Health and Wellbeing Board

3 September 2014

Time 12.30 pm **Public Meeting?** YES **Type of meeting** Oversight

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

Information for the Public

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Agenda

Part 1 – items open to the press and public

Item No. *Title*

MEETING BUSINESS ITEMS - PART 1

1 **Apologies for absence (if any)**

2 **Notification of substitute members (if any)**

3 **Declarations of interest (if any)**

4 **Minutes of the previous meeting** (Pages 1 - 6)
[To approve the minutes of the meeting held on 9 July 2014 as a correct record]

5 **Matters arising**
[To consider any matters arising from the minutes of the meeting held on 9 July 2014]

6 **Summary of outstanding matters** (Pages 7 - 10)
[To consider and comment on the summary of outstanding matters]

7 **Health and Wellbeing Board Forward Plan 2014/15** (Pages 11 - 14)
[To consider and comment on the items listed on the Forward Plan]
[Viv Griffin]

8 **Safeguarding Children's Board Annual Report 2012-13 - Report of the Independent Chair** (Pages 15 - 102)
[To consider the report of the Independent Chair of the Safeguarding Children's Board for 2012 – 13]
[Stephen Dodd]

9 **Better Care Fund - progress report** (Pages 103 - 112)
[To receive a position report in connection with the Better Care Fund] [TO FOLLOW]
[Noreen Dowd]

10 **Joint Strategy for Urgent Care - Equality Analysis** (Pages 113 - 166)
[To consider the Equality Analysis for the Joint Urgent Care Strategy and the adoption of specific recommendations contained therein]
[Noreen Dowd]

11 **Child Poverty Strategy** (Pages 167 - 178)
[To consider an update on progress in delivering Wolverhampton's Child Poverty Strategy and future governance arrangements]
[Kerin Jones]

12 **Progress update - Joint Health and Wellbeing Board Strategy Priority - Drugs and Alcohol** (Pages 179 - 198)
[To receive an update on Key Performance Indicators, the Alcohol Strategy reporting dashboard and information on other issues of relevance]
[Ros Jervis]

13 **Children, Young People and Families Plan - 2014 - 2024** (Pages 199 - 212)
[To consider and comment on the Children, Young People and Families Plan – 2014 – 2024]
[Fiona Ellis]

14 **Refreshed Joint Dementia Care Strategy and Implementation Plan - 2014 - 2016** (Pages 213 - 216)
[To consider the refreshed Joint Dementia Care Strategy and Implementation Plan 2014 – 2016]
[Anthony Ivko]

15 **Feedback from Sub Groups** (Pages 217 - 232)
[To receive feedback from the following Sub Groups}

(i) Adults Delivery Board (Viv Griffin) (Verbal report)
(ii) Public Health Delivery Board (Ros Jervis)

16 **Exclusion of the press and public**
[To pass the following resolution:

That in accordance with Section 100A(4) of the Local Government Act 1972 the press and public be excluded from the meeting for the following items of business as they involve the likely disclosure of exempt information on the grounds shown below.]

17 **Proposals to deliver planned care at Cannock Chase Hospital for Wolverhampton patients**
[To receive a verbal update from representatives of the Royal Wolverhampton NHS Trust and the Wolverhampton City Clinical Commissioning Group in connection with the current position with the proposals for the delivery of planned care Cannock Chase Hospital for Wolverhampton patients]
[RWT / WCCCG]

Meeting of the Health and Wellbeing Board

Minutes - 9 July 2014

Attendance

Chair	Cllr Sandra Samuels (Lab)	
	Cllr Steve Evans (Lab)	
	Cllr Val Gibson (Lab)	
	Cllr Paul Singh (Con)	
	Helen Hibbs	Wolverhampton City CCG
	Simon Hyde	West Midlands Police
	Ranjit Khutan	University of Wolverhampton
	Ros Jervis	Director of Public Health
	Dr Kiran Patel	NHS England - Local Area Team

Employees

Noreen Dowd	Chief Operating Officer, Wolverhampton City Clinical Commissioning Group
Glenda Augustine	Consultant in Public Health, Community Directorate
Chris Irvine	Wolverhampton Voluntary Sector Partnership
Tony Ivko	Assistant Director - Older People and Personalisation
David Kane	Head of Finance, Delivery Directorate
John Wright	Democratic Support Manager
Steve Brotherton	Head of Older People Commissioning
Sue Mckie	Healthy Start to Life Programme Manager
Sue Wardle	Consultant in Public Health
Sarah Carter	Programme Director BCF
Tim Johnson	Strategic Director, Education and Enterprise

Item No. *Title*

1 **Apologies for absence**

Apologies for absence were submitted by Emma Bennett, Viv Griffin Proffessor Linda Lang and Sarah Norman

2 **Notification of substitute members**

R Khuttan attended the meeting in place of Proffessor Linda Lang

3 **The Late Bob Jones**

The Chair paid tribute to Bob Jones, the Police and Crime Commissioner, who had recently passed away.

The Committee stood for a minutes silence in his memory.

4 **Declarations of interest**

There were no declarations of interest

5 **Minutes of the previous meeting (7 May 2014)**

Resolved

That the minutes of the meeting held on 7 May 2014 be approved as a correct record and signed by the Chair subject to the following amendments

- Apologies for Absence 3rd line delete the word “local”
- Add Maxine Bygraves to the list of attendees
- Change Noreen Dowd’s job title to Interim Director

6 **Matters arising**

There were no matters arising

7 **Summary of outstanding matters**

The following issues were noted:

- Child Poverty Strategy – Ros Jervis would talk to Keren Jones about the timing of the submission of the report
- Primary Care Strategy – was listed twice but no date was set for when it would be reported
- Children’s Trust Board – it was noted that written reports on the work of the Trust Board would be submitted to this meeting in future

8 **Health and Wellbeing Board Forward Plan 2014/15**

There were no issues raised

9 **Better Care Fund - progress report**

A report was received on the progress made on the development of the Better Care Fund programme.

It was noted that the initial submission of the Better Care Fund Programme had been made to NHS England in April. A further iteration was required to be submitted in early August 2014 with a more robust financial analysis. It was felt that rather than hold a special meeting to approve the further submission delegated authority should be given to the Chair and other members of the Board to approve it.

Work was ongoing on working towards national and local metrics associated with the development of the Better Care Fund programme. It was noted that as part of the consideration of the impact on the acute sector a work programme was being developed to look at the impact of reducing the number of bed days. It was felt that a local view was needed on how to measure the impact on the acute sector. This would aid benchmarking. It was noted that 85% of funding was being spent on existing resources and there was a need to develop a more integrated care pathway.

It was recognised that engagement with community groups would be an important part of the design of services. Mapping work was already underway to understand the level of existing community provision.

Resolved

1. That the report be received
2. That delegated authority be given to Councillor Samuels, Helen and Hibbs and Sarah Norman to approve the further submission of the Better Care Fund Programme to NHS England

10 **Urgent Care Strategy - update**

Consideration was given to a report on the joint urgent and emergency care strategy. The strategy had been reported to and agreed by the CCG Governing body on the day before the meeting of the Board.

It was considered important to understand the equality impact assessment of the strategy and felt that this should be reported to the next meeting of the Board

Resolved

1. That the report be noted
2. That details of the equality impact assessment of the joint urgent and emergency care strategy be reported to the next meeting of the Board

11 **Joint Re-ablement and Intermediate Care 2014 - 16 - update**

A report was considered on the Joint Re-ablement and Intermediate Care strategy 2014-16.

Resolved

That the Joint Re-ablement and Intermediate Care strategy 2014-16 be approved

12 **Director of Public Health Annual Report - Obesity Call to Action**

The Director of Public Heath gave a presentation on the Public Health Annual report 2013/14. The report focussed on the issue of obesity in the city.

It was noted that 13% of reception class children were obese and this rose to 25% by year 6. 70% of the population of the city was overweight. 54% of the population did not participate in any physical activity. It was noted that deprivation played an important role.

The report was intended to act as a call for all to engage with this issue and get the message out regarding the need to combat obesity.

The Board was asked to pledge its support for action to combat obesity and to support a conference to be held in the autumn on the subject.

It was noted that obesity was a particular problem amongst certain ethic groups and therefore there was a need to involve community groups in the fight against obesity.

Resolved

1. That it be recognised that obesity presents a serious a serious health issue for the health of the city and that rates of excess weight in Wolverhampton are significantly worse than national and comparator areas
2 That the Public Health Annual Report 2013/14 ‘A Call to Action’ on obesity in Wolverhampton be endorsed and supported.
3. That the Autumn Obesity Call to Action Conference be supported.
4. That individual partner agencies be asked to make pledges of support to take action as part of their commitment to a partnership ‘whole systems’ approach to tackling obesity and to attend the Autumn conference.

13 **Local Government Declaration on Tobacco Control**

A report was received on the Local government Declaration on Tobacco control. The declaration had been developed by Newcastle City Council as a means of showing commitment to the importance of tackling issues related to smoking. The declaration gave a number of specific commitments to tackling smoking. A number of other councils had already signed the declaration.

Resolved

That the Board requests that the Council and partner organisations sign the Tobacco Control Declaration

14 **Care Act 2014**

The Board received a report on the progress made on implementing the Care Act and the personalisation programme. The act placed additional responsibilities on the Council. The government had said that the implications of the Act would be cost neutral on the council but it was anticipated that there would be additional costs incurred. The report detailed the changes arising from the Act.

A Board had been created to manage the implementation of the Act and work was also ongoing with 14 other councils on how to respond to the Act .

It was noted there was concern that the implications of the Act could cost additional £5 million at time when there was a need to save money.

It was felt that in conjunction with the other councils a letter should be sent to the Department of Health to raise awareness of the need for adequate funding to be available to ensure that the requirements of the Act are deliverable

Resolved

That a further progress report be submitted to the October meeting of the Board

15 **Wolverhampton City Clinical Commissioning Group - 5 Year Strategic Plan**

Consideration was given to the Five Year Strategic Plan for the Wolverhampton Health and Social Care Economy. The five year plan built upon detail provided in the two year operational plan. The production of the five year strategy was a requirement from NHS England for all health and social care economies. The Health and Well-Being Board was required to sign off the plan.

Resolved

1. That Five Year Strategic Plan for the Wolverhampton Health and Social Care Economy be approved
2. That any further changes to the plan would be represented to the Health and Well-Being Board for final approval.

16 **Feedback from Sub Groups**

- **Children's Trust Board**

A review had been undertaken of the terms of reference and the membership of the Children's Trust Board. The review had also looked at the structure of Board and its relationship with other boards.

The children, young people and families plan would provide the focus for the work programme. It was noted that there was a need for partner organisations to bring items forward.

The annual stakeholder event was being planned.

Concern had been expressed at levels of attendance at Board meetings. The partnership agreement had stressed the need for consistency of attendance for partners with an aspiration that all members of the board would attend 80% of meetings. Most representatives had signed and returned the agreement

- **Adult Delivery Board**

The content of the report of the progress made by the Adult Delivery Board was noted.

- **Public Health Delivery Board**

The 10 June meeting of the board had closed down the previous years' work streams and had agreed seven new ones for the forthcoming year.

The Board had also received a report on the social inclusion model

17 **Exclusion of press and public**

Resolved

That in accordance with Section 100A(4) of the Local Government Act 1972 the press and public be excluded from the meeting for the following item of business as it involves the likely disclosure of exempt information relating to the financial or business affairs of any particular person (including the authority holding that information)

18 **Capital Programme Projects - NHS England**

The Board received a report on the developments with the provision of GP surgeries in Bradley, Bilston Urban Village, The Scotlands and Heath Town

Resolved

1. That the report be received
2. That the report be considered by the Health Scrutiny Panel

Agenda Item No. 6

Health and Wellbeing Board

3 September 2014

Report Title	Summary of outstanding matters
Cabinet Member with Lead Responsibility	Councillor Sandra Samuels Health and Wellbeing
Wards Affected	All
Accountable Strategic Director	Sarah Norman, Community
Originating service	Delivery
Accountable officer(s)	Carl Craney — Democratic Services Officer Tel — 01902 55(5046) Email — carl.craney@wolverhampton.gov.uk

Recommendations for noting:
The Health and Wellbeing Board is asked to consider and comment on the summary of outstanding matters

1.0 Purpose

1.1 The purpose of this report is to appraise the Board of the current position with a variety of matters considered at previous meetings of the Health and Wellbeing Board.

2.0 Background

2.1 At previous meetings of the Board the following matters were considered and details of the current position is set out in the fourth column of the table.

DATE OF MEETING	SUBJECT	LEAD OFFICER	CURRENT POSITION
1 May 2013	Child Poverty Strategy – Timelines, Six Target Wards And Membership Of Stakeholder Workshop	Keren Jones (WCC)	Report to 3 September 2014 meeting
8 January 2014	Certification of Deaths	Ros Jervis (WCC)	Report to a future meeting
8 January 2014	Primary Care Strategy	Noreen Dowd (WCCCG)	Report to a future meeting
	Children's Safeguarding Action Plan – New approach	Emma Bennett (WCC)	Report to a future meeting (via Children's Trust Board report)
8 January 2014	Better Care Bill / Special Educational Needs of Children	Anthony Ivko (WCC)	Report to a future meeting
8 January 2014	Report back from SEND Sub Group	Viv Griffin (WCC)	Report to a future meeting
31 March 2014	Health and Well Being Strategy – Performance Monitoring	Helena Kucharczyk (WCC)	Quarterly reports
31 March 2014	Children's Trust Board – future structure, membership, frequency of meetings	Emma Bennett (WCC)	Report to July 2014 meeting (via Children's Trust

	and terms of reference		Board report)
31 March 2014	NHS Capital Programme – NHS England – GP practices in Wolverhampton	Les Williams / Dr Kiran Patel (NHS England)	Quarterly reports
7 May 2014	Wider Determinants of Health	Further consideration of challenges to ways of working to promote “whole systems” approach.	Report to future meeting
7 May 2014	Better Care Fund	To receive proposals in relation to the governance arrangements	Report to this meeting

3.0 Financial implications

3.1 None arising directly from this report. The financial implications of each matter will be detailed in the report submitted to the Board.

4.0 Legal implications

4.1 None arising directly from this report. The legal implications of each matter will be detailed in the report submitted to the Board.

5.0 Equalities implications

5.1 None arising directly from this report. The equalities implications of each matter will be detailed in the reports submitted to the Board

6.0 Environmental implications

6.1 None arising directly from this report. The environmental implications of each matter will be detailed in the report submitted to the Board.

7.0 Human resources implications

7.1 None arising directly from this report. The human resources implications of each matter will be detailed in the report submitted to the Board.

8.0 Corporate landlord implications

8.1 None arising directly from this report. The corporate landlord implications of each matter will be detailed in the report submitted to the Board.

9.0 Schedule of background papers

9.1 Minutes of previous meetings of the former Shadow Health and Well Being Board and associated reports and previous meetings of this Board and associated reports

Agenda Item No. 7

Health and Wellbeing Board

3 September 2014

Report Title	Health And Wellbeing Board – Forward Plan 2014/15
Cabinet Member with Lead Responsibility	Councillor Sandra Samuels Health and Wellbeing
Wards Affected	All
Accountable Strategic Director	Sarah Norman, Community
Originating service	Communities/Health, Wellbeing and Disability
Accountable officer(s)	Viv Griffin — Assistant Director Tel 01902 55(5370) Email Vivienne.Griffin@wolverhampton.gov.uk

Recommendation

That the Board considers and comments on the items listed in the Forward Plan

MEETING	TOPIC	LEAD OFFICER
3 SEPT 2014 (1230 HOURS)		
	Report from Sub Groups	Viv Griffin / Emma Bennett / Ros Jervis (WCC)
	Better Care Fund – progress report	Noreen Dowd (WCCCG)
	Urgent Care Fund – Equality Impact Assessment	Noreen Dowd (WCCCG)
	Wolverhampton Safeguarding Children Annual Report	Alan Coe (Independent Chair – WSCB)
	Child Poverty Strategy	Keren Jones (WCC)
	Drugs and Alcohol priority update	Ros Jervis (WCC)
	Children, Young People and Families – Strategic Framework	Fiona Ellis (WCC)
	Dementia Care update	Anthony Ivko (WCC)
	Mid Staffordshire NHS Foundation Trust / Cannock Chase Hospital	David Loughton CBE RWNHST
5 NOVEMBER 2014 (1400 HOURS)	**YOUNGER ADULTS THEMED MEETING**	
	Report from Sub Groups	Viv Griffin / Emma Bennett / Ros Jervis (WCC)
	Joint Strategic Needs Assessment (JSNA) – Refresh	Ros Jervis (WCC)

	Implementation of Action Plans following Francis Report – Update	WCCCG / RWHNHST
	Healthwatch Annual Report	Maxine Bygrave (W'ton Healthwatch)
	Children, Young People and Families – Strategic Framework	Fiona Ellis (WCC)
	NHS Capital Programme – Update	Dr Kiran Patel NHS England
	Mental Health Strategy	Sarah Fellows (WCC)
7 JANUARY 2015 (1230 HOURS)	Report from Sub Groups	Viv Griffin / Emma Bennett / Ros Jervis (WCC)
4 MARCH 2015 (1400 HOURS)	Report from Sub Groups	Viv Griffin / Emma Bennett / Ros Jervis (WCC)

To be added at some appropriate point: YOT input JSNA

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Agenda Item No. 8

Health and Wellbeing Board

3 September 2014

Report title	Safeguarding Children's Board Report 2012-13 Report of the Independent Chair
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Wellbeing
Wards affected	All
Accountable director	Sarah Norman, Community
Originating service	Children's Safeguarding
Report to be/has been considered by	Wolverhampton Safeguarding Children's Board 11th February 2014

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1. Provide assurance to Wolverhampton Safeguarding Children Board that the respective agencies represented on the Health and Wellbeing Committee report annually to their respective boards on children's safeguarding;

2. Ensure all agencies represented at the Board have internal assurance mechanisms that can demonstrate their role and performance in relation to safeguarding arrangements for children and young people.

3. Note the report

1.0 Purpose

1.1 The Wolverhampton Safeguarding Children Board and the health and Wellbeing Committee represent the aspects of the partnership agenda of the City and have a responsibility to hold one another to account. This is represented by a formal agreement recently signed by the Chairs of both Boards and is included in the schedule of background papers. The annual report of the Safeguarding Children Board offers a formal opportunity to ensure that this relationship in practice operates in accordance with the protocol. From the perspective of the Children's Safeguarding Board it provides an arena for challenge and an opportunity to seek assurances from members of the Health

and Wellbeing Board that their constituent organisations discuss and review safeguarding at their respective Boards and, where relevant, scrutiny committees.

2.0 Background

2.1 Safeguarding Children's Boards are statutorily required to publish an annual report on the effectiveness of children's safeguarding and promoting the welfare of children in the local area. The Board is a broad partnership of key agencies who have a collective responsibility for safeguarding children and providing mutual assurance that the practice of safeguarding reflects jointly agreed policies and protocols. The board meets four time a year with much of its business conducted through a range of committees that report into the Board. It is expected that annual reports are presented to the Chief Executive, the Leader of the Council, the chair of the Health and Wellbeing Board and the local Police and Crime Commissioner. The annual report describes the combined activities made in respect of children safeguarded at a local level.

2.2 This report relates to the year 2012-13 when the Board was chaired by the previous chair, William Anderson. It was signed off by the Safeguarding Children Board in May. There was some delay in its production due to a number of staff changes within the children's safeguarding service and from key partners who would be required to contribute to the report. It is intended that future reports including that for 2013-14 will be presented to the Health and Wellbeing Board at an agreed timescale on an annual basis.

2.3 There is an executive summary which provides the key activities and highlights key achievements for the reporting year.

3.0 Progress, options, discussion, etc.

1.1 Towards the end of the reporting year, the need for a review of board was recognised. This presented a number of challenges that that have now been addressed, some of these being:

- Review of the Governance arrangements, including board membership
- Clarity regarding agency roles and responsibilities in a climate of significant change
- Revised branding
- Review of the WSCB Committees

1.2 Progress made in the areas mentioned will be covered in greater depth in the 2013 -14 annual report to the Health and Wellbeing Board

4.0 Financial implications

4.1 As this report covers the period 2012 -13, there are no associated financial implications.

5.0 Legal implications

5.1 Health and Wellbeing Boards (HWBB) were established by the Health and Social Care Act 2012. They are intended to be a forum where key leaders from the health and care system work together to improve the Health and Wellbeing of their local population and reduce health inequalities.

5.2 The Children Act 2004 required each local authority to establish a Local Safeguarding Children Board (LSCB). It is the key statutory mechanism for agreeing how the relevant organisations in each local area will co-operate to safeguard and promote the welfare of children and to ensure that these agencies are effective. It operates under guidelines known as 'Working Together to Safeguard Children'; the latest version came into effect from 15th April 2013.

5.3 Outlined in Working Together is the responsibility of the Chair to publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area. As stipulated in the related guidance, the annual report will be submitted to the Chief Executive, Leader of the Council, the local police and crime commissioner and is presented here for the attention of members of the health and wellbeing board.

5.4 Following discussions between the Independent Chair of both Wolverhampton Safeguarding Adults and Children Boards, and the Chair of the Health and Wellbeing Board, it was agreed that there should be a formal agreement outlining this relationship.

5.5 The attached protocol sets out the distinct roles and responsibilities of the Boards, the interrelationships between them in terms of safeguarding, and wellbeing and the means to ensure effective co-ordination between the all Boards.

6.0 Equalities implications

6.1 Within this report covering the period 2012 -13, there are no equality implications. However issues of ensuring a greater understanding of safeguarding children features more prominently in both the 2013-14 report and in current priorities.

7.0 Environmental implications

7.1 There are no specific environmental implications.

8.0 Schedule of background papers

10.1 Annual Report of the Wolverhampton Safeguarding Children Board 2012-13
10.2 Executive Summary
10.3 Joint protocol between Wolverhampton Health and Wellbeing Board and Wolverhampton Safeguarding Children Board.

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Wolverhampton Safeguarding Children Board

ANNUAL REPORT- Summary Version 2012- 2013

Page 1

Most young people in Wolverhampton can and do rely on a partnership of dedicated professionals who they can turn to when they are at risk of or subject to abuse, neglect or exploitation. They have a right to receive the best possible help from teachers, nurses, doctors, police officers, probation officers or social workers. This report describes how they all those people and the agencies who employ them work together and individually to do just that.

This year's report describes what all agencies have been doing individually and together to help young people to be safer. As importantly it says what we are doing in the next 12 months and beyond to further improve outcomes for them. As the independent chair of the Wolverhampton Safeguarding Children's Board, as a resident of the City and as a parent and grandparent I am committed to helping young people feel and be safe. It is a massive responsibility and none of us undertake it lightly. I know my colleagues on the Board and every professional who works with young people here shares that ambition.

Alan Coe

Why do we have a Board and what is an annual report?

Wolverhampton Safeguarding Children Board (WSCB primary purpose is to improve outcomes for children and young people. We have a collective statutory responsibility to monitor and hold all partners to account for their safeguarding arrangements. We produce evidence to demonstrate that the partnership works well together. We want to be sure that we try and prevent children getting into risky situations and ensure they are protected if they do. We also strive to learn from situations where children or young people have needed protection; we are constantly improving ways to identify what works well, what needs to change and what we could do differently together. This is a summary of a much fuller report and highlights what we have done, what problems we have faced and what are plans are for the next two years.

Make up of the Board

The Board's membership includes all the main partners who regularly work together to protect young people. They include the NHS, Council representatives including children's social care Services, The Police, Probation, The Voluntary sector and representatives of representatives of the community. It has an independent chair.

ACTIVITIES DURING THE YEAR

The time of the Board and its member has been spent a number of important areas. They are :

- ensuring that where children and young people are abused the response has been fast and effective;
- making sure more people understand their role in safeguarding young people; and
- improving the way we identify people who are potentially at risk and by intervening and offering support reducing the chances that they will be subject to abuse or exploitation.

Our successes

The full report gives much more detail of what individual agencies and the partnership have achieved. These are a few highlights:

- We have trained staff on a new policy that makes it clearer when children may have reached the threshold for direct intervention to make them safe. This is important as it is essential we know when to try and offer support in a preventative way and also know when we must intervene to protect young people from direct harm.
- We have launched a new protocol for staff about what to do when young people might be subject to sexual exploitation.

- Through a nationally and locally reported conference we have raised the profile of the issue of 'forced marriage.' We are now writing guidance to support help people know what to do if they become aware of the issue.
- There has been city wide training about the dangers of the 'hidden harm' done to children by the substance abuse of adults who are responsible for their wellbeing.

- To assure ourselves that all partner organisations have appropriate measures in place to safeguard children each organisation is asked to audit and report back on what it is doing. We have analysed the response on this and it has informed our work plan for next year. The audit process needs more work before we can totally confident about the consistency and reliability of the responses we have had.

- We delivered multi-agency training at 65 events. This was more than previous years. It was offered to member agencies at a range of venues city-wide.

- *Promoting Safeguarding Week* took place during the week of October half-term. A broad range of agencies , including Health, youth service and children centres celebrated the week by having a stand placed in prominent areas ie, reception areas, and foyers to advertise and promote services and raise the profile of safeguarding

- The Mental Health Trust is raising awareness among its staff working with adults to ensure they are also focussing on children in the family. This has included training sessions and information sheets to ensure children are included in assessments and appropriate action is taken if there are concerns.

- There is improved practice concerning the response to young people who deliberately self-harm

- The Council children's social care services are now increasingly being delivered locally and with partners. Children and their families can now expect easier access to support locally form a wider range of professionals.

Prevention in Partnership

Much work that helps safeguard children and young people is not done directly by the Safeguarding Board. Wolverhampton Domestic Violence Forum (WDVF) launched the City's multi-agency Violence against Women and Girls 3-year strategy and detailed action plan during the year. Its key strands of work are around domestic violence, sexual violence, forced marriage, female genital mutilation, and so-called honour crime.

The work of the Safer Wolverhampton Partnership supports prevention and early identification of people likely to be exposed to danger and abuse. The partnership works with a range of partners to deliver national programmes such as Troubled Families and Hidden Harm. With partners

such as Base 25 the Empower and Inspire programmes have been successful in helping young people increase their self-esteem and confidence and make informed decisions.

Child Protection Activity

In the past year the number of families with children with Child Protection Plans has gradually increased. Interpretation of this statistic is difficult and conclusions are hard to reach. This can be seen as a success if it is the result of better identification of children and young people at risk of or having been the subject of abuse. A decline in economic activity in the city and a rise in associated pressures on individuals and families is thought to be one contributor to any rise.

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Wolverhampton Safeguarding Children Board

ANNUAL REPORT
2012- 2013

Contents

Chairs Introduction

Most young people in Wolverhampton can and do rely on a partnership of dedicated professionals who they can turn to when they are at risk of or subject to abuse, neglect or exploitation. They have a right to receive the best possible help from teachers, nurses, doctors, police officers, probation officers or social workers. This report describes how they all those people and the agencies who employ them work together and individually to do just that.

A whole range of agencies and organisations are represented at the Board. But also we have representatives of the community. We all have a responsibility to ensure we keep children safe by both our own individual actions but more importantly by making sure that the services we represent are always focussed on listening to children and protecting them. I joined the Board in March 2013. As I arrived an external peer challenge to the Board, which we had requested, was underway. It told us that we work well together but needed to feel more confident in constructively challenging one another where we thought children were not being as well protected as they could be. I think we are getting better at that but will be able to say so with greater confidence by the time of our next Annual Report.

This year's report describes what all agencies have been doing individually and together to help young people to be safer. As importantly it says what we are doing in the next 12 months and beyond to further improve outcomes for them. As the independent chair of the Wolverhampton Safeguarding Children's Board, as a resident of the City and as a parent and grandparent I am committed to helping young people feel and be safe. It is a massive responsibility and none of us undertake it lightly. I know my colleagues on the Board and every professional who works with young people here shares that ambition.

Alan Coe

1.1 Overview Report on 2012-2013 from the Board Manager. Communities Directorate: Health and Wellbeing.

This report reflects the work undertaken in 2012/13 by organisations and agencies in Wolverhampton to safeguard and promote the welfare of children and young people and sets out how this will be developed and strengthened in 2013/14.

Wolverhampton Safeguarding Children Board (WSCB) is the statutory mechanism for agreeing how the relevant organisations work together to safeguard and promote the welfare of children and for ensuring the effectiveness of that work. It is required to produce and publish an Annual Report on the effectiveness of safeguarding in the local area. It covers these activities from April 2012 to March 2013 and is the fifth Annual Report of WSCB.

There are contributions from Board members and the chairs of all sub-groups as well as from other partnerships. It also draws on the numerous monitoring reports that are reported to WSCB on a statutory basis e.g. allegations against professionals working with children; private fostering. However, it does not seek to repeat these in full, rather to use them to inform this assessment of the effectiveness of WSCB.

All WSCB members have provided the key achievements and challenges were for their individual agency during 2012-13. These have been collated, and give a good description of what we do and give an idea of the current position in relation to safeguarding in the City.

The Board was established in April 2006. In March 2011 the Board appointed its first Independent Chair, William Anderson, for a period of two years. In March 2013 a new independent chair was appointed, Alan Coe,

The period of this report has seen significant change in personnel, The Head of Safeguarding, Janet Toplis, retired in November of 2012, the Deputy Head of Safeguarding, Liz Norris, who also retired shortly afterwards, in January 2013.
The named Doctor for Safeguarding, Deepak Kalra, also retired at the end of March 2013. The Board thanks them for their valuable contribution to the safeguarding agenda within the City of Wolverhampton.

There is now a new Head of Service for Safeguarding Children, Dawn Williams, who has joined Wolverhampton and brings with her a wealth of experience and knowledge in regard to safeguarding both adults and children , including the functioning of Safeguarding Boards, A separate Business Manager, supports the Board's operational activity and to ensure it works effectively. Under these new arrangements 2013/14 will see a review of Governance, membership, and structure in order to strengthen and improve outcomes for the children and young people of Wolverhampton.

WSCB's primary purpose is to improve outcomes for children and young people and has a collective statutory responsibility to monitor and hold all partners to account for their safeguarding arrangements. Throughout the year, we produce evidence to demonstrate that the partnership works well together. We want to be sure that there is early identification of emerging safeguarding needs and that

they are addressed effectively and responded to swiftly. We also strive to learn from situations where children or young people need protection; we are constantly improving ways to identify what works well, what needs to change and what we could do differently together.

In statutory guidance these functions are referred to as:

- Ensuring the effectiveness of local services safeguarding and child protection
  practice.
- Co-ordinating services to promote the welfare of children and families.

That includes a broad range of responsibilities, from raising awareness of child safeguarding and protection with professionals, volunteers, children, young people and the communities they live in; through to reviewing child deaths and conducting Serious Case Reviews.

WSCB's approved strategic priorities for 2012-2013 included:

Priority 1

To contribute to the consultation about new statutory guidance - Working Together to Safeguard Children 2013,
Performance against this activity: WSCB formed a small task and finish group that undertook a wide consultation exercise in line with the following consultation guidance received. Feedback from the sessions were collated and forwarded to the Department for Education (DFE) within the required timeframe of 4th Septemeber 2012.

Priority 2

To strengthen the local activities for children at risk and those subject to sexual exploitation (CSE); and to ensure provide associated training to raise the awareness of CSE for professionals across the city.
Performance against this activity: in response to the 'Department for Education Tackling Child Sexual Exploitation Action Plan, Wolverhampton has created an operational panel as a 2nd tier reporting directly to the Missing and Compromised Strategic Group to monitor on-going prevalence and response to child sexual exploitation. In addition, a number of awareness raising materials has been devised in respect of child sexual exploitation that can be used by whole workforce and with children and young people, parents and wider community.

Priority 3 Performance Management Framework

To continue develop a robust Performance Management framework and dataset to monitor and improve safeguarding of children and young people across the city. **Performance against this activity**: development and monitoring of the dataset throughout the year has strengthened how information is collated from both

strategic and agency partners, asking the right questions, with sufficient challenge and rigour, and having a robust system that encourages scrutiny of information intelligently which is vital to enable local areas to focus on the impact they make to children and young people's lives.

Priority 4 Risk Management and Early Intervention

To scrutinise the effectiveness of safeguarding arrangements of partner agencies in managing risks to keep children safe, **Performance against this priority:** was monitored under section 11 of Children Act 2004 by way of an -line survey distributed to members measure and monitor compliance and to assure WSCB that across the partnership, there is evidence the required common features that ALL provider of services for children and young people or work with children and young people need to have in place at a strategic and organisational level.

Priority 5

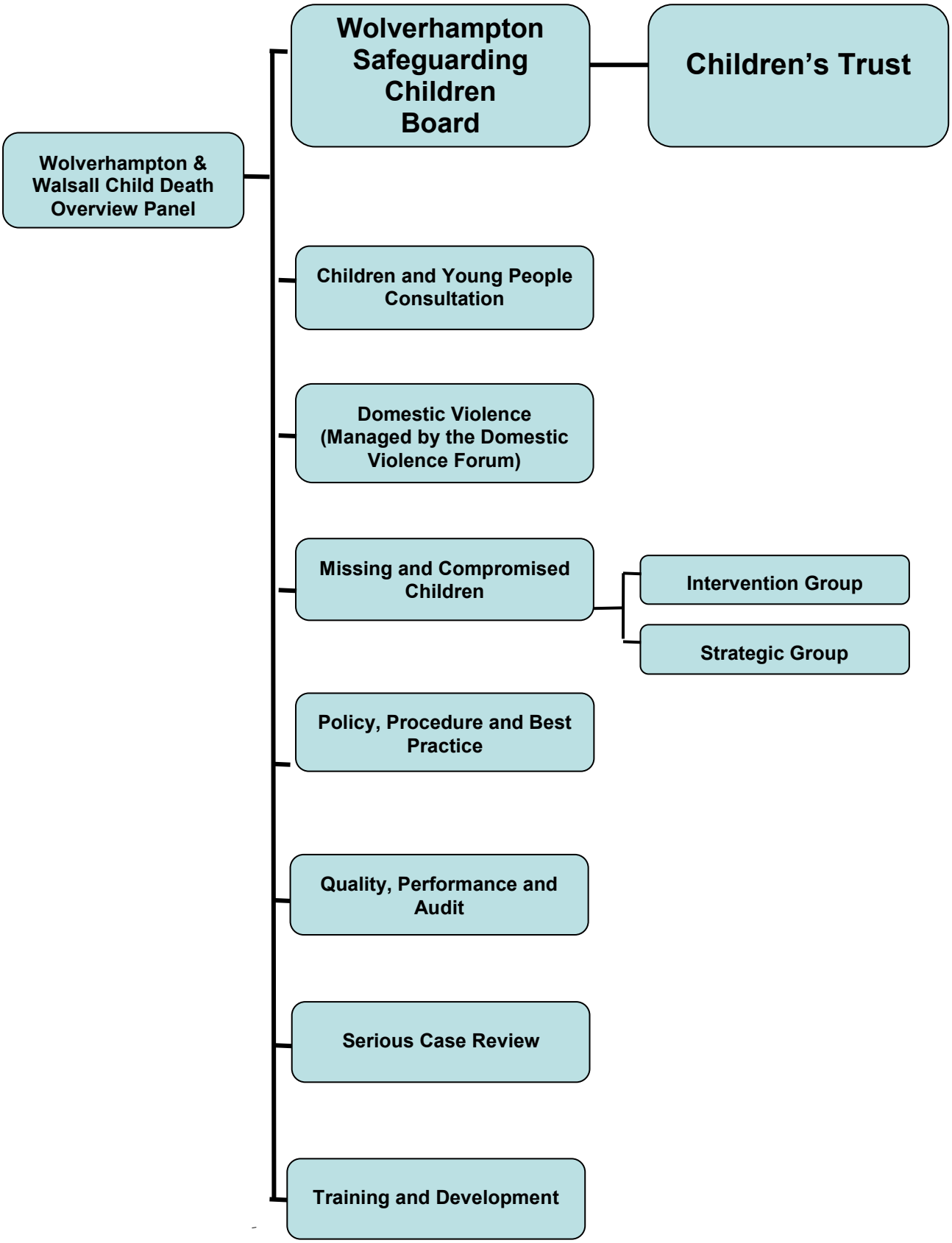
Develop the joint working protocol for assessment, support and case management of children with additional needs in response to the 'Aiming High for Disabled Children' guidance. Performance against this priority: The Safeguarding Disabled Children Practice Guidance 2009 outlines a number of areas where Local Safeguarding Children Boards should consider action, a Task and Finish group was set up to look at the implications of the guidance for Wolverhampton. A number of areas have been identified for development, and work is underway to address the following:

- Same treatment and assessment of a disabled child as of a non-disabled child, when Child Protection concerns arise (but with additional considerations according to need).
- Using interpreters more effectively
- Working together more effectively – all agencies.
- Staff development (ensure communication is effective).
- Equality – enabled to assess children properly.
- Advocacy.
- Involvement of CPS – knowledge of what there is available to assist investigation.
- Training
- Clear joint working protocols for investigation – Disabled Children's Team and Duty and Assessment, clear roles and responsibilities of different services
- Learning disability (child or parent) – communication/ways of working
- Information sharing.

Priority 6

Strengthen the relationships and protocols for engagement between respective Boards: Children's Trust, Health and Wellbeing, Early Intervention, School Improvement Boards and the Wolverhampton Safer Partnership. **Progress against this priority:** Until the time of agreeing this priority, the relationship between CTB, HWB and WSCB exist on an informal basis. However, the government guidance 'Working together to Safeguard Children' published in 2010, describes a more formal approach to the relationships through the publication of a brief set of protocols based on current guidance. A joint protocol was devised and endorsed at each of the respective strategic Boards during 2012

2 **Structure Chart**



3 Make up of the Board

3.1 The Board's membership is in line with statutory guidance. There are also a number of professional advisors to ensure the Board has the relevant advice and guidance to deliver its duties to the full. Advisors are from key agencies and/or have lead responsibilities within their respective agencies for safeguarding, and child protection in the city.

3.2 There have been changes in representatives during the year. Despite this, the Board maintains a clear focus on safeguarding and improving outcomes for children in the city.
Throughout the year, representation has been as follows:

- Independent Chair – William Anderson for the period 1st March 2011 to 28th February 2013
- Independent Chair – Alan Coe – from March 2013

3.3 **Core Members and Funding Partners**

- Vice Chair: Head of Probation, Staffordshire & West Midlands Probation Trust, Wolverhampton LDU: Neil Appleby
- Assistant Director of Nursing, NHS Walsall/BCC Lead for Quality and Effectiveness: Sally Roberts
- Cabinet Lead Member: Councillor Sue Constable
- Deputy Chief Nurse – Transformation and Workforce – RWHT : Mari Gay
- Designated Doctor, Safeguarding WCPCT/ RWHT: Dr Deepak Kalra
- Designated Senior Nurse, Safeguarding Children: Mandy Viggers, WCCCG/RWHT
- Director for Children and Young People Services – Black Country Partnership Foundation Trust (BCPFT): Sue Marshall
- Executive Lead Nurse- Wolverhampton city CCG; Manjeet Garcha (from Jan 2013)
- Head of Nursing, Education and Development-NHS –Lynn Fieldhouse (from Nov 2012)
- Named Doctor, Safeguarding, RWHT: Dr Deepak Kalra , Consultant Paediatrician
- Operations Manager, Prospects Connexions: Rosemary Robbins
- Senior Police Officer, Wolverhampton : Jane Parry, Det. Chief Inspector for Public Protection Unit for West Midlands Police
- Senior Police Officer- Superintendent for local policing, Wolverhampton: Jan Thomas-West
- Service Manager for Early Intervention, CAFCASS: Jonathan Leadbeater

Other Partners

- Assistant Director - Children and Family Support : John Welsby
- Assistant Director – Health and Wellbeing; Vivienne Griffin (March 2011)
- Base 25: Janet Meredith, Project Co-ordinator (Rosemary Robbins)
- Chief Children's Service Officer -Trust, Partnership Development Safeguarding and Youth: Rob Willoughby

- City of Wolverhampton College: Lesley Cross, Student Support Manager
- Early Years, Wolverhampton Head of Service: Julia Spencer
- Head of Service, Safeguarding : Janet Toplis(upto Sept 2012)
- Head of Service, Safeguarding : Dawn Williams(from Dec 2012)
- Head of Youth Offending Team (YOT), Wolverhampton: Sally Nash
- Independent Schools Representative: Vincent Darby, Headteacher, Wolverhampton Grammar School
- Local Education Authority, Primary Schools Representative; Sarah Hay, Headteacher, Eastfield Primary School.
- Local Education Authority, Senior Schools Representative: Ann Brown, Headteacher, Westcroft Sport and Vocational College.
- Principal Inspector – Schools Skills and Learning(formerly Quality & Improvement Directorate) : Keith Martin
- Strategic Director, Community : Sarah Norman
- Strategic Health Authority West Midlands: Helen Hipkiss, Programme Consultant- Children Services
- West Midlands Ambulance Service : Julie Ashby-Ellis, Head of Safeguarding
- West Midlands Fire Service : Mike McKee, Station Commander
- Wolverhampton Domestic Violence Forum: Kathy Cole-Evans, Strategy Co-ordinator
- Youth Organisation Wolverhampton: Stephen Dodd , Co-ordinator

Professional Representatives/ Advisors to the Board

- Deputy Head of Service, Safeguarding: Elizabeth Norris
- Head of Children in Need and Child Protection, Wolverhampton: Andy Campbell
- Legal Department , Wolverhampton City Council: Tracey Christie, Assistant Solicitor
- Training Co-Ordinator, Wolverhampton: Gillian Ming

Lay Advisor

- Rimpi Bhagat
- Anne Marie Salmon

3.4 **Attendance at WSCB Meetings**

Agency	**% Attendance over the year Apr12 - Mar13**
Chair WSCB	100
Assistant Director – Children and Family Support	86
Assistant Director- Health and Well Being	43
Assistant Director of Nursing Quality and Safety - NHS	14
Assistant Director – Safeguarding, Business Support and Community Services	100

Cabinet Member for Children and Young People	71
CAFCASS	0
Children's Safeguarding Service- (HOS)	100
City of Wolverhampton College	29
Connexions	86
Designated Doctor for Safeguarding	43
Designated Senior Nurse for Safeguarding Children WCPT/RWHT	86
Director of Children & Young People's Services – BCPFT- NHS	43
Domestic Violence Forum	71
Early Years	29
Executive Lead Nurse - WCCG	0
Head of Community Safety - WCC	100
Head of Nursing & Midwifery Education and development	100
Independent Schools	57
LEA Schools - Primary	57
LEA Schools - Secondary	71
Named Doctor, Child Protection RWHT	71
Principal Inspector –Education WCC	43
Probation	100
Strategic Director for Community	43
Strategic Health Authority	0
West Midlands Ambulance Service	0
West Midlands Fire Service	43
West Midlands Police	100
YOT	86
YOW	100
Professional Advisors:- Children in Need and Child Protection Children Safeguarding Service – (Deputy head) Legal Department WSCB Business and Training Manager	 57 57 0 100
Lay Advisors R Bhagat A Salmon	 0 29
WSCB = 6 Development Day = 1	

4 ACTIVITIES DURING THE REPORTING YEAR

4.1 The period between April 2012 and March 2013 has been a busy one. The following emphasises the activities undertaken with some indicating towards developmental potential moving forward:

4.2 Promoting Safeguarding Week took place during the October half-term and was attended by a number of agencies engaging with members of the public. Included during the week were representatives from the following agencies:
Base 25
Youth Service

4.2 The Child Sexual Exploitation (CSE) Protocol was launched in January 2013, in response to the guidance issued by Department for Education in November 2012. The event was attended by 68 delegates from a range of services across the city receiving presentations from, West Midlands Police, Base25, Empower Project, the Transition and Safeguarding Service

4.3 A Forced Marriage Conference, Jointly organised by both Adult and Children safeguarding Board, West Midlands Police, the Forced Marriage national charity, Karma Navana, Birmingham Legal Services and Judge Cardinal took place in February 2013 . The event was attended by 150 delegates and attracted attention from the National & local press and television stations and raised the profile of issues relating to Forced Marriage. Jasvinder Sanghera and 'Yasmin' from Karma Nirvana spoke movingly about their experiences of forced marriage. Other speakers included His Honour Judge Cardinal, Detective Sergeant Trudy Runham from West Midlands Police and Chaz Akoshile from the Forced Marriage Unit. Solicitor Monika Bindal from Birmingham City Council and Kathy Cole-Evans from Wolverhampton Domestic Violence Forum also contributed to the day.

Jasvinder Sanghera (Karma Nirvana) is pictured here
With Judge Cardinal, Kathy Cole-
Evans (Wolverhampton Domestic Violence Forum)
Monika Bindal (Solicitor)
Dawn Williams (Head of Children's Safeguarding),
Penny Darlington (Head of Adults Safeguarding)

4.4 A 'Cross Border Safeguarding in Faith' Event, organised and hosted by Dudley Safeguarding Children Board, was jointly facilitated by the WSCB training coordinator and the Youth Opportunities Wolverhampton (YOW) manager. This event was attended by faith groups from both Wolverhampton and Dudley.

4.5 WSCB was instrumental in the organisation of the Anti-Bullying Conference that took place in January 2013 for young people from primary, secondary and Pupil Referral Units. A total of 156 young people attended. The day

included a number of workshops, two of which covered safeguarding matters, both these workshops were oversubscribed, and the feedback from young people suggested that they wanted more involvement and a voice in safeguarding matters, this will be picked up and explored further within the development of the Junior Safeguarding Board.

4.6 The WSCB were actively involved in the development of early intervention work within the city and the threshold policy was refreshed by the Policy and procedures sub-group. In turn, the WSCB led on a number of threshold training sessions across Wolverhampton.

4.7 The Cry Peace annual community event, organised by the youth service was this year attended by members of WSCB to raise the profile of safeguarding and to engage with some of the 'hard to reach' groups in the City.

4.8 The work to develop a Junior Safeguarding Board has continued and alongside devising 'postcards' that have been distributed to all schools, a number of other events has been attended and young people are now putting themselves forward to become members of a junior board.

4.9 **Reviews**

In March 2013 the Local Government Association (LGA) were commissioned to conduct a peer review of safeguarding services for children and young people in the city. The review team was made up of members from other local authorities who acted as, "critical friends". The team spent a week in Wolverhampton assessing how well we performed against a set criterion.

Although the Peer Review was not an inspection, the process provided the Council and our partners with an in-depth overview of the safeguarding arrangements, whilst highlighting a number of strengths, there were also areas for improvements. It was a supportive but challenging process which helped us to recognise what we were doing well, and also where change is needed.

During 2012, the Board agreed to undertake a significant incident review by way of testing out a alternative 'systems' model that was developed and piloted by SCIE (Social Care Institute for Excellence) . The approach taken was favoured by Professor Eileen Munro, for testing out alternative models for carrying out systematic reviews.

During this annual report period the WSCB progressed with a SCR in respect of a child who died in 2011 and In January 2013 a new SCR was commissioned following the death of a child in the summer of 2012.

4.10 Audit Activity

4.10.1 **Section 11 Audit**

The Board issued Government's response to the Laming Inquiry placed a duty on all agencies to ensure that they safeguard children and young people and have appropriate measures in place and that responsibilities are clearly set (Section 11 Children Act 2004). In response to this, the section 11 audit disseminated to partners in July 2012 to form part of the evaluation to measure the effectiveness of safeguarding arrangements of agencies represented on the Board. It used a web based questionnaire and asked Board members to complete on behalf of their individual agency. Responses received were clear and relatively easy to correlate, however, there were areas of information that was lost and some aspect was said to be too time consuming.

The actions in the 2011/12 Business Plan are now complete and were signed off at the WSCB Development Day in April 2012.

5 Reports outlining the activities from WSCB Sub-groups

5.1 Policy, Procedure and Good Practice

Terms of Reference

- To review, amend and update all policy and procedures on a regular basis as necessary
- To support partner agencies in developing their own protocols and ensure that they comply with policies and procedures of Wolverhampton's Safeguarding Children's Board.
- To ensure multi-agency procedures comply with "working together" and review procedures in light of any changes to this working document.
- To review as necessary thresholds for working with Children in Need.
- To review as necessary the procedure for conducting Section 47 enquiries and associated Police investigations including circumstances where joint enquiries are necessary and or appropriate.
- To review policy and procedures in respect of children who move between local authorities.
- To seek the views of children and ensure these are considered and clearly promoted in policies and procedures.
- To develop and support good practice across agencies.

Objectives for 2012/13

1. Sub group members wrote the city's threshold policy and on its publication organised and delivered multi-agency training to launch the policy (first half of 2012).
2. In response to the sub group's on-going review of the WSCB procedures manual, Sub group members wrote the Strategy Discussion/Meeting policy update which was accepted by the board in February 2013.
3. The sub group oversaw the development of the following multi-agency guidance

5.2 **Hidden Harm – Parental Substance Misuse and the effects on children. (12. 03 2013).**

Impact for Children and Young People

1. The publication of the Threshold policy and subsequent city wide multi-agency training of staff has seen an increase in not only the number of Common Assessment Framework (CAF) assessments being completed but also the number of agencies completing them. More multi-agency teams around children are therefore being established closer to the point of additional needs arising so allowing for earlier offers of help to children and their families.
2. The strategy discussion/meeting policy update sets out clearly the multi-agency approach required when considering whether or not a child is suffering significant harm. Since this update it has become routine to involve the Duty Paediatrician in Strategy discussions which hitherto had not been the case.
3. Children need their parents to understand how their capacity to parent is undermined by substance misuse. This guidance supports staff to assist parents towards that aim and in turn supports children of substance misusing parents. In addition the guidance highlights the importance of improved collaboration between adult agency staff and children agency staff.

5.3 **Quality & Performance**

Brief Terms of Reference

- To enable Wolverhampton Safeguarding Children Board to scrutinise performance across agencies in terms of child safeguarding activity.
- To assist constituent agencies to assure their child safeguarding activity.
- To develop and sustain a multi-agency approach to audit.

Objectives for 2012/13

- Ongoing development of multi-agency child safeguarding dataset and pursuit of lines of enquiry based on the data presented.
- Embedding of multi-agency case file audit process.
- Oversight of section 11 of review for all constituent agencies, designed to audit and then improve their safeguarding capabilities.

5.4 **Serious Case Review Subgroup**

Brief Terms of Reference

The Serious Case Review Sub Group was established as a standing group to advise the Chair as and when a Serious Case Review or Independent Management Review should be undertaken, to review outcomes from Serious Case Reviews, to monitor Action Plans, to design briefing training for

Serious Case Reviews. It is also to undertake review of case which do not meet the criteria for a serious case review and identify areas for improvement and to consolidate areas of good practice and disseminate the learning from these.

Objectives for 2012/13

To maintain a watching brief on case management and to establish where and when Serious Case Reviews or Management reviews should be undertaken.

Maintain an overview of recommendations from recent SCR and Management Reviews and ensure Action Plans are completed with evidence base of actions.

5.5 **WSCB Strategic Sexually Exploited Missing and Trafficked (SEMT)-** Formally Missing & Compromised Sub-group

Brief Terms of Reference

- Assure the WSCB that service provision is co-ordinated effectively to identify, protect and safeguard victims and potential victims of CSE and compliant with child protection procedures.
- Ensure WSCB have an overview of the scale and profile of CSE victims and those frequently missing from home or care.
- Ensure WSCB have oversight of a CSE offending profile, vulnerable locations and disruption/enforcement plans.
- Deliver and embed the CSE Strategy in Wolverhampton including a cohesive offender disruption/enforcement plan.
- Recognise emerging themes repeat locations, individuals, communities and co-ordinate a multi agency response

Objectives for 2012/13

The aim was to reinvigorate the strategic SEMT meeting which had lapsed due to changes in some key personnel. The Group reconvened on the 7th of March when the current chair was elected, and have met in total three times to date. (23rd August 2013).
The objective was to drive the CSE Strategy that was launched in February 2013 and ensure that this was in synergy with the Regional CSE Strategy. To oversee the Operational SEMT Panel work and ensure that those frequently missing from home were also subject of safeguarding intervention through the SEMT panel.

Overview:

The CSE Strategy has been revisited to ensure that it is fit for purpose. There is a short life Task and Finish group reviewing the TOR and operating model of the Operational SEMT.

A CSE Performance Framework, Risk Assessment; Information sharing Protocol; Workforce Induction Pack and Data Collection tool have been agreed for implementation once ratified by the WSCB.
Governance has been established with the strategic group overseeing the operational work and reporting to the WSCB on a six monthly basis commencing in November.

There was agreement to devise a Service Level Agreement between the WSCB and Base 25 regarding current services provided to support victims of CSE.

During the fiscal year of 2012/2013, 450 Wolverhampton children and young people were reported missing to West Midlands Police; 96 of those were missing for more than 24 hours. Future reporting to WSCB will provide a breakdown of the number of repeat missing episodes, and identify whether the child or young person was missing from home or residential care.

5.6 **Training and Development- Encompassing Single and Inter- Agency Training**

Brief Terms of Reference

In addition to the common WSCB sub-committee terms of reference the sub-committee operates:

- To support the identification, planning, delivery and effectiveness of local Safeguarding Children inter-agency training programmes via the guidance of existing training and workforce strategies, the findings of research and enquiry and lessons learnt from case review.
- To ensure that the delivery of training is relevant to and representative of the needs of the local community and encompasses issues of equality and diversity.
- To ensure that where possible training is informed by the views and experiences of service-users.
- To work within the budgetary requirements of the Board and to submit business reports to the Board in accordance with need.

Objectives

- To identify areas of work needing to be undertaken and make recommendations to the WSCB through the Chairs Executive Committee.
- To facilitate prioritisation of the work in line with the work programme and inform WSCB of any identified gaps and new areas for development.
- To maintain links with existing sub-committees and working groups in order to ensure collaborative attention is paid to Safeguarding Children matters.
- To develop and monitor effective consultation mechanisms with service members and users.

- To complete reports, monitor and make recommendations to WSCB on learning opportunities and activities.

Achievements 2012 / 2013

- Throughout the defined year a programme of multi-agency learning and development was delivered on behalf of WSCB and for member agencies who engage in local service provision to children, young people and their families across the city.

- The programme covered a broad range of subject areas which incorporated eighteen face to face themed topics and resulted in the delivery of sixty-five events.

- The total number of courses and places made available within the annual programme was in excess of the previous year's activity, and a level of oversubscription for certain courses occurred.

- The multi-agency programme is well-established and has a good reputation as has been reflected in the feedback and findings from course evaluation to date. Consultation events, including feedback from the Peer Review which took place in March 2013 also supported the understanding that the training opportunities provided by WSCB to the workforce have been appropriate and valued.

- Courses available were in line with local priorities and up-dated during the year to both respond and reflect issues raised via media spotlight, outside-of-area case reviews, findings of research and the directives of overarching policy and guidance.

- The WSCB website does not just offer information, but is now the host for booking on to all WSCB courses, receiving post course feedback, and populating certificates.

- '***Promoting Safeguarding Week'*** took place during the week of October half-term in partnership with other key agencies whose sphere of work contributes to keeping children and young people safe from harm and abuse. In addition, other agencies, including Health, youth service and children centres celebrated the week by having a stand placed in prominent areas ie, reception areas, and foyers to advertise and promote services and raise the profile of safeguarding work of there were a number in order to continue to build upon the existing works.

Impact for Children and Young People

- The overall programme of work as undertaken by the Training and Development Sub-Committee, has served to support and enhance the knowledge, skill and competency of a multi-agency workforce in the context of both operational and strategic activities and across a broad topic area. The overall aim of such work has been to serve the needs of

children and young people, to build the trust confidence in having a workforce in who they can rely inn terms of their individual and collective safety and well-being.

- As effected during the preceding years, attention has been paid to raising the level of public awareness and understanding that ***'Safeguarding Children from Harm and Abuse is Everyone's Business'***, and with the aim of enhancing local communities' contribution that enables children and young people to be safe from harm and abuse.

Looking forward brief overview of work anticipated for 2013 /2014

The focus of the work of the Training Sub-Committee for the forthcoming year is as follows:

- To support WSCB with the overall business priorities and to pay attention to the specific elements of the programme of work that relate to the learning and development of the local multi-agency workforce.
- To continue to contribute to the learning, development and education of the multi-agency workforce on Safeguarding Children matters via a streamline programme of training activities that reflects the identified priorities.
- To liaise and communicate with the community and representative groups on their engagement in the business of safeguarding children and young people.
- To ensure there is a clear communication route between the training sub, and other sub-groups to furnish the programme of activities.
- To ensure the learning from the findings of local and outside-of-area case reviews are disseminated to the workforce to enhance city-wide practices.
- To develop a robust relationship with Adults Safeguarding in terms of aligning courses which cross over and to both areas of work.
- To continue to monitor the impact of multi-agency training through a series of pre and post course evaluation process to ensure both value for money and there is an identifiable impact on practice.

5.7 Violence against Women and Girls

Wolverhampton Domestic Violence Forum (WDVF) launched the City's multi-agency Violence against Women and Girls 3-year strategy and detailed action plan during the year. Despite its name, which mirrors the name of the Government's strategy, the strategy covers women and girls, men and boys, as victims and perpetrators. Its key strands of work are around domestic violence, sexual violence, forced marriage, female genital mutilation, and so-called honour crime.

Violence against women and girls and particularly domestic violence (DV) remains a high volume community safety and safeguarding children issue for Wolverhampton. In line with the general economic downturn there has been a rise in reported domestic violence to specialist agencies, with the number of DV incidents reported to Wolverhampton Police in continuing to be around 5000 during 2012/13.

In 2013/14 there were 360 domestic violence victims identified at very high risk of serious harm or homicide, with 405 associated children. Fortnightly multi-agency risk assessment conference (MARAC) arrangements took place to jointly assess and develop integrated action plans to reduce the level of risk to these victims and their children. Twice weekly meetings continue to take place at Wolverhampton Domestic Violence Forum's co-located multi-agency team to undertake crisis intervention and safety planning for very high risk victims that come to the attention of agencies between the fortnightly MARAC meetings.
There were 1882 domestic violence cases involving children and pregnant children referred to WDVF's co-located multi-agency team during the year. These cases were jointly risk assessed and screened by a Children's Social Worker, Safeguarding Nurse, Child Protection Police Officer, and Independent DV Adviser. Alcohol continues to be a significant factor in domestic violence cases, acting as both a dis-inhibitor for violence, and an inappropriate coping mechanism for both victims and perpetrators. Nationally the cross-over of these two issues is known to be between 50-75%. There were 376 cases involving children or pregnant women where alcohol was already recorded on the files as a significant factor in the violence (20% of the total number of jointly screened cases where there are children and pregnant women).

Wolverhampton Domestic Violence Forum worked alongside the Safeguarding Children Board and the Safeguarding Vulnerable Adult Board to host a highly successful conference on Forced Marriage and Honour Based Violence. The conference raised awareness of these issues, and identified a number of themes to be driven forward through WDVF and the Safeguarding Boards. These include raising awareness in schools, and developing joint children and adult protocols for dealing with forced marriage and honour crime.

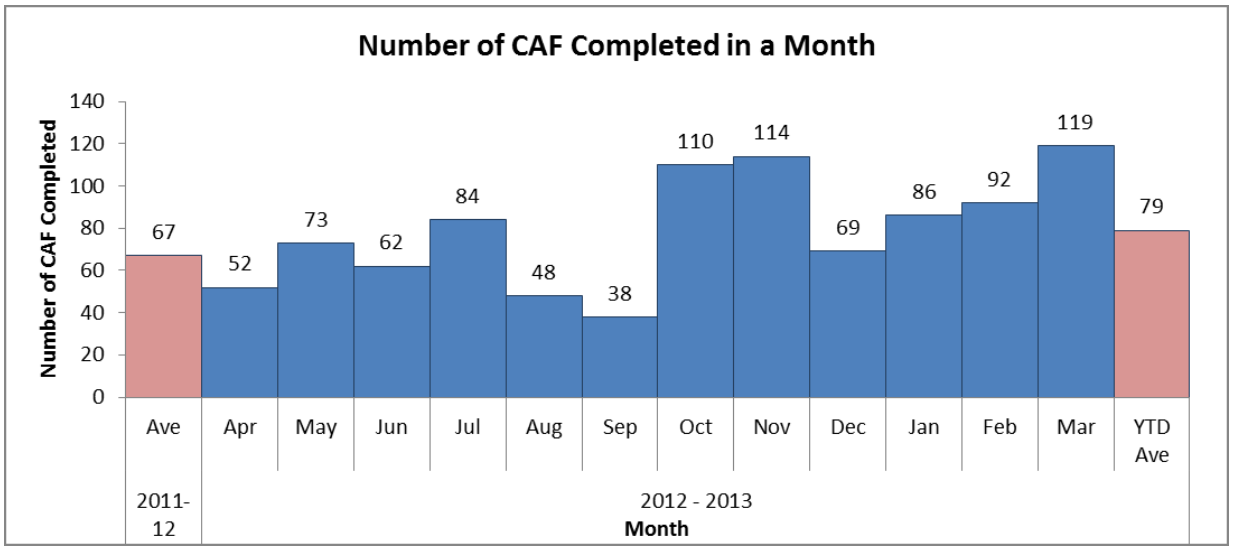
SWP's Domestic Homicide Review (DHR) Panel completed and submitted to the Home Office one domestic homicide review during the year. The Home Office DHR Quality Assurance Panel commended the partnership on a thorough report. There were 24 strategic recommendations arising from the review, in addition to individual agency recommendations from Internal Management Reviews.
Wolverhampton Domestic Violence Forum and Women's Aid successfully attracted Home Office funding for two shared resources between Wolverhampton and Sandwell to work with girls and young women around the Ending Gang and Youth Violence agenda. Work has continued with the Safeguarding Children Board to develop care pathways for public sector and third sector organisations to work with this group of young women and girls around the child sexual exploitation agenda.

The quality of services for victims of sexual assaults has been improved by the new Sexual Assault Referral Centre (SARC) service provider contract. There has been a significant rise in demand for the services of Wolverhampton Domestic Violence Forum's newly re-established Independent Sexual Violence Advisory (ISVA) Service during the year. The ISVA forms a critical element of the care pathway for victims of sexual

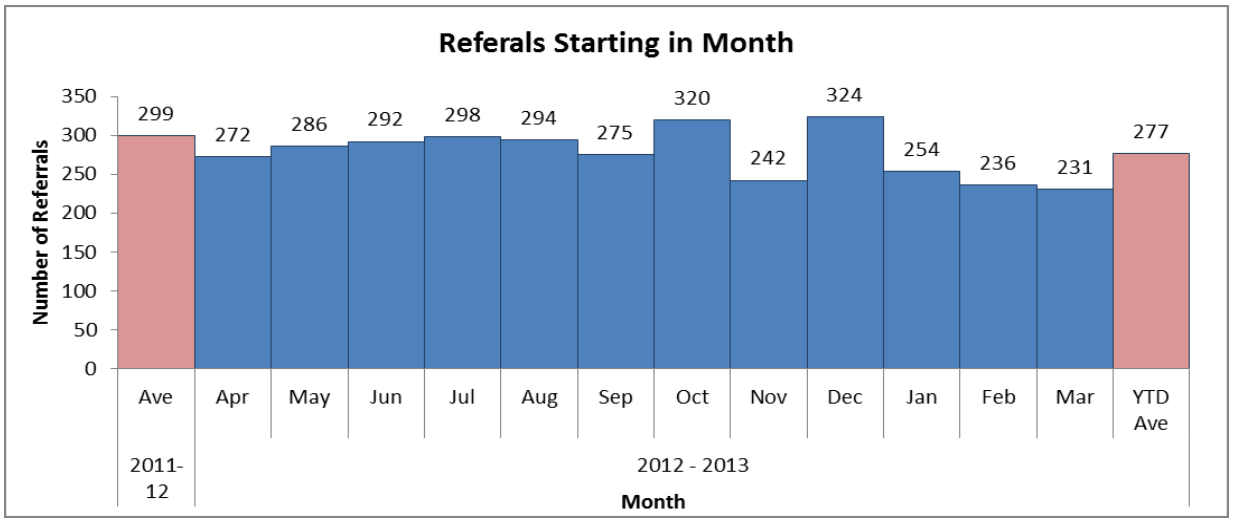
violence above the age of 13 years accessing the SARC's services, and/or criminal justice proceedings.
Priorities for 2013/14 include:

- Driving and monitoring delivery of the 24 strategic recommendations arising from Wolverhampton's Domestic Homicide Review.
- Delivering the City's Violence Against Women and Girls Strategy action plan.
- Strengthen existing arrangements by putting in place a MARAC Operating Protocol and Overarching Domestic Violence Protocol for Wolverhampton.
- Building on the 2012/13 work to develop systems and criteria to better integrate very high risk MARAC domestic violence cases into existing priority and prolific Integrated Offender Management arrangements.
- The Partnership has invested in piloting and evaluating the use of video badge cameras for domestic violence cases in order to capture better evidence, drive up the early guilty plea rate, bring more offenders to justice, and safeguard victims.
- Reducing the attrition rate of domestic violence cases.

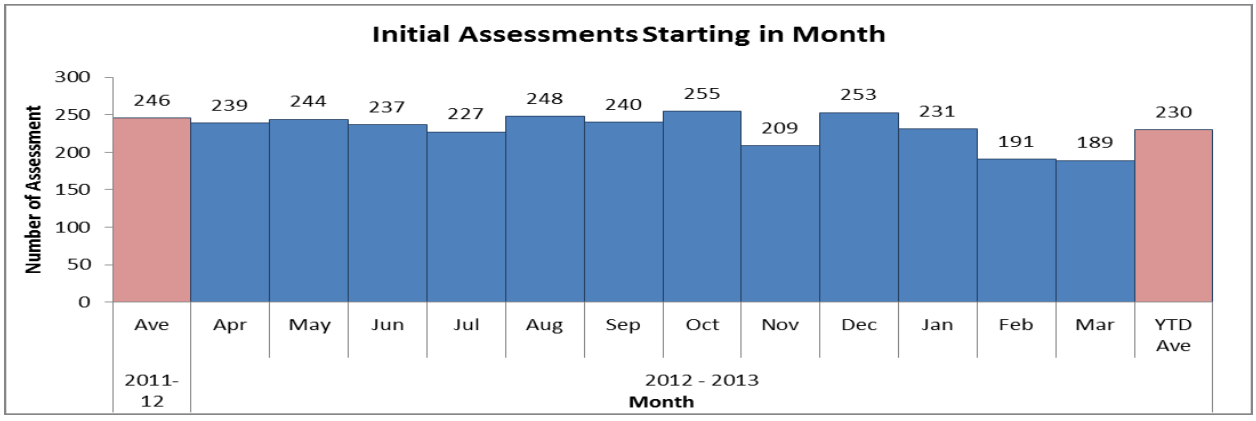
6. LAC & CP Statistics for the year 2012-2013



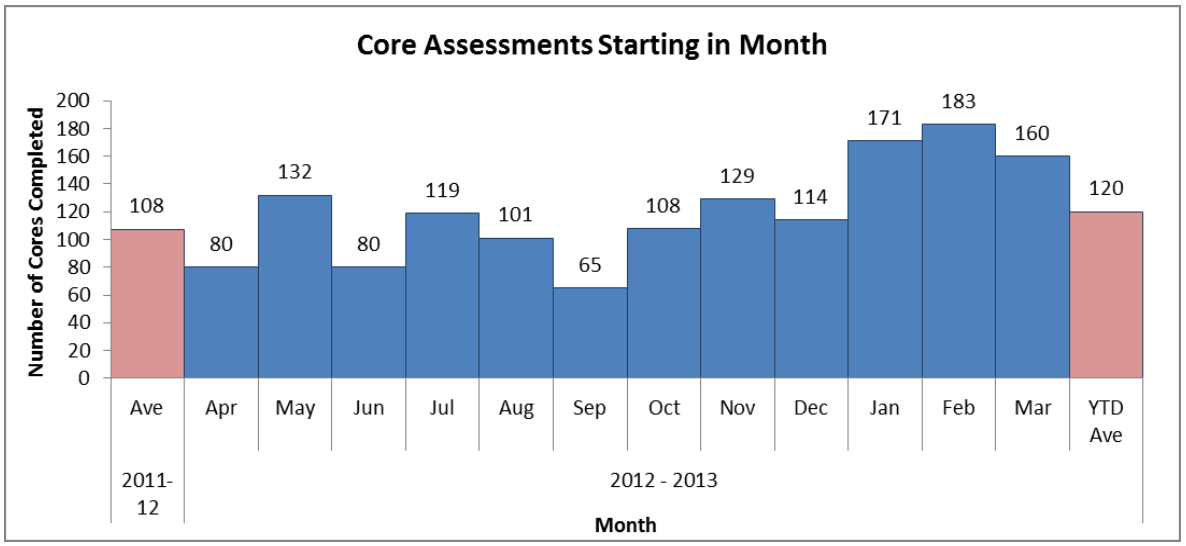
The chart above shows the number of CAF completed for each month in 2012-2013. The figures fluctuations across the financial year but show a peak in October, November and March. The year to date average number of CAF's (79) is above 2011/12 out-turn (67) and marginally above the current target of 77 hence there has been an improvement.



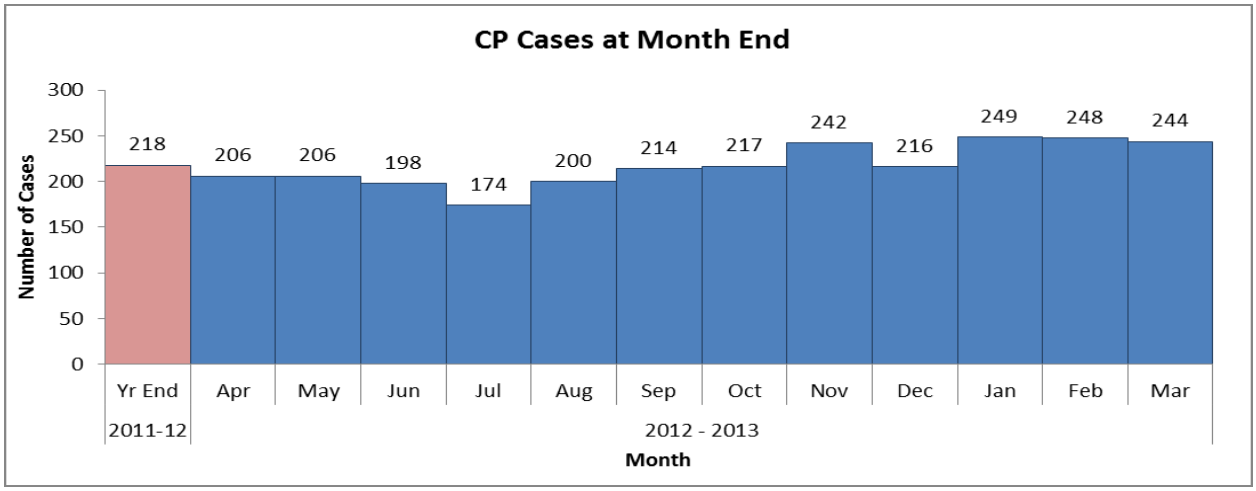
The chart above shows the number of new referrals received in a month has remained relatively constant over the period except a marginal increased in October and Dec.



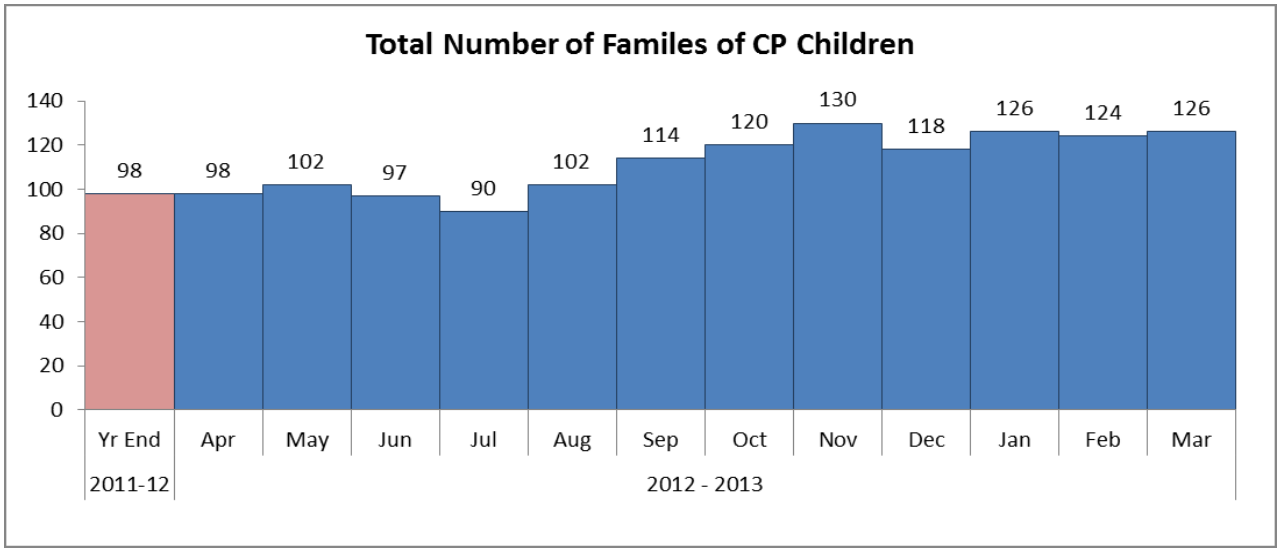
The Chart above shows the number of initial Assessment completed in each month of the year. The figures shown similar patterns to that of the referrals which makes statistical sense since the figures show 83% of referrals in the year went on to have an Initial Assessment completed.



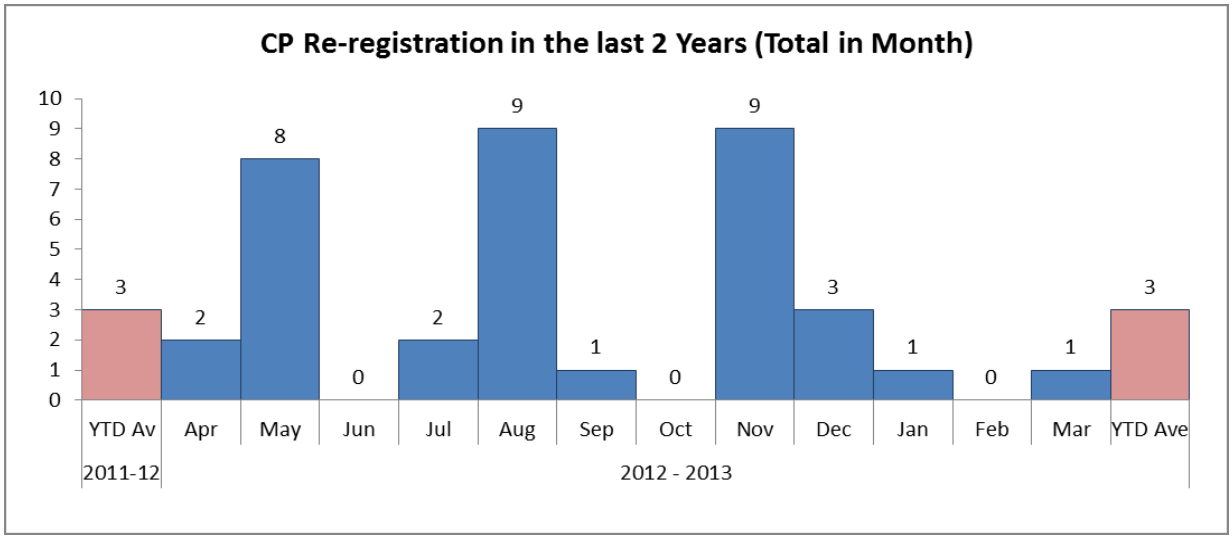
The chart above shows the number of Core Assessments carried out in each month of the year. The figures as shown above fluctuate around relatively small margins over certain months but the increase is significant in 3 successive months from January to March. Also, year to date average is slightly higher than last year's out-turn average.



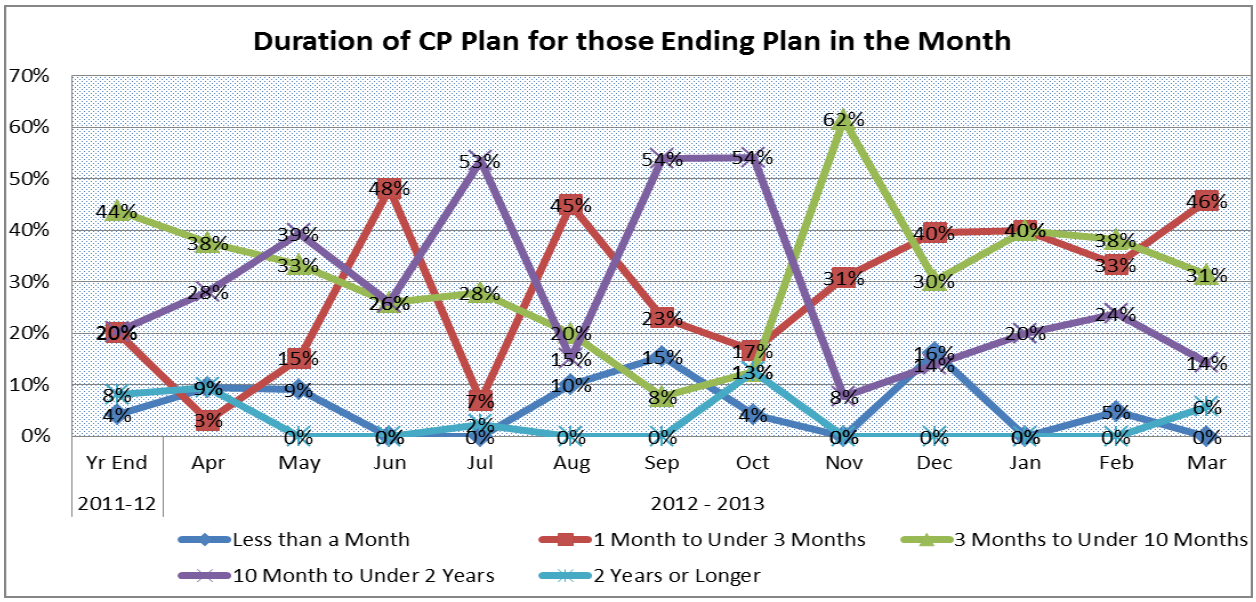
The Number of Children with a CP plan at month end has remained relatively constant at the start of the year till November when it gradually increased, declined in December and again increased but at a declining rate for 3 months from January.



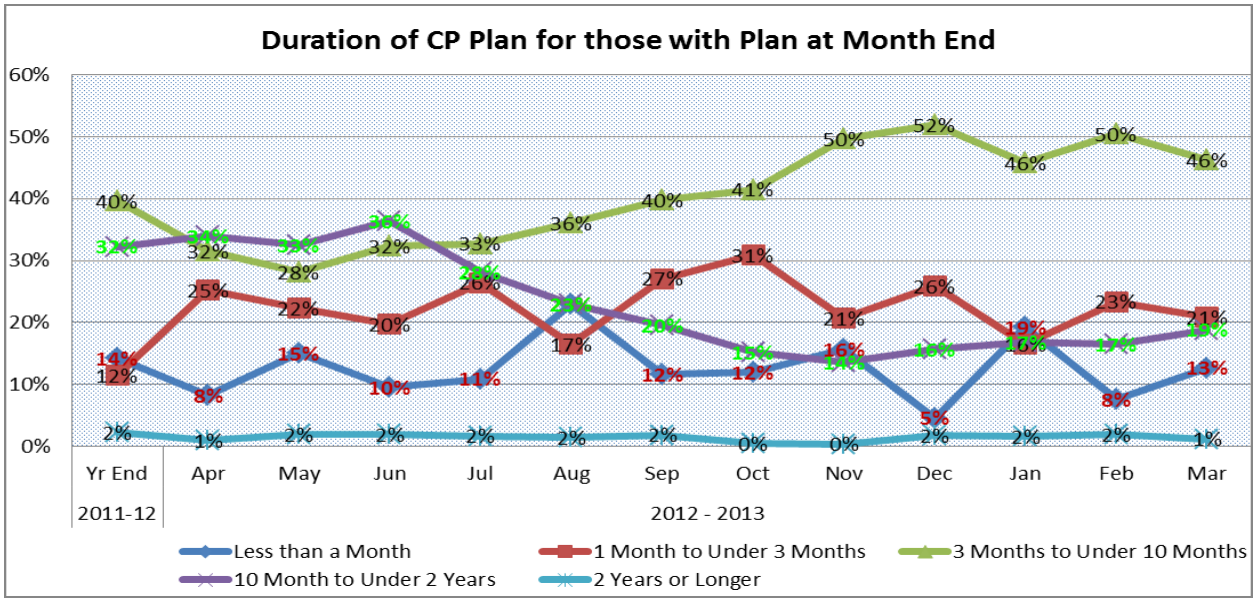
The Number of families with children with CP plans has gradually increased over the financial year from a minimum of 90 families in July to a maximum of 130 in November which is approximately 31% increased. However considering the figures at year start and end the increase is approx. 22% which is still significant.



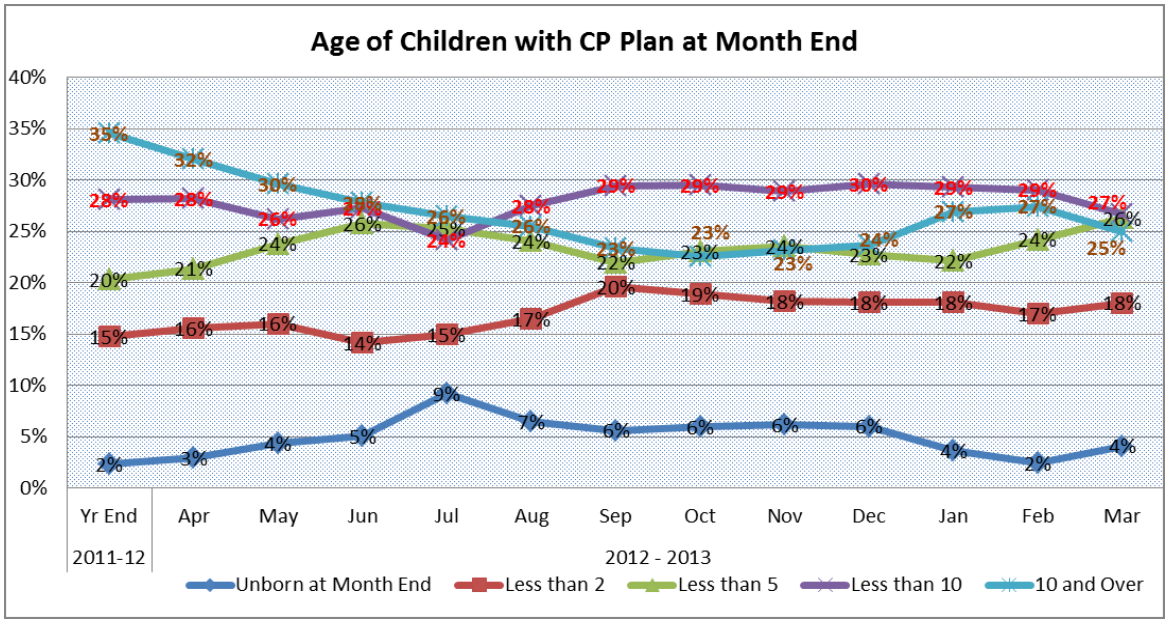
The year to date average (3) is equal to the last year's average of 3. However the is a significant rise of CP re-registrations in May, August and November. However it is worth noting that the number of sibling group can have a significant bearing to the figures ant the highest figures in those 3 months could be attributed to such issue.



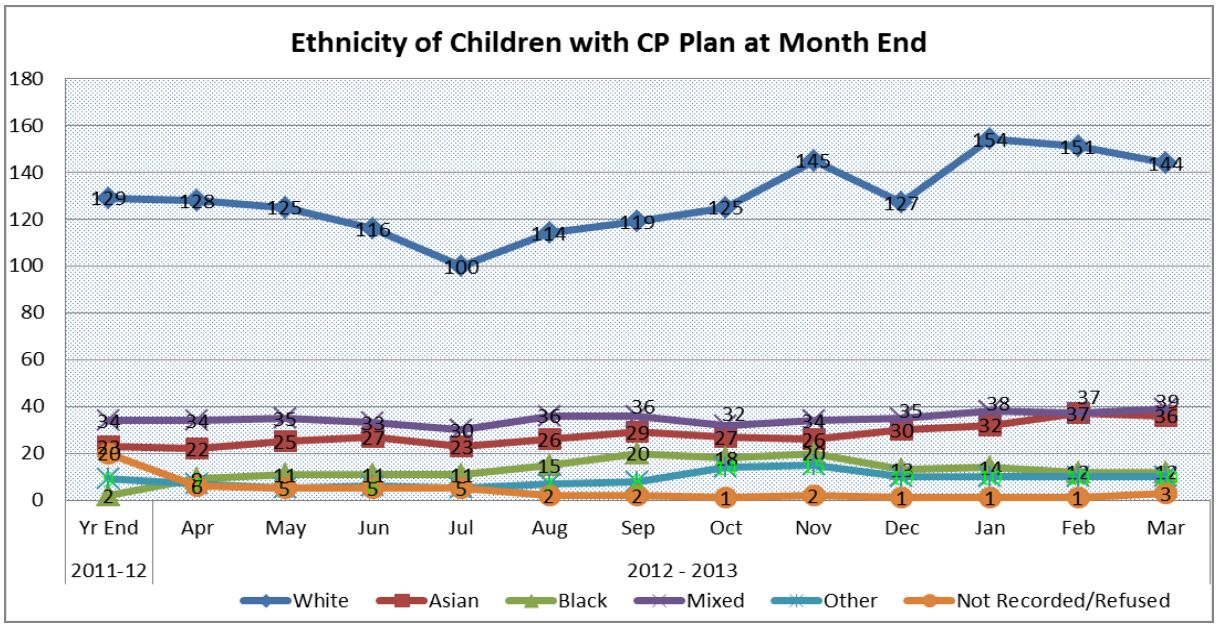
According to the chart above there are relatively fewer Child Protection Plans that ends under a month or over two years. The highest proportion in one single month is 3 to less than 10 months category which ascended to 62% in November but dropped to 31% in March. The most frequent highest category is 10 months to less than 2 years.



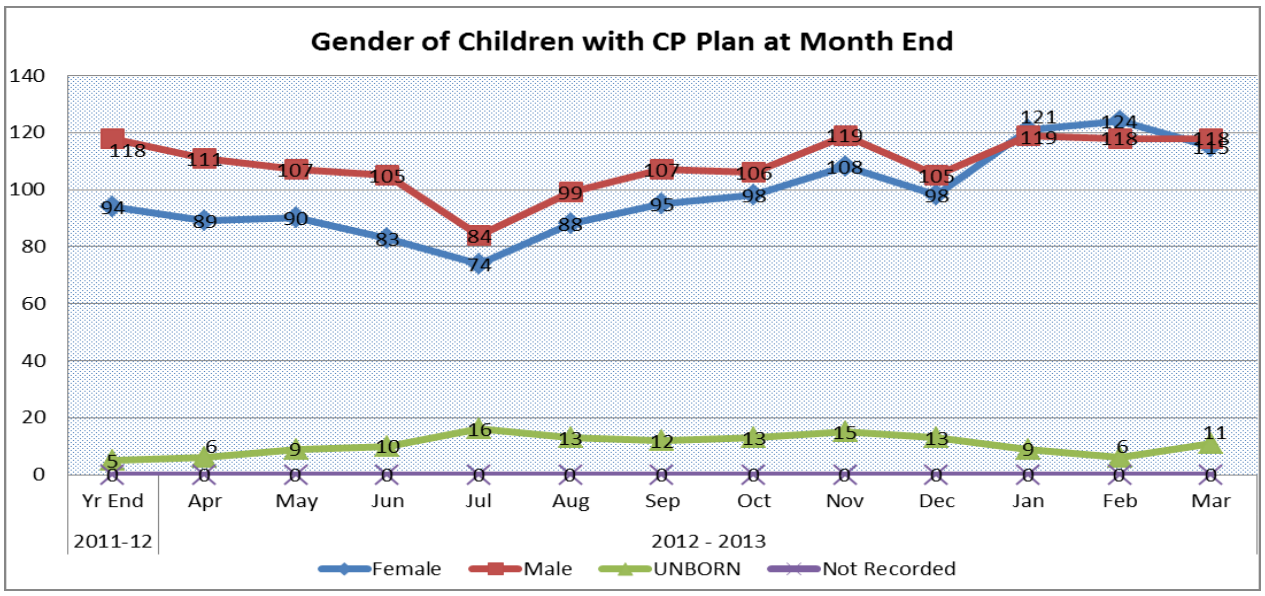
Majority of CP Plans last between 3 month to under 10 months which gradually increased over the year as illustrated in the chart above. The second most consistent higher category across the financial year is (1 month to less than 3 months) duration category. Fewer than 3% CP plans last more than 2 years and relatively smaller percentage of CP plans last less than a month.



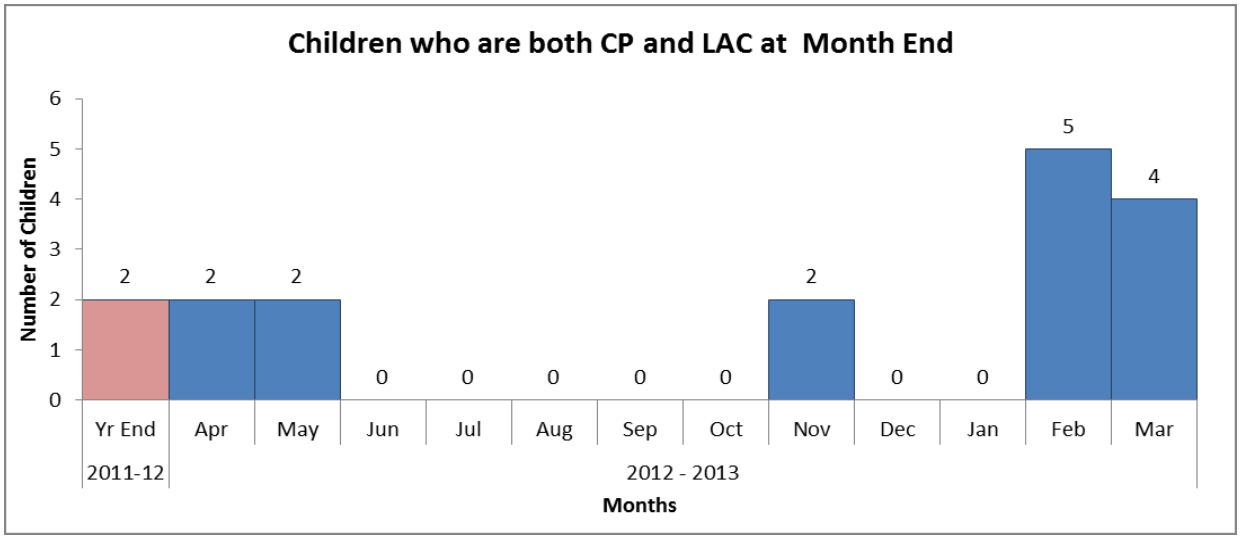
The proportion of children aged less than 10 years with a CP Plan has gradually increased over the year whiles those 10 and over years declined at the beginning of the years but slightly increased in January and February. The under 2's and less than 5 categories according to the chart are diametrically opposed - when under 5's is going up the under 2's is going down.



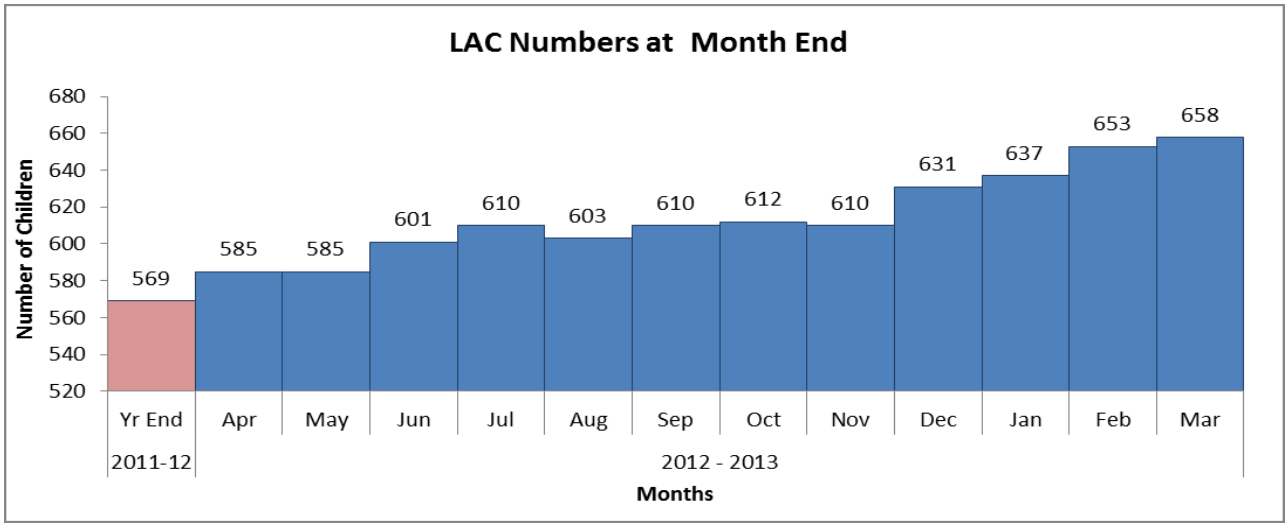
As clearly illustrated above, the highest numbers and with a significant margin of CP cases are from a white ethnicity background followed by mixed ethnicity. The number of "Not Recorded/Refused" ethnicity category has decreased over the course of the year.



The figures above show that there are consistently more Males than Females who have had CP plan during the course of the year except for January and February where there are slightly fewer males than females. The number of Unborn gender has gradually increased over the months but decreased at the same time that the Male/Female numbers have gone up which could be attributed to the fact that some children are born and the gender recorded.



The number of children with both CP and LAC has remained flat lining either at nought or 2 except towards the end of the financial year and in Feb/Mar where the numbers climb to 5 and 4 respectively.



The chart above shows that LAC numbers have fluctuated around insignificant margins at the start and during the course of the year up till December when the numbers consistently increased over the rest of the financial year.

7 Agency Contribution to Wolverhampton Safeguarding Children Board Annual Report 2012/13

7.1 Agency: Base 25 - Empower

Objectives for 2012/13

Empower Programme – Overall aim is: To reduce the number of young people in Wolverhampton aged 11 – 16 that are being/or are at risk of being sexually exploited

Specific aims are to:

- **Increase referral rate of male clients.**
- **Increase overall referral rate.**
- **Implement new comprehensive holistic assessment.**
- **To improve the early identification of young people at risk.**
- **To increase self-esteem of young people.**
- **To increase confidence of young people.**
- **To improve young people's ability to make informed decisions**

- **Additional aims for young people are to:**
  - Increase knowledge around healthy relationships.
  - Increase knowledge around staying safe.
  - Increase knowledge around the grooming process.
  - Improve knowledge of sexual health.
  - Improve knowledge around protective behaviours.

Achievements against the Objectives :-

- **Increased overall referral rate**
  - Over 2012/2013 the referral rate increased from an average of 2 per calendar month to 5 per calendar month.

- **To improve the early identification of young people at risk.**
  - Increased number of referrals made to Empower
  - Increased number of agencies referring to The Empower Project

- **To increase self-esteem of young people**
  - Young person's self assessment Richter score of self esteem has improved.
  - Workers assessment of young person's self esteem has improved.
  - Overall Identity and social relationships vulnerability score improvement in Empower young people.
  - Parents and/or professionals perspective positive feedback of young people's improved self esteem.

- **To increase confidence of young people**
  - Willingness to attend sessions.

- Ability to participate in sessions.
- Willingness to explore new ways of thinking.
- Parent and/or professional perspective.

- **To improve young people's ability to make informed decisions**.
- Reduced vulnerability scores have been evidenced in all young people that engaged in the project.
- Parent and/or professional perspective has shown an improvement in the decisions made by young people.
- Changes that the young person has made in their choice and relationships have been evidenced in the clients engaged with Empower.

Regarding additional aims:

- Increased knowledge around healthy relationships.
- Increased knowledge around staying safe.
- Increased knowledge around the grooming process.
- Improved knowledge of sexual health.
- Improved knowledge around protective behaviours.

The following progress has been achieved:

- Young person's understanding in relation to the sessions has improved
-
- Workers perception of the young person's knowledge has also increased.
- The young person's vulnerability score has reduced in all clients.

Improvement Plans where barriers have existed.

Increasing male referral rates has been a difficult area to improve on, so from September we will be working in conjunction with BLAST to analysis our service and increase referral rates with male clients.`
Most of our referrals are for white British clients, Empower would like to increase the referral rate within other ethnicities, so plans are in place to approach faith groups to attempt to make links, and continue to raise all professionals' awareness around CSE as it is still widely a hidden harm.

Objectives for 2012/13

Inspire Programme – Overall aim is to: To reduce the involvement of Young people aged 10 – 18 from participating in gang related activity

Specific aims are to:

- **To increase self esteem**
- **To increase self confidence and emotional resilience**
- **To improve young people's ability to make informed decisions**
- **To increase self awareness and sense of identity**

- **To minimise harm to self and others.**

The majority of the girls/young women involved in inspire have had 1 to 1 structured programmes of work developed with them around: relationships, exploitation, learning about gangs, grooming, local area gangs, sexual health, confidence and self-esteem, staying safe, protective behaviours, self-presentation and communication skills

Achievements against the Objectives :-

The project is measuring outcomes in a variety of ways; this process includes feedback from young people, those affected by their behaviour and professionals. At various stages during the individual programme the worker will review and evaluate progress with the young person, this is captured through various assessment tools, case notes and evaluation forms. A summary of these outcomes are included below against the specific aims.

- **To increase self esteem (aim to increase)**
  - Most of the young women completed the Warwick and Edinburgh Mental Well-being scale and saw an increase of between 12% and 19% in their well-being score.
  - Indicators of change for the older girls were identified in what they said, changes in their behaviour and through the perceptions of the workers regarding their observations. These changes included them being more positive about who they were, an increase in the regularity regarding their appointments, a more positive attitude to sticking to curfew times, a positive change in their personal presentation, a more accountable attitude towards their responsibilities (their accommodation, conditions relating to being on Tag, child care responsibilities) with more optimism shared about the future.
  - The girls in school also demonstrated an increase in self-esteem, this was demonstrated more around their attitude towards the relationships that they were in and what was going on with their relationships at home. They also spoke about a change in the way that they thought about themselves and in their approach to relationships with the boys that they were attracted to. They spoke more about respecting themselves and changes in their attitudes towards engaging in sexual relationships.

- **To increase self-confidence and emotional resilience**

  - All girls showed an increased enthusiasm in talking about themselves to the workers and through the process, demonstrated an ability to take on board alternative perspectives and explore new ways of thinking. The older more chaotic girls demonstrated increased confidence in the way that they thought about their individual situations, making more positive decisions to change the difficult and complex situations that they were faced with.

- The younger girls on the programme also demonstrated an increase in confidence. This in particular was demonstrated in their ability to take responsibility for themselves and in their willingness to explore new ways of thinking. Most of the girls had strong entrenched views about what they wanted and this was very much focused around being associated with a gang and being 'protected' by a male that had a 'reputation'. These 'views' have changed and the young women have spoken openly with workers about these issues.
- The workers have both been effective in engaging with the girls regarding their emotional well-being and emotional resilience. They have enabled the girls to express themselves in a number of creative ways. One of the older girls in particular used a process of developing a 'comic strip' to relay what was going on in her life. By utilising a number of creative approaches and enabling the girls to have an opportunity to talk about their anxieties or concerns has enabled the girls to develop trusting relationships. These relationships have been important in building a foundation of trust for the girls in both professionals and more concisely, with adults; something that has previously been missing at home due to the negative impact of parents. This means that the young women are now able to utilise positive support to improve their social conditions because of the positive 'role modelling' provided by the workers.
- Through this process, the girls have been able to talk about their feelings and have demonstrated ability in managing upsets and disappointments. Both workers involved in delivering the Inspire project are experienced at delivering work around anger management and these skills have been utilised in the work delivered with these girls. In particular, work around attitudes, values and beliefs using 'icebergs' (commonly used in CBT) has enabled some of the girls to explore some of their learnt behaviour (from home, often about the use of violence, anger, control, patriarchy and gender roles) in order for them to develop some useful strategies around managing their anger and expressing themselves in a more positive way.

- **To improve young people's ability to make informed decisions**
  - There has been considerable impact regarding the decision making processes of the girls engaged in the programme. All of the girls to some degree have demonstrated an ability to make better informed decisions. The programmes of work developed for the girls have enabled them to increase their knowledge on topics that are relevant to them and have provided them with the opportunity to test out their decision making in relation to these topics through conversations and simulation type exercises. This has impacted positively in the girl's attitude and decision making around the use of social networking and meeting/forming relationships with boys/men where there are indicators that they might be being groomed. The choices that the girls are making about relationships and their attitude towards having sex have changed. The girls have shown more motivation towards school and in engaging in positive activities.

- **To increase self-awareness and sense of identity**
  - Through the programmes developed for the girls, concepts of self and identity have been explored at all stages across all of the thematic areas. The girls have been able to locate themselves within the context of their own lives and have demonstrated an awareness of those that have influence on them and how they influence and impact on others. This has also impacted on their confidence, self-esteem and their ability to make decisions. The girls have shown ability to empathise with others and an understanding around their own emotional literacy with regards to how others make them feel.
  - Most of the girls were desperately trying to fit in and feel part of a group. Gangs represented to them a sense of 'belonging' offering protection and stimulation. A lot of work developed with the girls was around deconstructing these concepts. The girls have demonstrated an understanding of the realities of the gang lifestyle and have identified alternative perspectives on 'belonging' and 'being a part of something'.

- **To minimise harm to self and others. (aim to decrease)**
  - A lot of the thematic work has been delivered around sexual health, exploitation, grooming, drugs and alcohol misuse, crime, violence and engaging in gang related activity. This has positively impacted on the behaviour of the girls involved in the programme. Most have demonstrated a change in attitude towards relationships, with all of the younger girls demonstrating a more confident approach and positive attitude towards staying safe. In particular there was a greater awareness around grooming and the process of being exploited.

Improvement Plans where barriers have existed.

To develop closer links with partner organisations delivering around the EGYV agenda.

Impact for Children and Young People

- ***At the start of the programme, one girl aspired to be pregnant with a male that belonged to a gang, this attitude changed by the end of the programme with her showing motivation to wanting to do better at school'***

- ***'At the start of the programme, one girl demonstrated a negative attitude, she wouldn't think twice about physically assaulting and taking from others, justifying her actions. This changed towards the end of the programme. She started to show some empathy towards others and started to take responsibility for her own actions. This was demonstrated by her commitment to stay away from the negative influences that were impacting on her previous behaviour and by abiding to the conditions of her Tag'***

- ***'One girl that was in a relationship at the start of the programme ended the relationship towards the end of the programme when she realised that the relationship that she was in was an abusive relationship'***
- ***'One girl recognised that she had anger issues and was motivated to want to address these issues in a constructive way. She was happy to be referred on to the anger management programme for additional support'***
- ***'Three of the girls involved in the Inspire programme have made decisions to be more responsible about their sexual health; this has resulted in them being supported to attend the GUM clinic and seek contraceptive advice'***
- ***'One of the girls was asked to look after a weapon, she chose to bring the matter to the attention of the worker; it was then reported to the police'***
- ***'One of the girls that openly gave out personal information on a popular social networking site has since changed her settings so that her personal information is now restricted'***
- ***'One girl on the programme justified her use of violence as being a reflection of how she had previously been treated. She later acknowledged that her experiences where her 'own' and they made her feel a certain way. She understood that her use of violence was a negative way for her to channel her emotions'***
- ***'One girl that was involved with a negative group of boys that engaged in smoking cannabis and low level crime had an epiphany moment towards the end of the programme. Through dialogue with the worker she realised that the validation that she was getting from these boys only served to make her feel bad about herself after she'd been with them; she realised that they were using her. She later chose to join a group at school that offered her a different and more positive sense of belonging.***
- ***'One of the girls was being encouraged to move down South to work in a bar belonging to a friend of a friend that was also offering to accommodate her. The risks regarding the move were explored with the worker and the girl herself reached the conclusion that the move might be unsafe'.***

Objectives for 2013/14

- To continue delivering against the key aims of the project.
- Without early intervention, there was enough indication that these girls were at greater risk of being vulnerable to be exploited and groomed in to gangs and becoming teenage parents. To continue at a stage of early intervention
- The individual tailored programmes of 10 sessions worked better with the younger girls. To continue developing this process of engagement.
- The individual tailored programme of 10 sessions was less effective with the older more chaotic girls; a more reactive approach appeared to be most effective although this impacted on more time being needed to deliver the

high intensity work. To explore different methods of sustaining the work with older teens.

- The glamorisation of gangs in popular culture has been identified as a motivator for girls wanting to be involved in a gang. In particular, the focus was around being in a relationship with a gang member. There is a clear need for educative work to deconstruct the discourse around the glamorisation of gangs and the gender role of gang members. To develop further.
- Girls from family back grounds where there was violence or severe dysfunction were identified as being more at risk of being attracted to gangs. To explore further.
- School was identified as a key partner in the work being effective. To continue developing the relationship with the pastoral staff in schools
- More research on female involvement in gangs is clearly needed to identify any significant trends. To continue monitoring.

Objectives for 2012/13

SAFE Programme – Overall aim is to: To reduce the number of young people aged 11 - 17 from using domestic violence

Specific aims are to:

- **To increase self esteem**
- **To increase self confidence and emotional resilience**
- **To improve young people's ability to make informed decisions**
- **To increase knowledge on topics of relevance**
- **To minimise harm to self and others.**

Achievements against the Objectives :-

The project is measuring outcomes in a variety of ways; this process includes feedback from young people, those affected by their behaviour and professionals. At various stages during the individual programme the worker will review and evaluate progress with the young person, this is captured through various assessment tools, case notes and evaluation forms. A summary of these outcomes are included below against the specific aims.

- **To increase self esteem (aim to increase)**
  - Mean average increase of **12.2%** in well being score for those engaged through 1 to 1 programmes
  - Mean average increase of **11.8%** with those worked with through a group work programme
  - Young people commented on an increase in positive friendships

- **To increase self confidence and emotional resilience**
  - Emerging themes from professionals, parents and young people involved in SAFE have included: Improved confidence and self-esteem:

Improved communication; Increased involvement in positive activities and ability to manage anger better.

- **To improve young people's ability to make informed decisions**

  Emerging themes from professionals, parents and young people involved in SAFE

  - have included: Making better decisions demonstrated by improved attendance and punctuality at school; improved behaviour in school; choices being made around their negative behaviour and friendship groups

- **To increase knowledge on topics of relevance**
  - Emerging themes from professionals, parents and young people involved in SAFE have included: Improved knowledge in topics of relevance

- **To minimise harm to self and others. (aim to decrease)**
  - Mean average decrease of **17.7%** in risk factor score for those engaged through 1 to 1 programmes
  - Mean average decrease of **5.6%** with those worked with through a group work programme
  - Emerging themes from professionals, parents and young people involved in SAFE have included: Less violent; Managing anger better; Using less abusive behaviours

Improvement Plans where barriers have existed.

As there has been a low turn out for group work programmes, they will now be delivered in the localities nearer to the client group to enable better attendance

Impact for Children and Young People

<u>Feedback demonstrating impact</u>

Young people involved in the individual programmes have provided written feedback regarding their progress on the SAFE programme:

- *"More confident talking to more people" "Less angry"*
- *"I have become more aware of how I react to things"*
- *"Started to accept mom's boundaries" "Less fall outs with mom and step-dad"*
- *"Less controlling with brother and sister" "Learnt how to put a time out in place"*
- *"Happier, less worked up" "More confident and less angry" "react better towards others"*

- *"Don't shout at mom" "Not as jealous of sister" "don't use physical violence"*
- *"Don't get angry as much" "Don't shout and have stopped throwing things when angry"*
- *"More relaxed" "Do more for myself and stopped being violent to others"*
- *"Caring more about school and what to do in future life"*
- *"Great experience talking to a professional"*
- *"Worker helped me to be more calm with mom and have fun with sister"*
- *"I could talk to the worker about how I feel"*

Feedback from professionals, parents, careers and extended family

- ***"I strongly feel that if ***** had not received support from the worker, then his controlling behaviour would of got out of control and it would have been a down ward spiral for both him and his mother – potentially leading to very bad situation"***

  Feedback taken from a letter from auntie

- ***"I have noticed a huge improvement in his behaviour; he now walks away from potential volatile situations with his mother. He tries to diffuse it using techniques the worker has introduced to him in order to control his anger/temper"***

  Feedback taken from a letter from family member

- ***"I feel he has been abducted by aliens and someone has given me a different son"***

  Mother talking about the SAFE work at a CAF meeting with other professionals

- ***"Hats off to Base 25 as teachers have noticed improvements in his behaviour and he is excelling in lessons and attendance has improved and is above 85%," "This preventing***
- ***legal action being taken and reducing addition pressure on the family"***

  Feedback from educational welfare officer in a CAF meeting

- ***" ********* has informed me that he is learning a lot from the worker and feels that he has someone that he can talk to"***

  Feedback from Dep. Head at a Child in Need meeting (CIN)

- ***"The support given to the family regarding the ***** boys has been of real help, the on-going support is of real benefit to the boys and is enabling them to focus at school"***

  e-mail from head of year

Objectives for 2013/14

- To continue delivering against the key aims of the project.
- Education (Schools and MAST) have continued to be most instrumental in referrals (50% in total). To explore a broader range of referral sources.
- MAST area's 1, 2, 7 and 8 have represented the largest number of young people accessing the programme. To monitor and explore trends.
- Moms have featured for the first time as a source of referral utilising the internet to find out about the service. The project will monitor this new trend.
- Learnt behaviour around domestic abuse continues to be the main indicator for those referred into the programme. The project has however identified new indicators that are focused around obsessive behaviours and parents that are unable to exercise legitimate parental role authority. To monitor and develop responses to these new indicators
- The project has consistently worked with an average of 19 new young people over each 6 month period totalling 57 young people worked with to date. To maintain this output
- The main target group engaging in the programme continues to be from the Bushbury, Lowhill and Scotlands area although Bilston is emerging as an area producing an increased amount of referrals (although this can be explained by group work being delivered in this locality). To monitor
- The target group continues to be 13 and 14 year old white British boys although there has been a considerable increase in the number of 11 and 12 year olds and 13 year old girls accessing the programme. To monitor and explore further the trend in girls accessing the programme
- The project will have an increased focus on working with the younger age group as an early intervention appears to enable better outcomes.
- Individual interventions are proving to be more effective than group work interventions. This is demonstrated through a higher decrease in the mean average risk factor score being achieved through the individual work.

7.2 Black Country Partnership NHS Foundation Trust

Objectives for 2012/13

1. To continue to raise awareness of safeguarding children responsibilities within both Child and Adult Mental Health (AMH) Services

2. To promote early help and the identification of children who may be acting as carers through the CAF process.

3. To ensure that all staff are confident in the safeguarding process and are aware of who to contact for support

4. To develop systems whereby safeguarding professionals can easily access data that identify:
    - whether our mental health (adult) clients are parents/carer's
    - how many of them have children who are receiving support due to the impact of their mental health difficulties on parenting capacity.
    - when children are acting as carers for the adult or other family members due to parent's incapacity

5. Ensure that all recording systems and assessments are set out clearly and in sufficient detail to establish children's needs and risks.

6. **I**mprove the working relationship and understanding of roles between child/adult mental health services and children's social care.

7. To monitor and sustain recommendations made within adult and child mental health services resulting from IMR's and SCR's

8. To continue to utilise the identified 'Safeguarding Links' within the teams for feedback and dissemination of information.

Achievements against the Objectives :-

1. Staff have attended Level 3 training where responsibilities are clearly outlined. Training passports have been handed out to support staff in monitoring their training needs and outline what is expected of them. The BCPFT Child Protection Policy (CP) has been amended and is awaiting ratification. Safeguarding Supervision is offered by the Named Nurse, and a data base is being set up to ensure this is carried out in line with the Supervision Policy (BCPFT). The Named Nurse receives copies of invites to Child Protection conferences, so is able to monitor attendance. Feedback from practitioners, suggest that involvement of adult mental health practitioners within child focused meetings, (from CAF to CP conferences) has increased.

2. The Named Nurse has worked with the CAF lead to deliver overview sessions as there has continued to be some confusion/lack of confidence in the process. These are based on staff being able to come to the sessions with questions that are then worked through, rather than a structured session. It also focuses on not simply identifying early

signs that may indicate the child's welfare may be affected by parents mental health difficulties, but to then reflect and act appropriately.

3. A safeguarding information sheet has been added to both the Needs and Risk Assessment for all AMH staff to access should they want to contact the Safeguarding professionals in Wolverhampton or other relevant agencies. A link to the CAF website has also been added to ensure staff can gain easy access at the time assessments are being completed. The Named Nurse attends the weekly Crisis Meetings at CAMHS to ensure there is consistent support from a safeguarding perspective.

4. Work has commenced to add documents to the electronic system (Care Notes) in order to try to capture current safeguarding activity. This has initially been set up to identify children on a child protection plan, and will include an element of monitoring and reporting. It includes questions that will identify if children and young people are acting as carers for parent(s) or siblings.

5. A significant amount of work has been done to include questions about children in assessments, care plans across both child and adult services. We are incorporating safeguarding into internal supervision templates as a basis to monitor compliance and ensure children focus in discussions. Compliance is also being monitored through a current audit of both electronic and paper documentation. This work is on going.

6. All referrals to Children Services are faxed to the Named Nurse who will monitor as required. Staff have been encouraged to chase social care for feedback as generally no contact is made, particularly when it is deemed that no further action will be taken. They are also encouraged to inform the Named Nurse should they be unhappy with the outcome, or if they have consistent difficulty in gaining information. Named Nurse liaises with social care if required, and they generally welcome discussion that offers a more in-depth insight into parental mental health issues, and the impact on children (BCPFT Escalation Policy). The Safeguarding Links have met with the Chair of WSCB to discuss relationships with social care, and have requested that one of their staff attend our next meeting - Named Nurse will send an invite.

7. Significant changes have been implemented following recommendations made from recent and current IMR's / SCR's, including the amended Deliberate Self Harm policy to ensure a multi-agency approach is taken for high risk children and young people who are admitted into hospital. Specific training needs have been identified and completed by staff, and policies amended. All Action Plans are monitored via the BCPFT Internal Safeguarding Children Forum which is chaired by the Executive Director for CYP.

8. The Link forum has proved very positive in ensuring that we maintain a high level of focus, particularly within AMH (including Early Intervention, Eating Disorders and Learning Disabilities). It enables front line staff to

bring concerns to the table for multi agency discussion and advice from Named professionals. This has been instrumental in understanding the real operational barriers staff face, and exploring ways in how we overcome them. The Links ensure that safeguarding children now holds a place on agenda's at team meetings.

Improvement Plans where barriers have existed.

1. Maintaining a focus on children!

2. Continue to monitor assurance against agreed SCR Action Plans (**NB** In relation to point 7 in the previous section a particular challenge for the BCPFT has been ensuring that the identified SCR Action Plan following the Internal Management Review relating to Child A have been implemented with the new Substance Misuse Provider in Wolverhampton. The Named Nurse has met with the provider's safeguarding lead in order to share the actions). How these have been implemented is yet to be tested by WSCB SCR Sub-group.

3. Continue to increase awareness and confidence in the role of AMH professionals in safeguarding children of adult service users through training, supervision and audit.

4. Training sessions / meetings around thresholds to ideally include Children's Social Care.

5. Lack of reliable data particularly for AMH. Currently there is no single system that is accessed by all mental health services in Wolverhampton so that we can easily obtain data around the children of service users to assess whether there is a need for early support. We also need to develop a system whereby we can access information on children who are receiving any form of additional support, and ensure this is monitored and reported on (both within adult and child mental health).

6. Ensuring that the Acute Services are more involved in safeguarding children activity, including a representative at Link meetings and ensuring there is senior management sign up to these (this is being addressed via the focus of the BCPFT Internal Safeguarding Children Forum)

7. Improve the quality of assessments of the impact of mental health difficulties on children, ensuring children's social care workers and child and adult mental health practitioner's work together to assess and agree effective action plans. This can be supported through joint training sessions around thresholds / toxic trio to ensure a mutual understanding from both sides. Plan to include a children's social care representative at Link Meetings on a 6 monthly basis to discuss concerns raised by the frontline practitioner's and enable social care to offer their perspective regarding thresholds, demands and responsibilities in an open forum.

8. Increasing confidence when it comes to early help and identifying impact on children when it is an 'obvious' safeguarding issue. This often relates to when children are perceived as the 'protective' factors in their parents lives when there are adult issues. A need to recognise the impact on that young person, how the young person is coping within the family environment and consideration of what the child's 'protective' factors may be.

9. Ensure all staff receives appropriate internal and external safeguarding children supervision as required.

Objectives for 2013/14

1. More reliable data collection regarding children living in a household where there are adult mental health issues
2. Monitor numbers of CYP where adult mental health issues have resulted in a CP Plan/CIN/CAF
3. Continue to offer joint training/supervision opportunities for children and adult mental health services to enable them to understand each others roles and the impact of adult mental health issues may have on CYP
4. Increased involvement in early intervention and identification of CYP who are affected by adult mental health issues or living within a household where they become the carer's for adults or siblings due to these issues. To identify the impact before it hits crisis point (continue to embed CAF within service areas)
5. To raise the Toxic Trio and Hidden Harm Agenda across multi-agency partners
6. Ensure there is sufficient resource within CAMHS to meet the increasing number of self harm referrals and impact this has on service delivery
7. Monitor compliance with the jointly agreed Deliberate Self Harm Policy (RWT/BCPFT)

Impact for Children and Young People

- Improved social and emotional outcomes for CYP
- CYP more able to make a positive contribution in both their social and personal lives
- Earlier identification and support for children and families resulting in more proactive management (Improved 'Think Family 'approach)

7.3 CAFCASS

Objectives for 2012/13

- Improving the quality of reports in both Public and Private Law cases. Using effective quality assurance and bespoke quality assurance tools to do this. The result being that children and families are provided with a good quality service.

- Ensuring that new report templates are rolled out to demonstrate the importance of evidence based analysis to a case.
- To support the rollout of the PLO and to reduce delay for children and young people
- To continue to promote the views of children and young people throughout the organisation.
- To develop our relationship with courts, local authorities and other partners.
- To continue to learn from complaints and capture compliments.
- To continue to build FCA morale.
- To recognise diversity and to increase diversity awareness amongst FCAs.

Achievements against the Objectives :-

- We have made progress in improving the quality of our reports. We have an internal quality assurance service called the 'National Improvement Service (NIS)'; National Improvement Service Managers carry out regular audits of service areas – they use the most up to date Ofsted methodology to complete these audits and learning points are incorporated into action plans for individual teams; the ultimate aim is that we have an all round good quality service for children and families.
- Our NIS have developed and rolled out this year a suite of quality assurance tools that cover all areas of our work: public law reports; private law reports; safeguarding reports; court observations; practice observations.
- We have already rolled out the PLO template for public law reports.
- We have developed our Children and Young People's Board over the last year. Young people from the board have sat on FCA interview panels and have attended team meetings. Young people have also helped develop the factsheets/literature that we provide on different aspects of the work ('putting your children first', 'working with teenagers'). We have had a number of young people from the board carry out office inspections over the last year. These inspections are geared towards ensuring that our office space and family rooms are child-friendly and welcoming – the report from the Birmingham Citadel Office was very positive.
- Our Customer Services Team are meeting deadlines for responding to complaints and the learning from these complaints is being cascaded to FCAs through team meetings.
- Human Resources have introduced the Health and Wellbeing Plan – FCAs are now able to claim back money on dentist/opticians appointments and other services; this has helped develop staff morale.
- On 10/07/2013 we had a Development Day for FCAs across Sussex and Suffolk – the theme was LGBT awareness and included a presentation by a local group called 'Transformers' that work with young people who identify as Trans. The day also looked at the language we use when describing diversity in family arrangements.
- Our Senior Service Manager chairs a Local Family Justice Board.

Improvement Plans where barriers have existed.

- We have been impacted by the changes in Legal Aid Funding and are developing our Early Intervention Teams to ensure a good service to Litigants in Person at Private Law first hearings; we are also developing our relationships with support services such as the Public Support Units at local courts.

Impact for Children and Young People

- A PLO timescale and template that reduces delay for children and young people in public and private law cases.
- Better quality reports that are evidence based and that ensure good outcomes for children and young people.
- More emphasis on the views of young people in how we recruit FCAs and in the recruitment process in general.
- The views of children and young people are taken into account in the way our offices and family rooms are presented and how we develop these.
- Improving the awareness of diversity across our FCA team so that they in turn can appreciate the diversity of families with which we work.
- Improving our relationship with Local Authorities to ensure that information is shared appropriately and children are safe in public and private law proceedings.

Objectives for 2013/14

- To develop further the quality of our reports.
- To continue to develop the role of the Children and Young People's board.
- To drive forward the PLO and any amendments to the Private Law Programme.
- To continue to work with our Local Family Justice Boards to improve practice and reduce delay.

7.4 Wolverhampton City Council

Objectives for 2012/13

1. Development of early intervention and family support services including completion of Children's Centre and MAST related reviews.
2. Redevelopment of FAST to make it more effective in LAC prevention/ rehabilitation.
3. The development of a more coherent operating model enabling families to access a fuller range of support earlier.
4. Ensure that Local Authority procurement, commissioning and contracting is sound and robust in reference to the safety and protection of children
5. Continue to monitor children who are Privately Fostered.

6. To ensure the recommendations made by Ofsted are incorporated into practice and to monitor the outcomes and actions.
7. Ensure that Scrutiny Panel of the Local Authority is updated regularly on the performance of the Safeguarding Children Board.
8. Maintain a focus on ensuring that Case Conferences, Statutory Reviews and Foster Home Reviews are completed to legal requirements and that they are timely and effective.
9. Ensure that all children in the city who apply for part time working are registered and protected from harm.
10. To support schools and colleges in their delivery of safe service for children and young people.

Achievements against the Objectives :-

1. In the light of extremely demanding financial times, our review of MAST and Children's Centres has been more positive than we could have anticipated. While resources available have reduced by around £2M, we are emerging with a clearly co-ordinated picture of Early Years and School Age services being delivered through 8 locality areas. We have also worked closely with RWHNHS Trust to develop closer working relationships in the field of under 5's work in particular.

2. FAST has been reduced in size but become better focused on its prime areas of enabling young people to live at home where family breakdown is possible through the establishment of a shift system operating across and outside of normal working hours.

3. Children, Young People & Families have developed a New Operating Model geared up to the development of local integrated services based on making "help" easier to access from a wider range of professionals with fewer "threshold" based barriers. The Model has been developed by service managers in conjunction with operational groups and has been welcomed by various Children's Partnership bodies and agencies as we move towards implementation.

4. The Community Directorate has reorganised its commissioning function bringing commissioning services for the first time into the same management team as operational services under Assistant Directors. The value of this has been seen in the greater rigour applied to in-house and external service developments and in the development of new responses to challenges as commissioners and operational managers have grown to understand each others perspectives.

5. The new arrangements for monitoring private fostering arrangements within Children, Young People & Families have been implemented.

We continue to publicise private fostering requirements and the support available, but numbers reported remain low.

6. A multi-agency inspection preparation group has been established to monitor response to last inspection and to ensure we maintain focus on emerging inspection framework. Progress against previous inspection action plan has been good.

7. CYP Scrutiny Panel received regular reports on the work of the LSCB prepared by the Head of Safeguarding.

8. While there have been some periods when Case Reviews etc. have been subject to cancellations at unacceptable frequency, overall efforts in this respect have been maintained and the responsibilities of managers made clear in the absence of social workers. Even when cancellations have been problematic though, performance against required timescales has been good (with meetings being rearranged within required periods).

9. The Local Authority's Child Employment Officer, who is based within the Safeguarding Children Service, makes regular visits to all known employers of children, to ensure that all the children they employ are registered and have been given appropriate and effective safety advice. In addition to this, twice yearly written reminders are sent to all known employers, and press releases are put in the local press as a means of raising awareness of the rules concerning employment of children. Any reports of children working without a permit or in a prohibited occupation are investigated without delay.

10 Through the Safeguarding service, schools and colleges received support in their delivery of their responsibilities for keeping children and young people safe. This level of interaction has included; devising a 'Model' Safeguarding policy, developing and contributing to the 'single agency training programme, and providing on-going advice and guidance in relation to safeguarding. Two half-day sessions has been organised for the Designated Child Protection Leads (DCPL) in this sector to ensure they are kept abreast with local and national information around safeguarding. This work was also extended to Governors' on the receipt of information from the Children's Commissioner Following the Somerset Serious Case Review. In Wolverhampton, an action plan was devised and cascaded to schools and colleges.

Improvement Plans where barriers have existed.

The main challenge to improving services in the context of intense pressure on Local Authority finance. As above, we have I believe continued to achieve improvements despite this, largely through more effective

targeting of resources – an approach that has a limited life-span in the face of future savings targets.

Enormous pressure on CiN/CP services has also meant improvements here have been subject to high caseload pressures. The indications are that early intervention is successful in identifying need, but I remain concerned that we have not yet fully turned around as culture of "referral onto social scare" to one of more proactive intervention by some universal and targeted services.

Impact for Children and Young People

There has been some reduction of universally available services but the focusing of resources leads to a greater focus on outcomes and across a number of services from early intervention through to child protection we have seen the development of imaginative and effective responses to need. Early signs are that the reconfiguration of commissioning should pay benefits in the longer term through the review of services and redesign of future provision.

Objectives for 2013/14

1. Piloting and roll-out of New Operating Model.

2. Effective establishment of new Children & Family Support areas with Early Years and School Age leads.

3. Better integration of youth work professionals across CYPF services.

4. Continued improvement in social work practice especially working with children and families in the community through on-going provision of professional development opportunities.

5. Continued focus on developing closure working relationships with partners in children's and adults through protocols, shared briefings and practice to enhance the welfare of children and families.

7.5 Prospects Services delivering Connexions/PAYP/Youth Contract in Wolverhampton

Objectives for 2012/13

The objectives are part of an overall Prospects Safeguarding Action Plan that defines a commitment to the welfare of all young people and vulnerable adults within Wolverhampton. It ensures that safeguarding underpins the way Connexions organise, deliver and manage services, including the deployment of staff. It also identifies on-going actions for the coming year to support the delivery of safe outcomes for the young people and vulnerable adults Connexions works with. The objectives are as follows –

- Ensure safeguarding continues to be a priority focus in all work with young people and respond effectively to any disclosures and concerns.

- Ensure all cases and concerns are regularly reviewed with staff members in supervision and good practice disseminated.

- Maintain appropriate referral and information sharing links with local partner organisations, including MASTs.

- Further embed an awareness of safeguarding thresholds in conjunction with CAF processes.

- Respond to local safeguarding issues and concerns, in particular those arising from any Serious Case Reviews and SCIE investigations

- Continue the schedule of level 2 training for all PAs and any additional targeted training for staff in specific thematic roles.

- Implement more robust and systematic client database recording processes.

- Implement the City's new referral process for Child Sexual Exploitation (CSE) concerns.

Achievements against the Objectives:-

- All safeguarding concerns continue to be recorded on the company's central log and secure Profile database and are discussed in managers' meetings and supervisions as appropriate.
- Reflective practice training sessions held to review safeguarding reporting linked to the continued embedding of CAF into all PA practice.
- PA delivery embedded within MASTs and TYS panels and PSISAs established with a range of partners e.g. TYS/Guns and Gangs partnership.
- All PAs have attended the latest Thresholds training run centrally by LCSB training unit
- Operations Manager attended a SCIE workshop relating to a LAC young person who died in 2011. Lessons learnt were noted and shared with the management team
- Internal safeguarding training in place and PAs have accessed City wide training for the homeless, drugs issues, neglect , alcohol, Hidden harm and Adolescents and assessment.
- Profile database development including the risk of poor outcomes tool [RONI]
- Team manager attended the CSE protocol launch and internal training sessions were delivered to staff on both the protocol with a referral process in place for PAs to raise concerns.

- Operations Manager attended LCSB meetings [75% attendance]

Improvement Plans where barriers have existed.

Individual targets set for all PAs linked to early intervention through the CAF process. Targets overachieved

Impact for Children and Young People

- A robust framework and processes are in place to enable staff to identify, respond and report on concerns raised by young people and vulnerable others.

Personal Advisers and their managers are trained and are able to respond appropriately to young people's needs and concerns.

Objectives for 2013/14

- Ensure safeguarding continues to be a priority focus in all work with young people and respond effectively to any disclosures and concerns.

- Ensure all cases and concerns are regularly reviewed with staff members in supervision and that good practice is disseminated.

- Ensure that appropriate links are established with the new Social Care Operating Model in particular for young adolescents

- Ensure that the delivery of the Connexions early intervention service delivery model, using the RONI tool, embraces safeguarding as a central theme.

- Ensure that safeguarding is central to our developing work with Families in Focus and to address issues/concerns through supervision and internal training as appropriate.

- Ensure that our PAs, working with young people in Transition who have learning difficulties and/or disabilities, are clear about their safeguarding responsibilities and the role they play in ensuring the best interests of their clients..

- Revision of all corporate documentation to reflect latest guidance on vetting and barring requirement and update service from the DBS – September 2013

- Development of corporate risk management processes to manage high risk clients/customers – always in conjunction with local partners – by Spring 2014

- Development of corporate safe recruitment e learning and training opportunities – Spring 2014

- Launch of new corporate site to track referrals – by December 2013

7.6 Safer Wolverhampton Partnership

Objectives for 2012/13

Information Sharing- There is an increasing need for information across agencies to be shared to identify and support those at risk of harm (adults, children, families); the development of an overarching Information Sharing Protocol demonstrates willingness for this to happen. Safer Wolverhampton Partnership will work with partners to develop the vehicles for information exchange to take place to direct targeted early intervention as part of programmes such as Troubled Families and Ending Gang and Youth Violence.

Women and Girls- We will continue to develop our targeted work to reduce vulnerability of women and girls through early identification and intervention, and to move towards the development of a city-wide strategy.

Gangs and Youth Violence- we will integrate our approach to gangs and youth violence into mainstream practice including established safeguarding processes for children and young people.

Hidden Harm- To support the development of a co-ordinated approach across the workforce to effectively manage Hidden Harm issues, given the local prevalence.

Achievements against the Objectives :-

Information Sharing- A number of purpose specific information sharing agreements have been produced to aid information exchange across agencies working to address issues around gangs, neighbourhood safety and Families in Focus and hidden harm of children for problematic drug and alcohol users. The Partnership Analyst will have access to the new Illy data system being introduced to enable relevant information to be shared across partners delivering against this programme. Membership of Channel panel has increased considerably over the last 12 months to provide more effective identification and coordinated support for individuals vulnerable to extremist ideology providing safe exchange of relevant individual data within a pre-criminal setting.

Women and Girls- WDVF has led the development of the Violence Against Women and Girls Strategy, which also addresses issues affecting boys and men. The strategy has been innovative by addressing the wider issues of forced marriage, honour based violence, female genital mutilation, sexual

violence and child sexual exploitation. The strategy was positively received and fully endorsed by SWP who will be taking a keen interest in its progression.

Gangs and Youth Violence- 2012/13 saw an extremely busy period of activity to reduce gang-harm in the city with marked results. The Home Office Ending Gang and Youth Violence programme was successfully delivered, providing newly commissioned services in the city, strong community buy-in and awareness of how partners are working together, outlined within the successful Citizens for change Conference in March 2013, and prepared a range of agencies to deliver gangs responses as part of their mainstream business. Consequently, Wolverhampton Probation Service now have a specialist team in place responding to gang linked offenders, a dedicated Police Gangs Tasking team has been established to provide focussed enforcement, YOT have trained their staff and developed a toolkit for use within their teams, Connexions were funded to provide a package of information support for use by parents and Gangs has been included as one of the local criteria within the city's Families in Focus programme. Underpinning all of this is a new information sharing agreement to aid information exchange between key partners.

Hidden Harm- 2012/13 supported the role of a designated officer assigned to develop and co-ordinate multi – agency Hidden Harm guidance and training to support and
Improve communication and overall co-ordination between services for children, young people, families and adult services. This would encourage services working together in the assessment and care planning stages for families with substance
misuse.

Improvement Plans where barriers have existed.

Despite the progress made on information exchange, further work is needed to refine the processes for this to happen swiftly and effectively in dealing with gang issues and tying this to existing structures, e.g MAST TYS Panels, Families in Focus.

Impact for Children and Young People

The approaches for providing targeted interventions have moved away from either children or adult delivery, towards a holistic family focussed intervention. The commitment to address hidden harm as part of the new drug and alcohol service launched in the city, and key working approach to address the needs of families within the FiF programme or as part of Channel Panel means that interventions are for the benefit of the whole family rather than just any one individual within it.

The Forced Marriage conference in March 2013 organised through WDVF highlighted clearly the vulnerability of young people who may be forced into marriage against their will and the potential harm directed at them if they object; sometimes taken against their will to other countries, the

conference aimed to alert practitioners to the risks and look out for the signs to identify and protect young people affected. This will provide a platform for more targeted work in the coming year.

Gangs and youth violence crime figures for 2012-13 have seen a marked reduction in offences against young victims of violent crime; youth violence involving knives has reduced by 42% in 2012/13, with Most Serious Violence Offences reducing by 17%. Exit pathways are now available for young people wanting to exit the gang lifestyle with the support of organisations such as Catch 22, EYES, YOT and Base 25 and through the launch of a new resource for use in all secondary schools within the city.

Objectives for 2013/14

Domestic Homicides – Shared Learning
There have been 25 domestic violence related deaths across the West Midlands since legislation was introduced for Domestic Homicide Reviews (DHRs) to be undertaken in April 2011 for each DV related death. Wolverhampton will be working with colleagues across the West Midlands to commission a piece of work to identify improved practice and organisational change with a view to reducing the number of deaths occurring and introducing better safeguarding arrangements for victims and children.

Channel and Prevent
To work with partners to sustain and mainstream Prevent activity and raise awareness of Channel as a safeguarding forum for case managing individuals vulnerable to extremist ideology. To deliver a targeted training programme to front line staff across agencies so they are alert and able to identify individuals at risk.

Violence Against Women and Girls
To progress delivery of the VAWG Strategy, and improve practice across all strands of the strategy to better safeguard vulnerable individuals.

Hidden Harm
Following the launch of Hidden Harm guidance, a coordinated workforce development programme will be delivered to front line practitioners during 2013-14.

7.7 Wolverhampton CCG

Objectives for 2012/13

1) Ensure that , on establishment, the local Clinical Commissioning Group is engaged in the business of WSCB and the Safeguarding Children responsibilities of this future commissioning organisation are explicitly understood and in operation during 2013.

2) Attend to the Safeguarding Children training and support needs of General Practitioners and primary Care services.
3) Continue to strengthen the local working arrangements and practice between the health provider sites via the functioning of the Joint Health Safeguarding Children Committee
4) Ensure that health care services attend to the local needs in light of the Munro review and the publication (pending) of the revised statutory ' Working Together' document and in the context of multiagency partnership working
5) Ensure that the existing work programme across the health care provider services maintains momentum and continues to reflect the on- going business priorities of the WSCB and the needs of the local service – users.

Achievements against the Objectives :-

1) Ensure that, on establishment, the local Clinical Commissioning Group is engaged in the business of WSCB and the Safeguarding Children responsibilities of this future commissioning organisation are explicitly understood and in operation during 2013.

   Wolverhampton Clinical Commissioning Group was established in Sept 2013 and assumed responsibility for commissioning health services on April 1st 2013 (previously the responsibility of Wolverhampton PCT).
   The Executive Lead nurse, Designated Doctor for Safeguarding Children and Designated Senior Nurse for Safeguarding Children are member of the WSCB.
   There is a safeguarding children policy in place across the organisation Safeguarding Children is a standing agenda item on the Quality and Safety Committee of the WCCG and this is reported quarterly. A paper detailing the implications of the 'Safeguarding Vulnerable People in the Reformed NHS – Accountability and Assurance Framework' published by the NHS Commissioning Board in 2013 was presented to the Committee and this is revisited to ensure compliance with the recommendations.

2) Attend to the Safeguarding Children training and support needs of General Practitioners and Primary Care services

   A series of Safeguarding Children Level 2 and 3 training sessions were undertaken in early 2013 to ensure that all staff were up to date with their training. A new Named Doctor for Safeguarding Children for Primary Care was appointed in 2012 whose remit is advice, training and support in safeguarding children for those working in primary care.

3) Continue to strengthen the local working arrangements and practice between the health provider sites via the functioning of the Joint Health Safeguarding Children Committee

   The Joint Health Safeguarding Committee is held bimonthly and is chaired by the Designated Doctor for Safeguarding Children and vice chair is the Designated Senior Nurse for Safe guarding Children. This committee is the

forum by which members attend to corporate Safeguarding Children business on behalf of local health care service providers and allows the monitoring or incidents, action plans and training by the CCG of the provider sites. It also acts as a means of disseminating information around Safeguarding Children and also enables health care providers to undertake pieces of work together

4) Ensure that health care services attend to the local needs in light of the Munro review and the publication (pending) of the revised statutory 'Working Together' document and in the context of multiagency partnership working.

The information and recommendations within the Munro Review and 'Working Together' have been disseminated to all health providers and have been incorporated into the Safeguarding Children training programmes with an emphasis on strong partnership working.

5) Ensure that the existing work programme across the health care provider services maintains momentum and continues to reflect the on- going business priorities of the WSCB and the needs of the local service–users.

The WSCB work programme and its on-going business priorities are shared and embedded within the work programmes of the different health providers. A Section 11 audit was undertaken by health in 2012 and the finding are reflected on the individual action plans.

Improvement Plans where barriers have existed.

The changes in the NHS over the year meant that clarity was needed during the transition phase, with business as usual during the transfer of commissioning of health services from Wolverhampton City PCT to Wolverhampton CCG despite some disruption. Now the CCG is fully established it will be easier to implement processes, investigate and monitor action plans

Impact for Children and Young People

Local Health Care services are committed to safeguarding children and young people and to their fulfilment of statutory responsibilities with regards to strategic and operational business. The work which has been undertaken over the last year has served to strengthen local Safeguarding Children arrangements in the interests of children, young people and carers.

Objectives for 2013/14

- To continue to embed the NHS accountability framework and the recently published "Working Together" across all health providers and strengthen the systems and processes across local services

- To attend to and monitor the relevant action plans and Safeguarding Children work programmes of the health care providers and the WCCG with regards to Safeguarding Children.

- For the CCG to request that health providers undertake and complete an annual Section 11 audit of the Children Act 2004 and monitor the subsequent action plans through the JHSCC.

- To maintain and enhance health care services' engagement in inter-agency safeguarding activity both from an operational and strategic perspective.

7.8 West Midlands Ambulance Service

Objectives for 2012/13

1. Develop robust auditing system of safeguarding referrals.
2. Maintain effective partnership working through attendance at boards and sub groups
3. Develop early notification of child deaths
4. Identify and deliver training to all staff re child protection

Achievements against the Objectives :-

1.

The safeguarding team carried out audits on the quality of the safeguarding calls which was designed to audit the following:

1. To assess the quality of the information recorded by the call takers
2. To assess the quality of the referral information passed to social care.
3. To assess the appropriateness of the referral from crews

The results of the audits were fed back to appropriate managers and actions taken as required.

2.
The safeguarding team has attended 17 Adult and/or Children's Boards meetings and sub groups during 2012/2013. Where possible, and when invited, WMASFT aim to attend each Board at least once during each year. WMASFT have contacted **ALL** Boards to ensure that for those that they do not attend the possibility of being a link member is requested so information and communication channels flow regularly. Whilst it is acknowledged that WMASFT attendance at Boards may not be as frequent as desired, this must be balanced against the demand placed upon a regional organization with limited resource. WMASFT welcome communication with **ALL** Boards and enhanced attendance is provided when and where necessary.

A system of early notification has been implemented so that the safeguarding team are alerted by text to the CAD number (incident

number) of every child under the age of 18 that dies or is in a life threatening condition.

In partnership with the Clinical Practice Governance Managers a ***"child death pack"*** has been developed with all the information that is required to be collected and ensure staff received support after such tragic events. This information is given to the safeguarding team so that the file is complete to ensure the quality of the information supplied to CDOP is of a high standard.

This has been a period of transition and following the recommendations of the Intercollegiate Document (2010) flexible learning opportunities have been offered via virtual learning (VLE) and a Work Book. Safeguarding topics have been included in both the Weekly Briefings (internal staff bulletin) and Clinical Times internal publications.
At the time of publication 74.63% for E&U and 55% for PTS had completed formal Educare safeguarding training. It is to be noted that Educare is only one form of formal safeguarding training with WMASFT and ALL staff have completed safeguarding training by a variety of mediums, including mandatory education, workbook, corporate induction and articles within staff magazines and clinical publications.

Audits planned for 2013/14 will identify the effectiveness of the training and the learning opportunities.

Impact for Children and Young People

There has been a slight decrease for child referrals from 1239 to 1152.
The overall number of referrals for children has dropped slightly to an average of 98 referrals per month in the year 2012/13. Birmingham and the Black Country continue to have the highest number of referrals. This correlates to Birmingham and the Black Country having the highest numbers of children with child protection plans in the West Midlands. Early indications show that the numbers of referrals are rising in Birmingham and the Black country areas for the coming year.

Action Plan – 2013/14 - WMASFT**Action**	**Responsible**	**Timescales**	**Tasks**
Audit ***1. Call audit*** ***2. Spot Check*** ***3. Direct referral***	Safeguarding team	**Quarterly**	Selecting 20 calls - listening and mark against audit template Attendance at station and using pre-determined questions to spot

			check knowledge of safeguarding.
Re- Design of referral process	Julie Ashby-Ellis	**December 2013**	Explore alternative methods of receiving and making referrals After consultation implement new system.
CQUIN-HVSU	Robert Cole/ Kelly Starkey	**On-going**	Identification of HVSU work in partnership with internal and external agencies to reduce number of calls and meet HVSU needs
Child Death Statistics	Safeguarding team	**On-going**	Collate review and map themes
On-going training	Safeguarding team	**On-going**	Working in partnership with Education and Training team to ensure that all safeguarding training is relevant and up to date and reflects new initiatives and themes

Objectives for 2013/14

7.9 West Midlands Fire Service

Objectives for 2012/13

- Promote 'Safeside' programmes to Childrens' Centres and MAST teams and Health & Wellbeing Board.
- Increase home safety check referrals from children's services providers (eg. Children's Services, MAST teams etc)
- Train all WMFS Vulnerable Persons Officers in CAF and Threshold awareness and cascade this training to watches.

Achievements against the Objectives :-

- All primary schools sent written invite to attend Safeside

- Community Advocate visited all Children's Centres to promote Safeside programmes and to raise awareness regarding home safety check referrals
- WMFS operational crews attended Children's Centres events to promote home safety checks
- Between 01/08/12 – 01/08/13 = 2,679 home safety checks carried out in Wolverhampton
- Home safety checks now allocated points relating to vulnerability and risk of fire.
- Wolverhampton points score 01/08/12 – 01/08/13 = 9,059 with each home safety check averaging 3.38 points. This is the 2nd highest points score in the brigade (covering 7 local authorities) meaning that our home safety checks in Wolverhampton have been targeted more efficiently at those more vulnerable or at risk of fire.
- Training in CAF and threshold awareness has been requested for Vulnerable Persons Officers – awaiting feedback.

Impact for Children and Young People

- Children and young people able to identify hazards in the home, on the roads etc.
- Children and young people are safer in the home, on the roads, in cars etc.
- Children and young people and their families who are identified as at greater risk of fire or having more complex needs receive a tailored service and signposting to other relevant service providers and are safer in their homes.
- WMFS is more 'service-user' focussed and hence children and young people receive an improved service.
- Children and young people receive more 'joined up' service due to WMFS working in partnership with more service providers.

Objectives for 2013/14

- Increase number of fire setter tutors (for children & young people) covering Wolverhampton area
- WMFS to broaden Home Safety Checks to include a 'child safety' element
- CAF & threshold document awareness training to be delivered to fire setter tutors and Vulnerable Persons Officers
- Paper to go to WMFS Corporate Board raising awareness of 'PIPOT' document & WMFS Human Resources Department to sign up to document

7.10 West Midlands Police

Objectives for 2012/13

Police Objectives as per the Local Policing Plan for Wolverhampton 2012/13

	Milestone	End of year Performance
Confidence in Police	88%	81%
Satisfaction that Police do a good job	88%	67.3%
Crime satisfaction with service	88%	88%
ASB satisfaction with service	80%	85.9%
Reduce Total Recorded Crime	-6%	-8%
Reduce Most Serious Violence	-7%	-13.3%
Reduce Burglary Dwelling House	-9%	-15.3%
Reduce Robbery	-8%	-31.7%
Reduce Business Crime	-8%	-8.2%
Solve and resolve Most serious violence	55%	41.3%
Solve and resolve burglary dwelling house	16%	16.9%
Solve and resolve robbery	23%	245.3%
Solve and resolve Serious sexual offences	42%	40.5%

Achievement against objectives:

Child abuse investigations fall within the crime categories for the purposes of performance indicators within most serious violence and serious sexual offences. Not all child abuse is detailed within those categories but falls within the crime continuum. Overall, there were 558 non-crime referral incidents received; 283 crimes of child abuse were recorded of which 110 were detected and the offender was brought to justice or subject of community resolution. Equivalent to 38.8% detection rate.

Overview of activities:

Throughout 2012 there was a focus on the political change from having elected members of the Police Authority hold the Chief Constable to account for operational policing matters; to the election of a Police and Crime Commissioner. PCC Bob Jones was duly elected and commenced office on the 22nd of November. The PCC had political responsibility, ownership of community safety budgets and authority to improve commissioning for community safety matters. Local Police and Crime panels were identified to support the PCC and were to include greater representation from local elected members.

West Midlands Police Public Protection sought methods to improve the corporacy, management and response to referrals of child abuse allegations from partners.

This was the one area of business and demand that had previously been routed directly through to a Child Abuse Investigation Team, whereas all other calls for service to West Midlands Police were routed through to a Contact Centre. This had led to a varied response provided across the ten Child Abuse Investigation Teams.
The Senior Leadership Team of Public Protection commenced a Central Referral Unit program that would provide a centralised response to all allegations of child abuse, raise standards across the region; ensure there

was a clear mechanism to manage invitation and attendance to Child Protection Conferences and capture previously hidden demand on police resources. The CRU consisted of initially two Sergeants and four experienced Detective Constables who would provide greater consistency of decision making and ensure compliance with statutory guidelines. This was a change for key partners in the way that agencies had previously worked with West Midlands Police. This was initially of some concern to senior officers within local authorities, who asked for greater engagement and consultation. A multi-agency workshop event was held in March 2013 to update senior partners on progress, and engage all in lessons learnt and the wider rollout of the CRU to include all seven local authorities.

On the 12th of November 2012 the Central Referral Unit went live with Wolverhampton and Walsall Local Authorities the first two of seven local authorities' referrals being managed in this way. Partners in Children's Services at Wolverhampton were well engaged and positive about the changes introduced. There were monthly Strategic Interface meetings between the Head of Service, Head of Safeguarding and Detective Inspector to identify any operational issues and themes. Then followed the commencement of a bi-monthly Regional Interface meeting involving the Black Country and the CRU staff, which allowed healthy discussion and debate regarding standards and thresholds.

An early evaluation of the CRU was presented to the Board in June 2013. The overall feedback and response articulated by John Welsby for Wolverhampton partnership was very positive.

There were two critical and complex child abuse investigations that commenced in Wolverhampton during 2012 that attracted significant media coverage. The first occurred on the 29th of May, twenty three month old child Daniel Jones died as a result of ingesting heroin. Both parents were subsequently arrested and charged with his death. The case was heard at Nottingham Crown Court on the 3rd of July 2013, Daniel's mother pleaded guilty to allowing or causing the death of a child and father admitted manslaughter. Both were sentenced to four and six years imprisonment respectively.

The second critical incident was Operation Partial, in September 2012 a five day old child received life changing serious head injuries as a result of her mother throwing her down a rubbish Shute from five floors up in a block of flats at Whitmore Reans. The child's mother was subsequently charged with attempted murder. The case was heard at Wolverhampton Crown Court on the 6th June 2013, the child's mother was found guilty of inflicting grievous bodily harm and sentenced to four years imprisonment.

As a result of changes in February 2011 to the policy in West Midlands Police regarding Domestic Abuse, it was identified during 2012 that there were fewer cases of domestic abuse being taken to partners for joint screening. The changes meant that instead of officers completing a Domestic Abuse Stalking and Harassment Risk Indicator (DASH) at every domestic abuse incident, accountability was given to officers to use their professional

judgement based upon set criteria to complete a DASH risk assessment and associated reports.

This was recognised by local partners and raised for discussion at the Board. At the same time this issue was raised by the force lead for Domestic Abuse Detective Superintendent Clare Cowley, who responded and initiated a force wide Task and Finish group to look at the issue. Superintendent Jan Thomas-West, a Board member representing Wolverhampton Local Policing was the representative for Wolverhampton. A training program commenced in the autumn of 2012 and was delivered to all Local Policing Response officers in addition to daily monitoring in place to review domestic abuse. There has since been auditing of domestic abuse in Wolverhampton which has shown a significant rise in domestic abuse incidents being recorded effectively and shared with key partners for discussion at Joint Screening. This work continues.

In February 2013 approval was given by the Chief Constable to review all areas of the work of Public Protection to identify continuous improvement and potentially redesign service delivery through Service Transformation. This was a six month planned project designed to continuously improve services to the public, and commenced in May 2013. A partnership secondee had been requested to represent all seven local authority Chief Excecutives for the duration of the program which concludes in November 2013. Key partners have been engaged in a series of workshops exploring service provision.
Regular updates are forwarded from the Program Team.

Improvement Plans where barriers have existed.

Domestic Abuse as per the above which remains work in progress with Local Policing colleagues.

Impact for Children and Young People

- Improved decision making regarding children at risk of significant harm because of child abuse.
- Improved joint working with Social Care and partners to safeguard and protect children vulnerable to child abuse.
- 110 offenders brought to justice or subject of a community resolution for abusing children.

Objectives for 2013/14

	Milestone
Public have confidence in Police	85%
Customer Satisfaction with service - Crime	88%
Customer satisfaction with Service - ASB	80%
Reduce Total Recorded Crime	-5%
Reduce Violence with Injury	-6%
Reduce Burglary Dwelling House	-7%
Reduce Business Crime	-6%

I have attached a copy of the Local Policing Plan for 2013/14 for the information of the Board.

7.11 Voluntary & Community Sector

Objectives for 2012/13

1. Develop links with faith groups to better support them with safeguarding needs

2. Promote Safe Network Standards and support VCS groups to work towards standards

3. Secure wider VCS representation on sub groups

4. Explore other avenues for supporting VCOs around safer recruitment inc. exploring other possibilities for continuation / resurrection of VCS Safer Recruitment Service

Inform VCS of developing safeguarding environment – including changes to Disclosure and Barring scheme, developments resulting from Munro

Achievements against the Objectives:-

1. **Develop links with faith groups to better support them with safeguarding needs**

- YOW co-ordinated a 'Safeguarding In Faith' event 20-04-13 to re-invigorate engagement with Faith Groups with collaborative support from Adults and Children's Safeguarding services and Inter-Faith and Regeneration Network..22 participants from 13 Faith groups (the vast majority were Christian) took part. This engagement was welcomed by participants with interest being shown in further opportunities to meet together, the Safe Network Standards and the support available locally to add to their faith based support (on the decrease for mainstream denominations).

2. **Promote Safe Network Standards and support VCS groups to work towards standards**

(a) Promotion

- YOW co-ordinated an event to promote Safe Network Standards 28-01-13 attended by 20 participants. 5 groups indicated they would definitely, and 5 that they were very likely, to sign up to the Standards. No requests for support forthcoming
- SNS page developed on YOW website .an 2013
- SNS incorporated in to new small groups toolkit being developed to support VCOs to be contract ready, which will be used as basis for

membership of new VCS prime Contractor consortium–People In Partnership (Wolverhampton) CIC.

- SNS promoted at Safeguarding In Faith event Apr 2013 (see above)

(b) Support

- One-to-one support to groups with safeguarding policy
- Supporting safeguarding training provision by
  - Funding and organising an 'introduction to safeguarding' course for voluntary and community organisations;
  - supported volunteer mentor safeguarding training for Improving Futures;
- Secured funding to improve 'Preventing and Responding to Bullying' Standard in 2013-14

3. Secure wider VCS representation on sub groups

Limited success to date but steps in place to improve on this:

- Agreement of need for, and interest in, a VCS safeguarding forum
- Invitation for a range of VCS reps (inc. safeguarding sub groups) advertised in Jan. Some interest in Safeguarding committees to be followed up.
- Additionally, YOW has co-ordinated VCO involvement in Safeguarding Peer Review, Multi-agency case file audit, and CAF reporting for EIB

4. Explore other avenues for supporting VCOs around safer recruitment inc. exploring other possibilities for continuation / resurrection of VCS Safer Recruitment Service

No funding available to support continuation of VCS Safer Recruitment Service.

VCOs now being directed to DBS umbrella body in Wolverhampton that has dropped its admin fee in response to findings of SRS that finance created a barrier to use!

More information on YOW website.

5. Inform VCS of developing safeguarding environment – including changes to Disclosure and Barring scheme, developments resulting from Munro

Regular Safeguarding updates by email distilling essential information and giving access to full, detailed documents and original sources.

Safe Network event and DBS update on 28-01-13

Also part of Safeguarding in Faith event in April.

Working Together circulated

New content and pages develop for YOW website since Sept 2012 to take account of changes.

Improvement Plans where barriers have existed.

Generally capacity is an issue. So we will continue to identify opportunities for one-to-one support (in addition to profile-raising events), and have a continued focus in Safe Network Standards including them in wider capacity building activity including the small groups toolkit and work of other capacity building workers in the sector.

YOW will seek to increase its focus on safeguarding still further e.g. in contract negotiations with WCC.

1. **Supporting Faith Groups**
   Clearly more work to be done to engage with Faith Groups to (a) build links with a wider range of faith groups and (b) provide further opportunities to support safeguarding leads in Faith groups.

   Connecting to wider range of Faith groups
   - will be part of Communication and Engagement committee work plan
   - Make use of existing opportunities
   - Strengthen links with and expectations of Inter-Faith and Regeneration Network

2. **Safe Network Standards**
   Barriers re. working towards Safe Network Standards - Create / take advantage of opportunities one-to-one interaction to support groups in prioritising working towards the Standards. e.g. preventing and responding to bullying work for 2013-14
   Obtain figures of SNS progress by VCOs in Wolverhampton from Safe Network to enable ore focussed follow up work.

3. **Wider representation of VCOs**
   Capacity as an issue – look for opportunities for wider representation on Task & Finish groups

4. **Safer Recruitment**
   Ways round no additional funding - Approach local DBS provider to see if they are willing to signpost organisations to YOW for further support on safer recruitment / safeguarding.

5. **DBS changes and safeguarding landscape updates**
   No barriers just further activity

Impact for Children and Young People

No direct impact on children and young people from YOW's WSCB representative work however:

- VCOs are better informed about safeguarding landscape

- VCOs are clearer about where they can obtain support around safeguarding from
- Safeguarding has a higher profile amongst VCOs

There is potential for

- VCOs to be more confident in their safeguarding policy and practice VCOs to create safer environments for their work with children and young people.

Objectives for 2013/14

The next step is look at developing a joint, children and adult's forced marriage and honour based violence protocol. Consideration is being given to this being developed regionally with neighbouring local authorities and West Midlands Police.

1. Lead on communication and engagement for WSCB
   a) Make links with, and provide support to, a wider range of faith groups
   b) Develop VCS safeguarding forum
   c) Develop broader involvement of VCOs in safeguarding
2. Continue to promote Safe Network Standards and support VCOs to work towards them
3. Provide safeguarding information across the VCS
   a) DBS briefing events
   b) Regular safeguarding updates
   c) VCO responsibilities under Working Together 2013

Allegation Management: Progress 2012- 2013

- Permanent full time LADO appointed in February 2013
- Implementation of "Guidance for dealing with Allegations"; DfE October 2012
- Contacts and Introductions established with Partner Agencies
- Procedures updated within Safeguarding Children Service
- Existing training programme for "Managing Allegations" has been updated and delivered to a multi-agency audience
- Dates made available to WSCB for "Managing Allegations" training to be delivered throughout the year
- Wolverhampton is represented at Regional Meeting for LADO's
- Self-introduction and presentation to all Head teachers at their Development Day outlining current changes to guidance and our expectations
- Database for recording and monitoring allegations further progressed, improving confidentiality and security of personal information

Priorities for 2013/14

- Working Together 2013 sets out expectations to resolve cases as quickly as possible and within certain timescales:
  80% of cases should be resolved in one month; 90% of cases within three months and all but the exceptional cases should be completed within twelve months.
  Further development is necessary to establish WCC effectiveness to meet these timescales
- Update WSCB website to incorporate recent changes in guidance
- A leaflet should be available for persons who are subject of an allegation explaining the process involved. This is in the process of being updated
- To continue to review, update and deliver Managing Allegations training to a multi-agency audience.
- Implementation of learning from National Serious Case Reviews:
  i.e. North Somerset; Birmingham
- Implementation of Conclusions and Implications Of Research Report – "Allegations of abuse against teachers and non-teaching staff"
- Raise awareness and remain updated on changes regarding Disclosure and Barring Service
- Consider Implications from ISA publication:
  "Safeguarding in Workplace: What are the lessons to be learned from cases referred to the Independent Safeguarding Authority" March 2012
- To promote the role and responsibilities of the LADO to wider organisations
- Designated Safeguarding Officer for Health to be represented at Position of Trust meetings
- To improve recordings and monitoring of outcomes of cases referred to Disclosure & Barring Service and other Regulatory Body
- To identify Emerging Themes from established data
- To ensure categorisation is consistent

Impact:

- Actions undertaken as a result of the process should impact on a more proactive use of Safe Working Practice; Specific training for staff and improved recruitment
- It is envisaged in future, this Annual Report will clearly identify Outcomes and Key Themes

Data:

Full report including Data for the period April 2012 and March 2013 as detailed in appendix 1

7.12 Child Death Overview Panel

The Child Death Overview Panel (CDOP) process commenced 1st April 2008. CDOP works in partnership across Walsall and Wolverhampton Safeguarding Children Boards and its function is to establish procedures to ensure a coordinated response to all child deaths.

Copies of all Child Death Review processes and procedural documentation are available on the Wolverhampton Safeguarding Children Board website (www.wolvesscb.org.uk).

Networking

Good links have been established with the following.

- CDOP contacts across the West Midlands Regional Network
- Coroner's Office
- Registrar
- Child Health Information Services
- Palliative Care
- Acorns Hospice
- Bereavement Services Helplines
- Neighbouring LSCBs
- West Midlands Perinatal Institute

CDOP Briefing Sessions

Briefing sessions are held throughout the year to inform agencies about the Child Death Review process and reporting requirements.

Future Developments

- Guidance notes have been received from the DfE for the completion of child death preventable data collection for the year 2012-2013 and LSCBs are required to submit relevant data by 31st May 2013. The data for Wolverhampton was submitted on 8th May 2012.
- Further CDOP briefing sessions to be held 2012.
- Continued attendance at CDOP Regional quarterly meetings throughout 2012\13.
- SIDS reduce the risks campaign was launched in October 2012 following a three year trend analysis of SUDI deaths recorded across both Wolverhampton and Walsall. Of the 34 SUDI deaths, 30 deaths reviewed identified co-sleeping and smoking as contributory factors. Awareness training has been introduced for all children's services professionals, supported by a public health poster campaign to highlight the risks of co-sleeping with babies under the age of 6 months.

Child Death Data & Wolverhampton Child Death Data and Trend Analysis

A summary of Wolverhampton child death statistics covering the period 1st April 2012 to 31st March 2013 is detailed in appendix 2

7.13 Private Fostering

Objectives for 2012/13

Overview of the Year's Activities 2011/13

Team/Staff Structure

On the 4th April 2012 a permanent social worker joined the Fostering team as the specialist worker for private fostering. The worker has worked in conjunction with the Duty and Assessment team once the notification has been received. The initial Assessments continue to be undertaken in the Duty and Assessment team and then cases are transferred onto the relevant Locality team for allocation. There has been better co-ordination in carrying out joint initial visits between the specialist private fostering worker and the Duty and Assessment team. Communication on the whole between the two teams has much improved and this has been evident when joint visits have not been possible.

A Private Fostering service improvement plan has been drafted and is awaiting finalisation for the coming year. This will however have to be amended to take into consideration recent changes in respect to the Fostering Team reconfiguration.

From December 2012 the Fostering Team embarked on a reconfiguration of the service. All social work staff will undertake the full range of specialism within the team. Staff will no longer specialise in specific areas. All staff will undertake 20 supervisory cases of mainstream, family and friends carers and private foster carers and 5 pieces of work. The specialist private fostering worker will carry 10 mainstream fostering supervision cases, 10 private fostering cases and 5 additional pieces of work. It is expected that the developmental aspect of the private fostering role will remain with the private fostering social worker.

Publicity and Marketing

The leaflets and some of the posters produced in May 2011 are still of good quality and have been re-ordered and distributed on request and proactively targeting relevant agencies in the community. However, a more generalised information leaflet for the public has been ordered to be placed in places of prominence.

In October 2012, we placed an information leaflet in the pay packet of all city council employees. At the same time the same leaflets were enlarged and used in a display in the Central Library in conjunction with the Parenting Institutes 'Parents' week. Library staff were most instrumental in affording us time to network with some of the parenting groups in operation at the time, whilst sharing information on private fostering. A lot of information was given, but it is very difficult to measure the impact of this.

Health

Following the campaign with Signal Radio in March the last presentation at the safeguarding board, the private fostering social worker has outlined and undertaken a series of activities with support and direction specifically from Amanda Viggers, Designated Senior Nurse for Safeguarding. Through this link, Information sessions have been delivered to Health Visitors, Midwives and Community mental Health Teams in the city. As a consequence, the private fostering social worker has been alerted to number of potential private fostering arrangements which had not been picked up. The Health sector has been most proactive as Champions for private fostering and disseminating information. There is still a lot more work required in this area.

Wolverhampton Football Club

The talks with Wolverhampton Football Club developed into looking at the processes involved with them caring for children and young people under their intensive training programme. A referral was placed with Duty and Assessment following the placement of two young people in the same host family home. There is an understanding that the Private fostering regulations will have to be adhered to at all times and we are developing the service to look at the policies and procedures that Wolverhampton Football Club have in place and the channels used to inform parents of our involvement.
There are plans for the football club to take on more children under the age of 16 into their Trialists and Apprenticeship schemes. It is projected that there may be up to 20 children as young as 12 years old being placed with host families. Rachel Warrender will be working closely with the private fostering social worker to ensure that policies and procedures are adhered to and reviewed accordingly.

City Council Teams

The private fostering social worker has taken information out to the various teams in the city; 2 MAST teams, Children's Centres, Children's disability Team and 3 Locality team via their team meetings.

Education

In September 2012 the internal mail shot sent 'Champion' request letters and leaflets to all the schools in Wolverhampton. Only two schools responded to the email. Moreton school in Low Hill, which had historically

high numbers of children in private fostering arrangements invited the private fostering social worker to talk to teachers at one of their training sessions following attendance at a Child in Need meeting. Full details of the Private fostering Power Point presentation and other private fostering literature were sent to that school for them to deliver the information in future training events.

Engage Website – A dedicated and interactive site for private fostering in the education sector, managed by the private fostering social worker. All information leaflets, links to specific Private Fostering website's e.g. the BAAF 'Somebody else's child' are included in this site. There are also sections for adding notifications to inform the education sector of events and additional information that are planned or currently taking place to promote awareness of the subject. During the time that the Engage site has been in operation, the private foster carers and a young person have contributed their stories to the notifications section. A second mailshot to all schools in the area will be made at the end of June 2013.

Attempts to engage with the Schools Admission panel has not been successful. The admissions forms clearly asks the question about private fostering arrangement, I have not secured the intelligence to find out what happens to the information after the panel/team manager have researched the information.

Information has been placed in a number of local agencies newsletters - Parent Partnership; Children and Families information newsletter, Mainstream Foster carer Support Group and the National Childbirth Trust.

Tettenhall Language College

The head of Pastoral Care of the College made a referral in respect to a student from Hong Kong who was placed with one of their 'Host' families.

Training/Briefing

The Power Point presentation 'Private Fostering Arrangements in Wolverhampton' has been updated and the private fostering social worker has worked well with Policy and Procedures writer Rachel Warrender to deliver Multi-agency Briefings to the Workforce of the council. The first Briefing scheduled for January 2013 had to be cancelled due to lack of take up. Flyers for the training had been sent out globally in November 2012. The second Briefing session in February 2013 yielded 8 applicants, and was well received. A Third briefing session is set for May 21st at the Beldray Centre.

Workforce Development

Plans are in place to include private fostering information/presentation as part of the Induction training for new workers to the city. There has been good co-ordination with this section in disseminating information on the

briefing sessions; one worker has attended the Private Fostering Support Group on an information giving session.

Systems and Processes

The mapping process for the delivery of private fostering arrangement has been drafted and is currently being amended. It is apparent that there are social workers who are still unsure what steps to take, firstly, in identifying a Private fostering arrangement and secondly, the process to follow once identified.

There has been an overhaul all of the forms and letters used for processing the arrangements, including an information pack for private foster carers and the young people concerned and evaluation forms for parents, carers and young people to complete during after the arrangement has taken place or ended.

A written Agreement format has been successfully utilised and the meetings have included parents, carers and young people. Appropriate permissions for medical matters and educational requests have therefore been obtained at an early stage to enable the private foster carers to ensure that the welfare of their charge is secured.

Several private fostering arrangements have ended for a number of reasons:

Young people reaching the age of 16 years.
Carers taking out Special Guardianship Orders
Children returning to their parents
Disqualification of the arrangement due to the criteria for Private Fostering being compromised.

Care First is now more accommodating to private fostering arrangements, but is not yet able to accommodate the assessment format for the Suitability Assessment Report. The suitability assessment form has now been amalgamated to one form and has been successfully used over the last 6 months.

Statutory visits are adequately reported in respect to the child on Care First. Supervision of the private foster carer is recorded in a similar format as mainstream carers but is not yet aligned to Care First.

A Support Group initiated by a private foster carer of long standing, ran from October 2012 to January 2013. Unfortunately not all private foster carers attended the meetings and as placements ended so did the support group membership. However the founder remains optimistic that the group will be resurrected. Her enthusiasm is utilised with her assisting the private fostering social worker with some of the information sessions for schools.

Private fostering arrangements have used some of the existing processes in supporting their care of the young people. Family Group conferencing has been accessed to resolve issues within the extended family of a young child and training for mainstream carers has been extended to and taken up by private foster carers.

The private fostering social worker has been attending the Profession Interest group for private fostering co-ordinated by British Agency for Adoption and Fostering. The group is made up of other specialist private fostering social workers from around the West Midlands. The PFSIG looks at the development of services, Offers support to specialist workers, relates practice to legislation and currently advise on Ofsted inspection with relevant information packs.

Private Fostering Arrangements details as at March 9th 2013

- 14 cases of Private fostering arrangements
- 11 cases have been closed during the year.
- 11 assessments have been started with 2 declined as unsuitable. Both recorded as disqualifications
- 2 assessments started with children being returned to their parents within a week of the arrangement
- 1 assessment with the child returning home after 9 weeks with the carer.
- 2 assessments in process.

Achievements against the Objectives :-

Ofsted Inspection of Private fostering Arrangements

The fostering services was inspected in February 2012. The next inspection will see the Private Fostering Services incorporate in the general inspection of Children's Services. It is expected that all work undertaken to raise awareness will be inspected. An E folder outlining activities has been set up with a hard backed copy. A spread sheet detailing all enquiries and advice on private fostering is also available for viewing.

Strengths and Weakness of the current service

Strengths

- There are two social workers involved with private Fostering arrangements. The Child has a social worker based in the locality team. The private foster carer is supported by the specialist fostering social worker.
- Policies and procedures are set in placed and is supported by a good website with appropriate and accurate information on Private fostering. This also links into the BAAF 'Somebody else's child's website.

- There is good working relationship between the professionals and the private foster Carers
- All private fostering referrals are directed to the Duty and Assessment Team.
- Private Fostering social worker is available for general advice and support.
- Awareness raising through Marketing and Publicity Activities is on-going.
- Notifications are being made by professionals.
- Support Group for the private foster carers established.
- Private Fostering Special Interest Group to support the specialist worker and their organisation is utilise by Wolverhampton Fostering Services.
- The Health Service have strongly supported the awareness raising of the Private Fostering Regulations.
- Some organisations who have historically arranged for children and young people to be cared for by Host families have been made aware of the regulations and have given appropriate notifications.

Weakness

- Notifications are not being received before the children and young people are in the arrangement.
- The timescale for completing the suitability assessment is hindered by the delay in obtaining all the required statutory checks within the 42 days deadline.
- Not all professionals are fully aware of their roles and responsibility in respect to Private fostering, and take up of briefing sessions have been slow with few take up of training places.
- There are still untapped numbers of Private Fostering arrangements that have not been identified, for example unaccompanied children, and Asylum Seeking situations.
- Public interest and co-operation has been difficult to engage.
- A developmental plan for private fostering has been drafted, but not activated.

Objectives for 2013/14

Future Developments

The targeting of professionals to assist in identifying children who may be in a private fostering arrangement continues to be the focus of the Fostering service. Therefore it our recommendation that the following should be followed:

- The continuation of Briefing sessions throughout the year to a multi-agency audience. This could involve linking in with nearby authorities and the PFSIG.

- Utilising the links forged with Health and Education, to involve managers on a higher level to ensure that information on private fostering is integral to their general information system and acted on. E.g. The admissions forms.

- Further developments with areas in Health and Education. Housing and the Police that are yet to be approached. E.g. Utilising hospital and General Practices electronic information boards.

- To actively recruit or involve individuals to become 'Champions' for Private fostering within their specific service areas and with partner agencies.

- Continued involvement with the Professional Interest Group, sharing experience, resolving difficulties and exchanging good practice.

- Greater interaction with the Voluntary Sector. Although some information has been given out to agencies through postal system or hand posting of information It would be beneficial of some of these agencies received a follow up face to face visit.

- Greater research of past private fostering arrangements to be able to target specific areas of the city, for information sharing and specific public briefing sessions.

Conclusion

Throughout the last year there has been a lot of co-operation from colleagues in enabling the Fostering team to raise the profile and requirements of the Children (Private arrangements for Fostering) regulations 2005. Thank you to all those individuals/agencies concerned.

A lot of progress has been made and a good measure has been obtained in terms of the depth of the assessments and the length of time taken to approve these placements. The foster carers and young people have been proactive in setting up the support group and also in becoming involved in the publicity materials and offering feedback on the new forms used.

8 Budget

Income	
Local Authority	£132,367.00
WCPCT	£30,000.00
West Midlands Police	£10,250.00
Staffordshire & WM Probation Service	£3,000.00
CAFCASS	£550.00
Connexions/Prospects	£2,000.00
Child Death Review	£12,591.00
Community Safety	£20,000.00
Total	**£210,758**

Expenditure	
Staffing	£109,169.00
Ind. Chair	£15,459.00
Consultants	£17,495.00
Training	£21,583.00
Licenses	£11,535.00
Website	£5,570.00
Other	£7,928.00
Refreshments	£1,494.00
Child Death Review	£12,591.00
Printing & Stationary	£6,196.00
Laptop	£787.00
Advertising	£951.00
Total	**£ 210,758**

9 Summary

Key Priorities for 2012 – 2013

The key priorities for 2012 – 2013 were determined and shaped largely by the Business Plane coupled with emerging local and national events and safeguarding matters, including the Boards evaluations of the effectiveness of local safeguarding arrangements based upon the Section 11 audits completed by member agencies: progress with the Boards Business Plan and Work Programme 2011-2013: its review of the national and local safeguarding context within the annual Development Day in March 2012: and, in particular, the findings and recommendations of the Peer Review process of Safeguarding in the City.

Having done so, the Board concluded that whilst maintaining its overall commitment to the broader areas of safeguarding, it would continue in the coming year to give priority to its core business of child protection including reviewing its Governance and member ship arrangements, strengthening frontline practice, protecting the most vulnerable young people from violence, maltreatment, neglect and sexual exploitation; and widening its engagement and communication work within the wider community.

In going forward, WSCB faces a new era and will need to produce a new business plan and update its work programme for 2013/14. At this stage, WSCB will have a particular emphasis to its strategic and performance management roles, whilst also focusing upon key areas for development and ensuring the continuing provision of front line services. As a result, the

Business Plan and Work Programme for 2013-14 will make arrangements for achieving the following priorities:-

The priorities for 2013/14 will include:

- Reviewing the governance arrangements for WSCB to ensure robust challenge to and evidenced accountability of all member agencies in delivering the safeguarding agenda.
- Continuous workforce development and training to ensure that staff have the requisite skills and experience to intervene effectively to safeguard children, and are managed and supported to do so.
- Improved provision of the range of services for particular young people: 11 – 18 year olds to safeguard and promote the welfare of young people.
- Improved practice and service delivery at the interface between Adult Services and Children's Social Care to ensure that effective support Services are provided to parents and to children in need, with a clear focus on safeguarding children at all times.
- Further improve the quality, and achieve consistency, in interventions, assessment, planning and interagency working to safeguard children and young people.
- Ensure a focus upon the child's journey through safeguarding services and the provision of help and support at the right time.
- Progress workforce development and training to ensure that staff have the requisite skills and experience to intervene effectively to safeguard children and promote their safe and appropriate care.
- Engage the wider community in safeguarding children.
- Utilise the combined resources of WSCB member agencies to underpin preventative strategies and services in challenging budgetary conditions.
- Establish a transparent line of communication with schools and GPs in safeguarding children – including Academies.
- Raise the profile of WSCB and its safeguarding agenda through effective communication and media strategies.
- Ensure that the potential impact on safeguarding and outcomes for children arising from service changes due to challenging budgetary conditions are overviewed by WSCB, and that agencies share information and cooperate to minimise the short and long term impact of changes in safeguarding children.
- Ensuring that there is a clear focus upon safeguarding children during times of significant organisational change for many constituent members of WSCB
- Further improve practice and service delivery at the interface between Children's Social Care and Adult Mental Health Services to ensure that effective support services are being provided to parents and to children in need – and ensuring that there is a clear and sharp focus on safeguarding children at all times.
- Ensure that messages from the Child Death Review process informs local practice and service development.

- Review the impact of the re-design of Children's Social Care Services upon safeguarding arrangements and outcomes.

These will be incorporated into the Work Programme for 2013 – 14.
During the course of the year, the Board will also give attention to national and local developments as directed.

Agenda Item No. 9

Health and Wellbeing Board

3rd September 2014

Report title	Better Care Fund Programme Update
Decision designation	AMBER
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Wellbeing
Key decision	Yes
In forward plan	Yes
Wards affected	All
Accountable director	Sarah Norman, Community
Originating service	Health, Wellbeing & Disability
Accountable employee(s)	Viv Griffin — Assistant Director Tel — 01902 555370 Email — Vivienne.griffin@wolverhampton.gov.uk
Report to be/has been considered by	Cabinet, 10th September Executive Team, 10th September

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Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to approve:

1. That authority be delegated to the portfolio holders for Adults, Health and Well Being and Resources, in consultation with the Director for Community and the Assistant Director Finance, to approve the Better Care Fund Programme Plan on behalf of the council, to be submitted by 19 September 2014.

2. That the council services and associated budgets for 2015/16 are agreed as part of the Better Care Fund Programme Plan under the delegation detailed above; be pooled in the

Better Care Fund, subject to the conclusion of a pooling agreement with Wolverhampton Clinical Commissioning Group (CCG) under Section 75 of the National Health Service Act 2006.

The Health and Wellbeing Board is recommended to note:

1. That the Better Care Fund Programme Plan will also require the approval of the Health and Well-Being Board, which has delegated authority for this approval to the Chair of the Health and Well-Being Board and the Chief Officer of Wolverhampton CCG.

2. That a further report will be provided to Health and Wellbeing Board following the submission by 19 September 2014, which will provide an update on the final Better Care Fund Programme Plan, and seek approval for the finalised Section 75 agreement.

1.0 Purpose

1.1 To seek delegated authority for the approval of the Better Care Fund Programme Plan to be submitted by 19 September 2014, and the services and budgets proposed for inclusion therein.

1.2 To provide Health and Wellbeing Board with an update on progress made in relation to the development of the Better Care Fund Programme Plan in Wolverhampton.

2.0 Background

2.1 The Better Care Fund Programme's focus is the delivery of integrated and sustainable health and social care services in Wolverhampton. Previously referred to as the Integration Transformation Fund, the programme was announced in June 2013 as part of the 2013 Spending Round. The fund incorporates a substantial level of existing funding to help local areas manage pressures and improve long term sustainability, and is an important enabler to take forward the agenda of integration (both service delivery and commissioning) at scale and pace. The £3.8 billion of ring fenced money presents an opportunity to improve the lives of some of the most vulnerable people in our society giving them control, placing them at the centre of their own care and support, make their dignity paramount and, in doing so, provide them with a better service and better quality of life.

2.2 The programme will build on existing work the Council and Clinical Commissioning Group have already undertaken in relation to joint development of programmes, and support the sustainable delivery of community facing, neighbourhood health and social care services to the people of Wolverhampton.

2.3 The funding is described as: "a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities". This funding arrangement is called the Health and Social Care Better Care Fund. NHS England, the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS) have worked closely together and, following some key changes, in July 2014, issued revised guidance on how the programme should be delivered, and the process for submitting plans.

2.4 At the centre of the governance process for the Better Care Fund submission and programme is the Health and Wellbeing Board, who are mandated to approve and jointly agree the plan prior to submission.

2.5 The governance infrastructure has been established and agreed, and the programme is overseen by a Transformation Commissioning Board which is chaired by the Director for Community. Reporting to the Board are;

- Transformation Delivery Board, which includes all partners and stakeholders,

- Finance and Information Core Group,
- Quality and Risk Core Group,
- Governance Core Group

3.0 Development of the Wolverhampton Better Care Fund Programme Plan.

3.1 The Better Care Fund does not come into full effect until 1 April 2015, however work has commenced regarding the development of a jointly owned plan, the focus of which is to deliver sustainable and resilient health and social care services embedded within local neighbourhoods and communities. This will be delivered through a whole system transformational change programme with a focus on delivering care as close to home as possible, and avoid unnecessary unplanned attendances at hospital, and maximising resilience and independence through community approaches. The Better Care Fund Programmes Plan will deliver a focus on the following areas;

- Delivering an integrated approach to community capacity building that improves social isolation and supports the development of personalisation – focusing on neighbourhoods and community
- Delivering fully integrated care pathways that support person centred care – putting the person at the centre of flexible and responsive support whether that is through community groups or healthcare staff
- Ensuring Wolverhampton has effective care coordination irrespective of complexity – to support the increasing number of individuals who are older, frail adults with complex physical health needs and are socially isolated
- Designing improved approaches to effective discharge planning and post discharge from hospital support which are delivered on an integrated basis, to ensure that people receive the right care in the right place at the right time
- Designing services which deliver consistent and responsive community access and effective support in a crisis
- Delivery of a model which is underpinned by evidence based metrics included within the Better Care Fund Programme – reduction in emergency admissions, reduction in permanent nursing and residential home placements, improved effectiveness of re-ablement, reduced delayed transfers of care, improved experience and an improved level of diagnosis in Wolverhampton for dementia
- Ensuring that Wolverhampton's health and social care commissioners and providers work in partnership and on an integrated basis to address the impact of a challenged local economy to deliver maximum benefit to the people of Wolverhampton.

3.2 Established in support of the aims of the programme, and to provide comprehensive, co-designed and agreed plans, are four core work streams, which are collaborations between health commissioning, health providers, social care commissioning and provision, and voluntary sector organisations have been established. The work streams are focussed on the following areas;

Primary and Community Care Work stream:

Developing Wolverhampton's transformational approach to fully integrated neighbourhood teams which deliver primary health, community health, social care, and voluntary support and interventions across a functional and service level of integration. Scope includes developing innovative approaches to person centred support, living well with 1 or more long term condition, single point of access and single assessment, wraparound care coordination and delivering reduced social isolation alongside building enhanced community assets which support staying well and living well. Primary care development and utilisation of enhanced services opportunities to deliver improved outcomes are also in scope for the programme Early adoptions include; targeted nursing home and residential care support and care coordination, alongside adoption of Eclipse risk stratification and pharmacology alert systems

Intermediate and Urgent Care Work stream:
Developing Wolverhampton's approach to alternatives to admission, effective discharge, and early discharge programmes. Scope includes recovery and reablement, residential and nursing care, enhanced community facing discharge liaison function, risk stratification and planning approaches.

Mental Health Work stream
Developing Wolverhampton's approach to fully integrated functional mental health community services, and the development of community facing pathways. Scope for the work stream includes, enhancing the development of fully integrated care pathways for mental health, including where crisis and urgent care needs occur, establishing a recovery pathway for those individuals placed in out of area hospitals and care which ensures care as close to home as possible, early intervention, achieving parity of esteem, the approaches to supporting those who no longer have enhanced needs and mental health awareness, anti-stigma and self-help.

Dementia Work stream
Developing Wolverhampton's approach to the challenge of increasing numbers of those diagnosed and undiagnosed with dementia. Scope includes; developing a fully integrated dementia care pathway which responds effectively to changing levels of need including developing an enhanced awareness raising and neighbourhood engagement approach, establishing integrated health, care and voluntary sector approaches which complement and enhance community care services, developing fully integrated enhanced care pathways, advanced planning, and systems of crisis management which supports a home as hub approach.

The developing proposed plan covers a three year period part year effect 2014/15, 2015/2016, and 2016/17 and reflects the preceding paragraphs.

The proposed plans must meet the following national conditions:

a. Plans to be agreed locally
b. Plans must protect local care services
c. 7 day working in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

d. Better data sharing based on the NHS number
e. A joint approach to assessments and care planning
f. Agreement on the consequential impact of changes in the acute sector

The national metrics to be used to monitor performance are:-
a. Delayed transfers of care
b. Emergency admissions (payment for performance)
c. Effectiveness of reablement
d. Permanent admissions to nursing and residential care homes
e. Patient and service user experience
f. Increased diagnosis of dementia

3.3 The jointly agreed plan must be submitted by 19 September 2014, and is currently in the process of being revised and developed in full.

3.4 Responsibility for commissioning health and social care services in Wolverhampton resides across three core organisations; Wolverhampton City Council, Wolverhampton Clinical Commissioning Group, and NHS England. The current key providers of services are NHS Trusts, City Council, and the private, voluntary and community sectors. The majority of health services are delivered by NHS Trusts (Black Country Partnership Foundation Trust and The Royal Wolverhampton NHS Trust) and social care services through some internal but predominantly external providers.

3.5 Wolverhampton faces significant challenges through increased demand for support caused by demographic changes, major reductions in council funding and the need to establish financially and operationally sustainable health and social care. This will require a shift in investment from acute to community and primary care services.

3.6 The health and social care economy within Wolverhampton is challenged financially with a significant QIPP programme in the CCG's current 5 year plan of £40 million and a five-year savings target for the council of £123 million. The Better Care Fund represents an opportunity to pool resources, in particular around community-based services in order to create an environment which demonstrates best value from joint investments. For both commissioning organisations this means transforming; to the CCG, this means enacting strategic intentions to transfer appropriate elements of care from a hospital setting and into the community as well as reviewing and transforming existing community based services to integrate and future proof a sustainable service.

3.7 Through collaborative working between the council and the CCG on a shared vision and plan through the Better Care Fund Programme, the risks of both destabilising the health and social care economy in Wolverhampton, and non-delivery of efficiency and savings programmes should be minimised. In pooling a jointly-held and agreed budget, the opportunity for further community-facing investment is maximised.

3.8 The newly created proposal regarding the pooled budget gives both the council and CCG an opportunity to share the risk and rewards of joint transformational work. The pooled budget (Section 75) agreement will provide the contractual vehicle by which the sharing

of risk in this arrangement will be articulated. If there is a failure to deliver to budget within the pool, both parties will be required to share the liability. On the other hand, a successful arrangement will not only manage within the pooled budget but will also create efficiencies in the broader economy that will enable a transformation of services from the funding that becomes available.

4.0 Financial implications

4.1 The purpose of the BCF is to achieve greater levels of integration across health and social care to improve outcomes and in so doing to shift investment from acute to community and primary care and deliver greater efficiency and value for money. Although the fund itself is new, the money is drawn primarily from existing NHS and council funding streams and currently-funded services are in the scope of the fund.

4.2 The current draft BCF revenue pooled budget for 2015/16 is £74.2 million. This includes a contribution of revenue funds to "accelerate transformation" of integrated community and primary based care. Of this £74.2 million, £23.3 million is made up of budgets that are currently managed by the council. It should be noted that the fund includes £6.3 million representing the NHS transfer to social care ('Section 256' funding).

4.3 The proposed 2015/16 BCF allocation includes funding of £2.0 million for the forecast financial impact of demographic growth on social care, and £1.0 million for Care Act implementation costs. The ongoing demographic growth pressure for 2016/17 and beyond is forecast to increase by £2.0 million per year: it is essential that the pooled budget is of sufficient scale to enable these efficiencies to be realised. The council's medium-term financial strategy (MTFS) currently assumes that these pressures will be funded in full from the BCF.

4.4 The receipt of a proportion of the BCF funding in 2015/16 will depend on meeting agreed performance targets in quarter four of 2014/15 and 2015/16: specifically, the main target which impacts upon available funds is to achieve a reduction in the number of non-elective emergency admissions. Other national metrics have been set and are required to be monitored, but do not have a payment-by-performance element. Achieving the reduction in non-elective admissions target is therefore a critical factor in securing full funding for all spending plans contained within the BCF.

4.5 The method for apportioning any under or over spend against the pooled budget is currently under development, and will be set out in the Section 75 agreement. Should the council be required to contribute to an over spend, this would create an additional budget pressure which is not identified in the MTFS. [AS/01092014/L]

5.0 Legal implications

5.1 The Planning Guidance for the Better Care Funds confirms that the Fund will be allocated to local areas where it will be put into pooled budgets under Section 75 NHS Act 2006 ("Section 75 Agreements").
Section 75 agreements allow for NHS bodies and local authorities to enter into partnership arrangements for a number of specified purposes including pooled fund arrangements, the exercise by NHS bodies of local health related functions, the exercise by local authorities of NHS functions and the provision of staff, goods and services or making of payments.

5.2 Regulations set out the terms requirements to be included in Section 75 Agreements. In relation to pooled fund arrangements these include, agreed aims and outcomes, the contributions to be made to the pooled fund by each party, how the pooled fund is to be managed and monitored, which body is to be the host party and audit arrangements. These arrangements are currently in development through the Governance and Risk Core Group.

5.3 The BCF funding from 2015/16 will be put into pooled budgets as part of Section 75 joint governance arrangements between CCGs and Council, with plans for spending the funds needing to be jointly agreed. Although this represents a shift in how decisions are made about investment this funding will be drawn primarily from CCG budgets. Taking this into account there will still be a significant reduction in resources across health and social care in Wolverhampton as a consequence of reductions in local authority budgets. An integrated governance structure has been agreed across all parties and the Health and Wellbeing Board is asked to formally delegate responsibility for the oversight of the Better Care Fund Programme to the Health and Wellbeing Board, as per the national guidance. *(AH/00011900/T)*

6.0 Equalities implications

6.1 There are no equalities implications specifically relating to the sign off of this submission. However, the detailed plan to implement the programme will require a detailed Equalities Impact Assessment.

7.0 Environmental implications

7.1 There are no environmental implications.

8.0 Human resources implications

8.1 Some transformational change outcomes may require TUPE arrangements to apply between providers if procurement is utilised to enhance provide a more mixed health and social care economy. This will not have a direct impact other than in relation to procurement advice and support.

9.0 Corporate landlord implications

9.1 There are no corporate landlord implications.

10.0 Schedule of background papers

10.1 Better Care Fund - Progress Report, report to Health and Wellbeing Board, 9 July 2014

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Agenda Item No: 10

Health and Wellbeing Board

3 September 2014

Report Title	Joint Strategy for Urgent Care Equality Analysis
Cabinet Member with Lead Responsibility	Councillor Sandra Samuels Health and Wellbeing
Wards Affected	All
Accountable Strategic Director	Dr Helen Hibbs, Chief Officer Wolverhampton Clinical Commissioning Group
Originating service	Wolverhampton CCG
Accountable officer(s)	Steve Corton — Senior Equality and Diversity Manager Tel — 0121 612 3824 Email — steve.corton@nhs.net

Recommendation(s) for action or decision:
The Health and Wellbeing Board is recommended to:

1. .Consider specific adoption of six recommendations 8, 10, 11, 19, 20 and 21 in the equality analysis document.

Recommendations for noting:
The Health and Wellbeing Board is asked to note:

1. The whole Equality Analysis, particularly the 21 recommendations set out on pages 40-42 of the document.

1.0 Purpose

1.1 To present the Equality Analysis (attached as an appendix) for the Joint Urgent Care Strategy to the Board, and to seek the Board's agreement to adopt specific recommendations in the equality analysis.

2.0 Background

2.1 Midlands and Lancashire Commissioning Support Unit (CSU) is contracted to provide equality and diversity support to Wolverhampton Clinical Commissioning Group. As part of this support, the Equality and Diversity Team of the CSU was asked to undertake an equality analysis of the 'Joint Strategy for the Provision of Urgent and Emergency Care for Patients using Services in Wolverhampton to 2016/17'. The analysis is focused on the impacts for Wolverhampton residents.

2.2 The methodology and regular updates on progress of the equality analysis is reported quarterly to the System Resilience Group (formerly the Joint Urgent and Emergency Care Board). This group considered the equality analysis at its meeting on 13th June 2014 and endorsed the 21 recommendations it contains. The Board further proposed that the equality analysis should be considered by the Health and Wellbeing Board to enable specific consideration to be given to those recommendations where the HWB Board has a definite role.

3.0 Equality Analysis

3.1 The analysis contains 21 recommendations. Wolverhampton CCG has adopted those recommendations relating directly to its remit through its Quality and Safety Committee on 13th May 2014. This also included commitments to partnership work from Public Health colleagues who attend the Q&S.

3.2 The Board is asked to adopt 6 specific recommendations from the report (numbering follows the analysis numbers), namely:

8. All agencies - opportunities to engage across the protected characteristic groups should be built in to proposed engagement and consultation as the implementation phase of the urgent care strategy progresses including specific outreach work where response rates show low engagement with particular groups.

10. All agencies – (because of the trend in homelessness in Wolverhampton and the disproportionate impact of homelessness on the costs of health provision – particularly skewed towards urgent and emergency care) – the implementation plans for urgent and emergency care should involve social housing providers and homelessness organisations as part of an integrated approach. Further work may be required to identify any geographical disparities in the location of homelessness people; to research the health experiences of homeless people; and to explore the potential for more effective and earlier interventions to prevent or reduce ill-health and to respond more appropriately to their healthcare needs.

11. The Health and Wellbeing Partnership to explore ways to better understand the health needs of the Wolverhampton based travelling communities and how they access healthcare. However, any such work and the resource commitment will need to be proportionate. Anecdotal information about healthcare demands may offer an appropriate starting point on which to build more targeted studies.

19 The Health and Well-Being Board consider specific support to be identified within the suicide prevention strategy for Lesbian, Gay, Bisexual and Transgender people.

20 All agencies to ensure that equality and diversity training is included in the mandatory training elements for each organisation. Where possible, agencies are recommended to share training opportunities, particularly where patient pathways necessitate involvement with different organisations. This would allow for consistency of approach, and highlight areas of complementary (or dissonant) practice. For all, training content should include information about all the protected characteristic groups; the public sector equality duty and the three aims; the significance and importance of equality monitoring; and the values, principles and pledges within the NHS Constitution as a minimum.

21 Staff involved in the design of surveys or questionnaires; in their distribution or completion with respondents should receive a comprehensive and timely briefing beforehand which covers: the significance and value of equality questions; the importance in ensuring a high % of completion from respondents; and how to confidently respond to respondents' questions in a way which is tactful, sensitive, and reassures people about the confidentiality of the information they share.

4.0 Financial implications

4.1 No specific financial implications have been identified in this report. An assumption has been made that all partner agencies involved in the Health and Wellbeing Partnership share the statutory Public Sector Equality Duty set out in s149 of the Equality Act 2010. The recommendations in the equality analysis are consistent with this duty. No timescale has been suggested for successful implementation of the recommendations, but partner agencies will need to prioritise within the budgetary limitations they have and make proportionate efforts to demonstrate their duty of 'due regard'.

5.0 Legal implications

5.1 The equality analysis contributes to the s.149 Public Sector Equality Duty, and specific recommendations are made to assist commissioners and providers when specifying and designing delivery of urgent and emergency care services. The equality analysis does not however obviate the need for individual organisations to undertake their own detailed equality analyses to accompany service change.

6.0 Equalities implications

6.1 Equalities implications are intrinsic to this report

7.0 Environmental implications

7.1 Environmental implications have not been considered in this report.

8.0 Human resources implications

8.1 Human resource implications have not been considered in this report.

9.0 Schedule of background papers

9.1 A full list of references has been given in the equality analysis document.

Report written by:

Steve Corton
Senior Equality and Diversity Manager
Midlands and Lancashire CSU
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Midlands and Lancashire Commissioning Support Unit

NHS Wolverhampton Clinical Commissioning Group

Report on Equality Analysis

Joint Strategy for the Provision of Urgent and Emergency Care for Patients using Services in Wolverhampton to 2016/17

Contents

Summary

Midlands and Lancashire Commissioning Support Unit (CSU) is contracted to provide equality and diversity support to Wolverhampton Clinical Commissioning Group. As part of this support, the Equality and Diversity Team of the CSU was asked to undertake an equality analysis of the 'Joint Strategy for the Provision of Urgent and Emergency Care for Patients using Services in Wolverhampton to 2016/17'. The analysis is focused on the impacts for Wolverhampton residents.

This document presents the analysis along with reasons for the conclusions reached, and makes evidence based recommendations to inform equality approaches in the procurement, operation, and continuous improvement of urgent and emergency care services.

The Equality Analysis considers two distinct, but related areas:

1. The equality impact of the reconfiguration of services, and particularly the relocation of the Walk-in Centre facility from Showell Park to a new Primary Care Centre at New Cross Hospital.

Assessment 1

The relocation of the Walk-in-Centre from Showell Park to New Cross Hospital will benefit some residents and disadvantage others. Although it is not possible to quantify the balance between 'winners' and 'losers', the demographic information available suggests that the health inequality gap between different groups is unlikely to be widened by the proposals. Proxies for deprivation discussed in the report such as no car ownership or receipt of Disability Living Allowance suggest that a greater proportion of low income households with mobility disadvantages may benefit from the re-siting. Furthermore, if the proposed improvements in primary and secondary care are realised, all protected characteristic groups should benefit from more accessible and responsive services. Urgent care for other distinct groups such as homeless people and migrants also has potential to improve.

2. A consideration of how *operationally*, urgent and emergency care services can adopt an equality approach towards different protected characteristic groups.

Assessment 2

Commissioners can ensure that robust equality considerations, sensitive to the particular needs of each protected characteristic group, are built into procurement in pre-qualification questionnaires (PQQs), and service specifications. Contracts can require providers to conduct further equality analyses on their service operations. Contractual information requirements can also be established which consider equality in the provider workforce and in the delivery of services. All NHS Trusts and private sector providers commissioned by the CCG will be required to demonstrate compliance with the general duty under s149 Equality Act 2010 (the Public Sector Equality Duty).

Recommendations are offered in the analysis as part of a specific equality action plan for services as they are developed **(at section 7)**.

1. Introduction

Urgent and Emergency Care – the case for change

1.1 The increase in demand for urgent and emergency care services, and the pressures this creates in the health economy of Wolverhampton have been clearly articulated in the strategy itself:

> **"It is understood that there is no single cause to the increased pressure nor is there a single solution. The existing system of providing urgent care in Wolverhampton is unsustainable and was not designed to cope with the significant and unpredicted increased levels of activity. Our patients are experiencing long waits and have told us that they are confused on how and where to access appropriate services. Doing nothing is not an option....The system has become complicated for patients and their expectations have led to immediate demands to be seen and treated for conditions that are not always urgent, with the default often being the ambulance service or the Emergency Department (ED)."**
>
> Joint Strategy (Wolverhampton CCG, 2013a; p6)

1.2 The intention is set out in the vision for the strategy:

> **"Our vision is for an improved, simplified and sustainable 24/7 urgent and emergency care system that supports the right care in the right place at the right time for all of our population. Our patients will receive high quality and seamless care from easily accessible, appropriate, integrated and responsive services. Self-care will be promoted at all access points across the local health economies and patients will be guided to the right place for their care and their views will be integral to the culture of continuous improvement."**
>
> Joint Strategy (Wolverhampton CCG; 2013a;p7)

1.3 'Access points' will include 'easy to access' 24 hours a day, seven days a week services, urgent GP appointments, Walk in Centres, Emergency Department, the Ambulance Service and emergency admissions to hospital. The crux of the reconfiguration is described as:

> **The new urgent & emergency care system will be improved and simplified for patients with access to general practice, community teams, a walk in centre at the Phoenix Centre, the ambulance service and a new Primary Care Centre and ED at New Cross Hospital. Patients will be encouraged to self-care or seek advice from pharmacy services or to be guided to the right place for their care through telephone access with NHS 111. The out of hours service and the Showell Park Walk in Centre (only the service, the building and GP practice will remain) will be relocated to become fundamental parts of the new Primary Care Centre which will offer care to primary care patients 24 hours a day, 7 days per week whether they walk in or are directed there by a healthcare professional.**
>
> Joint Strategy (Wolverhampton CCG, 2013a; p23-24)

1.4 The Consultation document *'Plans for Urgent and Emergency Care Services in Wolverhampton'* summarised the proposals for change for residents and invited respondents to indicate if they were supportive of them:

> **"At the heart of our plans is the move to bring together some of the city's urgent and emergency care services into one building, which is expected to open in early 2016. This will be a brand new purpose-built centre that will be open 24 hours per day and 365 days per year at New Cross Hospital"**
> Plans for Urgent and Emergency Care Services (Wolverhampton CCG; 2013b)

The timetable for change

1.5 The strategy for urgent and emergency care services outlines the 'what', 'where' and 'when', and explains that the 'how' will be detailed within the *implementation plans*. There are 4 distinct phases for implementation:

Phase 1 – December 2013 – December 2014
Consultation, and development of implementation plans. This phase will include a new Emergency Department with a co-located Primary Care Centre, and supporting ambulatory and diagnostic facilities. Subsequent developments are proposed and include a second and third floor housing Emergency Admissions Units for Children (PAU), Medical Patients (AMU), Surgical Patients (SAU) and a proposed Clinical decisions Unit (CDU). The new ED Business case is tightly linked to the emerging Urgent and Emergency Care Strategy and work has been undertaken to provide assurance to the CCG's that the new ED will improve quality.

Phase 2 – November 2013 – December 2016
Improve Primary Care

Phase 3 – November 2013 – December 2016
Improve Secondary Care

Phase 4 – December 2016 – December 2017
Review and amend

Responses to the proposals so far

1.6 The methodology for the consultation, and a summary of patient responses are included in a 'Feedback Report' ' (Wolverhampton CCG; 2013) The consultation was undertaken between 2 December 2013 and 2 March 2014. 94% of respondents to the survey expressed support for the plans for urgent care.

1.7 Key themes emerging from patients included issues around access to services: especially GP appointments; transport and parking at urgent care facilities; and reducing confusion about the sytem through education and communication. Healthwatch Wolverhampton has said it agrees with the principle of creating a simple system with fewer options, layers and improved information, and that this will be better for the people of Wolverhampton. It also stressed the importance of on-going involvement of patients and residents in the development of the service specification.

1.8 There was a demand for information on the impact of the proposed changes for the Eye Infirmary, including its connectivity to the new centre. There is an expectation that the services should be linked or co-located in order to make it easier for eye care patients to travel between the two. This should be supported with clear and accessible information.

1.9 Healthwatch Wolverhampton has expressed the view that more needs to be done to clarify care pathways for ophthalmology urgent care patients.

1.10 Healthwatch Wolverhampton has also expressed the view that the current pharmacy provision is not effective.

Equality and diversity research methodology

1.11 204 individuals responded to the consultation survey which was, given the reach of the consultation process, a low response level. Responses to specific equality questions included on the survey form (questions on disability, ethnicity etc) were not well completed, and there are lessons here for improving the confidence of questioners when asking for equality information, and too for the reassurances given to the public about why the information is being collected, and how it is to be used. The minority ethnic completion percentage for respondents was much lower than for the Wolverhampton population overall, suggesting that different venues, and specific outreach approaches need to be identified in the future. Both these points are included in the recommendations arising from this analysis and should help to influence implementation plans.

1.12 However there was significant coverage, and a very wide range of stakeholders included in the consultation process, and so it is reasonable to conclude that the vast majority of Wolverhampton residents had an opportunity to access the materials and to respond if desired.

Survey of organisations

1.13 A separate short survey was undertaken, targeted at voluntary and community organisations who work with protected characteristic groups as defined by the Equality Act 2010. This survey was kindly distributed by both the Wolverhampton Equality and Diversity Forum (EDF) to their membership list, and by the Wolverhampton Voluntary Sector Council using their organisational database. This survey was designed to be complementary to the consultation questionnaire, and to capture any currency of information, through the knowledge and understanding of representative groups, about how urgent and emergency care services are operating. The questions asked about:

- Positive experiences of urgent care health services?
- Any difficulties experienced?
- Improvements which could be made?
- Whether services understand (or don't understand) the particular needs of different groups?
- Whether people feel listened to?
- Whether privacy and dignity are respected by services?

1.14 The survey ran over a six week period from early January through to 21st February 2014. 23 organisational responses were received. The findings from this survey have been used to inform the local issues included in the analysis of protected characteristic groups from **section 4** . In general the responses have been positive and focussed on patient experiences of urgent care. Some concerns were expressed about the needs of people with mental health problems, and patients with learning disabilities. These echo some of the concerns highlighted about Accident and Emergency services by the CQC Quality Report following the recent inspection of New Cross Hospital (CQC, November 2013).

1.15. Issues were not raised in this survey concerning the rationale for the proposed changes to urgent and emergency care, nor for the proposed re-siting of urgent care facilities in Wolverhampton.

1.16 Wolverhampton CCG will work with provider organisations to ensure that as plans for re-modelled urgent and emergency care services develop and are implemented, that thorough consideration is given to the appropriate collection of equality monitoring information, and that equality analyses (impact assessments) help to inform the receptiveness and sensitivity of services to diverse needs.

2 The Context for Equality Analysis

Strategic Commitment

2.1 There are explicit commitments to equality and diversity in the strategy itself:

> **"The Urgent and Emergency Care Board is fully committed to promoting equality of opportunity, eliminating unlawful and unfair discrimination and valuing diversity, so that we can remove or minimise disadvantages between people who share a protected characteristic and those who do not. All Urgent and Emergency Care services will ensure that services are appropriate and do not discriminate on the basis of the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or beliefs, sex and sexual orientation...The rights and pledges contained in the NHS Constitution will be upheld at all stages of the patient journey through Urgent and Emergency Care (p9)**
> Joint Strategy (Wolverhampton CCG, Royal Wolv'hampton NHS Trust; 2013; p9)

2.2 To ensure this, a regular Equality report has been considered by the Board (on a bi-monthly basis) submitted by the Midlands and Lancashire Commissioning Support Unit which has sought to identify improvements in the equality approaches adopted by the process – especially to consultation methods, and to data collection systems.

The Public Sector Equality Duty

2.3 Clinical Commissioning Groups (CCGs) are now listed as public authorities in Part 1 of Schedule 19 to the Equality Act 2010. This means that Wolverhampton CCG is subject to the general Public Sector Equality Duty required by s.149 of the Act. S.149 states that the CCG must ***"have due regard to the need to***:

i. Eliminate discrimination, harassment, victimisation, and any other conduct prohibited by the Act;
ii. Advance equality of opportunity between persons who share a relevant protected characteristic***** and persons who do not share it;
iii. Foster good relations between persons who share a relevant protected characteristic and persons who do not share it."

*****Protected characteristic groups' are described in paragraph 2.7 below.

2.4 Having ***due regard*** for advancing equality (2nd aim) involves:

- **Removing or minimising disadvantages** experienced by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low

2.5 In the case of *R (Brown) v Secretary of State for Work & Pensions [2008] EWHC 3158 (Admin).*the Court set out some principles for public bodies to guide them in

compliance with the duty to give due regard to relevant equality needs. These include that:

- When a public authority makes decisions that do or might affect a protected characteristic group, it must be made aware of its duty to have due regard to the aims in the Equality Duty. An incomplete or mistaken appreciation of the Duty will mean that 'due regard' has not been paid.
- The 'due regard' must be exercised with rigour and with an open mind. It is not a question of 'ticking boxes'. The Duty has to be integrated within the discharge of the public functions of the CCG. **It involves a conscious and deliberate approach to policy-making** and needs to be thorough enough to show that 'due regard' has been paid before any decision is made.
- If the CCG has not specifically mentioned the relevant general Equality Duty when carrying out a particular function, this does not mean that the Duty to have 'due regard' has not been performed. However, it is good practice for the policy itself, or the CCG, to make reference to the Duty and any code or other non-statutory guidance. This will reduce the chance of someone successfully arguing that 'due regard' has not been paid to equality considerations. This is also likely to enable a public authority to ensure that factors relevant to equality are taken into account when developing a policy.
- It is good practice for public organisations to keep an adequate record showing that they have actually considered the Equality Duty and pondered relevant questions. Appropriate record-keeping encourages transparency and will discipline those carrying out the relevant function to undertake their Equality Duties conscientiously.

The role of Midlands and Lancashire Commissioning Support Unit

2.6 Midlands and Lancashire Commissioning Support Unit (MAL CSU), as part of its support to Wolverhampton Clinical Commissioning Group, was asked to help facilitate an Equality Analysis on the Joint Strategy for Urgent and Emergency Care services. The aims in producing this report were to:

i. Establish a baseline on current usage of urgent and emergency care services within Wolverhampton with regard to **protected characteristic groups**.
ii. Assess the equality impact on the local population of potential changes as part of the plans in Wolverhampton.
iii. To use the process of Equality Analysis, as guided by the route map (Appendix 1) to inform decision-making.
iv. Identify opportunities to promote equality
v. Recognise the potential risks to the strategy from not addressing inequalities.
vi. To suggest ways to mitigate these risks

2.7 The **'protected characteristic groups'** are defined in Part 1 of the Equality Act 2010 and cover people who are specifically offered protection by the Act. Before the Equality Act, all NHS organisations already had to demonstrate that they were treating people of different races, people with a disability, and men and women fairly and equally. The 2010 Act has added groups of people to the equality duty. These are set out in Table 1 below:

Table 1: Definition of Protected Characteristics

Protected Characteristic	Definition
Age	**This refers to a person having a particular age (for example, 52 years old) or being within an age group (eg 18-30 year olds; 'older people' or 'children and young people'. Specific discussions about age will usually be given context by the nature of the services under consideration.**
Sex	**Someone being a man or a woman**
Disability	**A person has a disability if s/he has a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities.**
Race	**Race refers to a group of people defined by their colour, nationality (including citizenship), ethnic, cultural or national origins. 'Ethnic group' is another descriptive term often used. This may refer to a long, shared history and common cultural traditions; a common geographical origin, language, literature, or religion may also be factors to consider.**
Sexual Orientation	**Whether a person's sexual attraction is towards their own sex (homosexuality), the opposite sex (heterosexuality), or to both sexes (bisexuality). The terms 'Lesbian', 'Gay', 'Bisexual' (LGB) are commonly used when describing the particular health experiences, prejudices, and challenges encountered by people whose sexuality differs from the majority heterosexual state.**
Gender reassignment	**People who are transitioning from one gender to another. A person who is Transgender is someone who expresses themselves in a different gender to the gender they were assigned at birth. Although the legislation covers gender reassignment, the term 'trans' better encompasses the wider community and has wide currency. Gender reassignment may also include people who are considering a sex change, but an intention to change sex is not a necessary requirement to be considered as trans.**
Religion or belief	**People with a religious or philosophical belief, (or people without a religion or belief e.g. Atheism). Generally a belief should affect your life choices or the way you live for it to be included in the definition. Political beliefs are not afforded protected characteristic status.**
Pregnancy and maternity	**Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in an employment context. In the non-work context, protection against maternity discriminatiion is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.**
Marriage and Civil Partnership	**People who are in a civil partnership or are married. Marriage is currently defined as a 'union between a man and a woman'. Same-sex couples can have their relationships legally recognised as 'civil partnerships'. Civil partners must be treated the same way as married couples on a wide range of legal matters**

Scope of the Equality Analysis

2.8 The Equality Analysis considers two distinct but related areas:

i. The equality impact of the reconfiguration of services, and particularly the relocation of the Walk-in Centre facility from Showell Park to a new Primary Care Centre at New Cross Hospital.

ii. A consideration of how operationally, urgent and emergency care services can adopt an equality approach towards different protected characteristic groups as users of services.

2.9 The focus of the analysis has been on the impact for residents of Wolverhampton, but not for visitors from neighbouring CCG areas seeking healthcare within Wolverhampton. Each CCG should consider the equality impact for its own population.

2.10 The impact on staff working for provider organisations has not been considered as part of this analysis. This work would need to form part of the equality analysis of specific implementation plans for each provider.

Method

2.11 Wolverhampton CCG at its inception in April 2013, adopted a process for Equality Analysis for many key areas of its work. This includes an equality analysis tool comprising a template and guidance. The CCG's Equality and Diversity Strategy and Action Plan (available at this link) sets out in detail how the CCG seeks to comply with its Public Sector Equality Duty.

2.12 For the Joint Strategy, in anticipation that a much wider group of stakeholders would be engaged in the process, an equality analysis 'route map' was produced by the CSU to illustrate how each stage could progress. A summary of this route map is attached at Appendix 1. The case for change set out in the Joint Strategy is focused on the issues which necessitate a reconfiguration of urgent care services and facilities. This equality analysis has therefore considered the potential impact of the case at an early stage and considers the information from the listening exercise carried out early in 2013, the formal public consultation held in early 2014, and a targeted survey of voluntary and community organisations which deal with protected characteristic groups (early 2014) [Discussed more fully in section 4]

2.13 A wide range of reports, statistical information, and transferable learning from equality analyses of urgent care services in other parts of the country were used as part of this analysis. A full list of these appears at the end of this document. In addition, equality information statistical returns from provider organisations were compiled, and additional service information was requested from those organisations directly involved in providing urgent and emergency care. These were used to try to understand the provision for protected characteristic groups as well as for non-statutorily protected groups who have significant healthcare needs (eg: homeless people; migrants; travelling communities). The conclusions and inferences made in this analysis have been made using these materials.

Assumptions

2.14 We have assumed:

i. No planned diminution of service has been identified either by withdrawing services, or restricting eligibility for existing services. The drivers for change emphasise the intention to enhance services and improve efficiencies by reducing unnecessary duplication, and offering clinicians and patients alike greater clarity along the treatment pathway.

ii. Provider organisations, in pursuance of meeting their own Public Sector Equality Duty under s149 Equality Act 2010 will conduct their own equality analyses to cover workforce and service impacts arising from implementation plans. These will form an important part of the implementation phase.

iii. Further engagement opportunities for patients and their families, and other stakeholders will continue throughout the strategy period (to 2017) and be effected through the joint partners to the strategy. These opportunities will be receptive to the perspectives of different protected characteristic groups.

3. Equality Impact of the reconfiguration of services

Relocation of Showell Park

3.1 Evidence considered by the Joint Urgent and Emergency Care Strategy Board found that:

"Further to the analysis of Walk-in-Centre use by patients, based on their registered GP Practice, it is clear that the proximity of the Walk-in-Centre to a patient's home or GP Practice has a significant impact on their use of walk-in-centre – ie the closer they are based to the walk-in-centre, the more significant their use"

(Wolverhampton City Council, 2012)

3.2 As well as high use from people living close to the walk-in-centre, the evidence also showed that the walk-in-centre was in higher demand when GP Practices are shut (evenings and weekends), and that for Showell Park walk-in-centre in particular, activity is localised around the physical location of the services. However there is also a significant duplication of Accident and Emergency use where patients visit Showell Park and then go on to visit A&E. This pattern of activity is shown in Figures 1 and 2 below

Figure 1: Showell Park activity in 2011/12 (Wolverhampton City Council, Public Health Intelligence Team 2013) – figures in brackets refer to the number of geographical 'lower super output areas' (LSOAs) that demonstrate each level of activity.

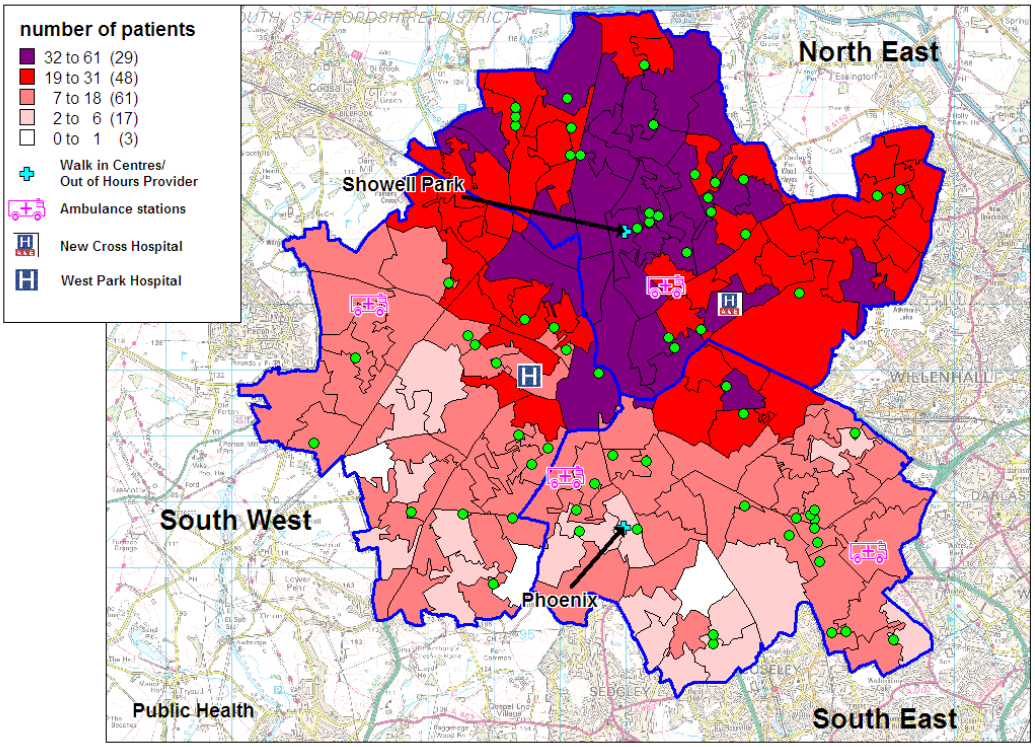
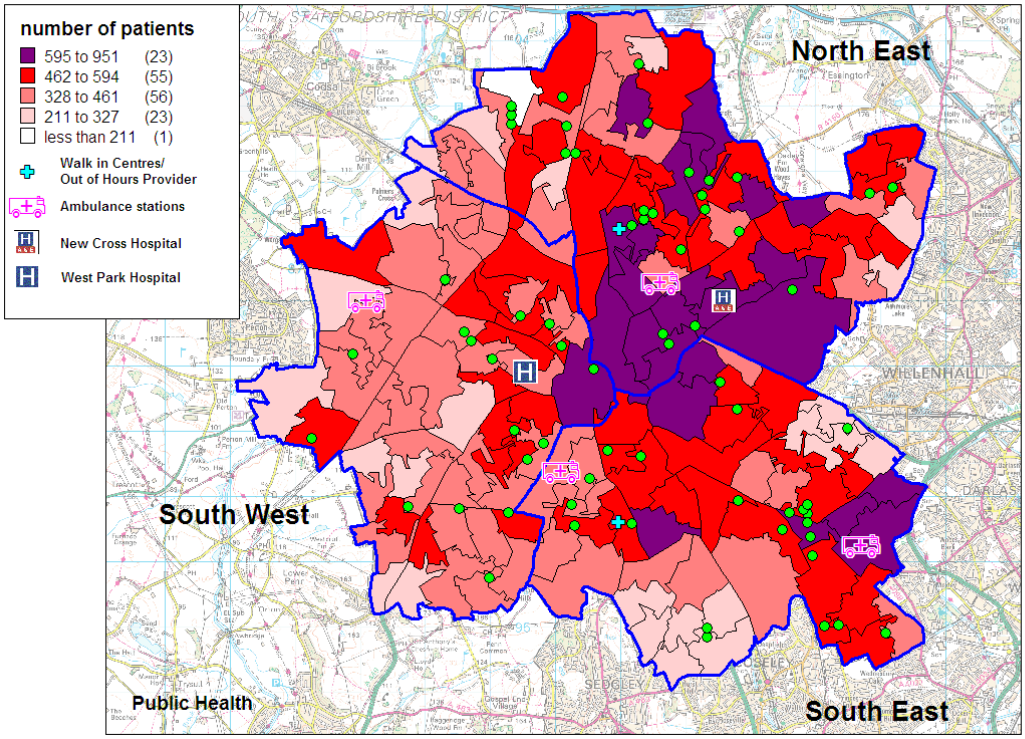


Figure 2: A&E attendances in 2011/2012 (Wolverhampton City Council Public Health Intelligence Team 2013)

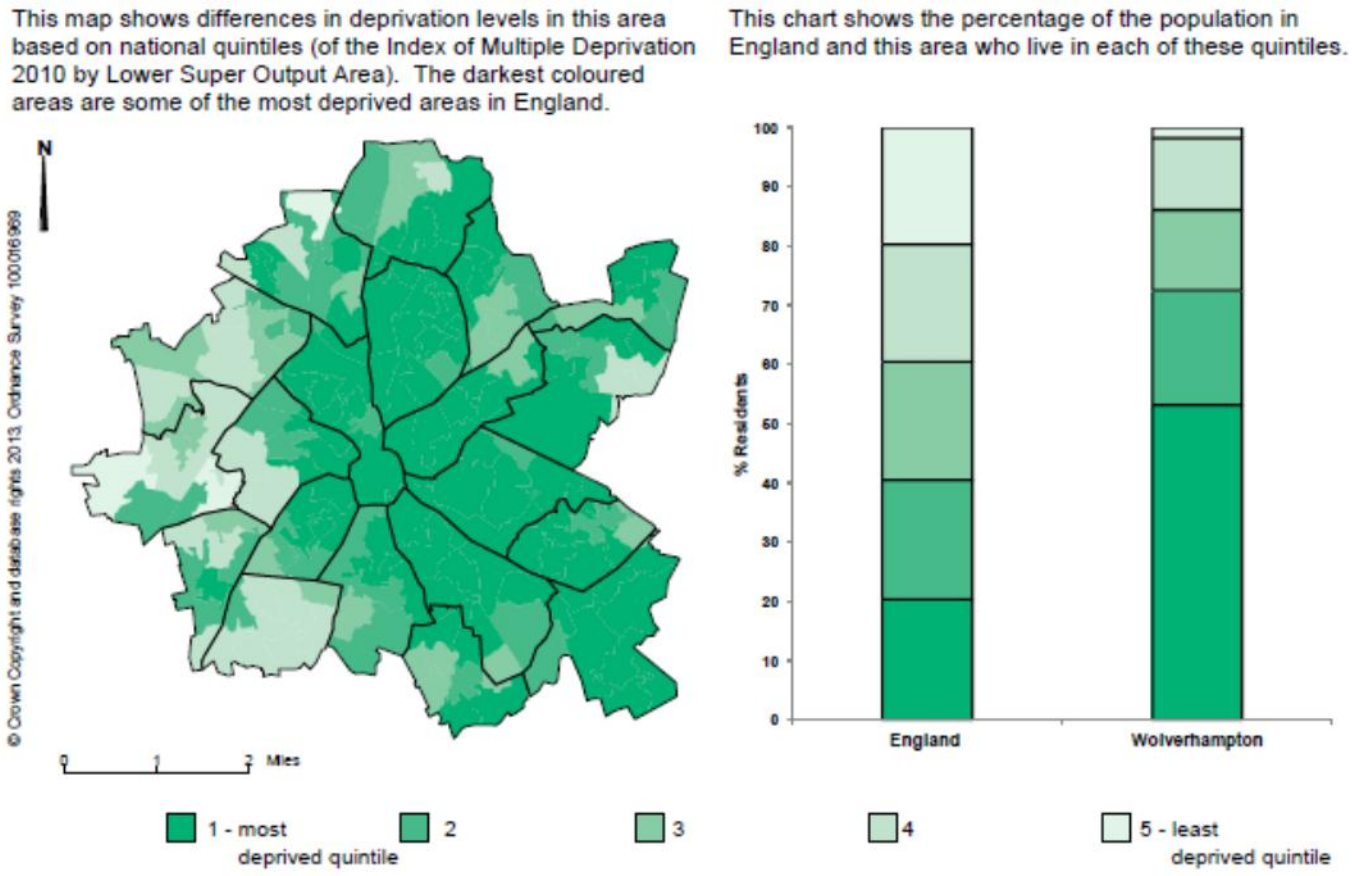


3.3 This suggests that the relocation of Showell Park walk-in-centre to a facility at New Cross (also shown on the map) will have a disadvantageous impact on residents living in the vicinity, and to the immediate North and West of Showell Park. Residents living to the South and East of Showell Park will be closer to the new facility. The question then arises, what is the magnitude of this impact? A definitive answer can not be given, but we can look for some clues in the demographic information we have available.

Demographic Information

3.4 The use of urgent and emergency healthcare services is inextricably linked to socio-economic factors and particularly to deprivation. Wolverhampton has high numbers of people living in deprived areas when compared to the figures for England – Figure 3.

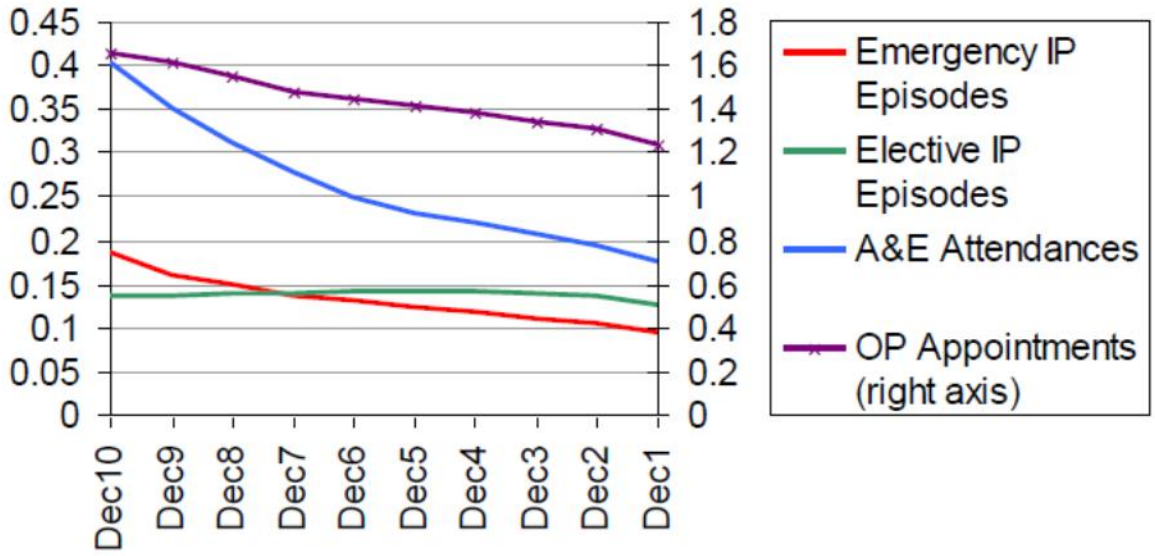
Figure 3 – Map of Deprivation in Wolverhampton (Public Health England 2013)



3.5 Figure 4, below, shows that while the number of elective admissions per head is broadly similar across all deprivation deciles, more deprived areas have more emergency inpatient admissions per head than less deprived areas. In this national study, A&E attendances from Decile 10 were more than double that from Decile 1 and show a steeper incline from Deciles 6 through to 10. Although these figures are for England in 2012 the authors contend that this finding is stable year on year, and

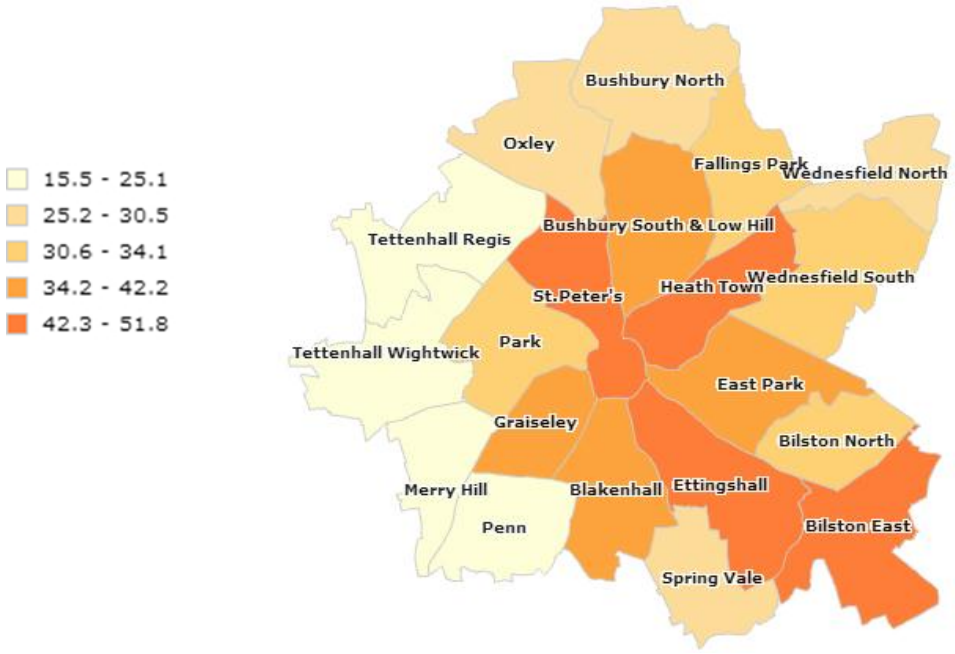
it is reasonable to conclude that the pattern in Wolverhampton is highly likely to be similar. Monitor (2014;p39) has found from primary research that "*people from lower socio-economic groups tend to be the most common users of walk-in centres*". The significance for the analysis is that geographic variation in deprivation will influence the use, not only of A&E, but the new Primary Care Centre and the retained Phoenix Walk-In-Centre.

Figure 4
Emergency and elective inpatient episodes for England, A&E attendances and outpatient appointments per head of population by deprivation decile (10 is most deprived, 1 is least deprived), patients of all ages (McCormick et al; 2012)



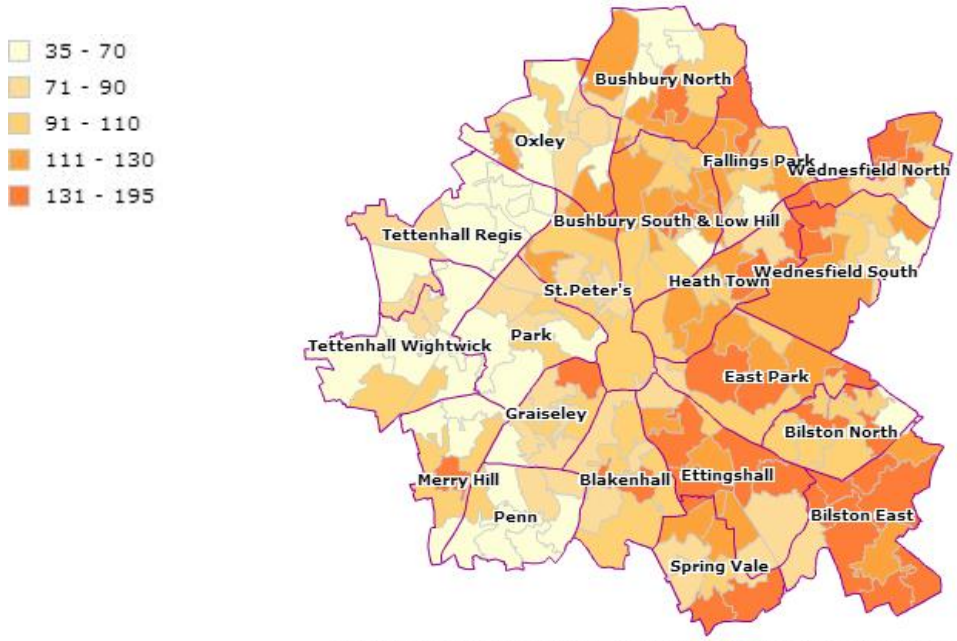
3.6 The following maps highlight some of the indicators of health and wellbeing which may have a contributory effect on the impact of relocating Showell Park.

Figure 5: % of households with no car or van – 2011 (Wolverhampton City Council 2013)



3.7 Figure 5 patterns of car ownership suggests that people living in St Peter's, Bushbury South and Low Hill wards are likely to experience most disbenefit because of an apparent reliance on other people for their transport needs – either public transport or lifts from friends, relatives. People in Heath Town and Wednesfield South (where car ownership is low) will be closer to the new Primary Care Centre at New Cross. Implementation plans should consider access to public transport networks for those people who need to travel further from these and other wards in the North of the City, particularly during the transition to discernible improvements in primary care.

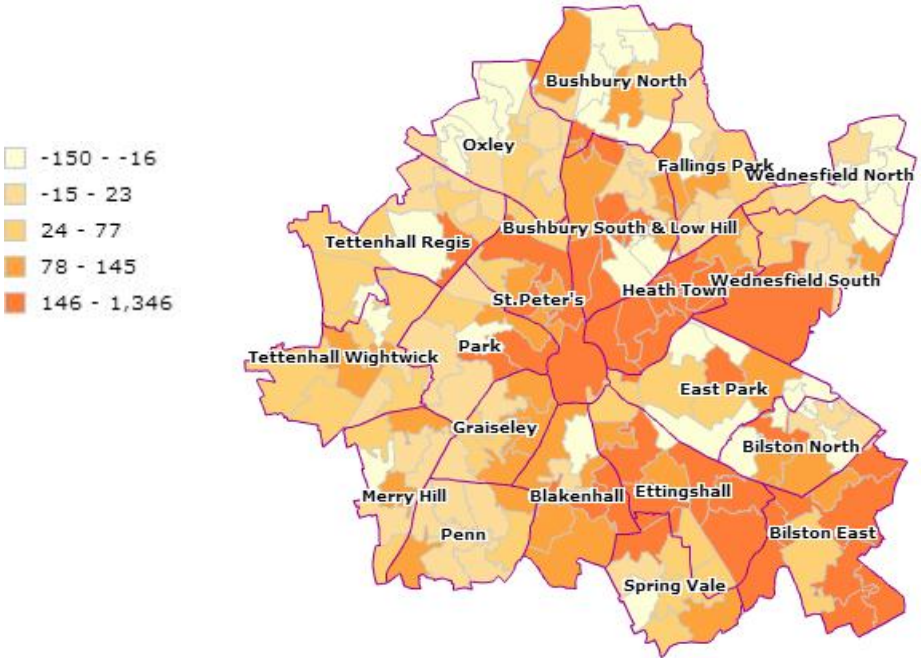
Figure 6 – Number of people who claim Disability Living Allowance (DLA) (Feb 2013) (Wolverhampton City Council 2013)



3.8 Figure 6 shows that the pattern for people who claim DLA (now being replaced by Personal Independence Payment (PIP) for over 16s and under-65s). DLA provides some money to eligible claimants as a contribution to extra costs caused by long term ill-health or disability. People needing DLA are less likely to be independently mobile, and more reliant on carers. The distinct skew of the pattern for higher levels of DLA claimants in the East of the Borough suggests that the relocation of the Walk-In-Centre facility to New Cross will be closer to a greater proportion of people with mobility difficulties and their carers.

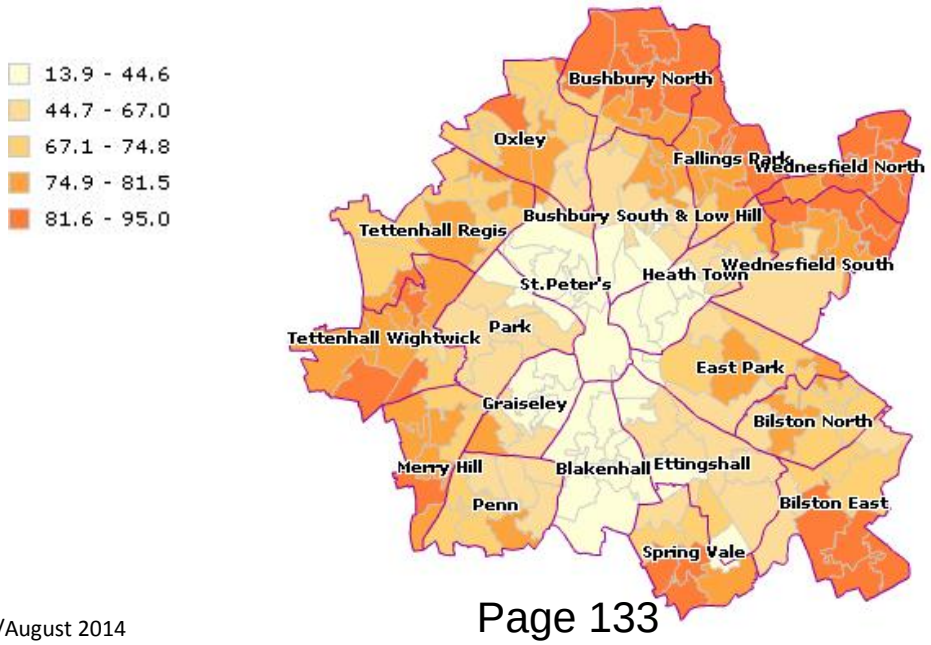
3.9 Figure 7 below shows the total change in population in the 10 years between the last two censuses (in 2001, and 2011) and indicates significant increases in the south-east and the east of the City. The relocation and siting of Urgent and Emergency Care services at a new purpose built centre at New Cross is consistent with the strategic intention to increase accessibility for patients – certainly if the proximity to the changing demographic of Wolverhampton residents is taken into account.

Figure 7: Change in total population between 2001 and 2011 (Censuses 2001, 2011)



3.10 Figure 8 shows the pattern of minority ethnic groups in the City area, based on Census 2011 information and using the descriptor of 'the % of residents who are White British'. In this map therefore, the ***darker*** the shaded area, the greater the proportion of White British people who are resident in the area. The pattern for minority groups correlates closely to the map of deprivation in Figure 3 above. The relocation of the Walk-In-Centre from Showell Park will mean that the facility is further away from patterns of residence for minority ethnic groups and there are likely to be people in these groups who are inconvenienced because of the move. It has not been possible to quantify this disbenefit however, nor to estimate any compensating benefits – eg those arising from the reduced duplication between Showell Park and A&E patient visits. Residency analysis also ignores any in-borough mobility for work, volunteering, or social visits.

Figure 8: Population % of residents who are White British (Census 2011)



Conclusion on the relocation of Showell Park

3.11 Because of the complexity of variables arising in the statistics and data available, it is difficult to make a cogent and assured assessment of the overall impact on protected characteristic groups and whether, on balance, the impact is differentially negative, or positive. There are competing claims – eg the closure of Showell Park will definitely inconvenience some people and extend travel times. Patterns of residency suggests that this will impact more negatively on poorer and minority ethnic groups in the City. However, it has not been possible to quantify this. Furthermore patterns of residency do not offer information about where people are located day-to-day – in work for example – and where they are most likely to access urgent care facilities from? The discussion above has also offered some possible arguments for benefits for some groups. And the apparent reduction in duplication between sites (which impacts negatively on other patients through less available consultation/treatment time) is an obvious benefit of co-locating facilities.

3.12 Offering conclusions on the magnitude of benefits and disbenefits would be speculative. Disbenefits may well be out-weighed by improvements in the system – especially if primary care improvements mean that people will be able to access their GP and attendant primary care services more easily, in their own locality and with a wider range of services available.

3.13 **Conjecture and uncertainty in modelling means that it can not be argued that there is any discernible differential impact overall (positive or negative) on any protected characteristic groups. Because of limited data collected by providers about usage patterns [see section 6 below] it is not possible to detect any spikes or gaps in service reach. If the vision for urgent and emergency care (including primary care improvements) is realised then all patients should benefit from improvements**.

4. Equality considerations for services

Introduction

4.1 Urgent and emergency care services should be prepared to provide for all citizens. Because services here are often provided at a time of heightened distress, and imminent danger to the wellbeing of patients, it is right that the focus of attention should be on the immediate health care needs of each person, and that healthcare staff (and patients) do not feel encumbered by unnecessary burdens of bureaucracy and form-filling, or in undertaking equality assessments which prove to be irrelevant to the 'core business' of patient care.

4.2 This section of the report – set out in **Table 2** below - considers the operation of services and how these impact distinctly on different protected characteristic groups to demonstrate how a consideration of diverse needs in planning and organising urgent and emergency healthcare can offer much improved experiences and outcomes for patients, as well as improving the working environment for staff.

4.3 Following a consideration of the challenges for service provision for each protected characteristic group in an urgent care context, this section then considers the challenges in the care of other groups not covered by the Equality Act 2010, and the key structural challenges to service reconfiguration which have an impact on all patients.

Key to Table 2

Protected Group = *Group as defined by the Equality Act 2010*	
Potential Impact	**Opportunity/Risk Mitigation**
Impact as discerned from available evidence. Full reference list given at back of this document.	*The opportunities available in service design and operations, and the potential for reducing risks through acknowledgement of the needs of different protected characteristic groups.*
Local Issues	
The issues arising from the consultation, the equality survey of organisations, local research or studies, and stakeholder comments received.	

Table 2 - Protected Characteristic Groups

Protected Group	AGE – Older People
Potential Impact	**Opportunity/Risk Mitigation**
The number of older people (65 year and above) living in the city has increased to 40,600 from 40,000 in 2001, a +1.5% increase. This represents 16.2% of the population, close to the English average of 16.5% but lower than that for the West Midlands (17.2%). The growing elderly population and the prevalence of long term conditions represents a significant challenge to health and social care services. Older people are significantly high users of A&E. **No discernible negative impact, but important issues to consider at implementation for improvements in service delivery. Positive impacts are contingent on improvements to primary/secondary care.**	Opportunity to consider accessibility to specific facilities as they are developed for **older people**; and to consult. NHS 111 pilots' usage data indicates high use of the service for patients aged over 80 when compared to the average use (DH 2012; p18). This is a potential beneficial use of technology as part of the overall integration of services. However please note that Older people also appear to be reluctant to use the telephone to access out-of-hours care (DH 2012; p20). Standards and recommendations for the care of older people in urgent care settings are set out in the 'Silver Book' (2012) along with specific recommendations for primary care, Emergency Departments and Urgent Care units. Example recommendations from the Silver Book are: **Rec 15**. There should be a distinct area in Emergency Departments which is visibly and audibly distinct, that can facilitate multidisciplinary assessments. **Rec 16** All units should have ready access to time critical medication used commonly by older people such as Levo-Dopa. **Rec 17** If a procedure is required for a person who is confused, two health care professionals should perform the procedure, one to monitor, comfort and distract, and the other to undertake the procedure; carers and/or family members should be involved if possible; cutaneous anaesthetic gel should be considered prior to cannulation, particularly if the person is confused. **Rec 18**. All urgent and emergency care units should have accessible sources of information about local social services, falls services, healthy eating, staying warm, benefits and for carers of frail older people. **Recommendation: Provider organisations should consider adoption of the Silver Book recommendations as appropriate for their areas of service**.
Local Issues	
Feedback from respondents to the Urgent Care Equality Survey (Appendix 2) offered issues for consideration by provider organisations. These include – Long waits for ambulances (sometimes two arrive); Triage phone management for access to ambulances needs to be more responsive to the needs of older people; Some issues of dignity – overly familiar use of first names without seeking permission first; concerns over inadequate facilities for the care of elderly patients; concerns that elderly people are not given appropriate priority and appropriate, timely care; long waiting times in A&E are particularly difficult for elderly patients, especially when having to sit for long periods when they need to lie down; communication with community services requires improvements; a suggestion that understanding of palliative care in A&E would help to ensure a safe discharge for patients; generally recognition that staff are caring but that time constraints force a focus on the presenting problem without seeing the whole picture for patients.	

Protected Group	AGE – Younger People
Potential Impact	**Opportunity/Risk Mitigation**
Monitor (2014, p39) found that younger people are the predominant users of Walk-in Centres, with people between 16 and 45 attending at higher rates than other age groups and those in the 25 to 34 year age bracket (23%) and the 16 to 24 age bracket (16%) were the most commonly attending patients. (Monitor patient survey report) Local figures for Showell Park in 2011/2012 show that the 0-5 age group were the largest group of users. Walk-In-Centre analysis in 2012 showed a significant increase in use by the 0-5 and 21-25 age groups. **No discernible negative impact, but important issues to consider at implementation for improvements in service delivery. Positive impacts are contingent on improvements to primary/secondary care.**	Opportunity to consider accessibility to specific facilities as they are developed for young people and parents with young children and to consult. NHS 111 pilots' usage data indicates high use of the service for patients aged 0 to 4, when compared to the average use (DH 2012; p18). This is a potential beneficial use of technology as part of the overall integration of services. The Royal College of Paediatrics and Child Health RCPCH (2012) have published 'Standards for Children and Young People in Emergency Care Settings' developed by the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings. Example standards set are: **Section 6 - Staffing and Training issues** **Standard 1:** Nurses working in emergency care settings in which children are seen require a minimum level of knowledge, skill and competence in both emergency nursing skills and in the care of children and young people. **Standard 9:** Emergency care settings seeing more than 16,000 children per annum employ a consultant with sub-specialty training in paediatric emergency medicine **Section 4 - Environment in emergency care settings** **Standard 1:** Emergency care settings accommodate the needs of children, young people and accompanying families and comply with DH 'You're welcome' and HBN 22 standards' (NB now superceded by HBN 15-01: Accident and Emergency Departments Planning and design guidance (Department of Health, April 2013) **Recommendation: Provider organisations should consider adoption of the Intercollegiate Committee Standards for Children and Young People in Emergency Care Settings (as appropriate) for their areas of service**
Local Issues	
Difficulties reported in obtaining same-day GP appointments for young people; some young people reporting that they feel that they are not listened to by their GP, and that some issues are pre-judged (eg: self-harm); privacy and dignity is not always respected. Suggestions for improvements include: more accessible appointments with GPs; more support for issues such as self-harm; and an idea for specific surgeries once a month for young people to discuss issues and access treatment. View expressed that it is a myth that young people do not want to access services. This needs to be broken.	

Protected Group	DISABILITY GENERAL ISSUES
Potential Impact	**Opportunity/Risk Mitigation**
The coherent integration of pathways across health and social care is a recurring concern nationally for patients with a disability and for carers. Physical access to facilities, and the availability of suitable equipment to meet the specific needs of people with different disabilities (particularly when emergency treatment is required) also figures prominently. **No negative differential impact identified at this stage. However this will need to be reviewed further at the implementation phase.**	There is an opportunity to consult people with disabilities – both directly and through representative organisations as part of the continuing consultation and particularly during the implementation phase; to consider accessibility improvements for people who have mobility problems, and/or who use mobility aids; for visually impaired people (colour schemes, and signage); Hearing impaired people and communication options generally. **Recommendation: Both commissioner and provider organisations should ensure that representatives from the Wolverhampton People's Parliament (part of the Changing Our Lives charity which supports people with disabilities of all ages) see www.changingourlives.org**
Local Issues	
There was a demand during the consultation for information on the impact of the proposed changes on the Eye Infirmary, including its connectivity to the new emergency centre. There is an expectation that the services should be linked or co-located in order to make it easier for eye care patients to travel between the two. This should be supported with clear and accessible information. Healthwatch Wolverhampton expressed the view that more needs to be done to clarify care pathways for ophthalmology urgent care patients. **CQC (2013)** commented "We found that the Trust had recently introduced good systems so that most patients could now be treated in A&E without having to be sent to the eye department to access specialist eye care for treatment. **This is an example of effective treatment for patients in the A&E department.**"	

Protected Group	DISABILITY – LEARNING DISABILITY
Potential Impact	**Opportunity/Risk Mitigation**
Having a learning disability can increase anxiety and distress (adding to the patient's vulnerability) as the individual may not understand why they are there or what to expect. Therefore it helps to make the situation as predictable as possible for the person – always letting them know what is happening. Consideration should be given to the appropriate reception and treatment for patients with a learning disability who arrive at an urgent care facility and to whether staff are sufficiently trained to safely discern the person's needs; to communicate effectively with the patient and their carer(s); and to ensure the best possible patient experience. **No negative differential impact identified at this stage. However this will need to be reviewed further at the implementation phase, and specific consideration given to pathways for people with a Learning Disability.**	**Royal College of Nursing (2013); Dignity in Health Care for People with Learning Disabilities (2nd edition) [London]** **"I was in a ward and a patient was screaming. Nobody did anything. I was scared" p14** The RCN publication offers excellent and useable examples of good practice. Commonly reported experiences for people with learning disabilities include: • Discrimination • Assumptions being made about individuals with no assessment • Lack of communication with the individual and their carers • Difficulty in accessing services • Staff with a lack of knowledge and skills in learning disabilities • Abuse and neglect This document can be used to pose questions for the urgent and emergency care pathways for people with a learning disability and to consider scenario testing. **GAIN (Guidelines and Audit Implementation Network, June 2010): Guidelines on Caring for people with a Learning Disability in General Hospital Settings (Northern Ireland)** This document proposes that: 'Staff within emergency care departments should develop a specific care pathway/protocol for identifying and caring for patients with a learning disability. **Bradley and Lofchy (2005) 'Learning Disability in the accident and emergency department Advances in Psychiatric Treatment 2005, 11:45-57** "An A&E department is generally a strange and unfamiliar environment for anyone. For people with learning disabilities, the experience may be particularly frightening because they may understand even less what is happening around them. Getting to A&E may also have been traumatic, for both the person and the family or care providers. Waiting can be anxiety provoking and contribute to behavioural disturbance" (p 47)

Protected Group	DISABILITY – LEARNING DISABILITY - CONTINUED

Potential Impact	Opportunity/Risk Mitigation
No negative differential impact identified at this stage. However this will need to be reviewed further at the implementation phase, and specific consideration given to pathways for people with a Learning Disability	Work undertaken in Lincolnshire in 2011 demonstrated that people with learning disabilities, although a small percentage of the population (0.3%), accounted for 6% of the Accident and Emergency budget. Over the next 20 years we will see a doubling in the number of people with learning disabilities. (ADASS 2013; p6**)** **Public Health England (2013a) Learning Disabilities profile for Wolverhampton** This document explains (at page 3) that the emergency hospital admissions (in 2009) for people with a learning disability were significantly worse than the England average. Identification of people with a learning disability in general hospital statistics was similarly poor. Administrative changes in access to hospital episode statistics means that PHE were unable to update these indicators for 2013. Adults with a learning disability known to GPs was significantly higher than the national average however the proportion having a GP health check was significantly worse. **Recommednation: Commissioner, and Provider organisations should work collaboratively to improve the data collection mechanisms for use of emergency care by people with Learning Disabilities and publish these regularly. Providers should consider using the RCN and the GAIN publications (particularly where these offer recommendations for emergency settings) as part of their equality analysis of facility design and pathway development.**

Local Issues

The lack of current, accurate statistical information about emergency care for people with a learning disability means that further exploration is required, with the objective of improving data collection mechanisms. At the time of preparing this report the local Learning Disability Self Assessment Framework (LD SAF) for Wolverhampton 2013 was not available.

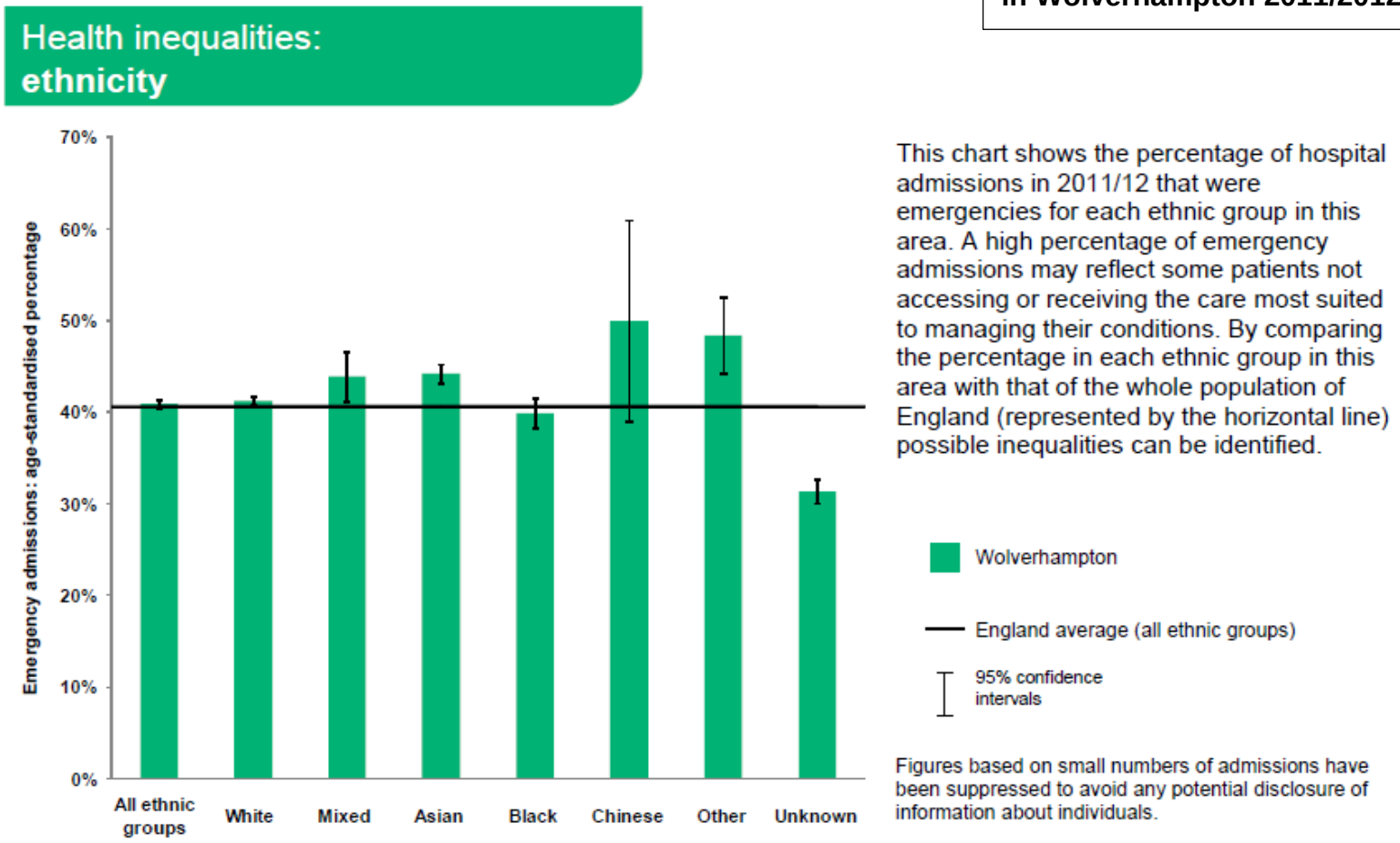
CQC (2013) refer (p18) to a listening event conducted with patients during the September 2013 inspection of New Cross Hospital: "..people spoke to us about delays in treating family members with learning difficulties and autism." This echoes the feedback received from the equality survey of organisations. The hospital has recognised this and the CQC reported that staff now prioritise these patients to reduce any distress caused by waiting.

Recommendation: Commissioner and Provider should monitor the effectiveness of this prioritisation and evaluate through further listening events to inform improved practice.

Protected Group	DISABILITY – MENTAL HEALTH
Potential Impact	**Opportunity/Risk Mitigation**
Concern has been expressed in a number of reports regarding national reconfigurations about mental health emergency care and the joint working between services not receiving adequate attention – please see this link . **No negative differential impact identified at this stage. However this will need to be reviewed further at the implementation phase, and specific consideration given to pathways for people with mental health problem.**	**The College of Emergency Medicine (Feb 2013); 'Mental Health in Emergency Departments – A toolkit for improving care' [College of Emergency Medicine, London]** The core principle of Mental Health in the Emergency Department: **"A patient presenting to ED with either a physical or mental health need should have access to ED staff that understand and can address their condition, and access to appropriate specialist services, regardless of their postcode, GP, or time of arrival." (p2)** **"Does the education and clinical knowledge of your staff in mental health match that for major trauma, cardiac arrest…?" (p2)** CEM standards for mental health are set out at page 15 and include: 1. Patients who have self-harmed should have a risk assessment in the ED; 2. Previous mental health issues should be documented in the clinical record; 6. From the time of referral, a member of the mental health team will see the patient within one hour...". Plus strong links with Community Mental Health Teams are advocated including **"Involvement in each other's induction programme really helps to improve response times and flow of service. For the pure psychiatry trainees or staff grades, they may have no knowledge of the ED's clinical standards or time requirements. Equally, we need to understand the competing pressures that exist in mental health"** (CEM, p11). Care plan management involving multi-disciplinary teams for substance and mental health for patients who will benefit from a consistent response. **Recommendation: Commissioner and providers consider a planned move towards adoption of the CEM standards over an agreed and realistic period of time.**
Local Issues	
CQC (2013) expressed concern about the safety of mental health patients at New Cross Hospital and the deprivation of liberty. There were also concerns about the delays in mental health trust staff reaching A&E. The Equality Survey of organisations identified concerns about practitioners being unable to "differentiate between psychosis and being under the influence" (ie of drugs or alcohol, particularly following self-medication). Requests for better mental health training for front line staff, but also timely follow up through after care services are seen as wanting. Bishop (2013) recommends that the Local suicide prevention strategy needs to include specific support for Lesbian,Gay, Bisexual and Transgender people Survey response from The Haven (which supports individuals who have been victims of violence and abuse) strongly advocating the long term funding of an Independent Domestic Violence Advisor to be based within the local emergency department and offer valuable preventive and cost effective support.	

Protected Group	RACE
Potential Impact	**Opportunity/Risk Mitigation**
Wolverhampton's Black and Asian Minority Ethnic (BAME) population has increased significantly since the 2001 Census and now represents over one third of the population at 35.5%. Nationally, the Afiya Trust suggests that "many minority ethnic communities have poor access to health and social care services for a variety of reasons including language barriers, lack of awareness/information, social isolation, lack of culturally sensitive services and negative attitudes about communities". (Afiya Trust 2010) Impact analysis is hampered by the lack of good equality monitoring information for ethnicity. **No negative differential impact identified at this stage. However this will need to be reviewed further at the implementation phase..**	**Hull, S; Mathur,R; Boomla,K (May 2011):** **"For general practice this means developing robust counts of ethnicity at practice level and using the data to monitor access and service utilisation. This is particularly important in urban areas which tend to be most ethnically diverse and where population mobility is greatest…At the local level one of the primary purposes of collecting ethnic category data about patients is to establish whether services are meeting the needs of different ethnic groups in the community and to assist future planning of service provision."** Monitoring of ethnicity locally, in Wolverhampton, is poor and can be improved. The figures for minority ethnic respondents to the urgent care consultation were low and so there are opportunities to consult different minority ethnic groups as part of the urgent and emergency care implementation phase – both in 'mainstream' consultation events and through dedicated outreach work. This should include a review to consider if appropriate interpreting facilities are available at some consultation events for patients whose first language is not English. Commissioner's service specifications and procurement process may wish to highlight public sector equality duty and set contractual information requirements on providers to demonstrate how they comply with statutory provisions. Provider opportunities to consider workforce development and talent management, recruitment , and promotion of equal opportunity policies. **DH (June 2011) A&E Clinical Quality Indicators; Best Practice Guidance for Local Publication** "25. Organizations are also encouraged to use the richness of their A&E data to analyse and present data that can be disaggregated by the equality protected characteristics defined by the Equality Act 2010 (for example, presenting data for different age, gender and ethnic groups where available); and to explore presenting their data in a way that aids understanding of the issues affecting particular clinical groups (for example, investigating attendances for patients with mental health issues)." **NHS Scotland Information Services Division (ISD) in their AE2 'A&E data recording reference manual (October 2013 v2.0) includes as potential data items: ethnicity, religion, sexual orientation.** **Butler, Christina, Hatzidimitriadou, Eleni and Psoinos, Maria (2010)** put a cogent case for the benefits of ethnic monitoring.

Figure 9: emergency hospital admissions in Wolverhampton 2011/2012.



FROM: **Public Health England (2013b) Wolverhampton Health Profile** (published 24th September 2013) available at: http://www.apho.org.uk/resource/view.aspx?RID=127042

This chart also emphasises the need for better equality monitoring and work to advance the issues identified by the Joint Urgent and Emergency Care Board around gaps in equality monitoring **(please see the Recommendations for DATA in section 7)**

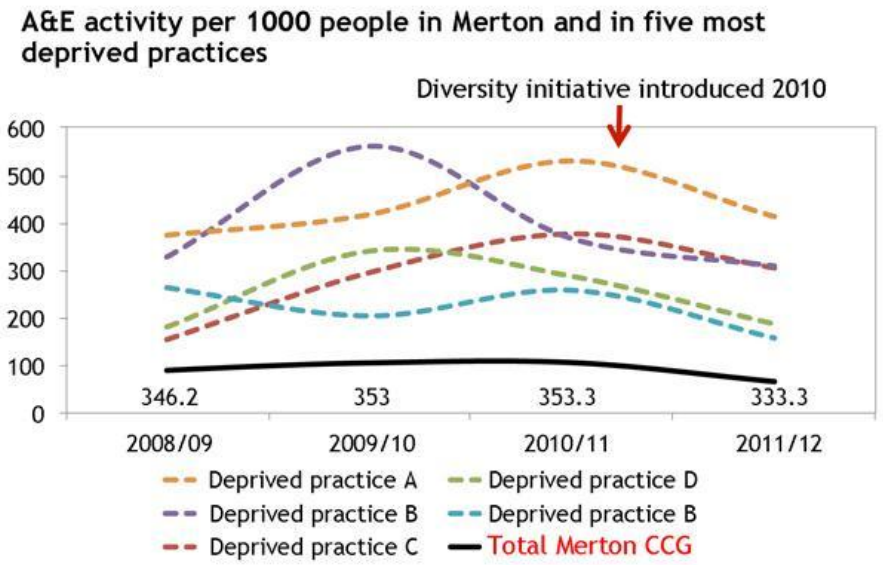
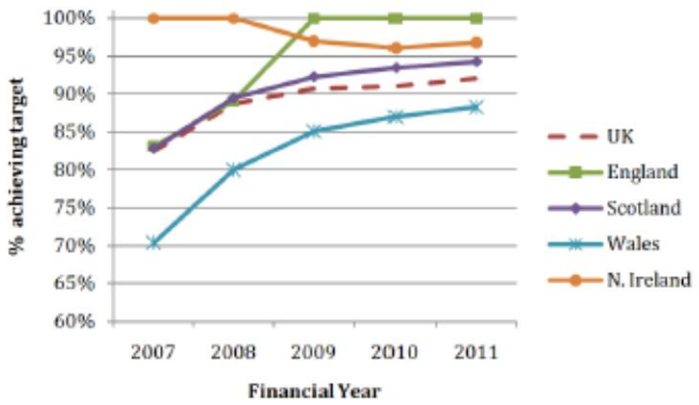


Figure 1. Proportion of UK practices achieving 100% ethnicity recording for all newly registered patients



*Graph produced using freely available NHS data[87], Data for UK and Wales missing values for 2010

Ford A et al (2013) Cutting A&E use and health inequalities. Nursing Times; 109: 24, 14-16

People from migrant communities may not use primary care because the services , expectations and payment requirements are very different in their country of origin. They may not feel comfortable communicating in English or they may feel embarrassed about health issues. 2 strangers in the room can accentuate these feelings (Health Care Professional and an interpreter). They may think that using A&E or urgent care services is easier or more appropriate without realising that there are other options.

The work in Merton (see adjacent figure) has been successful, breaking into the cycle of inequality and changing the way in which A&E services are used including reduced A&E activity in the 5 most deprived ward areas.

In Wolverhampton, the health profile shows that, at the very least the statistics suggest that there are cues for further exploration.

NCRM – National Centre for Research Methods (March 2013) 'Availability and use of UK based ethnicity data for health research (Working Paper 1/13)

P9 'When hypothesising about and interpreting the mechanisms through which ethnicity is related to health, it is essential to be clear that health outcomes are determined by factors associated with ethnicity, not ethnicity itself. The distribution of these factors, such as genetic influences, socio economic deprivation, migration status, cultural practices, and lifestyle manifest unequally in different population groups and can be conceptualised, broadly, as ethnic differences."

P13 The recording of ethnicity was removed from the programme in 2011(QOF under GMS) and now relies on an expectation that this will be recorded by GPs.

Protected Group	RACE - CONTINUED

Potential Impact	Opportunity/Risk Mitigation
	Lawrenson,R et al (1998) offers a useful general conclusion that ethnic origin is recorded but not on every patient; recruitment of staff from ethnic minorities may require positive action; formal training in place for staff to gain an appreciation of issues facing patients from ethnic minorities; interpreters and written materials. Although this paper is from 1998, the issues it identifies are still pertinent to the situation now.

Local Issues

No specific local issues have been identified around race (ethnicity) and urgent and emergency care services. The Equality Survey of organisations did not express any concerns around discriminatory practice. However equality monitoring of ethnicity for service use is poor, and ethnicity recording for complaints information is similarly weak.

Recommendation: Equality monitoring mechanisms need to be improved.

Protected Group	RELIGION
Potential Impact	**Opportunity/Risk Mitigation**
No negative differential impact identified at this stage. However this will need to be reviewed further at the implementation phase	Opportunity for providers to consider workforce composition and planning as local populations change, and to consider the cultural sensitivity of services provided. Religion is increasingly being recognised as an important signifier of customs and traditions which may have a bearing on health and prevalence of ill-health (for example dietary habits). It can also help, in consideration alongside data on race (ethnicity), to identify physical, cultural, or behavioural barriers to accessing health and social care services. There are sometimes concerns expressed about the work required to capture and analyse such information and whether or not it is proportionate. However, provider organisations are subject to the public sector equality duty and need to demonstrate that they are eliminating discrimination, and minimising disadvantage across all protected characteristic groups. This information can also usefully be compared to a provider's workforce data (for race and religion) to demonstrate if the composition of the workforce reflects the communities it serves? The absence of any robust local data here does not allow for any form of analysis. Useful resources include: **Northern Ireland inter-Faith Forum (2005) 'Check up - A guide to the special healthcare needs of ethnic-religious minority communities' and the guide by the Department of Health (January 2009).** The DH guide identifies the important role that Chaplains and spiritual care givers have in the planning (as well as the delivery) of urgent care.
Local Issues	
None identified but caveat that information collection mechanisms are poor. **Recommendation – included in a general recommendation about equality monitoring and data collection.**	

Protected Group	SEXUAL ORIENTATION
Potential Impact	**Opportunity/Risk Mitigation**
Although no specific issues have been identified with the case for change in Wolverhampton; Issues have been identified nationally with same sex partners not having easy access to loved ones in emergency/urgent circumstances, or not being included in consultations in the same way that heterosexual couples/married partners would. **No negative differential impact identified at this stage. However this will need to be reviewed further at the implementation phase**	Opportunity to gather further evidence from Lesbian, Gay, and Bisexual and Transgender (LGBT) groups locally/regionally to see if anecdotal reports of poor experiences can be addressed. **Bishop, M (2013) 'Out in the City – exploring the experience and needs of Lesbian, Gay, Bisexual and Trans People in Wolverhampton' [LGBT Network Wolverhampton and Wolverhampton City Council, Wolverhampton]** Section 2.11- "Just over 34% respondents did not feel Wolverhampton hospitals were meeting the needs of LGB and T people; 11% felt they did, 55% had never used hospital services in Wolverhampton." Section 2.12 – significantly higher numbers of LGB and T people who self harm, contemplated suicide, or attempted suicide. **(NB link this finding to the College of Emergency Medicine (2013) p 15 – CEM standards for mental health included 1. Patients who have self-harmed should have a risk assessment (in the ED).** **Stonewall (2008) 'Serves You right: Lesbian and gay people's expectations of discrimination [Stonewall, London]** Stonewall describes staff comments and antagonistic attitudes in response to current affairs stories or radio news openly discussed in front of patients: **"The surgeon said he thought it ridiculous that gays could now get married and what on earth was the world coming to recognising this type of union. He went on to ask his assistant if she realised gays could adopt as well, he thought it outrageous."** [Conversation overheard by a lesbian patient during treatment to reattach nerves in her finger (Stonewall, 2008;p15). **Stonewall recommendations: dignity and respect. 'Health providers should inform all staff that discrimination on the grounds of sexual orientation is unlawful and that the GMC can stop Doctors from practising if they discriminate against lesbian and gay people (Stonewall, 2008, p20).**
Local Issues	
The work by Bishop (2013) and the LGBT network offers the most recent and comprehensive survey of LGBT service users although no specific questions are included about urgent and emergency care. There are however important cues for further exploration including treatment of LGBT people in primary care; professional attitudes towards LGBT people; and staff training.	

Protected Group	GENDER REASSIGNMENT
Potential Impact	**Opportunity/Risk Mitigation**
Patients who have stigmatising conditions can end up in urgent and emergency departments partly because of limited access to other health care services. Therefore inclusive policies, awareness and training are key to all provider operations. No specific issues have been identified in Wolverhampton, but anecdotal issues raised nationally with trans groups around courtesy of treatment, respect and dignity issues for a person's preferred identity. **No negative differential impact identified at this stage. However this will need to be reviewed further at the implementation phase**	There are concerns in trans communities about recording gender reassignment status and the potential for identifying people where postcode information is also identified. Opportunity to engage further and for Providers to review policies for reception and treatment for patients and carers; and training for staff**.** **ICD 10 (WHO International Statistical Classification of Diseases and Related Health Problems 10th Revision ICD-10)** still lists at **F64 Gender identity Disorders** including F64.0 Transexualism and F64.1 Dual-role transvestism, whereas the APA DSM-V - the American Psychiatric Association's 'Diagnostic and Statistical Manual of Mental Disorders ' which may well influence the release of ICD-11 in 2017 has now moved away **from 'disorder' to 'dysphoria'**. This may have a positive impact on the treatment of transgendered individuals by removing the stigmatism of individuals having a 'disorder'. A diagnosis of Gender identity Disorder implies that the problem lies within the patient, suggesting and setting a context for treatment that the patient needs to be cured or 'fixed' emotionally or mentally. The reclassification in DSM-V recognises the mental state that accompanies being transgendered within a society that stigmatises the condition. – ie the problem to be addressed is not the person's identity but rather the distress that is often experienced by those who need access to medical transition care. **Transgender Patients: Implications for Emergency Department Policy and Practice (Journal of Emergency Nursing 2005; 31: 405-407)** **"A young woman trauma patient has arrived in the emergency department. When her clothes are cut off, her breasts and male genitalia are apparent. Will the care she receives be influenced by this discovery? Ideally gender expression and identity should not make a difference in health providers' care delivery. But in reality negative attitudes and lack of knowledge can compromise the care of transgender patients."** (p405) This scenario acts as a useful cue to ask an appropriate question of providers – how would such an individual be treated in your organisation? How do you know?
Local Issues	
The work by Bishop (2013) and the LGBT network offers the most recent and comprehensive survey of LGBT service users although no specific questions are included about urgent and emergency care. There are however important cues for further exploration including treatment of LGBT people in primary care; professional attitudes towards LGBT people; and staff training.	

Protected Group	SEX

Potential Impact	Opportunity/Risk Mitigation
No negative differential impact identified	

Protected Group	PREGNANCY AND MATERNITY

Potential Impact	Opportunity/Risk Mitigation
No negative differential impact identified	**Recommendation: Access and mobility issues should be considered for visitors and ability for mothers to breastfeed; for parents to change babies as part of Providers' consideration of service use.**

Protected Group	MARRIAGE AND CIVIL PARTNERSHIP

Potential Impact	Opportunity/Risk Mitigation
No negative differential impact identified	No specific issues with plans for change. Issues have been identified nationally with same sex partners not having easy access to loved ones in emergency/urgent circumstances, or being included in consultations in the same way that heterosexual couples/married partners would.

5. Groups not protected by the Equality Act 2010

5.1 There are some key groups which are not covered by the Equality Act but are vulnerable, often marginalised, and have a significant impact on health services.

Homeless people

5.2 Wolverhampton City Council's Homelessness Strategy 2011-2014 identified that:

- 1 in 5 people suffer from mental health problems
- The suicide rates of homeless people are 34 times greater than the population as a whole.
- 80% of street homeless people are addicted to drugs or alcohol
- The life expectancy of someone who is street homeless is 42.
- Rough sleepers are 13 times more likely to be a victim of violent crime.

5.3 The number of homeless households in Wolverhampton is significantly worse than the England average (Public Health England Community Mental Health and general Health profiles 2013) despite successful homelessnes intervention strategies adoopted by the City Council.

5.4 Homeless people attend A&E up to six times as often as the general population; are admitted four times as often and once admitted, tend to stay three times as long in hospital as they are invariably more sick. As a result, acute services are four times, and unscheduled hospital costs are eight times those of general patients. Nearly 90% of all 'NFA – No Fixed Abode' admissions are emergency admissions compared to around 40% for the general population. (Deloitte Centre; p5)

5.5 Because of the trend in homelessness in Wolverhampton and the disproportionate impact of homelessness on the costs of health provision – particularly skewed towards urgent and emergency care – the implementation plans should involve social housing providers and homelessness organisations as part of an integrated approach. Further work may be required to identify any geographical disparities in the location of homelessness people; to research the health experiences of homeless people; and to explore the potential for more effective and earlier interventions to prevent or reduce ill-health and to respond more appropriately to their healthcare needs.

Travelling Communities

5.6 The Equality and Human Rights Commission has stated:

> **"There is evidence that groups about whom very little research has been conducted, notably Gypsies and Travellers, asylum seekers and refugees, have particularly low levels of health and wellbeing. Those without fixed addresses, such as Roma, gypsies and travellers, asylum seekers and refugees, have difficulty in accessing services and their needs are often different and unknown."**
>
> (EHRC 2010)

5.7 Statistics for 'gypsy or travelling communities' are difficult to estimate. The Department of Communities and Local Government count of 'Gypsy and Traveller Caravans' from January 2013 suggests that 58 caravans are located within the City boundary – 40 are 'socially rented' and 18 are on land owned by traveller's themselves. Reliable estimates of the number of individuals and their age profile have not been secured for this report.

5.8 It would be useful, through the Health and Wellbeing Partnership to explore ways to better understand the health needs of the Wolverhampton based travelling communities and how they access healthcare. However, any such work and the resource commitment will need to be proportionate. Anecdotal information about healthcare demands may offer an appropriate starting point.

Migrants and Asylum Seekers

5.9 The Faculty of Public Health briefing (2008) states that:

> **"Asylum seekers are one of the most vulnerable groups within our society, with often complex health and social care needs. Within this group are individuals more vulnerable still, including pregnant women, unaccompanied children and people with significant mental ill-health" (p1)**

5.10 Newall (2013) explains that information on migrant populations can be obtained from a range of data sources, "however no one source is able to provide a detailed picture of all new migrants to the UK that have settled in the City." He suggests that 3.8% of Wolverhampton's population arrived from outside the UK in the past 5 years. This compares to 2.9% for the West Midlands Region. In 2011, 22.9% of primary school aged children and 18.5% of secondary school pupils in the City have a non-English first language (Regional averages are 18.9% and 13.8% respectively).

Migrants registering for health services

5.11 Newall provides a useful summary for Wolverhampton:

> **"Migrant patients who have never previously registered with the NHS are given a marker for their first patient registration, known as a flag 4. Flag 4 registrations in the City are equivalent to 13 per 1000 of the resident population for 2010. This represents 3228 new migrant patient registrations in 2010-11, a negligible change from of from 2009-10 (3224), however it is an increase of over 700 new registrations per year from 2008-9. The Clinical Commissioning Group or Public Health department may be able to break this information down further info nationality, gender and age profiles by analysing patient registration data. The City has a higher level of new GP registration per 1000 residents than the West Midlands Region as a whole for 2010, which was 8 per 1000 of the resident population."**

5.12 Understanding the process of GP registration for migrants, and for asylum seekers, and collating the statistics can offer useful information about the likely demands on primary care, and on urgent and emergency care. As Newall suggests, the CCG or Public Health Department may analyse patient registration data, and obtain more contemporary figures than those presented in this summary.

5.13 The Social Care Institute for Excellence (2010) publication 'Good Practice in social care for asylum seekers and refugees' though targeted at social care, has a useful set of principles from which urgent and emergency health care services could learn:

- A humane, person-centred, rights-based and solution-focused response to the [health] care needs of asylum seekers and refugees
- Respect for cultural identity and experiences of migration.
- Non-discrimination and promotion of equality
- Decision-making that is timely and transparent and involves people, or their advocates, as fully as possible, in the process.

6. Data Considerations

6.1 The collation of equality data is a pivotal stage in developing any equality analysis work in support of strategic decision making because from this, we can begin to build a picture of how responsive urgent and emergency care services are to patients from the different protected characteristic groups. Initial concerns were raised by the lack of equality information returned to Wolverhampton CCG (See **Table 3 below**), and so a letter was sent out to key provider organisations on 23rd October 2013, seeking replies by 25th November 2013. The tone of the letter acknowledged that there would undoubtedly be gaps in equality information but sought at this stage to explore with each provider organisation what was available, and any barriers they felt there were to collecting information. The letter (and its purpose) was discussed at the Joint Urgent and Emergency Care Strategy Board on 8th November 2013.

6.2 From the replies received from 3 provider organisations we have identified specific difficulties in the collection and analysis of equality information The main issues can be summarised as:

i. Partial information only about protected characteristics is collected – typically for age, gender and ethnicity only – although some limited information is available on Learning Disability. High 'not stated' returns (ie where patients have chosen not to state ethnicity) render analysis of some of this information as unreliable.
ii. No consistency in the type of equality questions being collected (eg for ethnicity one provider simply asks 'White', 'Black', 'Asian' 'Other').
iii. Providers have tended to be guided by the contractual requirements set by previous commissioners, rather than by any conviction that such information offers useful business or strategic information. Historically, Wolverhampton PCT did not ask for equality information returns as part of the contractual information requirements. This has led to a situation where minimal equality information is collected by rote, and analysis is very rarely undertaken.
iv. Where information is collected, it resides in several different systems, which makes collation and analysis, and consideration of 'whole system' services time consuming.
v. Concerns by Providers that a move to collect information about a wider range of protected characteristic groups will impinge on precious staff time and impact on waiting times for patients.

vi. Where there has been consistently high 'not stated' numbers from patients, there has not been any promotion among patients (or indeed healthcare staff) to explain to patients the rationale for collection, and to offer assurances about anonymity of information and use of aggregated (not individual) data. Among staff the value of equality monitoring does not appear to have been discussed, nor any support in helping staff to feel confident about asking for such information in a sensitive manner, and at an appropriate time.

6.3 In short, it appears that equality monitoring information is not being used, and is not considered, organisationally, to be useful.

6.4 Providers have valid concerns about the potential resource commitment required to collect, collate and analyse equality monitoring data and the impact on waiting times. It is also the case however that NHS Trusts, and 3rd party suppliers are bound by the public sector equality duty in s149 Equality Act 2010 which requires them to eliminate discrimination and show due regard to minimising disadvantage for the protected characteristic groups: age; disability; race; religion/belief; sex; sexual orientation; gender reassignment; pregnancy and maternity; and marriage and civil partnership. In order to demonstrate compliance with these provisions, each organisation will need to understand something about the different patients it serves, and so collection of equality information is a necessary first step. As stated in the letter to providers:

> **"Wolverhampton CCG and the Joint Urgent and Emergency Care Board ... recognise that such information may not be readily available and that a number of information repositories may need to be interrogated in a variety of ways. We also understand that extracting such information may be considered to require disproportionate effort when compared to how useful it is. We do not wish to create unnecessary burdens on our partner organisations. If you consider that acquiring some information would be too onerous, then please share with us what these barriers are."**

6.5 To develop these issues further, the Senior Equality and Diversity Manager of Midlands and Lancashire Commissioning Support Unit is working with the Head of Contracting and Procurement at Wolverhampton CCG on the following:

i. Reviewing the equality information and assurances offered by intending providers in PQQs (Pre Qualification Questionnaires); service specifications, and contractual information requirements.
ii. A standing item of 'equality monitoring' at each Data Quality Review Meeting.
iii. Once barriers have been addressed - seeking to secure an agreement across Joint Commissioning partners and Provider organisations to collect equality information in a consistent way which offers comparative analysis between organisations, and with population data (for example using Census 2011 categories as a starting point, but adapted to reflect local needs and demands

Table 3 - Summary of equality data received by WolverhamptonCCG from providers

	Admissions	A & E	Phoenix Centre	Showell Park	Primecare	PALS	111	WMAS
Age	Y	Y	Y	Y	Y	N	N	N
Sex	Y	Y	Y	N	Y	N	N	N
Race/Ethnicity	S	S	S	N	N	N	N	N
Religion or Belief	N	N	N	N	N	N	N	N
Sexual Orientation	N	N	N	N	N	N	N	N
Gender Reassignment	N	N	N	N	N	N	N	N
Pregnancy and Maternity	N	N	N	N	N	N	N	N
Marriage and Civil Partnership	N	N	N	N	N	N	N	N
Disability	N	N	N	N	N	N	N	N
Non-Statutory								
Homeless people	N	N	N	N	N	N	N	N
Sex workers	N	N	N	N	N	N	N	N
Travellers	N	N	N	N	N	N	N	N
Migrant workers	N	N	N	N	N	N	N	N
Asylum seekers	N	N	N	N	N	N	N	N

PALS – Patient Advice and Liaison Service
WMAS – West Midlands Ambulance Service

Key	
Y	Yes, available
S	Yes, available but not well completed
N	Not available in current data

Data it would have been helpful to consider

6.6 The Public Health Observatory (PHO) creates a “deprivation score” for each lower super output area (LSOA) from 1-10 with 1 being the most deprived and 10 being the least deprived. It would be useful to organise the geographical location of GP Practices into each of these deciles and to identify usage of urgent and emergency care servcies by decile and by GP Practice. We would expect to find higher use from more deprived areas. Unfortunately this data has not been collated.

6.7 Further analysis of the trends in deprivation scores (as evidenced by IMD figures) for example for health, income and employment, were outside the scope of this analysis but could yield useful information to advise partnership approaches – through the health and wellbeing Board, which are receptive, say, to housing and regeneration challenges; changes in the welfare system, and to patterns of employment.

Summary of usage data

6.8 Because of the significant gaps in data collected, it is difficult to draw any reliable conclusions about the use of Urgent Care facilities in Wolverhampton, and in some cases, no analysis is possible. Establishing a baseline in line with our first aim (**see paragraph 2.6 (i)**) has therefore not proved to be possible at this stage in the project. However it has been very useful to discover that there are data gaps. Wolverhampton CCG has already begun work with its provider organisations to improve on the routine collection of equality information, and to harmonise the collection methodologies so that comparative statistics are available. We understand that this will need to be proportionate, and may need to be accompanied by appropriate training for staff so that questions are asked confidently, with sensitivity to patients’ circumstances (not when a person is in pain, discomfort or anxious about waiting to be seen), and with promotion among patients so that they can be reassured of the reasons why data is being collected, how it will be used, and the anonymous nature of aggregated data.

7. Recommendations

DATA

1. **The CCG works with its Provider organisations to improve on the routine collection of equality information from patients, and by staff, and to harmonise the collection methodologies between providers so that comparative statistics are available (eg by using Census 2011 classifications but with flexibility to enable patients to self-define where this is possible). This should include staff training approaches (see Recommendation 21), and the joint promotion (across health and social care agencies) of equality monitoring with users of services.**

2. **The CCG explores the availability of benchmark data for similar services in other CCG areas. to help establish baseline positions.**

3. **The CCG and provider organisations work collaboratively to improve the data collection mechanisms for the use of emergency care by people with a learning disability and publish these regularly. Providers should consider using the RCN (2013) and the GAIN (2010) publications, particularly where these offer recommendations for emergency settings, as part of their equality analysis of facility design and pathway development.**

4. **'Equality monitoring progress' becomes a standing item at each Data Quality Review Meeting.**

CONTRACTS

NB: all NHS Trusts and private sector providers commissioned by the CCG will be required to demonstrate compliance with s149 (the Public Sector Equality Duty), and this requirement is included within the standard form of NHS Contract.

5. **CCG to ensure that robust equality considerations are built into pre-qualification questionnaires (PQQs); service specifications; and by requiring providers to conduct further equality analyses on their service operations.**

6. **Provider organisations to implement and publish internal reviews of their use of equality information for services, and for their workforce and to assess their compliance with the Public Sector Eequality Duty (s.149 Equality Act 2010). Action plans to be published which allow for discernible improvement in equality approaches.**

7. **CCG to establish contractual information requirements which consider equality in the provider workforce and in the delivery of services, with a requirement to report on these and demonstrate compliance with s.149 of the Equality Act 2010.**

CONSULTATION AND ENGAGEMENT

8. **All agencies - opportunities to engage across the protected characteristic groups should be built in to proposed engagement and consultation as the implementation phase of the urgent care strategy progresses including specific outreach work where response rates show low engagement with particular groups.**

9. **CCG and Provider organisations should ensure that representatives from the Wolverhampton People's Parliament (part of the Changing Our Lives charity which supports people with disabilities of all ages see www.changingourlives.org) and the Wolverhampton Equality and Diversity Forum are consulted and involved in any planned engagement work.**

PARTNERSHIP WORK

10. **All agencies - because of the trend in homelessness in Wolverhampton and the disproportionate impact of homelessness on the costs of health provision – particularly skewed towards urgent and emergency care – the implementation plans for urgent and emergency care should involve social housing providers and homelessness organisations as part of an integrated approach. Further work may be required to identify any geographical disparities in the location of homelessness people; to research the health experiences of homeless people; and to explore the potential for more effective and earlier interventions to prevent or reduce ill-health and to respond more appropriately to their healthcare needs.**

11. **The Health and Wellbeing Partnership to explore ways to better understand the health needs of the Wolverhampton based travelling communities and how they access healthcare. However, any such work and the resource commitment will need to be proportionate. Anecdotal information about healthcare demands may offer an appropriate starting point on which to build more targetted studies.**

12. **The CCG and Public Health Department of Wolverhampton City Council should consider an analysis of patient registration data to understand current processes for the GP registration for migrants, and for asylum seekers, and how these statistics can be effectively and economically collated at regular intervals.**

OPERATIONS and STANDARDS

13. **Provider organisations should consider adoption of the Silver Book (2012) recommendations - 'Quality Care for Older People with Urgent and Emergency Care Needs - as appropriate for their areas of service**

14. **Provider organisations should consider adoption of the Intercollegiate Committee Standards for Children and Young People in Emergency Care Settings - RCPCH (2012) - (as appropriate) for their areas of service.**

15. **The CCG and Royal Wolverhampton NHS Trust should monitor the ongoing effectiveness of the prioritisation plans reported to CQC in September 2013 for people with learning difficulties and autism, and evaluate through further listening events to inform improved practice.**

16. **The CCG and Provider organisations consider a planned move towards adoption of the College of Emergency Medicine (2013) standards for mental health in a phased manner over an agreed and realistic period of time.**

17. **Providers to conduct equality analyses (equality impact assessments) on the proposed operations of their services at an early stage of planning, and to include user groups in this planning. CCG to require evidence of these contractually.**

18. **As informed by Recommendation 17 - Access and mobility issues should be considered for all visitors to urgent care facilities including the topography of the area (eg to avoid inclines for people with mobility difficulties); internal colour schemes (to enable visually impaired users of services to discern between different surfaces); internal fire doors (to enable wheelchair users to move independently through public areas of a building); appropriate signage; facilities for parents to change babies and ability for mothers to breastfeed – all as part of a Provider's consideration of service use.**

19. **The Health and Well-Being Board consider specific support being identified within the suicide prevention strategy for Lesbian, Gay, Bisexual and Transgender people.**

STAFF TRAINING

20. **All agencies to ensure that equality and diversity training is included in the mandatory training elements for each organisation. Where possible, agencies are recommended to share training opportunities, particularly where patient pathways necessitate involvement with different organisations. This would allow for consistency of approach, and highlight areas of complementary (or dissonant) practice. For all, training content should include information about all the protected characteristic groups; the public sector equality duty and the three aims; the significance and importance of equality monitoring; and the values, principles and pledges within the NHS Constitution as a minimum.**

21. **Staff involved in the design of surveys or questionnaires; in their distribution or completion with respondents should receive a comprehensive and timely briefing beforehand which covers: the significance and value of equality questions; the importance in ensuring a high % of completion from respondents; and how to confidently respond to respondents' questions in a way which is tactful, sensitive, and reassures people about the confidentiality of the information they share.**

8. Conclusion

8.1 Marmot's (2010a; 2010b) concern was with the 'social determinants' of ill-health or the 'causes of the causes' of health inequalities – those fundamental social and economic conditions which have been shown to have an impact on how healthy a person will be during the course of their life. This includes the conditions in which people are born, grow, live, work and age. It includes an individual's education and employment opportunities in life and their earning potential; it can include belonging to a minority group or being socially excluded from mainstream society. Inequalities in the social determinants of health act as barriers to addressing health disparities. The equality approaches identified in this analysis, and explicitly included in the 21 recommendations above, are crucial complementary elements to any Health and Well Being strategy which is concerned with a person's 'life course', and in minimising the disadvantages each citizen may encounter during this life course.

8.2 The clinical case for a change in urgent and emergency care services in Wolverhampton has been clearly articulated. The strategy is designed to improve health outcomes for residents and visitors to Wolverhampton. The intention to rehabilitate facilities, improve access and navigability for patients, to remove unnecessary duplication and significantly enhance patients' experiences of urgent care (including primary care) should offer a positive and beneficial impact for all patients, including the statutorily protected characteristic groups. There is no planned diminution of existing services. In this context there are no negative differential impacts identified at this stage for any of the protected characteristic groups covered by the Equality Act 2010.

8.3 A more detailed assessment of urgent care services ***operationally*** can be made by ensuring that equality considerations are built into pre-qualification questionnaires (PQQs), and specifications, and by requiring providers themselves to conduct further equality analyses on their service operations where these are not already a systemic part of service planning. Contractual information requirements can also be established which consider equality in the provider workforce and in the delivery of services, with regular (eg quarterly) reports submitted to the commissioner which are required to demonstrate statutory compliance with s.149 of the Equality Act 2010. All NHS Trusts and private sector providers commissioned by the CCG will be required to demonstrate compliance with s149 (the Public Sector Equality Duty).

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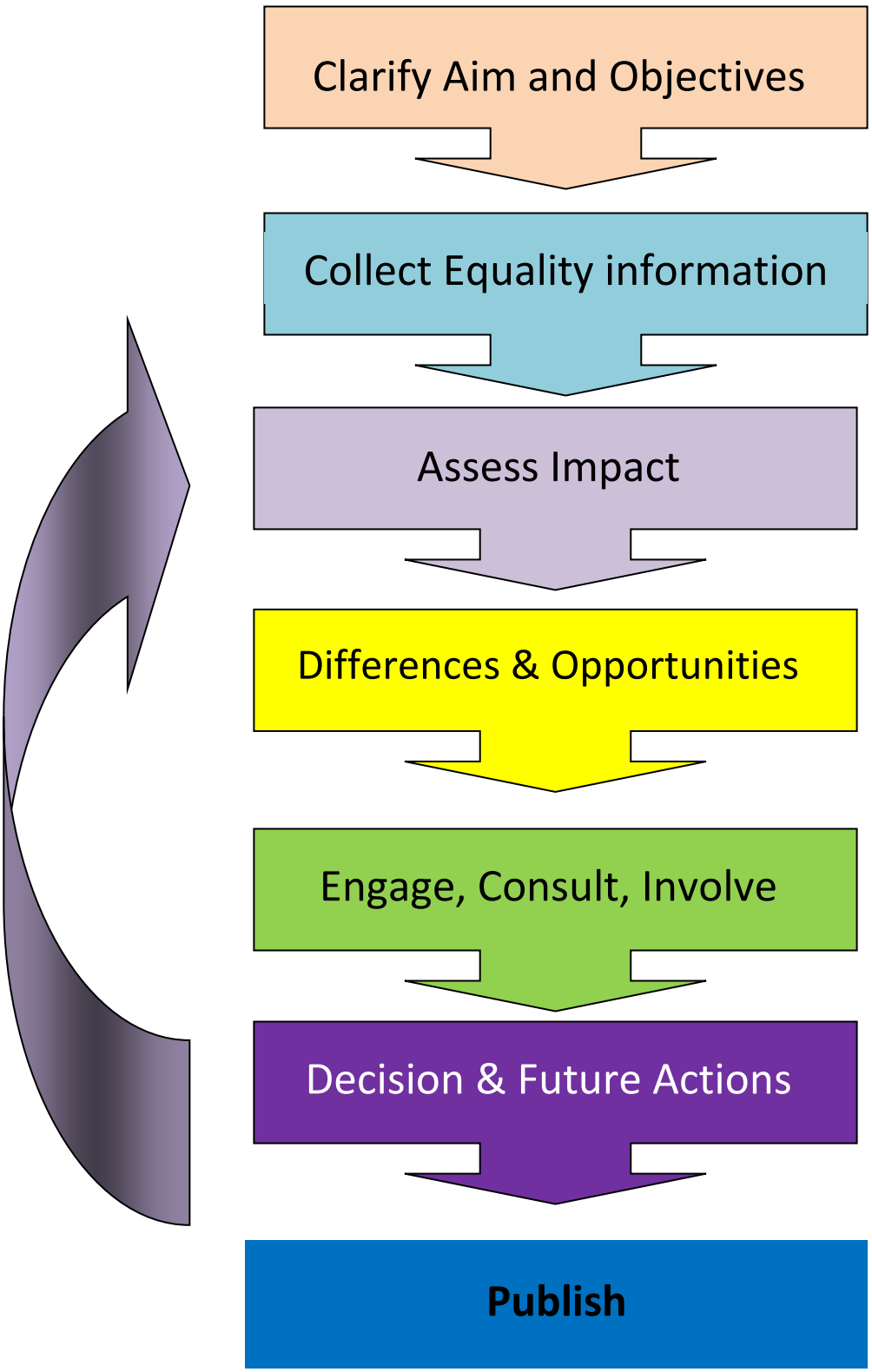
Route Map for Equality Analysis



Appendix 2

Summary of Questions asked in the Urgent Care Equality Survey January – February 2014

NB. These are shortened forms of the questions asked. The original survey was piloted with several organisations before wider distribution.

Q1: Name and address of your organisation (please include website if any).

Q2: Contact details for someone we can keep informed of progress

Q3: Please tell us a little about what your organisation does and who it helps?

Q4: Which protected characteristic groups do you work with/represent?

Q5: Positive experiences of urgent care health services provided in Wolverhampton?

Q6. Difficulties experienced?

Q7. Improvements you would wish to see?

Q8. Do providers of services understand the needs of the people you work with?

Q9. Does the group/community feel that their views are listened to by providers?

Q10. Does the group feel that their privacy/dignity as patients is respected

Q11. Please tell us three things you would like the NHS in Wolverhampton to change for the better for this group?

Three things?
(from the equality survey, Q11 – see Appendix 2)

Please tell us three things you would like the NHS in Wolverhampton to change for the better for this group/community?

Group providing support to recipients of direct payments

- Gender specific support on A&E
- Safe space to come down if high or drunk
- Quicker access to mental health support while in urgent care

Counselling and support group for children and young people aged 6-25

- Appointments at GPs more accessible – same day
- More support for issues such as self harm
- Specific surgeries once a month for young people to discuss issues and access treatment, break the myth that young people do not want to access services.

A hospice

- Improved communication with commnity services
- Access to health care professional that has an understanding of palliative care patients.
- Better discharge planning

A nursery and children's centre

- More community based provision

A residents and tenants association

- Keep the local walk-in-centre

Residents in the vicinity of Prestwood Road

- [The Hospital] to be concerned about being a better neighbour to us
- Try looking at the issues from our viewpoint too
- Realise that by trying to put a quart in a pint pot something gets spilled [reference to traffic congestion]

A community association

- Better care for the elderly
- More suppoprt in the community
- Better support for carers

A support agency for people with mental health problems

- Educate GPs in mental health awareness
- Educate hospitals/A&E in mental health awareness

An organisation which supports victims of violence and abuse

- To fund the posts of [currently] volunteer Domestic Violence staff in place
- To advertise the [Domestic Violence Advice] service within their own departments and literature
- To integrate Domestic Violence training with Safeguarding Training and make it compulsory attendance.

A church based welfare project

- Support services
- More staff
- Time management [context not explained]

A church

- Improved facilities at New Cross for elderly patients
- Speedier access to ambulance care – triage phone management needs to be more responsive to the particular needs of older people.
- 24 hour GP care.

Agenda Item No. 11

Health and Wellbeing Board

3 September 2014

Report title	Wolverhampton Child Poverty Strategy Update	
Cabinet member with lead responsibility	Councillor Gibson	
Wards affected	All	
Accountable director	Tim Johnson	
Originating service	Economic Partnerships and Investment	
Accountable employee(s)	Heather Clark Tel Email	Heather Clark 01902 555614 heather.clark@wolverhampton.gov.uk
Report to be/has been considered by		

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1. Consider the role they can play in delivering the Child Poverty Strategy and input into the new governance arrangements for tackling child poverty through the Social and Economic Inclusion Board.

1.0 Purpose

1.1 To provide an update to the Health and Wellbeing Board on progress in delivering Wolverhampton's Child Poverty Strategy and future governance arrangements.

2.0 Background

2.1 Wolverhampton's revised Child Poverty Strategy was signed off by Cabinet in June 2013. The strategy outlined actions under four building blocks: financial inclusion; employment and skills; early intervention, health and educational attainment; and housing and neighbourhoods. In addition, it aimed to shift our approach from managing the consequences of child poverty by moving away from crisis interventions (high cost) to preventative (prevent families falling into crisis and support families out of poverty) and to break the cycle of child poverty for future generations. The actions stated in the strategy itself were always meant to be rolling given the changes in this area, in particular around welfare reform.

2.2 At the time of the development of the strategy, nearly one third of children (17,925) in Wolverhampton live in poverty. Wolverhampton continues to have higher levels of child poverty than our Black Country neighbours and nationally. The latest figures show a decline in child poverty (defined as income below 60% of median income before housing costs) from 31.1% in 2010 to 30.6%, however it is likely that this is due to falling income in general against which child poverty is measured.

	2006	2007	2008	2009	2010	2011
Dudley	21.2%	22.1%	22.0%	23.1%	22.5%	22.1%
Sandwell	30.4%	31.6%	30.8%	31.6%	30.4%	29.6%
Walsall	27.8%	29.6%	28.4%	29.7%	28.8%	28.5%
Wolverhampton	29.6%	30.7%	30.8%	31.5%	31.1%	30.6%
England	**20.80%**	**21.60%**	**20.90%**	**21.30%**	**20.60%**	**20.10%**

2.3 We are aware that certain equalities groups are more prone to Child Poverty in particular lone parents, ethnicity and disability, as highlighted in Wolverhampton's Child Poverty Needs Assessment. Child poverty figures are not available locally broken down by these groups apart from lone parents, however the principals of Wolverhampton's Child Poverty strategy to target those most in need in terms of the areas with the highest levels of child poverty and most vulnerable groups.

2.4 The Government has recently released a consultation on the national Child Poverty Strategy which focuses on supporting families into work and improving their earnings, improving living standards and raising educational attainment, in line with the building blocks of Wolverhampton's Child Poverty Strategy. The strategy also focuses on tackling the root causes of child poverty which align with our approach of focusing on prevention and breaking the cycle.

3.0 Status of Child Poverty Strategy

3.1 Reducing Child Poverty is a key priority under Wolverhampton's City Strategy 2011-26. A key result of which is that by 2026, no more than 10% of our families live in poverty. Under the new structure for Wolverhampton Partnership, the new City Board will replace the Wolverhampton Partnership Executive Board. A Social and Economic Inclusion Board will be responsible for developing and delivering plans to get more people into work, tackle worklessness and some of the wider determinants of poverty including child poverty. Membership will consist of at least 50% from voluntary and community networks, alongside key public agencies that are able to directly contribute to the delivery of a Social and Economic Inclusion Plan which will incorporate the Child Poverty Strategy.

3.2 Currently the Children's Trust and Health and Wellbeing Board oversee the delivery of the strategy receiving regular updates on progress, however in future this will be the role of the Early Help Board. The Children and Young People's Plan have identified a particular priority on reducing the harm of child poverty and is currently developing key outcomes going forward. These will particularly focus on dealing with the symptoms i.e. crisis, whereas the Economic and Social Inclusion Board focus will be primarily on prevention and breaking the cycle.

3.3 Outlined below are a summary of progress against key priority actions:

Priority Actions	**Responsibility**	**Progress**
Financial Inclusion Reducing Indebtedness	**Economic Partnerships** with Welfare Benefits team, Citizen Advice Bureau	Overview: Wolverhampton Tackling Indebtedness Plan has been produced outlining a series of actions to address indebtedness. The Plan recognises the challenge – with Wolverhampton having the 9th highest indebtedness in England and Wales – and the need for additional resources to address the issue. Examples of action: Local Advice Wolverhampton (LAW) aims to builds capacity of other agencies freeing up specialist advice workers to deal with more complex cases given funding for advice is limited. Key challenges: of particular concern is the impact of cuts, for example the end of funding for Local Discretionary Grant Scheme has resulted in the Benefits Helpline ending end March 2013. Funding for debt advice is limited with the majority of funding focusing on preventative activities.
Families better able to manage their money	Citizen Advice Bureau and Wolverhampton	Overview: Wolverhampton's Tackling Indebtedness Plan also outlines a series of preventative actions to improve money management skills, seek resources to

	Advice Agencies Consortium WAAC, Wolverhampton Homes, Education Business Partnership and Schools	increase support available targeting affected by the rollout of Universal Credit and encourage more affordable forms of credit Examples of action: the Big Lottery funded Better Off in Wolverhampton supports young social housing tenants to improve their financial management skills. Local Advice Wolverhampton (LAW) which is building capacity of organisations to produce financial statements freeing up specialist advice for more complex cases. Financial capability will be part of the national curriculum from September and our Education Business Partnership is working with several local banks to deliver financial capability training within school children. Key challenges and opportunities: building financial capability is increasingly important with Universal Credit which will pay benefits monthly in arrears. An intervention around financial inclusion has been included as an intervention under the Black Country European Investment Strategy. Personal budgeting support will be a key element of DWP's Local Support Services Framework.
Employment and Skills Families with multiple needs	Families in Focus with Job Centre Plus	Overview: employment is one of the outcomes of Families in Focus, Wolverhampton's troubled families programme which aims to tackle deep-seated problems including intergenerational unemployment and disengagement from school and work among families facing problems including mental health issues, alcohol and substance misuse and domestic violence. Examples of action: The secondment of a dedicated Jobcentre Plus adviser to the Families in Focus (troubled families) programme has proved particularly successful. One key worker has supported four members of the same family into work. Key challenges and opportunities: continued focus around 'getting sorted' is required to move families with complex needs towards employment. A troubled families intervention is being developed as part of social inclusion under the Black Country European Investment Strategy.
Parents moving	Schools, Skills	Overview: Digital inclusion is important not only to

closer to and into quality sustainable employment	and Learning with Economic Partnerships	enable people to apply and manage their Universal Credit account online, but also in respect of the wider benefits around skills and employment, accessing services, consumer benefits and improving health & isolation. Wolverhampton's Digital Inclusion Strategy recognises the importance of digital inclusion for job search including Universal Jobmatch, online applications and life chances. Examples of action: £2.8 million has been secured by Accord Housing on behalf of the Black Country focused on supporting social housing tenants in estates with high concentration of worklessness to find work and increase their weekly earnings Key challenges and opportunities: Black Country European Investment Strategy is focusing its social inclusion interventions on 'getting sorted', an identified gap in moving residents towards sustainable employment. In addition, a specific intervention is being developed to provide intensive support for over 25's. In future, all claimants must have an e-mail address and have registered for Universal Job match before they can claim benefits.
More Wolverhampton families getting Wolverhampton jobs	Schools, Skills and Learning with JCP, Work Programme and voluntary community sector providers	Overview: Wolverhampton Employability Group brings together various providers of employment services in Wolverhampton to encourage joint working including DWP, Work Programme providers and voluntary community sector. Examples of action: The City Job Fair held on 14 May 2014 and attracted 2,300 attendees with 45 exhibitors including 35 employers. In addition, we are in discussion with providers to provide support for those interested in applying for jobs at Sainsbury's. The first enhanced Work Club network has met and is looking for more advanced work clubs such as Neighbourhood Employment and Skills Service (NESS) centres to buddy smaller community organisations. Key challenges and opportunities: Changes in rules relating to lone parents means they must undertake work related activity when their youngest child turns 3. A representative from Children's Centres is in discussion with NESS centres to work in partnership to provide support to this target group.

Reduced in work poverty	Schools Skills and Learning	Overview: 20% of children in poverty are in families where someone is working, therefore the strategy must also address in work poverty. Examples of action: Wolverhampton Growth Pledge aims to encourage providers and employers to sign up to key principals including upskilling in the workplace. Key challenges and opportunity: The comparatively low level of investment by Black Country employers in skills has been identified as a particular issue. This will be reflected in the priorities of the Black Country Strategic Economic Plan.
Moving young people towards and into employment	Wolverhampton VCS Schools, Skills & Learning	Overview: tackling youth unemployment remains important due to the need to break the cycle of poverty. Youth unemployment is currently 9.7% in Wolverhampton compared to 8.7% Black Country, 5.3% West Midlands and 4.1% England. Examples of action: together with mainstream support under the Youth Contract, Wolverhampton Voluntary Community Services (VCS) are leading on behalf of the Black Country Talent Match, a £10 million project aimed at supporting young people facing barriers into employment. The project has recruited staff and is currently commissioning. Wolverhampton Growth Pledge aims to encourage employers to offer work placement and apprenticeship opportunities. Key challenges and opportunities: in recognition of the high levels of youth unemployment, the Black Country is eligible for additional Youth Employment Initiative resources to match European Investment Fund resources as reflected in the Black Country European Investment Strategy.
Early Intervention	Children's Services	Overview: Eight Integrated Children and Family Support Services, co-locating services targeting under and over 5's and their families to improve outcomes, have been established. The hubs act as one-stop-shops for services bringing together social worker including family support workers, health visitors and MAST. Examples of action: A 'meeting the needs of families in Wolverhampton' conference was held on 5 February

		2014 as part of Families in Focus. Key challenges and opportunities: As part of the rollout of Families in Focus, take-up of the local integrated offer will be part of the criteria.
Improving health outcome for children and families	Public Health	Overview: Public Health Children's commissioning group has been set up includes all relevant commissioners of 0-5 services. Examples of action: The Family Nurse Partnership (FNP) Programme recruitment to posts commenced February 2014. A 3 year funded British Heart Foundation; Hearty lives project is underway to provide diet and physical activity interventions to families with children on the child protection register or identified in need. Key challenges and opportunities: obesity remains an issue therefore interventions are being targeted at families with children identified as overweight or obese. Secondary prevention focused on addressing known risk factors in these young people and primary/secondary prevention for other family members
Improved educational attainment resulting in better life chances for children	Education	Overview: Wolverhampton's Growth Pledge aims to get employers to sign up to principals of offering work placements as part of the four plus campaign which recognises that children with four or more contacts with employers have better life chances. Examples of action: The investment in Wolverhampton's schools including the Building Schools for the Future programme is reflected in the higher than national average educational attainment figures Key challenges and opportunities: more work is required around primary schools.
Housing and Neighbourhoods Reduced number of evictions and associated homelessness	Housing and Wolverhampton Homes	Overview: As part of the Welfare Reform Programme Board, the Housing Issues strand has been undertaking a series of actions aimed at reducing the impact of welfare reform, in particular spare room subsidy, to avoid eviction. Rent Arrears remain below target (both Wolverhampton Homes and total of all managing agents). Housing Benefit assessors are working within

		Wolverhampton Homes to support speedier turnaround of claims. Examples of action: Wolverhampton CAB led a successful bid for Big Lottery improving financial confidence for 'Better off in Wolverhampton'. The project works with young people living in social housing to improve their financial capability thus addressing the risk of homelessness. Support includes budgeting, accessing financial services and supporting through benefit changes and is available on a one-to-one and group basis. Key challenges and opportunities: possession rates remain high. Under Universal Credit, residents will have to pay their housing benefit direct to the landlord emphasising the importance of personal budgeting support.
Improved quality standards in private sector housing	Private Sector Housing	Overview: the quality of the private rented sector remains a challenge. Proposals are currently going through Scrutiny around a "Wolverhampton's Rent with Confidence" campaign. Therefore, the Council's Private Sector Housing team is looking at ways to achieve better education, better enforcement and better standards. Examples of action: A Housing Stakeholder event was held at the Molineux in November 2013. This helped to inform proposals to increase opportunities for Private Sector Leasing, strengthen enforcement against poor conditions, and look for alternative funding opportunities and partnership approaches to tackling poor property conditions and short termism of tenancy associated with the PRS. Key challenges and opportunities: Private Sector Housing is looking at better education, better enforcement and better standards to address the sheer scale of the problem in the private rented sector. –An easily recognised Star Rating is being considered. Star ratings are easily understood by customers; for example food safety, restaurants, and hotels. ***(See Appendix 1).*** It is hoped that by introducing a star rating of landlords, we will be supporting accreditation and the professionalism of the sector, and hopefully

		signpost tenants towards the best landlords, allowing the Council to focus on those who chose to operate at below acceptable and legal standards. A formal consultation process will run from August to October with a view to implementing Rent with Confidence from 1 January 2015. The Council is also considering Additional Licensing as a means of tackling some of the poorest conditions in all multi-occupied premises.
Reduced fuel poverty	Private Sector Housing	Overview: fuel poverty impacts on one in four residents and is likely to remain an issue as wages stagnate whilst bills continue to rise. Examples of action: Home surveys are currently on offer as part of Cosy Homes providing advice on energy efficiency and fuel supply. An affordable warmth grant targeting low income and at risk of ill health including insulation and those with no, old or inadequate central heating. Improvements to private sector housing are currently underway in Low Hill through Energy Company Obligation (ECO). Key challenges and opportunities: fuel poverty remains an issue especially for those using pre-payment meters. Resources to improve energy efficiency are limited in the privately rented sector.
Target those areas of the city with greatest need	Neighbourhood Services	Overview: Deprivation including child poverty tends to be concentrated in certain areas of the city. Examples of action: work is underway to develop an asset based approach to wellbeing and resilience in Heath Town building on existing physical, social and economic assets. An action plan was presented to the Wellbeing and Resilience Board in May. Key challenges and opportunities: further work is needed focusing on areas with concentration of needs. A targeted community approach is included as one of the social inclusion interventions in the Black Country European Investment Strategy.

4.0 Financial implications

4.1 There are no financial implications of Wolverhampton's Child Poverty Strategy, however there are gaps in delivery that require additional resources to address. Any additional resource requirements for implementation will be subject to the normal budgetary approval processes. There are also potential consequences of not dealing with preventative aspects of child poverty which could have adverse impacts on service demand in future. [ES/02062014/R]

5.0 Legal implications

5.1 The Council as a Responsible Authority has a duty under section 23 of the Child Poverty Act 2010 to prepare a Child Poverty Strategy in conjunction with partner agencies. [RB/21052014B]

6.0 Equalities implications

6.1 An Equalities Analysis was produced at the time of the development of the strategy and did not foresee any negative impact from the Child Poverty Strategy. The Child Poverty Needs Assessment highlighted that certain groups are most vulnerable to child poverty including lone parents, black minority ethnics (BME's) and people with disabilities, therefore the Strategy itself will actively target those groups most vulnerable to child poverty having a positive impact on equalities.

7.0 Environmental implications

7.1 Addressing issues in relation to housing and neighbourhoods is one of the key building blocks in the Child Poverty Strategy. This includes actions to improve quality standards in private sector housing and reduce fuel poverty.

8.0 Human resources implications

8.1 There are no human resource implications to this report.

9.0 Corporate landlord implications

9.1 There are no corporate landlord implications to this report.

10.0 Schedule of background papers

- Wolverhampton Child Poverty Strategy, Cabinet 19 June 2013
- Child Poverty Implementation Plan, Children's Trust Board Wellbeing and Resilience 7 November 2013

Appendix 1

PROPOSED STAR RATING SYSTEM

Landlords will be able to obtain the ranking of scores using the following suggested criteria:

0 stars = an unknown landlord (not known to the Council). The descriptor for this is that this landlord has no track record with the Council at all; has not applied for any licenses that may be applicable, is not accredited through the NLA/RLA/MLAS, and is not known to the Council through any complaints.

1 star = a licence holder (or registered with the Council in some way). One star will automatically be awarded to any landlord that has come forward for any mandatory/additional/selective licensing as applicable. If the landlord is not NLA/RLA/MLAS accredited or has had any Housing Standards intervention with the Council during the last 5 years they will remain at 1 star until Housing Standards are satisfied that they have improved (i.e. following a full and detailed property inspection).

2 stars = an accredited landlord and/or a member of the NLA or the RLA. 2 stars will go to any accredited landlord in recognition of the training element they have undertaken providing Housing Standards have not had to issue any notices – if they are accredited and have had a valid notice served since their accreditation (to remain in force for 5 years) they go back to 1 star only.

3 stars = a three star landlord recommended by the Council with a “rent with confidence” status. For this the landlord will be as a minimum accredited to the 2 Star standard and have had no Housing Standards interventions and meet further conditions to demonstrate the level of service and property standards being offered.

The Council also wants to highlight any criminal landlords – a criminal landlord is one which has been prosecuted for Housing Act Offences (or similar which means they do not meet the not fit and proper test). This will be for the duration of the prosecution if relevant, and a link to the details of the offence will be available for prospective tenants to see (but no longer than 5 years or subject to the Rehabilitation of Offenders guidance).

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Agenda Item No. 12

Health and Wellbeing Board

3 September 2014

Report Title	**Progress Update on Joint Health and Wellbeing Strategy Priority: Alcohol and Drugs**
Cabinet Member with Lead Responsibility	Councillor Sandra Samuels Health and Wellbeing
Wards Affected	All
Accountable Strategic Director	Sarah Norman, Community
Originating service	Community/Public Health
Accountable officer(s)	Ros Jervis — Director of Public Health Tel — 01902 55(1372) Email — Ros.jervis@wolverhampton.gov.uk

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Recommendation(s) for action or decision:

That the Health and Wellbeing Board:

1. Note the update on the key performance indicators and other issues in relation to the alcohol and drugs priority in the Joint Health and Wellbeing Strategy 2013-2018.
2. Note the new reporting dashboard, agreed at the November 2014 meeting of the Health and Wellbeing Board, which summaries progress with the Wolverhampton Alcohol Strategy 2011- 2015.The dashboard is still under development and review but represents an improvement in monitoring progress with the Alcohol Strategy.
3. Note that the Alcohol Strategy strategic leads will be undertaking a review and refresh of the strategy as it nears the end of its term.
4. The board to make comments as necessary on any issues reported in this performance update, especially the response to the minimum pricing loophole concerning super strength cider
5. The board to make comments on the Alcohol Strategy reporting dashboard.

1.0 Purpose

1.1 Alcohol and drugs is one of the key priorities in Wolverhampton's Joint Health and Wellbeing Strategy (JHWBS) 2013-2018, approved by the Health and Wellbeing Board at its September 2013 meeting. This report is to:

- Provide members of the Board with regular updates regarding the key performance indicators used in the JHWBS to monitor performance for this priority. This September 2014 update includes a 2013/14 end of year performance overview.

- Present the Alcohol Strategy reporting dashboard to the board for comment. This dashboard is still in development but will be the basis for future monitoring of the Wolverhampton Alcohol Strategy 2011- 2015.

- Provide a report to the Board on any other issues of relevance to this JHWBS priority area.

2.0 Background

2.1 The Joint Health and Wellbeing Board approved Wolverhampton's Joint Health and Wellbeing Strategy at its board meeting on 4 September 2013. One of the top five priorities identified by the Board was Alcohol and Drugs, with the following key high level targets to monitor progress:

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

- Improvement to the top quintile of performance nationally for :
  - Percentage of drug users in treatment who complete treatment and do not represent within six months (opiates)
  - Percentage of drug users in treatment who complete treatment and do not represent within six months (non-opiates)

2.2 At the meeting on 6 November 2013, the Board agreed that the implementation plan for the alcohol strand of this priority should be the Wolverhampton Alcohol Strategy 2011-2015. Reporting would be by exception and via a reporting dashboard to streamline the reporting of indicators to monitor progress with the Wolverhampton Alcohol Strategy 2011-2015. This dashboard is presented to the board for the first time as Appendix 1.

2.3 The meeting also agreed that the implementation plan for the drugs strand of the priority would be through the NACRO contract overseen by a multiagency Joint Commissioning Board.

3.0 Performance Update

3.1 Wolverhampton Joint Health and Wellbeing Strategy 2013- 2018 indicators

In relation to the indicators contained in the JHWBS, nationally validated performance feedback on drug and alcohol treatment from Public Health England is received quarterly and the summary from the latest release in May 2014 shows that:

Indicator	Current performance
Reduction in three year average alcohol related mortality rates per 100,000 all ages population from a baseline of 19.6 in 2008 - 2010	Provisional figures for 2011- 2013 shows a three year average mortality rate of15.6 per 100,000 all ages population. This continued reduction in rates is to be cautiously welcomed, and continued monitoring will establish if this downward trend is sustained
Improvement to the top Quartile nationally for the percentage of drug users in treatment who complete treatment and do not represent within 6 months (opiates)	The percentage of opiate users who completed treatment successfully and did not re-present within six months for the year ending May 2014 was 5.6%; below the top quartile range of 7.84%-11.58% and significantly below the national average. For non-opiate users the percentage of successful completions who did not re-present to treatment within six months was 32.9%; below the top quartile range of 47.96% and 65.29% and also significantly below the national average. Both indicators have seen a decrease from the previous 12 month period.
Improvement to the top quartile nationally for the percentage of drug users in treatment who complete treatment and do not represent within six months (non-opiates)	

Further reporting (by exception) and an end of year performance overview is given below for alcohol and drugs separately.

3.2 Performance Update (by exception): Alcohol

3.2.1 Reporting dashboard

The Alcohol Strategy reporting dashboard is given in Appendix 1. The dashboard is still a work in progress and may need some additions and modifications and is presented to the Board for comment on the format.

3.2.2 Exception reporting and end of year (2012/13) overview

Goal 1: A Whole Community Approach to Changing Alcohol Habits in Wolverhampton

The focus has been on providing education. This includes children, young people and their families having access to accurate and consistent information in relation to the harms of alcohol. KPIs relate to the number of schools in Wolverhampton delivering the

Wolverhampton Drug Education Programme (WDEP) or their own drug education programme as part of their planned delivery of non-statutory Personal, Social, Health & Economic (PSHE) education. Healthy Schools deliver and report on this outcome**.**

The WDEP is accessible via the www.trustdecca.com website. The programme provides lesson plans and resources from Year 1 to Year 11 inclusive. The programme is primarily designed for use within mainstream school settings and is presented in a 'spiral' format – revisiting substance related topics with age appropriate activities. It is recommended that the programme be delivered as part of a planned PSHEe curriculum. PSHEe is non-statutory – schools should aim to meet the needs of their pupils, but it is left to the individual school's discretion as to which elements of PSHEe (including drug education) they include in their curriculum.

The education also includes improving knowledge within the workforce. This is to ensure the earliest possible identification of risk and risky behaviour affecting the well-being of children & young people and enable them to receive the support they need as quickly as possible to reduce that risk. The work includes Regular drug use screening tool (DUST) and Substance Misuse training offered to schools and children's workforce.

The early identification work also involved providing opportunities for children and young people to discuss alcohol related issues. The confidential, health advice for teenagers (CHAT) was developed in six secondary schools. The service was managed by Youth Service, School Nursing and Connexions. Monitoring forms were developed to capture issues highlighted. The monitoring reports showed did not highlight alcohol.

A Goal 1 indicator previously reported on the number of CAF's from the substance misuse service. However, this service has recently been tendered, resulting in data being unavailable.

Goal 2 Developing a Well Managed Night Time Economy

Strategic Objective i) A prosperous and diverse, high quality, night time economy

- The Statement of Licensing Policy is currently under review and will be presented to the Licensing Committee on 12 November 2014 to commence a formal public consultation, this will include revisions to the Cumulative Impact Policy (CIP):

  West Midlands Police have advised that they have witnessed a reduction of violent crime and anti-social behaviour in the current CIP area. Following discussion at the Responsible Authorities Forum the draft Statement of Licensing Policy propose introducing CIP in four additional areas within Wolverhampton and extending the City Centre area to additional surrounding streets.

  The policy has allowed greater control to ensure that licensing objectives have been met and have promoted the prevention of public nuisance, crime and disorder.

- The Responsible Authority Forum and multi-agency task force are on-going to ensure proportionate enforcement. Effective intervention management is also on-going with reviews and interventions being regularly used to ensure compliance with licensing requirements.

- The National Food Hygiene Rating scheme has been adopted and went live 20/9/13 and has shown the positive impact of the revised food hygiene service which has resulted in a 100 fold increase in 4 and 5 star premises.

Strategic Objective ii) A safe and well regulated night time economy

- To reduce the sale of alcohol to intoxicated persons, all off licenses in the city are regularly visited by West Midlands Police and any issues are communicated through the Responsible Authorities Forum.

- To prevent the underage sales of alcohol, advice packs have been provided by us directly or on our behalf by West Midlands Police to new licensed premises, those who have complaints against them and those subject to review. A 'high risk list' is used to manage actions in relation to the underage sales of alcohol with 33 complaints of which 28 are for off licenses and 5 for on licenses received this year alone. They have all been sent advice letters.

- Test purchases have been carried out at 25 different premises with two underage sales witnessed at one premises. A prosecution was undertaken and a conviction was secured against the seller resulting in fine. Stringent conditions were also added to the premises licence including having CCTV and robust staff training to reduce the likelihood of further underage sales.

Strategic Objective iii) A night time economy that is supported by responsible businesses

- WCC premises adopt best practice in relation to the sales and promotion of alcoholic drinks to meet to aims of promotion a well-managed responsible business.

Goal 3: Combating Alcohol Related Crime and Disorder and Increase Community Safety

Operation Stay Safe is the deployment strategy that contains tactics for effectively policing the night time economy. This strategy is regularly updated to meet the dynamic demands created from this area of business.

The use of preventative methods is still a mainstay of the overall Alcohol Strategy. All seizures made under the powers conferred by the designated public places order (DPPO) are now collated on the Police Corvus intelligence system. This provides a single point of collation for all Officers; there have been an average of 1 entry per day (over the last 50 days) on the system detailing seizures, some entries relate to multiple alcohol seizures. Section 27 Dispersal (the power to disperse people involved in anti-

social behaviour (Asb) where alcohol is a factor) is a power that is also available to officers, there have been 27 notices issued so far this calendar year.

Officers on Wolverhampton local police unit (LPU) are now regularly wearing Lapel Cam's. Their effectiveness is monitored as part of an academic study the results of which can be reported on at a later date.

NACRO staff have been deployed as part of Operation Stay Safe (to offer educational advice), significantly during the Football World Cup. This is not a tactic that will be regularly used, however it will be considered as a tactical option for specific times of the year.

Operation Sentinel is a West Midland police (WMP) approach to highlight vulnerability. Alcohol is a factor in domestic violence incidents, and medium and high risk victims/offenders are referred to Wolverhampton substance misuse service, and there is an outstanding task to now include standard risk subjects.

The alcohol dashboard contains the relevant alcohol related statistics for Wolverhampton LPU.

Goal 4: Improving Health and Alcohol Treatment Services in Wolverhampton

Alcohol misuse poses a threat to health and wellbeing in Wolverhampton. Excessive alcohol consumption does not just cause liver disease; it causes a range of health harms, including injury due to alcohol related assaults and increases the risk of developing conditions such as hypertension, stroke and coronary heart disease and cancers. Therefore, the indicators chosen to track progress with reducing health harms from alcohol focus on alcohol related mortality which encompasses a range of conditions and also include other measure such as numbers receiving alcohol related interventions via NHS health checks; alcohol specific admissions to hospital and service users receiving treatment.

Alcohol related mortality rates

Latest (currently provisional) annual reporting for 2011-2013 shows a three year average mortality rate of 15.6 per 100,000 all ages population. This continues a steady downward trend from a peak in 2006-08 as shown in Appendix 2, Figure 1. This figure shows how Wolverhampton's position on alcohol mortality is increasingly moving towards its comparator group, Centres with Industry, which is the Alcohol Strategy 5 year target (originally a standardised rate of 15.5 per 100,000 population which we have provisionally almost reached). This seemingly sustained fall in mortality rates is welcomed and work must continue to sustain this as we are still some way from the age standardised national average of 10 deaths per 100,000 population. Appendix 2, Figures 2 and 3 show that the rate of improvement is more rapid in females where the Wolverhampton rate is below the comparator group, although rates for females are much lower than for males. For males, the reduction in mortality has shown a slight increase after a sustained fall and remains higher than our comparator group.

There is a link between deprivation and alcohol related mortality and also age as alcohol is killing people at a younger age. Appendix 2, Figure 4 shows that the main group where alcohol mortality is high is amongst our most deprived population in Wolverhampton and that the gap in mortality experience across the city remains the same or is increasing.

In terms of age distribution, Appendix 2 Figure 5 shows mortality over a 5 year period from 2009-2013 and the ages where mortality is highest are from 40 to 69. This is why alcohol is a big killer in relation to premature mortality in Wolverhampton.

Therefore, future focus on reducing mortality should continue to target males from the most deprived areas

However, whilst mortality is decreasing, alcohol related admissions are increasing. This may mean that alcohol related illness is being treated earlier and more effectively, and so the relationship between admissions and mortality may be complex and need further examination.

Alcohol treatment services

Section 3.3 below reports on alcohol treatment services as part of the three year substance misuse contract for drug and alcohol services.

3.2.4 Other issues to report to the Board

Alcohol Strategy 2011-2015 review

As the Wolverhampton Alcohol Strategy nears the end of its five year term, the Alcohol Strategy Strategic Leads meeting has decided, at its next meeting,to undertake a review of the strategic objectives that underpin each of the goals. Currently the meeting feels that these four strategic goals are still the key areas to concentrate on, but a refresh is needed, given the changing circumstances and changing needs of the city and its residents. The results of this review will be reported for approval of the Board at the next scheduled update of this priority area.

'Minimum Pricing' guidance on the sale of super strength cider

In response to concerns about alcohol fuelled violence and the public health problems associated with excessive drinking, the Government's Alcohol strategy of March 2012 included a commitment to introduce a minimum unit price for alcohol. However, in July the Government announced that it would not be proceeding with minimum unit pricing after all. Instead there would instead be a ban on the sale of alcohol below cost price (the level of alcohol duty plus VAT).

However, there has been some confusion over the duty category of some products, especially relating to the classification of super strength ciders as 'still' rather than 'sparking' which has the effect of reducing a two litre bottle of super strength cider from £6.20 to £1.60, super strength lagers and ciders can cause serious damage to health,

premature deaths and social devastation to individuals and families and are amongst the cheapest to buy.

Wolverhampton Alcohol Strategy Strategic Leads Group has produced a briefing at the request of the portfolio leader for Health and Wellbeing. The call to action, from the Portfolio Holder for Health & Wellbeing is for government to take a sensible approach and immediately clarify the duty issue on sparking ciders to include those that are causing the most harm to individuals, families and communities and that a letter should be sent to express our concerns.

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The HWBB asked to endorse the above action.

Report on 'Get Home Safe' Christmas Campaign

Wolverhampton City Council has been running a successful Christmas Campaign for several years called 'Get Home Safe', aimed at women aged 18 – 25 who are travelling home after a night out in the city centre. In 2013 the campaign was run at lower cost and achieved better value. In 2012, the total spend for the campaign was £7,700. This year the budget totalled around £3,100 and saw an increase of 94% in users. Mobile phone users provided the key communication channel as well as Facebook reaching many more people to promote the campaign. The 2014 campaign will start around September and will be even more cost effective - for example by using Twitter.

3.3 Performance Update (by exception) Drugs

Wolverhampton City Council commenced an initial three-year contract with substance misuse and crime reduction charity NACRO to deliver a new, consolidated drug and alcohol treatment service for young people and adults on 1 April 2013. The contract is delivered by NACRO in partnership with Birmingham and Solihull Mental Health NHS Foundation Trust and Aquarius. A payment by results element is attached to outcomes achieved over the period of the contract.

Performance Overview 2013/14

The first year of delivery has seen performance in successful outcomes in Wolverhampton decline significantly. The scale of the change, workforce restructure, new IT and case management systems and implementation of the operating model have contributed to this. A number of performance and quality work streams have been established to address this in addition to the quarterly contract monitoring meetings. Financial penalties will be applied to any future performance under national and cluster benchmarks.

In summary, treatment completions were statistically lower than the national average and the cluster average (drug treatment comparator areas only). Successful completion of substance misuse treatment without re-presentation to treatment for at least six months is a good indicator that an individual has recovered from substance misuse dependency. The latest representations data shows that of the opiate users who successfully completed treatment in the 12 months to September 2013, 25% re-presented to

treatment within six months; an increase on the previous period. No non opiate user representations have been reported.

Figures 1, 2 and 3 below shows trends in successful completions and representations to treatment over the past two years for opiates, non opiates and alcohol service users.

Figure 1

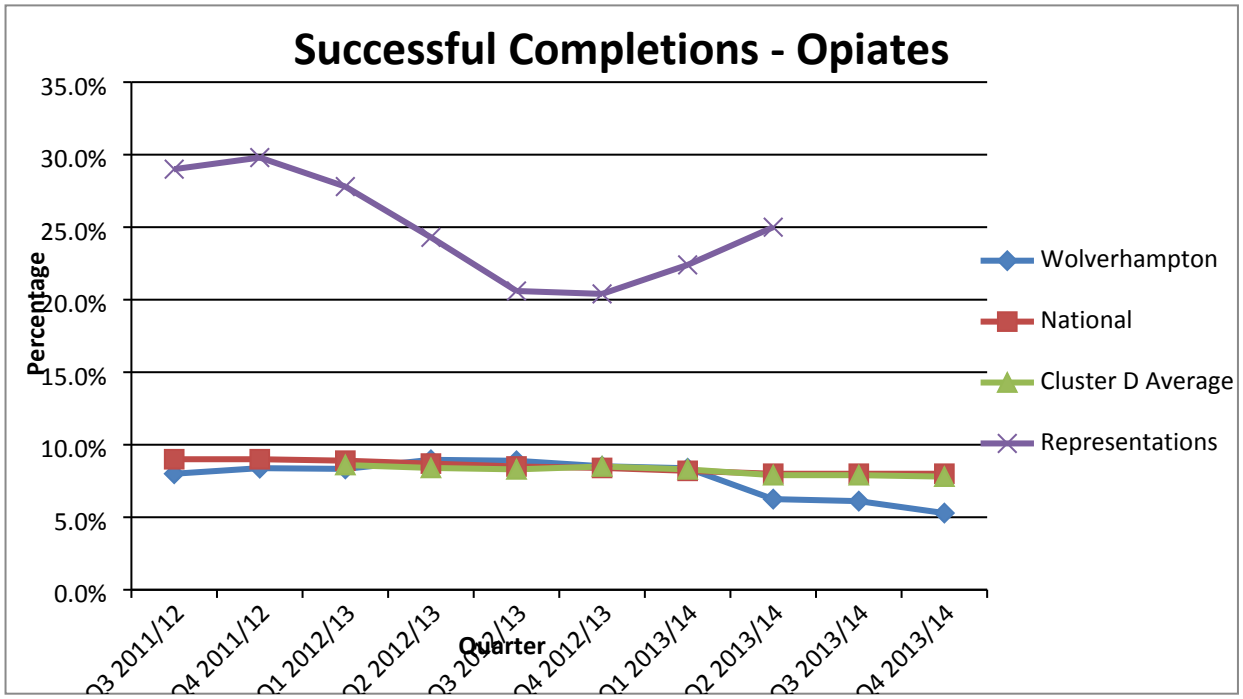


Figure 2

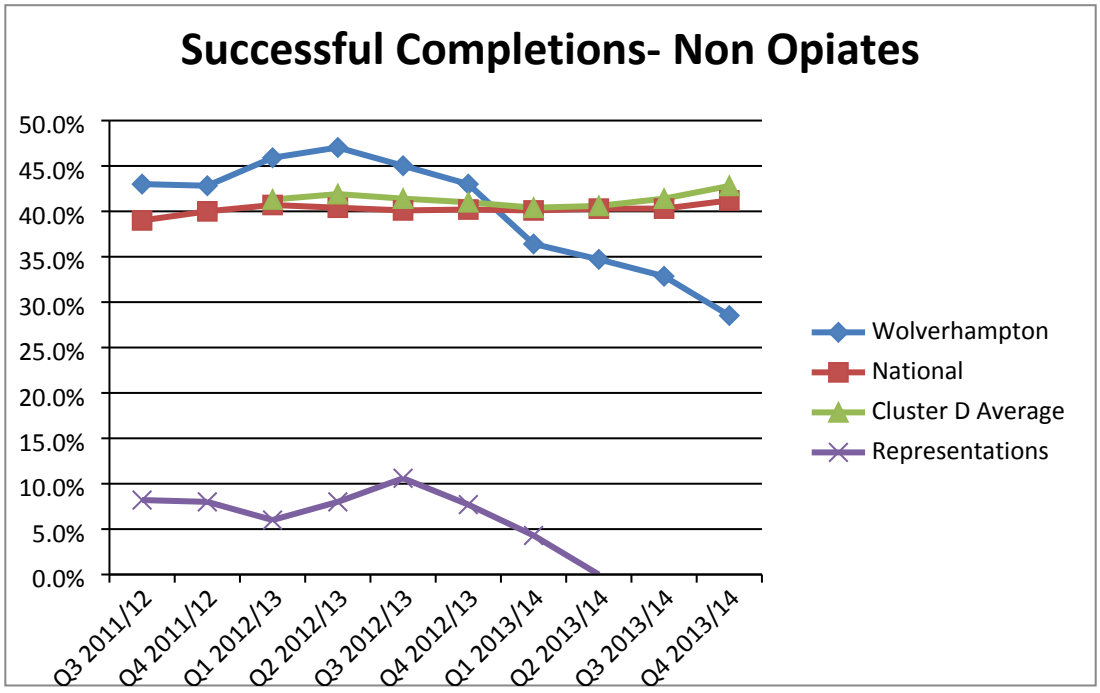
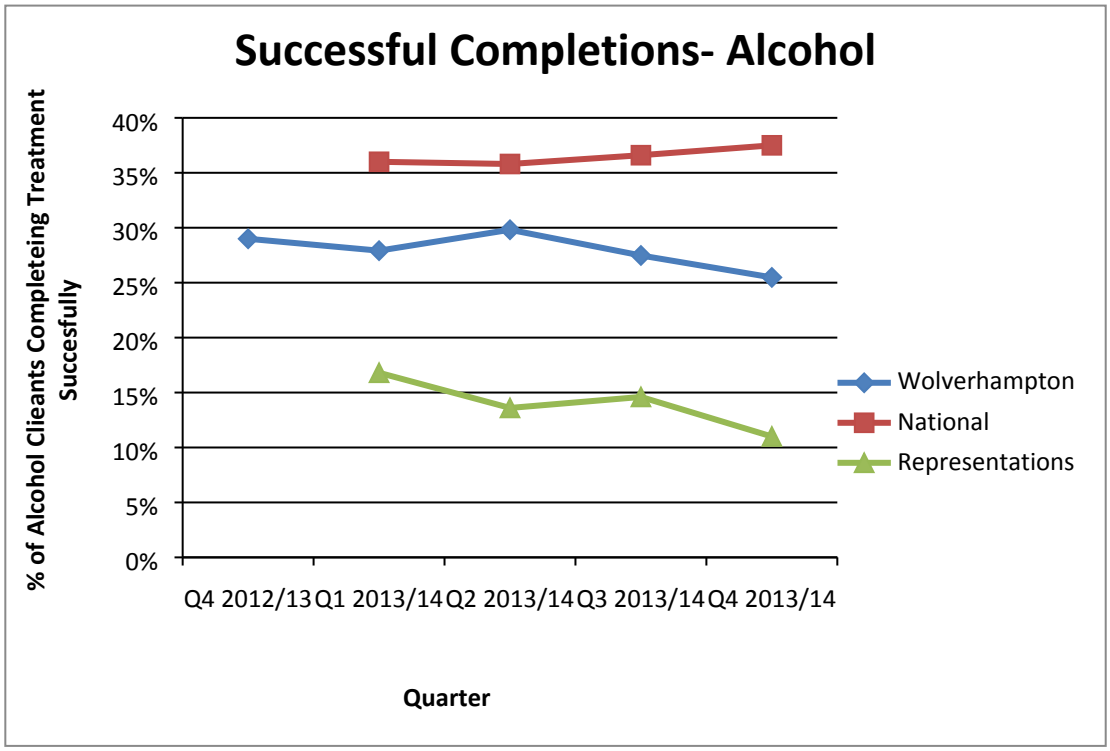


Figure 3



Exception reporting for current quarter (Q1- 2014)

In addition to the concerns around performance of the service, Public Health's quality review undertaken in June 2014 identified the following concerns and gaps:

- A significant reduction in capacity of the drug and alcohol workforce particularly nursing staff; the perception is that this is affecting the resource around clinical and risk assessments.
- Reduced staffing capacity in the criminal justice sector.
- Gaps in workforce skill set i.e. mental health awareness.
- Varied service user experience of the' treatment offer'.
- Inconsistencies in frequency of contact and the level of support offered by key workers.
- A lack of service visibility, information to the public and wider stakeholders about what the service offers

An improvement plan will be submitted by the service in August 2014.

4.0 Financial implications

4.1 There are no direct financial implications arising from this report.

4.2 Any actions arising will be delivered within the approved budgets held under Public Health, or other mainstream budgets held by services and external agencies that are responsible for delivery of specific actions.

4.3 Funding for Public Health is provided to the Council by the Department of Health in the form of a ring-fenced grant. The total funding settlement for Public Health for 2014/15 is £19.3 million, of which £5.5 million is allocated against the NACRO contract..

[NM/20082014/P]

5.0 Legal implications

5.1 There are no direct legal implications arising from this report. However, a number of the actions contained within the Wolverhampton Alcohol Strategy Action Plan will require specific legal involvement on an individual, case by case, basis.

[RB/18082014/D]

6.0 Equalities implications

6.1 The broad aims and objectives of the Joint Health and Wellbeing Strategy and Wolverhampton Alcohol Strategy are intended to reduce the harmful impact of alcohol (and drugs) on health & wellbeing and reduce health inequalities.

7.0 Environmental implications

7.1 There are direct environmental implications arising from this report as several actions contained within the Alcohol Strategy and action plan seek to improve environmental conditions, particularly within the City Centre.

8.0 Human resources implications

8.1 There are no direct HR implications of this performance update report.

9.0 Corporate landlord implications

9.1 There are no direct corporate landlord implications arising from this report.

10.0 Schedule of background papers

10.1 Papers to Health and Wellbeing Board
REPORT TO THE SHADOW HEALTH AND WELLBEING BOARD – Wolverhampton Alcohol Strategy 2011 – 2015. 5 September 2012

REPORT TO THE HEALTH AND WELLBEING BOARD – Joint Health and Wellbeing Strategy Update. 1 May 2013

REPORT TO THE HEALTH AND WELLBEING BOARD – Alcohol Strategy – Progress Update. 3 July 2013

REPORT TO THE HEALTH AND WELLBEING BOARD - Wolverhampton Joint Health and Wellbeing Strategy 2013 – 2018 and JSNA. 4 September 2013

REPORT TO THE HEALTH AND WELLBEING BOARD - Progress Update on Joint Health and Wellbeing Strategy Priority: Alcohol and Drugs. 6 November 2013

10.2 Papers to Licensing Committee
REPORT TO LICENSING COMMITTEE – Wolverhampton Alcohol Strategy 2011 – 2015. 27 June 2012

REPORT TO LICENSING COMMITTEE - Wolverhampton Alcohol Strategy 2011 – 2015. 27tJune 2012- Update Report. 13 February 2013

REPORT TO LICENSING COMMITTEE – Alcohol Strategy: Progress Update. 22 May 2013

REPORT TO LICENSING COMMITTEE – Update on Wolverhampton Alcohol Strategy 2011 – 2015 18 December 2013

10.3 Papers to Cabinet
REPORT TO THE CABINET (RESOURCES) PANEL – Substance Misuse Procurement Programme. Tuesday 21 February 2012

REPORT TO CABINET – Section 75 Agreement With Wolverhampton City PCT. Wednesday 11 April 2012

REPORT TO THE CABINET (RESOURCES) PANEL – Substance Misuse Procurement Programme. Tuesday 27 November 2012

10.4 Papers to Health Scrutiny Panel
REPORT TO HEALTH SCRUTINY PANEL – Wolverhampton Substance Misuse Services Consultation Findings. Thursday 12 April 2012

REPORT TO HEALTH SCRUTINY PANEL – Wolverhampton Substance Misuse Service Contract Award and Mobilisation. Thursday 7 February 2013

Wolverhampton City Council

Wolverhampton Alcohol Strategy 2011/2015
Alcohol Strategy Leads Performance Report

Goal	Indicator	Target		Benchmark	2011/12	2012/13	2013/14 Q1	2013/14 Q2	2013/14 Q3	2013/14 Q4	2013/14 final		Commentary
Goal A Whole Community Approach to Changing Alcohol Habits in Wolverhampton	No of schools delivering the Wolverhampton Drug Education Programme or other drug education programme as part of planned delivery of non statutory PSHE education	Target relates to 13/14 % schools				30/09/13					31/07/14		
	- Primary schools (43 schools)	59				48					58		
	- Secondary schools (13 schools)	76				76					**76**		
	- Special schools (5 schools)	85				50					**33**		
	- PRUs (4PRUs)	100				50					100		
	- Total schools	65				52					61		
Goal 2: Developing a Well Managed Night Time Economy	Reduced number of vertical drinking establishments within the city centre. (to 36 by 31.3.2014	36		43	39	39.00	39	39	39	39	39		
	Increased number of restaurants in the city centre. (to 30 by 31.3.2014)	30		27	27	28.00	28	28	30	31	31		
	No of premises licence reviews.	_		_	_	_	_	2	5	7	7		
	Implement national food hygiene rating scheme.	Y		N	N	N	Completed				Y		

	Increased number of 4 and 5 star food premises in city centre (to 70 by 31.3.2014)	70		28	36	59.00	_	70	107	127	127		
	Number of premises deemed 'High Risk' and requiring multi-agency visit (to 10pa by 31.3.2014)	10pa		18	6	5.00	_	6	10	11	11		
	Number of city centre premises subject to formal enforcement action.	9pa		13	6	0.00	_	2	2	2	2		
	No of off licences identified where u/age drinking / sales identified as an issue.(to 18pa by 31.3.2014)	18		27	23	3.00	_	_	20	26	26		
	No of off licences visited.(ALL identified above)	All above		All	All	1.00	_	_	13	20	20		
Goal 3: Combating Alcohol Related Crime & Disorder and Increase Community Safety Due to Alcohol Misuse	Wolverhampton - VWI						447	483	475	417			Performance in the last quarter of 2013-14 showed a reduction towards the lower control limit, with February in particular recording low levels.
	Wolverhampton - Alcohol ASB						199	184	193	152			Levels followed a decreasing trend throughout the financial year, with levels remaining below the long term average during Q4
	City Centre - VWI						69	56	86	68			Performance showed more control in the City Centre than the LPU as a whole during Q4, with

													levels remaining controlled
	City Centre - VWI NTE						44	36	64	54			Performance mirrored that of VWI across the LPU. Of note, the proportion of City Centre VWI that was NTE related increased during Q4 to 79%
	City Centre - Alcohol ASB						62	47	55	60			Levels were more controlled in the City Centre compared to the whole LPU, however an increase was seen in March
	City Centre - Alcohol ASB NTE						32	25	37	42			As seen with VWI, the proportion of Alcohol related ASB committed during the NTE period has increased consistently, with 70% occurring during the NTE in Q4
	A&E Alcohol related assaults						58	70	58	50			
Goal 4: Improving Health and Alcohol Treatment Services in Wolverhampton	Number of health checks completed per annum in 16-40 year olds (Source - Lifestyles data	6000		No benchmark available	no data	no data	56	299	813	626	1794		New community locations + businesses added. Improved data collection
	Number of eligible adults achieving an improvement on the AUDIT C tool to less than 8 (sensible)	1500		No benchmark available	no data	no data	22	42	29	25	118		As above there will be a need to review benchmark/targets they are a long way from being achievable

	Reduce alcohol related age standardised mortality rates for people all ages to that of our ONS comparator group within 5 years	15.5 (07/09)			19.4 (08/10)	19.06 (09/11)	16.08 2010-12				15.6* (11/13)		*provisional figure
	Reduce the rate for alcohol specific admissions by 3%	3% reduction		No benchmark available	727	716	787				787		no longer presented as a rate but as actual number of admissions annually
	% of all service users in alcohol treatment in any 12 month period will leave treatment successfully			33		28.00	28	29.8	27.5	25.5	25.5		

Appendix 2 Alcohol Mortality Trends

Figure 1:

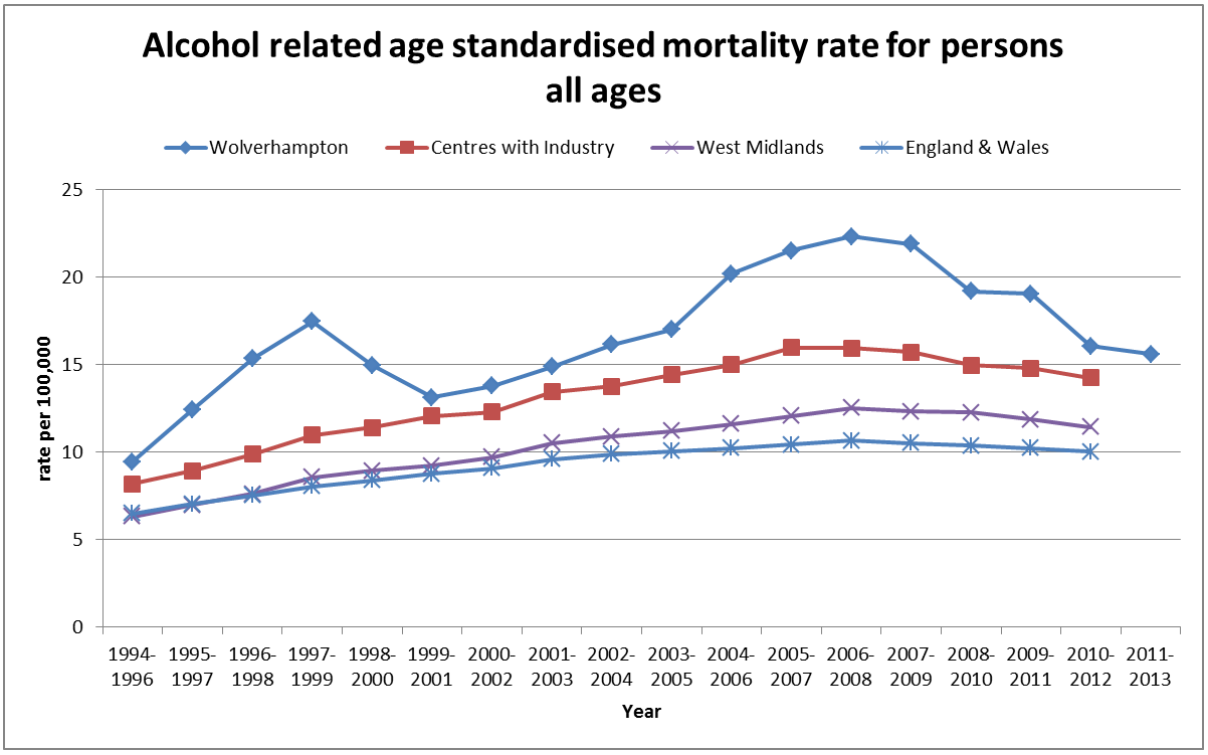


Figure 2:

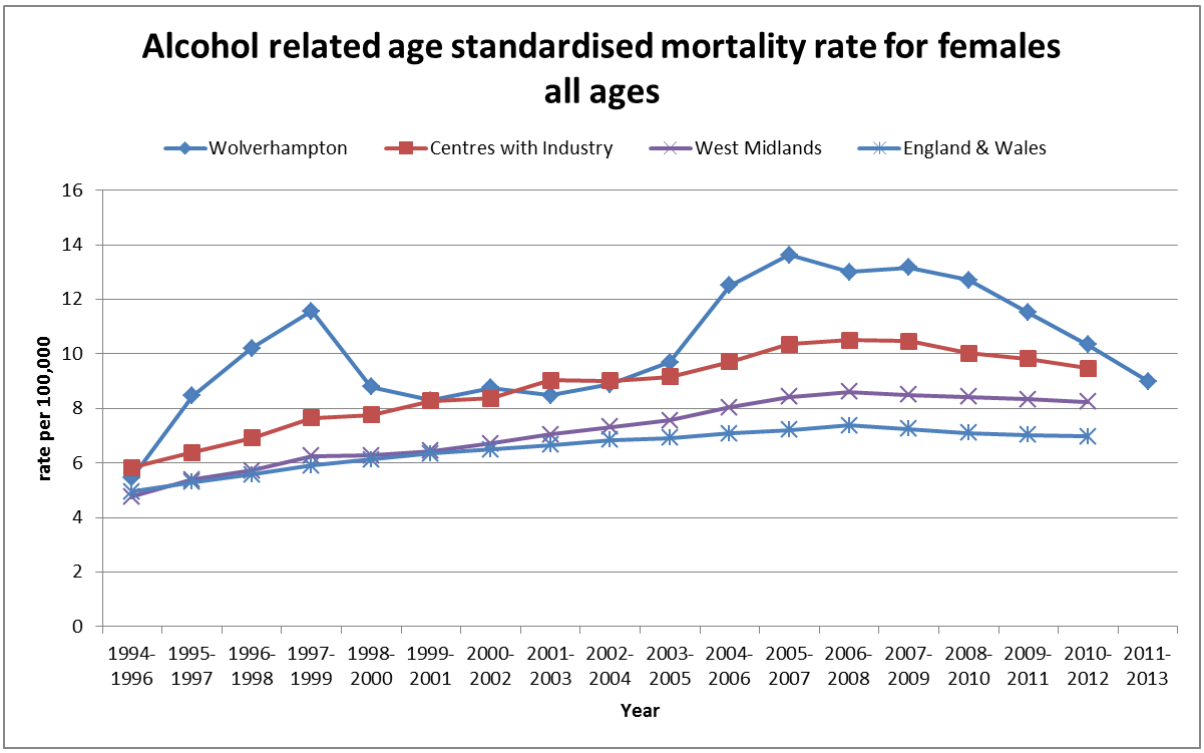


Figure 3:

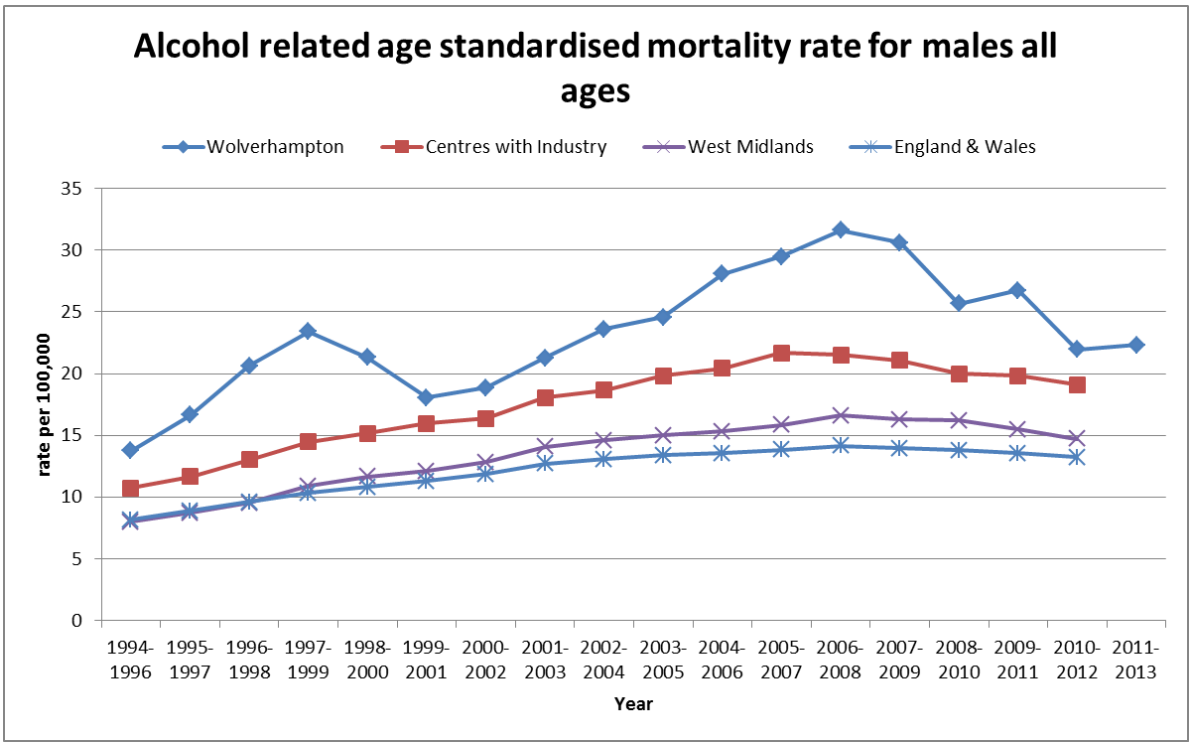


Figure 4

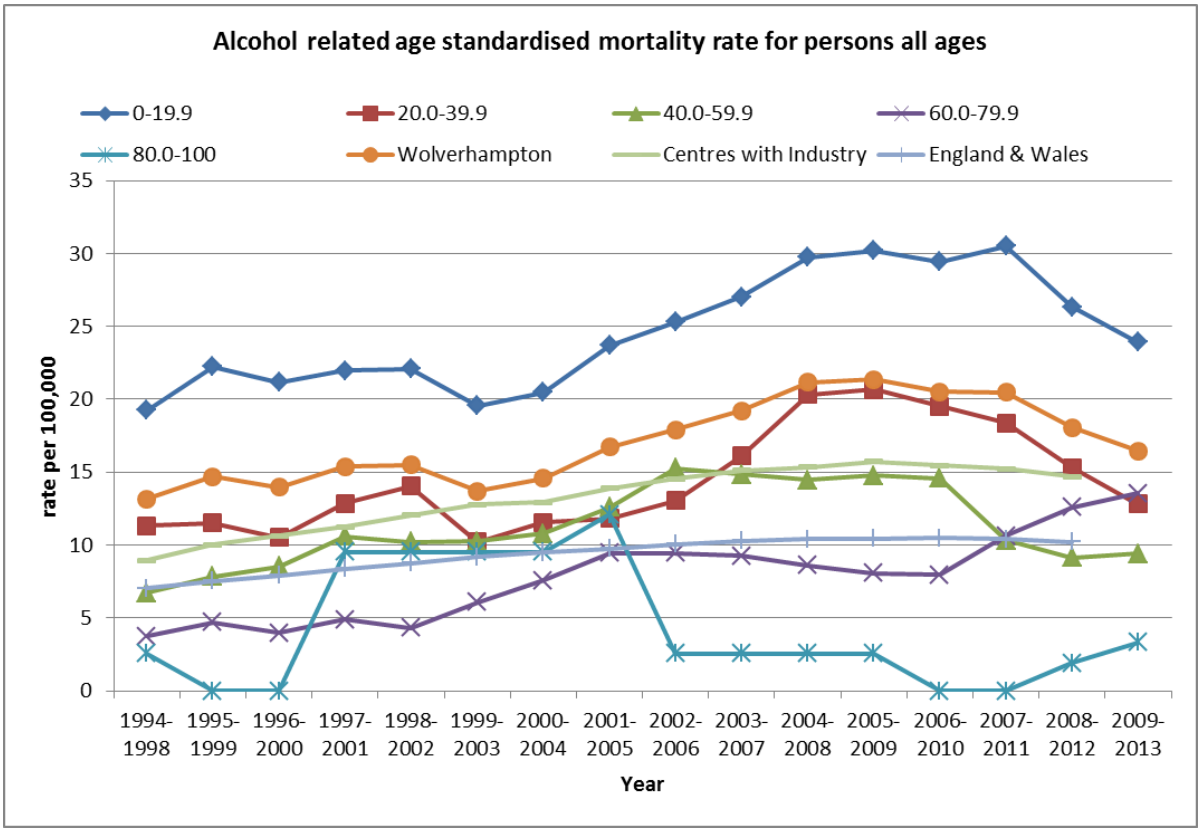
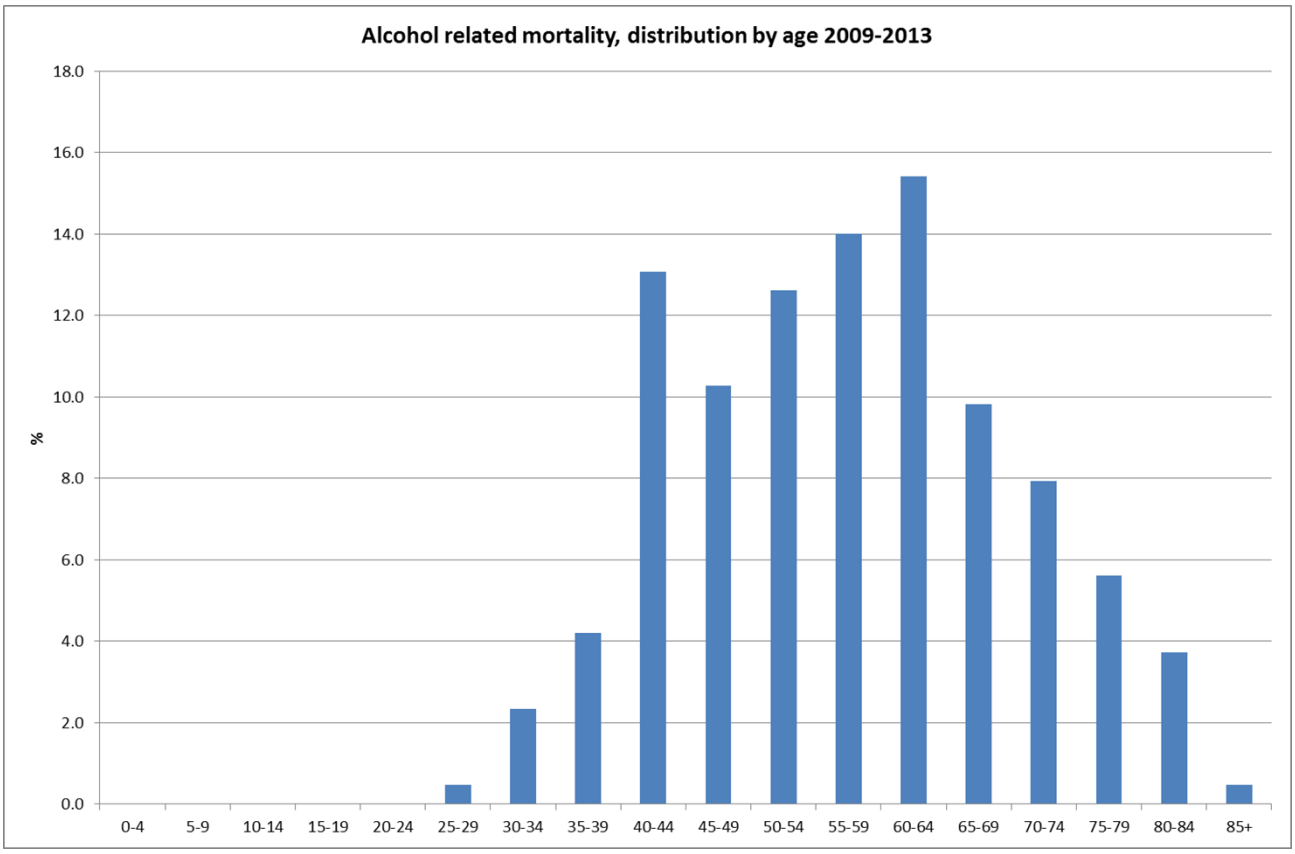


Figure 5:


Alcohol related mortality, distribution by age 2009-2013
%
18.0
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
0-4
5-9
10-14
15-19
20-24
25-29
30-34
35-39
40-44
45-49
50-54
55-59
60-64
65-69
70-74
75-79
80-84
85+

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Agenda Item No. 13

Health and Wellbeing Board

3 September 2014

Report title	Children, Young People & Families Plan 2014-2024	
Cabinet member with lead responsibility	Councillor Val Gibson Children & Families	
Wards affected	All	
Accountable director	Sarah Norman, Community	
Originating service	Commissioning - Children, Young People & Families	
Accountable employee(s)	Fiona Ellis	Commissioning Manager – Children, Young People and Families
	Tel	01902 553251
	Email	fiona.ellis@wolverhampton.gov.uk
Report to be/has been considered by	Children's Trust Delivery Board	10 September 2014
	Children's Trust Board	24 September 2014

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1. Comment on the structure of the draft strategy document and in relation to how delivery of the strategy will be monitored and reported.

1.0 Purpose

1.1 To present the draft Children, Young People and Families Plan 2014-2024 to Health and Wellbeing Board and receive comment.

2.0 Background

2.1 The current Children and Young People's Plan expires in 2014. The new Children, Young People and Families Plan will be a 10 year plan and has been developed in partnership with a broad range of stakeholders. Detail of the development process for the plan and the identified priorities has previously been reported to Health & Wellbeing Board.

2.2 The draft plan has now been developed and includes outcomes and measures for each of the priorities identified. The detail of the measures in terms of their source data and targets will be held in a separate document with a summary of progress against outcomes produced four times a year.

2.3 Comment is invited in relation to the structure of the draft strategy document and in relation to how delivery of the strategy will be monitored and reported. The draft strategy document is attached at Appendix A.

3.0 Financial implications

3.1 The total approved net budget for 2014/15 for the Children, Young People and Families Service is £49.7 million.

3.2 The cost of publishing the plan is anticipated to be minimal as it will be published electronically with limited paper copy summaries available and will be met through existing resources.

3.3 There are no additional financial implications associated with the development of the Children, Young People & Families Plan. However, there will be financial implications in delivering the plan. These implications will be contained within the more detailed plans that will underpin the delivery of the children, young people and families plan.

[NM/21082014/X]

4.0 Legal implications

4.1 There are no immediate legal implications arising from this report.

[RB/22082014/B]

5.0 Equalities implications

5.1 The equalities implications associated with the Children, Young People and Families Plan are being considered by a multi-agency panel made up of Equality and Diversity Forum members. This will be the first of such panels which will aim in future to offer early challenge and comment in relation to equality and diversity issues for a broad range of strategies and plans. The process tested through this strategy will be further developed with the aim of embedding the Equalities Panel process into strategy production more widely and at an earlier stage with the more detailed plans that will underpin the children, young people and families plan 2014-24.

6.0 Environmental implications

6.1 None.

7.0 Human resources implications

7.1 None.

8.0 Corporate landlord implications

8.1 None.

9.0 Schedule of background papers

9.1 None.

Healthy, Happy Families
Wolverhampton Children Young People & Families Plan
2014-2023

About this plan

The Children's Trust in Wolverhampton wants children, young people and their families to be healthy and happy. The purpose of this plan is to set out what we will do so that children, young people and families in Wolverhampton can live healthy, happy lives. This plan sets out our priorities for the next 10 years.

About Children, Young People and Families in Wolverhampton[1]

Wolverhampton has a population of 251,557. About 25% of Wolverhampton's population is children and young people (aged 0-19). 4.5% of 0-19 year olds in Wolverhampton are disabled. There are currently 63,177 children and young people (aged 0-19) living in the city and the numbers are rising. In the last 10 years, the number of children aged 0-15 in Wolverhampton has increased by 1,367 – but over a quarter of this increase was seen in just one year between 2012 and 2013. Over the life of this plan, the numbers of children and young people are likely to continue to rise and we need to make sure that services in the city can continue to meet the needs of the growing population of children, young people and their families. We predict that by 2024, the 0-19 year old population in the city will have grown by over 1,000. The chart below shows the current proportion of 0-19 year olds by gender and age.

[1] Statistics used in this section are the most recent available at the time of writing and are taken either from 2011 Census or Office of National Statistics Mid-year Estimates 2013.

In terms of ethnicity, most 0-19 year olds in Wolverhampton are of White ethnicity (59%), with the next highest proportion being those of Asian/Asian British ethnicity at 20%. 0-19 year olds of Mixed heritage (11%) or Black/African/Caribbean/Black British (8%) are lower in proportion. 2% of 0-19 year olds in Wolverhampton are of other ethnicity.

Over a quarter of 0-15 year olds live in lone parent households and around 44% live in households that have a married couple or a couple in a same sex civil partnership. A further 15% live in households with a co-habiting couple and 13% are living in households that are not 'one family' households.

Wolverhampton is in the 6% most deprived areas in the country and levels of deprivation in the city continue to rise. The recession has caused a significant increase in the number of people receiving key out-of-work benefits in Wolverhampton. As of April 2014, 6.3% of the city's population claim Job Seekers Allowance, which is one of the highest rates nationally. Nearly one third of children in the city live in poverty and almost 60% of all 0-19 year olds living in the city, live in a deprived area.

How we developed this plan

This plan has been developed through a range of organisations working together to share information and through seeking the views of children, young people, parents and carers. We gathered lots of information that organisations already had about the needs of children, young people and families living in Wolverhampton to identify the key things we needed to address so that children, young people and families can live healthy, happy lives. We then asked children, young people, parents and carers what they thought we should do in relation to the key areas of need we identified. This information gathering is called needs analysis. The key information we considered can be found on www.wolverhamptoninprofile.org.uk.

We used the information we gathered through the needs analysis to develop the vision, priorities and outcomes for the plan.

What does this plan want to achieve?

This plan wants to achieve an improvement in how healthy and happy children, young people and families living in Wolverhampton are. From the information we gathered, there were four clear priority areas – if we tackle these we can really make a difference in making children, young people and families' lives healthier and happier. The four priority areas are:

- Child Poverty
- Education, Training and Employment
- Family strength
- Health

This section outlines what we found out through the needs analysis and what we are going to do about it.

Child Poverty

What did the needs analysis tell us?

Nearly one third of children in Wolverhampton live in poverty. Wolverhampton continues to have higher levels of child poverty than our Black Country neighbours and nationally. Wolverhampton is the 20th most deprived local authority (out of 152 authorities nationally). Over 82% of Wolverhampton children in poverty live in households where no one is working. 59% of all 0-19 year olds living in Wolverhampton live in a deprived area.

Reducing Child Poverty is a key priority under Wolverhampton's City Strategy 2011-26. Wolverhampton also has a Child Poverty Strategy which aims to reduce child poverty levels in the city.

What are we going to do about it?

We aim to **reduce the harm caused by child poverty**. The Wolverhampton child poverty strategy is already focussing on reducing child poverty. This plan will focus on reducing the harm to children, young people and families caused by child poverty.

We will ensure services are in place to improve the health, education, employment and living conditions of children, young people and families living in poverty.

Education, Training and Employment

What did the needs analysis tell us?

Wolverhampton has a high number of young people not in education, employment or training (NEETs) compared to the England average. The City performs poorly in relation to young people achieving 5 or more A*-C GCSEs including Maths and English compared to the average for the rest of the country. Wolverhampton has high Secondary school absence rates compared to the England average. Youth unemployment in Wolverhampton is twice the national average. As at 31 August 2012 53% of primary pupils were attending good or outstanding schools -this placed Wolverhampton amongst the lowest levels nationally. As at 31 August 2012 70% of secondary pupils were attending good or outstanding schools -this placed Wolverhampton around the middle compared to other local authorities nationally.
The recession has caused a significant increase in the number of people receiving key out-of-work benefits in Wolverhampton. As of April 2014, 6.3% of the city's population claim Job Seekers Allowance, which is one of the highest rates nationally. Over 14,000 children in poverty live in households where no one is working. This is almost 83% of all children in poverty within Wolverhampton. There are around 9,800 households with dependent children in the city where no one in the household works.

What are we going to do about it?
We aim to **increase achievement and involvement in Education, Training and Employment** through ensuring services are in place which aim to:

- Improve school readiness
- Increase early engagement with schools
- Improve attainment
- Improve school attendance
- Improve quality of education provision
- Increase participation of 16-18 year olds in Education, Training and Employment
- Increase the number of parents in paid work

Family Strength

What did the needs analysis tell us?

The numbers of Looked After Children in Wolverhampton continues to rise. Looked After Children are those who need to be cared for by the Local Authority because they can no longer stay in the family home. Looked After Children are normally cared for in foster families or residential care homes. The needs analysis highlighted four key areas in relation to reasons for the children no longer being able to stay in the family home. These are:

- Family violence and child physical abuse
- Poor home environment, overburdened parents and high levels of neglect
- Children, mainly adolescents with behaviour problems and poor family relationships
- Young children exposed to risks from parental substance misuse and criminal activity

What are we going to do about it?

We aim to increase the number of **families that are strong.** We will ensure services are in place which aim to:

- Increase parenting skills and resilience
- Reduce domestic violence
- Reduce parental substance misuse
- Reduce neglect
- Support parents with their mental ill-health

Health

What did the needs analysis tell us?

Wolverhampton has the highest rate of infant deaths in the country. The gap between Wolverhampton and the national average in relation to infant deaths has increased in the last 20 years. The number of children who die before their first birthday has increased in the last two years. Overweight and obesity rates for children who are in their first year at school have increased. 15% of children in the last year of primary school are overweight and there has been an increase in the percentage of these children who are obese.

What are we going to do about it?
We aim to **improve the health of children, young people and families** by ensuring that children, young people and their families receive the right support so that:

- Fewer children are obese
- More children survive infancy
- Fewer parents have mental ill-health
- Fewer children and young people misuse substances

How will progress against this plan be measured?
Progress against each of the measures will be reported 4 times a year. Every 3 months one of the priorities will be looked at in more detail. This means that each priority will be looked at in detail at least once a year. If progress against measures is not improving, we will identify the issues and make recommendations that will improve progress.

Our priority is to…	The outcome for children, young people	We will monitor our progress on

	and their families will be that…	**outcomes by measuring…**
Reduce the harm caused by child poverty	Children, young people and their families living in poverty have improved health	Measures for this outcome are included in the priority 'Improve the health of children, young people and families'
	Children and young people living in poverty have increased access and achievement in education	Measures for this outcome are included in the priority 'Increase achievement and involvement in education, training and employment'
	More young people and parents living in poverty are in employment	Measures for this outcome are included in the priority 'Increase achievement and involvement in education, training and employment'
	Families in poverty live in better housing conditions	The number of properties with families made decent/improved in the private sector
		The number of energy efficiency measures carried out to property for families with children
		The number of families supported to sustain tenancies to prevent homelessness
	Families in poverty are more financially stable	Delivery of related outcomes in Wolverhampton's indebtedness plan (part of the Child Poverty Strategy)
		The number of families seeking help from the Citizens Advice Bureau in relation to debt
Increase achievement and involvement in education, training and employment	Young children are well prepared when they start school	The number of young children referred late to Child Development Team
		The number of young children who develop a level of speech, language and communication skills appropriate to their age and level of development

		The number of young children who meet the national average level of personal well-being, emotional development and social resilience and are able to take advantage of the learning opportunities available to them
	More young children are engaged early with schools	The number of children who have access to free nursery provision at ages 2, 3 and 4
		The number of children who are able to attend school nursery provision
	Children and Young People make good progress at school	The standards in schools and academies
	Children and Young People regularly attend school	School attendance and Absence rates
		School exclusions
		The number of pupils not in Full Time Education (PNIFTED)
		The number of hours of provision provided.
	Children and Young People attend good quality schools	The quality of provision in schools and academies
	More 16-18 year olds are in education, employment and training	The number of young people aged 16-24 who are participating in apprenticeship schemes
		The number of young people 16-18 Not in education employment or training (NEET)
	More parents are in paid work	The number of parents in employment
Make Families Stronger	Families experience less domestic violence	The number of people who are reporting domestic violence to the Police for the first time
		The number of people who are reporting domestic violence to the police who have reported domestic violence to the police

		before
	Fewer parents, children & young people misuse substances	Measures for this outcome are included in the priority 'Improve the health of children, young people and families'
	Parents have better parenting skills and are more resilient	The number of children becoming - children in need - subject of a child protection plan - Looked After Children Information from Early Help services
		The number of parents receiving early help support with their parenting skills
	Fewer parents have mental ill-health	Measures for this outcome are included in the priority 'Improve the health of children, young people and families'
	Fewer children and young people are subject to neglect	The number of Early Help Assessments where neglect has been identified as a factor
		The number of referrals to Children's Services for reasons of abuse or neglect
		The number of children subject to Child Protection Plan for reasons of neglect
Improve the health of children, young people and families	Fewer children are obese	The number of obese children at school entry (4-5yrs)
		The number of obese children at school year 6 (10-11yrs)
	More children survive infancy	The number of babies dying in the first year of life
		The number of women smoking during pregnancy

		The uptake of women's Healthy Start Vitamins
	Fewer parents have mental ill- health	The number of adults who are receiving treatment/successfully complete or maintain treatment for mental ill-health and are living with children
		The number of Early Help Assessments where the mental health of the parents has been identified as a factor
	Fewer parents, children & young people misuse substances	The number of adults who are in treatment/successfully complete treatment for drug or alcohol use and are living with children
		The number of children/young people who successfully complete treatment for drug/alcohol use
		The number of Early Help Assessments where the substance misuse of the parents has been identified as a factor
		The number of Early Help Assessments where the substance misuse of children/young people has been identified as a factor

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Agenda Item No. 14

Health and Wellbeing Board

3 September 2014

Report title	Refreshed Joint Dementia Strategy and Implementation Plan 2014-2016
Cabinet member with lead responsibility	Councillor Steve Evans Cabinet Member for Adult Services
Wards affected	All
Accountable director	Sarah Norman, Community Directorate
Originating service	Commissioning – Older People
Accountable employee(s)	Steve Brotherton — Head of Commissioning – Older People Tel: 01902 555318 Email: steve.brotherton@wolverhampton.gov.uk Grace Forrester — Joint Commissioning Officer Tel: 01902 551167 Email: grace.forrester@wolverhampton.gov.uk
Report to be/has been considered by	CDMT — 23 June 2014 CCG DMT — 1 July 2014 Adult and Community Scrutiny Panel — 8 July 2014 Cabinet — 23 July 2014

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

Approve the Refreshed Joint Dementia Strategy and Implementation Plan 2014 - 2016.

1.0 Purpose

1.1 To seek approval from Health and Wellbeing Board for the draft Refreshed Joint Dementia Strategy and Implementation Plan 2014-2016.

2.0 Background

2.1 The National Dementia Strategy was published in February 2009, setting out a vision for transforming dementia services by achieving better awareness, early diagnosis and high quality treatment at whatever stage of the illness and in whatever setting.

2.2 In 2010/11 the Department of Health set four priority areas to support local delivery of the Strategy. These areas provided a focus on activities that are likely to have the greatest impact on improving quality outcomes for people with dementia and their carers.

1. **Good quality early diagnosis and intervention for all**
2. **Improved quality of care in general hospitals**
3. **Living well with dementia in care homes**
4. **Reduced use of antipsychotic medication**

2.3 These areas provided a focus on activities that are likely to have the greatest impact on improving quality outcomes for people with dementia and their carers.

2.4 In response to the above requirements a two year Joint Dementia Strategy was approved in 2011. This strategy has now been reviewed with an updated implementation plan in response to current drivers. The Draft Refreshed Joint Dementia Strategy is attached to this report.

3.0 Progress

3.1 The Health and Social Care Act (2012) set out a new responsibility for the National Institute for Clinical Excellence (NICE) to develop guidance and associate quality standards in order to better serve people with dementia. These standards are also supported by the Social Care Institute for Excellence (SCIE).

3.2 In 2012, the Prime Minister issued a dementia challenge setting the goal of ensuring that the diagnosis, treatment and care of people with dementia in England should be among the best in Europe. A Central Government Mandate to NHS Commissioning Boards followed focusing on tackling barriers that stop services working together to serve people with dementia.

3.3 A number of actions have been completed from the current strategy:

- Development of health and social care managers and staff across the city in the care economy to becoming leaders and champions of dementia
- Dementia ward and outreach service at New Cross Hospital
- A Dementia Friendly Communities Conference in response to the Prime Minister's Challenge on dementia
- Established Wolverhampton's local Dementia Action Alliance Forum
- Evaluation and Value for Money Review of Inpatient/Residential Facilities for People with Dementia
- Improving standards in care homes in response to quality concerns
- Raising awareness for GP through a GP education event
- Wolverhampton Arts and Culture Services (WAVE) engage and support people living with dementia to access arts and cultural activities
- Development of six Dementia Cafés across the city, one for people who speak Asian languages and one for the Black African/Caribbean community
- A two year programme raising public awareness of dementia
- Development of pilot project using 'Smart Technology' and smartphones to raise awareness of dementia and local services

3.4 Consultation and review

3.4.1 The current strategy has been subject to the following consultation process:

- Alzheimer's Society consulted with people living with dementia and their carers regarding their experiences and views on the services they receive and the support they require as their journey with dementia progresses
- GP's and other health care professionals were consulted at the GP Education Event
- A local Dementia Review was carried out by Public Health for Wolverhampton
- Two workshops have taken place with the Better Care Fund Dementia Work Stream members consideration been given to the outcomes outlined in this strategy and the identification of priorities, timelines, principles and metrics. A further workshop has been arranged for September 2014.
- Consultations with a variety Professionals and Councillors through established formal networks as outlined below.

Groups consulted	**Dates**
Community Directorate Management Team (CDMT)	23 June 2014
Clinical Commissioning Group Delivery Management Team (CCG DMT)	1 July 2014
Cabinet	23 July 2014
Health & Wellbeing Board	3 September 2014

4.0 Financial implications

4.1 The recommended strategy is consistent with the approved Medium Term Financial Strategy; there are therefore no financial implications arising from the report. Any additional actions ensuing from the strategy will be subject to the normal governance requirements, including if appropriate, budget approvals.

[AS/14082014/O]

5.0 Legal implications

5.1 There are no direct legal implications arising from this report at this stage.

[RB/18082014/F]

6.0 Equalities implications

6.1 This report has equality implications and Equalities Analysis has been undertaken. It will continue to be reviewed and monitored as part of the future implementation plan

7.0 Environmental implications

7.1 There are no environmental implications associated at this stage with the report.

8.0 Human resources implications

8.1 There are no human resources implications associated at this stage with the report

9.0 Corporate landlord implications

9.1 There are no corporate landlord implications associated at this stage with the report

10.0 Schedule of background papers

10.1 There are no additional supporting papers

Agenda Item No. 15(ii)

Health and Wellbeing Board

3 September 2014

Report Title	Public Health Delivery Board: Chairs Update
Cabinet Member with Lead Responsibility	Councillor Sandra Samuels Health and Wellbeing
Wards Affected	All
Accountable Strategic Director	Sarah Norman, Community
Originating service	Community / Public Health
Accountable officer(s)	Ros Jervis — Director of Public Health Tel — 01902 551372 Email — ros.jervis@wolverhampton.gov.uk

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Recommendation(s) for action or decision:

That the Health and Wellbeing Board (HWBB) notes progress against the newly agreed key work streams of the Public Health Delivery Board (PHDB) which will form the Boards work programme for 2014/15.

1.0 Purpose

1.1 To inform the HWBB of the new work streams of the PHDB, as agreed through the Business Planning Cycle and matters arising from its meeting of 31July 2014.

2.0 Background

2.1 A key focus of the July meeting was to present an update of the public health business plan for 2014/15. A progress report on each priority was presented to provide assurance of service delivery and support for the Community Directorate and Corporate Business Plans. This update is detailed in section 4 which reviews each of the 7 priority areas.

3.0 Joint Health and Wellbeing Strategy

3.1 The Alcohol & Drugs priority of the Joint Health and Wellbeing Strategy was reported to the PHDB at its July meeting, and included an update as to progress against both the drugs and alcohol agendas. A report was discussed at the Public Health Delivery Board meeting and this priority is the subject of a separate agenda item for presentation to this Health and Wellbeing Board meeting.

4.0 The Public Health Delivery Board Work Programme

4.1 The activities related to achievement of each priority are tabulated in Appendix One alongside the performance measures, targets and progress to date.

4.2 Priority One - Effective public health commissioning

4.2.1 The commissioning strategy is currently in draft and will be shared and refined with the team at a workshop on 7th August. External consultation is to commence in September to include identification of joint priorities with Clinical Commissioning Group (CCG) and Local Authority commissioning programmes.

4.3 Priority Two - Developing public health processes to support transformation

4.3.1 The Public Health governance framework is in development to include the risk management and incident management processes for all public health functions. Work has started to identify the governance requirements for each Public Health commissioned service for inclusion in contracts going forward.

4.4 Priority Three - Integrating the healthier places team into Public Health

4.4.1 A shadow Healthier Places team has been established comprising Healthy Schools, Sport Development and Parks (Development) & Countryside service. A restructure for the whole service is to be undertaken for each team to come together as one service

area that reflects public health priorities with an emphasis on the wider determinants of health agenda. The sport development and investment strategy is a key document that will be remodelled by this team to reflect Public Health's call to action for obesity and work has commenced to undertake this piece of work.

4.5 Priority Four - Reducing obesity across the life course

4.5.1 The Public Health Annual Report 2013/14 was launched at the Health and Wellbeing Board in July and we are building on the publication of the report to raise awareness of the issue through media interest. The Board expressed involvement in the work streams to deliver the 'obesity call to action'. The report will be presented to other boards over the next few months and pledges have already been made. Several work streams, including planning for the autumn obesity summit are underway.

4.6 Priority Five – Healthcare Advice

4.6.1 The Memorandum of Understanding (MOU) for Public Health's core offer with the CCG has been agreed and signed. The initial objective to look at a risk stratification tool is currently on hold following further discussion with the CCG.

4.6.2 The development of the Pharmacy Needs Assessment is well underway, and the Local Pharmaceutical Committee, GPs, Health watch and the CCG Patient Engagement Lead are advising through the recently established Reference Group.

4.7 Priority Six – Smoking

4.7.1 The Health and Wellbeing Board, July 2014, agreed in principal to recommend that the Council sign up to the Local Government Declaration on Tobacco Control. Once this has been done work can commence on engaging stakeholders and developing a strategy. The Board recommended to support the development of a tobacco control strategy and consider future commissioning opportunities.

4.8 Priority Seven – Health Protection and Emergency Preparedness Resilience and Response (EPRR)

4.8.1 The Health Protection Lead Practitioner post has been appointed to and the Health Protection work plan is now a key objective for development.

4.8.2 A draft Wolverhampton Concept of Operations (ConOps) for the management and response to public health incidents was agreed at the Health Protection Forum in May, with a few minor amendments.

4.8.3 A service specification is now in place between CCG and Royal Wolverhampton Trust (RWT) for provider response to an incident. It has been recognised that there is a need for a communications plan to be developed to sit alongside these two documents.

4.8.4 Wolverhampton CCG are now purchasing EPRR services from public health. In addition Wolverhampton, Walsall and Sandwell CCGs and Public Health teams have agreed in principle to a joint EPRR function, with a preferred option out for consultation.

5.0 Financial implications

5.1 This report has no direct financial implications. Funding for Public Health is provided to the Council by the Department of Health in the form of a ring-fenced grant. The total funding settlement for Public Health for 2014/15 is £19.3 million. The work streams set out in this report will be funded from this allocation.

[NM/18082014/N]

6.0 Legal implications

6.1 There are no direct legal implications arising from this report.

6.2 Governance arrangements for health and wellbeing are regulated by statute and secondary legislation. Under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 the Health and Wellbeing Board is constituted as a Committee under section 101 of the Local Government Act 1972 with power to appoint sub-committees.

RB/18082014/E

7.0 Equalities implications

7.1 The Public Health Service seeks to ensure equality of opportunity as it delivers its core functions and aims to reduce health inequalities. By taking a needs based approach to all commissioned services including the use of equality impact assessment tools we aim to ensure that the needs and rights of equalities groups are considered.

8.0 Environmental implications

8.1 There are no direct environmental implications arising from this report.

9.0 Human resources implications

9.1 There are no direct human resource implications arising from this report.

10.0 Corporate landlord implications

10.1 There are no direct corporate landlord implications arising from this report.

11.0 Schedule of background papers

11.1 Health & Wellbeing Board 3 July 2013 Public Health Delivery Board – Progress Report

Health & Wellbeing Board 4 September 2013 Public Health Delivery Board – Progress Report

Health & Wellbeing Board 6 November 2013 Public Health Delivery Board – Progress Report

Health & Wellbeing Board 8 January 2014 Public Health Delivery Board – Progress Report

Health & Wellbeing Board 4 February 2014 Public Health Delivery Board – Progress Report

Health & Wellbeing Board 8 April 2014 Public Health Delivery Board – Progress Report

Health & Wellbeing Board 8 April 2014 Public Health Delivery Board – Progress Report

Health & Wellbeing Board 7 May 2014 Public Health Delivery Board – Progress Report

Health & Wellbeing Board 9 July 2014 Public Health Delivery Board – Progress Report

Appendix 1: Public Health Business Plan: Priority One - Effective public health commissioning

Activity	Performance Measures	Target	Progress to Date (July 2014)
1. Develop Public Health strategic commissioning plan in line with the Public health Outcomes Framework and Local Priorities.	**100% of milestones against development and production of plan achieved**	**Commissioning plan completed by December 2014**	• **First draft commissioning strategy document to be completed by end of August.** • **A communication plan is in development.**
2. Identify joint commissioning priorities with the Local Authority and CCG. To include Children's Public Health, 0-5 years, health visiting function transfer from NHS England.		**Contract reviews and tender preparation completed by March 2015**	• **Commissioning strategy consultation to commence in September** • **Health visiting transfer; quality work stream and pathways mapping is concluding.** • **NHS Local Area team infrastructure being established with further guidance in September.**
3. Define clear healthy lifestyles outcomes for Wolverhampton incorporating our obesity call to action and reducing harm from smoking and smoking related activities.			• **Annual report on Obesity published – reported separately.** • **Smoking cessation services and NHS health checks under review; project plan to be completed.**
4. Prioritise contracts requiring retender and review during 2014-15 and develop and implement the frameworks in order to undertake these programmes.			• **Project plans in place for retender of sexual health services and school nursing.** • **Drug and Alcohol quality review completed. To be published by end Aug** • **Needle exchange tender issued.**
5. Contract management process established against all specifications/minimum data sets/targets and outcomes in place.			• **Contract management variations** • **Minimum data sets created and shared with providers**

Priority Two – Developing public health processes to support Transformation			
Activity	**Performance Measures**	**Target**	**Progress to Date (July 2014)**
1. To provide a robust Governance framework to support Public Health functions	**A Governance Framework is agreed by September 2014**	**100% of all components of the Governance processes in place with agreed audit criteria by March 2015**	• **Governance framework in development** • **Work commenced to identify the governance requirements for Public Health commissioned services**
2. Establish Public Health Communications plan that addresses internal and external communication needs	**The Public Health communications plan is agreed and established by September 2014**	**100% of the communication needs identified in the plan are delivered by March 2015**	• **Scoping to commence August 2014**
3. A comprehensive Public Health Workforce Development plan is in place to ensure effective delivery of public health function	**All eligible Public Health staff will have a work plan by June 2014**	**100% of all eligible staff will have an induction, appraisal and personal development plan by March 2015**	• **Workforce development plan is in progress** • **Slippage means new timescales to be agreed.**
4. Establish a quality audit programme to maintain and improve the quality of commissioned services	**A Quality assurance process has been identified for all commissioned services by December 2014**	**100% of all commissioned services to have an audit programme by March 2015**	• **Discussions commencing with Royal Wolverhampton Trust to participate in Clinical Audit Cycle**
5. To provide a comprehensive research governance service across the council that ensures all research is robust and of high quality	**A research governance framework is established by September 2014**	**95% of all research governance requests are responded to within the agreed timescale**	• **Research Governance proposal agreed at Public Health Delivery Board June 2014** • **Framework in development**

Priority Three – Integrating the healthier communities team into Public Health			
Activity	**Performance Measures**	**Target**	**Progress to Date (July 2014)**
1. Implement restructure for Healthier Places Team following transfer and disaggregation of budgets for Sports Development / Healthier Schools / and Parks (Development) and Countryside	**Creation of project plan, structure and work programmes for individual teams**	**Project plan to be developed by May 2014** **New Structure to go live by end of September 2014**	• **Head of Service Post established and allocated.** • **Service established in shadow form.** • **Formal restructure to be undertaken in August following appointment of Head of Service.** • **No progress regarding work programmes.** • **Budgets not yet fully disaggregated**
2. Complete Asset mapping profile for the City to include physical and non-physical assets and develop an electronic database.	**Production of database**	**Database to be established by October 2014**	• **No progress**
3. Refresh the Sport Development and Investment Strategy	**Refresh the document**	**Document to be politically endorsed by November 2014**	• **Strategy to be revised (not refreshed) to reflect obesity: call to action priority.**
4. Refresh the Sport Development and Investment Strategy (Shared with Priority 3)	**Refresh the document**	**Document to be politically endorsed by November 2014**	• **Strategy to be revised (not refreshed) to reflect obesity: call to action priority**.

Priority Four – Reducing obesity across the life course			
Activity	**Performance Measures**	**Target**	**Progress to Date (July 2014)**
1. To produce an Annual Report of the Director of Public Health for 2013-14 on the health of the population in Wolverhampton	**A report produced which focusses on a 'call to action' to kick-start Wolverhampton wide action on the important health issue of obesity.**	**Completed by May 2014**	• **Report now completed and published and presented to Health and Wellbeing Board in July 2014.** • **Further presentations are planned e.g. to RWT Trust Board and Children's Trust Board**
2. To follow up the Annual Report with a whole health economy summit to agree a Wolverhampton wide approach	**Summit organised and held**	**Completed by end of October 2014**	• **Summit planning underway** • **Task and finish group meetings are being arranged**
	Action plan agreed by the Health and Wellbeing Board	**Action plan agreed by December 2014**	• **Awaiting summit**
3. Complete asset mapping profile for the City to include physical and non-physical assets and develop an electronic database. (Shared with Priority 3)	**Production of database**	**Database to be established by October 2014**	• **Database is being compiled by Healthy Place team**

Priority Five – Healthcare advice: delivering mandated function			
Activity	**Performance Measures**	**Target**	**Progress to Date (July 2014)**
1. Agreement and delivery of the Core Offer Work Plan with a focus on infant mortality and child health and wellbeing.	**Work plan agreed and completed**	**100% of the Core offer is delivered by March 2015**	• **Work plan discussions commenced**
2. Development of a prevention strategy for Wolverhampton to support the reduction in long term conditions. **database.**	**Prevention strategy output informs Primary Care and Public Health commissioning**	**100% of the Prevention Strategy is completed by December 2014**	• **Prevention strategy in progress**
3. Work with Wolverhampton Clinical Commissioning Group and Central Midlands Commissioning Support Unit apply a risk stratification tool to the local population	**A valid risk stratification tool is agreed and the process for implementation finalised by August 2014**	**50% of the population has been included in the risk stratification process by December 2014**	• **This objective is currently under review due to change in CCG plans**
4. Establish a Public Health pharmacy work stream to include the production of the pharmaceutical needs assessment.	**Work plan agreed by October 2014**	**100% of the pharmacy work plan is completed by March 2015**	• **A PNA Reference Group has been established and met in mid-July. The group agreed TORs and an action plan. The questionnaire to pharmacies has gone out. A community questionnaire is being developed** • **The job description for the PH Pharmaceutical Lead has now been graded and the business case is due for submission.**

Priority Six – Tackling Health Inequalities: reducing smoking			
Activity	**Performance Measures**	**Target**	**Progress to Date (July 2014)**
1. Develop a plan for prevention in schools to increase tobacco control activities in schools	**Education prevention plan evaluated and disseminated by July 2014**	**100% of schools informed of education prevention**	• **Resources developed by young people as part of the ECLIPSE Peer mentoring programme have been disseminated to schools and are now included in the wider drug education programme.**
2. Develop a local Tobacco Control Strategy that includes E Cigs	**Tobacco Control Strategy completed with partners**	**Tobacco Control Strategy completed and partners signed up by December 2014**	• **The Health and Wellbeing Board have in principal agreed to recommend that the Council sign up to the Local Government Declaration on Tobacco Control.**
3. Develop a strategy to reduce infant mortality	**Multi-agency strategy to reduce infant mortality developed by September 2014**	**100% of interventions commissioned to reduce infant mortality are evidence based and have robust evaluation plans**	• **The first multi-agency meeting was held in May 2014 with all partners in agreement to develop a plan to reduce infant mortality.**

Priority Seven – Health Protection and Emergency Planning and Preparedness: delivering mandated function			
Activity	**Performance Measures**	**Target**	**Progress to Date (July 2014)**
1. Develop the Health Protection Forum Work Plan 2014-15.	**Work plan agreed within six months**	**100% of the work plan delivered by March 2015**	• **Data dashboard to aid prioritisation agreed by Health Protection Forum** • **HP Lead appointed and due to start 1st September**
2. Develop robust Health Protection monitoring and surveillance systems	**Monitoring and surveillance systems operational by June 2014**	**100% of cases reported and recorded within the system**	• **Developing a suite of methods, including the HPF data dashboard, the screening and immunisation assurance framework, a quarterly report from PHE on cases reports and incidents, and care homes infection surveillance group**
3. Establish Joint Clinical Commissioning Group/Public Health Emergency Planning Resilience and Response function (EPRR)	**Agreed function operational by September 2013**	**100% recruitment to the EPRR function**	• **PH EPRR lead providing a service to CCG from 1st June 2014** • **Preferred option for BC joint EPRR service out for consultation**
4. Develop and integrate Public Health incident response into WCC Incident Plan and conurbation plans	**Plans agreed by Health Protection Forum by October 2014**	**100% of the Incident Plan established and fully operational by December 2014**	• **Draft Wolverhampton ConOpsfor PH incident response agreed at Health Protection Forum.** • **Need to develop process for testing plan** • **Communications Strategy development to commence.**

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