HEALTH SCRUTINY PANEL

A meeting of the Health Scrutiny Panel was held on 26 February 2013.

PRESENT: Councillors Dryden (Chair), Biswas, Cole, Harvey, Junier, S Khan, Mrs H Pearson and P Purvis

PRESENT BY INVITATION: K Morrison, Chair of Parents 4 Change, Co-opted Member (Children with Complex Needs).

ALSO IN ATTENDANCE: Councillor J Sharrocks, Chair of Social Care and Adult Services Scrutiny Panel.

OFFICERS: J Bennington, J Catron, H Douglas and E Kunonga.

APOLOGIES FOR ABSENCE There were no apologies for absence received.

DECLARATIONS OF INTERESTS

There were no declarations on interest made at this point of the meeting.

1 **MINUTES - HEALTH SCRUTINY PANEL 7 FEBRUARY 2013**

The minutes of the Health Scrutiny Panel held on 7 February 2013 were submitted and approved as a correct record.

2 **CHILDREN WITH COMPLEX NEEDS - EVIDENCE FROM PUBLIC HEALTH RELATING TO CHILDHOOD IMMUNISATION**

The Scrutiny Support Officer submitted a report the purpose of which was to introduce senior representation from the Directorate of Public Health to provide information relating to Childhood Immunisation in Middlesbrough. At a previous meeting it had been suggested by the Directorate of Public Health that two of the most significant determinants on infant health were low birth weight/pre term delivery and immunisation take up. In order to assist deliberations a series of questions had been provided as outlined prior to the meeting.

In a report previously circulated details were provided on the uptake rates for childhood immunisation in Middlesbrough. The data used was mainly from the annual returns to the Health Protection Agency (2009-2011).

It was acknowledged that immunisation was one of the most effective, safe and cost-effective public health interventions. Vaccination protected individuals and communities from the risks of infectious disease. Community protection was achieved by high levels of immunisation coverage to create 'herd community'. The whole community was protected when 'herd community' levels of vaccination coverage was achieved which for most diseases was around 95% coverage which was sufficiently high to prevent any sustained circulation of infections.

The childhood Immunisation programme was an integral component of the UK immunisation programme and aimed to eradicate, eliminate or contain disease. Children were routinely offered protection against ten infectious diseases. The World Health Organisation (WHO) recommended that, on a national basis at least 95% of all children should have three primary doses within the first year of life to provide immunisation for diphtheria, tetanus, polio and pertussis (whooping cough). WHO also recommended that over 95% of children received one primary dose by their second birthday to immunise for measles, mumps and rubella.

National evidence showed that inequalities in immunisation uptake had been persistent and resulted in lower coverage in children and young people from disadvantaged families and communities who were less likely to use primary care services. It was pointed out that there were variations in the uptake of childhood vaccinations across the population with lower uptake in groups such as babies of pregnant women who were not immunised against rubella or who were carriers of hepatitis B virus; asylum seekers; homeless families; looked after

children; children with physical or learning difficulties; children of teenage or lone parents; children not registered with a GP; younger children from large families; children who were hospitalised and some ethnic groups.

In response to clarification sought from Members as to the reasons for a lower take up of vaccinations in relation to children looked after it was explained that factors such as large numbers in temporary foster care moving from one placement to another was a possible explanation. Whilst children may be registered with a GP and reminder letters sent to attend for vaccination difficulties arose when children such as those from travelling families often moved around different locations.

In the case of children with complex needs who were admitted to hospital for lengthy periods of time it was suggested that there was scope for greater liaison between acute services and primary care in terms of checking immunisation although it was recognised that it would depend on the type of vaccination, storage requirements and illness of the individual child.

The report outlined the full range of immunisations provided by the UK routine childhood immunisation programme which aimed to protect children against preventable childhood infections of diphtheria, tetanus, pertussis, haemophilus influenza type b (Hib), polio, meningococcal serogroup C (MenC), measles, mumps, rubella, and pneumococcal.

The Panel was advised that the childhood immunisation rates had tended to be higher in Middlesbrough than the national average with the exception of diphtheria, tetanus, pertussis, polio and Hib (DTaP/IVP/Hib) at 12 months but lower than the North East average and lower than the recommended level of 95% cover necessary for herd immunity and to prevent outbreaks.

Most recent figures showed that there was an increase in uptake of immunisation in Middlesbrough in line with the national and regional trends. The most recent returns for 1st birthday vaccination coverage showed that Middlesbrough was below both regional and national averages for DTaP/IVP/Hib, Men C and Pneumococcal (PCV). The coverage was also below the 95% coverage recommended by the World Health Organisation (WHO). Such trends required further investigation as to the reasons for reduced rates.

It was pointed out that the North East generally was performing well against the national average and it was acknowledged that the percentage rates for Middlesbrough were not significantly different from the North East and national averages. Further community engagement and raising awareness was required especially having regard to increased numbers of cases of measles and whooping cough.

MIddlesbrough's immunisation cover rates achieved by 2nd birthday were more varied with the coverage for primary diphtheria, tetanus and polio reaching the 95% WHO recommended level. MMRI coverage remained below 90%. Vaccine coverage at 5th birthday continued to improve as the number of vaccinations that met the 95% cover had increased from the previous return. PCV primary and booster remained a challenge with coverage under 90%. The report outlined in figures 1 to 3 the immunisation coverage rates at 1st birthday for the Q1 and Q2 data 2012-2013 (April-September 2012).

A power point presentation was provided which assisted in demonstrating the immunisation rates in Middlesbrough as outlined in the report.

Whilst there had been global efforts to eradicate the disease of polio it was noted that given the migration of population it would only take one child infected from the few countries in Africa and Asia which remained polio-endemic for children to be at risk of contracting polio.

Inevitably there was greater scope to provide immunisation programmes at school but it was recognised that not all children would have received the 1st birthday vaccination. Differing views were expressed regarding current prevailing legislation which provided in some cases that the decision to have certain vaccines remained with the children. One of the difficulties was ensuring that appropriate information was available and that parents were empowered to explain the benefits of having the vaccinations.

In considering current arrangements via GP practices for children to receive booster vaccinations it was felt that there could be a gap in such a service in terms of the armed forces and their families working in different locations. Members suggested that assurances should be sought as to whether or not the armed forces had the relevant support and appropriate information available.

In considering the immunisation rates at the 5th birthday in Middlesbrough between 2008 and 2012 with particular regard to MMR 1and 2 reference was made to an impending meeting focussing on the need for a specific campaign to raise awareness and engage with the community in order to increase the take up of immunisation given the increased number of cases of measles.

It was confirmed that the ability for GP Practices to receive financial incentives if targets were met to increase the uptake of immunisation still remained under current arrangements.

In commenting on the snapshot of statistical information on a ward basis regarding the 1st year primary diphtheria, pertussis, tetanus and polio September 2012 Members were interested to note the levels of uptake which showed that wards such as Marton and, Stainton and Thornton had a lower level of uptake than North Ormesby and Thorntree. Members indicated that one possible explanation related to the effectiveness of GP Practices. It was noted however that in overall terms all wards were seen to be performing well and many had shown an increased uptake.

Confirmation was given that in terms of the health reforms the NHS Commissioning Board would be responsible for the commissioning of services and Local Area Teams would administer them. Although the scrutiny role of the Health and Wellbeing Board was recognised Members had a concern that whilst local measures could be pursued ultimately the responsibility of commissioning rested elsewhere with other competing priorities and delays could occur in responding to specific local demands.

The Panel commented on the need to raise awareness to the importance of vaccination and ways of how this could be achieved including the possibility of a press release from the Local Area Team, NHS Commissioning Board.

The report outlined a number of areas for further investigation including the following.

(a) Bringing commissioning and delivery of vaccination programmes to be in line with NICE and professional guidance services needed to be more flexible and accessible to maximise uptake.

(b) It was considered that every effort should be made to vaccinate individuals with a focus on improving the offer and availability of immunisation services for vulnerable groups through collaborative efforts primary care, school, community heath services and children's services.

(c) There was a recognised need for community engagement especially with vulnerable and high risk groups using social marketing approaches to promote and raise awareness of immunisation programmes. Public health transition into local authorities provided opportunities for greater community engagement on public health issues through the roles of elected members, community leaders and other existing community engagement mechanisms.

(d) Work was ongoing to improve the quality of data and information sharing between primary care, universal children's services and other relevant sources especially for children in at risk groups to support opportunistic vaccination and immunisation.

(e) As the health economy underwent radical reforms it was important that a seamless transition was achieved for immunisation and vaccination programme with service continuity and organisational memory being preserved. To ensure that immunisation uptake remained a priority the health and wellbeing board would need to be assured that the new NHS and public health arrangements were addressing the lowest coverage areas and vulnerable groups.

In conclusion Members acknowledged the suggested areas for further investigation by Officers as outlined above and identified the following areas for further examination by the Panel:-

(i) confirmation as to what measures were currently in place to check children looked after in terms of immunisation programmes and how successful were such measures;

(ii) that further information be sought as to what measures were in place with regard to the sharing of information between primary care and acute services with particular regard to children when they have lengthy stays in hospital;

(iv) further information be sought on the support and information available to armed forces and their families;

(v) it was suggested that in consultation with the Chair and Vice-Chair a letter be forwarded to Cameron Ward the Local Area Team Director, Durham, Darlington and Tees, NHS Commissioning Board to seek assurances around the role of the Health and Wellbeing Board and its relationship with the NHS Commissioning Board and Local Area Teams in terms of ensuring that appropriate action is taken when necessary in response to problems specific to the local area;

(vi) a further breakdown of the data received in respect of GP Practices be made available to the Panel.

AGREED as follows:-

1. That the Officers be thanked for the detailed information which would be incorporated into the overall review.

2. That further information be provided in respect of items (i) to (vi) outlined above.

3 **CHILDREN WITH COMPLEX NEEDS - EVIDENCE FROM DEPARTMENT OF WELLBEING, CARE AND LEARNING**

The Scrutiny Support Officer submitted a report the purpose of which was to introduce representation from the Department of Care, Wellbeing and Learning to provide evidence on the educational needs and existing educational provision for Children with Complex Needs.

Evidence presented to the Panel demonstrated that advances in medical technology and knowledge dictated that more children with complex needs were being delivered successfully and living longer. As such, an important aspect to consider was how their educational needs were being met and the nature of the educational services available to them. It was also considered that specific attention should be given to the extent to which current services were configured to be able to accommodate rising numbers of Children with Complex Needs.

In order to assist deliberations a series of questions had been forwarded prior to the meeting. The Deputy Director Achievement highlighted the key points of a report previously circulated.

The report gave an indication of the key points of the current SEND legislation which was seen as the most wide-ranging review of the area for over 30 years since the Warnock report set the direction for the current SEN framework. Although the full impact of the proposals had yet to be determined the LA response had been to initiate an audit of its current provision with a view to drafting and consulting on a Strategy for Vulnerable Learners that would guide the local implementation of the policy.

It was acknowledged that there was a lack of clarity from the Government on future arrangements including the funding regime which was complex and needed to achieve a fair balance.

Specific reference was made to the new Education, Health and Social Care Plan (EHSCP) which replaced statements and spanned ages from 0-25. It would contain commitments to

resources from health and social care as well as education and would set out learning and life outcomes as well as needs.

The Panel acknowledged the need for further clarity with regard to future funding arrangements in respect of Academies. With effect from 1 April 2013 a multi-agency team including education, health and social care would undertake a massive exercise examining the overall needs and funding arrangements. A comment was made however that there were a relatively small number of children subject to EHSCP with the vast majority of children with needs not being eligible.

Given the new Health Reforms with effect from 1 April 2013 the Panel considered it prudent to gain a perspective from the Clinical Commissioning Group with regard to EHSCPs.

Parenting was often the key to effective early intervention but there was concern given the increasing economic difficulties. Reference was made to impending legislation and SEN review the opportunity for parents to train as key workers.

It was also noted that funding arrangements were to be explored including the national funding framework for specialist provision that allowed more transparency and consistency between areas and better alignment between pre and post 16 provision. The trial of delegated funding to schools for alternative provision for SEN pupils would be evaluated.

Given that Middlesbrough had more vulnerable learners than neighbouring authorities and that there were projections that suggested that the numbers of children with complex needs were set to rise significantly in the future, the legislation would have profound implications for service provision in Middlesbrough with greater need for effective early intervention and prevention.

The report gave an indication of the categories of vulnerability. Children/young people entered Middlesbrough's settings/schools with a range of risks of not fulfilling their potential in terms of outcomes. Many children and young people required Wave 1 / Wave 2 levels of intervention. Quality First Teaching and Care, Support and Guidance enabled the majority of pupils to make appropriate, positive progress. A number of pupils needed more intensive or more specialist input in order to address their needs at Wave 3/ Wave 4 levels of intervention. The report outlined the categories of children/young people identified as requiring such interventions which included culture and language; attendance and mobility; not in school/at risk of exclusion; END; transitions; health and wellbeing; and home circumstances.

In order to cope with the level and complexity of need in Middlesbrough a range of bases/units in mainstream schools complemented the special school provision in the Town as outlined in the report submitted.

The imposed Government minimum floor standards to be achieved by primary schools in relation to English and Mathematics was seen by Members as a possible barrier when endeavouring to cope with the increasing number of children with higher levels of complexity of need.

In terms of access to the variety of provision available it was stated that there was a range of referral processes. Using the proposals for Education, Health and Care plans as a guide, the Cleveland Unit which currently had a waiting list had pioneered a simplified, multi-agency referral system which would be used as a model to review and simplify the overall system.

In response to the proposed legislation and funding changes, Middlesbrough LA had instigated a review of all its SEND provision. The Panel was advised that the initial details were descriptive and formed the basis of the information provided in the report under the heading specialist provision for pupils in special education needs. It was confirmed that a further stage of the review had been completed providing recommendations for strategic decision-making. The following recommendations were draft proposals which would form the basis for further consultation with special school leaders in Middlesbrough's Inclusion/Collaborative and Headteachers of schools with specialist bases/units:-

(a) Audit of all vulnerable learners (0-19), to identify their locality and level of service provision to establish a baseline.

(b) Rationalise existing referral panels to establish a central referral pathway and hub for early years intervention services.

(c) Develop the role of the Cleveland Unit to retain a central hub for the most complex children and their families, to establish a central referral pathway, to track and monitor vulnerable learners, to establish spokes for community based provision in the localities where the need has been identified as the greatest, to support workforce development.

(d) Develop greater accountability of service provision in line with the principles of best value.

(e) Develop tracking and monitoring systems for vulnerable learners (i.e. virtual school, Capita One), narrowing the gap.

(f) In line with the proposals of the SEN Green Paper develop a multi agency referral panel and move towards a single plan for vulnerable learners.

(g) Undertake a pilot to develop a single panel for early years referrals for vulnerable learners (CU, Portage, Inclusion Support).

(h) Review the CAF process to simplify systems for parents/carers and professionals to ensure simply and easy access to appropriate interventions/services for vulnerable learners and their families.

(i) Develop a workforce development strategy for supporting children, young people and families for early help as part of the strategy explore new ways of supporting agencies and practitioners with best practice initiatives.

AGREED as follows:-

1. That the Officers be thanked for the detailed information provided which would be incorporated into the overall review.

2. That further information be sought on the engagement of the Clinical Commissioning Group with regard to Education, Health and Social Care Plans.

4 **OVERVIEW AND SCRUTINY BOARD UPDATE 5 FEBRUARY 2013**

In a report of the Chair of the Health Scrutiny Panel, Members were advised of the key matters considered and action taken arising from the meeting of the Overview and Scrutiny Board held on 5 February 2013.

NOTED