2013-18 (*attached)*
   5.2 Verbal Update on Public Health Transition
   5.3 Verbal Update on Special Education Needs Pathfinder bid

6. **ITEMS REQUIRING DECISION**

6.1 Draft Immunisation Strategy (incorporating an action plan which indicates key priorities relating to immunisation uptake) (*attached)*
6.2 Partnership Arrangements underneath the Shadow Health and Wellbeing Board (attached)

7. ITEM FOR DISCUSSION

Presentation on:-

7.1 Troubled Families
7.2 Risk Taking Behaviours

8. FUTURE AGENDA ITEMS

9. ANY OTHER BUSINESS

SHADOW HEALTH AND WELLBEING BOARD

MINUTES AND DECISION RECORD

27 February 2012

The meeting commenced at 9.30 am in the Civic Centre, Hartlepool

Present:

The Mayor, Stuart Drummond - In the Chair

Statutory Members

Councillors: Jonathan Brash (Housing and Transition Portfolio Holder)
Pam Hargreaves (Transport and Neighbourhoods Portfolio Holder),
Gerard Hall (Adult and Public Health Services Portfolio Holder).
Chris Simmons (Children's Services Portfolio Holder),
Hilary Thompson (Performance Portfolio Holder),

Nicola Bailey, Acting Chief Executive
Jill Harrison, Assistant Director, Adult Social Care
. Louise Wallace, Assistant Director, Health Improvement

Margaret Wrenn, Hartlepool LINK Chair

Non Statutory Members: -

Dave Stubbs, Director of Regeneration and Neighbourhoods

Also Present:

David Brown, Director of Operations as substitute for Martin Barkley, Chief Executive, Tees and Esk Valley NHS Trust
Les Jones, Head of Community Safety as substitute for Dave Turton, District Manager, Cleveland Fire Authority

Officers:

Hannah Gill, Modernisation Lead, Housing, Care and Support
Phil Hornsby, Head of Service
Carole Johnson, Head of Health Improvement
John Lovatt, Head of Service
Amanda Whitaker, Angela Armstrong, Democratic Services Team

34. Apologies for Absence

Councillor Robbie Payne (Finance and Procurement Portfolio Holder), Councillor Cath Hill (Culture, Leisure and Tourism Portfolio Holder),

Councillor Peter Jackson (Regeneration and Economic Development and Skills Portfolio Holder), Christopher Akers-Belcher, Hartlepool LINK, Carole Langrick, North Tees and Hartlepool NHS Foundation Trust, Stephen Childs, NHS Hartlepool, Martin Barkley, Tees and Esk Valley NHS Trust, Simon Featherstone, North East Ambulance Service, Dr Paul Pagni, Clinical Commissioning Group and Dave Turton, Cleveland Fire Authority

35. Declarations of interest by Members

Councillor Brash declared a personal interest relating to his employment in a local General Practice and relating to a family member role in Clinical Commissioning Group

36. Minutes

The minutes of the meeting held on 16th January 2012 were confirmed.

37. Matters arising from Minutes

HealthWatch – Verbal Update – The Assistant Director, Adult Social Care advised the Shadow Board that there had been no further guidance nationally on the new HealthWatch service. A report would be submitted to Cabinet on 19th March regarding the available options for commissioning the new service. Officers responded to Portfolio Holders who sought clarification in relation to responsibility for awarding the contract and whether there was any greater clarity in terms of the relationship with scrutiny. Discussion followed on issues relating to the strategic role of this Board and partnership working.

Department of Health Letter – the Mayor highlighted that he had arranged for a letter from the Department of Health to be tabled at this meeting. The letter was a response to a letter which the Mayor had sent, co-signed by the Chair of the Clinical Commissioning Group, in relation to the proposed new hospital development (Minute 30 refers)

Decision

The updates were noted.

38. Feedback from Children's Services Portfolio Holder on attendance at Leadership Academy

The Children's Services Portfolio Holder advised the Board that the Leadership Academy comprised three one day sessions over a three month period. The course had been addressed by a number of eminent speakers. The first session had included Peter Kelly who had spoken about the challenges and opportunities in Public Health in the North East, Louise Ainsworth, Assistant Director North East Public Health Observatory who had led a discussion on Joint Needs Assessment and David Burnby who had talked about Outcomes based Accountability and the need to bring all agencies together with service users, residents and community

representatives. The session had concluded with a discussion on Leadership, outcomes and accountability and focussed on Jonathan Bradshaw's four areas of need.

The second day had included sessions led by the Deputy Regional Director of Public Health on the social determinants of Health and the challenge of inequalities in Health. There was an address by the Director of Public Health, Gateshead on the developing role of the Director of Public Health in tackling the complex problems of health inequalities. The sessions had finished with a session on Partnership working and the principles for sustaining partnerships.

The Portfolio Holder highlighted the 'strong messages' arising from the sessions including the need for leaders to have the confidence to support what works and to stop doing those things that don't work.

Decision

The presentation was noted.

39. Feedback from Acting Chief Executive on Regional Health and Wellbeing Board Event – 31 January

The above event had been attended by the Council's Acting Chief Executive and the Chair of Hartlepool LINK. A verbal update was provided to the Board on the event including the presentations and discussions which had related to public health challenges, transition plans, lack of availability of guidance and the role of both Shadow Boards and that of providers.

Decision

The update was noted.

40. Joint Strategic Needs Assessment progress

The Assistant Director, Health Improvement provided a verbal update on progress in relation to the Joint Strategic Needs Assessment. The Board was advised that the Assistant Director would be checking progress with topic leads to ensure the website was uploaded. There were no areas of concern. In response to a question raised at the meeting regarding access to the website, the Assistant Director advised that access was currently restricted to topic leads. A verification process was currently being undertaken and the website would not be 'live' until the June deadline. It was intended that a further report would be submitted to the Board.

Decision

The update was noted.

41. Public Health Transition Plan for Hartlepool (*Assistant Director, Health Improvement*)

The Public Health Transition Plan for Hartlepool 2011-2013 had been circulated. It was intended that a further report would be submitted to the Cabinet meeting on 5th March setting out the key issues, actions, timescales, responsible officer(s) and progress regarding the transfer of Public Health from NHS Hartlepool to the Council. The Plan would subsequently be submitted to the Regional Director of Public Health by the deadline of 16th March 2012. An Officer group had been set up to ensure the Plan was implemented when appropriate.

Decision

The report was noted.

42. Public Health Improving Outcomes and Supporting Transparency (*Assistant Director, Health Improvement*)

The Assistant Director, Health Improvement, reported on the public health outcomes framework for England, 2013-2016. Part 1 of the Framework, which had been circulated, introduced the vision for public health, the outcomes to be achieved and the indicators that would determine how well heath was being improved and protected.

The Shadow Board was advised that a response, relating to the indicators, had been sent from the Council. It was highlighted that it would be necessary to review the information which was already collated by partner organisations and how this would be available post 2013..

It was highlighted that the Framework consisted of two overarching outcomes that set the vision for the whole public health system. The outcomes were increased healthy life expectancy and reduced differences in life expectancy and healthy life expectation between communities.

During the discussion which followed presentation of the report, reference was made to the number of indicators included in the Framework. It was recognised that it would be important how that information was communicated to the public. It was further suggested that a small group could consider performance related issues and report back to this Board.

The Acting Chief Executive and the Assistant Director, Health Improvement responded to issues arising from the breakdown of indicators in terms of local disaggregation, inequalities and equalities characteristics. It was noted that it was intended that a report would be submitted to the Council's Corporate Management Team and to this Board when Officers had concluded the mapping exercise.

Decision

The report was noted.

43. North East Health and Wellbeing Board Transition Workstream – Local Authority Level of Preparedness – Hartlepool's position *(Assistant Director, Health Improvement)*

The Health and Wellbeing Board workstream had been established as part of the NHS Transition Programme. Its purpose was to support local authorities in their responsibility to establish Health and Wellbeing Board by April 2013. The outcome of an assessment undertaken in January had been collated and had been circulated with the agenda for the meeting. The document reflected Hartlepool's position in terms of level of preparedness.

The Acting Chief Executive advised that Authorities were working towards the Framework which had been set regionally. The Board was assured that, in terms of preparedness, this Authority was ahead of other Local Authorities. The issue in Hartlepool related to the level of ring fenced budget. There was recognition, expressed at the meeting, that the method of allocation in terms of Government streams had been previously based on population rather than need. It was considered important for the Board to be conscious of the issues which had been raised.

Decision
The report was noted.

44. Immunisation Strategy

The Assistant Director, Health Improvement advised the Shadow Board that it was necessary to seek the comments of the Health Protection Agency and the Primary Care Trust on the Immunisation Strategy. It was, therefore, intended to submit the Strategy to the April meeting of the Board. In the meantime, the Assistant Director had spoken to Head Teachers who had been very supportive and appreciate of the issues which had been highlighted by the Board.

The Assistant Director assured the Board that the report to the April meeting would address operational issues in addition to the development of the strategy.

Decision

The update was noted.

45. Draft Work Programme *(Assistant Director, Health Improvement)*

The Board agreed the work programme which had been circulated. The Assistant Director clarified the proposed terms of the report on relationship with other partnerships scheduled to be submitted to the April meeting of the Board.

It was agreed that a report on Clinical Commissioning Group development and NHS changes should be added to the work programme to allow the Board to provide and overview and understanding of the links and new

architecture for NHS. The Assistant Director, Health Improvement undertook to discuss with colleagues in order that appropriate timeframe could be determined

Decision

The report was noted.

46. Consultation on Plain Packaging for Cigarettes

The Head of Health Improvement advised the Board on the Plain Packs Protect campaign which calls for plain standardised cigarette packaging with images of the health problems caused by smoking on the front of the packs. Examples of current packaging were circulated at the meeting. It was highlighted that cigarettes were the only product on the market which, if used in accordance with manufacturers' instructions, would kill half of its users. Evidence had shown the campaign for plain packaging would be effective. It was noted that from April, cigarette packets would no longer be on display in shops and supermarkets but behind screens instead. Board Members expressed their support of the campaign.

The Head of Health Improvement and the Assistant Director, Health Improvement responded to issues raised by Board Members including awareness of dangers of smoking, the need to highlight the cost of smoking and the need for the campaign to have some relevance to young people and adults. Members of the Board noted that smoking contributed to premature death and referred to the effectiveness of repetitive messages. Reference was made also to the need to reinforce the message relating to the implications of passive smoking.

The Assistant Director, Health Improvement referred to the support which had been expressed for the campaign. Reference was made to the multi faceted approach and the Board was advised that FRESH was commissioned by 12 Primary Care Trusts in North East and would become a responsibility of the Local Authority, subject to legislation post 2013.

It was noted that consultation has just commenced. The Board was advised that the campaign could be supported by accessing the FRESH north east web site.

Decision
The Board expressed their support of the campaign.

47. Presentations on
(i) Reablement
(ii) Housing, Care and Support Strategy

The Board received a presentation by John Lovatt, Head of Service, which gave Members an overview of reablement in terms of its key features,

principles, operation and 'model' potential outcomes. It was noted that the essence of reablement was to work with individuals who have support needs to re-build their confidence, support the development of daily living skills and promote community access and integration. The key features of reablement included helping people to do things for themselves. It is outcome focussed, time limited and built on what people can already do and supports them to regain skills to increase their confidence and independence. The principles underlying the strategy included promoting prevention, maximising recovery and providing continued support. The presentation addressed how those principles could be achieved and presented an overarching operational health and social care model. 'Model' potential outcomes included increasing the number of people helped to recover from serious illness and injury, increasing the number of people managing their own care and support and less dependency on intensive services. In addition, more people would be physically active and live independently and there would be a reduction in emergency bed days associated with repeat acute admissions. There would also be reduced duplication, re-organised pathways and removal of professional boundaries. In addition, clinicians, other professionals, local councillors and the 'public' would be brought together to develop neighbourhood approaches.

Members of the Board were supportive of the Board considering the issues which had been highlighted by the presentation. The Board agreed to a suggestion made by the Assistant Director, Adult Social Care, that a report be submitted to a future meeting in relation to the effectiveness of the service in terms of the number of people going through reablement.

A presentation was then given, by the Modernisation Lead, Housing, Care and Support, on the Housing, Care and Support Strategy which replaces the Older Person's Housing, Care and Support Strategy. The new strategy aimed to 'provide people with appropriate housing and the right level of care and support to ensure that individuals can live as independently as possible and choose where they live and with whom'. Six vulnerable groups had been identified namely mental health, substance misuse, learning and physical disabilities, young people and older people. An action plan was being developed from the strategy and a steering group had been established to ensure work was completed. It was noted that it would be the responsibility of this Board to oversee performance and ensure completion.

The Board discussed issues arising from the presentations. A Portfolio Holder enquired whether arrangements would be made to brief elected Members and also asked that information be circulated to all Members of the Council. In terms of consultation, the benefits of involving the youth parliament and 50+ Forum were highlighted. Discussion also took place regarding how the Board could make sure strategies were linked with housing market renewal.

The Board was alerted to older people being targeted by a company, from out of town. The view was expressed that any issue which affected people who were vulnerable was of interest to this Board. The Director of Regeneration and Neighbourhoods undertook to refer the issue to his

trading standards officers. It was suggested also that a campaign could be featured in the Hartlepool Mail in terms of 'where to go for good advice'.

48. Future Agenda Items

This item had been addressed as part of consideration of the work programme (minute 45 refers)

49. Any Other Business

(i) Appointment of Director of Public Health – The Acting Chief Executive advised the Board that the post of Director of Public Health had been advertised. It was proposed that interviews be held in April. The process was being led by the Primary Care Trust. It was proposed to include council representation in the recruitment process.

The meeting concluded at 11.30 a.m.

CHAIR

Draft Hartlepool Joint Health and Wellbeing Strategy, 2013-18

Partnership organisations
To be added: Sign-up page with organisations' logos.

Foreword
To be added: To be written by the Health & Wellbeing Board Chair.

Executive Summary
To be added: Summary of Commissioning Intentions / Priorities.

1. Vision

For the people of Hartlepool:

Improve health and wellbeing, reduce health inequalities and improve efficiency.

This will be achieved through integrated working, focusing on outcomes, improving efficiency and balancing the economy.

Appendix 1 summarises the scope, policy context, relationships and aims of the Strategy.

2. Purpose

The Joint Health and Wellbeing Strategy (JHWS) is a high-level summary outlining how Hartlepool Borough Council, Hartlepool Clinical Commissioning Group and other key organisations will address health and wellbeing needs of Hartlepool and help reduce health inequalities.

The Health and Social Care Bill (2011) establishes Health and Wellbeing Boards ('Boards') as statutory bodies responsible for encouraging integrated working and developing a Joint Strategic Needs Assessment and Health and Wellbeing Strategy for their area[1]. The JHWS is underpinned by the Joint Strategic Needs Assessment (JSNA) and together they will provide a foundation for strategic, evidence-based, outcomes-focused commissioning and planning for Hartlepool.

3. Hartlepool – current health and wellbeing

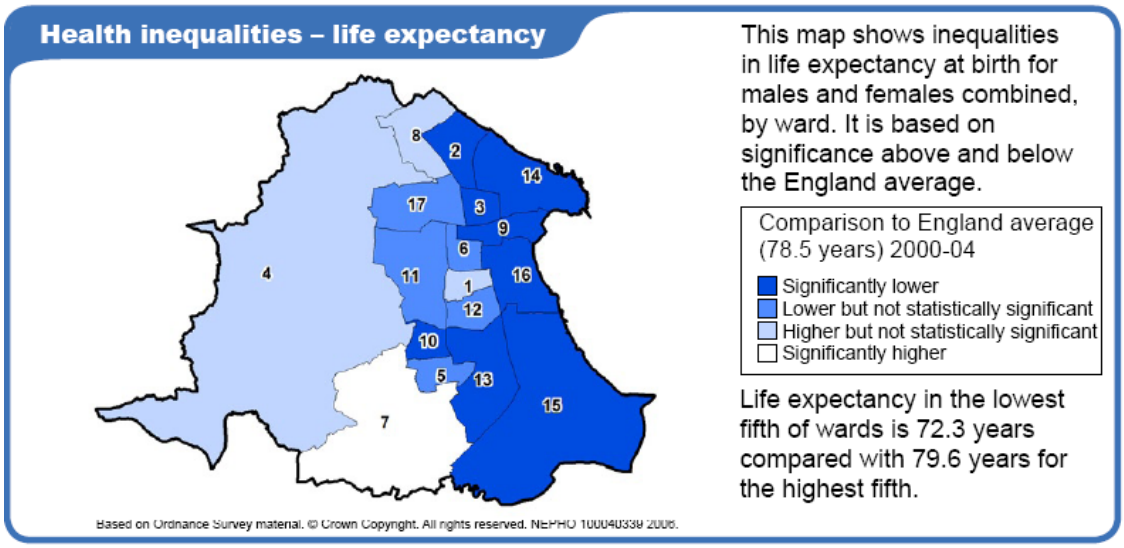
Health in Hartlepool is generally improving. There has been a fall in early deaths from heart disease and stroke; and the rate of road injuries and deaths is better than the England average[2].

However, there is still much to do (**Box 1**). Health in Hartlepool is still worse than the national average. Levels of deprivation are higher and life expectancy is lower than the national average. **Figure 1** shows the variation in life expectancy between wards in Hartlepool. This variation reflects the deprivation at ward-level: areas with the highest deprivation have the lowest life expectancy.

Box 1: At a glance: Health initiatives and challenges in Hartlepool[4]

- Levels of deprivation are higher and life expectancy is lower than the England average.
- Inequalities: life expectancy is 9 years lower for men living in the most deprived areas, compared to least deprived areas. The difference is 7 years for women.
- Over the last 10 years, the death rate from all causes has fallen for men but has fluctuated for women.
- The early death rate from cancer has changed little over the last 10 years.
- Both the death rate from smoking; and the percentage of mothers smoking in pregnancy are worse than the England average.
- The percentage of physically active children is better than the England average
- Alcohol-related hospital admissions are higher than the national average
- Childhood immunisations rates are significantly lower than the national average

Figure 1: Map of ward-level life expectancy in Hartlepool[3]



(Based on 2001 census data. Updated data will be available in 2012).

Ward legend

1	Brinkburn	10	Owton
2	Brus	11	Park
3	Dyke House	12	Rift House
4	Elwick	13	Rossmere
5	Fens	14	St. Hilda
6	Grange	15	Seaton
7	Greatham	16	Stranton
8	Hart	17	Throston
9	Jackson		

4. What does this Strategy cover?

This Strategy outlines the strategic health and wellbeing priorities for Hartlepool. It builds on the good work already underway[4], whilst maximising the opportunity for better integration of services and closer partnership working presented by moving much of current NHS Public Health services, into Local Authorities. Working together with other areas in the North East will help achieve better outcomes and value, for the 'big issues' in health and wellbeing[5]. The JHWS supports the ten themes of *Better Health, Fairer Health* (2008)[5,6] – the North East's vision and 25 year plan for improving Health and Wellbeing (**Box 2**).

Box 2: *Better Health, Fairer Health* (2008)[o]

- Economy, culture and environment
- Mental health, happiness and wellbeing
- Tobacco
- Obesity, diet and physical activity
- Alcohol
- Prevention, fair and early treatment
- Early life
- Mature and working life
- Later life
- A good death

'Health and Wellbeing' has a broad remit and delivery through a range of partner organisations is central to delivering improvement. This Strategy encompasses and is embedded in the three 'domains' of Public Health practice: Health Protection, Health Services and Health Improvement[7].

Whilst it is important to acknowledge the range of areas involved, the Strategy focuses on areas of work impacting directly on health and wellbeing, or acting as clear 'wider determinants' of health and wellbeing:

- Health care services (including Health Protection)
- Social care services
- Individual lifestyle factors

- Social and community networks
- Housing
- Employment
- Environment

To focus activity in these areas, key outcomes have been selected to drive the Strategy (Section 7).

Other elements of health and wellbeing (initially summarised by Dahlgren and Whitehead in their social model of health[8]) (**Appendix 2**) will be outside the direct remit and influence of the Health and Wellbeing Board and its partner organisations. They will be delivered through associated strategies and work programmes within Hartlepool Borough Council, the NHS and associated partners. Communication and governance processes will ensure links between departments and strategies to limit duplication, further build joint working and integration and enable economies of scale. These processes are outlined in **Appendix 3** and the work programme will also define partners responsible for delivering the outcomes in this Strategy.

5. Our Values

To work together successfully and achieve the vision set out in this Strategy, it is important that all organisations involved sign up to and work within, a set of shared values[5]. For Hartlepool, these values fit with the proposed operating principles for Boards[9] and the Board Terms of Reference. The values are:

- Partnership working and increased integration[10] across the NHS, social care and Public Health
- Maintain an oversight of and work within the budgets for health and wellbeing
- Focus on health and wellbeing outcomes
- Focus on prevention
- Focus on robust evidence of need and evidence of 'what works'
- Shared decision-making and priority-setting, in consultation with CCGs and other key groups
- Support joint commissioning and pooled budget arrangements, where all parties agree this makes sense
- Maximise the process of democratic accountability and develop the Strategy and related plans in consultation with the public and service users

The new Health and Wellbeing Board and Joint Health and Wellbeing Strategy provide the opportunity not only to build on previous good work, but to maximise partnerships and evidence base to generate new ways of tackling challenges to health and wellbeing. 'Asset-based' approaches appreciate and mobilise community talents, skills and assets and can be used to maximise wellness[11]. Actions to deliver the priorities in this strategy aim to facilitate this approach.

6. What do we already know? – The case for improving health and wellbeing

There is a 9 year difference in male life expectancy between the most advantaged and the most disadvantaged wards in Hartlepool[2]. We know that socio-economic inequalities lead to inequalities in life expectancy and disability-free life expectancy[12]. Furthermore, the relationship between these is a finely graded – for every decrease in socio-economic conditions, both life expectancy and disability-free life expectancy drop. Social and economic inequalities are important causes of this relationship[12]. In his *Strategic Review of Health Inequalities in England* (2010), Prof. Sir Michael Marmot argues that fair distribution of health, well-being and sustainability will impact positively on the country's economic growth. To improve health and wellbeing, action is needed across all social determinants of health to reduce health inequalities. To make a difference, action to improve health and wellbeing should be across all socio-economic groups but at a greater scale and intensity as the level of disadvantage increases[12] (**Appendix 4**).

We also know that focusing on early years interventions – giving children the best start in life – helps deliver the greatest benefits in health inequalities and economic terms. Health and wellbeing improvements delivered during childhood can reap benefits both in early life and throughout the individual's life-course[12].

7. Identifying our key outcomes

Key outcomes and objectives have been developed in consultation with the public, service users and partner organisations, through LINkS membership on the Health and Wellbeing Board (and the development of HealthWatch), democratically elected member representation on the Board, and the consultation process (**Appendix 5**). The process of prioritising activities to form the objectives was also carried out using a robust and valid framework (**Appendix 6**). There are some key activities, which we know we help deliver on our aims and are effective, evidence-based and good value for money. They also fit with the priorities indentified by the community.

Key outcomes and objectives have been developed with the following in mind:

- Local Authority 'mandated' services
- Clinical Commissioning Group draft plans
- Current JSNA commissioning intentions
- Hartlepool Public Health Transition Plan

<u>Local Authority mandated services</u>[13]

Under the coalition government's proposals for the new Public Health system, Local Authorities will be mandated to provide the following:

- Appropriate access to sexual health services

- Steps to be taken to protect the health of the population, in particular, giving the Director of Public Health a duty to ensure there are plans in place to protect the health of the population
- Ensuring NHS commissioners receive the public health advice they need
- The National Child Measurement Programme
- NHS Health Check assessment

Consideration is also being given locally to the various additional services not covered by this list, which would be important to continue to provide e.g. stop smoking services.

Clinical Commissioning Group draft plans

Close working with Clinical Commissioning Groups (CCGs) has been important throughout the process, to ensure the Strategy is embedded in CCG plans from the outset. This will facilitate integrated commissioning. Due to the broad nature of health and wellbeing, improvements will only be seen if the health and wellbeing agenda is also embedded in wider relevant Local Authority strategies and services. The work programme (**Appendix 7**) outlines how this is being done.

The draft Clinical Commissioning Group plan[14] for Hartlepool and Stockton-on-Tees has highlighted the key challenges:

- Cardiovascular disease
- Cancer
- Smoking –related illness e.g. COPD
- Alcohol-related disease

These match with the results of a 2010 public engagement campaign, which recorded the views of 1883 people (area) regarding priorities for them and their families. See **Appendix 8** for an overview of the draft CCG commissioning plan.

Current JSNA commissioning intentions

The 2010 Hartlepool JSNA[4] outlines commissioning intentions for health and social care. The JSNA is currently being refreshed to produce a live web-based system through engagement with key partners. Priorities may need to be revisited following the publication of the refreshed JSNA, in consultation with partners.

Hartlepool Public Health Transition Plan

The transition plan outlines the proposed activity to be funded through the Public Health budget (**Appendix 9**). This is subject to confirmation of the budgets available and therefore may change.

Suggested key outcomes

The suggested strategic key outcomes for consultation are:

- Every child has the best start in life
- Reduce the gap in life expectancy
- Improving wellbeing for those with long-term conditions

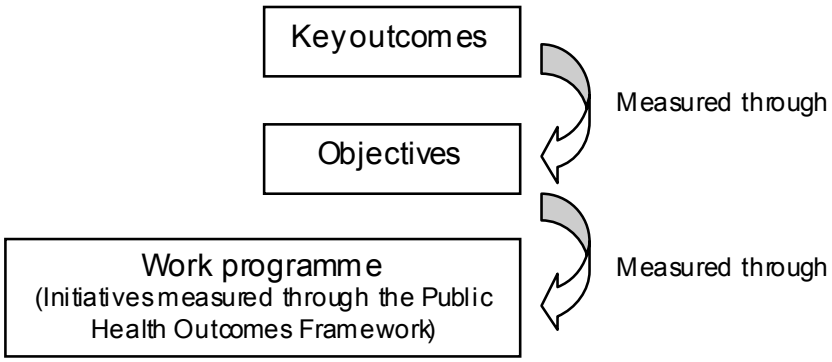
Through:

- Tackling health inequalities: proportionate universalism and tailoring interventions – those most in need
- Building social capital

8. Objectives

To describe how the key outcomes will be addressed, a range of objectives have been identified through the consultation process. Delivery on the objectives will be ensured through the work programme which supports this Strategy. The work programme specifies the detailed initiatives to deliver on the objectives and will also ensure coverage of the outcomes expected in the new Public Health Outcomes Framework[15]. **Figure 2** summarises the mechanism for ensuring delivery on the key outcomes.

Figure 2: Delivering on the key outcomes



Outcome: Every child has the best start in life

In Hartlepool:
INSERT KEY FACTS ABOUT CHILDREN IN HARTLEPOOL:

- Immunisation
- Smoking in pregnancy
- Breastfeeding
- Educational attainment
- Alcohol misuse
- Under 18 conceptions
- Parenting and literacy skills

ENTER PICTURE/ GRAPH

Research shows

- Unimmunised children are at a far greater risk of contracting childhood illnesses such as measles, which can have serious health consequences.
- Smoking or exposure to smoke in pregnancy increases the risk of premature birth and low birth weight. Teenage mothers are much more likely to smoke during pregnancy.
- Babies who are breastfed have a reduced risk of illness in the short- and long-term.
- Educational attainment is directly linked to employment prospects. Better employment prospects are linked to better health and wellbeing outcomes.
- Alcohol misuse among parents can impact on children's health and wellbeing. Misuse among children is linked to other risk-taking behaviour e.g. teenage pregnancy. Alcohol admissions to hospital are increasing,
- Teenage pregnancy rates are higher than the national average. Babies born to teenage parents tend to have worse health and wellbeing outcomes. Some STI rates are also increasing.
- Increased confidence in parenting and family literacy skills impact positively on children's health, wellbeing and educational attainment.

What we plan to do

- Increase childhood immunisation rates
- Reduce smoking in pregnancy
- Increase breastfeeding
- Increase the number of young people who are 'work-ready' and increase appropriate employment opportunities
- Reduce the prevalence of alcohol misuse
- Provide sexual health services which are accessible to young people
- Promote parenting and family literacy skills

Outcome: Reduce the gap in life expectancy (within Hartlepool and between Hartlepool and the national average)

In Hartlepool:
INSERT KEY FACTS ABOUT LIFE EXPECTANCY IN HARTLEPOOL

ENTER PICTURE / GRAPH

Research shows

What we plan to do

- Reduce smoking prevalence
- Reduce the prevalence of alcohol misuse (including binge drinking in the wider population as well as those with chronic alcohol problems)
- Tackle the current obesogenic environment
- Increase appropriate employment opportunities and the number of people who are 'work-ready', particularly among young people
- Increase early diagnosis and management of cancer (including through improved screening rates)

Outcome: Improving wellbeing for those with long-term conditions

In Hartlepool:
INSERT KEY FACTS ABOUT LONG-TERM CONDITIONS IN HARTLEPOOL

ENTER PICTURE / GRAPH

Research shows

What we plan to do

- Increase the availability of safe, healthy and affordable housing to those most in need (through improving existing housing as well as providing new homes)
- Increase the proportion of people with a long-term condition, who are enabled to self-manage their condition in their own home
- Ensure appropriate health and social care services and support for people with dementia

9. Strategy ownership and review

This Strategy is owned by the Shadow Health and Wellbeing Board. It will be reviewed by the Board on a 3-yearly basis.

Next review date: April 2013.

References

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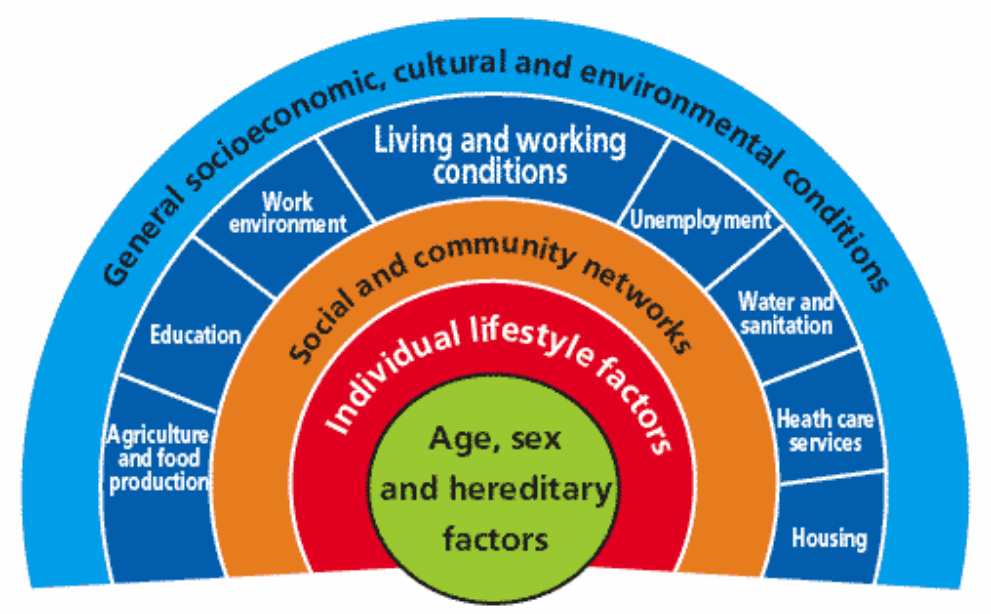
Appendices

Appendix 1 : Summary model

To be added.

Appendix 2: Social model of health (REF)



Appendix 3: Communication and governance processes to ensure delivery of the Strategy

To be added.

Appendix 4: Priority policy areas outlined in the Marmot report (2010)[7]:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention

Appendix 5: Consultation process for identifying objectives

The seven Health and Wellbeing Board subgroups will be used as a focus for consultation on priorities. It is proposed the seven subgroups are mapped to existing groups to maximise structures already in place. A series of events will be planned in January – February 2012 to enable these prioritisation discussions, each beginning with the context of key evidence (facilitated through JSNA topic leads) and progress on key Public Health indicators.

The Strategy should also be developed with CCGs in the spirit of co-production to embed the Strategy in CCG plans from the outset and facilitate integrated commissioning, rather than aligning plans through a *post-hoc* checking mechanism.

There will be consultation on the draft Strategy, according to statutory requirements and Local Authority processes. 'Face the Public' events will be used as an opportunity to consult on the draft strategy in June 2012 (which will also support parallel consultation on the draft JSNA). Haringey Shadow Health and Wellbeing Board has produced a consultation document which includes an example of a public consultation questionnaire[9].

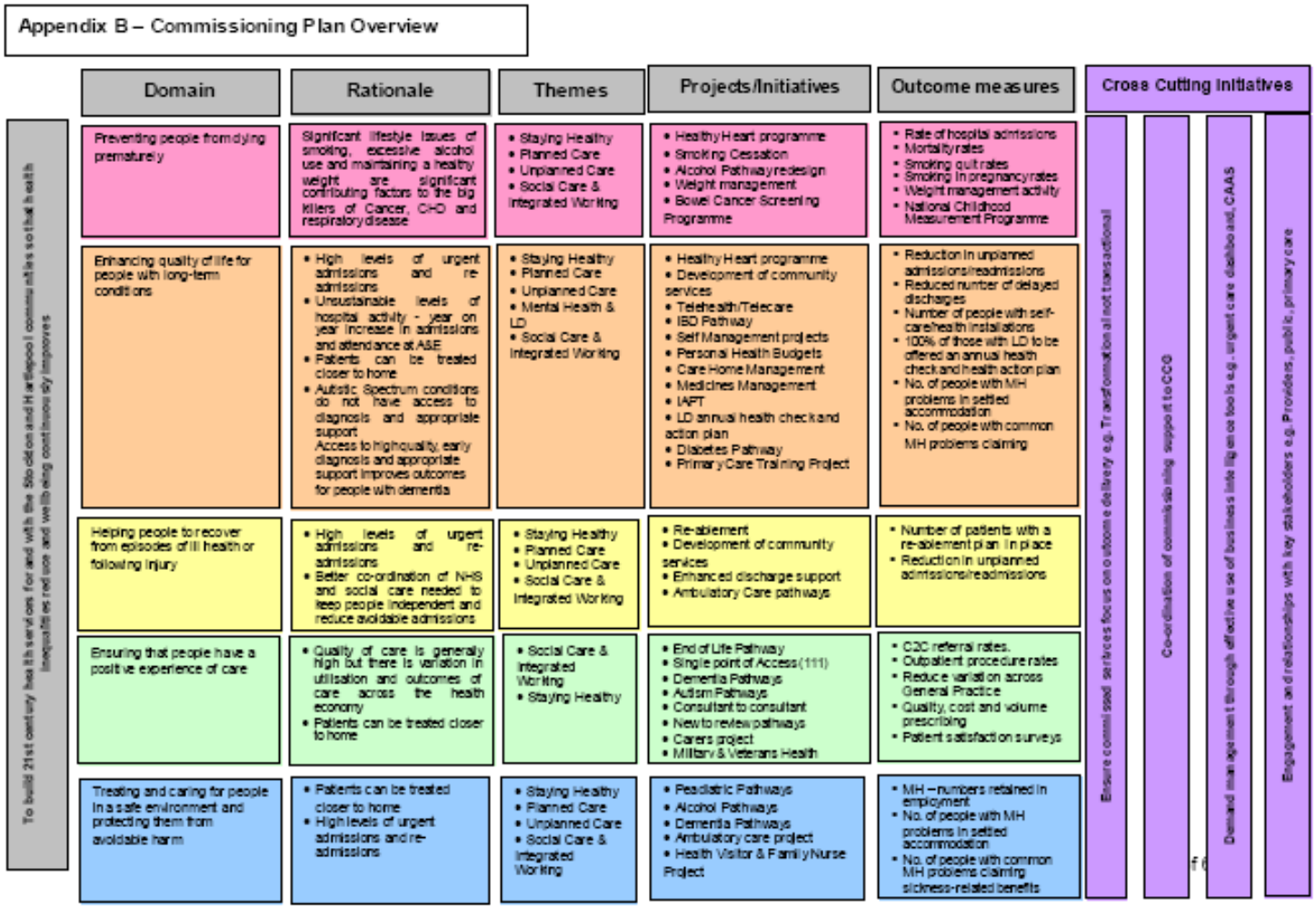
Appendix 6: Prioritisation mechanism and framework
To be added.

This will clarify the principles and the 'must-dos', and explicitly consider the evidence- and needs-base and political priorities.

Appendix 7: Work programme
To be added.

A work programme will be defined to agree timescales and organisational accountability for contributing towards outcomes. This should include a risk log for the implementing the Strategy.

Appendix 8 : Hartlepool and Stockton-on-Tees draft CCG commissioning plan overview



Appendix 9 : Hartlepool Public Health Transition Plan: Proposed activity to be funded from the Public Health budget

Public health topic	Proposed activity to be funded from Public Health budget
Sexual health	Testing and treatment of sexually transmitted infections, fully integrated termination of pregnancy services, all outreach and preventative work
Immunisation against infectious disease	School immunisation programmes, such as HPV.
Seasonal mortality	Local initiatives to reduce hospital admissions and seasonal excess deaths
Accidental injury prevention	Local initiatives such as falls prevention and reducing childhood injuries
Public mental health	Mental health promotion, mental illness prevention and suicide prevention
Nutrition	Locally led initiatives
Physical activity	Local programmes to reduce inactivity; influencing town planning such as the design of built environment and physical activities role in the management / prevention of long tram conditions
Obesity programmes	Local programmes to prevent and treat obesity, e.g. delivering the National Child Measurement programme; commissioning of weight management services
Drug misuse	Drug misuse services, prevention and treatment
Alcohol misuse	Alcohol misuse services, prevention and treatment
Tobacco control	Tobacco control local activity, including stop smoking services, prevention activity, enforcement and awareness campaigns
NHS Health check	Assessment and lifestyle interventions
Health at work	Local initiatives on workplace health and responsibility deal
Prevention and early presentation	Behavioural/ lifestyle campaigns/ services to prevent cancer, long term conditions, campaigns to prompt early diagnosis
Children's public health 5-19	The Healthy Child Programme for school age children, school nurses, health promotion and prevention interventions by the multi professional team

Community safety and violence prevention and response	Specialist domestic violence services that provide counselling and support services for victims of violence including sexual violence
Social exclusion	Support for families with multiple problems, such as intensive family based interventions
Dental Public Health	Targeting oral health promotion strategies to those in greatest need.

IMMUNISATION STRATEGY 2011-2012, NHS TEES (draft copy)

Peter Kelly's forward

After clean water immunisation is the most effective public health intervention in the world, saving lives and promoting good health Immunisation plays a critical part in preventing ill health and helping people lead healthier lives etc

1.0 Introduction

Immunisation is generally regarded as one of the most effective and cost- effective public health interventions in modern health care. It is also one of the few direct health interventions that can be quantified and measured. The importance of immunisation has been re-determined recently with the H1N1 pandemic which highlighted the need for worldwide preventative measures to be deployed promptly and safely on a considerable scale. The impact of this programme raises two issues, namely the importance of a sustainable and robust immunisation strategy to enable completion of the programme without detriment to other routine vaccination strategies and the collaboration of partner organisations to enable efficient implementation. Although the NHS is currently facing challenging times and the greatest transition that it has ever experienced, it is essential that we do not loose focus on the delivery of our public health agenda. The public health outcomes framework for England 2013-2016 (DH, 2012) gives reference to population vaccination coverage as a critical indicator to be taken to protect the public's health. Public health England will have a core role in the delivery of these improvements supported by NHS's and local authorities locally. 2012/2013 will be a crucial year in which further developments of the public health outcomes framework will emerge for this purpose although our key actions in this document will remain consistent, this strategy will remain a live and evolving document.

2.0 Background

2.1 Global Background

Around the world immunisation policy and strategy is largely based on the World Health Organisations (WHO) global policies. WHO is responsible for directing and co-ordinating public health policy across the globe and with regard to immunisation, for setting coverage rates and disease elimination targets such as for polio and measles

Global Alliance for Vaccines and Immunisation (GAVI), and the Expanded Programme on Immunisation (EPI), are two such programmes committed to ensuring all children throughout the world are vaccinated against vaccine preventable diseases (VPD). The success of these programmes can be measured in developing countries by the significant drop in mortality rates form VPD from one in four children (30 years ago) to a current level of one in 10 children (to reflect adults).

2.2 National Background

The DH and the JCVI receive advice from a variety of experts on subjects such as epidemiology, mathematical modelling and future predictions of infectious diseases, safety issues, quality control and public opinion. All these factors help to define, inform and develop immunisation policy in the UK . The effectiveness of the policy can be

measured in two ways. Firstly by the numbers of individuals vaccinated and secondly by the reduction in transmission of infectious disease or herd immunity. In September 2009 the National Institute for Health and Clinical Excellence (NICE) published public health guidance 21 'Reducing the difference in the uptake of immunisations', which focused on increasing immunisation uptake among children and young people aged under 19 years in groups and settings where immunisation coverage is low.

The guidance gives 6 clear recommendations to implement under the following headings:
1. Immunisation programmes
2. Information systems
3. Training
4. Contribution of nurseries, schools, FE colleges
5. Targeting groups at risk of not being fully immunised
6. Hepatitis B immunisation for infants

3.0 Local Position
2.3.1 Background
The challenges to achieve national uptake targets around children's immunisations, influenza and pneumococcal for older people, are well recognised in Teesside. Immunisations are also required throughout life to protect from travel and occupational related infections and it is essential that the population of Teesside have access to these, to protect themselves and their families. It is therefore a key responsibility of Tees Primary Care Trust to ensure vaccination programmes are commissioned and delivered in a well-organised and structured manner, in order to maximise the availability and uptake of vaccinations to achieve national targets, developing herd immunity to prevent outbreaks of infection.

The population of Teesside is approximately 550,000. There are four individual PCT`s who historically worked independently. Currently, there is one Tees wide Public Health Directorate served by two community provider services, one north of the river and one south.

The current position is that some of the childhood immunisation uptake rates across Teesside are falling below DH and local vital signs targets, the latter requiring an uptake rate of approximately 95% coverage in childhood immunisations to achieve herd immunity. This increases the risk of child morbidity from a variety of infectious diseases which are preventable through vaccination. Even in areas of good uptake there may be pockets of individuals who are unimmunised or partly immunised and therefore at risk from infectious disease as evidenced by the recent measles outbreak in Hartlepool 2009, shortly followed by the need to respond to the H1N1 Pandemic Vaccination Programme. Local uptake data can be seen in Appendix1. This impacted on our ability to be proactive towards increasing the vaccination uptake. Although various local and national initiatives have been implemented to improve uptake, this remains sporadic and uncoordinated. Additionally, methods of data collection vary across the patch and some discrepancies in data accuracy have been identified.

In May 2010 we were visited by the National Support Team (NST) to provide robust support to help meet national targets and improve our commissioning and delivery systems. The diagnostic visits from the NST to Tees PCT and local partners highlighted the challenges and opportunities of our current delivery system. The recommendations of the NST visit are highlighted briefly in the following 5 categories.

Five Key areas

1. Vision – the need for a systematic approach to immunisation and the development of a multi-disciplinary immunisation strategy and an immunisation action plan.
2. Data – Standardisation of data collection
3. Training – Review workforce requirements to ensure that there is a sustainable and skilled workforce
4. Industrialisation – Identify, evaluate and industrialise good practice across Teesside
5. Communication – Build on existing communication networks

2.3.2 Routine childhood immunisations
Currently all childhood immunisations, with the exception of the school leaver booster and HPV are delivered through GP practice (table 1) and supported by health visiting teams.
Responsibility for childhood immunisation however should not rest solely with the GP or practice nurse. The National Institute for Clinical Excellence (NICE) has produced guidance on "Reducing Differences in the Uptake Rates of Immunisation", which suggests:

- Improving access to immunisation services
- Adopting a multifaceted coordinated programme as part of local child health strategy
- Ensuring vaccination status is monitored as part of a wider assessment of child health
- Engaging and involving the wider population including, children's services, education, and other health professionals.

We recognise that a more flexible approach to vaccination is needed in order to provide a more equitable service across Teesside
Table 1

Age	Diseases Protected Against	Vaccine given	Location given
Two months old	Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b (Hib) Pneumococcal infection	DTaP/IPV/Hib and Pneumococcal conjugate vaccine (PCV)	GP Practice
Three months old	Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b (Hib) Meningitis C (meningococcal group C)	DTaP/IPV/Hib and Men C	GP Practice
Four months old	Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b (Hib) Meningitis C (meningococcal group C) Pneumococcal infection	DTaP/IPV/Hib and Men C and PCV	GP Practice
12- 13 months	Haemophilus influenza type b (Hib) and meningitis C Measles, mumps and rubella (German measles) Pneumococcal infection	Hib/MenC MMR and PCV	GP Practice
Three years and four months or soon after	Diphtheria, tetanus, pertussis and polio Measles, mumps and rubella	DTaP/IPV or dTaP/IPV and MMR	GP Practice
Girls aged 12 to 13 years	Cervical cancer caused by human papillomavirus types 16 and 18	HPV	School

13 to 18 years old	Tetanus, diphtheria and polio	Td/IPV	School
High risk groups all ages/ over 65 year olds	Influenza, Pneumonia	Influenza Pnuemococcal PPV	GP Practice/ Home visit
All ages	Hepatitis A and B, Rabies, Typhoid, Japanese encephalitis, Yellow fever etc	Travel vaccines	GP Practice/ private clinic

2.3.3 Adult immunisation schedule:

Influenza vaccination

The purpose of the seasonal flu immunisation programme is to offer protection to those who are most at risk of serious illness or death should they develop flu. National uptake targets are in place for influenza vaccine uptake in the over 65year olds and the at risk groups.

Uptake rates are as follows:

- 75% uptake for people aged 65 years and over as recommended by the WHO
- 75% uptake for people under age 65 with clinical conditions which put them more at risk from the effects of flu, and pregnant women, as recommended by the EU

A trajectory target for increases in uptake in clinical risk groups and pregnant women has been outlined as 60% in 2011/12, and 70% in 2012/13, so that an uptake of 75% can be reached or exceeded in 2013/14. As can be seen from the clinical risk uptake data below is somewhat of a challenge.

Transmission of flu health care settings can be significantly reduced by immunisation of health care workers. Uptake of flu vaccine in health care workers in Teesside can be seen below.

Routine vaccination of poultry workers is no longer included in the programme.

Table 2. Seasonal Flu Vaccine Survey (GP) - February 2011 (1 Sep 10 to 28 Feb 11) % uptake rates

PCT	Over 65's	At risk	Pregnant women
Hartlepool	71.80%	52.90%	42.90%
Stockton	72.40%	48.10%	45.60%
Middlesbrough	75.10%	49.80%	35.10%
Redcar & Cleveland	78.10%	54.10%	45.40%

Pnuemococcal vaccination

Polysaccharide pneumococcal vaccine (PPV) is currently offered to all people over the age of 65 years. There is no currently no target for this vaccine and as highlighted in the next section the efficacy of this vaccine is questionable. However, pneumococcal disease is a major cause of morbidity and mortality in the elderly and individual vaccination should still be encouraged.

2.3.4 Changes to the immunisation schedules
Horizon scanning is important in order to prepare for changes in the current immunisation schedules (childhood and adult). Currently the Joint Committee for immunisation and Vaccination (JCVI) are examining evidence and have recommended:

- Changing the delivery of meningitis C vaccine to babies from 2 doses to 1 dose (with 12 month booster) and including an adolescent men C vaccination. Booster doses of other vaccines in adolescence are also being considered.
- Including other age groups 0-6 months and 5years to 18 years into the influenza programme. The impact of these changes on both Primary care and school nursing services could be immense and forward planning is necessary to ensure service delivery. Additionally a planned programme of public information and awareness raising is required as part of our strategy.

Epidemiological evidence has also shown that polysaccharide pneumococcal vaccine (PPV) does not significantly reduce invasive pneumococcal disease in the elderly and although this programme is still in place further considerations of this programme may possibly be made in the future.

Introduction of a herpes zosta vaccine for over 75 year olds is also being considered

2.3.5. Non routine immunisations
Hepatitis B for neonates
Without vaccination up to 90% of babies born to hepatitis B infected mothers will become chronic hepatitis B carriers, which in turn increases their risk of both cirrhosis of the liver and hepatocellular carcinoma in later life. About 25% of those infected in childhood will die from these causes. If these babies are vaccinated, in over 90% of cases, perinatal transmission can be avoided. Successful disease prevention can only be provided if the vaccinations are given according to the schedule.

In the two localities of Teesside (South Tees and North Tees) there are different service models currently employed to follow up babies once discharged from maternity services. Within this strategy we aim to ensure that there is a robust pathway in place to ensure vaccination and follow up of all babies born in Teesside.

Tuberculosis
Over the last 50 years, the demographic pattern of tuberculosis has changed from a disease which affected a wide range of the population to one which now predominately affects certain sub groups of the population with 2/3rds of the cases being born abroad. Due to the declining rates in the indigenous population, in 2005 the schools programme for BCG population was discontinued and replaced with a targeted vaccination programme for at risk groups. Locally the rate of TB diagnosis varies across Teesside. Rates of TB diagnosis between 2007-2010 (source HPA):
Middlesbrough 17.8 per 100,000
Stockton 4.7 per 100,000
Hartlepool 6.6 per 100,000
Redcar and Cleveland 3.6 per 100,000
The national average is 15.3 per 100,000.

2.3.5 Child health information Systems
The implementation of child health information and reporting systems across Tees is currently very different in the South of Tees and North of Tees PCT areas.

In the two South of Tees PCT areas a single Child Health Information System (CHIS) records a comprehensive range of data relating to all children for whom the two South of Tees PCTs have responsibility. This single CHIS is managed by the Middlesbrough,

Redcar and Cleveland Community Services Child Health Records Department (MRCCS CHRD). Amongst other things the South of Tees CHIS provides lists of children in need of immunisation to all GP practices across the two South of Tees PCT areas. South of Tees GP practices return details of the childhood immunisations they have completed to the MRCCS CHRD so that the South of Tees CHIS can be kept up-to-date. In addition the MRCCS CHRD currently compiles the quarterly COVER reports for the two South of Tees PCT areas.

In the two North of Tees PCT areas, two different CHISs are in operation, one for each North of Tees PCT area. The range of data held within these CHISs is currently not as comprehensive as that held by the South of Tees CHIS. Neither of the North of Tees CHISs currently sends lists of children needing immunisation to the GP practices. The compilation and reporting of quarterly COVER data is carried out by the Tees PCTs Primary Care Informatics team (Tees PCI) which forms part of the Tees Directorate of Strategic Intelligence. Put simply, there are actually three different kinds of system in operation within the North of Tees PCT areas.
What has become apparent during the course of an evaluation exercise is that none of the child health information and reporting systems currently in operation across Tees is without fault or fully serves the needs of those that it endeavours to serve.

4.0 The Vision, aims and objectives

Our vision is that people of Teesside live longer, "healthier lives". Through this strategy we aim to fully protect people of Teesside against vaccine preventable diseases. We will strive to provide flexible vaccine programmes that will reflect the evolving needs of the population of Teesside.

It will also ensure that services deliver equitable immunisation programmes by being flexible to meet the needs of local communities. Utilisation of evidence from uptake data, horizon scanning to identify trends in population demographics and identifying new vaccine developments is important in informing developments to enable workforce and service delivery planning.

4.1 The aims of this strategy are:

- Reduce the risk of vaccine preventable disease by maximizing the uptake of vaccinations
- To achieve herd immunity in the Teesside population
- To ensure that immunisation services are equitable and accessible to all
- To provide high quality, standardised immunisation services through effective commissioning

4.2 The objectives of this strategy are:

Based on the 2009 NICE guidelines and aim to work in partnership with all key stakeholders across Tees to using a bottom up approach to develop an inclusive strategy which reflects that immunisation is every bodies business.

- **Immunisation programmes**. To provide a multifaceted, coordinated approach to immunisation programmes, improving access to services and providing tailored information and support.

- **Information systems**. Ensure NHS Tees child information systems are up to date reconciled and consistent.
- **Training**. Ensure that all staff who give and/or advice on immunisations are adequately trained in line with national minimum standards and competent to deliver this service.
- **Contribution of nurseries, schools, FE colleges.** Work in partnership with other organizations to promote and deliver immunisation programmes**.**
- **Targeting groups at risk of not being fully immunised**. Ensure immunisation services are accessible to all to address health inequalities and high risk groups are targeted appropriately.
- **Hepatitis B and BCG immunisation for neonates.** Develop a targeted and coordinated programme for neonates across acute and community settings.
- **Seasonal Influenza and Pneumococcal.** Increase uptake rates to reflect the DH trajectory over the next 3 years.
- **Other immunisation programmes:** Ensure HPV and BCG programmes are running effectively
- **Communication.** Develop an internal and external communication plan, paying particular attention to community engagement and a social marketing initiatives
- **Horizon scanning** to identify risks and trends in population demographics, and identify new vaccine developments to enable workforce and service delivery planning.

5.0 Progress and challenges

5.1 What progress have we made?

- ❖ We have an established immunisation strategy group
- ❖ We have established a governance structure for immunisation committees and sub groups
- ❖ We have previously developed some effective partnership working with local authorities during a recent measles outbreak and pandemic flu response.
- ❖ We have begun to develop links with the local Be Healthy groups, enabling us to share data and explore ways to improve immunisation uptake.
- ❖ We have established a hepatitis B stakeholder group and action plan for Teesside

5.2 What are the challenges?

- Maintaining focus throughout the current transitional phase and changes in the organisational and contractual delivery of health care services.
- Securing funding to support new initiatives
- Confusion regarding responsibility and accountability in delivering vaccine programmes
- PCT vital signs targets are higher than those of the services providers e.g. GPs
- Targets vary across the four PCT 's.
- Immunisation services do not offer patient choice or flexibility Clinic times and capacity not able to meet the demand for vaccination services not accessible due to demands of working hours.
- Securing funding for new initiatives

6.0 Performance management

In order to ensure the effectiveness of the strategy, continual monitoring of the uptake rates and performance of service providers is required.
This strategy will focus on commissioning high quality services to enable us to maximise uptake by achieving our objectives, focusing on raising awareness of the importance of immunisation across the community and ensuring that Teesside has a trained and skilled workforce to deliver immunisation programmes with the knowledge to inform families.

NHS Tees is committed to ensuring the population it serves is protected from vaccine preventable diseases and the following section of this strategy describes the outcomes and actions required to meet the objectives of this strategy, to ensure that vaccine preventable diseases are prevented by maximising uptake. These actions will be incorporated in commissioned contracts

- Continual monitoring of immunisation uptake at practice level and population level will ensure that areas of poor uptake are identified at an early stage and enable staff responsible for delivery to be alerted and actions to be put in place to improve uptake in a more pro-active response.
- Continual monitoring of performance against contracts as described within the Strategy will indicate progress and provide an early warning of a drop in uptake of immunisations.
- We can be assured that this strategy has been successful when we are reaching national targets equitably across Teesside. This will ensure that we do not have vulnerable groups of unvaccinated people in Teesside. The Immunisation Strategy Group will be responsible for monitoring the strategy and immunisation uptake and developing action plans to ensure that uptake continuously improves and is maintained across Teesside.

7.0 Governance

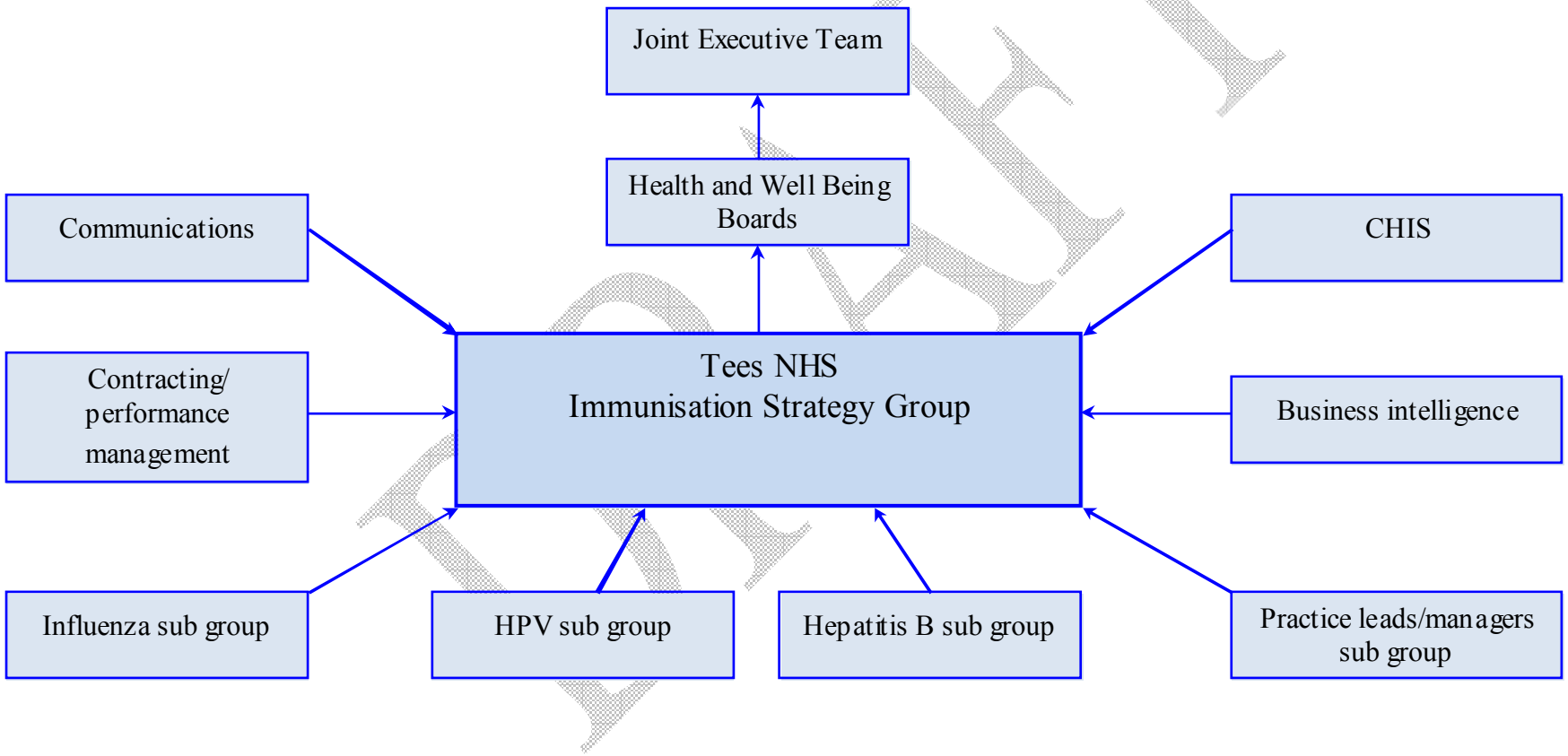
A number of groups will be responsible for the implementation and performance monitoring of the strategy. The public health contracts manager in collaboration with relevant contracting authorities provides overall co-ordination and support of the commissioning process.

The Immunisation Strategy will be implemented through the Immunisation Strategy Group.

Significant events involving vaccination will be reported according to PCT policy to ensure that lessons are learned from aspects of good and poor practice.

The NHS Tees Immunisation Strategy Group is responsible for:
_ Monitoring the strategy.
_ Developing and implementing the action plan.
_ Monitoring immunisation uptake.
_ Providing quarterly updates to health & wellbeing boards

Tees NHS Immunisation Strategy Governance Structure



8.0 Cost of implementing the strategy
It is anticipated that the majority of objectives in this strategy can be delivered through contracted services that are already in place with appropriate funding and therefore is cost neutral.

Changes in the National Immunisation Programme and additional campaigns attract new monies from the DH, which will be used to commission the delivery of the additional services and provide training where necessary.

Over the life of the strategy resources may need to be re-distributed depending on service development and cost implications against any current DES or LES will occur as uptake across all immunisations needs to increase to meet national targets.
Additional resources may be required for:

- Working more closely with schools and colleges
- Providing training where appropriate
- Reconciling child health information systems and GP practice records to ensure consistency.
- Ensuring accurate transfer of immunisation information between providers and between services
- and systems.
- Undertaking audit and quality assurance of immunisation records.
- Providing Outreach programmes for children from traveler, or new immigrant families.
- Providing home visits to parents who do not bring their children to attend immunisation appointments.
- Developing media campaigns
- Developing social marketing initiatives
- Developing immunisation awareness campaigns.

9.0 Action plans :Are rated:
Priority 1 – to be completed in 12 months
Priority 2 – to be commenced within 12 months
Priority 3 - ongoing

Objective 1: Immunisation programmes

	Objective	Action	Priority	RAG rating/progress	Who should take action
1.1	Develop a robust strategy group to monitor and deliver on the proposed action plans	Widen membership of strategy group to include Commissioners, managers and coordinators (PCTs), children's services, Sure Start children's centres and services for vulnerable groups, Health professionals responsible for children and young people's immunisation services e.g. paediatricians, health visiting and school nursing teams, GPs	P1	Group Established Dec11	Toks NC JL RF
1.2	Ensure there is an identified healthcare professional in the PCT and every GP practice who is responsible – and provides leadership – for the local childhood immunisation programme	Contact Practice leads to establish a Practice leads sub group. Attend practice manager/nurse forums Work with the Practices to ensure leaders are identified and trained to take responsibility for immunisations and are aware of national and local guidelines. Work with Practice leads and practice managers and Health Visitors to address immunisation issues in Practice Work with Practices on the Vaccine Efficiency Savings Programme Audit (VESPA) Work with school nurses/health visitors to establish a seamless service in the community	P 1 P1 P1 P1	Previous flu survey revealed all practices have a representative	Public Health/ Primary Care Public health, Practice leads, Practice managers, medicines management
	Objective	**Action**	**Priority**	**RAG**	**Who should take action**

				rating/progress	
1.4	Improve access to immunisation services.	Work with practices on encouraging flexibility of immunisations appointments for parents/carers i.e extending clinic times, ensuring children and young people are seen promptly and by making sure clinics are child- and family-friendly. Work with primary care contracting on current requirements within GP contracts and how to use targets for payments. Work with local authority to establish and develop new services to capture "difficult to reach" patients "Pilot" community engagement model to improve immunisation uptake.	P1 P1		Public health, Practice leads, Practice managers, Public health/ Community services,/ NEPCSA/Contracting/CCG PH/Service providers/contracting local authority
1.5	Ensure Equitable immunisation programmes are delivered through flexible services to meet the needs of local communities. Services will be planned taking into consideration the reasons for poor vaccine uptake,	Establish the requirements of both DES and LES contracts and formalise the process of renewal Contracts and Service level agreements will be reviewed to reflect changes in local and national targets. Performance will be managed and uptake data fed back to providers at quarterly meeting Ensure Immunisation targets to are consistent across all four PCT's	P 1 P 1 P 2		PH/Contacting Contracting/PH PH/ PH
1.7	Ensure there are enough	Investigate with CHIS if this is a problem in Teesside	P2		PHF/PH/CHIS

	immunisation appointments available so that all young people and children can receive immunisations in a timely manner				
1.8	Ensure young people and parents know how to access immunisation services and information.	Review content of GP contracts and service specifications include: _ Providing patients with tailored information, advice and support on the vaccinations and immunisation including the benefits and risks. _ Ensuring patients have the opportunity to discuss any concerns they might have about immunisations.	P2		PH/CCG/Practices/Comms

Objective 2: Information systems

	Objective	Action	Priority	RAG rating/progress	Who should take action
2.1	Ensure PCTs and GP practices have a structured, systematic method for recording, maintaining and transferring accurate information on the vaccination status of all children and young people.	Set up sub group (CHIS working group)to look at the problems associated with information recording and dissemination	P1	Group formed April 2011	PH/CHIS/ PCI
		Meet with Practice Managers to discuss any concerns with CHIS	P1	Agreement from North Tees Practice Managers	PH/CHIS/ PCI
		Establish one centralised repository of data across North Tees.	P1	Specification developed for North Tees Foundation	PH/CHIS/ PCI
		Meet with Stockton and Hartlepool CCGs to secure agreement to proposal to merge CHIS across Teesside.	P1	Agreement from LMC Dec11	PH/CHIS/ PCI
	Monitor vaccination status as part of a wider assessment of children and young people's health	Ensure data collection systems are in place to allow accurate reporting to GP and CHD. :	P1		PH/CHIS/ PCI

	Objective	**Action**	**Priority**	**RAG rating/progress**	**Who should take action**
2.2	Record any factors which may make it less likely that a child or young person will be up-to-date with vaccinations in their patient records and the personal child health record.	Investigate current practices and work with service providers to establish data sets.	P2		PH/Practices
2.3	Ensure up-to-date information on vaccination coverage is available and disseminated to all those responsible for the immunisation of children and young people.	Work with service providers to establish communication links through CHIS working group Gather information for practices and Public health on prospective numbers of children requiring information per quarter	P2		PCI PCI/CHIS

Objective 3: Training

	Objective	Action	Priority	RAG rating/progress	Who should take action
3.1	Ensure all staff involved in immunisation services are appropriately trained and updated regularly	Ensure service specification includes mandatory training requirement.	P2		PH
		Plan for provision of professional training from April 2012	P2		PH
		Develop tier 2 and 3 training to deliver to all agencies in contact with families and young people	P2		PH
3.2	Ensure training complies with national minimum standards	Investigate sources of appropriate training and obtain tenders	P1		PH

Objective 4: Contribution of nurseries, school, colleges of further education

	Objective	Action	Priority	RAG rating/progress	Who should take action
4.1	Work with nurseries and schools to support immunization programmes.	Monitor practice of schools monitoring of vaccination status on school admission Engage with school nurses regarding immunisation uptake rates Formalise processes for feedback on coverage to CCGS/Scrutiny Panel/Children's Services	P1 P1 P1 P1		PH School nurses
4.2	Work with community nurses to ensure systematic and consistent messages are delivered to parents	_ Establish links with local children centre leads. _ Ensure early years establishments have up to date information on immunisations. _ offer training to staff to advise young people and their parents about the vaccinations recommended at secondary school age and provide information in an appropriate format. Children's Services will be commissioned to ensure immunisations are promoted at every possible opportunity including school education programmes Ensure that promotion of childhood immunisation is included	P1 P1 P1 P1 P1		PH school nurses

		in childhood specification			

Objective 5 :Targeting groups at risk of not being fully immunised

	Objective	Action	Priority	RAG rating/progress	Who should take action
5.1	Improve access to immunisation services for those with transport, language or communication difficulties, and those with physical or learning disabilities.	Audit in Practice what Information is provided in different formats, for example, for those whose first language is not English	P2		
		Collate local data and analyse validity in order to assess as to whether specific population sub groups have low or high immunisation uptake rates. Utilise findings to commissioning services to increase access to areas or individuals with low immunisation uptake.	P1		
		Commissioned services will establish the reasons why children have failed to attend two or more appointments by contacting the parents or guardians and feed this information back to the Child Health department and will take action as far as possible to ensure that children who have failed to attend to appointments are immunised.	P1		
		Work with local authority to establish and develop new services to capture "difficult to reach" patients "Pilot" community engagement model to improve immunization uptake.	P1		
5.2	Ensure Prison health services should check the immunisation history of all offenders	Establish links with prison nurses to determine current service and uptake for immunisation in this group	P2		
		Work with Offender Health on audit of local resources within prisons for immunisation			

5.5	Ensure the immunisation status of looked after children is checked during their initial health assessment, annual review health assessment other statutory reviews.	Establish links with LAC nurses to determine current service and uptake for immunisation in this group	P1		

Objective 6:Hepatitis B immunisation for infants

	Objective	Action	Priority	RAG rating/progress	Who should take action
6.1	Implement DH recommendations on hepatitis follow up for babies born to hepatitis B positive mothers (see sub group action plan)	Identifiy person responsible for coordinating the local Hepatitis B vaccination programme for babies. Establish a working group of stakeholders to implement the regional NESHA hepatitis B framework for the screening and vaccination of infants. Group to feed back to Immunisation strategy group 3 monthly. Develop an local action plan to implement necessary processes to achieve a robust and continuous service across Teesside Monitor programme and quality assurance in terms of patient safety and service delivery	P1 P1 P1 P1	In place Established Dec 11 Developed Dec 2011	PH, maternity services, Acute services, community services, CCG's
6.2					

Objective 7: Seasonal influenza and pneumococcal uptake rates

	Objective	Action	Priority	RAG rating/progress	Who should take action
7.1	Increase the awareness of the importance of increasing flu vaccine uptake amongst service providers	Provide feed back to Practices on uptake rates. Continue to identify practices with low uptake and work with practices to highlight areas of improvement Contact practice with good uptake to assess good practice Continue to ensure all service providers are trained and up to date with the relevant information on influenza Work with midwives to increase awareness of the importance of flu vaccine for pregnant women	P1 P1 P1 P1 P1		PCI & PH
7.2	Increase the awareness of the importance of increasing flu vaccine uptake amongst the public and at risk groups	Identify groups with low vaccine uptake and work with Communications department to produce information for the public highlighting the importance of flu vaccine for these groups	P1		Comms/PH
7.3	Increase uptake of flu vaccine amongst health care workers	Increase awareness of the benefits of flu vaccine both for the HCW and their patients	P1		Comms/PH
7.4	Ensure opportunistic pneumococcal vaccination is undertaken by service providers	Explore with practices what methods could be employed to improve pneumococcal uptake	P2		PH/commissioned providers

Objective 8: Other immunisation programmes: Ensure HPV and BCG programmes are running effectively

	Objective	Action	Priority	RAG rating/progress	Who should take action
8.1	HPV-Ensure service provider contracts are up to date and fit for purpose	Re establish HPV sub group to initiate communication on 2011/12 contract	Priority 1	Commenced Jan 2012	PH
8.2	HPV-Ensure systems are in place for up load of current data to open Exeter	To be included in the 2011/12 contract	Priority 1		
8.3	HPV- Ensure systems are in place for up load of retrospective data to open Exeter	Investigate other PCT areas methods of up loading data	Priority 1		
8.4	HPV-Ensure seamless transition from use of cervarix to Gardasil in September 2012	Re establish HPV sub group meetings to determine current training needs.	Priority 2		
8.5	BCG- establish current contract arrangements	Develop links with acute respiratory teams	Priority 2		

Objective 9: Develop an internal and external communication plan, paying particular attention to community engagement and a social marketing initiatives

	Objective	Action	Priority	RAG rating/progress	Lead
9.1	Improve communication around current immunisation programmes with health professionals within primary care, acute trusts and community settings.	The Immunisation Co-ordinator and public health team will work with the communications department and partners to promote immunisations through various community groups at a local level.	P2		
9.2	Improve communication around current immunisation programmes with the public.	Engage with relevant community and voluntary services and the general public to enhance knowledge and understanding of immunisation.	P2		
9.3	Engage communities in the development or change to current immunization programmes through social marketing initiatives	Engage with relevant community and voluntary services and the general public to enhance knowledge and understanding of immunisation. Work to publicise immunisation issues through media events and campaigns.	P2		

Objective 10: Horizon scanning to identify risks and trends in population demographics, and identify new vaccine developments to enable workforce and service delivery planning.

	Objective	Action	Priority	RAG rating/progress	Who should take action
10.1	Ensure Service providers are aware of possible future changes to immunisation schedules and capacity issues	Keep abreast of JCVI meetings and current research into possible need for booster vaccinations in specific age groups Develop links with the Health Protection Agency to update on local and national infectious disease issues.	P3 P3	Ongoing	PH
10.2	Ensure public are given appropriate information and awareness on new emerging vaccines and vaccine programmes	Engage with relevant community and voluntary services and the general public to enhance knowledge and understanding of immunisation. Work to publicise immunisation issues through media events and campaigns.	P3		
10.3					

References

Department of Health 2006 Immunisation against infectious disease D Salisbury, M Ramsay, K Noakes
Department of Health 2005 Vaccination services: Reducing inequalities in uptake
Department of Health 2004 Choosing Health: Making healthy choices easier
Department of Health 2005 Vaccination services reducing inequalities in uptake
Department of Health 2008 Operational Plans2008/09 - 2010/11, (Implementing the 2008/09 Operating Framework) National Planning Guidance and "vital signs"
Joint Committee for Immunisation and vaccination (JCVI) http://www.dh.gov.uk/ab/JCVI/index.htm

Appendix 1. Local Cover data 2010/11

12 month cohort

		DTaP/IPV/HiB	Men C	PCV
Eligible	*n*	12,243	12,243	12,243
Immunised	*n*	11,527	11,449	11,469
	%	94.2%	93.5%	93.7%

24 month cohort

		DTaP/IPV/HiB	MMR	Men C	HiB/Men C	PCV
Eligible	*n*	11,998	11,998	11,998	11,998	11,998
Immunised	*n*	11,545	10,705	11,521	11,025	11,154
	%	96.2%	89.2%	96.0%	91.9%	93.0%

5 year cohort

		DT/Pol	Pertussis	HiB	MMR	Men C	PCV
		Primary	*Primary*	*Infant*	*1st dose*	*Infant*	*Infant*
Eligible	*n*	11,719	11,719	11,719	11,719	11,719	
Immunised	*n*	11,326	11,334	11,300	11,145	11,304	
	%	96.6%	96.7%	96.4%	95.1%	96.5%	

		DTaP/IPV	HiB/Men C	MMR	PCV
		Booster	*Booster*	*2nd dose*	*Booster*
Eligible	*n*	11,719	4,952	11,719	4,952
Immunised	*n*	10,632	3,636	10,485	3,954
	%	90.7%	73.4%	89.5%	79.8%
			*		*

** Due to scheduling parameters, data for Hib/Men C and PCV for the 5 year cohorts was only collected for the last 2 quarters*

SHADOW HEALTH AND WELLBEING BOARD REPORT

Report of: Assistant Director of Health Improvement

Subject: PARTNERSHIP ARRANGEMENTS UNDERNEATH THE SHADOW HEALTH & WELLBEING BOARD

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1. PURPOSE OF REPORT

1.1 To consider and agree the partnership arrangements that sit underneath the Shadow Health & Wellbeing Board and how they will feed in and support the work of the Board.

2. BACKGROUND

2.1 Prior to the introduction of the Shadow Health & Wellbeing Board the Health & Wellbeing Partnership had been in place for a number of years. As part of its structure there were a number of groups that sat below the Partnership and fed into its work through its performance management arrangements.

2.2 In order to ensure that the Shadow Health & Wellbeing Board builds on the strengths of the previous structure it is now timely for the Board to review the range of bodies' currently in place and agree on their role within the new structure.

2.3 The following bodies have been identified as currently in existence:

- Children's Partnership (statutory)
- Learning Disabilities Partnership Board (statutory)
- Safeguarding Children Board (statutory)
- Safeguarding Vulnerable Adults Board
- Mental Health Consultation Group (currently being developed by Geraldine Martin)
- Coronary Heart Disease Local Implementation Team (LIT)
- Diabetes LIT
- Long Term Conditions Planning Group
- Carers Strategy Group
- Champions of Older Lifestyles Group (formerly 50+ Forum)
- British Heart Foundation Group

- Teenage Pregnancy Strategy Group
- 'Be Healthy' Group
- Housing Care & Support Group
- SEN Pathfinder (nationally funded pathfinder rather than a group)

This is not an exhaustive list and there may be other bodies that the Board may wish to consider including.

3. ISSUES FOR CONSIDERATION

3.1 The Shadow Health & Wellbeing Board is asked to consider:

1. Which bodies from paragraph 2.3 need to be included within the partnership structure of the Shadow Health & Wellbeing Board?
   (i) Are there any groups that can be merged or disbanded?
   (ii) Are there any additional groups that need to be included?
   (iii) Are there any new groups that need to be established?

2. How will the work of these bodies feed into the Shadow Health & Wellbeing Board?
   (i) Through the performance management arrangements of the Health & Wellbeing Strategy?
   (ii) Annual presentations on their work and current priorities?
   (iii) Should the Chair's of those bodies be invited to attend the Shadow Health & Wellbeing Board as non-voting members?

4. RECOMMENDATIONS

4.1 The Board is requested to consider and agree the partnership arrangements that sit underneath the Shadow Health & Wellbeing Board and how they will feed in and support the work of the Board.

5. CONTACT OFFICER

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