CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

6 June 2019

Time 1.30 pm **Public Meeting?** YES **Type of meeting** Scrutiny

Venue Committee Room 3 - Civic Centre, St Peter's Square, Wolverhampton WV1 1SH

Membership

Chair Cllr Phil Page (Lab)
Vice-chair Cllr Paul Singh (Con)

Cllr Obaida Ahmed
Cllr Paula Brookfield
Cllr Bhupinder Gakhal
Cllr Milkinderpal Jaspal
Cllr Lynne Moran
Cllr Susan Roberts MBE
Cllr Wendy Thompson
Tracey Cresswell (Healthwatch)
Sheila Gill (Healthwatch)
Dana Tooby (Healthwatch)

Quorum for this meeting is three voting members.

Information for the Public

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Agenda

Part 1 – items open to the press and public

Item No. *Title*

MEETING BUSINESS ITEMS

1 **Apologies**
[To receive any apologies for absence].

2 **Declarations of Interest**
[To receive any declarations of interest].

3 **Minutes of previous meeting** (Pages 3 - 10)
[To approve the minutes of the meeting held on 21 March 2019 as a correct record.]

4 **Matters Arising**
[To consider any matters arising from the minutes.]

DISCUSSION ITEMS

5 **Public Health Performance Report** (Pages 11 - 28)
[The receive a report on an overview of Public Health performance for the year 2018-2019. The report details some key areas of work undertaken during 2018-2019, notes some of the challenges and successes throughout the year and seeks discussion and feedback from the Panel].

6 **Update on Suicide Prevention** (Pages 29 - 56)
[To receive an update report on suicide prevention].

7 **Transition from Children's to Adults' Services for Young People** (Pages 57 - 80)
[To receive a report from, The Royal Wolverhampton NHS Trust, on the transition arrangements from Children's to Adults' health services].

8 **Update on Child Death Overview Panel** (Pages 81 - 86)
[To receive a report on the Child Death Overview Panel].

9 **Health Scrutiny Work Programme** (Pages 87 - 90)
[To consider the lastest version of the Health Scrutiny Work Programme].

CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

Minutes - 21 March 2019 Agenda Item No: 3

Attendance

Members of the Health Scrutiny Panel

Cllr Obaida Ahmed
Sheila Gill
Cllr Jasbir Jaspal (Chair)
Cllr Milkinderpal Jaspal
Cllr Asha Mattu
Cllr Susan Roberts MBE
Dana Tooby
Cllr Martin Waite

Witnesses
David Loughton CBE (Chief Executive – Royal Wolverhampton NHS Trust)
Sarah Treadwell-Baker (Action Hearing Loss)
Stephen Marshall (Director of Strategy and Transformation – CCG)

Employees
Martin Stevens (Scrutiny Officer) (Minutes)
David Watts (Director of Adult Services)
Dr. Ankush Mittal (Consultant in Public Health)

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies**
Apologies for absence were received from Cllr Paul Singh and Tracey Cresswell.

2 **Declarations of Interest**
Cllr Susan Roberts declared an interest on item 5 – Cancer Services, as her husband was currently undergoing cancer treatment at the Newcross Hospital.

3 **Minutes of previous meeting**
The minutes of the meeting held on 24 January 2019 were confirmed as a correct record.

4 **Matters Arising**

The Chair asked for an update on the progress of the new car parking at the Newcross Hospital. The Chief Executive of the Royal Wolverhampton NHS Trust responded that work would commence on the drainage and electricity infrastructure for the new car park in two weeks' time. The major works would commence at the end of June during the school holidays, when there would be less demand on parking. A Member of the Panel asked if there would be a Bike Share docking station at the hospital. The Chief Executive of the Royal Wolverhampton NHS Trust responded that he had learnt about the initiative that morning. He had asked his staff to enquire further about the project. He was trying to encourage more of the staff at the Trust to use public transport.

A Member of the Panel commented that he had received reports that some Royal Wolverhampton NHS Trust staff had been abusive to residents on Victoria Road, Vicarage Road and other nearby roads over car parking issues. It was alleged that some staff members had been parking inconsiderately and blocking residents in their drives. He requested that the Chief Executive write to all Trust staff about the matter. The Chief Executive of the Trust responded that he would ask his security staff to carry out some patrols of the named streets and if number plates were supplied to him, he would be able to identify the staff members.

The Chair asked if there had been any developments regarding the pension cap tax limit. The Chief Executive of the Royal Wolverhampton NHS Trust responded that he had raised the issue again at a national level. It was clear that the NHS were being hit harder than any other public body. Consultants were leaving the Trust, some of which he regarded as irreplaceable, citing the example of a dementia specialist consultant who had recently left the Trust.

The Chair paid tribute to the work of Jeremy Vanes, Chairman of the Royal Wolverhampton NHS Trust, who was stepping down from the role at the end of the month. She would be sending a letter to him on behalf of the Health Scrutiny Panel. The Chief Executive of the Royal Wolverhampton NHS Trust commented that Mr Vanes would be taking up a position as Chief Executive of the Citizens Advice Bureau in Warwickshire. The new Chairman of the Trust's Board would be Professor Steve Field CBE, which he believed to be an excellent appointment.

5 **Cancer Services**

The Chief Executive of the Royal Wolverhampton NHS Trust stated that in his capacity as Chairman of the West Midland's Cancer Alliance he had been asked to attend a meeting with the Health Minister later that day about the deteriorating position nationally. The 62 day cancer target had not been hit since December 2015. The Trust was in a difficult position, particularly in relation to some of the specialist services it offered and in robotic surgery. The Queen Elizabeth and Heartlands Hospital in Birmingham were not fully utilising their robot. The robot at Newcross Hospital in Wolverhampton was virtually at full capacity. Some patients chose to wait longer for treatment, breaching the time standards themselves, so they could be operated on by a robot, rather than conventional surgery.

The Chief Executive of the Royal Wolverhampton NHS Trust commented that a particular issue at the present time was late tertiary referrals. 66% of tertiary referrals

from the Black Country and beyond were coming in late. Late was defined by the national cancer waiting times as being received after 38 days. The fact that so many tertiary referrals were being received late meant it was increasingly difficult to meet the 62 day target. The recovery action plan had originally been based on average referrals into the Trust of 1380 per month. The figure had remained static for both 2016/17 and 2017/18. For 2018/19 referrals had been averaging in excess of 1550 per month. He did not believe that the numbers had reached a high peak and would fall down to previous levels. The high number of referrals were causing physical capacity issues both with the machines and lack of staff to cope with the demand. He believed that many of the staffing problems were down to not enough doctors being trained nationally over the last 15 years. The pension tax cap also deterred some consultant medical staff from working overtime.

The Chief Executive of the Royal Wolverhampton NHS Trust commented that there was a particular concern about the spike in referrals at speciality level. The Breast Service had capacity to see 340 patients per month and ran additional lists at weekends to support short term increases. This model had been sustainable in the past. Referrals had reached 500 in the months of October, November and January. Some positive news was that the five year survival rate for breast cancer was very good and was levelling up to European partners.

The Chief Executive of the Royal Wolverhampton NHS Trust stated that the mobile machines the Trust were using were only operating at 60% efficiency. They were costing £100,000 a week to run. He required £14 million in capital funding for two static MRI machines. There was a huge problem with capital in the NHS, he had raised it with the Health Minister. He had outsourced all non-cancer MRI work, to free up capacity for cancer services. He cited as an example a person needing an MRI scan for their back, which would now be done at the Nuffield. The Trust was using all of the available capacity in the private sector. There were certain limitations to what the private sector could do as they did not have the intensive care back up facilities. He was not prepared to send scan results oversees because the quality of work was not up to the high standard he expected, when it had been used in the past. 2,500 more doctors were in training, but it would take 12 years for this to have full effect. The Scrutiny Officer asked about the financial impact of having to use the private sector for scans. The Chief Executive of the Trust responded that the Trust was going to be £10 million in deficit at the end of the year, the Trust had not had a deficit in ten years.

A Member of the Panel commented that she had been displeased with her husband's standard of recent cancer treatment at Newcross Hospital. Not knowing the appointment times long enough in advance had been particularly problematic. Whilst accepting that the staff were working hard, she was critical of the communication between them. The Chief Executive of the Royal Wolverhampton NHS Trust advised her to contact the Patient Advice Liaison Service (PALS) with any specific complaints. Overall scheduling within cancer treatment services would improve in the next three weeks, after the service had received their new linear accelerator.

A Member of the Panel asked about patient pathways and at what stage they were informed about their life prospects. Her concern was to ensure that patients received the right level of support at the appropriate time. The Chief Executive of the Royal Wolverhampton NHS Trust commented that processes would vary depending on the nature of the cancer and the patient. He suggested that Healthwatch representatives

should come into the Trust to talk to the staff working in cancer treatment services about pathways and support. The Panel requested that Healthwatch report back to the Panel, the information they obtained from the visit. The Chief Executive commented that it was important to be mindful of the heavy workload and pressures staff were under. Asking staff to continuously work overtime did not improve the service or communication, as efficiency would decrease.

The Consultant in Public Health remarked that Public Health were aiming to increase the number of people undertaking cancer screening in the City. The uptake of screening in Wolverhampton was low compared to other areas in the West Midlands. There was a risk of putting even more pressure on cancer pathways, however this risk was outweighed by the fact that early diagnosis gave better outcomes for the patient and generally reduced overall treatment costs. There was no doubt that prevention was better than cure. The Chief Executive agreed with the Consultant in Public Health's analysis. There were some hard to reach people in some of the communities in Wolverhampton, who were presenting late with cancer symptoms and consequently had poorer outcomes.

A Member of the Panel raised the point that the publicity about the importance of bowel screening needed to be improved. The Consultant in Public Health reported that the NHS were changing bowel cancer screening to a single sample test, which he hoped would improve the uptake. The Chief Executive of the Royal Wolverhampton Trust stated that the Trust working collaboratively with Public Health needed to increase their efforts to improve cancer screening throughout the City. There needed to be a hard-hitting message. He suggested that there should be a new effort in about three months' time, after he had put some more resources in place in cancer services. He was acutely aware that Public Health had received significant cuts to their resources, which made it harder for there to be people pushing the message in communities. The later people presented with cancer symptoms the more it cost the NHS. Investment in cancer screening would change the financial profile of the NHS in the future. The Consultant in Public Health agreed that there had been a reduction in their resources, but they did have an absolute resolve to improve cancer screening. He was pleased that the Trust wanted to work with them to improve cancer screening rates, as it was an absolute priority for Public Health. A Member of the Panel commented that cultural attitudes towards cancer screening needed to change to improve uptake. The Director for Strategy and Transformation at the CCG commented that at a care home in Germany he had previously worked at, it had been a requirement to record the stools of the residents each day.

The Director of Strategy and Transformation of the CCG stipulated that the referral rate from the primary sector had increased into cancer services, particularly for breast cancer. He was happy to confirm that there was nothing to suggest that these had been inappropriate referrals. The Chief Executive of the Royal Wolverhampton NHS Trust also confirmed that the referral rate had increased, which coincided with the confirmed cancer diagnosis rate, proving that they were not inappropriate referrals.

6 **Mortality and Learning from Deaths in Wolverhampton Update**

The Chief Executive of the Royal Wolverhampton NHS Trust presented a report on mortality and learning from deaths in Wolverhampton. A phenomenal amount of work had taken place in conjunction with Public Health on the area of mortality and in part the situation was improving. Deaths relating to alcohol were particularly high in Wolverhampton and this had been a persistent theme for many years. Smoking related illness over time would decrease, which they were already starting to observe. The Trust had not gamed the clinical coding system to drive their income. Improvements had been made to the coding of co-mobilities, the Trust had been an outlier but were now coming into line.

The Chief Executive of the Royal Wolverhampton NHS Trust remarked that he was particularly proud of the implementation of the Medical Examiners at the Trust. Deaths were now investigated by someone who had not had any involvement with the patient. A new Bereavement Centre had also been established at the Newcross Hospital. He had received many thank you letters from bereaved families, complimenting the Trust for the way they had received information on the death of their loved one. This had been one of the real benefits of the new method of working.

The Chief Executive of the Royal Wolverhampton NHS Trust commented that there had only been three cases at the Trust where care had been less than satisfactory. This was proportionately what would be expected when analysing the published literature on mortality at hospitals. There was a city-wide work programme, with Sally Roberts at the CCG trying to replicate the work that she had completed at Walsall in the care homes. Too high a proportion of people died in hospital in the Wolverhampton area, when it would have been more suitable for them to have died in a care home or at home. In Shropshire the numbers were half that of the Wolverhampton area. He wanted people to have dignity in death and it was important for suitably trained Trust staff to have the difficult conversations with family members about end of life care.

The Chief Executive of the Royal Wolverhampton NHS Trust stated that they had identified with the GP practices that the Trust worked with, all the people that were assumed to be in the last twelve months of their life. He was using his transplant co-ordinators to train staff in primary care about having difficult conversations. Proper end of life care plans needed to be put in place for each person to ensure that they didn't spend their last hours unnecessarily in hospital. Families expectations needed to be appropriately managed. A Member of the Panel asked if there were any timescales for the "dignity in death" proposals. The Chief Executive of the Royal Wolverhampton NHS Trust responded that work was taking place but needed to progress faster. He was acutely aware that care homes were also facing enormous pressures in relation to their workforce capacity. They did not always have the rightly skilled people on shift when someone was close to death, which meant 999 was called unnecessarily. There had been some excellent infection prevention control work that had taken place in the nursing homes in the past.

The Director for Strategy and Transformation stated that there was a joint programme, which had been operating for the last few months, where primary and secondary care clinicians were working together to improve end of life care. An Epack solution had been agreed, where if a person had been flagged at being end of life, there would be a medical record to state they need to be treated in a different

way and not admitted to hospital unnecessarily. It had also been agreed that £400,000 in collaboration with the Trust, for investment in end of life community response had been set aside. A gold standard framework had been reinstituted, to ensure that patients recognised they were on a end of life care pathway and treated accordingly.

The Chair of Healthwatch asked for some further information on how the end of life care messages were being managed from a communication perspective. The good work taking place needed to be shared with the wider public. The Chief Executive of the Royal Wolverhampton NHS Trust offered to come back to her with further information in the future. It was obviously a sensitive subject and there had been some issues in Liverpool with end of life care communications. He wanted to ensure patients and families were fully informed before wider communications.

The Chief Executive of the Royal Wolverhampton NHS Trust remarked that on the issue of Brexit he was not overly concerned, the situation reminded him of the Millennium Bug. The most important part was to ensure the continuous supply of drugs. He understood the Government had made contingency plans in this area. The Trust was fortunate in that they were in a consortium with the Hospital Corporation of America for purchasing.

7 **Presentation from Voluntary Organisation - Action Hearing Loss**

Sarah Treadwell-Baker (Development Projects Manager) from Action Hearing Loss gave a presentation on the work of the charity. A copy of the presentation slides are attached to the signed minutes. The Chair, on behalf of the Panel, thanked her for the excellent presentation. The Consultant in Public Health commented that it was important to increase awareness of what was available for hearing tests, as there was no single national screening for all ages model. The third sector could play a valuable part in improving people's lives, particularly in the higher risk areas such as care homes. The Director for Adult Services welcomed any sort of screening programme as it was clear people disengaged more socially when their hearing was poor.

8 **Black Country Partnership NHS Foundation Trust - Draft Quality Accounts**

The Chair asked for any questions on the Black Country Partnership NHS Foundation Trust draft quality accounts to be submitted to the Scrutiny Officer by the middle of April. She intended to submit a written response on behalf of the Panel, which was required by 1 May 2019. The Chair of Healthwatch confirmed that they would also be submitting a response. She was concerned about the amount of time and resource that had been wasted over potential mergers. She was aware of a lack of support from CPNs (Community Psychiatric Nurses), difficulty in accessing appointments, problems in mental health in maternity and particularly postnatal support. They had a lot of intelligence about the lack of support for young people, some of which had stemmed from changes in contracts. She was particularly concerned about the waiting times and the links with GPs for referrals. She was aware of some young people, who unless were in immediate crisis, were waiting twelve months for an appointment.

The Director for Strategy and Transformation of the CCG stated that there was a spectrum of problems relating to young people's mental health, that were not all in the remit of the Black Country Partnership NHS Foundation Trust. There had been a reduction in non-statutory services in recent years, so it was important to fully

understand that some issues were not treated as a health problem and therefore did not fall within the remit of the Trust.

Resolved: That representatives from the Black Country Partnership NHS Trust be invited to a Special Informal Health Scrutiny Panel meeting to be held at a date to be confirmed in April 2019 at the Civic Centre.

9 **Brexit Update**

The Director for Adult Services – City of Wolverhampton Council and the Director for Strategy and Transformation of the CCG gave an update on the preparations their organisations were taking with reference to Brexit.

The Director for Adult Services commented that every Head of Service had been asked to produce business continuity plans, that had Brexit type issues. From an adult social care perspective the Council had used the same guidance which had been issued for health providers to frame their contingencies. Their biggest concern was the supply of medication. This was supposed to be being dealt with nationally by the NHS. There was not a high prevalence of EU workers in Wolverhampton and so uncertainties over EU workers status was not causing a large amount of concern. There was a regional resilience forum which was helping to co-ordinate preparations.

A Member of the Panel commented that the biggest concern members of the general public had was regarding access to medicines. It was important that a message of confidence was relayed to the public that preparations were in place.

10 **Work Plan**

Resolved: That the Health Scrutiny Work Programme be agreed.

The meeting closed at 3:30pm.

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Agenda Item No: 5

CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

6 June 2017

Report title	Public Health Performance Report 2018-2019	
Cabinet member with lead responsibility	Councillor Jasbir Jaspal Public Health and Wellbeing	
Wards affected	All	
Accountable director	John Denley, Director for Public Health	
Originating service	Public Health	
Accountable employee(s)	Dr Ankush Mittal Tel Email	Consultant in Public Health 07851 755 598 ankush.mittal@wolverhampton.gov.uk
Report to be/has been considered by	Public Health Leadership Team	21 May 2019

Recommendation(s) for action or decision:

The Scrutiny Panel is recommended to:

1. Note the contents of the report.
2. Note the approach undertaken by Public Health to address challenges and successes achieved in support of the aims detailed in the “Vision for Public Health 2030 – Longer, Healthier Lives” document.

1.0 Purpose

1.1 The purpose of the report is to provide the Panel with an overview of Public Health performance for the year 2018-2019.

1.2 The report details some key areas of work undertaken during 2018-2019, notes some of the challenges and successes throughout the year and seeks discussion and feedback from the Panel.

2.0 Background

2.1 UK Public Health practice is a diverse and professional discipline which broadly aims to improve health and reduce health inequality in populations, partly through the delivery of public health services, but largely through joint efforts with the wider society. No one system can meet the public health needs of our people alone.

2.2 The profession is based around three fundamental pillars - Health Improvement, Health Protection and Healthcare Public Health.

2.3 Population based changes in health and behaviour are long term projects and this is reflected in the document previously presented to the Panel – “The Vision for Public Health 2030 – Longer, Healthier Lives”.

2.4 To achieve the ambitious targets detailed in the vision, Public Health has focussed on different approaches to issues where previous traditional approaches have failed to produce changes.

2.5 These approaches are multi-faceted including influencing and advising local health partners on local needs and intelligence, investing in evidence-based approaches to maximise and sustain the long-term health of the population, offer public health advice and support to internal and external partners, commission and monitor local public health services, use technology and novel approaches to reach new audiences, whilst continuing to deliver our statutory public health responsibilities.

3.0 Progress through 2018-2019

3.1 To achieve significant population public health changes is a long-term process, however throughout 2018-2019 there were a number of successes against targets set in the Public Health Annual Report to note. A more detailed summary of these achievements is included attached to this report. A summary of these include, but are not limited to: -

- NHS health checks: - are now solely provided through primary care (GPs) partners. Through closer, collaborative working with Wolverhampton Clinical Commissioning Group (CCG), Primary Care group managers and GP practice staff across the city and a

complete review of the system there has been un-precedented rise in the access and uptake of NHS Health Checks. (The aim of the health checks being to identify individuals who may be at a high risk of numerous undiagnosed conditions such as heart disease, stroke, cardiovascular disease, hypertension, type II diabetes etc.

- Engagement between health visiting services and families with young children is at the highest level since 2013.

- Working with regional partners to collate and revamp the system for child death scrutiny, to create the blueprints for better evidence on infant mortality and local risk factors.

- Significant reduction in the number of rough sleepers in the City, using a public health approach to homelessness.

- A joint programme of activities centred around the new 'Flu Fighters' campaign, resulting in the delivery of 28,000 flu fighters comics to young children across the City. This, along with a concerted social media campaign, resulted in the highest increase of flu vaccine uptake amongst school aged children in the West Midlands. City of Wolverhampton school children moving from the lowest to the highest uptake rates for the Black Country in one season.

- Helping to shape the development of the new ICS systems, including advances in the access to and interpretation of health intelligence, assisting in use of data to prioritise and evidence health interventions.

- Being a leading regional partner in community safety, building stronger links and strategy with WM Police, education and young people including reshaping the way in which licences for the sale of alcohol are planned for and permitted.

3.2 **Challenges**

Despite some early successes, challenges have been encountered some of which remain both internally and across the system, including

- Establishing clear roles and responsibilities following a significant restructure within the Public Health team,
- Continual reduction in the Public Health grant,
- the continued disadvantage faced by the poorest communities in austere and uncertain times,
- some of the highest ever rates of childhood obesity,
- poor access to cancer screening,
- an evolving and ever-changing health system

Public Health continue to work through these issues and via new approaches, opportunities arise to influence, improve systems and make a difference, which will lead to longer, happier and more equal lives for residents.

4.0 Questions for Scrutiny to consider

4.1 Given the long-term objectives and deliverables associated with Public Health, how often would the Panel require an update of achievements and challenges of the service?

4.2 Would the Panel welcome a discussion on the new approaches to achieve Public Health objectives?

5.0 Financial implications

5.1 There are no direct financial implications arising from this report.
[AJ/24052019/Y]

6.0 Legal implications

6.1 There are no direct legal implications. Public Health continue to deliver their statutory responsibilities.

[JA/240519/C]

7.0 Equalities implications

7.1 No direct equalities implications from the report. The work of Public Health is population based. Within individual work streams there may be occasions where projects require an equalities analysis. This will be undertaken, and advice sought from the equalities team.

8.0 Environmental implications

8.1 Whilst the remit of Public Health can include areas such as air pollution, contaminated land etc there are no direct Environmental Implications with this report.

9.0 Human resources implications

9.1 There are no human resources implications

10.0 Corporate landlord implications

10.1 There are no corporate landlord implications

11.0 Health and well-being implications

11.1 The report details achievements and challenges over the past year for Public Health. It also recognises the challenges for forthcoming year. The focus of this work includes to

help people live longer, healthier and more active lives, reduce inequalities and ensure everyone is protected from harm, serious incidents and avoidable health threats, ultimately to improve the health and well-being of Wolverhampton residents.

11.2 The challenges detailed in section 3.2 have a potential to have an adverse effect on the ability for Public Health to deliver its objectives and therefore may have implications for the health and well-being of residents. These implications will be detailed in separate reports if or when these occur.

12.0 Schedule of background papers

12.1 The Vision for Public Health 2030 – Longer, Healthier Lives

12.2 Detailed Public Health Performance Report (included with Health Scrutiny Panel agenda)

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Public Health Detailed Performance Report

1 Remit of Public Health

1.1 UK Public Health practice is a diverse and professional discipline which broadly aims to improve health and reduce health inequality in populations, partly through the delivery of public health services, but largely through joint efforts with the wider society. No one system can meet the public health needs of our people alone.

1.2 The profession is based around three fundamental pillars - Health Improvement, Health Protection and Healthcare Public Health.

1.2.1 Health Improvement relates to a holistic approach to managing population health needs, with a focus on improving people's circumstances and behaviours through the organised efforts of society.

1.2.2 Health Protection relates to the proactive and responsive elements of the management and mitigation of health threats, and covers areas such as infection prevention and control, chemical, radiological and environmental hazards.

1.2.3 Healthcare Public Health is related to healthcare rationing, which incorporates a range of skillsets including the profiling and prioritisation of population health needs, evidence-based commissioning, and health economic evaluation.

1.3 Public Health practice is led by Consultants in Public Health, who can work in a range of organisations, although are most commonly employed by Public Health England and Local Authorities in the UK. Directors of Public Health are statutory appointments based in Local Authorities, who provide leadership and oversight of local public health issues.

1.4 Local Authorities are responsible for 6 mandated public health functions:

- 1.4.1 Universal health visitor reviews
- 1.4.2 Weighing and measuring children (National Child Measurement Programme)
- 1.4.3 Providing a comprehensive sexual health service
- 1.4.4 Providing NHS Health Checks
- 1.4.5 Healthcare public health advice to NHS Commissioners
- 1.4.6 Providing health protection assurance and planning for and responding to emergencies posing a public health threat

1.5 The Director of Public Health also has a role in influencing the licencing activity of local authorities to consider public health needs.

1.6 The functions above are specific elements of a complex system which underpins health and wellbeing, including the best start in life, an excellent education, a stable rewarding job, and a decent home in a thriving community. Directors of Public Health therefore also have an important leadership role in bringing together a wide range of stakeholders and local communities, helping shape society to meet its most essential needs. As part of this wider role, Public Health teams may perform a variety of other functions or provide other non-mandated services (e.g. drug and alcohol services, infection prevention services etc.).

2 Our City's Public Health Challenges

2.1 Since 2013, Public Health are starting to see an overall reduction in life expectancy and a widening of the gap in health and life expectancy between our wealthiest and most deprived communities.

2.2 Having the best start in life, an excellent education, a stable rewarding job, and a decent home in a thriving community are the strongest factors that influence both how long a person is likely to live and their overall health.

2.3 The challenge then, within the context of continuing financial pressures, is to tackle some of these entrenched issues with even fewer resources.

2.4 This is why our approach will do more than support behaviour change and health services, but seek improvements in the broad socio-economic factors which impact on people's lives.

3 Our Vision

3.1 Public Health have published a simple yet comprehensive vision paper setting out the overarching strategy and objectives of the Public Health department, including rationale, approach and targets.[1]

3.2 By 2030, our thriving City will:

Help people live longer, healthier and more active lives

Offer every child the best start in life

Close the gap in healthy life expectancy both within the City and between Wolverhampton and the England average

Ensure everyone is protected from harm, serious incidents and avoidable health threats.

4 Our Approach

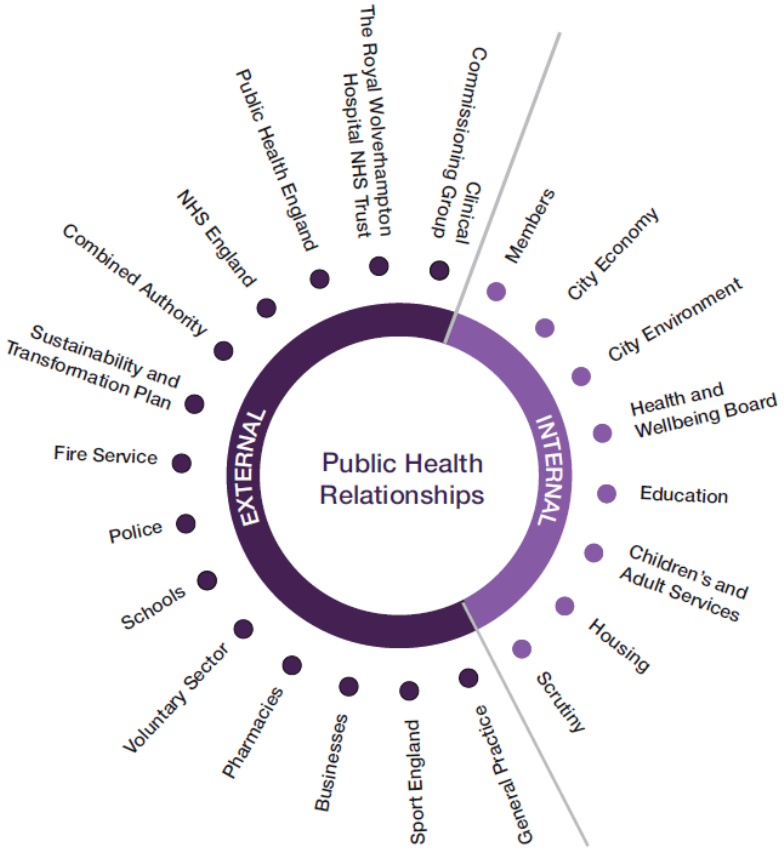
4.1 Public Health will continue to deliver on our statutory public health responsibilities.

4.2 Public Health will offer public health advice and support, both internally, and to key partners, such as the NHS.

4.3 Our key to extending the reach of public health actions across the City will be a service equipped with the skills to engage, influence and persuade, with the ability to tell the story using data and evidence, whilst continually strengthening relationships.

[1] Public Health Vision 2030
https://www.wolverhampton.gov.uk/health-and-social-care/health-and-wellbeing/strategies

4.4 Our role will be to assist and encourage partners to think more broadly than current crises and support them to invest in evidence-based approaches to maximise the long-term health of the population of Wolverhampton.



5 Our Targets

The 2010 white paper *Healthy Lives, Healthy People*[2] set out an ambitious vision for public health in the 21st century, based on an innovative and dynamic approach to protecting and improving the health of everyone in England. The test that the white paper sets is clear – Public Health will have succeeded only when Public Health as a nation are living longer,

[2] Department for Health and Social Care (2010). Healthy Lives, Healthy People: https://www.gov.uk/government/publications/healthy-lives-healthy-people-our-strategy-for-public-health-in-england

healthier lives and have narrowed the persistent inequalities in health between rich and poor.

5.1 Life expectancy and healthy life expectancy

5.2 The improvements Public Health want to make will take time to achieve. That is why Public Health have chosen a range of short to medium term public health indicators which, if Public Health deliver well, and in partnership, will show that Public Health are moving in the right direction together, and allow us to evaluate our progress.

5.3 Current local priorities

Priority	Indicators		
Starting and Developing Well (0-24 age group)	• Increase the number of children ready to enter school • Tackle inequalities in educational attainment	• Continue to reduce levels of teenage pregnancy • Continue to tackle infant mortality	• Top performer in chlamydia detection
Healthy Life Expectancy	• Increase access to employment for people with mental health problems • Reduce substance misuse related reoffending	• Top performer in drug and alcohol recovery • Reduce the number of rough sleepers	• Increase physical activity • Reduce smoking prevalence • Top performer in uptake of NHS Health Checks
Healthy Ageing	• Increase wellbeing of carers	• Increase uptake of influenza vaccination	• Keeping people well in their community
System Leadership	• Embed Public Health and prevention in an integrated health and social care system	• Joint intelligence unit established for the City	• Working together across the whole public sector to improve health outcomes

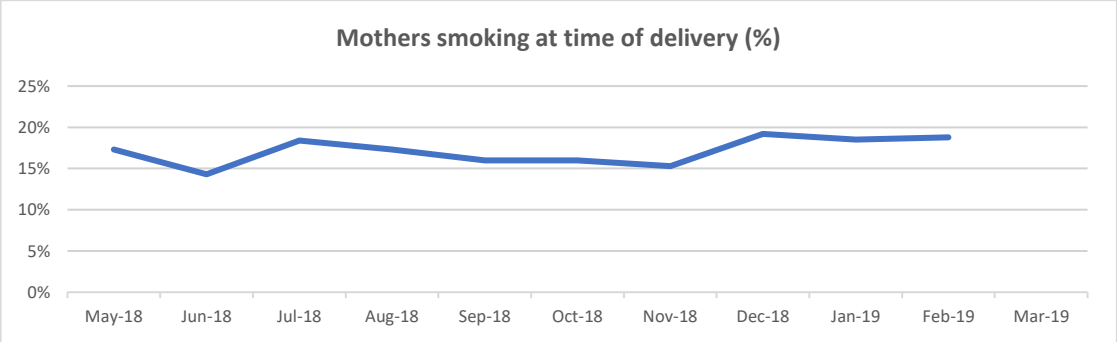
5.4 National Priorities: Public Health Outcomes Framework

The Public Health Outcomes Framework[3] sets out a range of indicators across the broad domains of public health at local and national levels. Many of these overlap or are consistent with our progress indicators above, and almost all will have some if not significant dependence on the essential issues Public Health aim to address as a department and as a Council, namely having the best start in life, an excellent education, a stable rewarding job, and a decent home in a thriving community.

6 Progress

6.1 Starting and developing well

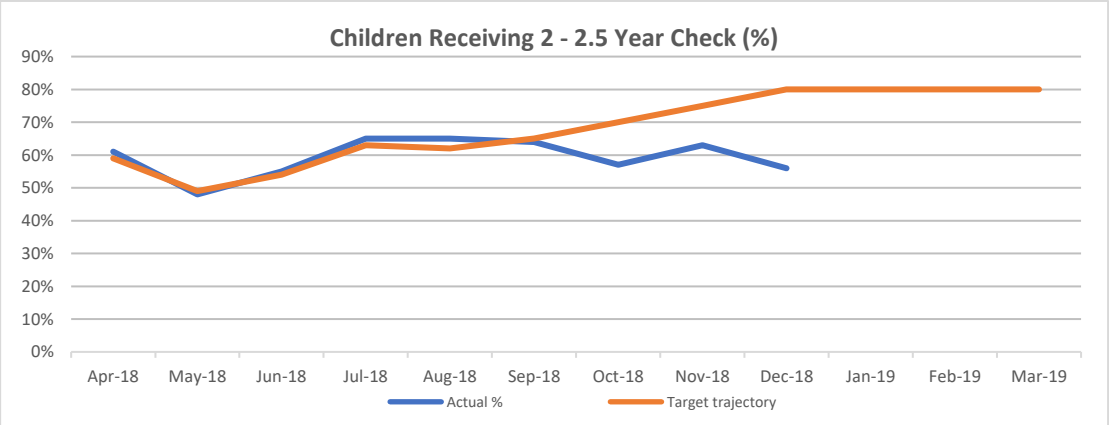
Reducing infant mortality



The percentage of pregnant women smoking at the time of delivery remained steady in the 10-month period between May 18 – February 19, despite a period of decrease between July 2018 and November when figures fell by 3.1 percentage points.

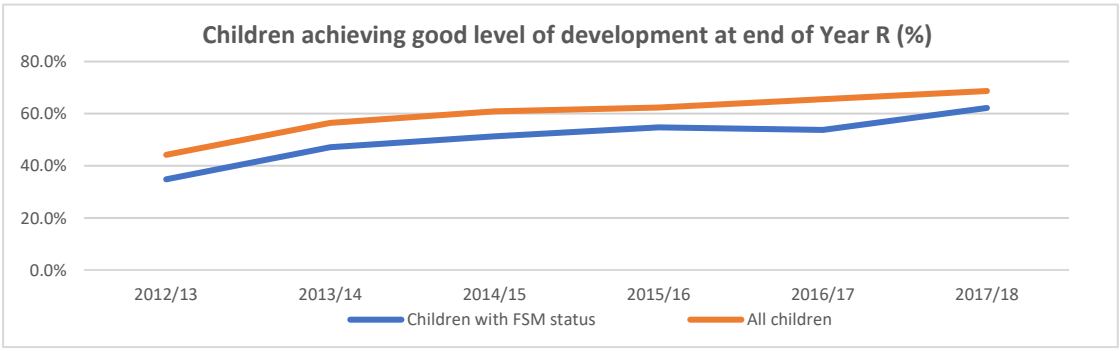
[3] Public Health England (2019). Public Health Outcomes Framework: https://fingertips.phe.org.uk/profile/public-health-outcomes-framework

Increase in the number of children ready to enter school



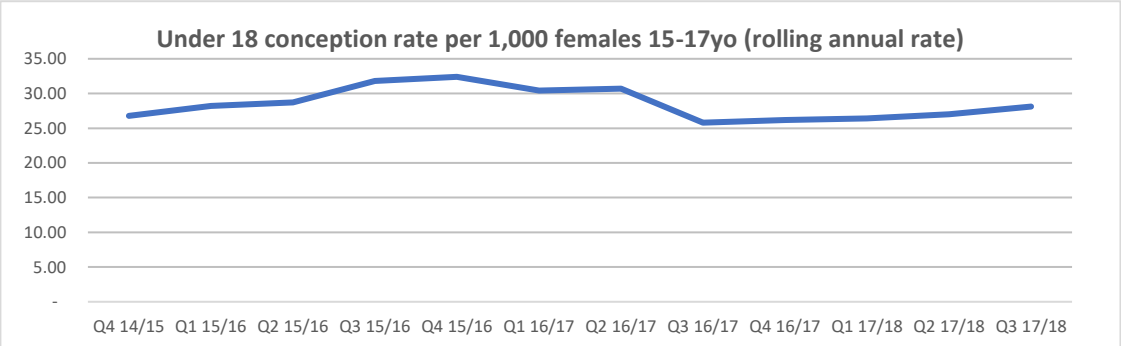
Between April 2018 and September 2018, the percentage of children receiving the 2-2.5 year check was in line with the target trajectory and actually exceeding it between June – September 2018. However, since September the figures fell below the target, as of December 2018 the indicator was 24 percentage points below the target figure.

Tackle inequalities in educational attainment



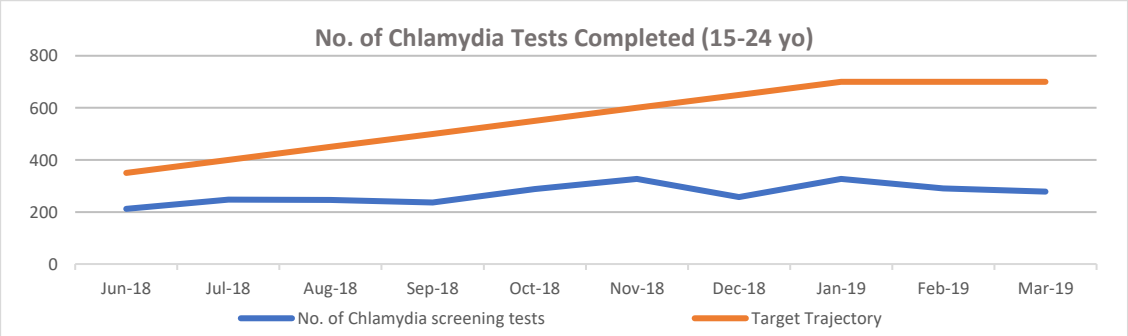
The percentage of children achieving a good level of development by the end of Reception has increased steadily over the past 6 years, for all children and for children receiving free school meals (FSM). The difference between the percentage of all children and children with FSM status has not seen any consistent change, with the gap varying between 11.7 and 6.5 percentage points. It should be noted that the smallest difference was seen in 2017-18, the most recent data point.

Reduce levels of teenage pregnancy



The rate of conceptions in females aged between 15-17 years has fluctuated between Q4 2014-15 and Q3 2017-18. There was a sharp decrease in the rate in the year up to Q3 2016-17, down to 25.8 per 1,000, however since, there has been a steady increase bringing the rate to 28.1 per 1,000 females in the year up to Q3 2017-18.

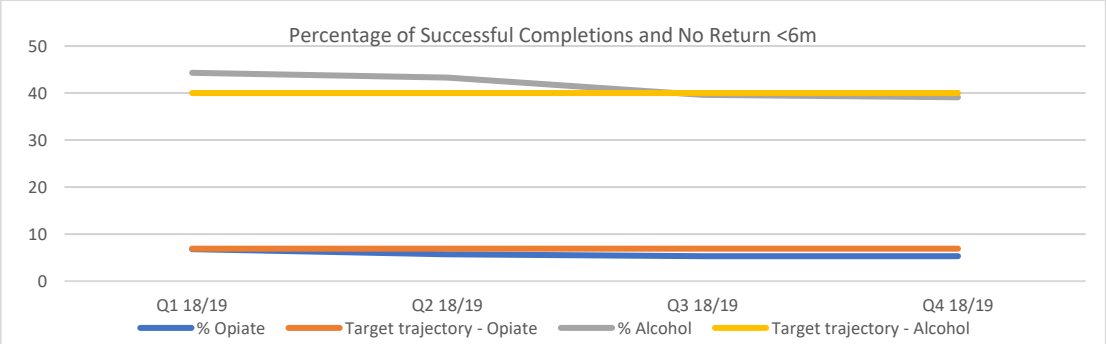
Improve chlamydia detection



The number of Chlamydia tests completed in Wolverhampton in those aged 15-24 years of age has fluctuated between 212 and 327 tests during the 10 month period between June 2018 and March 2019. During this period, it has remained considerably lower than the target trajectory.

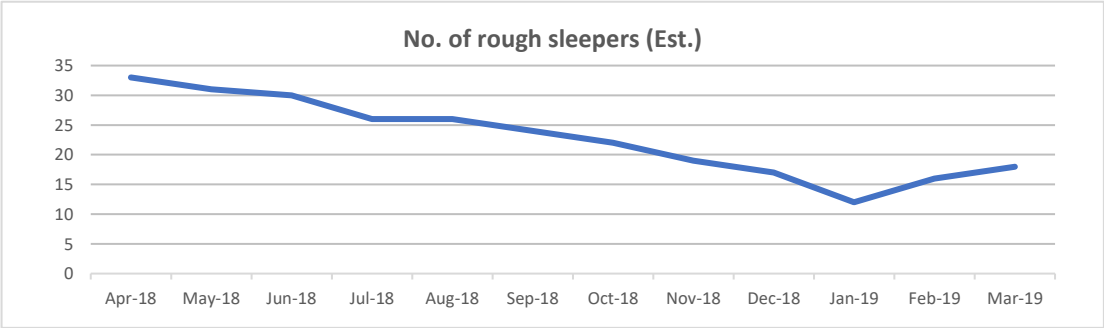
6.2 Healthy Life Expectancy

Drug and alcohol recovery



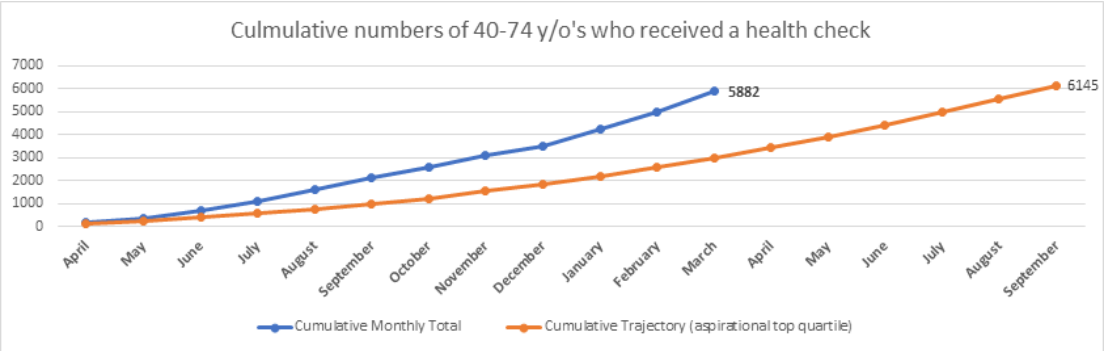
The percentage of successful completion of alcohol treatment in Wolverhampton decreased slightly over the course of 2018-19, but remained approximately in line with the target trajectory by Q4 2018-19, having started the year exceeding the 40% target. The Opiate treatment completion figures began 2018-19 in line with the 6.9% target, however since Q2 it has remained slightly lower and as of Q4 was at 5.3%.

Reduce number of rough sleepers



The estimated number of rough sleepers in Wolverhampton has reduced considerably between April 2018 and March 2019. As of April 2018, there were an estimated 33 rough sleepers, by January this figure was reduced to almost a third with an estimated 12 rough sleepers. As March 2019, there were an estimated 18 rough sleepers in Wolverhampton.

Uptake of NHS Health Checks



There has been a steady increase in the number of health checks being completed in Wolverhampton. The indicator has been exceeding its target since April 2018 and as of March 2019, there were 5,882 health checks completed, which is almost double the 3,000 target.

Reduce smoking prevalence

In our Lifestyle Survey of over 9,000 residents in 2016 and a consultation on smoking services in 2018, smokers told us if they wanted to quit they would prefer to go it alone or would access information online. Public Health have worked closely with the CCG and local GPs to develop a 'self-help stop smoking support prescription' that is embedded into the GP clinical system, which directs people to evidence-based support tools.

Reduce % of physically inactive adults

An Active City Strategy is being developed, building on the Towards an Active City framework produced in 2017. This sets out a vision to support every resident to be active every day, with a particular focus on those who are currently inactive (i.e. doing less than 30 minutes of moderate physical activity per day). The strategy will include working closely with our in-house leisure provider, WV Active, to develop an offer that meets the diverse needs of our residents.

Substance misuse-related reoffending

A stakeholder summit was held in April 2019 to relaunch the Substance Misuse Partnership. This will support the development of the updated Substance Misuse Strategy, which will take a life course approach to prevention, treatment and recovery. The strategy will link to work around licensing and reducing rates of reoffending related to substance misuse.

Increasing access to employment for people with mental health problems

The Joint Public Mental Health & Wellbeing Strategy for Wolverhampton (2018-2021; produced in partnership with NHS Wolverhampton CCG) sets out a shared vision for every resident in the City to have the best mental health that they possibly can at every stage of their lives. This incorporates our aim to reduce inequalities in employment for people with

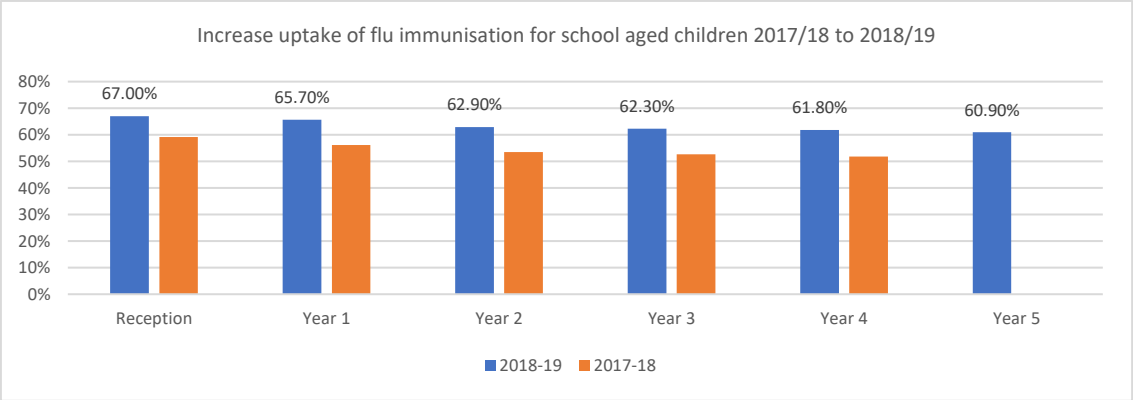
mental health problems and is a key objective in the action plan for Addressing Poverty Through an Inclusive Economy being developed through the Inclusion Board.

6.3 Healthy Ageing

Increase wellbeing of carers

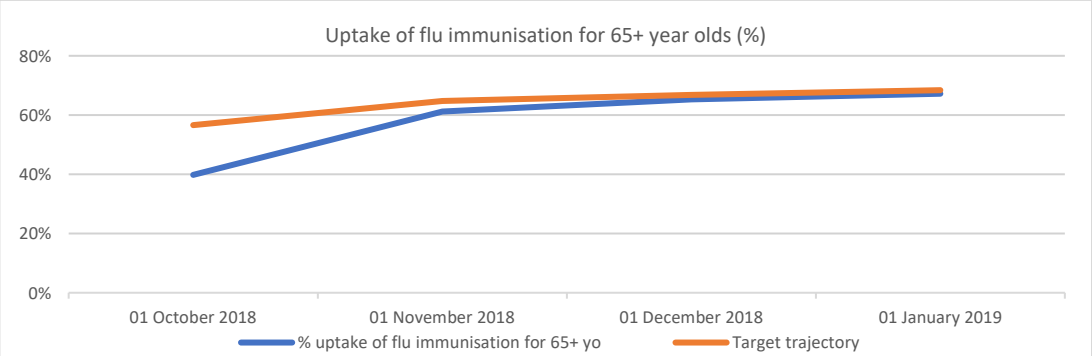
A strategic group has been set up to look at how the Health and Social Care system can be mobilised to improve the wellbeing of carers. There is not yet an appropriate indicator to measure carers wellbeing, because the PHOF indicator has a number of caveats that make it inappropriate.

Uptake of influenza vaccination



In the 2018-19 flu season, there was an increase compared to the previous year, in flu vaccination coverage in all year groups that were offered the flu vaccine (Reception – Year 5). The proportional increase seen in Wolverhampton in overall uptake was the highest in the West Midlands.

The uptake of flu vaccines for those aged below 65 and considered to be at risk of complications started off slowly in the 2018-19 flu season. However, by November 2018 the uptake was close to its target (39.3%). The uptake followed the target trajectory closely in the second half of the flu season.



The 2018-19 flu season was a challenging year for the flu vaccination campaign for over 65's, due to the initial confusion among GP's about the appropriate vaccine and then the national shortage of the vaccine. In Wolverhampton we had 5 GP practices that had no vaccines that

were appropriate for the over 65 population. However, we managed to mobilise the primary care system and liaised with suppliers ourselves to ensure that all GP's had some of the appropriate vaccines. The challenges we faced meant that there was poor performance in the first half of the flu season, but caught up with the target uptake by January 2019, finishing just 1.2% below our target. Work has begun to ensure that the same issues do not arise in the upcoming flu season.

Keeping people well in the community

Public health offer advice and support to both local and regional multi-agency fora addressing the healthy ageing agenda, with a system focus on frailty and end of life. We have advocated for and helped design plans for a holistic approach to support for our older residents, which focuses on the wider socio-economic needs as well as physical and mental health.

7 Conclusions

7.1 With the help of partners across the system, including the NHS, Public Health are starting to see change.

7.1 Public Health are starting to see some of the highest levels of engagement between health visiting services and families with young children since 2013.

7.3 Public Health are working with regional partners to collate and revamp the system for child death scrutiny, to create the blueprints for better evidence on infant mortality and local risk factors.

7.4 Public Health have significantly reduced the number of rough sleepers in the City, using a public health approach to homelessness.

7.5 Public Health have seen an un-precedented rise in the access and uptake of NHS Health Checks.

7.6 Public Health have significantly improved access to flu vaccines in school aged children, moving from the lowest to the highest uptake rates in the Black Country in one season.

7.7 Public Health have significantly helped to shape the development of the new ICS systems, including advances in the access to and interpretation of health intelligence.

7.8 Public Health have been a leading regional partner in community safety, building stronger links and strategy with WM Police, education and young people. Public Health are also reshaping the way in which Public Health plan for and permit licences for the sale alcohol.

7.9 Despite some early successes, challenges remain across the system, including the continued disadvantage faced by our poorest communities in austere and uncertain times, some of our highest ever rates of childhood obesity, and poor access to cancer screening to name just some. Together Public Health can work through these issues and make a difference, which will lead to longer, happier and more equal lives for our residents.

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Agenda Item No: 6

CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

06 June 2019

Report title	Update on Suicide Prevention	
Cabinet member with lead responsibility	Councillor Jasbir Jaspal Public Health and Wellbeing	
Wards affected	All	
Accountable director	John Denley, Service Director Public Health and Wellbeing	
Originating service	Public Health and Wellbeing	
Accountable employee(s)	Lina Martino Tel Email	Consultant in Public Health 01902 553420 Lina.Martino@wolverhampton.gov.uk
	Parpinder Singh Tel Email	Senior Public Health Specialist 01902 555475 Parpinder.Singh@wolverhampton.gov.uk
Report to be/has been considered by	Public Health Leadership Team	14 May 2019

Recommendation(s) for action or decision:

The Scrutiny Panel is recommended to:

1. Provide feedback on progress of the Suicide Prevention Stakeholder Forum against the guidance issued by the Centre for Public Scrutiny.
2. Provide support to the Suicide Prevention Stakeholder Forum in addressing challenges highlighted in Table 1.

Recommendations for noting:

The Scrutiny Panel is asked to note:

1. Progress of suicide prevention work in achieving the aims set out in the strategy and action plan.

1.0 Purpose

1.1 To provide members of the Health Scrutiny Panel with an update on the work of the Suicide Prevention Stakeholder Forum.

2.0 Background

2.1 In 2012 the government published the national suicide prevention strategy *Preventing Suicide in England: A Cross Government Outcomes Strategy to Save Lives*. Since then, four progress reports have been published, the most recent one being published on 22 January 2019[1].

The national strategy has two key objectives:
1). Achieve a reduction in the suicide rate in the general population in England; and
2). Offer better support for those bereaved or affected by suicide.

Six key areas of action were identified to help achieve these objectives:

a. reducing the risk of suicide in key high-risk groups
b. tailoring approaches to improve mental health in specific groups
c. reducing access to the means of suicide
d. providing better information and support to those bereaved or affected by suicide
e. supporting the media in delivering sensitive approaches to suicide and suicidal behaviour
f. supporting research, data collection and monitoring

2.2 The strategy provides recommendations for local action, setting out the role Public Health should play in mobilising local efforts. The strategy recommends that local authorities conduct a suicide audit, produce a suicide prevention action plan and set up a multi-agency suicide prevention group.

2.3 The national data available for England and Wales shows that only 28% of suicides occur in people who are in contact with services i.e. 72% of those who died by suicide were not in touch with secondary mental health services within one year prior to death.

Therefore, the majority of people who take their life by suicide are not known to mental health services, or did not have recent contact with services, highlighting the need for a public health approach to suicide prevention. Prevalence data for those who are known to mental health services shows that the majority are cared for within the community setting, which further supports a public health approach.

2.4 Latest figures show that in 2017, 5821 suicides were registered in the UK, equating to 16 suicides each day. Whilst there was a reduction in male suicides in 2017, men continue to make up three quarters of all suicides. Suicide remains as one of the leading avoidable causes of death for young and middle-aged men and women. Suicide attempts

[1] https://www.gov.uk/government/publications/suicide-prevention-fourth-annual-report

will be much higher, with research suggesting suicide attempts are tenfold in comparison to completed suicides.

2.5 The impact of suicide is profound. Each suicide impacts a significant number of family, friends, work colleagues and communities. Furthermore, research estimates the cost of one suicide to be £1.7m, this consists of costs to services and the economy i.e. time lost from work impacting productivity.

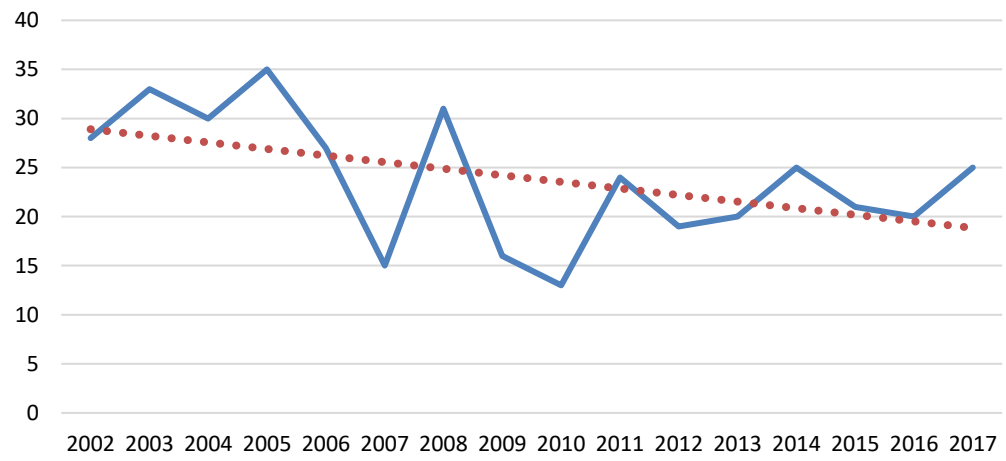
2.6 There are other key national and regional policies, which we need to be mindful of. Regionally the West Midlands Combined Authority has established a Mental Health Commission. The ensuing 'Thrive Action Plan[2]' launched a zero-suicide ambition for the region. The NHS 'Five Year Forward View[3]' has set a target of reducing suicides by 10% by 2020-2021. The more recent NHS Long Term Plan[4] reinforces these targets and also aims to put in place suicide bereavement support for families and staff working in mental health crisis services in every area of the country.

3.0 Prevalence

3.1 In Wolverhampton, 66 deaths were registered as suicides for the period of 2015-2017 (3-year period), of these, 54 (82%) were male.

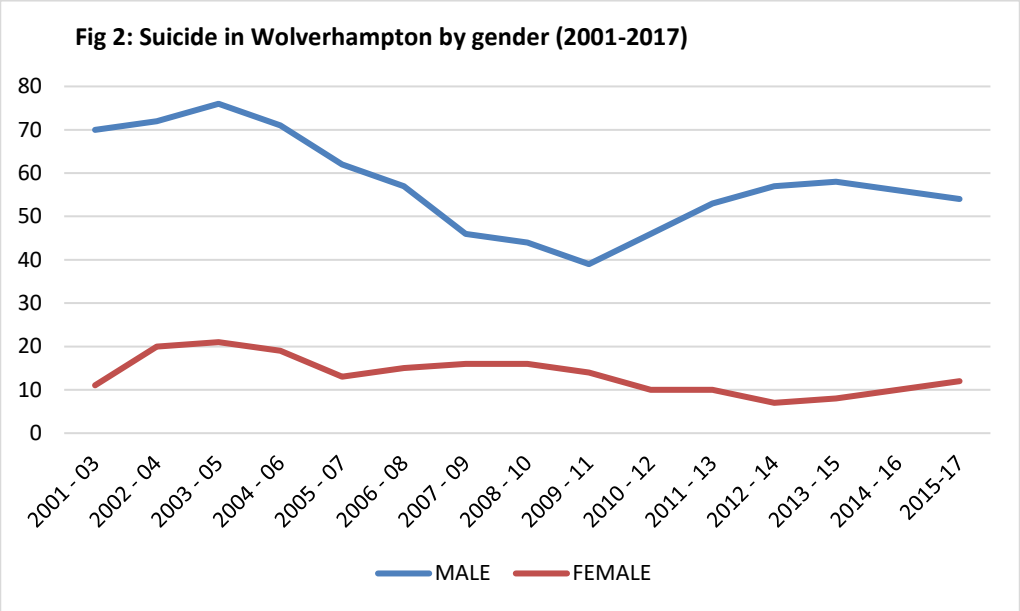
3.2 In 2017, there were 25 cases where suicide was concluded as the underlying cause of death. For 2015 and 2016 this figure was 21, and 20 respectively.
Figure 1 provides an illustration of suicides in Wolverhampton since 2002. Whilst there are fluctuations from year to year, there has been an overall downward trend.

Fig 1: Suicides in WV 2002-2017



[2] https://www.wmca.org.uk/media/1420/wmca-mental-health-commission-thrive-full-doc.pdf
[3] https://www.england.nhs.uk/five-year-forward-view/
[4] https://www.england.nhs.uk/long-term-plan/

3.3 Men account for the sizable proportion of suicides nationally. This is replicated locally with men making up approximately 80% of all suicides in Wolverhampton.



4.0 Progress

4.1 The Centre for Public Scrutiny issued guidance in October 2018 titled *'Providing a lifeline: Effective scrutiny of local strategies to prevent or reduce suicide'*[5]. The guidance states: *'It is important for councils to be transparent about their progress on suicide prevention planning and a key way to achieve this is by involving overview and scrutiny functions in developing plans and monitoring outcomes. This guide provides advice for scrutiny committees about questions to ask as part of the local assessment and assurance process'.*

4.2 The guidance outlines ten key points that scrutiny functions should ask to assess whether suicide prevention approaches in the locality are fit for purpose, proportionate to local suicide risks and rates, and engage the right partners in the right actions. Table 1 provides a progress update against each of these key ten points.

Table 1: Wolverhampton's suicide prevention progress against the key ten points outlined in The Centre for Public Scrutiny guidance *'Providing a lifeline: Effective scrutiny of local strategies to prevent or reduce suicide'*

No.	Guidance	Wolverhampton progress
1	Is there a plan, strategy or agreed approach for the area?	A suicide needs assessment was undertaken in 2015. This formed the basis for the current Suicide Prevention Strategy and Action Plan (Appendix 1). The strategy and action plan was produced in conjunction with partners and directed by the multi-agency Suicide Prevention Stakeholder Forum. The

[5] https://www.cfps.org.uk/wp-content/uploads/CfPS-Providing-A-Lifeline-WEB-final.pdf

		strategy is aligned to the national strategy and broadly mirrors the key areas of action. Progress is monitored through the quarterly forum meetings.
2	Who are the partners and what are the governance arrangements?	The Suicide Prevention Stakeholder Forum (SPSF) was established in 2015. SPSF is independently chaired and consists of multiple agencies. The suicide prevention membership consists of over 80 professionals, with a regular attendance of 20+ at each quarterly meeting. Attendees include representation from Public Health, University of Wolverhampton, Samaritans, Compton Care, Kaleidoscope, Wolverhampton Voluntary Sector Council, Clinical Commissioning Group, Education Psychology Service, Police, Wolverhampton Homes, Black Country Mental Health Trust, local authority mental health support, Safeguarding, Prison Service (this is not an exhaustive list). SPSF report to Health and Wellbeing Together, with the most recent update provided to the full board in October 2018. The forum has Terms of Reference to steer the group in its function.
3.	Which individuals and organisations have been involved?	Partners outlined in section 2 were involved in the formation of the current action plan. The recently refreshed action plan was formulated through two planning sessions held in May and October 2018.
4.	Are there specific groups in the community that need help and support?	In line with the national strategy and various pieces of research and data there are a number of groups who are at higher risk of suicide ideation. Groups that are at increased risk are highlighted within the local action plan. For example, men make up over three quarters of suicide across the city. The plan therefore identifies the need to do more with men. This may take the form of targeted campaigns, engaging with partners to influence their activity and training/raising awareness amongst professionals. Similarly, refugees and migrants, and LGBT community are identified as being at increased risk, which is reflected in the local action plan.
5.	What support is available for people bereaved through suicide?	SPSF has been working with Kaleidoscope Plus Group and Compton Care to establish bereavement support. Both groups are now running bereavement support services, with Kaleidoscope providing suicide bereavement specifically. Support takes the form of group work. Cruse Bereavement offer 121 support but operate at a regional level which naturally impacts response time. Organisations are being encouraged to provide the Help Is At Hand resource to anyone they engage who has been bereaved by suicide. Organisations such as the Police and

		part of Children Services have, or are in the process of, starting to use this resource. The suicide prevention web-page within the Wolverhampton Information Network (WIN) also offers information on bereavement support. http://www.wolverhampton.gov.uk/suicide-awareness The forum is also establishing a suicide specific website which will offer bereavement signposting and information. The NHS Long Term plan has committed to establishing suicide bereavement support for families and staff working in mental health crisis services in every area of the country. Locally, we are working with Black Country Partnership Foundation Trust to remain updated on this and the wider mental health trust suicide prevention plan.
6.	Are there any barriers to sharing information between organisations?	Some data is currently shared around suicide and suicide attempts. For example, Network Rail share information on incidents taking place in Wolverhampton stations. They also share information on interventions that have taken place in Wolverhampton stations and railway bridges. These interventions vary in detail and may include Network Rail staff, members of the public, relatives, friends, contractors or other such parties intervening in an act of potential suicide. Information sharing for real-time surveillance of suicide has been problematic. For real time surveillance to be effective, data from Police, Coroner and Ambulance Service needs to be shared on a regular basis. More recently, positive steps have been taken to implement real time surveillance at a regional level as data holders operate beyond local authority boundaries. This work is being led through the Black Country Sustainability and Transformation Partnership (STP) suicide prevention leads group.
7.	What level of funding and resources exist to support the implementation of the plan, strategy or approach?	Currently, no funding is aligned to the work of the Suicide Prevention Stakeholder Forum. However, Public Health allocate staff time to coordinate this work. Moving forward, the forum will be considering forming into a formal body such as a charity which will facilitate receipt of external funding. The Mayor of Wolverhampton has chosen the Suicide Prevention Stakeholder Forum as one the Mayor's charities for municipal year of 2019-2020. Money raised through the Mayor's office will be donated to the forum to fund suicide prevention activity.
8.	Are there particular	The Suicide Prevention Stakeholder Forum has been developing well as a multi-agency partnership and has

	challenges and successes in the area?	delivered various campaigns to raise awareness of suicide prevention (Appendix 2). E-training in suicide prevention has been promoted across various workforces, take up of the training and feedback has been positive. The forum has been successful in engaging various services and gaining their commitment to take action within their respective organisations. For example, the forum has engaged highways and transport to look at high risk locations such as bridges, prisons have been engaged to understand the measures being taken in secured estates to reduce suicide risk, children's mental wellbeing services have been engaged to ensure suicide risk is understood and responses are appropriate. In 2016, the University of Wolverhampton, who form part of the Suicide Prevention Stakeholder Forum, won the Times Higher Award for outstanding student support for their innovative approach to suicide prevention. This included a commitment to train all staff in suicide awareness, self-harm awareness and emotional resilience and resourcefulness for self. This has gone on to form the basis of best practice within the higher education context[6]. However, there is still further development required in relation to engaging the coroner for data sharing, working within primary and secondary care to embed suicide prevention approaches and delivering targeted campaigns to high risk groups such as men, which require additional financial resource.
9.	How are ambitions for suicide reduction and prevention decided?	The overarching vision for Wolverhampton is to reduce the rate of suicide, which is in line with the national ambition. The Suicide Prevention Stakeholder Forum agree the key outcomes for this work and shape the prevention agenda. This plan of action is endorsed by all member partners and the Health and Wellbeing Together Board. The most recent action plan was formed in October 2018 and subsequently endorsed at the Health and Wellbeing Together meeting held on 17 October 2018. When setting the prevention agenda, the Suicide Prevention Stakeholder Forum considered all relevant policies, guidance and best practice. For example, the forum considered the national suicide prevention strategy[7], Public Health England's

[6] https://www.universitiesuk.ac.uk/policy-and-analysis/reports/Documents/2018/guidance-for-sector-practitioners-on-preventing-student-suicides.PDF
[7] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf

		(PHE) *'Local Suicide Prevention Planning: a practice resource'* guidance[8], PHE and National Suicide Prevention Alliance's *'Support after a suicide: A guide to providing local services'* – amongst other key guidance documents available and promoted nationally.
10.	Does the plan, strategy or approach represent a 'whole system' approach to preventing or reducing suicide?	The action plan represents a multi-agency approach and incorporates the involvement of various organisations. Positive progress has been made to democratise suicide prevention across the spectrum of services, from prevention to crisis. For example, social care workers have completed suicide prevention training enabling the identification of early signs of suicide ideation amongst vulnerable individuals, highways and planning are working with the forum to identify potential hotspot locations, the mental health trust is in the process of training all staff in suicide prevention and improving practices so staff and families are better supported following suicide bereavement. The University of Wolverhampton have set out suicide prevention as a strategic priority since 2014. This provides all staff groups with the opportunity to receive awareness training in suicide, self-harm, emotional resilience and resourcefulness for self. The training is offered monthly and to date over 800 staff and students have received this training. The University have also recognised that suicide mitigation and response remains a non-compulsory component of health professional curriculum and to that end are kneading the same modules in to the curriculum for undergraduate and post graduate nursing of all fields, physio therapy, paramedics, pharmacy. The vast majority of their students live in the city and go on to work locally. The forum is also working with the charity arm of Wolverhampton Wanderers Football Club by linking into the 'Heads For Health' project. This project has been funded through premier league funding with contributions made by the City of Wolverhampton Council and the Clinical Commissioning Group. The initiative works specifically with men with the aim to improve mental well-being. Through the forum connecting with Head For Health the project also now includes messages of suicide prevention, with plans to introduce suicide safety planning in the near future. The Mayor of Wolverhampton has pleasingly chosen the Suicide Prevention Stakeholder Forum as one the Mayor's charities for municipal year of 2019-2020, which will further

[8] https://www.gov.uk/government/publications/suicide-prevention-developing-a-local-action-plan

		help with raising the profile of suicide prevention across the City.

5.0 Next steps

5.1 The suicide prevention strategy currently runs up to 2020. A process to review the city's approach and form a new strategy will commence in early 2020. This will take stock of new guidance, best practice and lessons learnt from the first strategy period.

5.2 The forum will continue to deliver on its action plan and will focus on raising awareness of suicide, promote training across workforces and strengthen bereavement support pathways.

5.3 Public Health is part of regional approaches to suicide prevention and will seek to maximise the opportunities this presents. For example, unblocking data sharing with the coroners officer, implementing real-time surveillance and galvanising campaign efforts on a regional footing.

6.0 Financial implications

6.1 There are no financial implications arising from this report. [MI/08052019/Q]

7.0 Legal implications

7.1 There are no legal implications arising as a result of this report.
[Legal Code: TS/07052019/Q]

8.0 Equalities implications

8.1 Suicide is significantly more prevalent in men, this peaks between the ages of 45-49. Research has shown there are also other cohorts within the community who could be more susceptible to suicide ideation. For example, the LGBT community, young people, migrant communities. The local action plan recognises this heightened vulnerability and aims to implement measures targeted at such specific sections of the community.

9.0 Environmental implications

9.1 None.

10.0 Human resources implications

10.1 None

11.0 Corporate landlord implications

11.1 None

12.0 Schedule of background papers

12.1 Health Scrutiny Panel report suicide prevention March 2018

Appendix 1 - Suicide Prevention Strategy and Action Plan
Appendix 2 - Summary of activity World Suicide Prevention Day

Making Wolverhampton a Suicide Safer Community

Wolverhampton Suicide Prevention Strategy 2016 - 2020

Wolverhampton Suicide Prevention Stakeholder Forum

Suicides in Wolverhampton – What do we know?

Suicide is a potentially preventable cause of death and is a significant cause of death in young adults. When someone takes their own life, the effect on their family and friends is devastating and many others involved in providing support and care will also feel the impact. In England, one person dies every two hours as a result of suicide and at least 10 times that number attempt suicide. The highest rates of suicide in the UK are amongst people aged over 75, and it is a common cause of death in men under the age of 35[i].

Suicide rates

Table 1 shows the overall numbers and rates per 100,000 populations for suicides and injury undetermined over a three-year period from 2012 to 2014. Over this period, there were 64 deaths registered in Wolverhampton (aged 15 and over), the majority (89%) being males.

Reporting of suicides in young children

In the UK, a coroner is able to give a verdict of suicide for those as young as 10 years old. However, the Office for National Statistics (ONS) does not include the under 15s in suicide figures due to the difficulty in determining the cause of death in young people This is because of the known subjectivity between coroners with regards to classifying children's deaths as suicide, and because the number in those aged under 15 tends to be low and their inclusion may reduce the overall rates[1].

The overall (persons) suicide rate in Wolverhampton is at the England average and lower than the West Midlands average. However, this latest data now shows that the rate for males is higher (but not statistically significantly higher) at 15.9 per 100,000 compared to 14.1 per 100,000 for England.

Table 1 Suicide rates in Wolverhampton

Indicator	Period	Wolves		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
4.10 - Suicide rate (Persons)	2012 - 14	64	8.8	9.1	8.9	15.7		4.5
4.10 - Suicide rate (Male)	2012 - 14	57	15.9	14.8	14.1	25.3		7.2
4.10 - Suicide rate (Female)	2012 - 14	7	*	3.7	4.0	-	Insufficient number of values for a spine chart	-

Source: Public Health Outcomes Framework (downloaded 5 April 2016)

This increase is reflected in the trend data shown in Figure 1 where it can be seen that Wolverhampton rates have been decreasing since 2003 and were lower than the England average but recent trends suggest an increase, closing the gap. However, we know that suicide rates can be volatile as new risks emerge. Previously, periods of high unemployment or severe economic problems have had an adverse effect on the mental health of the population and have been associated with higher rates of suicide. Evidence is emerging of an impact of the current recession on suicides. Therefore an increase in suicide rates in the coming years would not be unexpected[ii].

Suicide is much more prevalent in males and there is a peak in the 30-34 years age group as shown in Figure 2.

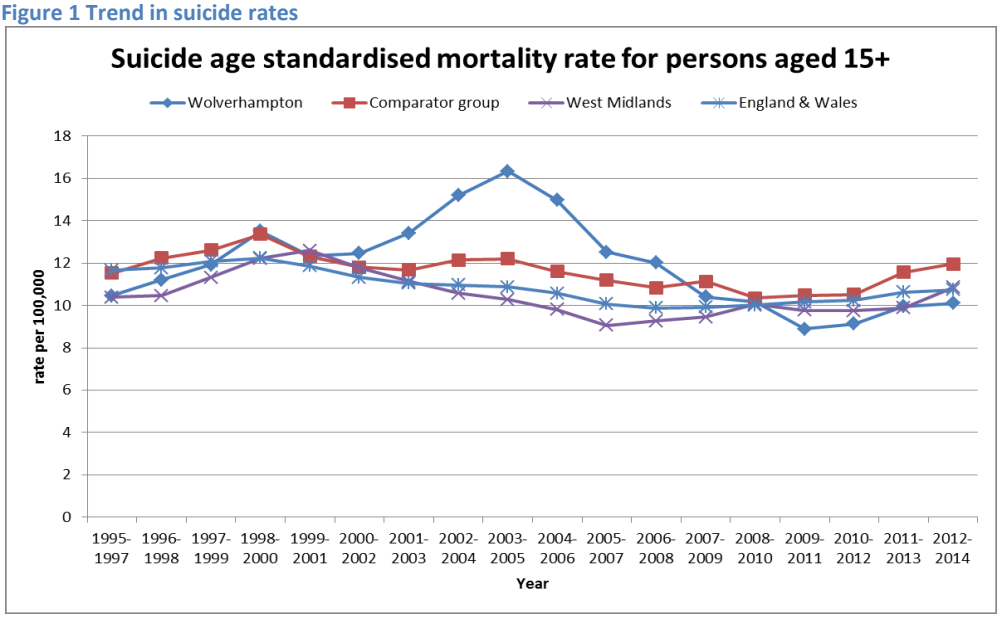
[1] http://www.samaritans.org/sites/default/files/kcfinder/branches/branch-96/files/Suicide_statistics_report_2015.pdf

This mirrors national trends. As stated above, there are no recorded suicides in the under 15 year age group as ONS has taken the decision to exclude under 15s from suicide figures as it cannot be determined whether these deaths are as a result of suicide or due to ill treatment.

Suicide rates are highest in our most deprived areas (Figure 3). In the most deprived parts of the city, the suicide rate is higher than the national average and higher than our comparator group average.

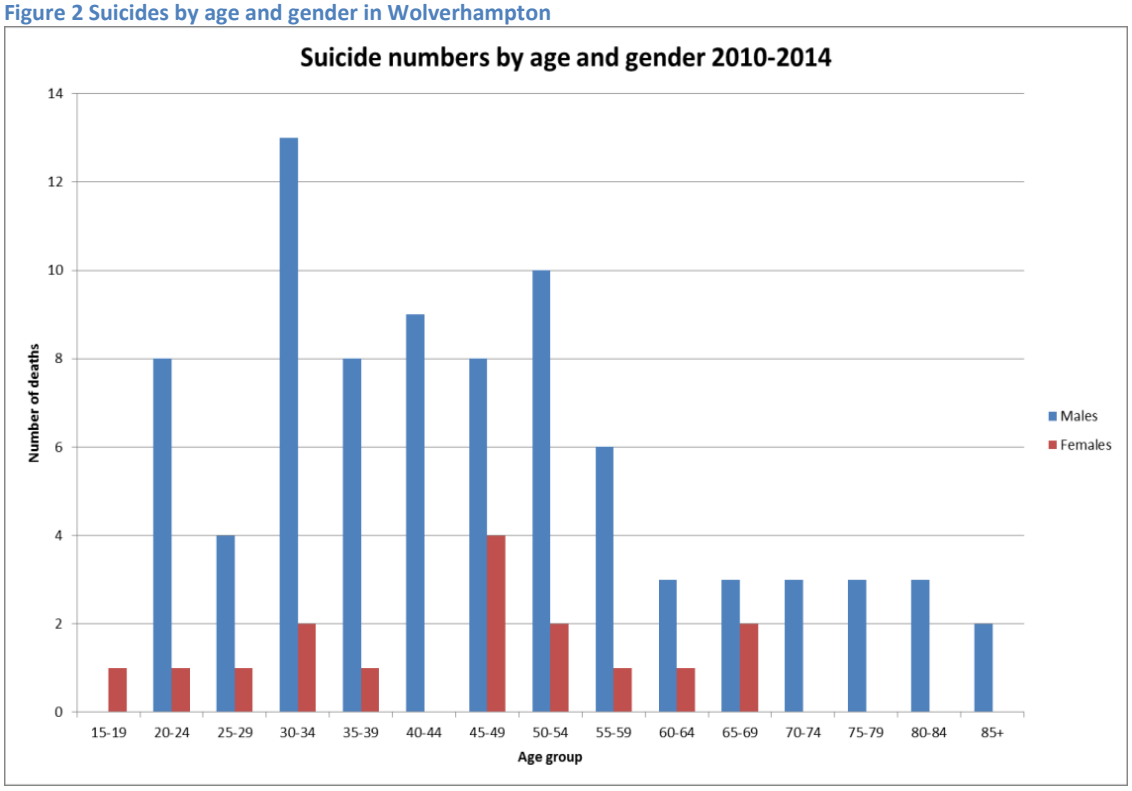
It is not possible to accurately analyse suicides by ethnic grouping as ethnicity is not available as part of the national mortality data set. The only data we have is available from a local audit of suicide cases between 2004 and 2008. This study highlighted that ethnicity is poorly recorded as it was not available in 20% of cases. In cases where ethnicity was recorded suicides amongst the Asian population appeared to be slightly over represented compared to the general population, however, these findings must be interpreted with caution due to the incompleteness of the data (Figure 4).

Figure 1 Trend in suicide rates



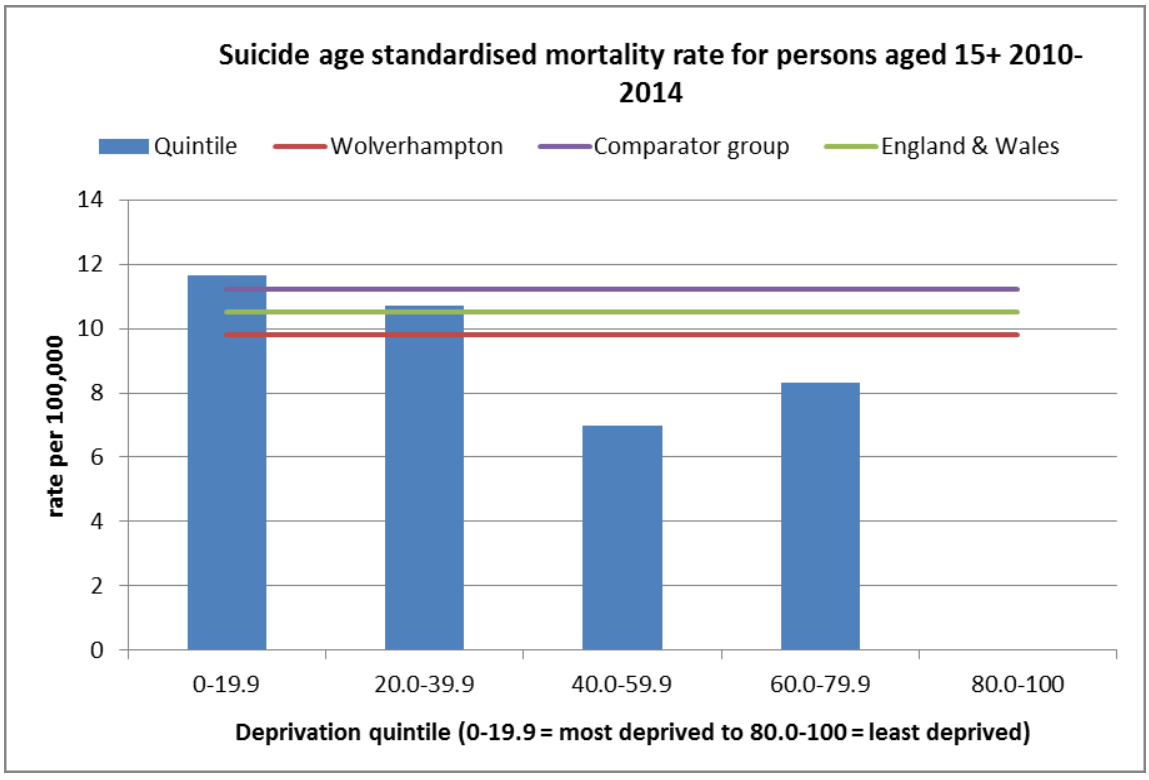
Source: Wolverhampton Public Health Intelligence Team

Figure 2 Suicides by age and gender in Wolverhampton



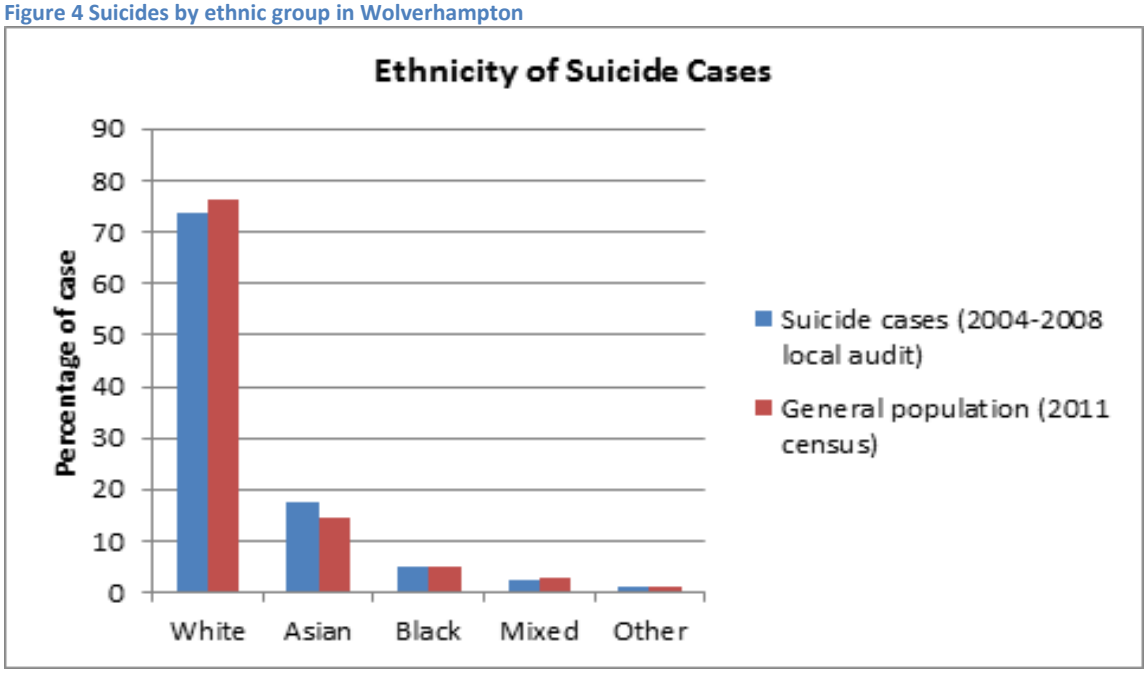
Source: Wolverhampton Public Health Intelligence Team

Figure 3 Suicides in Wolverhampton by deprivation quintile



Source: Wolverhampton Public Health Intelligence Team

Figure 4 Suicides by ethnic group in Wolverhampton



Source: Wolverhampton Public Health Intelligence Team

Suicide prevention needs assessment

In addition to ONS data, a comprehensive mental health and suicide prevention needs assessment has been undertaken co-produced between Wolverhampton Public Health and Wellbeing and Wolverhampton Samaritans in 2015. Over 20 organisations were involved in the needs assessment, which included an online survey distributed to local primary care. Risk factors and key findings identified were:

- Non-heterosexual sexual orientation with the greatest risk being in homosexual men due to the discrimination that these groups may experience.
- Areas of deprivation are associated with increased suicide rates, and over half of Wolverhampton residents are in the most deprived 20% of the country. Homelessness is higher in Wolverhampton than nationally, and multiplies the risk of suicide by nine.
- Isolation increases the risk of suicide, whereas marriage confers protection against suicide. The risk of suicide is increased by bereavement – especially when a male partner loses their spouse. The risk of suicide in men is four times greater when their partner dies by suicide than by any other cause.
- Risk of suicide risk increases with depression severity, and in Wolverhampton the incidence and prevalence of depression is higher than nationally. Wolverhampton has a higher alcohol related hospital admission rate than nationally, and heavy drinking confers a three-fold increase in suicide risk. Physical illness also raises suicide risk, particularly in terminal and chronic conditions.
- Stakeholder consultation identified migrants, men and deprived communities as being at the greatest risk of mental health problems locally. In contrast, women are more likely to approach their GP for mental health support. The most commonly reported triggers for mental health crisis were (1) relationships, (2) employment, (3) housing and (4) drugs/alcohol.
- The biggest gaps in provision were for men and for migrants.

Vision – A Suicide Safer Community in Wolverhampton

What is a Suicide Safer Community

The previous section reported the numbers of death due to suicide in Wolverhampton, but suicides are not inevitable. Suicide attempts are up to 20 times more frequent than completed suicides [iii] and many people can have thoughts about suicide – for example one in four (26%) of young people in the UK experience suicidal thoughts[iv]. But most do not act on these thoughts. Most want help to stay alive. A Suicide Safer Community[v] is a concept in which people are supported to stay alive with organisations and stakeholders coming together to:

- Prevent suicides
- Promote public education and awareness
- Provide support to people bereaved by suicide and promote healing and recovery
- Promote the mental health and wellbeing of all its citizens

In addition, suicide prevention should be set into the context of the fact that:

- Nationally in England and Wales only **28%** of suicides occur in people who are in contact with services
- This means that **72%** of those who died by suicide were **NOT** in touch with secondary mental health services within one year prior to death.

Therefore, most people who commit suicide are not known to mental health services, or had not had recent contact with services, highlighting the need for a public health approach to suicide prevention.

Vision

To make our community 'suicide safer' our vision is that Wolverhampton:

- is a place where mental wellbeing and good mental health is seen as important as good physical health, at all ages from childhood to older ages
- people are supported during difficult times and try not to think of suicide as an action
- And that professionals and the wider community feel confident to provide that support.

How are we going to make Wolverhampton a Suicide Safer Community

Many factors can contribute to someone thinking about taking their own life and while these factors can be intertwined and complex, they are amenable to change. However, preventing suicide has to address this complexity which is why organisations, communities, individuals and society as a whole need to work together to make suicide safer places. No one organisation can address this complexity alone.

The evidence suggests that there is a sliding scale of opportunities to intervene to prevent a suicide - based on prevention, intervention and post suicide support. In particular we need to have a wider programme of work to reach the 72% of those who are not in contact with specialist mental health services, while ensuring that all opportunities to prevent suicides within mental health settings are taken. Post suicide, we know that family and friends are up to 3 times more at risk of taking their own lives. Therefore, our approach is to:

1. become a suicide safer community
2. push for Zero suicide approach in local NHS care – both primary and secondary
3. Establish post suicide support.

Figure 5 Opportunities to intervene

Source: Public Health England

Why do we need a strategy?

In 2012 the government published *Preventing Suicide in England: A Cross Government Outcomes Strategy to Save Lives*. The national strategy has two overall objectives

- A reduction in the suicide rate in the general population in England
- Better support for those bereaved or affected by suicide

It identifies 6 key areas of action to support these objectives. These are:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behavior
6. Support research and data collection.

The strategy recommends that local authorities conduct a suicide audit, produce a suicide prevention action plan and set up a multi-agency suicide prevention group and Wolverhampton has achieved these requirements. This strategy brings these elements together so that all agencies are working towards the same goal and can see what they can contribute to suicide prevention locally.

Suicide prevention audit

The mental health and suicide prevention needs assessment, referred to above provides robust evidence base for our suicide prevention work and informs the suicide prevention action plan.

Suicide prevention stakeholder forum

A multi-agency Suicide Prevention Stakeholder Forum has been established to oversee the delivery of the Wolverhampton Suicide Prevention Action Plan 2015. The forum will take a public health approach to suicide prevention and brings together key stakeholders in the city to focus action on

suicide prevention (for both children and adults), address the national strategy and develop and deliver the Wolverhampton Suicide Prevention Action Plan.

Membership of the forum includes organisations/networks likely to have the greatest impact on reducing suicides in Wolverhampton and includes representatives from Wolverhampton Samaritans, Black Country Partnership Foundation Trust, CCG, Police, local authority adult, children's and public health teams, Network Rail, PAPYRUS, British Waterways and a wide range of voluntary sector organisations.

The group reports to Wolverhampton Health and Wellbeing Board.

Suicide prevention action plan

The suicide prevention needs assessment and additional stakeholder views from the Wolverhampton Mental Health Stakeholder Forum form the basis of the Suicide Prevention Action Plan.

Outcomes

The success of the strategy will be judged through progress towards, or achievement of, the actions identified in the action plan which will mark progress towards making Wolverhampton a suicide safer community. The action plan will be reviewed and updated annually to take into account new guidance and evidence on suicide trends in Wolverhampton. The action plan will be monitored by the Suicide Prevention Stakeholder Forum at its quarterly meetings.

WOLVERHAMPTON SUICIDE PREVENTION STAKEHOLDER FORUM
ACTION PLAN 2019-2020

AIMS

- Provide a multi-agency approach to suicide prevention across Wolverhampton
- Raise awareness of suicide, compelling organisations and the community to take positive action
- Upskill workforces through information and knowledge enabling them to better understand and respond to poor mental wellbeing and suicide ideation
- Influence services and policies so that suicide prevention is robustly considered and embedded in routine business
- Provide a coordinated suicide support offer which can be accessed by services and communities
- Support NHS partners in reaching suicide reduction objectives set out in the Five Year Forward View report

OUTCOMES

Measure	Source
Reduction in the number of suicides across all age groups	• Office for National Statistics • Black Country Coroner
Reduction in emergency hospital admissions for intentional self-harm	• Hospital Episode Statistics
Reduction in the number of self-harm instances in young people	• Hospital Youth Link • CAHMS (A&E)
Positive changes in mental health prevalence	• Public Health England Mental Health Profile

OBJECTIVE	AREA	WHAT WE WILL DO
Reduce the risk of suicide in key high-risk groups	Young and middle-aged men	Link into the Head for Health project, identifying opportunities to embed suicide prevention within the project's delivery plan
		Deliver a suicide prevention awareness raising campaign aimed at men
		Engage with construction industry to support suicide prevention awareness amongst their workforce
	People in contact with the criminal justice system	Engage with the Youth Offending Team and, support staff upskilling in suicide prevention
		Engage Probation Service to understand and, improve pathways out of prison into community
	People with a history of self-harm	Collate information on self-harm amongst young people and share this with services to raise awareness of suicide risk to young people
	People in the care of mental health services, including inpatients	Support BCPFT in delivery of their suicide prevention strategy and nationally set standards (zero suicide for inpatients, 10% reduction across NHS)
OBJECTIVE	**AREA**	**WHAT WE WILL DO**
Tailor approaches to improve mental health in specific groups	Migrant communities	Support the Migrant Mental Health Task Group through influencing and working in partnership with key health services
	LGBT	Engage the LGBT Alliance to explore opportunities to embed suicide prevention in current services aimed at LGBT communities
	Rough Sleepers	Seek opportunities for collaboration between the Suicide Prevention Stakeholder Forum and the Rough Sleepers Group

	Children and Young People	Identify, obtain and analyse self-harm data to inform and improve service responses
		Share lessons learnt from Serious Case Reviews for children who took their life by suicide in Wolverhampton. Be assured that recommendations from these reviews have been implemented in practice
		Produce policy and guidance around self-harm/suicide prevention for schools
		Identify and address training needs across the workforce including, GP's, School Nurses and School Designated Mental Health Staff
	People who misuse drugs or alcohol	Engage commissioned drugs and alcohol treatment provider to identify trends and risk of suicide in the individuals they support. Agree plan of action to address any identified issues
	People who are especially vulnerable due to social and economic circumstances;	Engage with The Department for Work and Pensions to identify trends and risk of suicide in the individuals they support. Agree plan of action to address any identified issues
		Engage with the City of Wolverhampton Council's Revenue and Benefits service to identify trends and risk of suicide in the individuals they support. Agree plan of action to address any identified issues
OBJECTIVE	**AREA**	**WHAT WE WILL DO**
Reduce access to the means of suicide	Railways	Receive regular updates from Network Rail on data (suicides on the railway system), training of staff and progress of other suicide prevention efforts
	Transport	Receive regular updates from British Transport Police on data (suicides on transport networks relevant to Wolverhampton) and progress of other suicide prevention efforts

	Planning and Highways	Invite City of Wolverhampton Council's Planning and Highways Department to identify opportunities to design out risk of suicide and how locations of concern can be reported and addressed
OBJECTIVE	**AREA**	**WHAT WE WILL DO**
Provide better information and support to those bereaved or affected by suicide	Provide support that is effective and timely	Engage Compton Care to support Bereavement Hubs
		Ensure services provide the Help is at Hand leaflet to people who have been bereaved by suicide
	Provide information and support for families, friends and colleagues who are concerned about someone who may be at risk of suicide	Create, and widely publicise a web portal bringing together information on suicide prevention and support services available across the City.
OBJECTIVE	**AREA**	**WHAT WE WILL DO**
Support the media in delivering sensitive approaches to suicide and suicidal behaviour	Promoting the responsible reporting and portrayal of suicide and suicidal behaviour in the media	Re-distribute Samaritans Media Guidelines to media outlets
		Engage Samaritans National Media team to understand work taking place at a national level with media outlets

OBJECTIVE	AREA	WHAT WE WILL DO
Working in partnership	Regional approach to suicide prevention	Engage with the Black Country Sustainability Transformation Plan
		Promote cross Black Country working through regular dialogue with other suicide prevention forums
OBJECTIVE	**AREA**	**WHAT WE WILL DO**
Raising awareness	Campaigns and events	Deliver promotional activity to coincide with Suicide Prevention Week
	Training	Deliver suicide prevention training to GP's
		Promote the Zero Suicide Alliance e-learning across workforces
OBJECTIVE	**AREA**	**WHAT WE WILL DO**
Support research, data collection and monitoring	Expand and improve the systematic collection of and access to data on suicides	Engage the Black Country Coroner to request routine data audits

References

[i] https://www.mentalhealth.org.uk/a-to-z/s/suicide
[ii] http://www.dh.gov.uk/health/files/2012/09/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf
[iii] http://forwardforlife.org/wp-content/uploads/2013/11/The_Biggest_Elephant_In_The_Room.pdf
[iv] The Princes' Trust Macquarie Youth Index 2014 http://bit.ly/12j0uGT cited in http://www.youngminds.org.uk/about/whats_the_problem/mental_health_statistics
[v] Developed by The Canadian Association for Suicide Prevention and Living Works.

Further reading/resources

Preventing suicides in public places A practice resource
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/481224/Preventing_suicides_in_public_places.pdf

Suicide prevention: identifying and responding to suicide clusters. A practical resource
https://www.gov.uk/government/publications/suicide-prevention-identifying-and-responding-to-suicide-clusters

Guidance for developing a local suicide prevention action plan: information for public health staff in local authorities
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/359993/Guidance_for_developing_a_local_suicide_prevention_action_plan__2_.pdf

Preventing suicide among lesbian, gay and bisexual young people: a toolkit for nurses
https://www.gov.uk/government/publications/preventing-suicide-lesbian-gay-and-bisexual-young-people

Preventing suicide among Trans young people: a toolkit for nurses
https://www.gov.uk/government/publications/preventing-suicide-lesbian-gay-and-bisexual-young-people

Suicide Prevention Profile
http://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide

Suicide Prevention Stakeholder Forum Wolverhampton

World Suicide Prevention Day

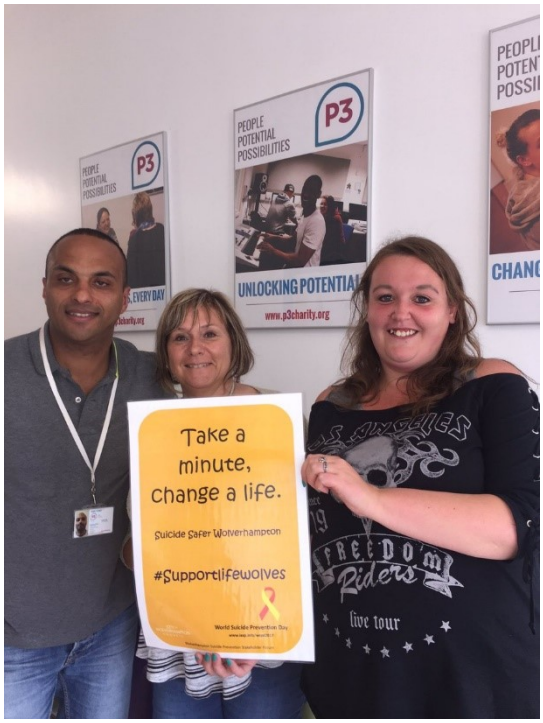
Activities included:

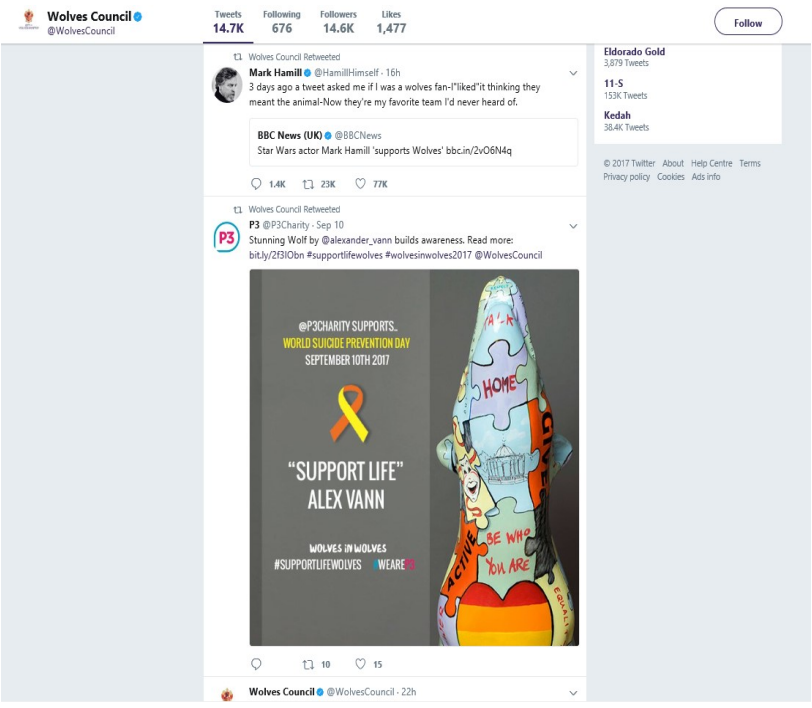
- Sub group formed to plan activities (Parpinder Singh, Heather Thomas, Paul Darke, Sarah Moseley and Louise Bloomfield)
- Samaritans media workshop
- Refugee Migrant Centre '5 ways to wellbeing' session
- Photoshoot with wolves in wolves, Chair of forum and elected member
- Press article sent to media outlets
- Press article shared on council's internal system and social media platforms. Twitter has 15k followers and Facebook 46k followers
- Hashtag, email banner and poster produced to aide social media presence
- Wolves FC players supporting campaign
- P3 promoting campaign with staff and users
- Walking for Health session by Healthy Lifestyle Team
- Healthy Minds offering free emotional and wellbeing checks
- Headstart supporting campaign and producing young people's podcast
- PAPYRUS supporting campaign via social media
- Wolverhampton Voluntary Sector Council promoting campaign with a large amount of voluntary groups, offering information on suicide prevention to visitors, supporting social media messages and using internal processes to promote campaign i.e. email banners
- Wolverhampton University hosting conference with keynote speakers as part of the ongoing efforts throughout September to promote suicide awareness

Poster used throughout the week by a range of services.

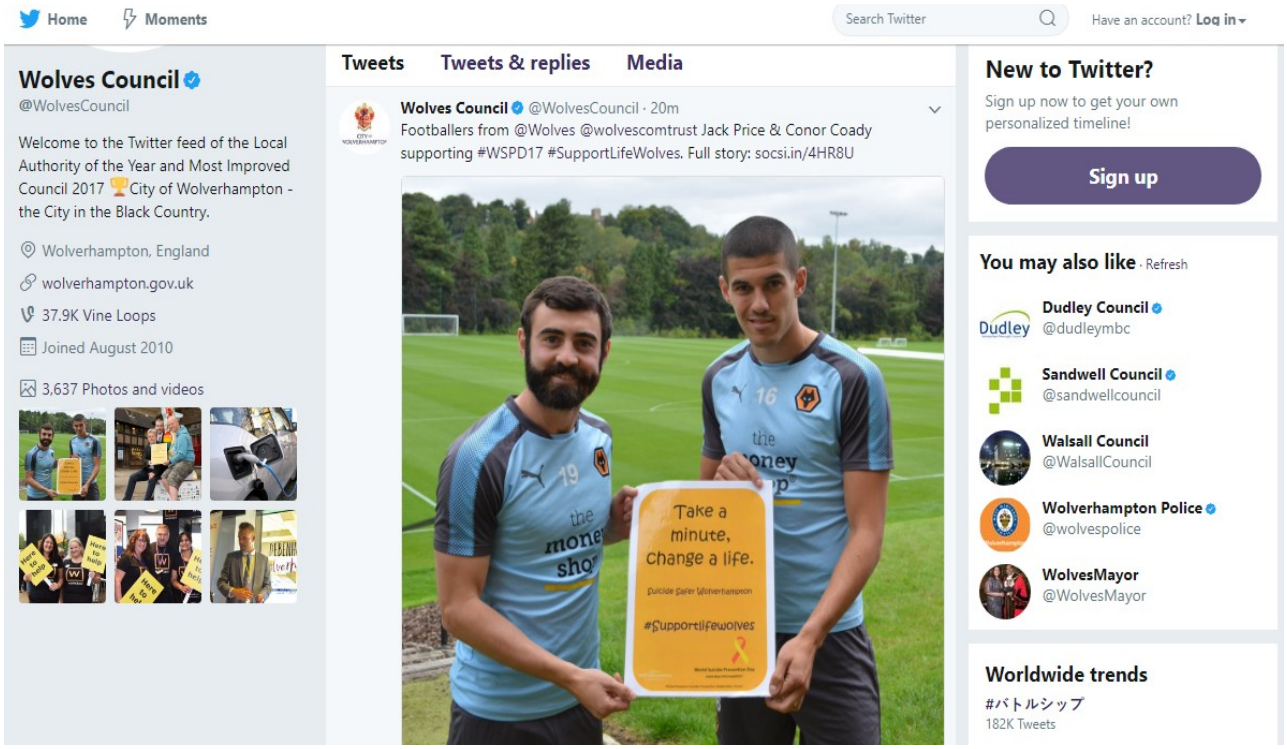
Photoshoot sent to media outlets to raise awareness. Pic: Dave Martin (Chair), Alex Vann (Artist for Wolves in Wolves) and Councillor Sweet (Elected member for Public Health and Wellbeing)

P3 Supporting World Suicide Prevention Day

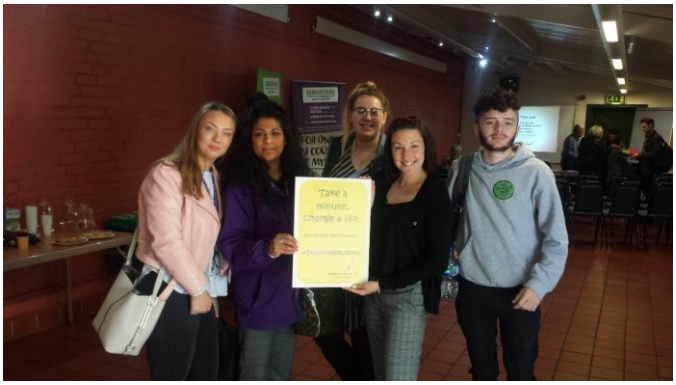




Wolves FC Supporting World Suicide Prevention Day



Samaritans Media Workshop



Agenda Item No: 7

Health Scrutiny Panel

6th June 2019

Report title

Transition from Children's to Adults' Services for Young People

Report of:

The Royal Wolverhampton NHS Trust

Recommendation(s) for action or decision:

The Health Scrutiny Panel is recommended to:

1. Support the approach by The Royal Wolverhampton NHS Trust to implement in co-production with children and young people, parents and the CCG to introduce a Trust wide Transition strategy. This will be in line with National best practice and NICE (National Institute for Care and Health Excellence) Guidance.

1.0 Introduction

1.1 A request had been made to RWT (The Royal Wolverhampton NHS Trust) to update this Panel as to current provision of services for children and young people with regards to Transition.

2.0 Background

Transition is a purposeful, planned process for adolescents with chronic physical & medical conditions as they move from child-centred to adult orientated health care.
The need for good transition:

- Children make up 20% of the population but are 100% of the future….
- Adolescent and Young Adulthood represents an opportunity to influence adult health
- Poor/no transition process associated with poor outcomes
- Support independent use of health care and progression into further education/employment
- Prevent condition complications occurring into adulthood
- Support proactive/preventative care around late effects of previous treatments

2.1 Currently there are well-established transition clinics in several specialities which have been developed in partnership with families and young-people. There are areas of good practice but it is recognised that there needs to be a Trust-wide approach to Transition for all children and young people with chronic health conditions. A trust-wide strategy for Transition in line with best practice is being developed with support from adult and children's services in collaboration with parents

In the strategy we are aiming to: -

- Involve young people and their families in the development, planning and delivery of services.
- Have a transition strategy and supporting documents in place to support transition with clear measurable outcomes for monitoring.
- Every young person with a long-term condition will have a planned transition of care, using the 'Ready, steady, go, hello programme, evident within health care records.
- Start the transition process early in the young person's clinical journey, by aged 14 at the latest and review regularly (at least annually).
- Ensure that each young person and their family has a named accountable individual responsible for supporting the young person through transition and transfer.
- Ensure that young people transferring across health care settings will have a documented transition plan and health passport to support good communication.
- Offer training and advice to young people and their families to prepare them for transition and transfer.
- Have services that are inclusive and responsive to the needs of young people and their families during transition and transfer.
- Have staff who are trained and have the necessary skills to care for young people and manage transition effectively.

- Work closely with young people, families, commissioners and/or other care providers to ensure timely arrangements for ongoing care are in place for individuals and also to jointly review services to ensure the process is efficient.

There will be plan to implement the strategy in co-production with children and young people and there is close working with the CCG in planning Transition for Children and Young people across the City with SEND.

3.0 Impact on Health and Wellbeing Strategy Board Priorities

Which of the following top five priorities identified by the Health and Wellbeing Board will this report contribute towards achieving?

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

4.0 Decision/Supporting Information (including options)

To support the approach by RWT to implement a Trustwide Transition strategy and develop further services to support children and young people through transition.

5.0 Implications

Please detail any known implications in relation to this report:
Health inequalities.

6.0 Schedule of background papers

- No background papers.

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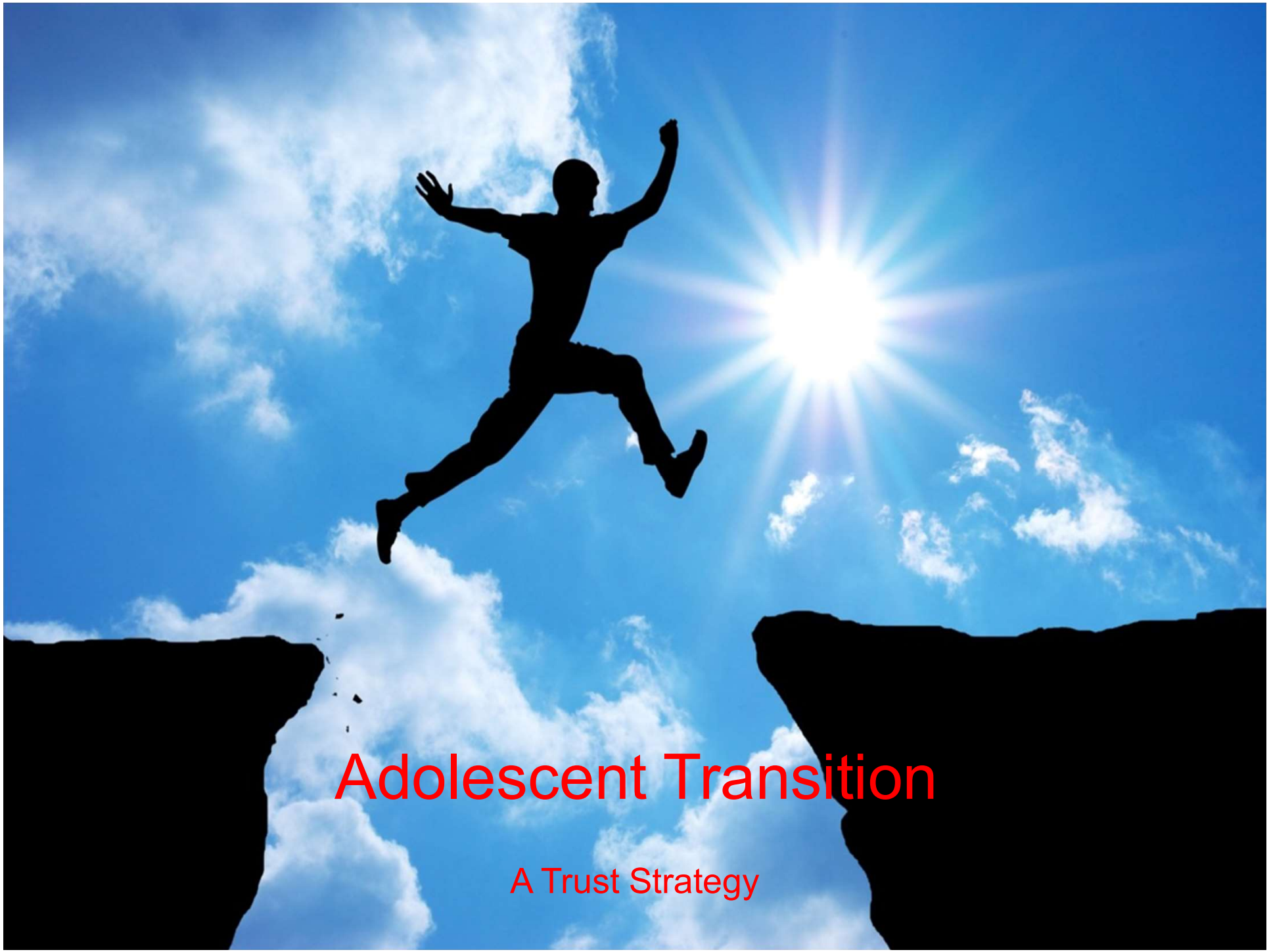

Adolescent Transition
A Trust Strategy

The Royal Wolverhampton NHS Trust

Transition

A purposeful, planned process for adolescents with chronic physical & medical conditions as they move from child-centred to adult orientated health care.

A process that addresses their

- -Medical needs
- -Psychosocial needs
- -Educational/vocational needs

*Note that transfer is a single event

The Royal Wolverhampton NHS Trust

The need for good transition…

Children make up 20% of the population but are 100% of the future….

Adolescent and Young Adulthood represents an opportunity to influence adult health

Poor/no transition process associated with poor outcomes

Support independent use of health care and progression into further education/employment

Prevent condition complications occurring into adulthood

Support proactive/preventative care around late effects of previous treatments

Outcomes for young people within 2 years of transfer to adult services	No transition	Using a Transition programme e.g Ready Steady Go	Comments
Kidney transplant patients: % who lost their transplant or died	25%	0%	*Prestidge et al 2012*
Diabetes patients: % of YP attending clinic in adult services	57%	78%	only had time to complete 'Go' as patients older *SCH unpublished*
Diabetes patients: Mean number of emergency admissions	1.01	0.45	50% reduction only had time to complete 'Go' as patients older *SCH unpublished*

The Royal Wolverhampton NHS Trust

Good Transition Results in….

Improved follow-up

Improved patient & parent satisfaction

Improved disease control & disease knowledge

Improved documentation of adolescent issues

Improved health related quality of life

Vocational readiness

The Royal Wolverhampton NHS Trust

What do Young People Want?

To start transition early

Individualised approach

Honest explanation of adolescent condition and associated health care

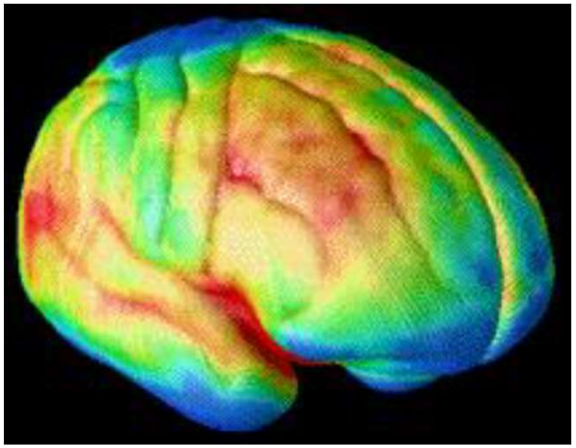
Continuity in health personnel

Opportunity to see health professional without parents

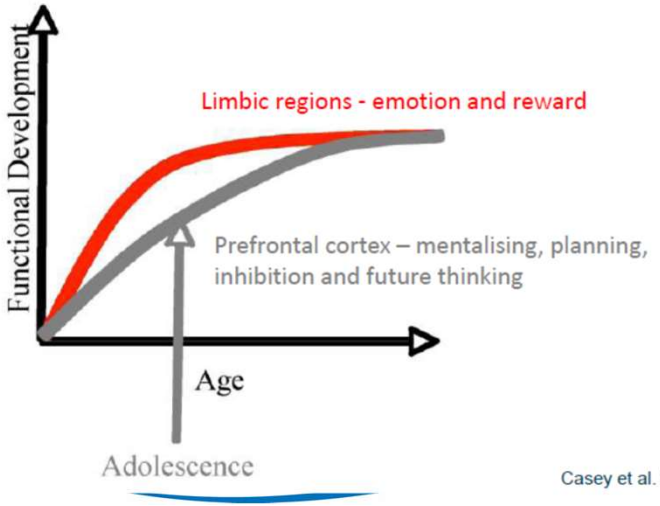
Able to express opinions and be involved in decisions

Address medical, psychosocial, educational/vocational needs

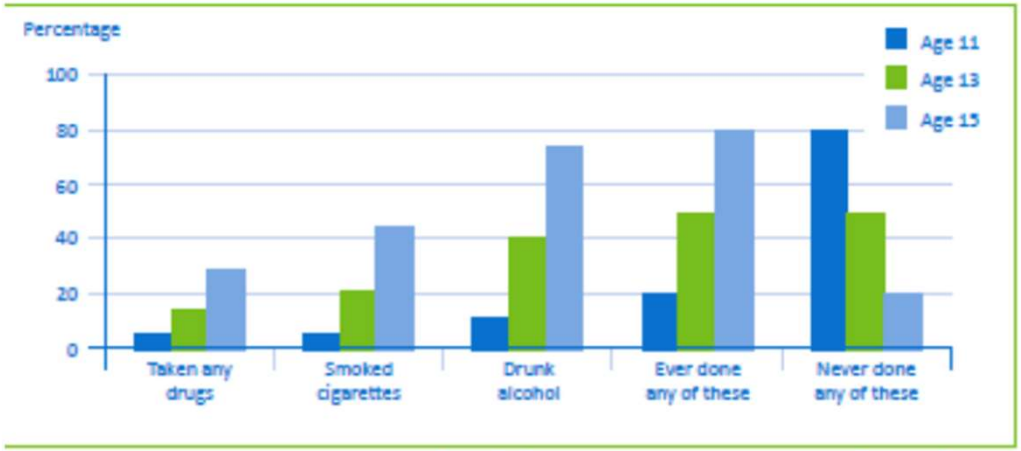
Risks taking in adolescents and young people



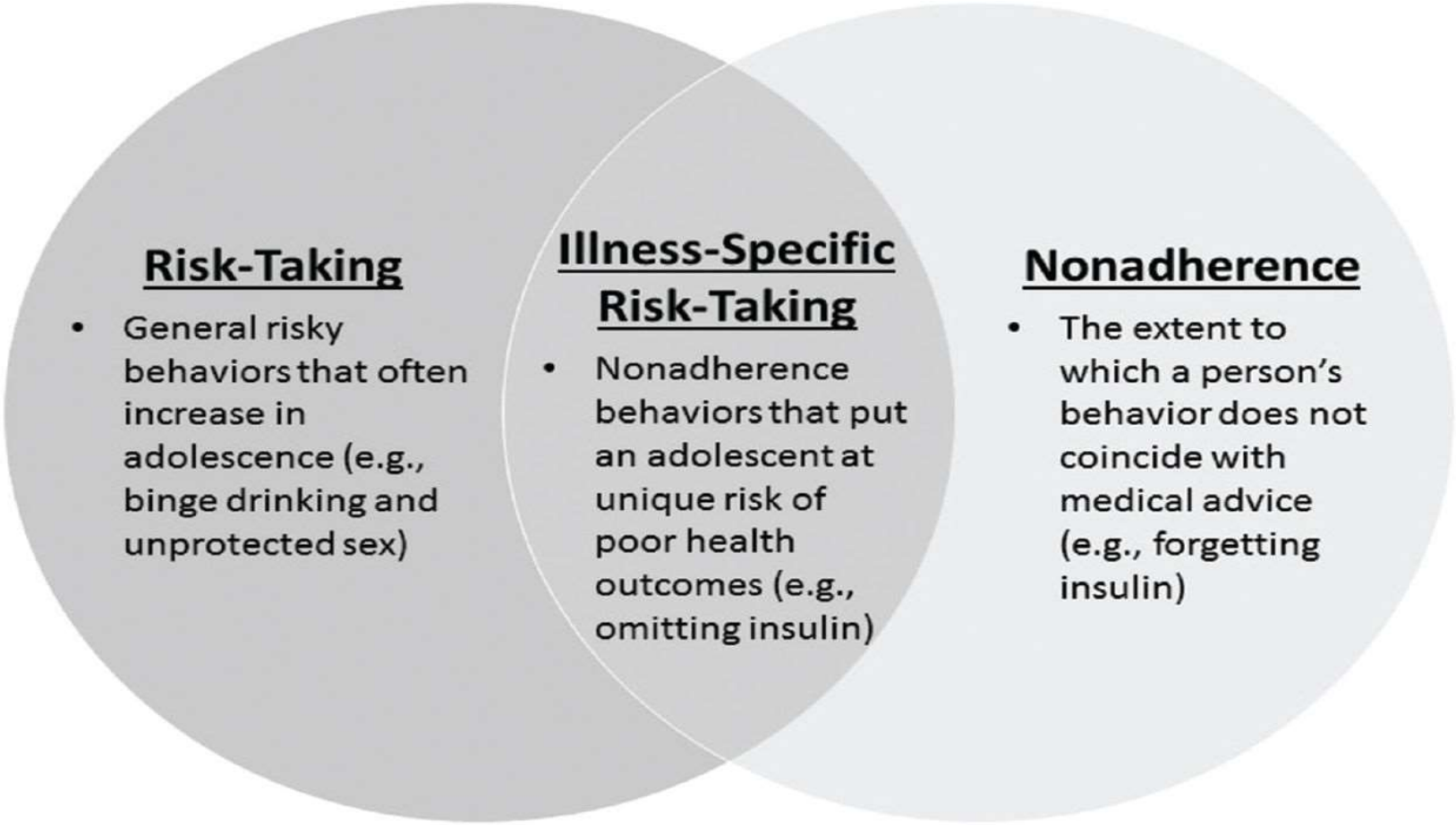
Five of the top 10 risk behaviours for disease burden are initiated and shaped in adolescence



Casey et al. 2008



Source: Smoking, Drinking and Drug Use among young people in England in 2011, Health and Social Care Information Centre » Download data


Risk-Taking
• General risky behaviors that often increase in adolescence (e.g., binge drinking and unprotected sex)
Illness-Specific Risk-Taking
• Nonadherence behaviors that put an adolescent at unique risk of poor health outcomes (e.g., omitting insulin)
Nonadherence
• The extent to which a person's behavior does not coincide with medical advice (e.g., forgetting insulin)

The Royal Wolverhampton NHS Trust

Effect of Adolescence on Having a Long Term Condition

Poor adherence and Disease Control

- Poorly developed abstract thinking and planning
- Difficulty imagining the future - 'Bullet Proof'
- Rejection of health professionals as part of separation from parents
- Exploratory 'risk taking' behaviours

Biological Impact on Disease

- e.g. increased insulin resistance

Associated Risk Behaviours

- Chaotic eating habits
- Smoking, alcohol and drugs
- Sexual risk taking

The Royal Wolverhampton NHS Trust

How do we address these needs?

The Royal Wolverhampton NHS Trust

Developmentally Appropriate Healthcare

Adolescence and Young Adulthood should be recognised across the health service as an important developmental phase (From the Pond Into the Sea, 2014)

- Preparing for adulthood (adolescent clinics, self advocacy, visits)
- Continuity of care (overlap with clear boundaries and responsibilities)
- Young person focused (involvement in decisions, holistic)
- Knowledge and Skills (Promote self efficacy)
- Training for professionals (RCP survey 2017 - 73% no formal training)
- Lead Coordinator
- Funding (reflect need rather than age)

The Royal Wolverhampton NHS Trust

Guidance and Legislation

The Royal Wolverhampton NHS Trust

Commissioning for transition to adult services for young people with Special Educational Needs and Disability (SEND) NHS England July 2018

Strategic vision across children's and adults' services….

Each local area should develop a joint mission or vision statement that clearly sets out the goals for young people and their families, and how services will work together to achieve a smooth transition.

The vision should be developed with young people, their families and professionals, and include information on how services will work together to help young people prepare for adulthood, with particular focus on:

- education and employment

- independent living

- having friends and relationships, and being part of the community

- being as healthy as possible – it is important to look at young people's health needs in a holistic way, including emotional and sexual health.

The Royal Wolverhampton NHS Trust

NICE Guidance

56 recommendations and 5 quality standards

Quality Standards

- Planning
- Annual Meeting
- Named worker
- Introduction to Adult Services
- Engagement after missed appointment


NICE National Institute for Health and Care Excellence

NICE guideline

Transition from children's to adults' services for young people using health or social care services

NICE guideline
Published: 24 February 2016
nice.org.uk/guidance/ng43

The Royal Wolverhampton NHS Trust

Ready, Steady, Go, Hello

What is it? - A purposeful , planned process for adolescents with chronic physical and medical conditions as they move from child centred to adult orientated health care

Why do it? – Reduce morbidity and mortality, promote vocational success.

Shifting emphasis to empower the young person has proven effective

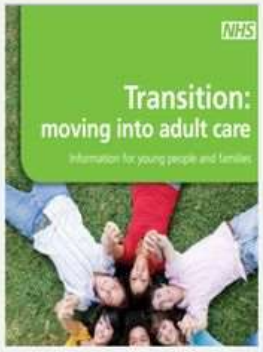
Generic programme working across sub specialities makes implementation easier

Simple to use, easy to implement, minimal cost, ‘traffic light system’ appealing

Who? – Adolescents aged >11years

Ready Steady Go: Moving through the programme

Ready Steady Go: Each Young person (YP) progresses at their own pace



11-12 yrs
YP and carer Introduced to Ready Steady Go programme with information leaflet + video
www.uhs.nhs.uk /readysteadygo

11 – 13 yrs
YP completes **Ready**
Issues addressed in bite sized pieces.
YP and carer introduced to concept of shared decision making and confidentiality
When ready YP seen on own for a few minutes during clinic.
Agree goals

14 – 16 yrs
YP completes **Steady**
Issues addressed in bite sized pieces
Aim to see YP for longer on own in clinic. Keep carer fully involved
Duplicate clinic letters offered to YP
Agree goals

16 – 18 yrs
YP completes **Go**.
Issues addressed in bite sized pieces
Work towards YP conducting whole clinic on own. Keep carers involved
Referral letter to adult team.
YP meets adult team.
On-going issues highlighted to adult team. Ideally all issues addressed prior to transfer.
Write transfer letter
Agree goals

1st adult clinic
YP +/- carer completes **Hello**
Issues addressed in bite size pieces by HCP.
Clinic letters sent to YP
Periodically **Hello** completed again to ensure knowledge + skills maintained
Any issues addressed.
Agree goals

Carer completes parent/carer questionnaire alongside YP questionnaires. Any issues discussed. Goals agreed.

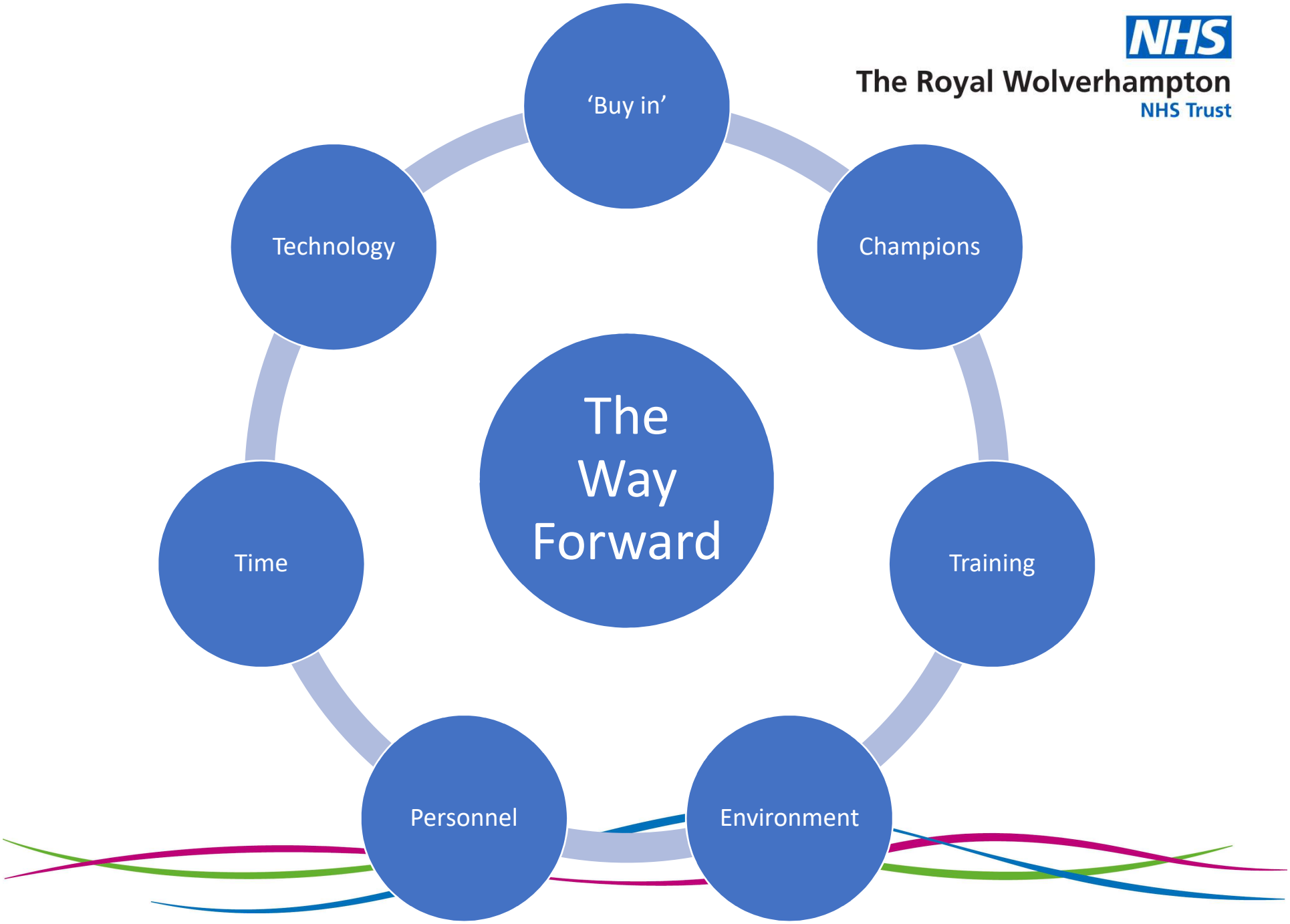
YP with learning difficulties completes as much as possible alongside carer who is YP advocate.

The Royal Wolverhampton NHS Trust

Ready, Steady, Go, Hello

- Knowledge
- Self Advocacy
- Health and Lifestyle
- Education/future
- Psychological Issues
- Transition

NHS
The Royal Wolverhampton
NHS Trust



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Agenda Item No: 8

CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny

6 June 2019

Report title	Update on Child Death Overview Panel	
Cabinet member with lead responsibility	Councillor Jasbir Jaspal Public Health and Wellbeing	
Wards affected	All	
Accountable director	John Denley, Director of Public Health	
Originating service	Public Health	
Accountable employee(s)	Neeraj Malhotra Tel Email	Consultant in Public Health 01902 558667 Neeraj.malhotra@wolverhampton.gov.uk
Report to be/has been considered by		

Recommendation(s) for action or decision:

The Scrutiny Panel is recommended to:

1. Note the progress being made to be aligned with new national guidance

Recommendations for noting:

The Scrutiny Panel is asked to note:

1. The changes in process and responsibility for Child Death Reviews
2. To approve the progress and direction of travel towards a Black Country CDOP

1.0 Purpose

1.1 To provide Health Scrutiny with an update in changes being made to the way child deaths are reviewed across the Black Country and provide reassurance that this will result in improvements across organisations.

2.0 Background

2.1 Responsibility for child death reviews (CDRs) has moved from the DfE to the DoH as the majority of child deaths have a medical cause. The *Children and Social Work Act 2017* set out the abolition of Local Safeguarding Children Boards (LSCBs) in their current form and as a result, Local Authorities were required to undertake a review of current local arrangements and to establish Child Death Overview Panel (CDOP) arrangements which are distinct from that of the LSCB.

2.2 In 2018, the new *Child Death Review Statutory and Operational Guidance (England)* set out the processes to be followed when responding to, investigating, and reviewing the death of any child, from any cause.

2.3 The guidance stipulates the requirement for “child death review (CDR) partners” (Local Authorities and Clinical Commissioning Groups) to make arrangements to review child deaths also in line with *Working Together to Safeguard Children (2018).* CDR partners have the authority to determine CDOP arrangements within their local area whilst ensuring that the statutory duties are retained and delivered effectively. They must ensure that their review area is aligned to existing networks of NHS care and Children’s Services and covering a child population such that the area typically reviews a minimum of 60 child deaths each year.

2.4 The CDR guidance outlines statutory responsibilities for CDR Partners (Local Authorities and Clinical Commissioning Groups) in each area, which include:

a. Review of all deaths of children normally resident in the relevant local authority area and, if appropriate, the deaths in that area for any non-resident child/ren.

b. Analysis of information from all child deaths reviewed, to confirm or clarify cause of death, determine any contributory factors, and to identify learning arising from the CDR process that may prevent future child deaths.

c. Making recommendations to all relevant organisations with a view to preventing future child deaths or promoting the health, safety and wellbeing of children.

d. Production of an annual report for CDR partners which includes local patterns and trends in child deaths, and an evaluation of the effectiveness of the wider CDR process in practice.

2.5 From 29 June 2018, child death review partners have had **up to 12 months** to agree arrangements for the review of each death of a child normally resident in their area. Local Safeguarding Boards will retain responsibility for the CDR process (including CDOP) until new measures are in place and appropriate handover arrangements are confirmed.

2.6 A National Child Mortality Database has been established and will be used to monitor national trends and identify emerging themes. Themed panels will be introduced, to discuss issues such as neonates, sudden unexpected death in infancy, suicide, cardiac, trauma and death in children with learning disabilities.

2.7 A successful Black Country partnership 'Early Adopter' bid was made outlining a vision to have a strategic Child Death Review (CDR) process. The bid aspired to make a positive difference to children's health and wellbeing through maximising partnership working and synergy between the areas and developing sustainable solutions to address any gaps. The recent legislative changes relating to LSCB and the CDR process, provides an opportunity to establish a single, coordinated resource across the Black Country.

3.0 Progress, options, discussion.

3.1 An early adopter steering group was established and Stakeholders from all 4 areas involved in the child death review processes and safeguarding arrangements were engaged and consulted on the development of possible options. The options presented to stakeholders by the steering group were for a Black Country Strategic CDOP that could:

a. Review ***all*** child deaths
b. Review ***no*** child deaths (but consider trends, data analysis, annual reporting and quality assurance)
c. Review ***some*** child deaths (plus the above)

3.2 There was a consensus from stakeholders not to dismiss any option but to maintain and develop the 2 operational CDOPs (Walsall / Wolverhampton and Sandwell and Dudley) whilst developing the strategic CDOP over time. This is the preferred option as it is considered to be cost effective and will provide an overview of the Black Country as a whole which will allow for more robust thematic learning (with a larger number of cases under consideration), improved co-ordination and the consistent implementation of new developments e.g. bereavement support.

3.3 Agreement from all Black Country LSCB areas to fund a Black Country CDOP Co-ordinator, administration and to adopt e-CDOP was confirmed at the Black Country Shadow Strategic CDOP meeting on 13 February 2019. e-CDOP is a cost effective, secure, flexible and web-based solution which allows the CDOP process to be managed efficiently, with effective and secure sharing of multi-agency information.

3.4 Work is progressing well to get a Black Country CDOP co-ordinator in post as quickly as possible. The post will be hosted by Wolverhampton and all four areas will contribute to this post. The co-ordinator will then be responsible for the streamlining of administrative roles across the patch.

3.5 As a result of the abolition of LSCB through the Act (2.1), CDR partners are required to consider and determine the future governance and accountability arrangements for CDOP locally. A proposal that each Health and Wellbeing Board has local strategic oversight of the Black Country CDOP was endorsed by the executive group of Health and Wellbeing Together on 20 February 2019.

4.0 Questions for Scrutiny to consider

4.1 How often would scrutiny like updates on both the process and the data relating to child deaths?

5.0 Financial implications

5.1 Wolverhampton (DPH) has agreed to host the funding for the Black Country posts and future financial commitments for e-CDOP. The table below details the proposed funding for the post.
CWC's contribution of £9,200 will be funded the ringfenced Public Health Grant

	Population	<18	Split
Dudley CCG	68811	24.8%	£10,525
Dudley Metropolitan Borough Council			£10,525
Sandwell MBC	81080	29.3%	£12,402
Sandwell and West Birmingham CCG			£12,402
Walsall CCG	67211	24.2%	£10,281
Walsall MBC			£10,281
Wolverhampton CCG	60091	21.7%	£9,192
City of Wolverhampton Council			£9,192
	277193	100.0%	**£84,800**

[MI/28052019/K]

6.0 Legal implications

6.1 The work that is being undertaken is to ensure all four Black country areas are compliant with the *Child Death Review Statutory and Operational Guidance (England)* as referred to in the body of this report.

6.2 Processing of personal data will need to comply with the General Data Protection Regulation.

[JA/240519/E]

7.0 Equalities implications

7.1 An equalities analysis on getting a co-ordinator in post has not been undertaken. However, with the implementation of e-CDOP, analyses will be possible in the future to see if there are variations in child deaths by different population groups. For example, by age, by ethnicity and by socio-economic status.

8.0 Environmental implications

8.1 As the post will be required to oversee processes being undertaken across the Black Country, there will be some travel involved that has not been previously required.

9.0 Human resources implications

9.1 Wolverhampton has agreed to host the BC CDOP posts on behalf of Black Country partners including Local Authority and CCGs. Advice has been taken from Sandwell and Wolverhampton HR teams to ensure the process being undertaken is compliant with correct HR processes. In the first instance, the post is being offered to those people across the four areas whose jobs are at risk and whose roles are of sufficient similarity to that being advertised.

10.0 Corporate landlord implications

10.1 There are no corporate landlord implications

11.0 Health and Wellbeing Implications

11.1 The establishment of a Black Country CDOP and the implementation of e-CDOP will enable more systematic and robust learning from child deaths to be applied across a larger area. This will contribute to strategic plans to reduce infant mortality.

12.0 Schedule of background papers

12.1 Child death review statutory guidance
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/777955/Child_death_review_statutory_and_operational_guidance_England.pdf

12.2 CDOP annual report 2018

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Scrutiny Work Programme

Health Scrutiny Panel

The Panel will have responsibility for Scrutiny functions as they relate to: -

- All health-related issues, including liaison with NHS Trusts, Clinical Commissioning Groups, Health and Wellbeing Board and Healthwatch.
- All functions of the Council contained in the National Health Service Act 2006, to all regulations and directions made under the Health and Social Care Act 2001, the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002,
- The Health and Social Care Act 2012 and related regulations.
- Reports and recommendations to relevant NHS bodies, relevant health service providers, the Secretary of State or Regulators.
- Initiating the response to any formal consultation undertaken by relevant NHS Trusts and Clinical Commissioning Groups or other health providers or commissioners on any substantial development or variation in services.
- Participating with other relevant neighbouring local authorities in any joint scrutiny arrangements of NHS Trusts providing cross border services.
- Decisions made by or actions of the Health and Wellbeing Board.
- Public Health – Intelligence and Evidence
- Public Health – Health Protection and NHS Facing
- Public Health - Transformation
- Public Health – Commissioning
- Healthier City
- Mental Health
- Commissioning Mental Health and Disability
- HeadStart Programme

Date of Meeting	Item Description	Lead Report Author	Notes
6 June 2019	• Public Health Vision – Review of Progress against national performance targets • Suicide Prevention • Ward sizes, age, transition arrangements for a young person moving to an adult ward • Child Death Overview Panel	Public Health – Ankush Mittal Lina Martino / Parpinder Singh The Royal Wolverhampton NHS Trust Public Health (Neeraj Malhotra)	
12 September 2019	• Public Health Annual Report • Healthwatch Annual Report • The Royal Wolverhampton NHS Trust - Quality Accounts– September 2019	Public Health – John Denley Tracey Cresswell RWT – Alison Dowling	

	• CCG Annual Report • National Audit of Care at the End of Life	RWT	
7 November 2019	• GP appointment waiting times – involve Wolverhampton Healthwatch • Review of the impact of the new Medical Examiner Role and the Registrar's Office at Newcross Hospital • Maternity Services – Quality Assurance • Pharmaceutical Ordering (Provisional) • Draft Budget	CCG – Helen Hibbs Royal Wolverhampton NHS Trust Royal Wolverhampton NHS Trust Finance - Council	
16 January 2020	• Reconfiguration of hyper acute and acute stroke services	CCG / RWT	
5 March 2020	• Mortality Statistics	RWT	

Potential Future Items:-

1. Black Country Partnership NHS Foundation Trust Merger
2. STP (Sustainability and Transformation Plans) (Suggested by Chair of Healthwatch)
3. West Park Hospital (Suggested by Chair of Healthwatch)
4. June 2020 – Review of the new Patient Experience, Engagement and Public Involvement Strategy.
5. West Midlands Ambulance – to address priorities identified in the Quality accounts and in particularly those on Maternity Care in the pre-hospital environment.
6. In the Quality Accounts, the National Audits showed significant non-compliance by RWT in a few areas, the Panel wishes to look at progress in these areas.
7. Primary Care - CCG

Work Plan Version: 29/05/19 12:52