Agenda Item No: **10**

Health Scrutiny Panel

19 September 2013

Report Title	Health and Wellbeing Board - Joint Health and Wellbeing Strategy
Classification	Public
Cabinet Member with Lead Responsibility	Councillor Sandra Samuels Health and Well Being
Wards Affected	All
Accountable Strategic Director	Sarah Norman, Community
Originating service	Community / Health, Wellbeing & Disability
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Recommendation

The Panel is asked to review and comment on the Health and Wellbeing Strategy which sets out the priorities for the Health and Wellbeing Board for 2013/14 and beyond.

1.0 Purpose

1.1 Health Scrutiny Panel is asked to comment on the priorities set within the Health and Wellbeing Strategy (Appendix 1) and to note the implementation plans outlined in the strategy.

2.0 Background

2.1 Health and Wellbeing Boards have the legal responsibility to publish a Joint Health and Wellbeing Strategy with the aim of improving health and wellbeing in their area. In developing the attached Health and Wellbeing Strategy the Board seeks to:

- Influence planning and delivery of integrated local services based on assessed needs and available assets
- Inform commissioning decisions to ensure they are focussed on the needs of service users and communities. This includes those services commissioned by the NHS England and Public Health England
- Tackle factors that impact upon health and wellbeing across service boundaries
- Influence commissioning of local services beyond health and care to make a real impact upon wider determinants of health
- Drive collective actions of NHS and local government, both commissioners and providers. Local authorities, CCGs and NHS Commissioning Board will need to have regard of the Joint Health and Wellbeing Strategy as they draw up their commissioning plans
- Engage with communities in the improvement of their own health and wellbeing
- Make best use of collective resources to achieve improved outcomes on the agreed priorities to be addressed
- Identify a robust evidence base
- Build on past work
- Link to the City Strategy –"Prosperity for All"

The Strategy is based on the five key health and wellbeing priorities identified by the Board:

- Wider Determinants of Health
- Alcohol and Drugs
- Dementia
- Mental Health
- Urgent Care

For each of these areas it commences with an implementation plan and outlines key outcome targets against which plans can be performance managed.

3.0 Financial implications

3.1 There are no financial implications associated with this report. [MK/05092013/S]

4.0 Legal implications

4.1 There are no legal implications associated with this report. FD/06092013/G]

5.0 Equalities implications

5.1 An equalities analysis has been completed for the Joint Health and Wellbeing Strategy.

6.0 Schedule of background papers

6.1 None.

Wolverhampton Joint Health and Wellbeing Strategy – 2013-2018

Ensuring good health and a longer life for all in Wolverhampton

Including the first phase implementation plan

August 2013

Foreword by Chairman of Wolverhampton's Health and Wellbeing Board

We are delighted to launch our first Health and Wellbeing Strategy for Wolverhampton. We believe this strategy is a significant step forward for the health and wellbeing of the City.

We are used to positive partnership working between Local Government and the NHS in Wolverhampton and we are also used to working hand in hand with the public. This document finds us all speaking with one voice on behalf of the new Health and Wellbeing Board in an attempt to tackle the most pressing health problems our City faces today.

Health and Wellbeing in Wolverhampton faces a number of significant challenges but we are determined to tackle these challenges by working together to achieve long term gains.

Our understanding of the issues facing Wolverhampton has been strengthened by an in depth consultation on this strategy's supporting Joint Strategic Needs Assessment with the public and our many partners.

It is important that we can measure the changes to services we intend to make and the improvements in health outcomes we hope to achieve. We have therefore included targets throughout the document. Many of these measures are ambitious and we intend to progress each of the key priorities.

We look forward to continuing to work with the public and our partners to make sure this remains a joint venture.

Councillor Sandra Samuels Chairman of the Board

1. Introduction

1.1 Overview

Welcome to Wolverhampton's Joint Health and Wellbeing Strategy. This is an overarching strategy for the city, together with an action plan for its implementation. It has been developed by leaders from across the local community working together through Wolverhampton's Health and Wellbeing Board. They have a collective focus – to improve health and wellbeing for all – so individuals and communities are able to live healthier lives, and to reduce some of the stark gaps in health experienced across the city.

1.2 Why we need a strategy

Health and Wellbeing Boards have the legal responsibility to publish a Joint Health and Wellbeing Strategy with the aim of improving the health and wellbeing in their area. This strategy provides a roadmap and gives a clear sense of direction. In developing the Health and Wellbeing Strategy, we seek to:

- Influence planning and delivery of integrated local services based on assessed needs and available assets
- Inform commissioning decisions to ensure they are focussed on the needs of service users and communities. This includes those services commissioned by the NHS England and Public Health England
- Tackle factors that impact upon health and wellbeing across service boundaries
- Influence commissioning of local services beyond health and care to make a real impact upon wider determinants of health

- Drive collective actions of NHS and local government, both commissioners and providers. Local authorities, CCGs and NHS Commissioning Board will need to have regard of the Joint Health and Wellbeing Strategy as they draw up their commissioning plans
- Engage with communities in the improvement of their own health and wellbeing
- Make best use of collective resources to achieve improved outcomes on the agreed priorities to be addressed
- Identify a robust evidence base
- Build on past work
- Link to the City Strategy –"Prosperity for All"
- Link to the Clinical Commissioning Group 'Integrated Commissioning Plan' and the vision of working closely and collaboratively with partners to deliver the 'Right Care in the Right Place at the Right Time'

1.3 Intelligence that has been used to shape the Joint Health and Wellbeing Strategy

The strategy needs to be focused on both health and wellbeing. Many factors can influence people's health and wellbeing including health issues such as heart disease caused by smoking and obesity and wider determinants such as feeling safe, being socially included and maintaining independence. The outcome priorities selected in the strategy have been chosen to reflect the full range of health and wellbeing priorities. The strategy heavily draws upon the evidence base outlined in the Joint Strategic Needs Assessment (JSNA). The JSNA is based upon the data drawn from the National Outcomes Frameworks for Health, Adult Social Care and Public Health. Data from about 120 indicators included in the national outcome frameworks has been analysed and presented to the Health and Wellbeing Board. The Health and Wellbeing Board reviewed this list of indicators and created a shortlist of outcomes where joint working can add value or which are current challenges to improving health and wellbeing in Wolverhampton. These were grouped and 2013-14 work will focus on groups 1 and 2 and detailed briefings have been produced to provide a useful evidence resource for these key health issues. The JSNA will be continually

updated to take account of the most recent versions of the outcomes frameworks in order to provide a detailed and up to date picture of health and wellbeing in Wolverhampton.

1.4 *Input from local people including the public, patients, partners and stakeholders*

Representatives of the Healthwatch, public, patients, partner organisations and other stakeholders undertook the same process as the Health and Wellbeing Board and prioritised a shortlist of outcomes. The outcome from these processes was highly compatible. Changes were made as a result of this input.

2. Strategic Direction

2.1 Our vision

Ensuring good health and a longer life for all in Wolverhampton.

2.2 Our goals

We want to improve the health and wellbeing of our most disadvantaged people and reduce inequalities in health and well-being across the city.

We want to raise the aspirations of people so they are motivated to take healthy choices to enable them to live longer, healthier and happier lives.

We want to create environments where the healthy choice is the easiest choice and support improvement in the wider determinants of health such as employment, poverty and housing that affect people's health and their ability to make healthier choices.

2.3 Our strategic priority outcomes

- ✓ Increase life expectancy
- ✓ Improve quality of life
- ✓ Reduce child poverty

2.4 Guiding Principles

The guiding principles underpinning the implementation of our Health and Wellbeing Strategy are outlined below:

- *Knowledge-led decision making* – understanding and interpreting information in all its forms – data, research and evidence, experience and expertise - and setting it within a local context is essential and will enable us to make the best possible decisions.

- *Innovation* – demand, need and expectations are increasing whilst we also face significant financial difficulties. We therefore have to think differently and do things differently. This will mean transformational change in some areas of providing services. We aim to deliver the ambitions of the strategy through being dynamic, forward-thinking and within a culture of innovation.

- *Integration* – many organisations and stakeholders will have a key part to play in successfully delivering our health and wellbeing ambitions. Some, if not all of these, are long-standing and difficult. The only way they can be tackled is through an integrated and joined-up approach across partners.

- *Outcome focused* – often strategies are full of impressive ideas that aren't measurable. It is our intention that this strategy is clearly focused on delivering outcomes and demonstrating change.

- *Value* – whether in a time of financial challenge or of plenty, we have a duty to make sure that the services we deliver or commission offer the greatest possible value in terms of quality, cost and outcome. For every initiative we implement, we aim to demonstrate the expected return in these terms of our investment.

3. Priorities Chosen by the Board

3.1 Being focussed

Wolverhampton faces considerable needs around health and wellbeing. We know this, because our JSNA process reviewed the national outcomes frameworks and highlighted 51 indicators (out of a total of 105 where we had local data) where we can be sure that Wolverhampton is performing worse than the England average. However, there is a danger that if the Health and Wellbeing Board tries to focus on all these areas of need that resource and energy will be spread too thinly to have an impact. Therefore, in the first phase, the Health and Wellbeing Board has decided to focus on a small number of priority areas.

The top five priorities identified by the Health and Wellbeing Board were:

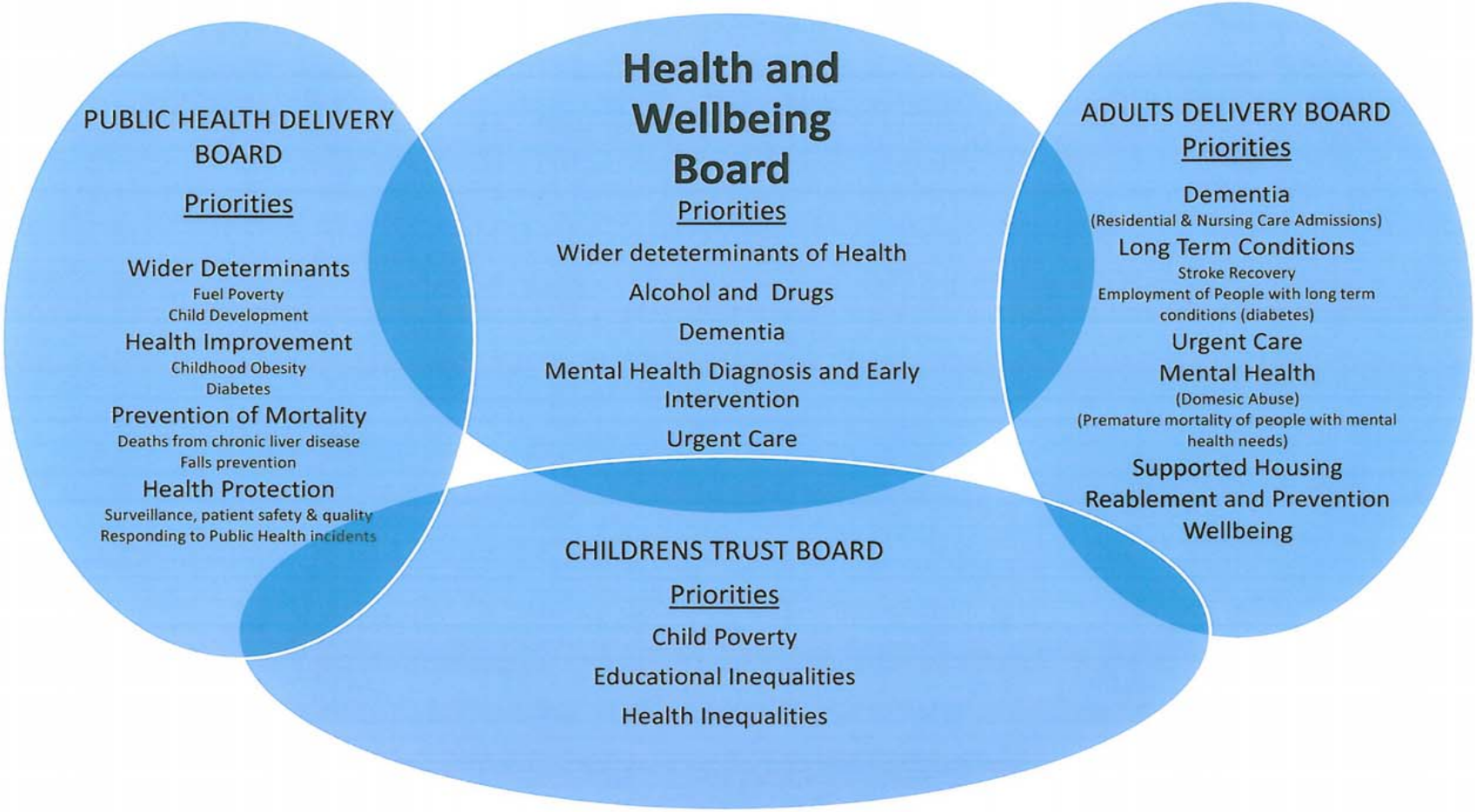
- **Wider Determinants of Health**
- **Alcohol and Drugs**
- **Dementia (early diagnosis)**
- **Mental Health (Diagnosis and Early Intervention)**
- **Urgent Care (Improving and Simplifying)**

In considering these priorities the Board identified the wider determinants of health as being a longer term priority and the other priorities as being of a short or medium term priorities. The Board has focused on those priorities which are key health issues identified in the JSNA; which are vital to the city and where, through partners working together, the Board can make a difference.

In addition to the Health and Wellbeing Board's priorities the priorities of the Board's three key sub-groups have been agreed as follows:

Sub-Group	**Priority**
Adults Delivery Board	▪ Dementia (Early diagnosis and residential and nursing care admissions) ▪ Long Term Conditions (Stroke Recovery and Diabetes) ▪ Urgent Care (Reducing demand) ▪ Mental Health (Diagnosis and early intervention, domestic abuse and premature mortality of people with mental health needs) ▪ Supported Housing, Re-ablement and Prevention ▪ Wellbeing
Children's Trust Delivery Board	▪ Child Poverty ▪ Educational Inequalities ▪ Health Inequalities
Public Health Delivery Board	▪ Wider determinants of health (Fuel poverty and child development) ▪ Health improvement (Childhood obesity and diabetes) ▪ Prevention of mortality (Deaths from chronic liver disease and falls prevention) ▪ Health protection

DELIVERING THE HEALTH AND WELLBEING BOARD PRIORITIES



Priorities

The health and wellbeing priorities have been selected to provide a number of high level evidenced based priorities which are a challenge to resolve and span organisational responsibilities. The JSNA and consultation with partners provided the evidence for the priorities and the sub-groups of the Board have endorsed the priorities and added to them. The priorities are also reflected in the Clinical Commissioning Group Integrated Commissioning Plan which highlights:

- **Dementia**
- **Urgent Care**
- **Diabetes**

as its priorities.

The Board will review progress made against its priorities at each meeting and they will be reviewed and refreshed annually.

PRIORITY 1 WIDER DETERMINANTS OF HEALTH

Lead Agency: Wolverhampton City Council (Public Health Department)

Sponsor: Ros Jervis (Director of Public Health)

Project Manager: Consultant in Public Health

Partners: All agencies/departments

What is the issue?

The health and well-being of individuals and populations across all age groups is influenced by a range of social, economic and environmental factors. We, as individuals, cannot always control them and they influence and often constrain the 'choices' we make and the lifestyle we lead.

The social determinants of health have been described as 'the causes of the causes' (of ill health). They are the social, economic and environmental conditions that influence the health of individuals and populations. They include the conditions of daily life and the structural influences upon them, themselves shaped by the distribution of money, power and resources at global, national and local levels. They determine the extent to which a person has the right physical, social and personal resources to achieve their goals, meet needs and deal with changes to their circumstances. There is a clear link between the social determinants of health and health inequalities, defined by the World Health Organisation as "the unfair and avoidable differences in health status seen within and between countries".

Lack of income, inappropriate housing, unsafe workplaces and poor access to healthcare are some of the factors that affect the health of individuals and communities. Similarly, good education, inspired public planning and support for healthy living can all contribute to healthier communities. Professor Sir Michael Marmot in his Strategic Review of Health Inequalities in England, Post 2010 – 'Fair Society Healthy Lives' presented an evidence-based strategy for the reduction of

health inequalities with a focus on policies and interventions that address the social determinants of health.

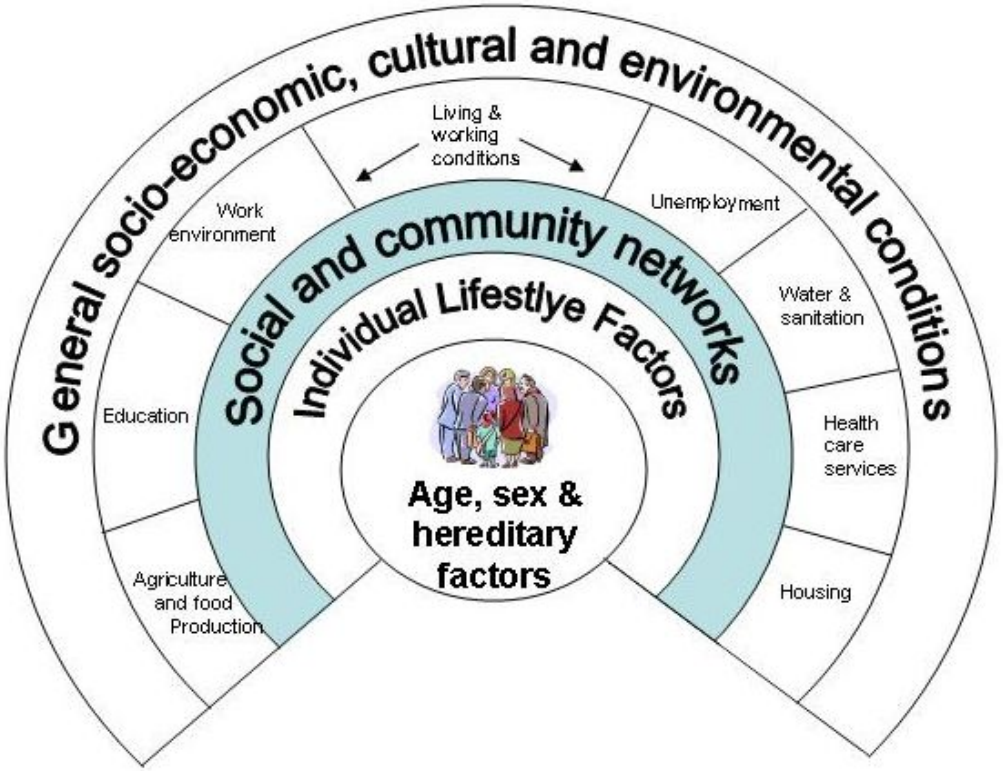
Why is it important

Addressing the contribution of the wider social determinants of health is crucial to health and wellbeing as we cannot make the large scale progress we need to make on tackling the big health issues of the 21st century, particularly on diet and weight issues, alcohol consumption, smoking, reducing health inequalities and tackling the big killers of cancer, CVD and respiratory illness, without systematic improvement across these areas. One of the difficulties in tackling health inequalities on the ground is a failure, for numerous reasons, to get a proper grip on the social determinants of health. Therefore the Health and Wellbeing Board consider this to be a key underpinning priority.

A model for the social determinants of health

A model often used to illustrate the wider determinants is the Dahlgren and Whitehead (1991) 'Policy Rainbow', which describes the layers of influence on an individual's potential for health (Figure 1). Some of these factors are fixed (core non modifiable factors), such as age, sex and genetics but there are other, potentially modifiable factors expressed in the diagram as a series of layers of influence including: personal lifestyle, the physical and social environment and wider socio-economic, cultural and environment conditions.

Figure 1: The Determinants of Health – the Policy Rainbow



The Rainbow model explained:

- In the centre of the figure, individuals possess age, sex and constitutional characteristics that influence their health and that are largely fixed.
- Surrounding them, however, are influences that are theoretically modifiable by policy. First, there are personal behaviour factors, such as smoking habits and physical activity.
- Second, individuals interact with their peers and immediate community and are Influenced by them, which is represented in the second layer.
- Next, a person's ability to maintain their health (in the third layer) is influenced by their living and working conditions, food supply, and access to essential goods and services.
- Finally, as mediator of population health, economic, cultural and environmental influences prevail in the overall society.

The size of the contribution of each of the layers to health has been estimated from research in the US as follows:

- 30% from genetic predispositions
- 15% from social circumstances
- 5% from environmental exposures
- 40% from behavioral patterns
- 10% from shortfalls in medical care

Therefore, 60% of what determines good or poor health comes from potentially modifiable circumstances of an individual's life – either directly related to the social and economic circumstances or related to behavioral patterns that will have been developed based on life experiences. Therefore taking action on improving the wider social determinants of health can have a huge impact on the health of Wolverhampton residents and impact on reducing health inequalities.

Figure 2 shows that local authorities are well placed to address these social and economic determinants of health as the services that can make a difference fall within their remit.

Figure 2: The social determinants of health and examples of local government services and activities that can make a difference

Source: adapted from Campbell F (ed.) (2010) The social determinants of heath and the role of local government. In http://publications.nice.org.uk/health-inequalities-and-population-health-phb4

What is the position and evidence in Wolverhampton?

The JSNA evidence from the various outcomes frameworks and in particular the Public Health Outcomes Framework spine charts highlights indicators relating to the wider determinants of health where Wolverhampton scores badly against national benchmarks. Children have a worse experience in a number of areas related to income deprivation and education, for example:

- 31% of children live in poverty – 10% higher than the England average
- 52% of children have a good level of development at age 5 – compared to 59% nationally
- Unauthorised absences at school are higher than average
- Amongst older age groups, 7.6% of 16- 19 year olds are not in education, employment or training – higher than the England average.

Indicators also show areas for improvement relating to adults and older people with higher rates of violent crime, more people affected by noise, higher numbers of homeless people and more households affected by fuel poverty.

However, there are other important indicators that measure the impact of social and environmental factors on the population, for example unemployment, educational attainment amongst adults, and demographic characteristics such as population structure and ethnicity. A broader measure of the wider determinants of health, the Index of Multiple Deprivation (IMD) is a composite index used to identify the most deprived areas across the country. The index combines a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score for small population areas in England.

The IMD shows that 52% of Wolverhampton's population falls into the poorest 20% of the national spread of social deprivation – i.e. over half of Wolverhampton's population live in the poorest areas in England which impacts on life expectancy and premature mortality rates in the City.

There are also stark differences within Wolverhampton itself between those living in the most and least deprived areas of the City – all of which results in males living on average, 6 years less in the most deprived areas compared to the least deprived areas and nearly 4 years difference for females.

How does it link to other strategies and priorities in Wolverhampton?

A consideration of the health impact should be a part of all local government department strategies which address the wider determinants of health. Strategies should consider, as standard, the question: – 'How does this strategy contribute to improving the health and wellbeing of Wolverhampton residents and in particular the most disadvantaged?' All strategies should be reviewed to examine the opportunities to promote health and new strategies should include a consideration of the opportunities to improve health and wellbeing and reduce health inequalities.

Strategies that have particular impact on the wider determinants are:

- Children, young people and families plan
- Transport
- Housing
- Education /Lifelong Learning Strategies
- Employment/Economic Regeneration
- Planning
- Environment/ Trading Standards
- Parks and Leisure

What is the evidence of effective interventions?

Action in partnership, in sectors such as housing, education, transport and employment offer real opportunities to improve health and reduce the health gap. It is important that partners are aware of the opportunities that exist to improve health outcomes in many of the core functions of local government and other agencies, not only in the services

that are delivered but in the way in which services are delivered to make sure that those who need them most are receiving them. Whilst in some areas the research evidence base could be strengthened, there are opportunities for local action to tackle the wider social determinants of health in the following areas:

Examples of opportunities for local action to tackle the wider social determinants of health

Wider social determinant:	***Example of opportunity:***
Community engagement	Enhancing mechanisms for getting people engaged and involved in things that matter to them
Housing and regeneration	Working with partners who provide housing or care services to address issues such as : quality of housing, ensuring that homes are safe (injury prevention) and addressing issues of fuel poverty.
Education	Investing in early years and in the quality of schooling which provide social, health and economic returns in the future
Community safety	Reducing crime and violence
Spatial planning	Healthy places result in healthy people. Planning authorities can do a great deal to plan for healthy environments. Not just those which promote physical activity but also promote mental wellbeing by including green space and opportunities to interact with others
Food and nutrition	Planning for food resilience and ensuring availability and access to healthy food
Transport	Particularly around injury prevention, including traffic calming measures and including walking and cycling in transport plans
Children's services	Those who deliver and commission children's services make a huge contribution to the social, mental and physical wellbeing of young people, providing them with vital skills and social capital which lead to better life chances as they grow up
Leisure and cultural services	Providers and commissioners of leisure and cultural services have the potential to influence health not simply through offering activity and promoting healthy lifestyle but also in the way culture shapes an area and communities within
Employment and the work environment	Fair employment and decent working conditions are major contributors to health and well-being. Workplaces also provide opportunities for health promoting interventions

The National Institute for Health and Clinical Excellence has produced a series of public health guidance in this area and also local government public health briefings (http://publications.nice.org.uk). Briefing 4 on Health inequalities and population health outlines NICE's recommendations for local authorities and partner organisations on population health and tackling health inequalities, many of which arise from the social determinants of health.

An 'asset model' takes as its starting point the need to identify and build on the positive features of individuals and communities, utilising such capacities and capabilities as exist to further empower them. This is in contrast to the usual 'needs led' deficit approach to tackling health and wellbeing issues. Assets can operate not just at the level of the

individual but, importantly, at the level of the group, neighbourhood, community and population. For example, these assets can be social, financial, physical, environmental, educational, employment related.. Conceived of in these ways, they relate directly to the social determinants of health and can provide an alternative way of dealing with the causes of ill health by looking for positive patterns of health and strengthening those social bonds and ties that go far in sustaining health, even in the face of disadvantage. Asset mapping is being undertaken in key neighbourhoods of Wolverhampton consistently affected by wellbeing and resilience issues and this work will inform a model of good practice in taking forward an asset based approach.

What are the planned actions, timescales and leads?

The return of public health to the Local Authority has provided an opportunity to address public health outcomes, including Domain 1: Improving the wider determinants of health, through a £1 million Public Health Transformational Fund. Bids of up to £250,000 per annum are invited from council directorates in partnership with other external agencies, for example the voluntary sector, public or private sector organisations, to be ratified by the Health and Wellbeing Board. The primary aim of the fund is to support the embedding of outcomes into directorates across the council so that improving the health of the population, and addressing health inequalities through the wider determinants becomes 'usual practice'

In addition to the Transformation Fund supporting the embedding of a culture of working 'upstream', there are a series of other actions that can support this process, for example:

- Review the extent to which existing NICE guidance relating to the wider social determinants of health has been implemented in Wolverhampton
- All City Council strategies adopt a 'health impact' approach. https://www.gov.uk/government/publications/health-impact-assessment-tools
- Existing relevant strategies (see 4 above) are reviewed to assess the potential for improving the health of Wolverhampton residents and reducing inequalities

- Refresh of the JSNA to include more intelligence on the wider social determinants of health, in particular to understand the risk factors for poor health outcomes

How will progress be measured?

Key high level targets:

Before measurable changes to population health can be achieved, there will need to be some underpinning actions and more integrated working to address upstream interventions before actual benefits to the population's health are achieved. For Year 1 the key deliverables are related to the Transformation Fund, i.e:

- Successful implementation of the Public Health Transformation Fund and approval of good quality projects to address factors such as education, skills, employment, housing, social capital/social connectedness.
- Each project that is approved will have associated evaluation and success criteria agreed as part of the approval process.

Progress will be monitored quarterly through the Public Health Delivery Board.

PRIORITY 2 ALCOHOL AND DRUGS

Lead Agency: Wolverhampton City Council (Public Health Department)

Sponsor: Ros Jervis (Director of Public Health)

Project Manager: Juliet Grainger (Substance Misuse Commissioning Manager)

Partners: West Midlands Police, YOT, CCG, GPs, Pharmacists

What is the issue?

Drug and alcohol dependency is a complex health disorder with social causes and consequences. No single factor can predict whether or not a person will become addicted. The risk of addiction is influenced by a person's personality, social environment, biology and age. The more risk factors an individual has, the greater the chance that taking drugs or harmful drinking can lead to addiction with a host of consequences for an individual's health for example drug use is linked to everything from heart and respiratory problems to psychosis and seizures, while heavy drinking is known as a causal factor in more than 60 medical conditions. Added to that is the increased likelihood of suffering violence and having unprotected sex that is seen among heavy drinkers.

Nationally, numbers using drugs have fallen gradually in recent years, in both adults and children. This success has been widely welcomed, and may be due to a combination of factors from better access to treatment and health promotion campaigns to a wider cultural shift away from traditional drug use and there is a growing concern about the use of so-called legal highs – substances that mimic the effect of banned drugs.

By comparison, alcohol-related problems among adults have been getting worse on many measures. Both hospital admissions and deaths linked to drinking have increased since the early 1990s. Overall it is estimated over 1million people in England have mild, moderate or severe alcohol dependence. About a third of these will face challenges that are similar to those people who are dependent on drugs.

There isn't really such a thing as a 'typical drug user', though people dependent on heroin and/or crack cocaine are statistically more likely to be white, male, in their thirties and from a background of high social deprivation. Alcohol misuse is also more common among people from deprived backgrounds – the most deprived fifth of people are up to three times more likely to have an 'alcohol related death' - but some of the largest rises in alcohol consumption have been seen among higher income groups in the past decade. Children growing up in families where parents are dependent on drugs or alcohol are seven times more likely to become addicted as adults[i]. Despite the relatively high number of injecting drug users, England has one of the lowest rates of HIV and hepatitis C among this group thanks partly to public health programmes such as needle and syringe exchange programmes. Cannabis is the most popular drug among occasional or casual users but no causal link between current cannabis use and the future use of more problematic drugs such as heroin or crack has ever been proved. [1]

The cost to the country in dealing with the consequences of alcohol and drug problems is significant. The bill for alcohol stands at about £20 billion a year once the economic, crime and health costs are taken into account and for drugs it tops £15 billion. However, Home Office research has shown that spending £1 on drug treatment saves £2.50 in crime and health costs of drug addiction.

What is the position and evidence in Wolverhampton?

Estimates show that there are 2,135 Opiate/Crack users and 5,264 dependant drinkers aged 16 years and over. There is no official estimate for the prevalence of drug use by young people at Local Authority level. However results of the Wolverhampton Health Related Behaviour Survey show that 25% of primary school pupils and 48% of secondary school pupils said that they have had an alcoholic drink, 5% of primary school pupils said they had been offered drugs, 12% of secondary school pupils revealed that they have been offered cannabis while 6% had taken an illegal drug; 3% of them in the month before the survey.

[1] Tackling drugs and alcohol. Local government's new public health role. Local Government Association http://www.local.gov.uk/c/document_library/get_file?uuid=ef73ac40-827e-4e7f-bb27-9b19fff157c0&groupId=10171

Mortality

Alcohol abuse is one of the leading causes of premature mortality in the city. Primary care mortality data shows that between 2006 and 2010 it was the third highest contributor to years of life lost (YLL) after infant mortality and CHD. Alcohol related mortality rates have increased over the last few years.

- Alcohol is currently one of the biggest contributors to Years of Life Lost (YLL) in Wolverhampton.
- In the period 2001-2005 it ranked 5th as a cause of YLL with 4,293 years of lives lost to alcohol related liver mortality
- The latest data- 2006-2010 shows that it has moved up to 3rd with 5,221 YLL

Top 10 causes of death and top 10 sum of YLL 2006-2010

Rank	Condition	Numbers	Rank	Condition	YLL
1	CHD	594	1	Infant deaths	9000
2	Disease of the respiratory system	403	2	CHD	7006
3	Lung cancer	389	3	**Alcohol related Liver mortality**	**5221**
4	**Alcohol related Liver mortality**	**236**	4	Disease of the respiratory system	4461
5	Stroke	227	5	Accidents	4444
6	Colorectal cancer	150	6	Lung cancer	4078
7	Breast cancer	140	7	Suicide & Injury Undetermined	3231
8	Accidents	130	8	Stroke	2626
9	Diseases of the nervous system	121	9	Diseases of the nervous system	2281
10	Infant deaths	120	10	Breast cancer	2269

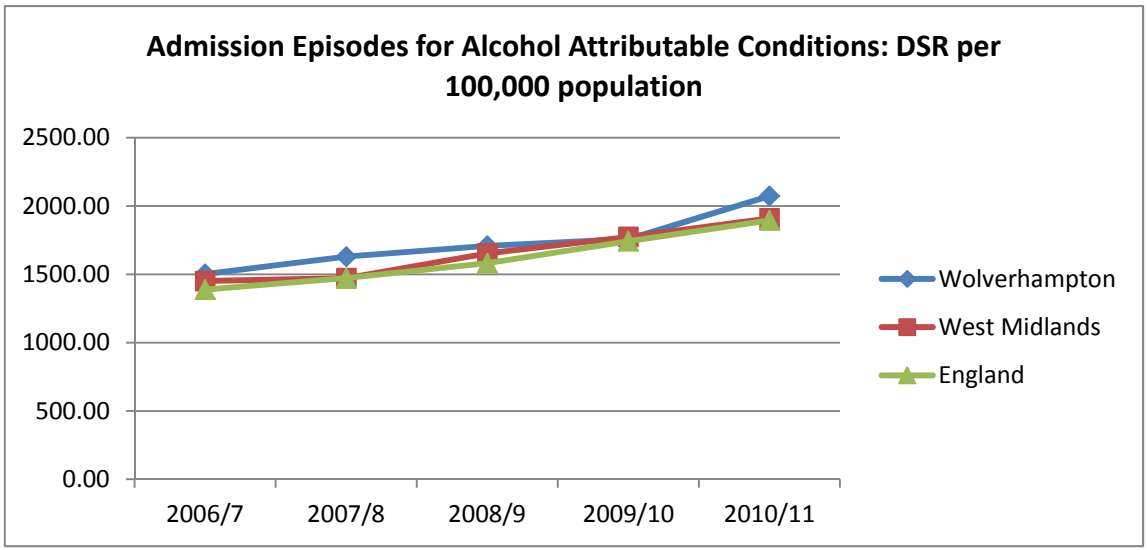
Source: Primary care mortality file

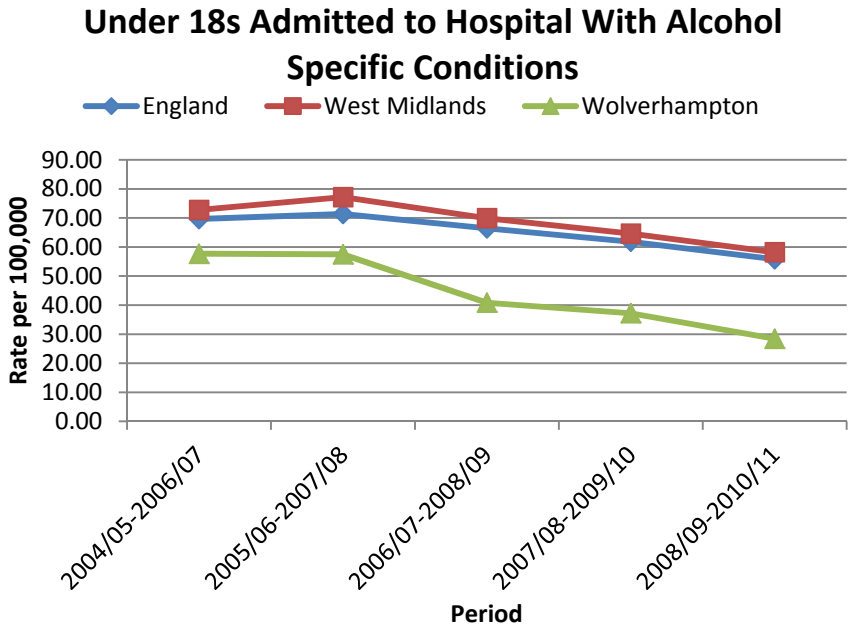
- The years of life lost annual potential for improvement shows the gap between the local value and the national average and gives an indication of the number of years of life lost that could be saved if the local value decreased to the national level.
- After infant mortality, alcohol has the biggest potential for improvement; between 2006 and 2010 494 YLL could have been saved if the rate of alcohol related mortality in Wolverhampton had been similar to the national rate.
- Alcohol related mortality has been on an upward trend over the last 17 years in Wolverhampton. In the last 3 years this trend has begun to level off, however, the gap to the national average remains almost double and rates are much higher than for the local authority comparator group, 'Centres with Industry'.
- The number of deaths related to drug use, published by the Office for National Statistics (ONS) at a national level show that there were 1,772 male and 880 female drug poisoning deaths (involving both legal and illegal drugs) registered in 2011, a 6 per cent decrease since 2010 for males and a 3 per cent increase for females.
- In 2011 the drug poisoning mortality rate was 63.8 deaths per 1 million population for males and 29.9 deaths per million population for females, both were unchanged compared with 2010.
- Deaths involving heroin/morphine decreased by 25 per cent compared with 2010, but they were still the substances most commonly involved in drug poisoning deaths (596 deaths in 2011).
- Locally the numbers are very low with only 52 deaths recorded between 1994 and 2012.

Hospital Admissions

As well as being a top cause of death, alcohol misuse also contributes to other health problems and impacts on service utilisation, in particular hospital activity. Hospital admissions for conditions related to drug use are generally lower.

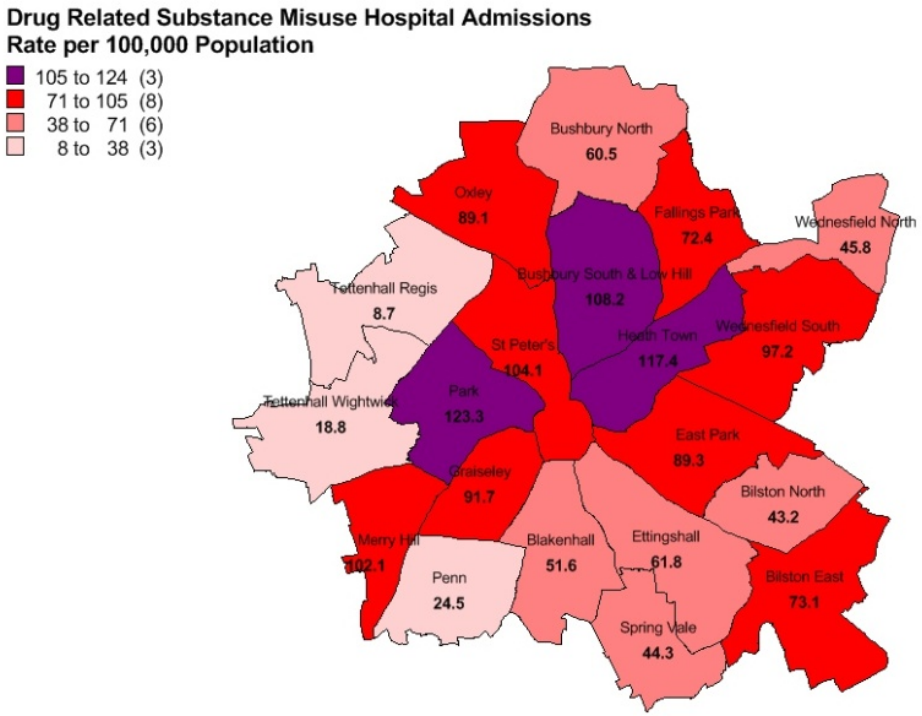
- In 2010/11, there were 2073 hospital admission episodes for alcohol-attributable hospital admissions per 100,000 population in Wolverhampton; nearly an 18% increase on the previous year.
- The rate of alcohol-attributable hospital admission episodes has seen a slow but steady increase over the past five years. However, the gap between the Wolverhampton rate and the national average is increasing.


Admission Episodes for Alcohol Attributable Conditions: DSR per 100,000 population
2500.00
2000.00
1500.00
1000.00
500.00
0.00
2006/7
2007/8
2008/9
2009/10
2010/11
Wolverhampton
West Midlands
England


Under 18s Admitted to Hospital With Alcohol Specific Conditions
England
West Midlands
Wolverhampton
Rate per 100,000
90.00
80.00
70.00
60.00
50.00
40.00
30.00
20.00
10.00
0.00
2004/05-2006/07
2005/06-2007/08
2006/07-2008/09
2007/08-2009/10
2008/09-2010/11
Period

- In contrast, hospital admissions for under 18s have shown an increase over the past 9 years and Wolverhampoton is significantly below the national and regional average.
- Between 2009 and 2011 there were 457 admissions related to substance misuse. This equates to a rate of 1.9 admissions per 1,000 population.
- The majority of admissions were for poisoning by narcotics. Mental health and behavioural disorders due to the use of opioids also represented a relatively high proportion of admissions.
- Between 2009 and 2012 there were 199 admissions for drug related conditions. This equates to a rate of 80 admissions per 100,000 population.

Rate of Drug Related Hospital Admissions 2009-2012



Source: Wolverhampton Public Health Department

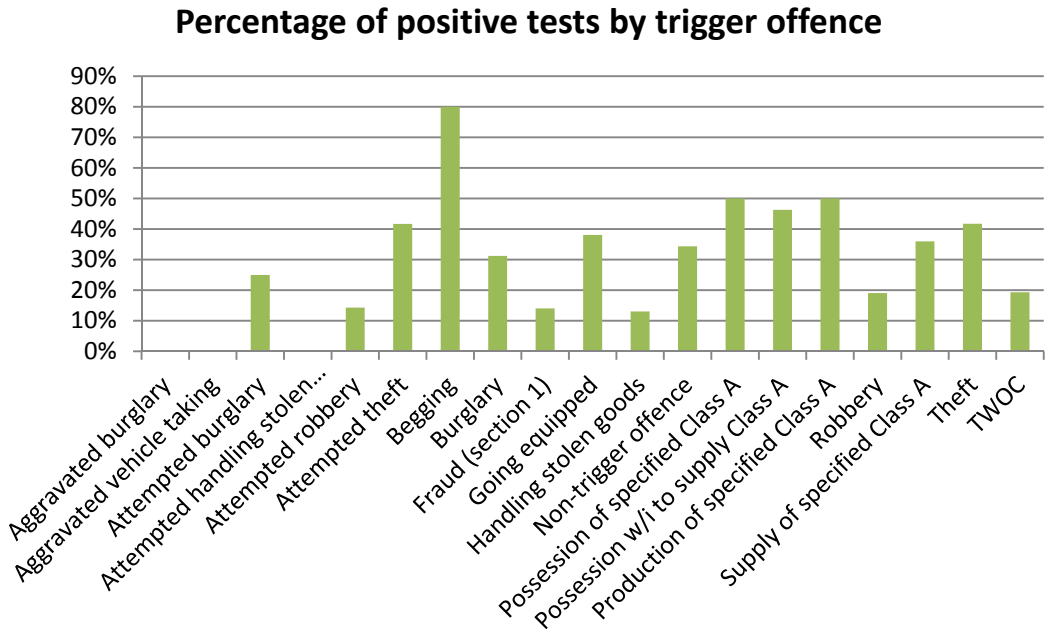
Rates of drug related hospital admissions during 2009-12 where highest in wards in the north east of the city and parts of the south west. Heath Town, Park and Bushbury South and Low Hill had the highest rates of admissions.

Services need to continue to engage people from the identified wards into treatment and reduce the risk of hospital admissions.

Crime

Alcohol has been identified as a factor in violent crime nationally and drug use tends to go hand in hand with acquisitive crime such as theft, shoplifting and robbery. However it is difficult to get an accurate picture of the extent of these crimes across the city because there is no consistent way of determining if an offence was fuelled by alcohol and/or drugs. Over half of young people and approximately a third of adults who come into substance misuse treatment every year in Wolverhampton come through criminal justice pathways.

- Any crime that the police deem to have been influenced by alcohol or where the offender may have been intoxicated is recorded with an 'alcohol Involved' marker.
- During 2011/12 there were 701 such crimes out of a total of 18,084 crimes recorded in Wolverhampton. The majority of these were assaults. This equates to just 4% of crimes in Wolverhampton.
- While this is an illustration of the role of alcohol in violent crime, it is thought that this figure does not give an accurate picture and is a significant underestimate of the actual number of crimes involving alcohol. As a guide, national estimates suggest that 55% of violent crimes are committed whilst the offender was under the influence of alcohol.
- Wolverhampton keeps a data base of people presenting to A&E after an assault and it shows that a proportion of assaults are committed when either the offender or the victim are intoxicated.
- Between February 2010 and January 2013 there were 1,234 attendances to A&E for assault related injuries. 54% of them were alcohol involved. 47 (7%) of the alcohol related assaults were domestic violence.
- The drug intervention programme which is a critical part of the government's strategy for tackling drug addiction gives the local police force powers to perform a drug test on any offender committing a 'trigger offence'.
- During the financial year 2011-12 there were 1,898 Wolverhampton residents who had tests successfully completed at Wolverhampton and Wednesbury police stations. 679 or 36% had a positive result. The chart below shows the test results for each trigger offence.



- This shows the link between drug use and certain types of offences. Offenders arrested for begging, production and/or possession of specified substances, possession with intent to supply, theft, and attempted theft and going equipped to steal had the highest probability of testing positive.
- Approximately 4% of drug offences were committed by young people under the age of 18.

Child Protection

Alcohol and drug abuse can affect an individual's ability to be a good parent to their children and this has an impact on social care and child protection.

- Wolverhampton Children's Social Care takes referrals from various sources for a wide range of issues affecting young people including substance misuse.

- In the 12 month period ending February 2013, there was a total of 3,406 referrals to children's social care, 144 (4.2%) were for substance misuse related issues. 92% of referrals moved on to receive an initial assessment while a small number were signposted to other services or no further action was taken.
- Of the 1,465 adults in drug treatment in 2011/12, 40% were parents or had some other contact with children. Similarly of the 759 adults in alcohol treatment, nearly 40% were parents or had contact with children.
- Parental substance misuse can be a factor to a child becoming looked after by the Local Authority. The number of looked after children in Wolverhampton has seen a significant increase over the past few years. It is currently not known how many of these involved substance misuse but a local case file audit of looked after children undertaken by Dartington Social Research Unit in conjunction with Children's Services, estimated approximately a quarter.

How does it link to other strategies and priorities in Wolverhampton?

Children and Young People's Plan (2011/14)

Action on alcohol and drugs will aim to:

- prevent children and young people from coming into contact with alcohol and drugs
- make sure there are effective young people's substance misuse services
- identify and address "hidden harms" and child protection issues that may be present in the children of substance misusers.

Safer Wolverhampton's Priorities

- Substance misuse is a priority for SWP

Taking action on alcohol and drugs will support reductions in crime and anti-social behaviour.

Wolverhampton's City Strategy (2011-2026)

Area 2: We are working to *Empower People and Communities* by
- doing things earlier and preventing things from happening

Area 3: We are working together to *Re-invigorate the City* by
- improving the city centre

Wolverhampton Alcohol Strategy 2011-2015

Priorities seek to improve alcohol treatment services and tackle alcohol related crime and disorder, including domestic violence and anti-social behaviour and the impact alcohol has on communities, children, young people and families.

- Supporting a whole community approach to changing alcohol habits
- Developing a well-managed -night time economy
- Combating alcohol related crime and disorder and increase community safety due to alcohol misuse
- Improving health and alcohol treatment services in Wolverhampton

What is the evidence of effective interventions?

There is a wide range of evidence of effective interventions for drugs and alcohol. However, there is a strong focus on ensuring that individuals can recover from dependency, primarily: -
Strategy 2010- Reducing Demand, Restricting Supply, building Recovery: supporting people to live a Drug free Life

The Strategy sets out the Government's approach to tackling drugs and addressing alcohol dependence, both of which are key causes of individual, family, societal and community harm. It sets out a fundamentally different approach to

preventing drug use in communities, and for drug and alcohol dependency, with the goal of recovery as its foundation. It sets out a whole system approach to commissioning recovery focused services. In relation to alcohol, the strategy aims to ensure that people who are alcohol dependent are provided with treatments, interventions in a holistic way (addressing any housing, employment or other social issues as well as the alcohol problem) which gives the best opportunity for recovery.

The Strategy describes the following "best practice outcomes":

1. Freedom from dependence on drugs or alcohol
2. Prevention of drugs related deaths and blood borne viruses
3. A reduction in crime and re-offending
4. Sustained employment
5. The ability to access and sustain suitable accommodation
6. Improvement in mental and physical health and wellbeing
7. Improved relationships with family members, partners and friends, and
8. The capacity to be an effective and caring parent

<u>NICE Guidance, e.g.</u>

- NICE Public Health Guidance 24- Alcohol-use Disorders: Preventing the Development of Hazardous and Harmful Drinking, (June 2010)
- NICE CG 100 - Alcohol Use Disorder: Diagnosis and Clinical Management of Physical Complications (June 2010)
- NICE CG 115 – Alcohol-use disorders: Diagnosis, assessment and management of harmful drinking and alcohol
- NICE PH guidance 43, Hepatitis B and C: ways to promote and offer testing to people at increased risk of infection, December 2012

Models of Care

- MoCAM Models of Care for Alcohol Misusers, provides best practice guidance for local health organisations in delivering a planned and integrated local treatment system for adult alcohol misusers. MoCAM outlines the activities and services which should be commissioned. Services should be delivered on a stepped model of care, starting with the provision of advice and information and moving to in-patient detoxification or residential services.
- Models of Care for treatment of adult drug misusers (NTA, 2006)

High Impact Changes for Alcohol

The Department of Health highlights seven practical measures, which if implemented at a local level have been identified as making the biggest difference to tackling alcohol related harms, including

- Improve the effectiveness and capacity of specialist treatment (community and hospital settings)
- Appoint an alcohol health worker (in hospital settings)
- Alcohol IBA – provide more help encourage people to drink less

What are the planned actions, timescales and leads?

A key strand will be to support the prevention agenda to provide a whole community approach to changing alcohol habits in Wolverhampton as driven through the alcohol strategy action plan.
Planned actions centre on ensuring that specialist treatment services are available and that "recovery" is achieved for individuals in a holistic way, encompassing, for example, housing, employment and other key factors.
A new integrated recovery focused substance misuse service (alcohol, drugs and young people's services) has been commissioned and procured. 'The service has been operational since 1 April 2013. The new model of service delivery will begin on 1st July 2013.
A single point of contact (SPOC) will be provided for referrals into drugs, alcohol and young people's substance misuse services to ensure quick and appropriate access into services.

A children's and young people's substance misuse service, including transition services for those aged 18-25 years old, if it is deemed that adult substance misuse provision is not appropriate.
The service will include alcohol and drugs pharmacological and psychosocial interventions (including identification and brief advice for hazardous and harmful drinkers) provided in the community. This is in addition to a drugs and alcohol service at New Cross hospital (provided through a hospital liaison nurse service).

Community and enterprise provision will be the vehicle for providing wrap around support and driving recovery. In addition to pharmacological and psychosocial interventions, a key strand of the service will be providing help and support to ensure individuals can address any social problems they may have (for example housing issues) and access employment and training. This is important as wider problems often impact on individual's substance misuse and affect their chances of recovery.

How will progress be measured?

Key high level targets:

Reduction in 3 year average alcohol related mortality rates per 100,000 all ages population from a baseline of 19.6 in 2008 – 2010.

Improvement to the top quintile of performance nationally for:

- Percentage of drug users in treatment who complete treatment and do not represent within 6 months (OPIATES)
- Percentage of drug uses in treatment who complete treatment and do not represent within 6 months (NON-OPIATES)

In addition quarterly monitoring and review meetings will be held with the provider and a suit of performance indicators have been established (some of which are performance related (PBR) and these will be used to identify and measure progress with Wolverhampton Alcohol Strategy and this will be the focus of monitoring meetings.

PRIORITY 3 DEMENTIA

Lead Agency: Wolverhampton City Council (Community)

Sponsor: Anthony Ivko (Assistant Director, Older People and Personalisation)

Project Manager: Steve Brotherton (Head of Older People's Commissioning)

Partners: All agencies/ Departments

What is the issue?

Dementia can affect anyone whatever their gender, ethnic group, age or class, however it is particularly prevalent in the population aged 65 years and over and with a growing aging population the number of people with dementia is set to significantly increase. Raising awareness of dementia across all sectors and the importance of delivering a person centred response is critical to making a real difference to the health and well-being of individuals and their families.

What is the position and evidence in Wolverhampton?

- There are 3000 people living with dementia in Wolverhampton
- This figure is forecast to rise by 44% over the next 20 years, representing an increase of 75 people per year
- Only 40% of people with dementia in Wolverhampton are on a GP dementia register
- It is predicted that the number of people diagnosed with an early onset dementia is underestimated by three times (Dementia UK 2007)
- One third of people with dementia are living in care homes (1000 people in Wolverhampton) with two thirds of the care home population at any one time made up of people with dementia (Alzheimer's Society 2007)

- Conversely, two thirds of people with dementia are living independently in their own homes (2000 people in Wolverhampton
- 40% of people in hospital have dementia; the excess cost is estimated to be £6 M per annum in the average General Hospital; co morbidity with general medical conditions is high; people with dementia stay longer in hospital, have poorer quality outcomes and one third of people with dementia admitted to hospital never return home (Alzheimer's Society, 2009)
- In a national survey of 1000 GPs only 47% said they had sufficient training to diagnose and manage dementia; 58% said they felt confident about giving advice about management of dementia-like symptoms (National Audit Office, 2010)
- Alcohol-related dementia is under-recognised and may account for up to 10% of all dementia cases –around 70,000 people in the UK. (British Journal of Psychiatry); 300 people in Wolverhampton
- An Alzheimer's Society Report in 2007 estimated the annual cost of dementia for the United Kingdom at more than £17 billion, or £25,000 per person (Alzheimer's Society 2007). Applying these figures to Wolverhampton gives a total annual cost of dementia to the Wolverhampton economy of £75 million pounds (3000 people X £25,000 per person). The Kings Fund predicts that the cost of dementia in England will rise to £34.8 billion by 2026 (Kings Fund 2008).

The following table gives a more detailed breakdown on the projected population of people with dementia in Wolverhampton:

POPPI (2011): Wolverhampton People with Dementia Population Projection

Age	2009	2015	2020	2025	2030
65-69	133	145	142	149	165
70-74	264	264	295	289	306
75-79	488	493	504	562	556
80-84	757	778	825	848	966
85+	1301	1520	1739	2034	2323
Total	**2943**	**3200**	**3505**	**3883**	**4315**

How does it link to other strategies and priorities in Wolverhampton?

The response to dementia in Wolverhampton has been developed through a partnership approach involving all key stakeholders, including Wolverhampton Clinical Commissioning Group, Royal Wolverhampton Trust, Black Country Partnership Foundation Trust, and Wolverhampton Public Health. This response is underpinned by the following:

- The Living Well in Later Life Strategy 2012-15 sets the direction for services for older people, focussing on prevention, aiming to improve the quality of life & independence of older people, and increasing participation in service planning & community activities. It targets the 20% of older people who are most at risk of entering the downward spiral of isolation and ill health, include people with dementia
- The Joint Dementia Strategy (2011) was co-produced through a series of workshops, attended by over three hundred people, and a range of consultation events. It adopts a person centred philosophy that recognises people with dementia as people first and foremost who have the same rights as everyone else to lead healthy, happy and fulfilling lives. The strategy focuses on the delivery of five key priorities: Good Quality Early Diagnosis and Intervention; Improved Quality of Care in General Hospitals; Living Well with Dementia in Care Homes; Reduced Use of Antipsychotic Medication; Improved Support for Carers
- The Joint Reablement Forward Plan (2011-2013) outlines the commissioning intentions with regard to reablement activity, emphasising the need to focus on the person and their individual circumstances as presented at every stage across all pathways
- The following outcomes frameworks:

    - *NHS Outcomes Framework 2013/14*
        - Enhancing quality of life for people with dementia
        - Estimated diagnosis rate for people with dementia
        - A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life

- *Adult Social Care Outcomes Framework 2013/14*
  - Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services
  - Proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation services
  - Permanent admissions to residential and nursing care homes
  - When people develop care needs, the support they receive takes place in the most appropriate setting and enables them to regain their independence
  - Delayed transfers of care from hospital, and those which are attributable to adult social care
  - People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual

- *Public Health Outcomes Framework for England, 2013-2016*
  - Increased healthy life expectancy
  - Reduced differences in life expectancy and healthy life expectancy between communities

There are further local and national strategies that have informed the local response:

- NICE Quality Standard 1 for Dementia
- NICE Quality Standard 30. Supporting People to live well with dementia(2013)
- NICE Quality Standard 13. End of life care for adults
- NICE Clinical Guideline 42. Dementia: supporting people with dementia and their carers in health and social care
- NICE: Support for commissioning dementia care (2013)
- The Adult Social Care: Choice Framework (2013)
- Caring for our future: reforming care and support (2012)
- Living well with dementia: a national dementia strategy (2009)

- Care Quality Commission: Position statement and action plan for older people, including people living with dementia
- Improving quality of life for people with long term conditions (2012)
- Whole System Demonstrator Programme: Telehealth and Telecare (2011)
- Prime Minister's Challenge on Dementia
- Think Local; Act Personal

What is the evidence of effective interventions?

- To improve awareness and education, Worcester University Association of Dementia Studies has delivered two training modules to external market and public sector providers. These modules have concentrated on developing dementia leaders (hire and fire positions) and champions (front line worker position) with each organisation required to nominate a representative for each of these modules. These two people are then tasked to go back to their organisation and deliver person centred changes that improve the health and well-being of people with dementia
- To improve quality, Bradford University School of Dementia have carried out a dementia care map of local care homes across the City. An Action Plan with the aim of improving well-being was delivered to the home and a follow up map completed six months later to check progress
- To improve in-patient experience and outcomes, a dementia ward has been developed at New Cross hospital in addition to an outreach service to other wards
- To improve quality, Dementia Care Matters have carried out an evaluation of the wards at New Cross hospital and made a quality and cost comparison with the University Hospital in Birmingham
- To improve community based resources, six dementia cafés have been established across the City, one café for Asian elders and one café for African Caribbean elders
- To raise public awareness, two Prime Minister Challenge conferences were held to launch the development of a dementia friendly City, including people with dementia as key note speakers, banks, building societies, retailers and faith groups

What are the planned actions, timescales and leads?

The following Action Plan has been agreed by Adult Delivery Board:

Action	Timeframe	Assigned Lead Organisation/Individual/s
Common Assessment Framework (CAF) – Project to commence 01 September 2013		
To establish a CAF project group	Within 30 days	Black Country Partnership Foundation Trust
To agree in principle a multi-agency CAF approach	Within 60 days	
To review CAF processes and understand its potential application for dementia	Within 60 Days	
To agree and deliver a CAF paper with recommendations to Adult Delivery Board	Within 90 Days	
Information Sharing Protocols – Project to commence 01 September 2013		
To review City wide information sharing protocols	Within 90 days	Wolverhampton City Council
Dementia Pathway - Project to commence 01 September 2013		
Through the multi-agency Joint Dementia Strategy Steering Group formulate and agree a revised pathway for dementia	Within 90 days	Joint Commissioners
Reablement – Project to commence 01 September 2013		
To establish a dementia reablement project group	Within 30 days	Wolverhampton City Council
To develop a reablement approach for people with dementia	Within 60 days	"
To agree and deliver a multi-agency reablement paper with recommendations to Adult Delivery Board	Within 90 days	"
Home as a Hub – Project to commence 01 September 2013		
To establish a dementia hub project group	Within 30 days	Wolverhampton Clinical Commissioning Group
To agree the scope of services in a dementia hub	Within 60 days	"
To agree and deliver a multi-agency dementia hub paper with recommendations to Adult Delivery Board	Within 90 days	"
Refresh of Joint Dementia Strategy		
To deliver a refreshed Joint Dementia Strategy & Implementation Plan	By 31 March 2014	Joint Commissioners

How will progress be measured?

Progress will be measured against the following statements where people living with dementia in Wolverhampton are able to say:

- *'I was diagnosed early*
- *'I understand, so I make good decisions and provide for future decision making'*
- *'I get the treatment and support which are best for my dementia and my life'*
- *'Those around me and looking after me are well supported'*
- *'I am treated with dignity and respect'*
- *'I know what I can do to help myself and who else can help me'*
- *'I can enjoy life I feel part of a community'*
- *'I'm inspired to give something back'*
- *'I am confident my end of life wishes will be respected'*
- *'I can expect a good death'*

In terms of integrated working, three core areas have been highlighted as critical in order to enhance the experience and outcomes for people with dementia:

1. Information Access and Care Planning: Grounded in in a commitment to ensure that timely information is available and managed safely across the system, ensuring that people with dementia only need to tell their story once
2. Home as the Hub of Service: Grounded in a commitment to ensure that living at home and retaining independent living is regarded as a default outcome consideration, including the development of early intervention; prevention & rehabilitation and community based opportunities, making 'home' a positive and realistic alternative for people with dementia
3. Developing the Community Capacity to Care: Grounded in a commitment to deliver a whole city approach, including developments with commercial sector partners to ensure a full range of life opportunities are available for people with dementia.

All of this will be evaluated by identifying:- reduced costs in health & social care; a shift in public expenditure from intensive to preventative services; increased numbers of older people engaged in local groups and networks; increased satisfaction of older people with their quality of life; reduction in health inequalities.

PRIORITY 4 MENTAL HEALTH

Lead Agency: Wolverhampton City Council (Community)

Project Sponsor: Viv Griffin (Assistant Director – Health, Wellbeing and Disability)

Project Manager: Sarah Fellows

Partners: All agencies

What is the issue?

It is acknowledged that at least one in four people will experience a mental health difficulty at some point in their life and that one in six adults and one in ten children in England under 16 years have a mental health difficulty at anyone time. It is also understood that half of those with lifetime mental health difficulties experience symptoms by the age of 14 *(No Health without Mental Health, 2011)*. We now know that mental illness is the largest disease burden upon the NHS, up to 23% of the total burden of ill health and the largest cause of disability within the United Kingdom *(No Health without Public Mental Health, Royal College of Psychiatry 2010)*, and that mental ill health often starts before adulthood and continues through life.

There are significant personal, social and economic costs, with particular risks from birth, into childhood and as young people move into adulthood and as they enter periods of physical and psychological change and development. It is also understood that physical health is inextricably linked to mental health. Poor mental health is associated with obesity, alcohol and substance misuse and misuse and smoking, and with diseases such as cardio-vascular diseases and cancer, *(No Health without Public Mental Health, Royal College of Psychiatry 2010).*

Mental health is a vital element therefore of the of the quality of life, physical health, emotional and social well-being and economic success and educational achievement of individuals, families and communities, and a key contributing factor in reducing the impact/s of physical ill-health, unemployment, homelessness, drug and alcohol misuse and crime.
It has been identified that the costs of mental health problems to the economy in England have been estimated at £105 billion - in comparison, the total costs of obesity to the UK economy are £16 billion a year and £31 billion for cardiovascular disease , and that in 2010/11, £12 billion was spent on NHS services to treat mental disorder, equivalent to 11% of the NHS budget and that treatment costs are likely to double in the next 20 years as by 2026, the number of people in England who experience a mental disorder is projected to increase by 14%, from 8.65 million in 2007 to 9.88 million (*No Health without Public Mental Health, Royal College of Psychiatry 2010).*

The cross–departmental mental health strategy '*No Health Without Mental Health' (2011)*, describes mental health as *'everyone's business'* and details the Government's aim to '*mainstream*' mental health within England, to establish and develop parity of esteem between mental and physical health, and to improve outcomes for all building and developing on previous National and Local priorities and work programmes in terms of improving existing services for people with mental health problems and addressing the wider and underlying causes of mental ill health. This includes an emphasis on the importance of promoting good mental health and intervening early, particularly in childhood and teenage years to prevent mental illness from developing and to reduce the impact of mental health difficulties when they do occur. The Strategy takes a life course approach therefore, recognising the importance of good maternal and parental mental health, protecting and promoting well-being and resilience through early and developmental years, and into adulthood and then on into our later years.

Addressing the impact and burden of mental ill health is a priority nationally and locally therefore, and mental health services have developed in Wolverhampton in keeping with national policy guidance in recent years –including improved access to psychological therapies (IAPT), an Early Intervention in Psychosis Service for those aged 14 years, integrated approaches to delivering health and social care, and the development of teams and services locally that were compliant with the model/s described within National Service Framework for Mental Health: modern standards and service models *(Department of Health, 1999)* – it is timely to now place a focus upon mental health promotion and prevention, intervening early when mental ill health occurs.

It is imperative therefore, the Wolverhampton our Health and Well-being Strategy is able to describe and deliver a cross agency programme of priorities that can meet the mental health promotion and early intervention needs of our population, while recognising and responding to the unique characteristics of the people that live in our City. To do this we will need to work together to reduce the impact of the stigma of mental ill-health, to deliver improved outcomes for people with mental health difficulties, - for example in terms of housing and employment - and provide focused interventions for people that fall into the most vulnerable groups, such as those from Black and Minority Ethnic communities, communities with high levels of deprivation and people who are unemployed, people who experience physical ill-health, people with co-occurring conditions, children and young people who are transitioning to early adulthood and / or have parents or carers with poor mental health, people without stable family and / or social support, people who are subject to / at risk of abuse and bullying and people leaving care.

It is important to continue to improve access to services therefore but also to develop an approach that provides mental health promotion initiatives, and particularly to imbed this approach within early and school years where the impact of these initiatives is understood to be potentially higher in terms of improving life term outcomes such as improved mental health, improved educational outcomes, improved employment, and reduced levels of anti-social behaviour, crime including violent crime, and reduced suicide *(No Health without Public Mental Health, Royal College of Psychiatry 2010)*.

We must aim therefore to deliver a range of mental health promotion interventions across the life span to prevent mental illness, promote well-being, improve emotional health and well-being, and increase resilience in individuals, families and communities. Improving and strengthening resilience is a key concept in terms of developing protective versus risk factors with specific interventions such as parenting programmes, improved maternal care and mental health promotion programmes for employers, schools and colleges, and all-age communities and groups. It is important to provide interventions which apply across the life course that protect health and well-being and promote resilience to adversity, with early and appropriate intervention if mental health difficulties occur. Strategies to promote parental mental health and effectively treat parental mental illness are also important as are targeted approaches to support the mental health needs of Older People including interventions to prevent and treat dementia, and to promote good mental health and well-being in later life, including, recognising and promoting the contributions older people make to families and communities, and to develop reablement initiatives as part of this plan to allow people who have been affected by

disability or ill-health to move to a position of increased self-support and self-management, improving self-esteem and self-efficacy and facilitating greater levels of social inclusion. This approach is a key strategic priority for the Joint Commissioning Unit in terms of helping people with mental health difficulties to recover and engage in a more active role within their families and communities, whilst increase their personal autonomy and self-direction.

What is the position and evidence in Wolverhampton?

A detailed needs analysis of Wolverhampton prevalence data in 2010 identified the following key factors.

- QOF data of psychotic registers reported the prevalence to be comparable with national data at (0.7%)
- QOF depression registers reported a similar prevalence (5.5%) to national predictions
- Low-level depression was thought to be more prevalent among Wolverhampton adults since 2.4% of the population (5,615 people) were claiming incapacity benefit (IB) on the grounds of mental health, which equated to 42% of those claiming the benefit. This is slightly higher than the regional average (39.5%), and the national average (41%)
- QOF indicators for mental health were slightly below the national achievement levels
- The average suicide rate in Wolverhampton was 11.6, compared with the national average of 8.3. There was also a large discrepancy between different wards in Wolverhampton, which further highlights the health inequality in the city
- The percentage of people with a long term limiting illness in Wolverhampton (21%) was slightly higher compared to West Midlands (19%) and also above the England average (18%).

The Wolverhampton Community Mental Health Profile 2010/11(Department of Health 2013) has identified the following:

- Wolverhampton has slightly higher than average directly standardised rate for hospital admissions for mental health (Local Value 184, National Average 172)
- Significantly lower than average directly standardised rate admissions for Alzheimer's disease and Dementia (Local Value 49, National Average 80)
- Wolverhampton has lower than average proportion of referrals for IAPT (Improving Access to Psychological Therapies Local Value 53.2, National Average 60.1)

- Slightly lower than average numbers of people receiving care and support as part of the on Care Programme Approach, rate per 1,00 population (Local Value 5.8, National Average 6.4)
- Higher than average contacts with mental health services per 1,000 population (Local Value 413, National Average 313)
- Lower than average in year bed days for mental health, rate per 1,000 population, (Local Value 184, National Average 193)
- Significantly higher than average contacts with Community Psychiatric Nurses, rate per 1,000 population (Local Value 274, National Average 169)

Key drivers for the current Mental Health Commissioning Strategy include the 6 priorities of 'No Health without Mental Health' (Dept. Health 2012), which are:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

Services have been configured and aligned from 2012 to provide IAPT (Integrated Access to Psychotherapy) as part of the Primary Care facing Well-Being Service and a strong emphasis is placed upon providing psychological therapies across all elements of the service model as a whole in keeping with national drivers.

In addition in February 2012 a Needs Analysis of CAMHS prevalence data revealed the following key factors:

- When comparing local use of services against a national prevalence tool utilisation of services last year suggests that there is an under use of universal and targeted services, an over use of specialist services and a significant increase in the use of in-patient hospital provision.

- Over the fiscal years 2011/12 and 2012/13 the requirement for hospital admissions rose by over 100%. The purpose of 75 % of in-patient admissions was to prevent harm to self.

- The Crisis Support and Home Treatment Service is providing support and treatment to significantly more females than males – most recent data tells us that 35% of referrals to this service were following acts of deliberate self-harm. In addition there is an increase in females in school years 11 and 12 accessing the Multi Agency Support teams for support.

- The Crisis Support and Home Treatment Service has also experienced a significant increase in requests for specialist assessment out of hours (an increase of 273%) as well as planned telephone support out of hours (an increase of 294%).

- Overall the Crisis Support and Home Treatment Service have received experienced a 25% increase in routine referrals.

- From April 2012 to date there have been 149 admissions to the paediatric wards at New Cross Hospital of children and young people who have engaged in acts of self-harm.

- Public Health data identifies that in 2011 there were no suicides of people aged under 18 years that were resident in the City. In 2012 there are known to have been 3 incidents of suicide in the under 18 age group, the youngest being a child aged 13 years. Each incident is the subject of a serious case review.

- Referrals into services regarding the mental health of teenage mothers, children and young people in contact with criminal justice services and referrals from substance misuse services into children and young people's mental health services are not consistent with national prevalence data for these high risk groups, suggesting under representation within mental health services. This includes data regarding referrals into mental health services for those classed as 'children in need' and looked after children. Only 17% of the looked after children population are known to children's and young people's mental health services currently.

- Prevalence data suggests that as many of 10% of young people aged 18-25 years are currently accessing adult mental health services. Specialist teams within children's and young people's mental health services have reported difficulties referring young people into adult mental health services, with poor use of transition protocols / processes, and differing criteria regarding referral into adult mental health service provision.

- The School Census Spring 2012 in Wolverhampton shows that the school age population is more diverse than the ethnicity of the City as a whole. Specialist teams and multi-agency support teams are being accessed by predominantly white British families. Children and young people from Black and Minority Ethnic groups are significantly underrepresented in the data regarding children and young people accessing mental health and psychological support services in the City.

All of the above information has been used to inform the development of the Wolverhampton Emotional and Psychological Well-Being Strategy for Children and Young People however it should be noted that within Adult and Children and Young People's Mental Health Services and Commissioning a strong emphasis should now be placed upon Public Mental Health to provide a focus upon providing mental health promotion and prevention for the whole population of our City, including hard to reach groups and people who have established mental health conditions.

How does it link to other strategies and priorities in Wolverhampton?

This Mental Health Priority links to a number of other strategies, initiatives and priorities. These include:

- Mental Health Strategy Re-fresh (including CAMHS Strategy, i.e. Strategy for the Emotional, Social and Psychological Well-Being of Children and Young People
- NHS Outcomes Framework 2013/14
- Social Care Outcomes Framework 2013/14
- QIPP
- No Health Without Mental Health (2011)
- No Health Without Public Mental Health (2011)

- Dementia Strategy
- Children and Young People's Plan

What is the evidence of effective interventions?

The Joint Commissioning Panel for Mental Health *'Guidance for Commissioning Public Mental Health Services' (JCP-MH, 2012)*, identifies that mental well-being is associated with a wide range of improved outcomes in health, education and employment, as well as reduced crime and antisocial behaviour such as, better physical health, longer life expectancy, reduced inequalities, healthier lifestyles, improved social functioning and better quality of life. The guidance also suggests that Public Mental Health should form a key part of the strategic plans of Health and Well-being Boards, and that this should involve:

- Strong data intelligence which details the current and future mental and physical health needs of the local population and both an assessment of the risk factors for mental disorder and the protective factors for well-being in the local population.
- A Health and Well-Being Board Mental Health 'champion'.
- A Strategic Plan to deliver appropriate interventions to promote well-being, prevent mental disorder, and provide early and pro-active treatment for mental disorder, ensuring that people with increased risk of mental disorder and poor well-being are proportionately prioritised in delivery of interventions ('proportionate universality').
- Strong collaboration and partnership working across all agencies to ensure a combination of initiatives that will address the broad range of social, cultural, economic, psychological and environmental factors at all stages of the life-course.

The JCP-MH guidance also highlights a wide-ranging body of good evidence to suggest the efficacy of public mental health interventions to reduce the burden of mental disorder, enhance mental well-being, and support the delivery of a broad range of outcomes relating to health, education and employment and further identifies that although current spending on prevention and promotion is less than 0.001% of the annual NHS mental health budget investment in the promotion of mental well-being, prevention of mental disorder and early treatment of mental disorder results in significant economic savings - including in the short term - across health, social care and criminal justice areas.

The JCP-MH guidance suggests that preventing disease can occur as follows:

- Primary prevention, which aims to **prevent ill health** by focusing upon the wider determinants of illness and utilises approaches that target the majority of the population
- Secondary prevention, which involves the **early identification** of health problems and early intervention to treat and prevent their progression
- Tertiary prevention, which involves working with people with mental ill health to **promote recovery and prevent or reduce the risk of relapse**

The JCP-MH guidance also suggests that promoting health can occur as follows:

- Primary promotion involves promoting the health and well-being of the **whole population**
- Secondary promotion involves targeted approaches to groups that have or are at risk of **developing poor health** and well-being
- Tertiary promotion targets groups with **established health problems** to help promote their recovery and prevent relapse.

The table below describes suggested Public Mental Health Interventions adapted from the JCP-MH Guidance, the outcomes of the NHS Confederation / New Economics Foundation, 'Five Ways to Well-being' (2011) and the five key outcomes of Every Child Matters / The Children's Act (2004) and the stakeholder involvement required:

Mental Health Promotion	Mental Health Prevention	Early Intervention	Five Ways to Well-Being / Outcomes from 'every Child Matters'	Key Stakeholders
• Starting Well • Developing Well • Living Well • Working Well	• Mental Disorder and Dementia • Health Risk Behaviour including alcohol and	• Treatment of Mental-Disorder and sub-threshold Mental Disorder	• Connect • Be Active • Take Notice • Keep Learning	• Public Health England • Universal and Primary Care Services • Secondary and Tertiary

Mental Health Promotion	Mental Health Prevention	Early Intervention	Five Ways to Well-Being / Outcomes from 'every Child Matters'	Key Stakeholders
• Ageing Well	substance misuse • Inequality • Discrimination and Stigma • Suicide and self harm • Violence and Abuse including bullying	• Promotion of physical health and prevention of health risk behaviour in those developing mental disorder • Promotion of recovery through early intervention • Recognition of Mental Disorder	• Give • Stay Safe • Keep Healthy	Care Services • Substance Misuse Use Services • Local Authorities • Social Care Providers • Education establishments • Housing Providers • Criminal Justice Services • Third Sector and Community Organisations • Faith groups • Environmental Planners

The JCP-MH Guidance (2012) suggests a number of ways that evidence supports that Public Mental Health promotion and prevention can reduce the impact and burden of mental ill-health and disorder. These include:

- 'Promote well-being and resilience with resulting improvements in physical health, life expectancy, educational outcomes, economic productivity, social functioning, and healthier lifestyles'.
- 'Prevent mental disorder, health risk behaviours and associated physical illness, inequalities, discrimination and stigma, violence and abuse, and suicide and deliver improved outcomes for people with mental disorder as a result of early intervention approaches'.
- 'Prevent mental disorder in childhood which leads to poorer outcomes and inequalities in adulthood, higher levels of unemployment and lower earnings, higher risk of crime and violence and higher risk of adult mental disorder'.

- ‘Prevent mental disorder during adulthood which leads to poorer outcomes and inequalities poorer educational achievement, higher risk of homelessness higher unemployment, higher rates of debt problems, increased suicide and self harm levels, increased health risk behaviours, including poor diet, and less exercise.’
- Deliver ‘economic savings by reducing the costs of mental disorder through prevention and improved outcomes as a result of early intervention, economic savings associated with improved well-being, such as reduced welfare dependency, reduced use of health and social care services, less crime and greater social cohesion.’
- Deliver ‘economic savings resulting from reduced health risk behaviour and subsequent physical illness.’
- Deliver ‘economic benefits associated with improved well-being due to improved educational outcomes, higher employment rates, and greater economic productivity.’
- Deliver ‘improved resilience and ability to cope with adversity, reduced emotional and behavioural problems in children and adolescents, reduced levels of mental disorder in adulthood reduced suicide risk, better general health, less use of health services and reduced mortality in healthy people and in those with established illnesses’.
- Deliver ‘improved educational outcomes, healthier lifestyle and reduced health risk behaviour including reduced smoking and harmful levels of drinking, increased productivity at work, reduced absenteeism and reduced burnout, higher income, stronger social relationships, increased social/community participation, reduced antisocial behaviour, crime and violence.’

Local initiatives should therefore focus upon identifying risk and protective factors for mental well-being, such as identifying high risk groups and developing and supporting initiatives to access employment / higher economic status, increase social net works and engagement and opportunities for education and physical activity, and developing emotional and social literacy life skills, including developing skills in relation to communication, problem solving and resilience. Different levels of emotional and cognitive resilience or ‘capital’ include:

- Emotional and cognitive: includes optimism, self-control and positive personal coping strategies
- social: includes networks and resources that enhance trust, cohesion, influence and cooperation for mutual benefit within communities
- Physical health

- Environmental: includes features of the natural and built environment which enhance community capacity for well-being
- Spirituality: incorporates a sense of meaning, purpose and engagement as well as religious belief for some. ‘

There is a compelling case, therefore to deliver a robust plan to provide a range of mental health promotion and prevention interventions across a ‘life course’ approach to improve the mental health and well-being of our resident population, to identify and target risk factors and develop and promote protective factors, working in partnership across agencies to reduce the burden of mental ill-health across upon a range of personal, social, familial and economic outcomes.

What are the planned actions, timescales and leads?

The planned actions, timescales and leads are described in the table below:

Priority Area	Set of High Level Action / Outputs	Timescales	Lead/s
1. Re-fresh / revisit the mental health data within the JNSA	To provide strong data intelligence which details the current and future mental and physical health needs of the local population, including levels of unmet need and both an assessment of the risk factors for mental disorder and the protective factors for well-being in the local population across the life span	By October 2013	PHE and SF
2. Promote good / positive mental health and well-being	Including universal proportionality i.e. targeted well-being promotion to facilitate recovery of those at risk of developing mental health difficulties and those with mental health difficulties. Sign up to ‘Time to Change’ campaign to tackle stigma locally	By October 2013	PHE and SF and MG and Education Lead

Priority Area	Set of High Level Action / Outputs	Timescales	Lead/s
	Develop Resilience Strategy for Wolverhampton as part of CAMHS Strategy and Adult Strategy re-fresh, which will deliver targeted mental health promotion interventions within schools and the wider community and utilise simple telehealth options where possible. Align with 'Five Ways to Well-Being' and Stay Safe Keep Healthy outcomes of 'every Child Matters'	By January 2014	
3. Address health risk behaviour in those with mental health difficulties and / or those at risk of developing mental health difficulties	Work with Public Health England to co-ordinate approaches for identified target audiences regarding: • Alcohol • Cannabis (skunk) • Tobacco • Obesity	By January 2014	PHE and SF and MG
4. Describe Early Intervention Care Pathways from Universal to Primary and Secondary Care for all care clusters in Adult Mental Health, i.e. 0-3, 4-8, 10-17, and 18-21, and diagnostic groups in CAMHS	• As part of CAMHS Strategy and Adult Strategy re-fresh, develop Early Intervention Care Pathways for all care clusters • Work with GPs and Provider Leads • Align with NICE Guidance • Identify pathways for key target groups	Drafts by April 2014	SF, MG SS and Provider Leads

Priority Area	Set of High Level Action / Outputs	Timescales	Lead/s
5. Re-fresh Care Programme Approach Policy across all agencies to promote reablement across all care clusters, and prevent relapse and re-admission/s where possible	• As part of CAMHS Strategy and Adult Strategy re-fresh • Work with GPs and Provider Leads • Align with NICE Guidance	Draft by April 2014	SF, MG SS and Provider Leads
6. For all of the above describe pathways for hard to reach groups.	• As part of CAMHS Strategy and Adult Strategy re-fresh. To include engagement initiatives for people from BME Groups, Looked After Children, people who are homeless, unemployed, are living with physical health difficulties and /or living in areas of socio-economic deprivation and people who are Disabled and /or have a Learning Difficulty	By January 2014	SF, MG SS and Provider Leads

How will progress be measured?

Progress will be measured via a dashboard developed by the Mental Health Strategy Steering Group and reported to the JCU Development and Delivery Group, Adult Delivery Board and Health and Well-Being.

The Dashboard will include a number of KPIs including:

- Access to Early Intervention Services
- Access to Psychological Therapies
- Numbers of people moving to recovery who are receiving Psychological Therapies
- Numbers of people entering employment
- Delivery of Mental Health Promotion initiatives
- Numbers of people leaving care and hospital and entering reablement / intermediate care

PRIORITY 5 URGENT CARE

Lead Agency: Wolverhampton City Clinical Commissioning Group

Project Sponsor: Richard Young (Director of Strategy and Solutions)

Project Manager: Rox Modiri

Partners: Local Authority, Royal Wolverhampton Trust, Black Country Partnership Foundation Trust, West Midlands Ambulance Service, South Staffordshire Clinical Commissioning Group

What is the issue?

Urgent and Emergency Care has been highlighted in the press both locally and nationally due to the extreme pressure that the entire system is under. The focus of attention has been on the pressures felt by the Emergency Department and the ambulance service, however the entire system has experienced increased activity and patients experiencing longer waits to be seen and treated and Wolverhampton is no exception.

What is the position and evidence in Wolverhampton?

The Joint Urgent and Emergency Care Strategy Board has been developed with partners from WCCG, SES&SP CCG, RWT, WCC and WMAS coming together to undertake a review of urgent and emergency care in Wolverhampton, develop an urgent and emergency care strategy and a commitment to work with our patients to develop a cohesive and sustainable way forward. In order to deliver the strategy but also to manage the wider Urgent & Emergency Care system, the Strategy Board will morph into the Urgent & Emergency Care Board. The board will continue to include health and social care leads who are both clinicians and managers but will also widen the membership by including patients, public health and mental health trust and communication representatives.

How does it link to other strategies and priorities in Wolverhampton?

Taking the views of our patients and stakeholders, and the extreme pressure the system is under, a cohesive vision for urgent and emergency care has been developed.

"Our vision is for an improved, simplified and sustainable 24/7 urgent and emergency care system that supports the right care in the right place at the right time for all of our population. Our patients will receive high quality & seamless care from easily accessible, appropriate, integrated and responsive services. Self-care will be promoted at all access points across the local health economies and patients will be guided to the right place for their care and their views will be integral to the culture of continuous improvement."

Urgent and Emergency Care Strategy Objectives:

- Improved Assessment and Discharge
- Managing Patient Expectation by clinicians working together
- Standardising and Improving Quality in Urgent Care by ensuring services are high quality and clinically robust
- Improve Timely Access to Services by improving access and operating hours
- Encourage Self-Care (wherever possible) by communicating with our patients
- Use of Risk Stratification by managing patients who are at high risk of admission into hospital
- Improved Communication by using technology and promotional campaigns
- Seamless and Consistent Urgent Care Services by ensuring all providers are managed through a system approach
- Explore and Develop Alternative Solutions by ensuring new solutions to improve quality within the system are identified, considered and delivered

Expected Benefits of Strategy:

- Appropriate reduction of ED attendances by 2016 by ensuring our pathways are correct
- Appropriate reduction in Emergency Admissions by 2016
- Patients arriving at ED by ambulance will be assessed by a nurse within 15 minutes.
- The sustainable delivery of the 95% ED target will be achieved 98% of the time
- An increase in Primary Care appointments by April 2015
- An increase in Mental Health Practitioners within the ED to improve urgent care provision for patients in crisis by April 2014

Wolverhampton Surge Planning Group –
The Surge Planning Group provides resilience support to the current Urgent & Emergency Care system by advising on tactical changes to manage surges in activity across Wolverhampton. The primary focus is on the urgent care system, the impact of pressure on those services and the decisions that need to be taken to alleviate the immediate pressures. This group will work to deliver the A&E Recovery Plan and will be overseen by the U&EC Board.

What is the evidence of effective interventions?

What are the planned actions, timescales and leads?
TBC

How will progress be measured?
TBC

Appendix 1 – Health and Wellbeing Board shortlisted outcomes – spine chart

Key:

- Significantly better than England average
- Not significantly different from England average
- Significantly worse than England average
- No significance can be calculated

Regional Key:

National average
Wton LA peers
Worst — Best
25th Pecentile 75th

	Indicator	Local Number	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Group 1	Alcohol related admissions per 100,000 2008-09	4628	1715.9	1582.7	2856.4		784.3
	Alcohol related mortality all ages 2007-09	164	22.3	10.4	33.6		2.2
	Children in Poverty 2010	17365	30.8	20.9	57.0		3.9
	Year R obesity rates 2009-10	333	12.2	9.8	14.7		5.4
	Year 6 obesity rates 2009-10	659	24.7	18.7	28.6		10.7
	Obesity rates in adults 2006-08 (estimated)	n/a	27.3	24.2	32.9		13.2
	% employed with long term conditions						
	% employed with long term conditions (Mentally ill and LD)						
Group 2	Male disability free life expectancy 1999-2003	n/a	58.3	61.7	50.4		71.5
	Female disability free life expectancy 1999-2003	n/a	60.8	64.1	54.0		71.3
	Incidents of domestic abuse						
	Circulatory disease mortality under 75 2007-09	639	85.2	70.5	122.1		37.9
	Prevalence of diabetes 2009-10	13886	6.9	5.3	7.9		3.3
	Infant mortality rates 2007-09	65	6.5	4.7	10.6		0.7
	Perinatal mortality rates 2007-09	123	12.1	7.6	14.7		2.0
Group 3	Child development at 2 years						
	Good development at age 5 2010	n/a	52.1	55.7	41.9		69.3
	Mortality rate for people with mental illness						
	Permanent admissions to residential and nursing homes per 100,000 2009-10	340	180.0	160.0	315.0		25.0
	An indicator on recovery from stroke						
	Early cancer diagnosis stages 1 and 2						
Group 4	Under 18 conception rates 2007-09	788	56.3	40.3	69.4		14.6
	Homeless households 2009-10	339	3.4	1.9	8.3		0.1
	Maternal smoking prevalence 2009-10	626	20.5	14.5	31.4		4.5
	Fractured proximal femur emergency admission rates 2008-09	n/a	130.0	98.0	141.2		0.0
	Access to green space 2005	n/a	29.2	87.5	12.4		97.3

[i] Tackling drugs and alcohol. Local government's new public health role. Local Government Association, January 2013. http://www.local.gov.uk/c/document_library/get_file?uuid=ef73ac40-827e-4e7f-bb27-9b19fff157c0&groupId=1017