APPENDIX 2: BIANNUAL PROGRESS REPORT October 2014 to March 2015 and year end outturns

Priority 1: ALL BABIES AND YOUNG CHILDREN HAVE THE BEST POSSIBLE START IN LIFE

Strategic outcome: 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 the 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

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The number of referrals to statutory social care has reduced to 3,935 in 2014/15 against a target of 5,590 and reflects the work to safely reduce the demand on social care. We will need to ensure thresholds remain safe for both referrals and progression to social care assessment during the coming year as we continue to have a lower rate of both referrals and assessments than our comparators.

Over the last six months we have sustained the higher number of families given targeted early help as a result of the Thrive programme. Recent changes to the joint working arrangements with health visitors have coincided with a reduction in the number of families identified as needing targeted support; this is an issue we are currently addressing with health visiting managers.

Levels of smoking in pregnancy remain an issue, particularly in certain geographical areas; a number of key actions are currently included within the Hastings and Rother (HR) CCG Health Inequalities action plan.

Data published by NHS England for the East Sussex CCGs fails the data quality threshold of more than 5% with a breastfeeding status unknown. This is the case nationally as well, where 13% are status unknown. Locally the position has improved over the three quarters of 2014/15 where data is published.

East Sussex combined CCGs

Q1 = 41% breastfed (20% status unknown)

Q2 = 36% breastfed (29% status unknown)

Q3 = 55% breastfed (8% status unknown)

Q1 - Q3 total = 44% breastfed (19% status unknown)

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). Targets: 2013/14 94.0%, 2014/15 94.5%, 2015/16 95% and to reduce the gap at District and Borough level from 4.2% in 2011/12 Q1 = 91.4% Q2 = 91.2% Q3 = 90.5% Q1 to Q3 year to date = 91.0% Q4 data will be available in July 2015. Gap position for Districts and Boroughs for 2014/15 will be available late summer. There has been a slight decrease in MMR dose 1 immunisation coverage during Q1 to Q3, Q4 data available 26/06/2015, to 91.0%, against an annual target of 94.5%. This issue was discussed at the most recent East Sussex immunisation co-ordination group. The CCG lead nurse will approach the Inequalities Fund to seek further funding for the St Leonard's project. This was a very successful initiative to address uptake, with an immunisation nurse working in the community and giving immunisations to those children who were behind schedule. The screening and immunisation team is currently going through a restructure. Once this is complete, and capacity has improved, our area team immunisation co-ordinators will work with individually underperforming practices. We will also be working closely with CCG primary care workforce tutors
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). Targets: 2013/14 Academic Year 2012/13 establish baseline, 2014/15 to be the same or narrower than the national average. 2015/16: to be the same or narrower than the national average. In East Sussex, the achievement gap between the lowest attaining 20% of children and the median is 29.5%. This is 4.4 percentage points better than the England figure (33.9%) and 7th among our statistical neighbours. Future targets have been set to remain below the national average.

Priority 2: SAFE, RESILIENT & SECURE PARENTING FOR ALL CHILDREN AND YOUNG PEOPLE

Strategic outcome: 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
- Reduced rate of inappropriate referrals to children's social care

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The number of children and young people getting 1:1 targeted support from Early Help services increased in 2014/15 to 6,592, from 6,232 in the previous year. This reflects the embedding of whole family key working in Children's Services and partner agencies. We have sustained the number of families supported over the last six months, which increased through the Thrive programme (2012-2015).

PERFORMANCE MEASURES AND TARGETS

2.1 Fewer children who need a Child Protection plan (CP); measured by the number of children with a Child Protection Plan.

Targets: 2014/15 502 plans, 2015/6 500 plans.

At the end of Q4 the number of children with a Child Protection (CP) plan is 469 against a target of 502, this has been achieved by implementing the CP action plan. This included challenging the ongoing high levels of children with CP plans and agreeing ways to reduce the number of children with a CP plan safely, for example, working with Independent Reviewing Officers and Child Protection Advisers to reinforce other robust planning mechanisms to safeguard children. Many of these children remain Children in Need (CIN) and continue to be supported by social workers with robust CIN plans.

2.2 To reduce the number of young people entering the criminal justice system; measured by the rate of first time entrants (FTE) to the criminal justice system per 100,000 population of 0-17 years old.

Targets: 2014/15 300 FTE, 2015/16 300 FTE

Provisional outturn for the year: 166 FTE per 100,000
Provisional Q4 outturn: 24 FTE per 100,000
Updated Q3 Data: 34 FTE per 100,000

First Time Entrants continue to be low as a result of the continued use of Community Resolution by the police for low level offences and the Targeted Youth Support pathway which sees young people being assessed by the Youth Offending Team and then receiving informal diversion work which prevents the young person from entering the criminal justice system.

Please note that the numbers are initially low when reported as there is a delay in receiving outcome data from the police. However, the numbers are updated each quarter for the previous quarter, the final outturn for the year will therefore be reported in Q1 of 2015/16.

Priority 3: ENABLE PEOPLE OF ALL AGES TO LIVE HEALTHY LIVES AND HAVE HEALTHY LIFESTYLES

Strategic outcome: 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

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Alcohol:

The Alcohol Steering Group continues to lead and co-ordinate multi-agency work to address alcohol related harm in East Sussex as set out in the Alcohol Strategy 2014 – 19 Delivery Plan.

As Hastings is one of the national Local Alcohol Action Areas, work has commenced with the Home Office and Public Health England (PHE) to develop and implement a delivery plan. As part of this work, a common approach to delivering the Alcohol Strategy 2014 – 19 harm reduction communications plan has now been agreed. A report has been produced which collates the local data on alcohol related health harm to help guide targeted interventions more effectively. In addition, a proposal to develop community engagement on alcohol-related issues has been funded by PHE and will be taken forward in 2015/16.

A recently commissioned training programme, which trains frontline staff to raise alcohol issues and give brief advice to clients and contacts, is now being delivered across the county.

Tobacco:

The multi-agency Tobacco Control Partnership continues to meet to co-ordinate tobacco control work across East Sussex. The partnership has refreshed its priorities for 15/16 which continue to include maternal smoking, high quality stop smoking services, joint campaigns to raise awareness of the harms of smoking, work to reduce the impact of exposure to other people's tobacco smoke, and work to address smoking amongst children.

Quit 51, the specialist stop smoking service, has continued to develop and improve smoking cessation provision in the first year of its contract. The Council's smoking cessation target for 14/15 has been achieved, with 3287 people quitting smoking through ESCC commissioned services against a target of 3028. Around 34% more people quit smoking with ESCC services compared to 2013/14.

Services provided by GP's and pharmacies have been reviewed and new service agreements have been developed. Targeted work has been undertaken with community pharmacies to support them to develop the services provided in this setting and attract more smokers into their services.

Work has commenced through GP's in Hastings and Rother (HR) to support practices to raise smoking with their patients and encourage them to attend stop smoking services. This includes staff training, direct mail-outs to registered smokers and improved IT support.

Obesity/Physical Activity:

The Healthy Weight Partnership continues to meet and has identified local priorities and an outline action plan. A programme of work to address obesity and increase physical activity is underway:

- Weight management services for adults and children, have now both started supporting people to achieve and maintain a healthier weight.
- Work has commenced with CCGs to develop a whole system care pathway including plans to develop Tier 3 weight management services. Tier 3 services are for clients who have not responded to previous tier interventions, and comprise a multi-disciplinary team of specialists.
- A triage tool is in development to support effective referral and self-care/management for people seeking to access the right support for them.

A range of community support, to enable people to eat more healthily and increase their physical activity continues to be provided e.g. a countywide health walks scheme, Healthy Living Clubs for older people and community led initiatives such as community champions/village agent's schemes. In addition the lottery funded Chances4Change programme was extended across the county and has developed community opportunities for physical activity and healthy eating, for example through linking with the Environmental Health led Eat Out Eat Well scheme to encourage local catering venues to increase their healthy food offer.

A programme of work to support healthy eating and increase physical activity in children has commenced. This includes support for early year's settings such as nurseries and child minders to increase the amount of physical activity and healthy food provided in their services and support to schools to improve their Personal Social and Health Education (PSHE) provision to support healthy

lifestyles. Social marketing research has been commissioned which will gather insight into the issues for local children and families around adopting healthier lifestyles which will be used to inform future work around physical activity/obesity.

Brief advice and signposting to relevant services:

Physical activity brief advice has been commissioned from Action for Change and has been delivered to a range of front-line staff across the county.

Alcohol Information and Brief Advice training for front line staff working with people at risk of drinking at increasing and higher levels is being provided across the county.

Behaviour change for health (Making Every Contact Count) training and support has been delivered to voluntary sector organisations to enable staff and volunteers to proactively raise lifestyle issues with clients and to refer people onto services. The programme also helps organisations think about how they can develop the health improvement support their service offers directly to clients.

CCGs in East Sussex are developing programmes to tackle health inequalities. In Hastings and Rother work is underway to increase the skills and confidence of all practice staff to raise lifestyle issues with patients and to consider how the CCG provider's might embed this approach in their work. In High Weald Lewes and Havens (HWLH) work is in development to identify how staff such as receptionists might have an increased role in supporting patients to access community services to improve their health.

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

Targets: 2013/14 reduction of 2% against 2010 to 2012 East Sussex average, 2015/16 10% reduction for 2015-2017 East Sussex and reduce gap between Hastings and Wealden measured in 2003-2005 59.5 deaths per 100,000.

Data for 2012 – 2014 due Autumn 2015

2011-2013 = 169.2 per 100,000 population which represents a 2.5% reduction on 2010-2012 (173.5)

2011-2013 gap = 83.8 (Hastings = 228.3, Wealden = 144.5). This is an increase in the gap for 2010-2012 (71.9) as Hastings increased from 217.8 to 228.3 and Wealden reduced slightly from 145.9 to 144.5.

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.

Target: 2014/15 20% offered, 50% received, 2015/16 20% offered, 70% received.

2014/15 results show 26.2% offered with 47% of those offered receiving an NHS Health Check

	Target	Actual	Diff (n)	Diff (%)
Eligible population	166,761	166,761		
Offered (%)	20.0%	26.2%		
Offered (n)	33,352	43,717	10,364	31%
Received (%)	50.0%	47.0%		
Received (n)	16,676	20,538	3,862	23%

Priority 4: PREVENTING AND REDUCING FALLS, ACCIDENTS AND INJURIES

Strategic outcome: 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

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Children and Young People:

At present, multi-agency work to reduce unintentional injury to children and young people is co-ordinated through the Local Safeguarding Children's Board (LSCB) Child Safety sub group, the Safer Sussex Roads Partnership and the East Sussex Road Safety Group. As part of the LSCB Child Safety Subgroup Workplan 2015-2017, a number of broad actions have recently been agreed as part of Outcome 1 "Accidents to children and young people are reduced". These focus on strengthening the use and sharing of data on accidents, monitoring the performance and outcomes of accident prevention initiatives, embedding new ways of working with early years practitioners to reduce risk of accidental injury (and expanding to other professionals), and utilising national and local resources/campaigns to raise awareness amongst at-risk populations locally.

A programme of accident prevention training for the East Sussex Healthcare NHS Trust (ESHT) (Health Visitors and Family Nurse Partnership (FNP)) and ESCC Children Services (Children Centre Keyworkers and Community) staff has now been completed. The Child Accident Prevention Trust (CAPT) was commissioned by ESCC Public Health to deliver 12 training courses between November 2014 and April 2015; designed to support practitioners that work with families with children under 5 years to confidently raise accident prevention with clients, deliver consistent accident prevention messages, and implement home safety checks. Over 140 early years professionals/practitioners have participated in the training; with additional staff benefiting from cascade sessions following two "train the trainer" courses. A follow up evaluation with all staff who participated in the training is due to take place during May/June 2015.

From October 2014, ESHT (Health Visitors, Community Nursery Nurse and FNP) practitioners and ESCC Children Centre Keyworkers have been able to refer families with children aged 0-2 years to the East Sussex Child Home Safety Advice and Equipment Service. This service is targeted at vulnerable families who are either identified through the Team Around the Family meeting, are a FNP family or have a safeguarding plan. Between 1st October 2014 and 30th September 2015, up to 550 families will benefit from a home safety assessment, advice, and having equipment fitted in the home. The Public Health Service continues to work with the key referring organisations as part of the 0-5 Accident Prevention Working Group to review the service, enhance referrals and achieve maximum impact for eligible families.

Following quite a marked increase in 0-4 admissions between 2012/13 and 2013/14, a comprehensive analysis of the causes of 2013/14 A&E attendances and hospital admissions has now been undertaken by Public Health Services. This has been shared with partners from the LSCB Child Safety Subgroup as a means to help inform appropriate actions to address the causes

of accidental injury in children under five (e.g. key messages delivered as part of Child Safety Week in June 2015)

East Sussex Fire and Rescue service provide free fire safety checks and smoke-alarms to vulnerable families. A Winter Home Check service, run by ESCC, provides a home visit for vulnerable families (and older people) to identify and address cold home issues. It also identifies home safety issues such as dangerous heating appliances and broken doors, windows etc.

Older People:

Otago Programme:

The Otago Programme is an evidence based approach for reducing the likelihood of falls in individuals who have fallen or are at risk of falling (in particular for those aged 80+), by delivering specially designed strength and balance enhancing exercises. By the end of the programme's first year in September 2014, 296 individuals had been referred to the service. Of these, 188 individuals had started a programme and 65 clients had completed a programme. Between October 2014 and February 2015 (March data available earliest late June) a further 212 clients were referred to the programme, 100 of these had started a programme by the end of February, and at least a further 47 clients had completed a programme. Quarter 4 data demonstrates a reduction in the volume of referrals to the programme with 41 referrals received in January and 26 in February. Work continues between the commissioner and service providers to improve data collection and communication pathways to minimise waiting times for clients and maximise client outcomes. Trials of new Postural Stability Instructor (PSI) classes for clients with more complex needs, and 'graduation' classes for clients who have completed a programme, in order to support ongoing maintenance of gains, are on hold until improvements in data collection and communication are achieved. A detailed programme protocols manual, and quality assurance programme are in development. The current contracts will be extended to March 2016 to allow time to trial and apply learning from the new classes, and to undertake a procurement exercise for delivery of a new contract and outcome based specification from April 2016 (subject to a further business case to be presented to the East Sussex Better Together Performance & Delivery Group in August).

Falls Management Service (FMS):

Since October 2013, the service had reported significant increases in throughput and reduced inappropriate referral volumes. An audit of the service in December 2014 suggested that reporting since this date had over-reported throughput and face to face assessments and interventions. A new data collection system was implemented in January to address this. Revised reporting received for January and February 2015 was in line with the findings of the audit (i.e. significantly fewer referrals were being accepted, a greater number of referrals being rejected, and fewer clients being discharged per month than previously reported). The revised reporting has provided much greater detail about volumes and activities within the service, and has been used to inform development of the falls prevention and management elements of the 2015/16 Joint Community Rehabilitation Service (JCR) specifications. The FMS was operationally integrated into the JCR at the start of April 2015 (with formal launch to referrers planned for June 2015), and work continues between the commissioner and service provider to finalise the specification and timescales for the launch of developments throughout the year. The changes will ensure that a greater number of clients are routinely offered multifactorial falls assessments and interventions in line with current NICE guidelines.

Fracture Liaison Service:

A decision was made not to award a contract for a Fracture Liaison Service following the tender process launched in September 2014. A new procurement exercise is being launched which will pursue the option of deployment through existing local fracture clinics. Service to be launched by April 2016.

Other:

The Falls and Secondary Fracture Prevention Project Group has been well attended by a broad range of stakeholders over the past year. The group has signed off the first draft of a whole systems pathway and draft screening tool (which will direct the user to appropriate services and support self-referral). Training in use of the tool and piloting with key services is to take place in coming months. The launch is planned by November 2015.

PERFORMANCE MEASURES AND TARGETS

4.1 To reduce emergency hospital admissions amongst children and young people for accidents and injuries; NB. In light of changes to the National Public Health Outcomes Framework (PHOF) measure, the Health and Wellbeing Board agreed to focus on reducing hospital admissions amongst the 0-14 year old age group, and update the indicator and target for future monitoring and reporting. **(ESCC Children's Services Portfolio Plan target)**

Targets: 2015/16 4% from 2011/12, based on 1.35% reduction per year.

Data still not published for 2013/14 in the Public Health Outcomes Framework http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/4/par/E12000008/are/E10000011/iid/90284/age/26/sex/4

Local data for 2014/15 will be available in the Autumn.

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.

Targets: 2014/15 reduction of 1% per year from 2013/14 baseline, 2015/16 2% reduction from 2013/14.

Q1 = 2,224
Q2 = 2,258
Q3 = 2,328
Q1 to Q3 year to date = 2,270 which is a 1% increase on 2013/14 baseline
The earliest Q4 data will be available is June.

Outturn for 2013/14 still not published in the Public Health Outcomes Framework http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/4/are/E10000011/iid/22401/age/27/sex/4

The 1% increase is made up of a 5% decrease in Eastbourne Hastings & Seaford (EHS), a 5% increase in Hastings and Rother and a 6% increase in High Weald Lewes and Havens. This suggests progress is unlikely to be in line with the target of a 1% reduction on the 2013/14 baseline, though is dependent on the Q4 outturn. Contributing factors to the above may include:

- EHS had the highest number of clients completing the Otago programme (69% of all completers in year 1);
- the number of clients that started or finished Otago classes was lower than anticipated, partly due to waiting times; and
- the FMS did not assess and offer multifactorial interventions to as many clients as anticipated or previously reported

Key milestones for developments within the programme to increase the impact in 2015/16 are outlined below:

	Milestone	Target date
1	Operational integration of FMS with JCR, with upskilling of staff and move to 7 day working for all therapy staff	01.04.15
2	ESHT formal sign off of updated JCR specification	29.05.15
3	JCR formally launch integration of FMS into service (including multifactorial assessments offered in line with NICE guidelines)	30.06.15
4	Community falls exercise programme provider publishes 20 month evaluation	31.07.15
5	Business case for post-2016 falls exercise programme signed off	31.08.15
6	Trial Postural Stability and 'Graduation' classes within community falls exercise programme	30.09.15
7	Formal launch of JCR screening of community falls exercise programmes	01.11.15
8	Launch revised pathway with screening and self-referral tool	01.11.15

9	Award community falls exercise programme contract (dependent on outcome of 5)	29.02.16
10	FLS launched	31.03.16

Priority 5: ENABLING PEOPLE TO MANAGE AND MAINTAIN THEIR MENTAL HEALTH AND WELLBEING

Strategic outcome: 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

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Children and Young People:

Action taken this year includes further training for family keyworkers in support for children and young people with mental health needs and closer joint working between The Child and Adolescent Mental Health Service (CAMHS) and the Emotional Well Being team within the Targeted Youth Support Service. We are also developing new arrangements for offering family key work where appropriate to the families of children and young people referred to CAMHS whose needs do not meet the threshold for specialist services.

Adults and Older People:

New specifications have been agreed and incorporated in to the contract with Sussex Partnership Trust (as our principal provider of mental health services), based on ‘care clusters’ which more closely reflect distinct care pathways appropriate to individuals meeting their definitions. There are 21 such clusters defined (nationally) which take in different severities of presentation and broad diagnostic categories including psychotic/non-psychotic disorders and cognitive impairment/dementia. This enables a more personalised approach to be taken to care planning and delivery.

Baselines have been established against new waiting time standards being introduced in 2015/16, which will ensure earlier identification and access to services for people with a first episode of psychosis, as well as providing those with common mental health problems access to psychological therapies.

Services were incentivised in 2014/15 through CQUIN schemes (Commissioning for Quality and Innovation), to target those with long term mental health problems and ensure their risks for physical health problems such as cardiovascular disease are identified and addressed through programmes such as tailored smoking cessation courses. Other initiatives related to linking mental health interventions with long-term conditions included the Health in Mind services providing cognitive behavioural therapies for participants on pulmonary rehabilitation programmes

addressing Chronic Obstructive Pulmonary Disease.

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 new 'friends and family test' survey questionnaires, who report their experience of Trust services was 'positive' and that they would be 'extremely likely' to recommend Trust services.

Targets: Amended 2015/16 'positive' 80%; 'extremely likely' to recommend 50%.

Overall patient experience of Trust services (friends and family test), was 'positive' for 89% of respondents, with 56.1% saying they would be 'extremely likely to recommend' Trust services

5.2 To report improved outcomes for people with mental health conditions arising from NHS mental healthcare;

Targets for 2015/16: a) numbers entering treatment – 7,500, b) numbers completing treatment who have recovered – 50% c) waiting times for treatment – 75% within 6 weeks; 95% within 18 weeks

The Health and Well-being Board considered and agreed a revision to this indicator at its meeting in January. This will focus on outcomes obtained from psychological therapies for the large numbers of people in East Sussex who experience common mental health problems such as anxiety and depression.

Baseline performance at end of quarter 4 against the new suite of targets for improving outcomes for more people who experience common mental health problems was: numbers entering treatment = 7,422; achieving recovery = 50%; access within 6 weeks = 61%; and access within 18 weeks = 90%

All measures are marked green as the targets for 2015/16 have been set and outturns at the end of quarter 4 will form a baseline for ongoing performance measurement.

Priority 6: SUPPORTING THOSE WITH SPECIAL EDUCATIONAL NEEDS (SEN), DISABILITIES (SEND) AND LONG TERM CONDITIONS (LTC)

Strategic outcome: 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)

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Children and Young People:

We have seen further development of the SEND reforms which came into place in September 2014. The SEND Joint Commissioning Team has been established as part of the SEND restructure. A Local Offer Development Manager and SEND Joint Commissioning Support Officer have been appointed. The SEND Joint Commissioning Strategy was agreed by the SEND Joint Commissioning Group and published on the ESCC website. The streams of work set out in the strategy are progressing, and the Joint Commissioning Group receives bi-monthly progress reports.

Work to maintain and improve the East Sussex Local Offer is ongoing. A Local Offer Working Group is being established. Personalisation is a key focus and the Personal Budget Policy has received approval. Work continues to integrate personal budgets across education, health and social care.

Work continues on the transfer of Statements of Special Educational Needs to Education, Health and Care Plans. Work also continues on Special School Place Planning and the development of a new SEN Matrix to support resource allocation and service provision decisions.

Adults and Older People:

The implementation of integrated community Health and Social Care teams has been agreed as a primary work-stream within the East Sussex Better Together programme. This programme of work seeks to bring together core health and social care professionals to provide greater integration and coordination of care to meet the needs of local people within a community setting. While the development of localities is based on a whole population approach, it has been agreed that a phased approach is taken to the development of the delivery model, starting with key services for adults with LTC, older people and those who are frail or vulnerable. Focusing on adults with LTC and older people as the initial priority area reflects the significant opportunity to redesign key community services to wrap care around the individual and shift activity and resources from acute to community based care.

This service redesign focuses on delivering simple access to services which are based around primary care and localities with multidisciplinary teams providing the following functions:

- Proactive Care
- Crisis intervention and admission avoidance
- In-reach into bedded care and supporting discharge
- Maintaining independence – rehabilitation and reablement
- Maintaining independence – planned and routine care

In 2014/15, work continued to ensure the foundations for the future service model are fully established. GP practices now hold regular monthly multi-disciplinary meetings to discuss patients who are identified as most at risk of hospital admission.

Community pathways for key ambulatory care sensitive conditions (conditions for which effective management and treatment should limit emergency admission to hospital) have now been implemented across the entire county.

PERFORMANCE MEASURES AND TARGETS

6.1 To improve measurable outcomes for children and young people with SEND; measured by the number of completed Education, Health and Care Plans.

Targets: 2013/14 85 completed plans. 2014/15 165, 2015/16 to be set after 2014/15.

During the period January to March 2015, 28 final East Sussex Education, Health and Care Plans (EHCP) have been issued for the first time. Cumulatively, during the period April 2014 to March 2015, 176 final East Sussex EHCPs have been issued for the first time; the target of 165 has therefore been achieved.

Proposed amendment to measure and targets:

The measure has been proposed for amendment as we are now focused on converting existing SEND statements to EHCP's rather than creating new ones.

Amended measure: Proportion of Statements converted to Education, Health and Care Plans

Target: 2015/16 50%

6.2 To increase the take up of Health Checks for people with Learning Disabilities (LD); measured by the percentage of patients on an LD register in East Sussex GP Practices who have received a health check within the financial year.

Targets: 2015/16 Target: To meet the England average (65% at the time the action plan was agreed) revised upwards if the England average increases.

Training sessions supporting Primary Care to offer and encourage the take up of annual health checks for people with LD will be rolled out in the membership engagement events. The training will be provided by Sussex Partnership NHS Foundation Trust.

6.3 To reduce the 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.

Targets: 2015/16 a) 20% reduction in number of admissions and b) 20% reduction in number of days between admission and discharge.

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.

Outturn position for 2014/15

Comparing 2014/15 data to the baseline year of 2012/13, ACS conditions admission rates have decreased by 3.3% in East Sussex. However, reductions were only achieved in two East Sussex CCGs: High Weald Lewes Havens (HWLH) and Hastings and Rother (HR) rates have decreased by 5.8% and 2.9% respectively; but Eastbourne, Hailsham and Seaford (EHS) rates increased by 4%.

The number of days between admission and discharge (bed days) has reduced by 13% in 2014/15 compared to the baseline year of 2012/13. The most significant reduction is at the Conquest Hospital
(-25%) and Eastbourne District General Hospital (-5.2%). However, for East Sussex patients going to the Princess Royal Hospital bed days have increased by 20% (1068 from 889) during the same period.

Q4 position for 2014/15

Comparing October 2014 to March 2015 data to October 2012 to March 2013 (the baseline year) data, ACS conditions admission rates have decreased by 1.3% in East Sussex. The picture varies across the three East Sussex CCGs: HR's admission rate has reduced by 7.9% and HWLH's by 7.5%; however EHS' rates have increased by 9.9%.

The number of days between admission and discharge (bed days) has reduced by 8.5% for October 2014 to March 2015 compared to the baseline year of October 2012 to March 2013. The most significant reductions are 31% at Conquest Hospital and 86% at Hurstwood Park (29 down to 4). However, for East Sussex patients going to the Princess Royal Hospital bed days have increased by 47% (435 up to 640) during the same period.

The RAG Rating is amber because the target is for 2016, so it is not possible at this stage to determine to what extent it will be achieved. The current trajectory for bed day reductions has fluctuated, making it hard to predict whether East Sussex is on track to achieve the 20% target.

Although progress has been made to achieve the admissions reduction target, it is also not yet clear whether a 20% reduction will be met.

Priority 7: HIGH QUALITY AND CHOICE OF END OF LIFE CARE (EOLC)

Strategic outcome: More 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

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All Primary Care practices in Eastbourne, Hailsham and Seaford (EHS) and Hastings and Rother (HR) CCGs are recording patient preference of care as part of their Locally Commissioned Service (LCS) for palliative care. The Local Commissioned Service audit will provide an understanding of how primary care delivers the preference of care in the EOLC pathway. The EOLC information held in primary care should become part of the Summary Care Record (SCR). The IT problems, which have been experienced nationally, in linking primary care held data with SCRs are scheduled to be resolved in 2015. Nationally there has been agreement in 2015 to have EOLC information automatically uploaded (with patient consent) to the SCR.

High Weald Lewes and Havens (HWLH) are using SCR as the mechanism for Electronic Palliative Care Coordination System (EPaCCS). HWLH practices undertaking the EOLC Locally Commissioned Service (LCS) also do after death analysis reviews.

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). Note: This is an interim indicator until an EPaCCS is in place.

Targets: 2014/15 increase by 1% each year from baseline, to 2015/16 50.3%.

At Q2 2014/15 data for Deaths in Usual Place of Residence has shown an increase for the combined East Sussex CCGs to 51%.

At the end of Q3 2014/15 the figure was 51.1%. Q4 data should be available at around the end of Q1 2015/16.

This target could become an ambition for the CCGs to be in the upper quartile of people dying at home, or in a home of their choice (nursing home).

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 EPaCCS or other coordination system.

Targets: 2014/15 40% EOLC patient data uploaded to EPaCCS, 2015/16 75%.

Proposed amendment to measure and targets:

The measure has been proposed for amendment as we are unable to calculate it in the current form.

New measure: the proportion of population on the Palliative Care Register (PCR) whose data has

been uploaded to the SCR/EPaCCS.

Targets: 2015/16 75%

It is hoped that we can achieve the 75% target in 2015/16 but this is reliant on the new automatic PCR functionality being available.

The new target will be calculated by dividing the number of clients on the SCR by the number on the PCR and then multiplying this by 100 to produce a percentage.

The enhanced Summary Care Record (SCR) is used for EPaCCS. This will be used to add the End of Life dataset “manually” or “automatically” to the SCR and is the basis for the EPaCCS solution.

Roll out of EPaCCS has commenced with Vision practices going live with the “manual” version initially. Roll out for all practices with the "automatic" version using updated clinical systems will follow. EOLC templates are being developed for use with the enhanced SCR; these will be posted on the CCG intranet together with guidance.

7.2 To improve the experience of care for people at the end of their lives; measure and target to be confirmed during 2014/15.

Targets: 2015/16 to be confirmed during 2014/15.

The approach to this measure will be examined as part of the baseline assessment to be carried out in Q1 15/16.

June-July 2015 – A structured evaluation is to be undertaken of East Sussex EOLC strategic outcomes and service provision against the national EOLC framework – this will inform future commissioning priorities and will align the approach to EOLC to East Sussex Better Together outcomes.