Report to:	**Health and Wellbeing Board**
Date:	**10 December 2013**
By:	**Keith Hinkley, Director of Adult Social Care and Health**
Title of report:	**East Sussex Health and Wellbeing Strategy Biannual Progress Report**
Purpose of report:	**To present a report on progress to date on delivering the East Sussex Health and Wellbeing Strategy 2013-2016**

RECOMMENDATION

The Board are asked to:

1. **Consider and comment on the report, and**
2. **Consider any action the Board may wish to take to address identified risks to delivery.**

1. Introduction

1.1. Based on an assessment of local needs and public consultation, the first Health and Wellbeing Strategy for East Sussex 2013-2016 was agreed by the East Sussex Health and Wellbeing Board in December 2012. The Strategy Action Plan was agreed in April 2013.

1.2. The Strategy focuses on seven priorities where the Health and Wellbeing Board believe a more integrated and joined up approach will help to improve outcomes, reduce inequalities and deliver efficiency savings that could be re-invested in service improvements.

2. Format of the report

2.1. This is the first report for the Health and Wellbeing Board describing progress made over the period April to September 2013 towards delivering the Strategy and Action Plan targets.

2.2. Appendix 1 sets out a summary of performance to date against the Action Plan targets.

2.3. Appendix 2 summarises key achievements, challenges and risks and provides detailed commentary on activity against the Strategy's actions, outputs and objectives in each of the seven priority areas. Data is included where available, along with a comment on the direction of travel toward achieving the end of year targets set out in the Strategy Action Plan.

3. Health and Wellbeing Strategy progress overview

3.1. It is clear from the report that a significant amount of activity is taking place linked to the actions, outputs, objectives and targets in the Health and Wellbeing Strategy. This includes an increase in integrated working across health and care, increased prevention and early intervention initiatives, and joint working across health, care and wider partners.

3.2. Although most Action Plan performance data is only available annually, comments on progress do not indicate any significant risks to achieving the end of year targets with the exception of reducing the number of older people admitted to hospital due to falls. This will not achieve the target reduction of 1% until 2014/15 due to the time it will take for service changes to take effect. However, in some cases performance is ahead of what was expected at the mid-year point and some targets may be exceeded.

4. Changes to action plan measures and targets

4.1. It is proposed that the Board is asked to note the following changes:

4.2. Priority 1 (Best Start) Outcome 1.2 (To improve the level of skills development of the lowest performing children at age 5): It is proposed that the definition of the performance measure is amended to mirror the description of the target already approved by the Board i.e. the percentage point gap between the lowest achieving 20% in the Early Years Foundation stage profile and the rest. This will ensure the description and annual targets continue to align with East Sussex County Council's (ESCC) Council Plan. The revised annual targets will be 2013/14 – academic year 2012/13 establish baseline; 2014/15 – academic year 2013/14 to be set following baseline; 2015/16 – academic year 2014/15 to be set following baseline.

4.3. Priority 2 (Parenting) Outcome 2.1 (Fewer children who need a Child Protection Plan): Since the action plan was approved in April 2013 the 2012/13 outturn, which was used as a baseline for target setting, has been confirmed at 52.6. Also, the 2013/14 target, which was based on population figures, has been revised to reflect new population figures.

4.4. Priority 4 (Falls, Accidents and Injuries) Outcome 4.1 (To reduce emergency hospital admissions amongst children and young people for accidents and injuries): This indicator, which is in the national Public Health Outcomes Framework, has changed and is now available separately as two indicators for two age groups 0-14 and 15-24 with changes also made to the criteria for selecting admissions from the hospital data. In East Sussex the rate for 0-15s for 2011/12 was 132.68 which is significantly higher than for England (118.22). For 15-24s in 2011/12 the rate was 127.57 which is significantly better than for England (144.72). It is therefore proposed that the focus should be on reducing hospital admissions amongst the 0-14 year old age group, and the indicator and target updated for future monitoring and reporting.

4.5. Priority 6 (Special Educational Needs, Disability and Long Term Conditions) Outcome 6.1 (To improve measurable outcomes for children and young people with special educational needs and disability (SEND): This was a new measure at the time the Action Plan was agreed and was included in the draft ESCC Council Plan. It has since been amended by ESCC and, to ensure continued alignment with the Council Plan, it is proposed that the number of Education, Health and Care Plans are measured rather than the number of children and young people who have a personal budget attached to their Education, Health and Care Plan; and that the following targets are set: 2013/14 = 85; 2014/15 = 165; 2015/16 target to be set after 2014/15.

5. Conclusions and Next Steps

5.1. A considerable amount of activity has taken place and steady progress is being made towards delivering the Strategy and Action Plan targets during these first six months.

5.2. The next biannual progress report covering the period October 2013 to March 2014, an end of year performance report with outturns on all Strategy Action Plan targets and a draft Annual Report on the work and achievements of the Board is scheduled for the Health and Wellbeing Board in July 2014. The final Annual Report will be presented to the Health and Wellbeing Board and County Council.

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APPENDIX 1: At a glance performance against Action Plan targets

HWB Priority	Ref.	Outcome indicator/measure	2013/14 Target	Mid-year position	RAG
1. Best start	1.1	Increase MMR vaccinations: MMR vaccination coverage for one dose (2 year olds)	94%	92% at Quarter 1 (April-June 2013)	ON TRACK
	1.2	Improve skills development: The percentage point gap between the lowest achieving 20% in the early years foundation stage profile and the rest	Academic Year 2012/13 establish baseline	Data for baseline will be available in Quarter 3	ON TRACK
2. Parenting	2.1	Fewer children needing a child protection plan: Rate per 10,000 (of 0-17 population) of children with a Child Protection Plan	49.7	52.4 at September 2013	ON TRACK
	2.2	Fewer young people entering the criminal justice system: Rate of first time entrants to the criminal justice system per 100,000	381 countywide	56 by Quarter 2 (Aug-Sept 2013)	ON TRACK
3. Healthy lifestyles	3.1	Reduce rates of mortality from causes considered preventable: Age-standardised rate of mortality from causes considered preventable per 100,000 population	Reduction of 2% against 2010-12 East Sussex average	Not known – data not available until end of year	**Not known, data not yet available**
	3.2	Increase offer and uptake of NHS health checks: % of eligible population aged 40-74 offered NHS Health Check who received an NHS Health Check in the financial year.	10% offered; 50% received	7.8% offered; 57% received at September 2013	ON TRACK
4. Accidents and falls	4.1	Reduce emergency hospital admissions amongst children and young people for accidents and injuries: Crude rate of hospital emergency admissions caused by unintentional and deliberate injuries in children and young people aged 0-17 years per 10,000 population	Reduction of 1.35% from 2011/12 baseline	This National Outcome Indicator has changed. Measure and target to be amended	**Outcome measure has changed**
	4.2	Reduce the number of older people admitted to hospital due to falls: Age-sex standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65 and over per 100,000 population	Reduction of 1% per year from 2011/12 baseline.	19% increase on Apr-Sep 2012 position	**Will not be achieved. New services commissioned**
5. Mental health	5.1	Improve the experience of NHS mental healthcare for people with mental health conditions: % of service users responding to survey questionnaires who report being 'satisfied' and / or 'very satisfied' with the mental healthcare services they received (return rates required being 33%).	By 2016: Satisfied 80%; Very Satisfied 50%	Interim data indicates good performance	ON TRACK FOR 2016

	5.2	Report improved outcomes for people with mental health conditions arising from NHS mental healthcare: Measure to be confirmed during 2013/14	2016 targets to be determined during 2013/14	Good progress being made	**ON TRACK**
6. SEND, disability and LTC	6.1	Improve measurable outcomes for children and young people with SEND (Special Educational Needs and Disability): Number of completed education, health and care plans.	85 completed plans	Good progress being made	**ON TRACK**
	6.2	Increase the take up of Health Checks for people with Learning Disabilities (LD): % of patients on a Learning Disability register in East Sussex GP Practices who have received a health check within the financial year.	By 2016: Meet the England average (65%) revised upwards if the average increases	Not known – data not available until end of year	**Not known, data not yet available**
	6.3	Reduce number of people with long term conditions being admitted to hospital and to reduce the time they spend in hospital: a) Proportion of people with ambulatory care sensitive conditions admitted to hospital as an emergency; and b) Number of days between admission and discharge.	By 2016: a) 20% reduction b) 20% reduction	Not known – data not available until end of year	**ON TRACK FOR 2016**
7. End of life care	7.1.1	More people identified as approaching end of life are cared for and die in their usual place of residence: Deaths at usual place of residence divided by all deaths	Increase by 1% each year from baseline	1% increase exceeded in all CCG areas	**ACHIEVED**
	7.1.2	More people identified as approaching end of life are cared for and die in their usual place of residence: Proportion of population served by GPs and Out Of Hours services that have access to information about people approaching end of life on an Electronic Palliative Care Coordination System or similar	Identify a system and host by Quarter 4	System identified, pilot planned	**ACHIEVED**
	7.2	Improve the experience of care for people at the end of their lives: Measure to be confirmed during 2013/14	Target to be confirmed during 2013/14	Progress being made to establish measure and target	**ON TRACK**

APPENDIX 2: EAST SUSSEX HEALTH AND WELLBEING STRATEGY 2013-2016

BIANNUAL PROGRESS REPORT April-September 2013-10-24

1. INTRODUCTION

1.3. Based on an assessment of local needs and public consultation, the first Health and Wellbeing Strategy for East Sussex 2013-2016 was agreed by the East Sussex Health and Wellbeing Board in December 2012. The Strategy Action Plan was agreed in April 2013.

1.4. The Strategy focuses on seven priorities where the Board believe a more integrated and joined up approach will help to improve outcomes, reduce inequalities and deliver efficiency savings that could be re-invested in service improvements.

1.5. This is the first report for the Health and Wellbeing Board on progress, key achievements and challenges during April to September 2013 in each of the strategy's seven priority areas. Data is included where available, as is a comment on direction of travel toward achieving the Strategy's end of year strategic outcome indicator targets.

2. NOTABLE ACHIEVEMENTS

2.1. The purpose of the Strategy is to provide a framework for the commissioning of services focusing on seven priorities. To deliver these priorities, the Health and Wellbeing Board also agreed that there should be greater integration and whole system working, more prevention and early intervention, joint working with partners beyond health and care and valuing and building on the strengths which individuals, families and communities have.

2.2. It is clear from the report that commissioners are taking the Strategy into account when developing commissioning plans and service specifications and that, whilst it is in many cases too early to measure or evidence the impact of this, a significant amount of activity is taking place linked to the actions, outputs, objectives and targets in the Health and Wellbeing Strategy.

2.3. Against a background of significant changes to the way the NHS is structured following Government reforms and the considerable financial challenges across the public and voluntary and community sectors, there is evidence of:

i. an increase in integrated working e.g. an expansion of multi-disciplinary Neighbourhood Support Team meetings and 'Team Around the Family' meetings to coordinate support across a range of services;

ii. 'whole system' developments e.g. smoking cessation services (priority 4) to support the health and wellbeing of people with mental health concerns (priority 5);

iii. increased focus on prevention and early intervention e.g. funding for respite care for carers to attend their own health appointments and "OTAGO" a type of exercise proven to help reduce falls amongst older people;

iv. joining up health and care with others who contribute to health and wellbeing e.g. recent agreement to establish a multi-agency cross-sector Obesity Partnership to develop an Obesity Prevention Plan;

v. initiatives to help build individual, family and community strengths e.g. increasing one-to-one support for vulnerable parents and using community resolution to help reduce the number of young people entering the criminal justice system for the first time; and

vi. reducing inequalities and improving access e.g. targeted 'healthy lifestyles' support for gypsy and traveller communities, and identifying and engaging with carers in hard to reach communities.

2.4. Although most action plan performance data is only available annually, comments on progress do not indicate any significant risks to achieving the end of year targets with the exception of reducing the number of older people admitted to hospital due to falls which will not achieve the targeted reduction of 1% until 2014/15 due to the time it will take for service changes to take effect. However, in some cases performance is ahead of what was expected at

the mid-year point and some targets may be exceeded.

3. PROGRESS REPORTS

Priority 1: ALL BABIES AND YOUNG CHILDREN HAVE THE BEST POSSIBLE START IN LIFE. The outcome we are aiming to achieve is that babies and young children develop well and are safe and healthy.

ACTIONS, OUTPUTS AND OBJECTIVES
• Ensure sufficient capacity is identified within midwifery, health visiting and children's centre services to provide high quality targeted support to all vulnerable parents who need it • Roll out across the county an integrated partnership approach to identifying those who need extra support and coordinating support with regular meetings between all relevant services in local areas • Increase breastfeeding support for women in the first five days after birth • Ensure that all pregnant women who smoke are identified and offered support to give up • Provide coordinated, personalised specialist support through a "single plan" for parents whose babies have special educational needs or disabilities As a result of this activity we would expect to see: • Fewer referrals to children's social care • More families with babies given targeted "early help" support • Further improvement in proportion of mothers choosing and able to breastfeed their babies • Fewer women smoking in pregnancy • Improved rates of infant immunisation and vaccination • More babies and young children with special educational needs or disabilities have a single plan for health, care and education
PROGRESS REPORT April-Sept 2013
Capacity for targeted support has been strengthened in Children's Centres through a service restructure. The Children's Centre Keywork service, building on the old Family Outreach Service, started in April 2013. The commissioning specification for Health Visiting continues to require targeted one-to-one support to be given priority with targets for the numbers of the most vulnerable families to be supported. Targeted support is also a priority for the midwifery service. As from September 2013 "Team Around the Family" meetings have been held regularly (either weekly or fortnightly depending on levels of need) in each of the nine coterminous Children's Centre and Health Visiting team areas of the county. These meetings are used to identify families needing targeted support and to coordinate that support across all relevant services. In the 12 months from 1 October 2012 to September 2013 targeted support was provided to 4109 children under the age of 5. There has been a steady rise in the number of children and young people of all ages supported through early help as a result of the County Council's THRIVE programme to reshape services to protect and support children and families. Midwifery services are now telephoning all women who leave hospital breast feeding their babies with a follow up telephone call for breast advice at Day 3. A specialist service has been commissioned to provide targeted support to encourage pregnant women to stop smoking including referral to the stop smoking service, targeted advice about the effects of smoking on themselves and their baby/other children, and information about the effects of second hand smoke. This support occurs at the time of booking with their midwife (around10- 12 weeks of pregnancy), throughout their pregnancy and at the time of delivery. Data on breastfeeding and smoking in pregnancy will be available for the next progress report. Plans for the roll out of single Education, Health and Care (EHC) plans for children and young people with special educational needs or disabilities from 2014 are on track. The single plan for

babies is put in place through the Disabled Children's Early Support Programme and will in future lead onto an EHC plan where appropriate.

Total monthly referrals to children's social care (all ages) have reduced from 846 in August 2012 to 551 in August 2013, following a pattern of gradual reduction since March 2011 (when the monthly figure was 1622).

PERFORMANCE MEASURES AND TARGETS

1.1 **To increase the percentage of children who have been immunised for measles, mumps and rubella (MMR) by age two**; measured by MMR vaccination coverage for one dose (2 year olds). 2013/14. Target: 94.0%

Immunisation is the most important way of protecting individuals and the community from vaccine preventable infectious diseases that can have significant impact on the use of NHS services. From April 2013 the NHS England Local Area Team has responsibility for commissioning immunisation services in East Sussex, including MMR.

The 2013/14 target is on track to be achieved. Currently national comparative data has only reported up to Quarter 1 (April-June) 2013 which shows a 92% take up of MMR at age 2. A more detailed analysis for 2013/14 will be provided in the next progress report once national comparative data is available.

1.2 **To improve the level of skills development of the lowest performing children at age 5**; measured by the percentage point gap between lowest achieving 20% in early years foundation stage profile and the rest (pending changes to early years assessment criteria). 2013/14 Target: Academic Year 2012/13 establish baseline.

The 2013/14 target is on track to be achieved. Foundation Stage profile results (skills at age 5) for summer 2013 will be reported in the next progress report due in July 2014.

Priority 2: SAFE, RESILIENT & SECURE PARENTING FOR ALL CHILDREN AND YOUNG PEOPLE. The outcome we are aiming to achieve is that parents are confident, able and supported to nurture their child's development.

ACTIONS, OUTPUTS AND OBJECTIVES

- Enhance the capacity and leadership of targeted early help services for parents who are struggling
- Ensure quick decisions and actions are taken where it is clear that parents do not have and cannot develop the capacity to provide good enough care for their children
- Invest in high quality training for all those who work with vulnerable families and ensure that support is streamlined and coordinated

As a result of this activity we would expect to see:

- More families given targeted early help support
- Improved rates of immunisation and vaccination
- Reduce the rate of inappropriate referrals to children's social care

PROGRESS REPORT April-Sept 2013

Capacity and leadership of targeted early help services for parents who are struggling has been strengthened through increased investment in services, additional management posts and a dedicated training and support programme for all early help service managers.

Since Autumn 2012 and particularly since April 2013, a significant training programme has been delivered for front line practitioners working with vulnerable families, as part of the County Council's THRIVE programme to reshape services to protect and support children and families. Through this programme and the linked national "Troubled Families" programme there has also been a significant increase in the number of family keyworkers coordinating and streamlining support for vulnerable families across a wide range of agencies.

The quarterly total snapshot of households supported by targeted early help services in September 2013 was 4675. This figure has risen steadily since the first snapshot in December 2012, when it stood at 4156. The increase reflects investment in services through the THRIVE programme. Changes in practice, in particular supporting more high need families for longer periods, are likely to slow down the increase in numbers of families supported.

PERFORMANCE MEASURES AND TARGETS

2.1 **Fewer children who need a Child Protection Plan (CPP)**; measured by the rate per 10,000 (of 0-17 population) of children with a Child Protection Plan. 2013/14 Target: 49.9*

The 2013/14 target is on track to be achieved. The rate of children with a Child Protection Plan (CPP) was 52.4 per 10,000 (0-17 population) in September 2013 down from 58 in September 2012. * Note the 2013/14 target, which was based on 0-17 year old population figures, has been revised to 49.7 to reflect new population figures.

The number and rate of CPPs has declined as a result of the County Council's THRIVE change programme, which has strengthened the help available before CPPs are needed, and encouraged a different approach to children's social work including spending more time supporting families and less time assessing cases. The programme also involves reducing the numbers of children admitted to care, however, and this will mean more CPPs as an alternative to care proceedings. Data here are monitored closely through the THRIVE programme.

2.2 **To reduce the number of young people entering the criminal justice system**; measured by the rate of first time entrants to the criminal justice system per 100,000. 2013/14 Target: 381 countywide.

The 2013/14 target is on track to be achieved. The Quarter 1 (April-June) 2013 outturn was 66 first time entrants per 100,000 equating to a reduction of 50% against the baseline. By Quarter 2 (July-October) 2013 there were 56 first time entrants per 100,000 equating to a 61% reduction against the baseline (subject to a possible slight increase when complete data has been validated).

The reductions are partly the result of the introduction of new community resolution alternatives to entry into the criminal justice system for lower level offences. A Community Resolution can be considered for minor offences where the offender admits to the offence, and can be used as an alternative to a Police Caution. A young person receiving a Community Resolution does not count as a first time entrant (FTE) to the youth justice system. The introduction of Community Resolution in East Sussex has led to a substantial decrease in the number of young people entering the criminal justice system. Given that Community Resolution is intended to be used for minor offences this inevitably leads to a smaller cohort of FTE who have committed more serious offences.

Priority 3: ENABLE PEOPLE OF ALL AGES TO LIVE HEALTHY LIVES AND HAVE HEALTHY LIFESTYLES. The outcome we are aiming to achieve is that more people will have healthy lifestyles to improve their prospect of a longer, healthier life.

ACTIONS, OUTPUTS AND OBJECTIVES

- Enhance the alcohol care pathway from prevention through to recovery and involving a range of health, care and other partners
- Develop and implement a cross-sector multi-agency Tobacco Control Plan
- Develop and implement a cross-sector multi-agency Obesity Prevention Plan
- Enable frontline staff to offer residents brief advice and signposting to relevant services

As a result of this activity we would expect to see:

- Fewer young people and adults drinking at increasing and higher risk levels
- Reduction in alcohol related crime
- Lower rates of smoking amongst young people, pregnant women and others in the general

population

- Increase in the proportion of the population achieving the minimum recommended rates of physical activity (all ages)
- More people of all ages eating 5 portions of fruit and vegetables a day

PROGRESS REPORT April-Sept 2013

Alcohol: The East Sussex Drug and Alcohol Action Team Board (DAAT) coordinate partnership work across the system to address alcohol use. Its Alcohol Steering Group meets regularly to oversee partnership plans across the alcohol care pathway. Work includes refreshing the East Sussex Alcohol Strategy and developing the care pathway using findings from an alcohol needs assessment commissioned by the Alcohol Steering Group, an East Sussex Drink Debate and a workshop with wider partners.

A health improvement specialist for children and young people has been recruited and came in to post in May. A children's Health Improvement Plan is in development which identifies evidence based ways of improving the health of children and young people and will inform children's health improvement commissioning plans.

Sussex Police are piloting an Alcohol Diversion Scheme across the county to help deal with alcohol related crime and anti-social behaviour. It helps those involved to be aware of their own drinking and the impact of their behaviour on themselves and others. A Community Alcohol Partnership between public services and local businesses has been developed in Hastings to reduce inappropriate alcohol sales, and an alcohol arrest referral scheme is being piloted to divert those arrested for alcohol related crime into treatment interventions and alcohol advice.

There is evidence to indicate that alcohol misuse affects crime levels in the Night Time Economy. Sussex Police data indicates that Public Place Violent Crime in the Night Time Economy was lower in the first quarter (April to June) of 2013/14 than the same period in 2012/13 decreasing from 332 crimes to 286 crimes. There were also 66 reported Serious Sexual Offences in the Night Time Economy in the first quarter of 2013/14. Whilst this is an increase compared with last year (58 offences) it is in line with the Police and Crime Plan target and is considered a positive development as it may indicate that more people are coming forward to report crimes rather than more crimes being committed.

Tobacco: A cross-sector multi-agency East Sussex Tobacco Partnership has been established and a Tobacco Control Plan has been developed covering 6 areas identified as being effective in preventing and reducing tobacco use. The Plan will be regularly reviewed and progress monitored through the Tobacco Partnership.

To help deliver the Plan the partnership ran a 'smoke-free homes and cars campaign' in July 2013 and a 'Stoptober' smoking cessation campaign during October. 'ASSIST', a tobacco prevention programme for young people is also being delivered in targeted schools across East Sussex and will be rolled out across the county. An illegal and illicit tobacco campaign is planned later in the year. A business case is being developed for further investment to support the delivery of the Plan.

A new health improvement specialist for children and young people came in to post in May and is developing a Health Improvement Plan identifying evidence based ways of improving children and young people's health and will inform children's health improvement commissioning plans.

Smoking cessation services are targeting and offering specialised support to pregnant women and their families to stop smoking.

Obesity/Physical Activity: A range of activity has taken place:

- A new health improvement specialist for physical activity, healthy eating and obesity came into post in April. Evidence of effective interventions to address obesity has been reviewed, and new weight management services are currently being commissioned.
- Partnership plans to increase physical activity have been developed at a local level across

the county. Active Hastings and Active Rother partnerships are developing whole system approaches to increasing physical activity in their areas.

- A proposal to develop a cross-sector Obesity Partnership to oversee an Obesity Prevention Plan was presented to the Public Health Systems Partnership in October. Following this, partners will be invited to join the partnership and participate in the development of a multi-agency plan which will incorporate the evidence based actions already underway.
- Low level support to enable people to lead healthier lifestyles has been funded through the East Sussex Commissioning Grants Prospectus e.g. health walks, older people's volunteer-led physical activity and healthy eating, and targeted support for communities e.g. Gypsy and Traveller communities.

Brief advice and signposting to relevant services:

- Alcohol Identification and Brief Advice (IBA) training is being commissioned to support those who may be working with increasing and higher risk drinkers to help them take advantage of opportunities to discuss alcohol use, give brief advice, and refer them to services if required. Training is expected to start in early 2014.
- A bid to the national lottery 'Chances for Change' programme as part of a partnership across the South East was successful and community capacity building approaches to support healthy lifestyles in Hastings and Eastbourne, including obesity, are being developed with voluntary sector partners.
- A voluntary sector organisation has been funded through the East Sussex Commissioning Grants Prospectus to test ways of incorporating Making Every Contact Count approaches into the routine work of voluntary organisations who work with clients who would benefit from lifestyle advice. Individual organisations have been funded to identify and enable ways for their staff to systematically include health improvement advice and signposting into their work.
- A training programme for Job Centre Plus staff has been developed and is currently being piloted in Hastings and Rother.

PERFORMANCE MEASURES AND TARGETS

3.1 **To reduce rates of mortality from causes considered preventable**; measured by age-standardised rate of mortality from causes considered preventable per 100,000 population; 2013/14 Target: Reduction of 2% against 2010 to 2012 East Sussex average.

There is no new data to report at this time as data is available on an annual basis.

3.2 **To increase both the percentage offered NHS Health Checks and the take up by those in the eligible population**; measured by the percentage of eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check in the financial year. 2013/14 Target: 10% offered; 50% received.

The 2013/14 target is on track to be achieved. At September 2013/14, 7.8% of the eligible population had been offered a Health Check, a substantial increase compared with 3.7% offered a check by this time last year and a greater proportion of the eligible population than that required to achieve the target (5% would be expected at this point). Of those offered a check in 2013/14, 57% have received one, which is a similar proportion to the proportion of those offered and receiving a check in 2012/13 (57% full year).

Priority 4: PREVENTING AND REDUCING FALLS, ACCIDENTS AND INJURIES. The outcome we are aiming to achieve is that fewer children, young people and older people have preventable falls, accidents or suffer deliberate harm by others or themselves.

ACTIONS, OUTPUTS AND OBJECTIVES

- Further research and analysis to better understand the causes of falls, accidents and injuries amongst children and young people so that interventions can be targeted at those at greatest risk of harm
- Develop a more integrated, evidence based approach to preventing and reducing falls, accidents and injuries such as coordinated accident prevention activity and campaigns, home safety checks and equipment schemes, and parenting support
- Enhance the falls and bone care pathway for older people with stronger links between community based, primary and secondary care settings and health, care and wider services

As a result of this activity we would expect to see:

- Fewer children and young people admitted to hospital for unintentional and deliberate injuries
- Fewer over 65's use emergency ambulance services due to a fall
- Fewer over 65's with first or preventable second fractures

PROGRESS REPORT April-Sept 2013

Children and Young People: An audit of child accident attendance at A&E has been undertaken and findings presented to the child accident prevention sub-group of the Local Safeguarding Children Board. NICE guidance and evidence of effective interventions has been reviewed and fully incorporated into the Board's Child Accident Prevention Plan. A national survey tool has been adapted to collect information on knowledge, skills, barriers, facilitators and practice for accident prevention in children's' settings and information from this will inform future plans for accident prevention. Free expert consultancy support has been offered by the Child Accident Prevention Trust to further develop East Sussex accident prevention plans.

Home safety equipment is being provided and fitted for targeted families across East Sussex through a partnership between District and Borough Councils, the County Council and the Health Visiting Service. The Health Visiting Service provides home safety and accident prevention advice to all families of young children through accident prevention sessions in community settings, and targeted advice is provided in the homes of vulnerable families. East Sussex Fire and Rescue Service provide free fire safety check and smoke-alarms to vulnerable families.

Older People: Work continues jointly between the three local Clinical Commissioning Groups and the County Council to implement the redesigned falls pathway across East Sussex. This includes:

- Delivering 'OTAGO' exercise classes which are proven to help reduce falls in older people. A programme is due to start in November 2013 in Seaford and will be rolled out across all Districts and Boroughs in the county in the coming months. The programme is being delivered by qualified OTAGO instructors in partnership with local leisure centres.
- Designing, agreeing and procuring a new fracture liaison service to provide stronger links between primary and secondary care for people who have had a fracture. Procurement will start in November with the aim of the service being in place from April 2014.
- Redesigning the NHS Community Falls Management Service to improve support for people who fall. The revised service, which started on 1st October 2013, will ensure support is available across East Sussex.

The winter home check service provides a home visit for vulnerable families and older people to identify and address cold home issues. This will also identify home safety issues such as dangerous heating appliances and broken doors and windows.

Data on the number of over 65's who use emergency ambulance services due to a fall and who have a first or preventable second fractures will be available later in the year.

PERFORMANCE MEASURES AND TARGETS

4.1 **To reduce emergency hospital admissions amongst children and young people for accidents and injuries**; measured by the crude rate of hospital emergency admissions caused by unintentional and deliberate injuries in children and young people aged 0-17 years per 10,000 population. 2013/14 Target: Reduction of 1.35% from 2011/12 baseline.

This indicator, which is in the national Public Health Outcomes Framework, has changed and is now available separately as two indicators for two age groups, 0-14 and 15-24, with changes also made to the criteria for selecting admissions from the hospital data.

In East Sussex the rate for 0-15s for 2011/12 was 132.68 which is significantly higher than for England (118.22). For 15-24s in 2011/12 the rate was 127.57 which is significantly better than for England (144.72).

The recommendation therefore is to focus on reducing hospital admissions amongst the 0-14 year old age group, and amend the indicator accordingly for future monitoring and reporting.

4.2 **To reduce the number of older people admitted to hospital due to falls**; measured by age-sex standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65 and over per 100,000 population. 2013/14 Target: Reduction of 1% per year from 2011/12 baseline.

The 2013/14 target will not be achieved. Comparisons between April to September 2012 and April to September 2013 show that falls related hospital admissions have increased by 19%. As the changes to falls and bone health services described above have only just been put in place, a reduction in falls related hospital admissions is not anticipated until 2014/15, when all services are up and running.

Priority 5: ENABLING PEOPLE TO MANAGE AND MAINTAIN THEIR MENTAL HEALTH AND WELLBEING. The outcome we are aiming to achieve is that people of all ages experience good mental health and wellbeing and those with mental health conditions and their carers are able to manage their condition better and maintain their physical health.

ACTIONS, OUTPUTS AND OBJECTIVES

- Develop the support pathway for children and young people with emerging mental health needs
- Enhance the mental health care pathway for adults, older people and their carers from prevention through to care planning and recovery with a more personalised approach within all care settings
- Align the mental health care pathway with care pathways for long term conditions and strengthen links with wider services

As a result of this activity we would expect to see:

- Earlier identification, diagnosis, support and treatment
- More people using community based support
- More people with more severe mental health needs having a comprehensive care plan
- Fewer incidences of self harm and suicide
- Improved physical health for people with mental health support needs
- Better mental health outcomes and quality of life for carers

PROGRESS REPORT April-Sept 2013

Children and Young People: The specialist mental health service, the Child and Adolescent Mental Health Service (CAMHS), runs regular sessions to brief other services working with children and young people, including schools, about the role of the specialist service, how it should be accessed, and ways in which the development of problems for children and young people can be prevented. In addition, the County Council's Targeted Youth Support Service is

working with CAMHS to develop a support service for young people with emerging mental health needs for which the specialist service is not an appropriate response.

For children and young people, joint commissioners for health and care have a target for the proportion of referrals to specialist assessment which lead to the provision of a service, designed to help track the appropriateness of referrals and levels of need. The percentage of referrals that go on to receive treatment has increased from 75% in 2012/13 to 79% in Q1 (April-June) 2013/14 which appears to indicate that the appropriateness has increased

Young Carers of people with mental health problems can now access personal budgets to enhance their quality of life.

A health improvement specialist for mental health (all ages) and older people has been appointed and came in to post August. Mental health promotion plans are being developed using the 5 steps to wellbeing approach. The County Council's website mental health pages are being developed and mental health promotion information is being incorporated into these. Mental health awareness training needs are also being reviewed.

Adults and Older People: One of the main vehicles for achieving a more personalised approach is moving from commissioning services towards commissioning individual episodes of care - these will be associated with each person achieving measurable improvements or outcomes in their mental health. Considerable progress has been made in the first 6 months of this year in understanding care and treatment being provided at this individual level.

Local mental healthcare staff are now involved extensively in multi-disciplinary Neighbourhood Support Team meetings taking place at GP Practice level, focusing on the full and wide range of needs of people with long term conditions. Community based service provision has also broadened as a result of procuring the Third Sector, via the East Sussex Commissioning Grants Prospectus, to provide support for 1800 people or more per year from 2013/14. This is an increase from previous levels of around 1300.

East Sussex is on target to achieve improvements in access to psychological therapies and recovery rates for people with common mental health problems such as anxiety and depression, which without treatment, can lead to deterioration and more serious and long term problems.

Numbers of people on a Care Programme Approach for people with more severe mental health needs having a comprehensive care plan is subject to audit and reporting by Sussex Partnership NHS Foundation Trust (SPFT) under annual Key Performance Indicator requirements.

The East Sussex Suicide Prevention Plan identifies a range of actions that local partners will work on over the coming year and the East Sussex Mental Health Strategy will contain sections on mental wellbeing and suicide prevention.

An incentivised programme has been introduced through which SPFT will improve physical healthcare of people with mental health support needs such as through improved access to smoking cessation.

Carers assessments consider the impact on the carer's own mental and physical wellbeing and take this into account in the support offered to both the carer and the cared for. A range of activities, some commissioned through the East Sussex Commissioning Grants Prospectus and delivered by Voluntary and Community Sector organisations, aims to support better mental health outcomes and quality of life for carers. This includes, but is not limited to, funding for respite care to enable carers to attend their own health appointments; training; one-to-one support, information and advice; health improvement support; free counselling; and a project reaching out to diverse, harder to reach communities to identify and engage more mental health carers to improve the support they receive, improve services for the people they care for and run small groups in rural areas.

In addition the Carers Support Service for people with dementia has been extended to increase support available to carers with less severe mental health problems and the Triangle of Care

process, which supports carers of people in hospital to be involved in care planning and treatment, has been extended into SPFT community services.

PERFORMANCE MEASURES AND TARGETS

5.1 **To improve the experience of NHS mental healthcare for people with mental health conditions**; measured by the percentages of service users responding to survey questionnaires who report being 'satisfied' and / or 'very satisfied' with the mental healthcare services they received, (return rates required being 33%). 2016 Target: Satisfied 80%; Very Satisfied 50%

Data is not available until later in the year. However interim data, based on 640 completed returns on patient satisfaction received with a 91% 'positive' response, indicates good progress and that the 2016 target is on track to be achieved.

5.2 **To report improved outcomes for people with mental health conditions arising from NHS mental healthcare**; measure and 2013/14 target to be confirmed during 2013/14.

The 2013/14 target is on track to be achieved. This is associated with the introduction of payments for episodes of care described above. Good progress is also being made in introducing outcome measures as part of this process, and will aim to be finalised as planned during 2013/14.

Priority 6: SUPPORTING THOSE WITH SPECIAL EDUCATIONAL NEEDS (SEN), DISABILITIES AND LONG TERM CONDITIONS (LTC). The outcome we are aiming to achieve is that those with SEN, disabilities and long term conditions have a better quality of life and longer life expectancy manage their condition better and maintain their physical health.

ACTIONS, OUTPUTS AND OBJECTIVES

- Develop a more person centred, coordinated approach to supporting the health and wellbeing of those with SEN, physical and learning disabilities, their parents and carers
- More children have a coordinated support plan for health, social care and education and personal budgets
- Develop an integrated 'whole system' approach to LTC with earlier diagnosis, care planning and joined up support for patients and carers
- Integrate mental health support into primary care and chronic disease management care pathways
- Roll out multi-disciplinary Neighbourhood Support Teams across the county

As a result of this activity we would expect to see:

- Earlier diagnosis and provision of personalised care in the community or at home
- More people feel supported to manage their condition better
- Better health outcomes for those with SEN, disabilities and long term conditions (all ages)
- Better quality of life for those with SEN, disabilities and long term conditions (all ages)
- Better physical health outcomes and quality of life for carers (all ages)

PROGRESS REPORT April-Sept 2013

Children and Young People: East Sussex County Council is a pathfinder authority, testing out proposed reforms to the system of support for disabled children and young people and those with Special Educational Needs.

All pathfinders are expected to have 85 Education, Health and Care (EHC) plans in place by the end of March 2014, which the County Council expects to achieve. Numbers have recently reduced slightly because some of the original pathfinder families had children whose needs would not qualify them for EHC plans. The reduction has been reported and explained in monthly returns to the Government's support partners.

We are confident that numbers will soon increase again as the new assessment and planning

process is now being offered to all new referrals. It has also been agreed, as part of pathfinder grant conditions, to target two age groups: children who will be starting school next year and young people who are approaching transitions e.g. from secondary to Further Education placements. These groups combined should ensure we meet the Government's target of 85.

Adults and Older People: Primary care-based multi-disciplinary Neighbourhood Support Teams were introduced 12 months ago, and now meet at 72 out of 76 GP practices throughout the county. They involve Adult Social Care staff, community nurses, mental health practitioners, and the third sector Living Well Service. The meetings aim to ensure that the care and support of people with complex needs is coordinated. In September two Project Support Officers came into post to offer additional support to GP practices to set up and run these meetings and evaluate their effectiveness including the impact the teams are having on strategic objectives such as personalised care in the community or at home, better health outcomes and better quality of life.

Investment has been made to increase capacity in community nursing and home care to avoid emergency hospital admissions for people who could be better supported in the community. This enhanced service is due to start in November 2013.

Recognising the complexities of developing an integrated “whole system” approach, East Sussex expressed interest in becoming a national pioneer site for integrated care. Over 100 areas across England applied, and East Sussex was one of only 28 areas shortlisted. Successful bids. Although East Sussex was not successful, the process has been helpful in progressing local plans for further integration of services.

PERFORMANCE MEASURES AND TARGETS

6.1 To improve measurable outcomes for children and young people with SEND (Special Educational Needs and Disability); measured by the number of completed education, health and care plans. 2013/14 Target: 85 completed plans.

The 2013/14 target is on track to be achieved. Although numbers have recently reduced slightly there is confidence that numbers will soon increase again as the new assessment and planning process is now being offered to all new referrals and two age groups are being targeted. These combined should ensure the 2013/14 target of 85 completed plans will be achieved.

6.2 To increase the take up of Health Checks for people with Learning Disabilities (LD); measured by the percentage of patients on a Learning Disability register in East Sussex GP Practices who have received a health check within the financial year. 2016 Target: To meet the England average (65% at the time the action plan was agreed) revised upwards if the England average increases.

At 31 March 2013, the average take up of Health Checks by patients on a Learning Disability (LD) register in East Sussex GP Practices was reported as 45%. Progress towards achieving the 2016 target will not be known until data collected by the NHS England Local Area Team becomes available and has been analysed.

In order to support registered GP surgeries to increase uptake, local Clinical Commissioning Group (CCG) commissioners are negotiating for LD Health Checks to become a specifically commissioned activity in the Service Specification of the Community Learning Disability Service (CLDT) provided by Sussex Partnership NHS Foundation Trust (SPFT). Commissioners are in discussion with SPFT to agree the function in the service specification, related skills required, capacity in the service and monitoring of service activity. The new service specification for CLDTs is scheduled to be agreed by the CCG Governing Bodies early in 2014, and implemented as of 1st April 2014.

6.3 To reduce number of people with long term conditions being admitted to hospital and to reduce the time they spend in hospital; measured by a) the proportion of people with ambulatory care sensitive conditions admitted to hospital as an emergency and b) the number of days between admission and discharge. 2016 Targets: 20% reduction in number of admissions and 20% reduction in number of days between admission and discharge.

Progress towards achieving the 2016 target will not be known until data becomes available and has been analysed.

This target (which is for 2016) measures people with ambulatory care sensitive (ACS) conditions - chronic conditions such as asthma, diabetes, angina, epilepsy, dementia, chronic obstructive pulmonary disorder (COPD), anaemia, hypertensive heart disease, acute and chronic bronchitis, atrial fibrillation and chronic viral hepatitis B. Active management such as vaccination, better self-management, disease management, case management or lifestyle interventions, can help prevent a sudden worsening of these conditions and reduce the need for hospital admission.

The multi-disciplinary Neighbourhood Support Team meetings and enhanced nursing and home care service, through coordinated support and active management of those with complex needs, will play an important role in helping to achieve our targets of fewer hospital admissions and shorter length of stay in hospital. ACS condition admission rates have reduced across all three East Sussex CCGs since April 2012, with the steepest reduction in Eastbourne Hailsham and Seaford CCG. In contrast, the overall Sussex admissions rate has remained stable, suggesting East Sussex is on the right trajectory. However, admission rates continue to be higher than the Sussex average for Eastbourne Hailsham and Seaford and Hastings and Rother CCGs.

The number of days between admission and discharge has been reducing at the Conquest Hospital and Eastbourne District General Hospital since April 2012. However, for East Sussex patients going to the Princess Royal Hospital, Hayward's Heath bed days have steadily increased since April 2012 (Royal Sussex County Hospital, Brighton and Tunbridge Wells Hospital bed days have remained stable).

Priority 7: HIGH QUALITY AND CHOICE OF END OF LIFE CARE (EOLC). The outcome we are aiming to achieve is that people who are approaching the end of life being cared for and dying in their preferred place of care and death and to receive the highest standards of EOLC in any setting.

ACTIONS, OUTPUTS AND OBJECTIVES

- Roll out delivery of the EOLC pathway (advanced care planning to bereavement support) throughout all public, private and voluntary and community sector health and care providers
- Continue EOLC training and workforce development for health and care staff and volunteers working in community, health and care settings

As a result of this activity we would expect to see:

- More people identified as approaching end of life have an advanced care plan
- Fewer people identified as approaching end of life die in hospital
- Staff providing EOLC in community, health and care settings meet the national end of life care core competencies and occupational standards

PROGRESS REPORT April-Sept 2013

East Sussex End of Life Care (EOLC) Programme Board's multi-disciplinary membership provides scrutiny and assurance on the delivery of the EOLC pathway, integrated working, clinical leadership and workforce development across a variety of settings.

A whole system approach is being taken to support discussions with patients, their family (where appropriate) and carers about preferred priorities of care as part of advance care planning. Further whole systems development includes in principle agreement by East Sussex County Council Adult Social Care and all three Clinical Commissioning Groups (CCGs) to develop an integrated EOLC and Dementia Pathway to ensure that people with dementia have equal choice and quality of EOLC.

Workforce development is key to ensuring professionals who provide support are equipped with

the right skills, competencies and confidence to support patient's needs along the EOLC pathway. In addition a skilled and confident multi-disciplinary workforce provides assurance to carers to avoid and best manage crisis situations. A range of initiatives therefore, supported by the CCGs and Adult Social Care, are taking place across health and social care including:

- Supporting access to the National EOLC e-learning programme for 76 organisations in East Sussex to date including Care Homes, Personal Assistants, Home Care, Voluntary Organisations, carers and integrated teams. Over 500 modules have been completed and work is in progress for the County Council's Adult Social Care training unit to sustain elements of the project;
- Appointing two EOLC Facilitators at East Sussex Healthcare NHS Trust (ESHT) to support workforce development planning for EOLC; and
- Providing Dementia training for Home Care providers which encompasses end of life issues.

A booklet to provide information to people after their caring role has finished has also been developed between Care for the Carers, the Carers Trust and the County Council.

The national EOLC Preferred Priorities of Care (PPC) tool is being adopted, introduced and rolled out to enable people identified as being within the last 12 months of life to discuss their preferences of care and place of death and record this in an Advanced Care Plan. For patients diagnosed with dementia this may take place earlier, when the person has mental capacity. This is being introduced from October 2013 across the Care Home setting with District Nurses and Macmillan nurses employed by ESHT and Home Care providers. In-reach support is also being provided to care homes with high A&E attendances and hospital admissions to help them write Advance Care Plans using the PPC tool with their residents. With their permission, information recorded in someone's Advanced Care Plan can be shared with other providers of their care.

The completion and sharing of this patient information is to support people to be cared for and die where possible in their place of choice. Sharing this information with in and out-of-hours services will enable patient preferences and priorities of care to be taken into consideration when making care decisions and help avoid unnecessary hospital admission/s and death in hospital if this is not what the person wants.

This is the beginning of a process to improve communications and sharing of information, which will take time to implement across health and social care, but will improve the patient and family experience of EOLC and support the delivery of personalisation and choice for people, key outcomes for the NHS (commissioners and providers), Adult Social Care and patients and carers.

PERFORMANCE MEASURES AND TARGET

7.1.1 **More people identified as approaching end of life are cared for and die in their usual place of residence**; measured by deaths at usual place of residence divided by all deaths (usual residence includes home, care homes (Local Authority and non-Local Authority) and religious establishments). NB. This is an interim indicator until an Electronic Palliative Care Coordination System (EPaCCS) (7.1.2 below) is in place. 2013/14 Target: Increase by 1% each year from baseline.

Deaths in Usual Place of Residence (DiUPR) data shows a steady increase in the percentage of people being supported to die in their usual place of residence i.e. their own home or a care home, and that all three local CCGs have exceeded the target of a 1% increase from the previous year's baseline which is encouraging and means that the 2013/14 target has been achieved

7.1.2 **More people identified as approaching end of life are cared for and die in their usual place of residence**; measured by the proportion of population served by GPs and Out Of Hours services that have access to information about people approaching end of life on an Electronic Palliative Care Coordination System (EPaCCS) or other coordination system. 2013/14 Target: Identify a system and host for EPaCCS by Quarter 4 (Jan-Mar 2014)

The 2013/14 target has been achieved. All three local CCGs have agreed to use the national

Summary Care Record (SCR) attached to the nationally secure NHS patient record system to host an enhanced Electronic Palliative Care Record (EPCR) including preferences and priorities of care. The SCR is a GP patient held record that can be viewed by in and out-of-hours providers, and will offer a simplified system of recording and sharing, with patient consent, up to date patient information.

A project lead has been appointed to upload SCR to GP systems in the Eastbourne Hailsham and Seaford (EHS) and Hastings and Rother CCGs, shortly to be followed by High Weald Lewes Havens CCG. Three GP practices in EHS CCG will pilot the EPCR as a phased approach to lead the way for implementation across the other CCGs.

7.2 **To improve the experience of care for people at the end of their lives**; measure and target to be confirmed during 2013/14

The 2013/14 target is on track to be achieved. All GP practices carry out multi-disciplinary palliative care meetings during which any changes in the health status of patients are reviewed. In addition, after a patient's death, care and family support is reviewed i.e. what went well, what didn't, learning points and follow-up actions required. The Health and Wellbeing sub-group of the Carers Partnership Board will identify commissioning outcomes to support the collection of data. When data is collected it can then be shared with the integrated Soft Intelligence Group to compare and validate against other data sources.