CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

27 April 2016

Time 2.00 pm **Public Meeting?** YES **Type of meeting** Oversight

Venue Committee Room 3 - 3rd Floor - Civic Centre

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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 5 - 14)
[To approve the minutes of the previous meeting held on 10 February 2016 as a correct record]

5 **Matters arising**
[To consider any matters arising from the minutes of the meeting held on 10 February 2016]

6 **Chair's Update**

7 **Summary of outstanding matters** (Pages 15 - 18)
[To consider and comment on the summary of outstanding matters]
[Viv Griffin]

8 **Health and Wellbeing Board Forward Plan 2015/16** (Pages 19 - 22)
[To consider and comment on the items listed on the Forward Plan]
[Viv Griffin]

9 **Health and Wellbeing Board - Mission Statement** (Pages 23 - 24)
[To consider the revised Mission Statement for the Health and Wellbeing Board]
[Viv Griffin / Ros Jervis]

10 **Joint Strategic Needs Assessment (JSNA) - Update** (Pages 25 - 48)
[To consider an update on the development of the Joint strategic Needs Assessment (JSNA) 2016]
[Ros Jervis]

11 **Infant Mortality Scrutiny Review - Update** (Pages 49 - 74)
[To consider an update on the implementation of the recommendations of the Infant Mortality Scrutiny Review that was undertaken from July 2014 to March 2015 to gather evidence in relation to the high rate of infant mortality in Wolverhampton]
[Ros Jervis]

12 **Update on Suicide Prevention** (Pages 75 - 102)
[To inform the Health and Wellbeing Board of the progress made in relation to the requirements outlined in the national suicide prevention strategy *Preventing Suicide in England: A Cross Government Outcomes Strategy to Save Lives*. In particular, progress in relation to the Mental Health and Suicide Prevention Needs Assessment, completed jointly with Wolverhampton Samaritans, the establishment of a multiagency Wolverhampton Suicide Prevention Stakeholder Forum and the development of a Suicide Prevention Action Plan for Wolverhampton.

In addition to gain the Board's approval for the approach being taken and the action plan, including any comments the Board has to make.]

[Ros Jervis]

13 **Headstart Stage 3 Bid**
[To receive a presentation on the current position with Headstart Stage 3 bid – see also www.headstartbid.com]

[Viv Griffin]

14 **Better Care Fund 2016/17 outline plan** (Pages 103 - 110)
[To advise Health and Wellbeing Board of the progress towards the establishment of a Section 75 Agreement between City of WolverhamptonCouncil ("CWC") and the Wolverhampton Clinical Commissioning Group ("CCG"), for the purposes of delivering the Better Care Fund in the business year 2016/17.
To advise Health and Wellbeing Board of the progress for developing the 2016/17 delivery plan. As previously agreed final approval of the 2016/17 BCF delivery plan is delegated to the Chair of the Health and Wellbeing Board, Cllr Samuels and Cllr Mattu with advice from the Transformation Director CCG (Steven Marshall), and BCF Lead for the CWC (Viv Griffin)]

[Viv Griffin]

15 **Children's Trust Board - Progress Report** (Pages 111 - 122)
[To provide the Board with an update on progress with the Children's, Young People and Families Plan (2015 - 2025]

[Cllr Val Gibson / Emma Bennett]

16 **Feedback on Shadow Combined Authority Mental Health Commission** (Pages 123 - 130)
[To receive an update on the progress to date of the Shadow Combined Authority Mental Health Commission and to raise raise the profile of the work of the Commission]

[Viv Griffin]

17 **Consultation on Joint Autism Strategy** (Pages 131 - 146)
[To receive the draft Joint Autism Strategy for consideration and comment as part of the consultation process]

[Kathy Roper]

18 **Minutes from Sub Groups** (Pages 147 - 158)
[To note the minutes of the meetings of the following Sub Groups:

i) Children's Trust Board (Cllr Val Gibson);
ii) Integrated Commissioning and Partnership Board (Linda Sanders) and
iii) Public Health Delivery Board (Ros Jervis)

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

Agenda Item No: 4

Minutes - 10 February 2016

Attendance

Members of the Health and Wellbeing Board

Councillor Sandra Samuels OBE	Chair, Cabinet Member for Health and Wellbeing
Ros Jervis	Service Director - Public Health and Wellbeing
Councillor Paul Singh	Shadow Cabinet Member for Health and Wellbeing
Alan Coe	Chair Wolverhampton Safeguarding Board
Ian Darch	Third Sector Representative
Simon Hyde	Chief Superintendent West Midlands Police
Linda Sanders	Strategic Director, People
Steven Marshall	Director of Strategy & Transformation
Dr Arko Sen	Wolverhampton Healthwatch
Jeremy Vanes	Chairman, The Royal Wolverhampton NHS Trust

Employees

Carl Craney	Democratic Support Officer
Richard Welch	Head of Community Recreation
Manjeet Garcha	Executive Lead Nurse
Juliet Grainger	Substance Misuse Commissioning Manager
David Loughton	Chief Executive of Royal Wolverhampton Hospital NHS Trust

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Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies for absence (if any)**
Apologies for absence had been received from Karen Dowman (Black Country Partnership NHS Foundation Trust), Dr Helen Hibbs (Wolverhampton City Clinical Commissioning Group), Cllr Val Gibson (City of Wolverhampton Council), Tim Johnson (City of Wolverhampton Council), Professor Linda Lang (University of Wolverhampton), Cllr Roger Lawrence (City of Wolverhampton Council) and Cllr Elias Mattu (City of Wolverhampton Council) together with Viv Griffin (City of Wolverhampton Council).

2 **Notification of substitute members (if any)**
Steven Marshall attended as a substitute member for Dr Helen Hibbs (Wolverhampton City Clinical Commissioning Group).

3 **Declarations of interest (if any)**
No declarations of interest were made relative to matters under consideration at the meeting.

4 **Minutes of the previous meeting**

Resolved:

That the minutes of the meeting held on 2 December 2015 be confirmed as a correct record subject to the addition in Minute No. 1 of "Alan Coe – Independent Chair, Wolverhampton Children's and Adults Safeguarding Boards" as having submitted an apology for absence.

5 **Matters arising**

With reference to Minute No. 8, ("Beat the Streets" initiative), Ian Darch advised that he had expressed his concerns at the previous meeting on the perception of the voluntary sector in relation to the process for commissioning the "Beat the Streets" initiative especially in the light of the funding cuts experienced by that sector. Ros Jervis, Director of Public Health, explained that "Beat the Streets" was a national initiative and could only be delivered by that company. She advised that the voluntary sector would play an integral role in delivery of the Obesity Action Plan and many other such initiatives. Ian Darch commented that he understood that the Public Health Funding Settlement had yet to be announced but that in the event that this would lead to further reductions in funding of the voluntary sector that any information be made known at the earliest opportunity. Linda Sanders, Strategic Director – People confirmed that the Public Health Funding Settlement had yet to be announced and commented that the "Beat the Streets" initiative was a national brand which could be delivered quickly.

Resolved:

That a meeting be held between Ian Darch, the Director of Public Health and Richard Welch, Head of Service for the Healthier Place Service to discuss this matter further.

With reference to Minute No. 10 (Better Care Technology), Dr Arko Sen suggested that optimum use need to be made of technology across the health and social care economy. The Strategic Director – People advised that technology was used across a range of services and its use was not confined to older people.

6 **Chair's Update**

The Chair, Cllr Sandra Samuels OBE reported that the official launch of the "Beat the Streets" initiative had been launched formally at Woodthorne School that morning. She reminded the Board that currently within the city 34.5% of adults and 65% of young people were classed as inactive. The initiative would run for seven weeks from Wednesday 24 February to Wednesday 13 April 2016 and that on-line registration for the scheme would be available from 15 February 2016.

190 Beat Boxes would be fitted across the city and 60,000 cards would be distributed. Up to 30,000 would be distributed to schools that registered for the scheme and the remainder would be available from distribution points which were at a variety of facilities including community centres, leisure centres, Phoenix Health Centre, the Civic Centre and the Wolverhampton Art Gallery. As at Friday 5 February 2016 45 schools had signed up to the initiative.

She advised that maps indicating the location of Beat Boxes were available for inspection together with examples of the fliers which were to be used to publicise the initiative. The objective of the initiative was to encourage children and young people to become active and also to encourage parents out of their cars with children

walking to school. The Director of Public Health reported that registration was open to teams and groups as well as individuals. Ian Darch asked whether there was any material available which could be distributed by the voluntary sector.

Resolved:

That a copy of the hyperlink together with a supply of fliers be forwarded to Ian Darch for onward transmission to voluntary sector organisations.

The Chair reported that she had attended, as an observer, a meeting held in January 2016 of the Wolverhampton City Clinical Commissioning Group (WCCCG) where discussions had been held in relation to funding and capital projects. She had raised the lack of General Practitioner (GP) facilities in the Whitmore Reans area. Subsequently, a bid had been made by the WCCCG to upgrade the facilities at the Whitmore Reans Health Centre.

The Chair reported on an outbreak of Novovirus at New Cross Hospital which had affected two Wards. David Loughton CBE Chief Executive of the Royal Wolverhampton NHS Trust advised that the outbreak had been spasmodic and was now relatively under control. He reported that the opening of the new Accident and Emergency Centre had created sufficient additional bed space to enable Wards to be closed and a deep clean exercise to be undertaken. The Director of Public Health commented that similar outbreaks had been experienced by many Acute Trusts across the country and on the excellent working relationship between the Council and the Trust's Infection Prevention and Control Team.

The Chair reported that she had attended a meeting of the National Tuberculosis (TB) Board when it had been considered whether the issue of TB should be included within Joint Strategic Needs Assessments (JSNA's). She advised that treatment was currently available for TB at the Refugee and Migrant Centre. Funding was available for patients to be screened at the Refugee and Migrant Centre with a target of 125 patients being screened from Wolverhampton and Walsall by the end of March 2016. Consideration was also being given to screening for Hepatitis at the Refugee and Migrant Centre.

Resolved:

That the Director of Public Health draw to the attention of the JSNA Working Group the possible inclusion of the issue of TB within the emerging JSNA.

The Chair reported on the problems with the Zika virus and that 3,893 cases which had been experienced in Brazil. A Briefing Note had been prepared by the Director of Public Health to appraise Councillors of the issue and the information was also available to employees. Dr Arko Sen commented that it had yet to be confirmed that mosquitos were the source of the problem. The Director of Public Health confirmed that the cause of the problem had yet to be confirmed and on the need to provide clinicians with the latest information. She reported that the Public Health Team was working closely with the Acute Trust and the Clinical Commissioning Group on the dissemination of relevant information.

The Chair reported on the future governance partnership arrangements for the Black Country NHS Partnership Foundation Trust, following a period of consultation, a combined partnership between the Black Country Partnership NHS Foundation Trust, Birmingham Community Healthcare NHS Trust and Dudley and Walsall Mental Health Partnership Trust had been agreed. This was a constructive move that would

ensure the sustainability of Mental Health Services across the Black Country and beyond and bring with it both clinical expertise and economies of scale.

At the invitation of the Chair, the Director of Public Health reported on a broad healthy lifestyle survey was being undertaken on a face to face basis with 9,000 residents. The purpose of the survey was to enable a greater understanding of lifestyle choices.

Resolved:

That a further report on the initial results of the survey be submitted to the next meeting.

7 **Summary of outstanding matters**

Resolved:

That the summary of outstanding matters be noted.

8 **Health and Wellbeing Board Forward Plan 2015/16**

Resolved:

That the report be received and noted.

9 **Better Care Fund 2015/16 progress report and 2016/17 outline plans** Steven Marshall, Director of Strategy and Transformation, Wolverhampton City Clinical Commissioning Group presented a report on the development and progress of the Better Care Fund including progress with the Dementia and Mental Health Workstreams and the outline plans for 2016/17. He reminded the Board that the Better Care Fund programme was delivering system wide changes with the aim of delivering the following six outcomes:

- Reduced Delayed Transfer of Care ("DTOC");
- Reduction in avoidable emergency admissions;
- Reduced admissions to residential and nursing homes;
- Ensured effectiveness of reablement;
- Improvement patient/service user experience;
- Improved dementia diagnosis rates.

He advised that "DTOC" remained a key issue to be delivered but that difficulties were still being encountered in achieving the target. A tri-partite agreement had been established between the Council, Clinical Commissioning Group and the Acute Trust to address this matter. With regard to the reduction in emergency admissions he advised that there had been an increase but this was due to the method of calculation with episodes of care and emergency admissions having conflicting numbers. There was , however, a requirement to report against the MAR (hospital data). He explained that the number of emergency admissions had actually reduced. In relation to the reduced admission to residential and nursing homes target, he reported that the figures had reduced and that Wolverhampton was one of the best performing areas in the country.

He reported that with the exception of the "DTOC" progress in achieving the targets was positive. He drew to the attention of the Board the establishment of the Community Neighbourhood Team (CNT) model. This model would see the establishment of three CNT's wrapped around small numbers of GP practices. He outlined the composition of the core teams which would include District Nurses and Social Workers.

He drew to the attention of the Board the current financial position together with the current projected overspend. With regard to the 2016/17 financial year, he explained that the final guidance was still awaited and the timetable for sign off of the Delivery Plan which necessitated a requirement for delegated authority to be granted in order to meet the time frame.

The Chief Executive of the Royal Wolverhampton NHS Trust commented on the emergency admissions target and advised that attendance at the A&E Centre had broken records three times in as many weeks and that this presented an issue with 19 patients waiting in corridors on the previous evening. For the first time in his NHS experience however, bed availability had not been a problem. With regard to "DTOC" he reported that the position had improved enormously in Wolverhampton in recent times. The Strategic Director – People commented that the Council, the Acute Trust and the WCCCG continued to work together to address this problem but that maintaining people at home did have financial implications.

Jeremy Vanes, Chair of the Royal Wolverhampton NHS Trust enquired whether the Better Care Fund programme would be continued beyond 2018/19. The Director of Strategy and Transformation responded that there was an assumption, at national level, that Health and Social Care would be integrated more by 2020 and that the Better Care Fund would continue but would require more than joint commissioning.

Resolved:

1. That the progress report on the current year's activity be noted.

2. That the intention to advise the Health and Wellbeing Board of the intention to establish a Section 75 agreement between City of Wolverhampton Council (CWC) and the Wolverhampton CCG for the purposes of delivering the Better Care Fund in the business year 2016/17, and process for developing this agreement, along with the progress to date be endorsed.
3. That the draft Section 75 agreement be taken to the CCG governing body meeting on the 8 March and to the CWC Cabinet meeting scheduled for 23 March 2016 for final approval by both partner organisations.
4. That the process for developing the 16/17 delivery plan, the progress to date be noted, and that the final approval of the 16/17 BCF delivery plan be delegated to the Chair of the Health and Wellbeing Board, Cllr Samuels and Cllr Mattu with advice from the Transformation Director CCG (Steven Marshall), and BCF Lead for the CWC (Viv Griffin) during March 2016.

10 **Joint Strategy for Urgent Care - Equality Analysis - Implementations of recommendations**

The Director of Strategy and Transformation presented a report which detailed action taken following the previous update in June 2015 on the equality analysis report relating to the Joint Strategy for the Provision of Emergency and Urgent Care in Wolverhampton.

The Independent Chair of the Children's and Adults Safeguarding Boards referred to paragraph 3.3 of the report inasmuch as it only indicated the training undertaken by the WCCCG staff. The Director of Strategy and Transformation explained that the report was a response to the Strategy Document which was the responsibility of the

WCCCG. The Chair of the Royal Wolverhampton NHS Trust advised that a new approach had been adopted by the Trust in relation to the collation and collection of training data and that it would be possible for figures in relation to training undertaken by Trust employees to be provided. The Strategic Director – People commented that specific training was not provided by the Council in relation to equality and diversity as it was an integral part of the Council's operating procedures. The Independent Chair of the Children's and Adults Safeguarding Boards reminded the Board that the original recommendations had required training data to be provided by all relevant agencies. The Strategic Director – People reiterated her earlier comments that this did not relate to the Council inasmuch as it had no responsibility for the urgent care of patients. Manjeet Garcha, Director of Nursing and Quality, WCCCG commented that generic information from the WCCCG was submitted regularly to the respective Safeguarding Boards on this issue and reminded the Board that the WCCCG as a Commissioner, was required to ensure that its Service Providers satisfied its requirements in respect of such training.

Dr Arko Sen enquired as to the possibility of equality and diversity training being provided to volunteers alongside NHS staff.

Resolved:

1. That the progress in relation to implementation of recommendations 8, 10, 11, 19, 20 and 21 in the Equality Analysis document which supported the Joint Strategy for Urgent and Emergency Care be noted;
2. That the relevant data in relation to training on equality and diversity undertaken by employees of the WCCCG and RWT be provided to the Independent Chair of the Children's and Adults Safeguarding Boards;
3. That the training needs of volunteers in relation to equality and diversity matters be considered alongside the needs of NHS staff, if appropriate.

11 **Obesity Call to Action - Progress Update**

The Director of Public Health presented a report which provided an update in relation to progress made for the Obesity Call to Action and subsequent production of an Action Plan on 29 July 2015. The report outlined the development of a whole systems approach which had been adopted and progress made against the five year Action Plan.

Cllr Paul Singh welcomed the report and initiatives but enquired as to whether there was any data available against which progress could be measured. The Director of Public Health advised that the aim of the plan was to reduce the percentage of residents who were overweight or obese. She explained that there was a 12 month delay involved with the collection and publication of the relevant data. Data collected by School Nurses had recorded, however, a slight reduction in the number of overweight children but there had been no movement in the number of obese children. Cllr Paul Singh expressed concern in relation to the ability of the Council to measure progress in the absence of relevant data. The Chair advised that the data would be available but was not to hand immediately. The subject of progress with Child Obesity was also being considered by a joint meeting of the Health and Children and Young People and Families Scrutiny Panels.

She reminded the Board that it was estimated that 40% of eleven year olds in the city were obese. She referred to paragraph 4.1 of the report inasmuch as it referred to the Public Health Funding Settlement and the cut imposed in the Autumn Statement. The Director of Public Health advised that the Wolverhampton budget had been

reduced by 6.2% which amounted to a £1.33 million in year reduction. A further reduction to the budget of 3.5% was anticipated. The funding formula was being revised and could lead to further significant reductions in the money available to the City of Wolverhampton Council.

Resolved:

That progress made against the Obesity Call to Action be noted.

12 **Public Health Commissioning Intentions 2016/17**

The Director of Public Health presented a report in connection with the Public Health commissioning intentions for 2016 – 17 and the aspirations for commissioning to improve the health of the population to 2019. She reminded the Board that a five year contracting strategy had been approved in 2014 and since that time a huge amount of work had been undertaken which would continue into future years. She reported that the Healthy Child programmes; 0-5 (Family Nurse Partnership and Health Visiting) and 5-19 (School Nursing) would remain as currently specified with the Royal Wolverhampton NHS Trust until August 2017. Redesign of these services and planning for a comprehensive consultation had commenced and would be fully developed during 2016 – 17 with a new contract commencing on 1 August 2017.

She referred to section 3 of the report inasmuch as it referred to “aspirations: tackling the big six health issues in Wolverhampton” and explained that in the absence of the Public Health Funding Settlement it was only possible to confirm the continuation of mandated services at the present time. In order to achieve longer term impact to improve the health of the population of Wolverhampton certain interventions were required but this would be dependent on the availability of resources. She emphasised that discretionary services were at risk depending on the funding made available in the Settlement.

She advised the Board that the spending review and Autumn Statement covering 2016 – 17 onwards represented an average real term saving of 3.9% each year to 2020 – 21. The savings would be phased in at 2.2% in 16 – 17, 2.5% in 17 – 18, 2.6% in each of the following two years and flat cash in 20 – 21. To prepare for this anticipated reduction scenario planning had been undertaken to prioritise Public Health programmes. Minimum provision would cover only prescribed service delivery. After the prescribed provision prioritisation would be undertaken to retain critical services tackling the key health issues for Wolverhampton. Discretionary activity would then only be provided if it was affordable within a revised total programme.

The Chair of the Royal Wolverhampton NHS Trust welcomed the report. He referred to Public Health voluntary sector contracts for the delivery of peer support, young people’s counselling and welfare and advice services expiring in 2016 and noted that a review commissioning and procurement exercise would be commenced later this year. He commented that there was a sense of trepidation felt by the providers of services to young people especially having regard to the reduced level of the voluntary sector. He requested that the voluntary sector be informed of the financial position at the earliest opportunity. The Director of Public Health acknowledged the position and the need to be open, honest and transparent with the voluntary sector on the financial position.

Resolved:

1. That the commissioning intentions be endorsed;

2. That the implications of the spending review and Autumn Statement on the public health grant allocation might require the reprioritisation of future commissioning intentions and the current contracting portfolio be noted;
3. That it be noted that any reductions would be applied to ensure delivery of prescribed services: Children 0 – 5 (health Visiting), sexual health, NHS health checks, National Child Measurement programme and surveillance and monitoring of health protection incidents, outbreaks and emergencies as primary functions.

13 **Francis Inquiry - progress on implementing recommendations**

The Director of Nursing and Quality, Wolverhampton City Clinical Commissioning Group presented a report which updated the Board on the progress made by the CCG in implementing the recommendations from the Francis Inquiry and a number of other reports. She suggested that an over- arching report on quality be submitted to future meetings.

The Chair of the Royal Wolverhampton NHS Trust commented that organisational memory was an issue in the short term for a variety of reasons especially having regard to staff turnover. He questioned how the health and social care economy would make the necessary steps to retain the knowledge and avoid moving backwards. The Chair suggested that quality checks needed to be conducted on at least a quarterly basis.

The Independent Chair of the Wolverhampton Children's and Adults Safeguarding Boards supported the comments made previously and commented on the duplication of reporting between this Board and the Safeguarding Boards. He opined that when lessons had been learnt from previous experiences that there was a need to ensure that this had actually occurred.

The Director of Public Health commented that improvements in the quality and safety of care provided had improved. She suggested that a quality and safety framework was required which ensured that continued improvement occurred.

The Chief Executive of Royal Wolverhampton NHS Trust reported on the difficulties the Trust encountered after recruiting nurses from abroad in obtaining the necessary immigration documentation. Furthermore, he commented on the problems with retaining qualified nurses once they had commenced their duties, with many choosing to seek alternative employment in locations such as Southampton. He advised that following the Care Quality Commission (CQC) inspection of the Manor Hospital at Walsall there was now an expectation that the RWT Maternity Unit would take responsibility for a further 500 deliveries. This was likely to re-ignite previous complaints regarding the closure of the Maternity Unit at Stafford Hospital.. The Chair queried whether the RWT had sufficient capacity to cope with the additional demands. The Chief Executive of Royal Wolverhampton NHS Trust reminded the Board of the decision taken by the Trust to undertake capital expenditure on a major project prior to the formal approval of the Business Case by the Department of Health while other Trusts had awaited formal approval or had taken no steps whatsoever.

Ian Darch commented that the human factors needed to be taken into account and that while the quality and safety issues were important the culture of each organisation was equally important.

Resolved:

1. That the report be received and noted;
2. That further consideration be given to the development of a quality and safety framework with the outcome being reported to a future meeting with a view to quarterly reports being submitted to the Board;
3. That the framework include an indication as to the most appropriate body to receive progress reports on specific developments from the various Inquiries / reports.

14 **Wolverhampton City Clinical Commissioning Group Primary Care Strategy**

The Director of Strategy and Transformation presented a report which informed the Board of developments with regard to the Wolverhampton City Clinical Commissioning Group (WCCCG) Primary Health Care Strategy. The Strategy had been approved in principle by the WCCCG Governing Body on 12 January 2016 and which had been ratified at a Members Meeting on 20 January 2016. He reported that the Strategy detailed what was to be delivered in relation to Primary and Community Care.

The Independent Chair of the Wolverhampton Children's and Adults Safeguarding Boards suggested that the document needed to make more reference to Safeguarding and in terms of GP engagement with Safeguarding issues to ensure that GP's were equipped to deliver what was expected of them. The Director of Nursing and Quality undertook to ensure that this issue was addressed through workforce development. Dr Arko Sen suggested that reference needed to be made in the document to tackling inequality issues.

Ian Darch commented that the WCCCG with support from the Voluntary Sector Council had been successful in obtaining a grant from the Big Lottery Commissioning Better Outcomes Fund to develop a Business Case that would appraise the option of using a Social Impact Bond to finance Voluntary and Community Sector (VCS) preventative well-being interventions for older people. WCCCG's overall aim was to make savings by reducing ambulance call outs, emergency hospital admissions and delayed discharges of older people. Initial cost profiling had indicated that investment in VCS prevention could lead to cashable savings of approximately £1 million over 5 years to the WCCCG. The City of Wolverhampton Council would also benefit in terms of savings and improved outcomes for older people. He suggested that reference to the Social Impact Bond proposition could be included in the Strategy.

The Director of Strategy and Transformation advised that an allocation of funding was also available for voluntary sector organisations to apply for funding to assist community care providers.

Resolved:

1. That it be noted that the Strategy had been adopted by the WCCCG Governing Body and ratified by the WCCCG members;
2. That the comments made during the consideration of the Strategy be noted.

15 **NHS Planning and Strategic Transformation Plan 2016/17**

The Director of Strategy and Transformation reported on planning guidance received from the Department of Health which required an Operations Plan to be produced for 2016 -17 and a Sustainability and Transformation Plan for 2020. Three years fixed funding had been indicated together with indicative funding for a further two year period. The Sustainability and Transformation Plan required a larger footprint than just Wolverhampton to be considered and the recognition that it had a wider footprint than the Black Country given the treatment of patients from South Staffordshire and Shropshire. He advised that various configurations of Trusts and organisations would be looked at.

He commented that this would be a thorny issue to address and would pose a challenge to social care providers. A systems submission was required by the end of June 2016 and a number of cross organisation Working Groups were being established to work on these requirements. The Strategic Director – People commented that there was a need to add value without duplicating effort and that there was a desire for the Black Country Authorities to work together at a Combined Authority level and/or across the Black Country.

The Chair queried whether these issues were to be considered by the Combined Authority, once established. The Director of Strategy and Transformation advised that the responses would be health driven nationally.

The Chair of the Royal Wolverhampton NHS Trust questioned what the changes would mean for that Trust. He suggested that local solutions were required rather than a footprint being imposed by the Department of Health. He commented that the identification of “the Wolverhampton ask” was required as the first step in responding to this issue.

Resolved:

That the report be received and noted.

16 **Children and Young People's Plan - progress report**

Resolved:

That this matter be considered at the next meeting of the Board.

17 **Minutes from Sub Groups**

Resolved:

That the minutes of the following meetings be received and noted:

i) Children’s Trust Board – 1 December 2015;

ii) Integrated Commissioning and Partnership Board – 3 December 2015.

[Carl Craney, Democratic Support Officer, reported that it would not be necessary to pass a resolution to exclude the press and public as the report on NHS Capital Programme due to be considered at Agenda Item No. 19 was not available]

18 **Exclusion of the Press and Public**

See Minute No. 17 above.

19 **NHS Capital Programme**

See Minute No. 17 above.

Agenda Item No: 7

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

27 April 2016

Report Title Summary of outstanding matters

Cabinet Member with Lead Responsibility	Councillor Sandra Samuels Health and Wellbeing
Wards Affected	All
Accountable Director	Viv Griffin – Service Director – Disability and Mental Health
Originating service	Governance
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
31 March 2014	Health and Well Being Strategy – Performance Monitoring	Helena Kucharczyk (CofWC)	Quarterly reports (included with Better Care Fund updates)
31 March 2014	NHS Capital Programme – NHS England – GP practices in Wolverhampton	Les Williams / Dr Kiran Patel (NHS England)	Quarterly reports
4 March 2015	Scoping the JSNA and analysing best exemplars nationally	Ros Jervis (CoWC)	Report to a future meeting
3 June 2015	Integrated Commissioning - Roles and responsibilities of the various partner agencies involved in Integrated Commissioning	Steven Marshall (WCCCG)	Report to a future meeting as part of a Better Care Fund – Update report.
2 December 2015	Suicide Prevention Action Plan- To receive details of the Action Plan	Ros Jervis (CofWC)	Report to this meeting
10 February 2016	Public Health Settlement – Effect of and implications on	Ros Jervis (CofWC)	Report to a future meeting

	the voluntary sector		
10 February 2016	Healthy Lifestyle Survey – Initial report	Ros Jervis (CofWC)	Verbal report on initial findings to this meeting
10 February 2016	Quality and safety framework - outcome of discussions with partner organisations on framework and quarterly reports thereafter	Manjeet Garcha (WCCCG)	Report to a future 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: 8

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

27 April 2016

Report Title	Health And Wellbeing Board – Forward Plan 2015/16 and 2016/17
Cabinet Member with Lead Responsibility	Councillor Sandra Samuels Health and Wellbeing
Wards Affected	All
Accountable Director	Viv Griffin – Service Director – Disability and Mental Health
Originating service	Disability and Mental Health
Accountable officer(s)	Viv Griffin Service 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

PRIORITIES OF THE HEALTH AND WELLBEING BOARD

The priorities of the Board are outlined in Wolverhampton Joint Health and Wellbeing Strategy – 2013-2018

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

MEETING 27 April 2016	TOPIC	LEAD OFFICER
	Minutes from Sub Groups	Viv Griffin / Linda Sanders / Ros Jervis (CofWC)
	Health and Wellbeing Board – Mission Statement	Viv Griffin / Ros Jervis (CofWC)
	JSNA Update	Ros Jervis (CoWC)
	Infant Mortality – Update	Ros Jervis (CoWC)
	Suicide Prevention Action Plan	Ros Jervis (CoWC)
	Headstart Stage 3 Bid	Viv Griffin (CoWC)
	BCF Plan 2016/17	Viv Griffin (CoWC)
	Action on sugar	Ros Jervis (CoWC)
	Feedback on Shadow Combined Authority Mental Health Commission	Viv Griffin (CofWC)
	NHS Capital Programme	Dr Kiren Patel (NHS England Local Area Team) / Steven Marshall (WCCCG)
	Children and Young People's Plan – progress report	Emma Bennett (CoWC)
	Consultation on Joint Autism	Kathy Roper

	Strategy	(CoWC)
June 2016 meeting	Minutes from Sub Groups	Viv Griffin / Linda Sanders / Ros Jervis (CoWC)
	Revised Health and Wellbeing Strategy	Viv Griffin / Ros Jervis (CoWC)
	NHS Planning Guidelines – Strategic Plan 2016/17 and 2020 Integration Plan	Steven Marshall (WCCCG) / Viv Griffin (CofWC)
	MERIT Vanguard	XXXXXXXX (Black Country Partnership NHS Foundation Trust)

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Mission

Promoting health, wellbeing and resilience

across the life course

Vision

- **Best start in life**
- **Supporting positive transition into adulthood**
- **Promoting wellbeing throughout adulthood**
- **Supporting a good healthy life expectancy**

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Agenda Item No: 10

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

27 April 2016

Report title	Joint Strategic Needs Assessment Update	
Cabinet member with lead responsibility	Councillor Sandra Samuels Public Health and Wellbeing	
Wards affected	All	
Accountable director	Linda Sanders	People
Originating service	Public Health	
Accountable employee(s)	Ros Jervis Glenda Augustine Tel Email	Director of Public Health Advanced Health Improvement Specialist: Needs Assessment 01902 559662 Glenda.augustine@wolverhampton.gov.uk
Report to be/has been considered by	Public Health Senior Management Team People Leadership Team	31 March 2016 11 April 2016

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1. Approve the progress and initial outputs of the Joint Strategic Needs Assessment.

1.0 Purpose

1.1 The purpose of this paper is to provide the Health and Wellbeing Board with an update on the progress of the development of the Joint Strategic Needs Assessment (JSNA) 2016.

2.0 Background

2.1 The JSNA is an integral part of improving population health and well-being and reducing local health inequalities. It aims to provide an assessment of the current and future health and social care needs of the local population. The identification of health and social care need will inform strategic planning alongside the commissioning of services to address unmet need. The JSNA will also support the monitoring of trends and evaluation of performance data in relation to commissioned services.

2.2 In October 2015 the Health and Wellbeing approved:

- The formal establishment of a representative JSNA Steering Group
- The publication of a wide compendium of population health and social care need
- The development of an 'interactive' electronic JSNA to provide access to the compendium findings to support commissioning and provide information and on-going engagement with interested parties.

2.3 A life course approach with defined topics was the chosen method for presenting the compendium of health and social care need (see Appendix One). Evidence gained from a review of the JSNAs across England demonstrated that this approach provided the most comprehensive capture of health and social care need. It enables a review of key ages and stages of life, highlighting critical periods throughout the life course for interventions to improve health and wellbeing.

2.4 This paper will outline developments that have taken place up to March 2016.

3.0 Progress on production of the Joint Strategic Needs Assessment.

3.1 A comprehensive JSNA Policy and Process document was produced outlining the following:

- JSNA Steering group: Membership and its governance structure
- The JSNA Process for Wolverhampton
    - Production of an Overview Report depicting a life course approach
    - Prioritisation process to identify areas for topic-specific JSNAs
    - Production of topic specific JSNAs
    - Templates for JSNA Content: Overview and Topic specific JSNAs
    - Quality review of the JSNA process
    - Stakeholder Engagement process

3.2 JSNA Steering Group

3.2.1 The first meeting of the JSNA Steering Group was held on 1 February 2016, with wide partnership engagement across health, social care and the voluntary sector (see Appendix Two). Draft terms of reference were presented and there was a detailed review of the policy and process document.

3.2.2 The second meeting of the Steering group is planned for 3 May 2016 where two chapters of the overview report will be reviewed. The highlights from the draft topic-specific report on children and young people with Special Educational Needs and Disabilities (SEND) will also be discussed. The aim of this report, once completed, will be to determine current service provision for this group of children and young people, identify any gaps in service provision and inform the commissioning of SEND services to address unmet needs.

3.3 Compendium of population health

3.3.1 The JSNA Steering Group approved the production of an overview report with six detailed of chapters across the life course and summary chapter, providing analysis on:

- How long people live: life expectancy and healthy life expectancy
- Causes of early death
- Start well
- Develop well
- Live, work and stay well – adults
- Age well

3.3.2 The first chapter of the JSNA is complete and provides an overview of life expectancy, health life expectancy, wellbeing and health and social care related quality of life. Data for Wolverhampton is presented in comparison to statistical neighbours and national outcomes. Ward level data and spend is provided for life expectancy. There is also a summary of what information is provided by the data and where applicable, indicative commissioning needs.

3.3.3 A complete analysis of chapter one is available in Appendix Three. The summary findings are:

3.3.3.1 *Life Expectancy*

- Life Expectancy at birth in males in 2012-2014 in Wolverhampton is 77.6 years which is a slight improvement from 77.5 years in 2011-2013
- Life expectancy at birth in females in 2012-2014 in Wolverhampton is 81.8 years which is a slight decrease from 82 years in 2011-2013
- Although life expectancy for females has been consistently higher than life expectancy for males, the gap in life expectancy between the genders has reduced from 9% (6.4 years) in 1991-1993 to 5% (4.2 years) in 2012-2014.
- The gap in life expectancy by ward has increased for both males (8.9 years) and females (6.9 years) in 2010-2014, compared to 6.2 years and 5.3 years respectively in 2001-2005

- *Life Expectancy Summary*: This means that although there is a gradual increase in life expectancy for both men and women in Wolverhampton, on average, our residents are still dying at a younger age than men and women in England. Whilst the gap in life expectancy between men and women in Wolverhampton is decreasing, the gap in life expectancy between wards has increased, indicating increasing inequalities by ward.

3.3.3.2 *Healthy Life Expectancy*

- Wolverhampton is performing poorly on healthy life expectancy at birth for both males (56.9) and females (58.3) in 2012-14. The trend for healthy life expectancy is not improving and the gap between healthy life expectancy and life expectancy is increasing for males (from 18 years in 2009-2011 to 21 years in 2012-2014) and very slightly decreasing for females (from 23.6 years in 2009-2011 to 23.5 years in 2012-2014).
- *Healthy Life Expectancy Summary*: This means that both men and women in Wolverhampton are living experiencing an increase in the number of years of ill-health prior to their death. Over a quarter of our resident's life expectancy is lived with increasing disability.

3.3.3.3 *Health Related Quality of Life*

- In 2014/15, more people in Wolverhampton rated their wellbeing as high or very high compared to low or medium for life satisfaction (67%), worthwhile (72%) and happiness (66%). Nearly 70% recorded low or medium level of anxiety, that is, high level of wellbeing.
- Although levels of satisfaction and 'feeling worthwhile' are lower than the average for the West Midlands and England, more people in Wolverhampton feel 'less anxious' (69%) compared to the regional (67%) and national (64%) average.
- The Health Related Quality of Life for adults and older people with long term conditions and mental health conditions in Wolverhampton is slightly improving. It is however, still significantly lower compared to West Midlands and England.
- *Health Related Quality of Life Summary*: This means that although Wolverhampton residents report lower levels of satisfaction and feelings of worth, they report less anxiety than the average individual in England.

3.3.3.4 *Social Care Related Quality of Life*

- Social Care Related Quality of Life (SCR QoL) in Wolverhampton is above the West Midlands and England average. However, the gap between male and female SCR QoL is increasing and there is a fall in SCR QoL overall since 2011/12.
- *Social Care Related Quality of Life Summary*: This means that Wolverhampton users of social care report less unmet needs relating to personal and social care and support needs (personal control and care, food and nutrition, accommodation, safety, social participation, occupation and dignity). However, there are inequalities between men and women, with women reporting less unmet needs than men.

3.3.4 The aim is to complete the additional chapters of the overview report by November 2016.

3.4 Interactive JSNA Website

3.4.1 The City of Wolverhampton Council Information and Communication Technology team are currently reviewing the options available for the creation of an interactive website. The options include designated page on the council website, with further development following the digital transformation programme or development of a separate website.

4.0 Financial implications

4.1 There are no explicit funding implications arising from the production of the JSNA products and administration of the Steering Group. Any costs arising from these functions will be met from existing budgets within Public Health. [AS/15042016/F]

5.0 Legal implications

5.1 There are no anticipated legal implications to this report. [RB/01042016/L]

6.0 Equalities implications

6.1 The process of analysing health and social care need may highlight inequalities in service access or provision which could adversely affect people differently or not meet the needs of certain groups. There will be specific recommendations made regarding commissioned services, where applicable, to address any inequalities identified.

7.0 Environmental implications

7.1 There are no environmental implications related to this report.

8.0 Human resources implications

8.1 There are no anticipated human resource implications related to this report.

9.0 Corporate landlord implications

9.1 This report does not have any implications for the Council's property portfolio.

10.0 Schedule of background papers

10.1 Wolverhampton Joint Strategic Needs Assessment: Policy and Process 2016 presented at JSNA Steering Group on 1 February 2016.

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JSNA Steering Group Membership

Representative	Name
Consultant of Public Health (Chair) (WCC)	Glenda Augustine
Advanced Health Improvement Specialist: Needs Assessment (WCC)	Bindweep Kaur
Public Health Intelligence (WCC)	Jason Gwinnett
Public Health Commissioning Manager (WCC)	Juliet Grainger
Public Health (WCC)	Neeraj Malhotra/Katie Spence
Head of service for Healthier Place Service (WCC)	Richard Welch
Housing (WCC)	Mila Simpson
Commissioning of Social Care (WCC)	Kathy Roper; Carole Bourne, Paul Smith
Transport (WCC)	Tony Patten
SEN Team (WCC)	Jill Wellings, Sandy Lisle
Business Intelligence (WCC)	Helena Kucharczyk
Skills and Employment (WCC)	Sue Lindup
Royal Wolverhampton NHS Trust	Cathy Higgins
Black Country Mental Health NHS Foundation Trust	Chris Masikane
Criminal Justice System/ Police	Inspector Derek Lambert
Wolverhampton CCG	Sharon Sidhu
Wolverhampton Voluntary Sector Council	Stephen Dodd
Wolverhampton Health-watch	Sam Hicks
Black Country Consortium	Manjit Galsinh

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Proposed Topics for the Joint Strategic Needs Assessment

Summary: Wolverhampton City: This section aims to highlight the city in terms of its demographics, population, economy, housing, transport and education. The aim will be to include adults with learning disabilities and in contact with mental health services in the sections below.

1.1. Local area: Wards, ONS classification, Urban/rural classification, social marketing category (MOSAIC, ACORN, People and Places)
1.2. Population: Total population, gender profile, age profile, Births, Migrant population, Disabled people, how the population has changed over the years and what is the projected change.
1.3. Ethnicity and Culture: Ethnicity, Religion, Languages, Country of Birth
1.4. Economy: Size of economy and rate of growth, Employment, Unemployment, working age people on out of work benefits, Occupations, socio-economic status, average income.
1.5. Poverty and Deprivation: Indices of deprivation, Child poverty, Fuel Poverty, Benefits, household income
1.6. Housing: household composition including single occupancy households, over 65s households, average household size, housing tenure, Green spaces, Outdoor recreation facilities
1.7. Transport: Public transport accessibility to GP services, MAIDeN Accessibility toolkit, access to car
1.8. Satisfaction of people with their neighbourhood?
1.9. What does this information tell us?

2. **How long do people live**: Summary messages, comparisons, trends, projections
   2.1. Life Expectancy
   2.2. Healthy Life Expectancy (at age 65)
   2.3. Health related quality of Life for people with long term conditions
   2.4. Health related quality of life for older people
   2.5. Social care related quality of life
   2.6. Self-reported well being
   2.7. What does this information tell us?
   2.8. Indicative Commissioning Needs

3. Causes of early death
   3.1. Infant Mortality

3.2. Excess mortality rate in adults with serious mental illness

3.3. Excess winter deaths

3.4. Under 75s Mortality rate from cancer

3.5. Under 75s Mortality rate from all cardiovascular diseases

3.6. Mortality rate from causes considered preventable (all causes)

3.7. Mortality rate from communicable diseases

3.8. Under 75 mortality rate from liver disease

3.9. Under 75 mortality rate from respiratory disease (COPD)

3.10. Deaths attributable to smoking

3.11. Estimated excess deaths among people with diabetes

3.12. Suicides (and injury of undetermined intent)

3.13. Include the following with each outcome above:

3.13.1. What does this information tell us?

3.13.2. Indicative Commissioning Needs

4. Start Well

4.1. Children and families living in poverty

4.2. Pregnancy and Post natal care

4.2.1. Legal Abortions

4.2.2. Smoking during pregnancy

4.2.3. Breastfeeding initiation and continuation rates

4.2.4. Percentage of low birth weight babies

4.2.5. Whooping Cough vaccination

4.2.6. User experience of maternity and post-natal care services

4.3. Family life and Parenting

4.3.1. Obesity in children

4.3.2. Physical activity in children

4.3.3. Oral health and tooth decay

4.3.4. School readiness

4.4. Vaccination coverage

4.5. Include the following with each outcome above:

4.5.1. What does this information tell us?

4.5.2. Indicative Commissioning Needs

5. Develop Well

5.1. Safeguarding children and young people

5.1.1. Looked after children

5.1.2. Children in need

5.1.3. Child protection

5.1.4. Domestic abuse and sexual violence

5.1.5. Emergency admissions to hospital

5.1.6. Hospital admissions as a result of self-harm (young people age 10-24 years)

5.1.7. Deaths in childhood

5.2. Supporting Young People

5.2.1. Alcohol and substance misuse young people (including hospital admissions)

5.2.2. Youth violence and vulnerability (age 10-24 years)

5.2.3. Young carers

5.2.4. 16-18 year olds not in education, employment and training (NEET)

5.2.5. Children with long term conditions

5.2.6. Children with mental health conditions

5.2.7. Disabled children

5.2.8. Children with Special educational Needs

5.2.9. Parental experience of services for disabled children, children with mental health conditions and special educational needs

5.2.10. Smoking in young people

5.2.11. Obesity in young people

5.3. Sexual Health

5.3.1. Chlamydia Detection rate

5.3.2. Teenage conceptions

5.4. Education

5.4.1. GCSE's achieved

5.4.2. Pupil absence

5.5. Include the following with each outcome above:

5.5.1. What does this information tell us?

5.5.2. Indicative Commissioning Needs

6. Live, Work and Stay Well – Adults

6.1. Crime

- 6.1.1. Anti-social behaviour
- 6.1.2. Domestic Abuse
- 6.1.3. Offending and re-offending
- 6.1.4. Violent crimes (including sexual offences)
- 6.1.5. Killed and seriously injured casualties on roads

6.2. Housing

- 6.2.1. Homelessness and rough sleeping
- 6.2.2. Vulnerable adults who live in stable and appropriate accommodation
- 6.2.3. Social isolation – Adult social care users and carers

6.3. Employment

- 6.3.1. Employment of vulnerable adults - Learning Disability
- 6.3.2. Employment of vulnerable adults – long term health conditions
- 6.3.3. Employment of vulnerable adults – mental health issues
- 6.3.4. Sickness absence

6.4. Lifestyle

- 6.4.1. Alcohol misuse (including hospital admissions attributed to alcohol)
- 6.4.2. Substance misuse
- 6.4.3. Smoking
- 6.4.4. Physical activity in adults
- 6.4.5. Utilisation of outdoor space for exercise/health reasons

6.5. Health Protection

- 6.5.1. Incidence of TB (all ages)
- 6.5.2. People presenting with HIV at late stage of infection
- 6.5.3. New diagnosis for sexually transmitted infections (exc Chlamydia aged under 25)

6.6. Service Utilisation

- 6.6.1. Use of NHS Dental services
- 6.6.2. A&E attendances and emergency admissions
- 6.6.3. Emergency readmissions within 30 days of discharge

6.6.4. Emergency admissions for acute conditions that should not normally require hospital admission

6.6.5. Use of GP services

6.6.6. Breast Cancer Screening

6.6.7. Cervical Cancer Screening

6.6.8. Uptake of NHS Health Checks

6.7. Patient voice

6.7.1. Satisfaction with local area

6.7.2. Satisfaction with local services

6.8. Include the following with each outcome above:

6.8.1. What does this information tell us?

6.8.2. Indicative Commissioning Needs

7. Age Well

7.1. Hospital Admissions

7.1.1. Emergency admissions in people aged over 65

7.1.2. Hip fractures in people over 65

7.1.3. Injuries due to falls in the over 65

7.1.4. Unplanned hospitalisation for chronic ambulatory care sensitive conditions

7.1.5. Delayed transfers of care from hospital

7.2. Co-ordination of care

7.2.1. Dementia care

7.2.2. Vaccination coverage for over 65

7.2.3. People feeling supported to manage their condition

7.2.4. People receiving direct payments

7.3. Management of Long term conditions

7.3.1. People with Diabetes

7.3.2. People with CVD

7.3.3. People with COPD

7.3.4. People with co-morbidities and multi-morbidities

7.3.5. Breast cancer survival

7.3.6. Prostate cancer survival

7.3.7. Bowel cancer survival

7.3.8. Lung cancer survival

7.3.9. Cancer: Early diagnosis and referral

7.4. End of life care

7.4.1. Effectiveness of reablement services

7.4.2. Permanent admissions to residential/ nursing care

7.4.3. Support at home

7.5. Support for Older people

7.5.1. Carers over 65

7.6. Include the following with each outcome above:

7.6.1. What does this information tell us?

7.6.2. Indicative Commissioning Needs

Joint Strategic Needs Assessment

Wolverhampton

Overview Report 2016

Chapter 1: How long do we live?

VERSION CONTROL

Version	Status	Description of version	Date Completed	Distributed to	Date of distribution
1.1	Draft	Chapter 1 and 2		Health and Wellbeing Board	27/04/2016

Summary of Outcomes

Section	Outcome	Latest data refresh year	Last data refresh year	Wolverhampton figure latest data	Better or worse compared to last data refresh	Better or worse compared to England (latest data)
How long do we live?	Life Expectancy (males)	2012/14	2011/13	77.6 years		
How long do we live?	Life Expectancy (Females)	2012/14	2011/13	81.8 years		
How long do we live?	Healthy Life Expectancy (males)	2012/14	2011/13	56.9 years		
How long do we live?	Healthy Life Expectancy (females)	2012/14	2011/13	58.3 years		
How long do we live?	Health related Quality of Life for people with long term conditions	2014/15	2013/14	0.719		
How long do we live?	Health related Quality of Life for people with mental health	2014/15	2013/14	0.49		
How long do we live?	Health related Quality of Life for older people	2012/13	2011/12	0.69		
How long do we live?	Social Care related Quality of Life	2012/14	2011/13	19.4		

Life Expectancy (LE)

Life Expectancy at birth has been defined[1] as

"...the average number of years a person would expect to live based on contemporary mortality rate"

For a particular area and time period, it is an estimate of the average number of years a newborn baby would survive if he or she experienced the age-specific mortality rates for that area and time period throughout his or her life.

Life Expectancy in Wolverhampton

-Life Expectancy at birth in males in 2012-14 in Wolverhampton is 77.6 years which is a slight improvement from 77.5 years in 2011-13; however the trend since 1991-93 is improving and the forecast shows further improvement. (Fig1)
-Life expectancy at birth in females in 2012-14 in Wolverhampton is 81.8 years which is a slight decreased from 82 years in 2011-13; however the trend since 1991-93 is improving and the forecast shows further improvement. (Fig1)

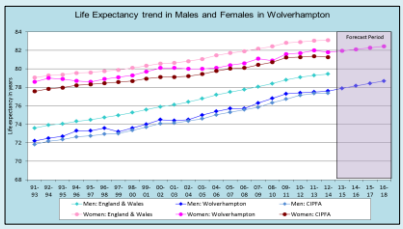


Fig1: Life Expectancy trend in Wolverhampton (Source: PHOF)

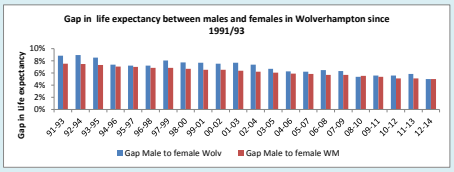


Fig 2: Life Expectancy gap by gender in Wolverhampton (Source: PHMD)

-Life expectancy at birth in females has been consistently higher compared to males in Wolverhampton and England&Wales
-However the gap in life expectancy between females and males has reduced since 1991-93 from 9% (6.4 years) to 5% (4.2 years) in Wolverhampton. (Fig2)

Life Expectancy in Wolverhampton compared to CIPFA nearest neighbours

-Life Expectancy at birth in males (2012-14) in Wolverhampton is better compared to 9 of 15 CIPFA nearest neighbours but significantly lower compared to West Midlands and England. (Fig3)
-Life Expectancy at birth in females (2012-14) in Wolverhampton is better compared to 12 of 15 CIPFA nearest neighbours but significantly lower compared to West Midlands and England. (fig4)

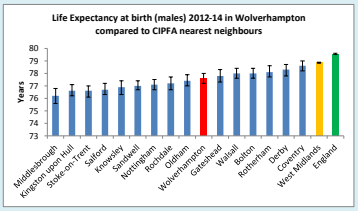


Fig 3: Life expectancy (males) in Wolverhampton compared to CIPFA (Source: PHOF)

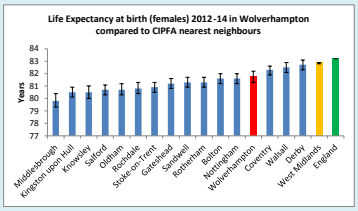


Fig 4: Life expectancy (females) in Wolverhampton compared to CIPFA (Source: PHOF)

Life Expectancy in Wolverhampton by wards

-Life Expectancy at birth in females in Wolverhampton in 2010-14 was worst in Bushbury South and Low hill (78.4 years), Health town (78.8 years) and Park (79.1 years). (Fig5)
Life expectancy at birth in females in Wolverhampton in 2010-14 is higher than the Wolverhampton average of 81.83 years in 9 wards and lower than Wolverhampton average in 11 wards.
-Life Expectancy at birth in males in Wolverhampton in 2010-14 was worst in Bushbury South and Low hill (72.8 years), Ettingshall (73.7 years) and Graisley (74.7 years). (Fig6)
Life expectancy at birth in males in Wolverhampton in 2010-14 is higher than the Wolverhampton average of 77.5 years in 10 wards and lower than Wolverhampton average in 10 wards.

Fig5: LE (female) in Wolverhampton by wards (Source: PHMD)

Fig6: LE (male) in Wolverhampton by wards (Source: PHMD)

-Ten wards in Wolverhampton have showed strong improvement in male life expectancy since 2001 and six of these wards demonstrate above national average life expectancy in 2010-14 which include Tettenhall Wightwick, Penn, Merry Hill, Oxley, Spring Vale and Wednesfield South.
However there are nine wards in Wolverhampton which have shown poor improvement since 2001 and demonstrate male life expectancy at birth below national average in 2010-14 (Fig7)

-Seven wards in Wolverhampton have showed strong improvement in female life expectancy since 2001 and three of these wards have demonstrated above national average life expectancy in 2010-14 which include Tettenhall Wightwick, Merry Hill and Spring Vale.
However there are ten wards in Wolverhampton which have shown poor improvement since 2001 and demonstrate female life expectancy at below below national average in 2010-14. (Fig8)

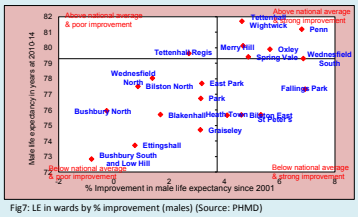


Fig7: LE in wards by % improvement (males) (Source: PHMD)

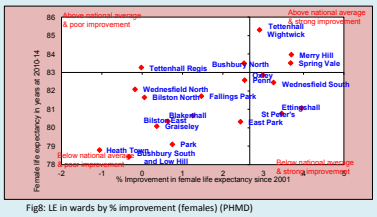


Fig8: LE in wards by % improvement (females) (PHMD)

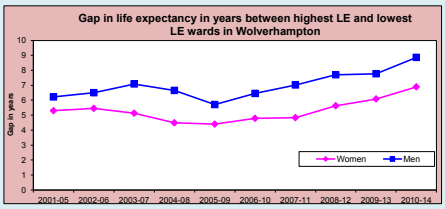
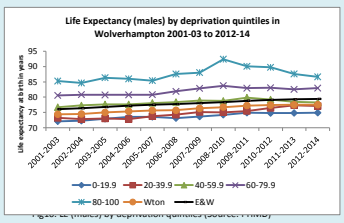
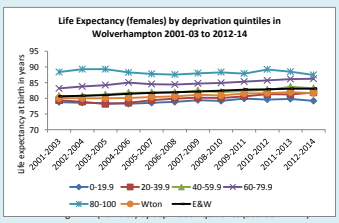


Fig9: Gap in LE amongst highest LE and lowest LE wards (Source: PHMD)

-Gap in life expectancy between the wards with highest and lowest life expectancy in Wolverhampton has increased for females from 5.3 years in 2001-05 to 6.9 years in 2010-14 as well as for males from 6.2 years in 2001-05 to 8.9 in 2010-14. (Fig9)

-Life expectancy in males and females is lower in most deprived areas of Wolverhampton. There has been a rise in LE in the most deprived quintile (0-19.9) by 2.8 years in males and 0.4 years in females and second deprived quintile (20-39.9) by 3.9 years in males and 2.5 years in females since 2001-03. (Fig10,11)





What does this information tell me?
-This indicator gives a context to healthy life expectancy figures by providing information on the estimated length of life. The two indicators are extremely important summary measures of mortality and morbidity. They complement the supporting indicators by showing the overall trends in major population health measures, setting the context in which local authorities can assess the other indicators and identify the drivers of life expectancy and healthy life expectancy[1].

-Wolverhampton's life expectancy is improving and the gap between life expectancy in males and females is improving as well. However, there are a number of wards within Wolverhampton where life expectancy is still below national average and there has not been much improvement since 2001. Also, the gap between highest LE ward and lowest LE ward is increasing for both males and females.

Indicative Commissioning Needs
- Life expectancy is an overarching measure of health and wellbing within the City and all commissioning activity should be aligned to identifying services with an ultimate aim of improving this measure.

References
1. Public Health Outcomes Framework Accessed at http://www.phoutcomes.info/
2. Public Health Mortality Database

Healthy Life Expectancy

The Public Health Outcomes Framework for England 2013-16 sets out two overarching aims, one of which is

Increased healthy life expectancy i.e. considering how healthily or how well we live in addition to how long we live' [1]

Healthy life expectancy at birth is the number of years that a newborn baby would live in a 'healthy' state if they experienced the death rates and levels of general health of the local population at the time of their birth, throughout their life.

In 2012-14, Wolverhampton had the worst Healthy life expectancy at birth for males in the West Midlands and is 3rd last for healthy life expectancy in females in West Midlands. (Table1)

Year	Male (Wolv)	Female (Wolv)	Male (WM)	Female (WM)	Male (England)	Female (England)
2009 - 11	59.30	58.00	62.50	62.80	63.22	64.15
2010 - 12	58.32	58.15	62.34	62.74	63.36	64.10
2011 - 13	56.57	58.84	62.41	62.84	63.27	63.95
2012 - 14	56.90	58.30	62.40	62.50	63.40	64.00

Table1: Healthy Life Expectancy in Wolverhampton, West Midlands and England (Source: PHOF, ONS)

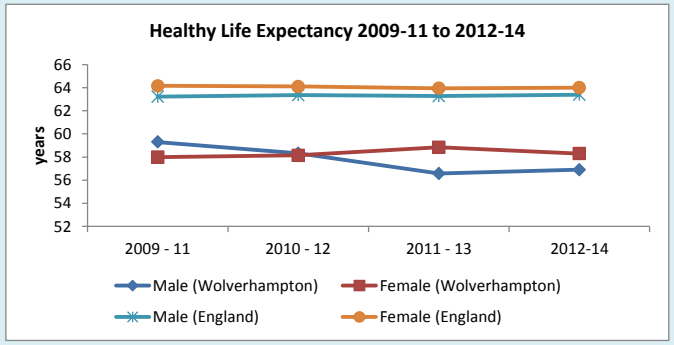


Fig1: Healthy Life expectancy 2009-11 to 2012-14 for males and females (Source: PHOF)

Since 2009-11, healthy life expectancy for males in Wolverhampton has decreased by 3 years from 59.3 years to 56.9 years in 2012-14; however it has slightly increased for females from 58 years in 2009-11 to 58.3 years in 2012-14 (Fig 1). Female healthy life expectancy has however has decreased slightly compared to 2011-13 by 0.6 years.

Comparing the healthy life expectancy with life expectancy in 2012-14, males in Wolverhampton lived 21 years of life in an unhealthy' state compared to 17 years in West Midlands and 16 years in England.
Similarly, in 2012-14, females in Wolverhampton lived 23.5 years in an 'unhealthy state' compared to 20.4 years in West Midlands and 19.2 years in England. (Fig2,3)

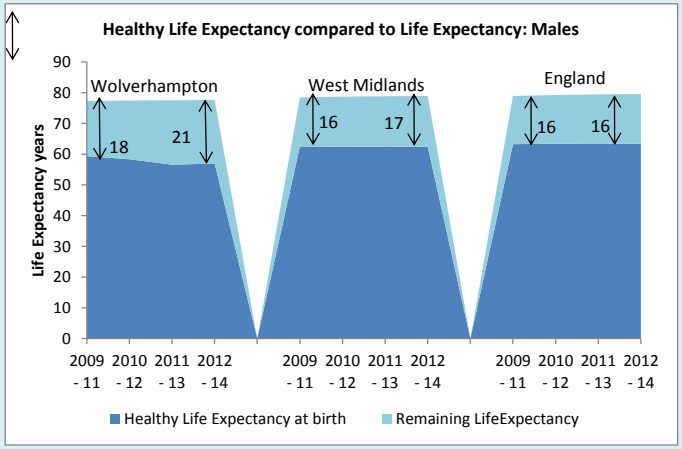


Fig2: Healthy Life expectancy compared to Life expectancy: Males 2009-11/ 2012-14

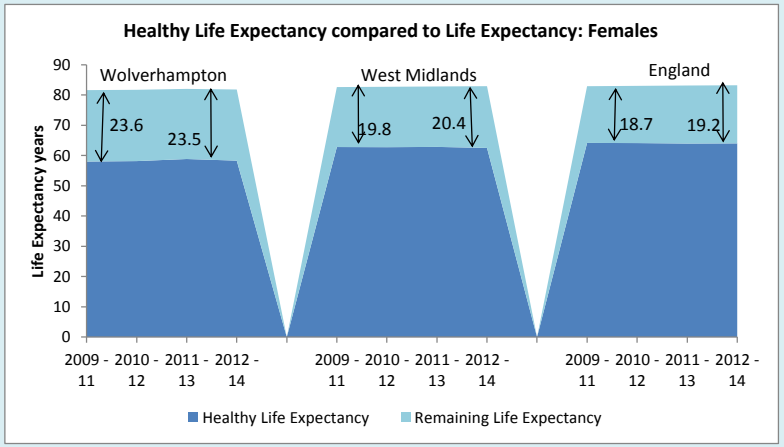


Fig3: Healthy Life expectancy compared to Life expectancy: Females 2009-12/ 2011-14

(Source: PHOF, ONS)

(Source: PHOF, ONS)

Comparing healthy life expectancy in Wolverhampton to CIPFA nearest neighbours

-Healthy life expectancy at birth for males in 2012/14 in Wolverhampton is the worst amongst CIPFA nearest neighbours and is significantly lower compared to West Midlands and England (Fig4)

-Healthy life expectancy at birth for females in 2012/14 in Wolverhampton is worse compared to most of the CIPFA nearest neighbours and is significantly lower commpared to West Midlands and England (Fig5)

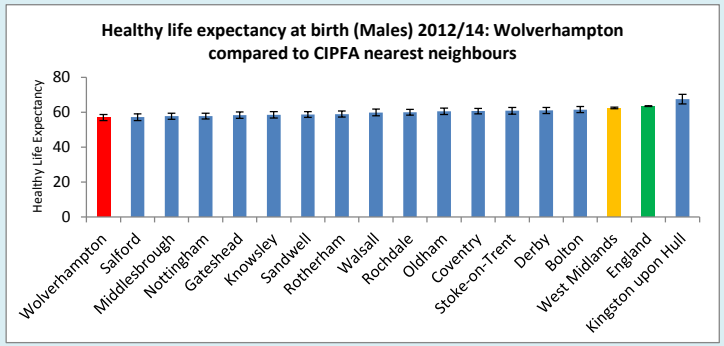


Fig4: Healthy life expectancy (male) in Wolverhampton compared to CIPFA nearest neighbours (Source: ONS)

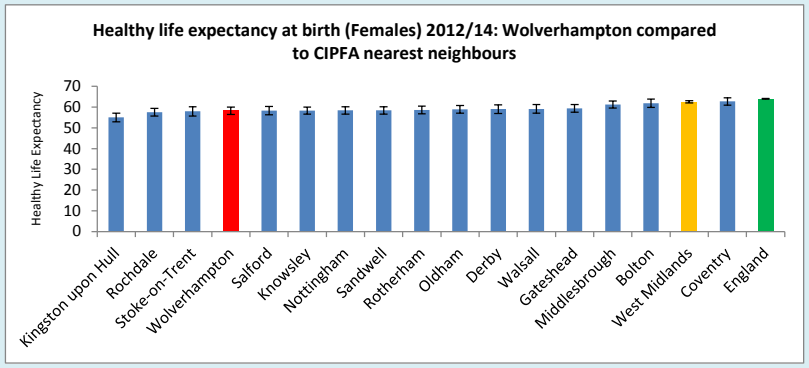


Fig5: Healthy life expectancy (female) in Wolverhampton compared to CIPFA nearest neighbours (Source: ONS)

What does this information tell me?

-Wolverhampton is performing poorly on healthy life expectancy at birth for both males and females. The trend for healthy life expectancy is not improving and the gap between healthy life expectancy and life expectancy is increasing for males and very slightly decreasing for females.

-Over a quarter of males (26.6%) and females (28.7%) life expectancy is charactersied by increasing disability

Indicative Commissioning Needs

- Healthy Life expectancy is key summary measure of population health and all commissioning activity should be aligned to identifying services with an ultimate aim of improving this measure.

References

1. Public Health Outcomes Framework Accessed at http://www.phoutcomes.info/
2. Spend and Outcomes Tool accessed at https://www.gov.uk/guidance/phe-data-and-analysis-tools
3. Office of national statistics accessed at www.ons.gov.uk

Self Reported 'Wellbeing'

Promoting 'Wellbeing' of our population is a major public health and social care agenda in the UK. People with higher wellbeing are more likely to have lower rates of illness and enjoy better physical and mental health.

"Wellbeing" is a broad concept, and it is described as relating to the following areas in particular[1] :

• personal dignity (including treatment of the individual with respect); • physical and mental health and emotional wellbeing; • protection from abuse and neglect;
• control by the individual over day-to-day life (including over care and support provided and the way it is provided); • participation in work, education, training or recreation;
• social and economic wellbeing; • domestic, family and personal; • suitability of living accommodation; • the individual's contribution to society.

How does the Wolverhampton population perceive their Wellbeing?
The Annual Population Survey conducted by the ONS incorporates questions on four dimensions of wellbeing i.e. life satisfaction, worthwhile, happiness and high anxiety within their survey. The response to each question is measured on a scale of 1-10 which is then analysed to provide a health score.

-Since 2011/12, 5%-9% more people in Wolverhampton have reported their wellbeing as very high across the four dimensions of wellbeing in 2014/15. During the same period, the percentage of people with low life satisfaction score and low happiness score in Wolverhampton have decreased whereas percentage of people with low worthwhile and high anxiety scores has increased.
-Similar patterns have been seen England and West Midlands for life satisfaction and happiness, however in contrast to Wolverhampton, high anxiety scores and low worthwhile score have decreased in England and West Midlands.

Time Trend: (Fig 1,2,3,4)
1. Low Satisfaction Score: Percentage of people reporting low self satisfaction in Wolverhampton has reduced from 11.7% in 2011/12 to 8.7% in 2014/15. Similar trend can be seen for West Midlands and England. Also, the gap between England and Wolverhampton has improved from 5.05% in 2011/12 to 3.95% in 2014/15.
2. Low Worthwhile Score: Percentage of people reporting low worthwhile in Wolverhampton has increased from 6.3% in 2011/12 to 6.7% in 2014/15. This is in contrast to the trend in West Midlands and England where the trend is reducing. The gap between Wolverhampton and England has also increased from 1.41% in 2011/12 to 2.88% in 2014/15.
3. Low Happiness score: Percentage of people reporting low happiness in Wolverhampton reduced from 12.5% in 2011/12 to 11.2% in 2014/15. It is important to note that these figures had reduced to 7.67% in 2013/14 and were better than England's average; however they have increased again in the last year. The trend in England and West Midlands has consistently reduced over the last 4 years.
The gap between Wolverhampton and England has also increased from 1.73% in 2011/12 to 2.2% in 204/15.
4. High Anxiety Score: Percentage of people reporting high anxiety in Wolverhampton has increased from 13.62% in 2011/12 to 17.33% in 2014/15. There has been a massive increase of 8% since 2013/14. Wolverhampton has previously been consistently better compared to England and West Midlands, but now has similar findings.

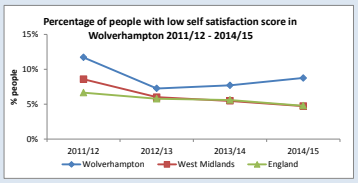


Fig1: %people with low self satisfaction score: Time trend (Source: PHOF)

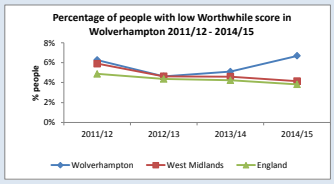


Fig2: %people with low worthwhile score: Time trend (Source: PHOF)

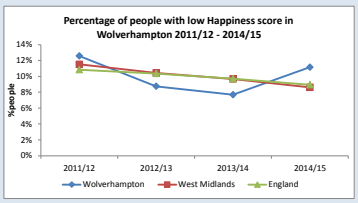


Fig3: %people with low happiness score: Time trend (Source: PHOF)

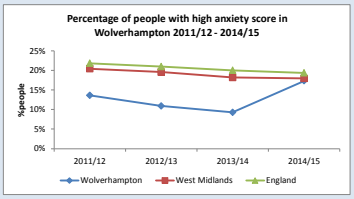


Fig4: %people with high anxiety score: Time trend (Source: PHOF)

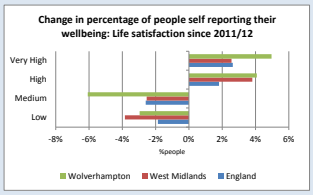


Fig5: Change in %people self reporting wellbeing: Life Satisfaction (Source: ONS)

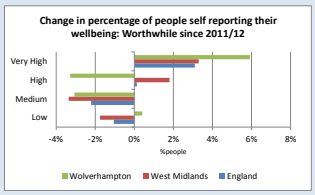


Fig6: Change in %people self reporting wellbeing: Worthwhile (Source: ONS)

Change in Percentage of people reporting low wellbeing (Fig5,6,7,8)
1. Life Satisfaction: In Wolverhampton more people have rated life satisfaction as 'very high' (5% more) and 'high' (4% more) in 2014/15 compared to 2011/12. Similar trends have been seen in England and West Midlands.
The average mean rating in Wolverhampton has improved from 6.67 in 2011/12 to 7.07 in 2014/15
2. Worthwhile: In Wolverhampton, nearly 6% more people have rated Worthwhile as very high since 2011/12; however 3.3% less people reported a 'high' rating in 2014/15. This is in contrast with England and West Midlands where more people have rated worthwhile as 'very high' or 'high'. In Wolverhampton, 0.5% more people reported a 'low' worthwhile rating since 2011/12 which is in contrast to England and West Midlands where fewer people have rated worthwhile as 'low'.
The average mean rating in Wolverhampton has improved from 7.2 in 2011/12 to 7.4 in 2014/15.
3. Happiness: In Wolverhampton, 8.7% more people have rated Happiness as 'very high' since 2011/12; however 0.5% less people reported a 'high' rating in 2014/15. This is in contrast with England and West Midlands where more people have rated happiness as 'very high' or 'high'. Wolverhampton follows a similar trend as England and West Midlands with fewer people rating happiness as 'medium' and 'low'.
The average mean rating in Wolverhampton has improved from by 0.4% since 2011/12.
4. Anxiety: In Wolverhampton more people have reported anxiety as very high' (3.7% more) and 'high' (1.1% more) in 2014/15 compared to 2011/12. This is in contrast with England and West Midlands where fewer people have reported 'very high' and 'high' anxiety.
In Wolverhampton, 4% more people have reported anxiety as 'low', which is similar to the trend observed in England and West Midlands.
The average mean rating in Wolverhampton has improved by 0.05% in 2014/15 since 2011/14, which is in contrast to the England's and West Midland's average mean rating which has reduced in the same time period.

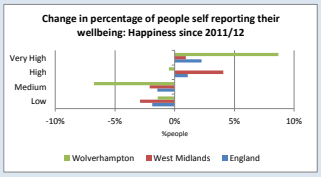


Fig7: Change in %people self reporting wellbeing: Happiness (Source: ONS)

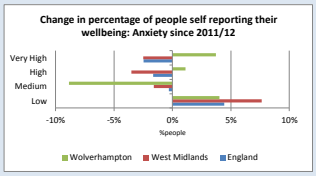


Fig8: Change in %people self reporting wellbeing: Anxiety (Source: ONS)

Comparing Wolverhampton to CIPFA nearest neighbours
(Fig9,10,11,12)
1. Low Satisfaction Score 2014/15: Wolverhamton scores the worst compared to CIPFA nearest neighbours and is significantly worse compared to England and West Midlands
2. Low Worthwhile Score 2014/15: Wolverhampton scores worse compared to most of the CIPFA statistical neighbours and is significantly worse compared to England and West Midlands
3. Very High Anxiety Score 2014/15: Wolverhampton scores better compared to the CIPFA nearest neighbours except Coventry. Also, Wolverhampton scores better compared to England and West Midlands, however this is not statistically significant.
4. Low Happiness Score 2014/15: Wolverhampton scores better compared to 10 out of 15 CIPFA nearest neighbours and is worse compared to England and West Midlands; however this is not sgnificant.

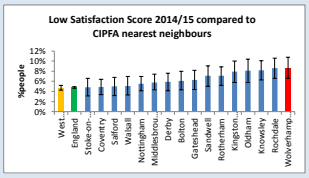


Fig9: Low Satisfaction score compared to CIPFA nearest neighbours (Source: PHOF)

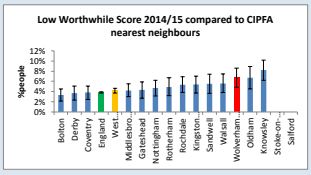


Fig10: Low worthwhile score compared to CIPFA nearest neighbours (Source: PHOF)

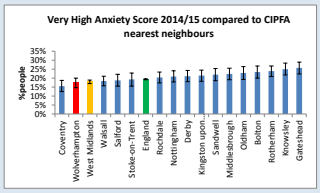


Fig11: Very high anxiety score compared to CIPFA nearest neighbours) (Source: PHOF)

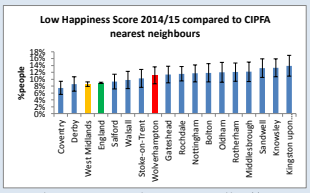


Fig12: Low happiness score compared to CIPFA nearest neighbours) (Source: PHOF)

What does this information tell me?
-Self reported well being is an important aspect of identifying the population's wellbeing which is related to educational attainment, health, population safety, employment and economic productivity[2].
-In 2014/15, more people in Wolverhampton rated their wellbeing as 'high' or 'very high' compared to 'low' or 'medium' for life satisfaction (67%), worthwhile (72%) and happiness (66%)
Almost 70% of people in Wolverhampton reported 'low' or meduim levels of anxiety, indicating an overall high level of wellbeing
-Between 65-72% of people in Wolverhampton are satisfied with their life, feel they have done things in life that are worthwhile and are happy, which is lower than England (between 75% and 83%) and the West Midlands (between 73% and 82%) . However more people feel less anxious in Wolverhampton (69%) compared to England (64%) and West Midlands (67%) in 2014/15.

It should be noted that all these indicators are just an estimate, based on a sample of the population, therefore is not a true representation of all people living in Wolverhampton, but provide a 'snap-shot' of individual well-being.

Indicative Commissioning Needs
The relationship between personal wellbeing and local circumstances is complex and can influence health and social care outcomes. Commissioned services should consider how the overall wellbeing of the population can be improved through the services provided.

References

1. Department of Health (2014), Care and Support Statutory Guidance, Department of Health: London
2. Department of Health (2010), Confident Communities, Brighter Futures. A framework for developing wellbeing, Department of Health: London
3. Office of National Statistics Accessed at http://www.ons.gov.uk/
4. Public Health Outcomes Framework Accessed at http://www.phoutcomes.info/

Health related Quality of Life (HRQoL)

WHO defines Quality of Life[1] as

> *...individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, level of independence, social relationships, personal beliefs and their relationship to salient features of their environment.'*

There is a broad agreement among the medical fraternity that HRQoL is the funcitonal effect of a medical/surgical condition and/or its consequent therapy on a patient[2].
In the UK, the Public Health Outcomes Framework and NHS Outcomes Framework incorporate measures of HRQoL to achieve the overarching aims of improving (healthy) life expectancy and enhancing the quality of life.

What does the Wolverhampton's population think about their HRQoL?

1. HRQoL for adults with Long term conditions (LTCs)

The annual GP Patient survey collects data on HRQoL utilising the five quality of life (QoL) dimensions of EQ-5D i.e. mobility, self care, usual activities, pain/discomfort and anxiety/depression. Each dimension is scored on 5 levels and the data is then analysed to develop a health score, where 0 is the worst imaginable health state and 1 is the best imaginable health state.
It should be noted that, as this is GP survey data, the findings relate to people registered with a GP in Wolverhampton

-The HRQoL for people with LTCs in Wolverhampton has slightly increased by 0.7% since 2011/12 from 0.712 to 0.719 in 2014/15. This is in line with the increase in HRQoL for people with LTCs in West Midlands. (Fig1)
-In 2014/15, the HRQoL for people with LTCs Wolverhampton (0.72) was lower than the HRQoL in England and West Midlands which have remained fairly constant at 0.743 and 0.73 respectively. (Fig1,2)
-Comparing the HRQoL for people with LTCs and HRQoL for all respondents, HRQoL for all respondents is higher; however the gap between the two has decreased in Wolverhampton by 0.6% (from 0.87 to 0.81) since 2011/12. This follows a similar pattern across England and West Midlands where the gap has reduced by 0.8%. (Fig2)

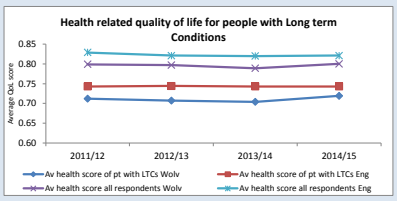


Fig1: HRQoL for people with LTCs 2011/12 - 2014/15 (Source: HSCIS)

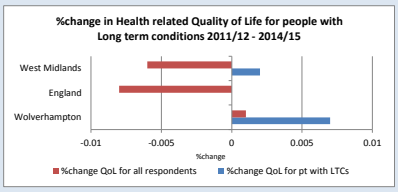


Fig2: %change in HRQoL for people with LTCs 2011/12 - 2014/15 (Source: HSCIS)

Comparing Wolverhampton to CIPFA nearest neighbours
In 2014/15, HRQoL for people with Long term conditions is higher in Wolverhampton compared to the CIPFA nearest neighbours. (Fig3)

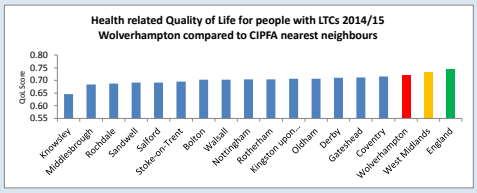


Fig3: HRQoL for people with LTCs in Wolverhampton compared to CIPFA nearest neighbours

2. HRQoL for adults with Mental Health Conditions (MHCs)

The data is collected via the annual GP Patient survey for the Clinical Commissioning Group (CCG) Outcome Indicators Framework and therefore the findings relate to people registered with a GP in Wolverhampton.

-The HRQoL for people with MHCs in Wolverhampton has slightly increased by 0.8% since 2013/14 from 0.48 to 0.49 in 2014/15. This is line with slight increase in HRQoL for people with MHCs in England.
-In 2014/15, the HRQoL for people with MHCs in Wolverhampton (0.49) is lower compared to HRQoL for people with MHCs in England (0.53).
-Comparing the HRQoL for people with MHCs and HRQoL for all respondents, HRQoL for all respondents is higher; however the gap between the two has increased in Wolverhampton by 0.3% since 2013/14.
This is in contrast to the national pattern where the gap has decreased by 0.1%.

3. HRQoL for older people

The data is collected via the annual GP Patient Survey for the Public Health Outcomes Framework, therefore the findings relate to people registered with a GP in Wolverhampton.

-The HRQoL for older people in Wolverhampton has increased by 1.1% since 2011/12 from 0.678 to 0.69 in 2012/13. This is in line with slight increase in HRQoL for older people in West Midlands. (Fig5)
-In 2012/13, the HRQoL for older people in Wolverhampton (0.69) is significantly lower than HRQoL in West Midlands (0.709) and England (0.726). (Fig4)
-Similar picture can be seen across the Black Country region, with all areas being significantly lower compared to West Midlands. (Fig5)

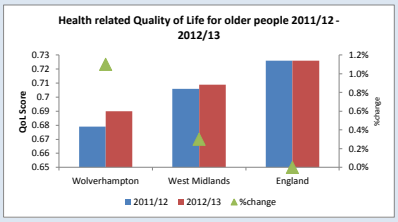


Fig4: HRQoL for older people (Source: PHOF)

Fig5: HRQoL for older people across West Midlands (Source: PHOF)

Comparing Wolverhampton to CIPFA nearest neighbours
In 2014/15, HRQoL for older people in Wolverhampton is higher compared to 10 out of 15 CIPFA nearest neighbours. However it is significantly lower compared to West Midlands and England. (Fig6)

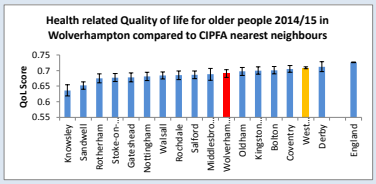


Fig6: HRQoL for older people - comparison with CIPFA nearest neighbours (Source: PHOF)

What does this information tell me?
Although the HRQoL for adults with LTCs and MHCs and older people in Wolverhampton is slightly improving, it is still significantly lower compared to the West Midlands and England.
These indicators provide a greater focus on preventing ill health, preserving independence and promoting well-being in these vulnerable groups of adults and older people.
It should be noted that the data collected from GP Patient survey focusses on the current state of health on the particular day the survey is completed and does not look into the positive or negative impacts of the chronic nature of the illness and/or long term input

Indicative Commissioning Needs
-HRQoL is a multi-dimensional concept that goes beyond direct measures of population health, such as life expectancy and mortality, and focuses on the impact of health status on the quality of life.
-Commissioned services should aim to assess how the service provided has improved the quality of the life of the service user.

References

1. World Health Organisation (1997), WHOQOL Measuring Quality of Life. World Health Organisation
2. Cella D (1995). Measuring quality of life in palliative care. *Seminars in Oncology* 22:73-81.
3. Health and Social Care Information Centre Accessed at http://www.hscic.gov.uk/
4. Public Health Outcomes Framework Accessed at http://www.phoutcomes.info/

Social Care Related Quality of Life (SCR QoL)

Social care related quality of life measure gives an overarching view of the quality of life of users of social care[1].

What does Wolverhampton's population think of their SCR QoL?

The Adult Social Care Survey collects data on eight domains of social care related quality of life i.e. control, dignity, personal care, food and nutrition, safety, occupation, social participation and accomodation[2]. This measure is an average score based on responses to the relevant questions on the survey.

-In Wolverhampton, SCR QoL has fallen slightly since 2011/12 from 19.5 to 19.4 in 2014/15 and is higher compared to SCR QoL in England and West Midlands. (Fig1)
-In Wolverhampton, SCR QoL has been better for females compared to males since 2011/12; however the gender gap slightly increased from 0.1 in 2011/12 to 0.2 in 2014/15. This is in contrast to England and West Midlands where males have better SCR QoL compared to females; however the gap between the two is increasing. (Fig2)

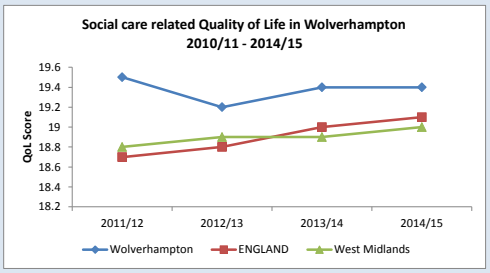


Fig1: SCR QoL in Wolverhampton 2010/11 - 2014/15 (Source: HSCIC)

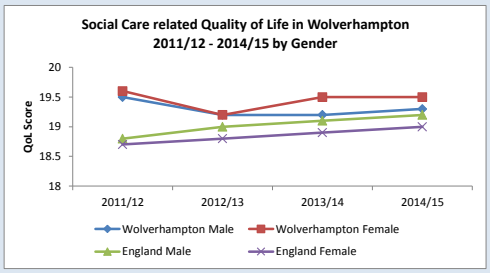


Fig2: SCR QoL in Wolverhampton by gender (Source: HSCIC)

-SCR QoL for adults aged 18-64 years in Wolverhampton has decreased since 2011/12. However there was a major fall in 2012/13 and it has consistently improved since then. This is slightly different from England and West Midlands where the SCR QoL has improved since 2011/12. (Fig3)
-SCR QoL for people aged over 65 has been consistent since 2011/12; however it shows a slight fall in the last year of 2014/15 from 19.1 to 19.0. The figures for England has shown a consistent improvement however, the figures for West Midlands show a consistent fall for people in this age group. (Fig4)
-It is to be noted that the SCR QoL for both 18-64 year olds as well as those aged 65 and over has been consistently higher in Wolverhampton compared to England and West Midlands. (Fig4)

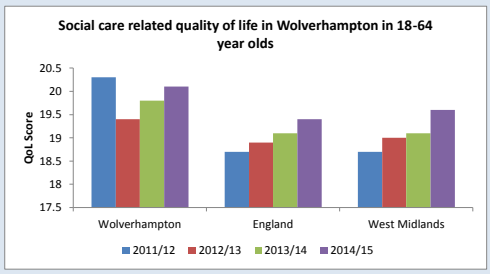


Fig3: SCR QoL in Wolverhampton for 18-64 year olds (Source: HSCIC)

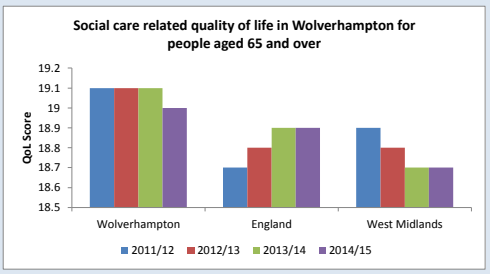


Fig4: SCR QoL in Wolverhampton for people aged 65 and over (Source: HSCIC)

What does this information tell me?

-SQR QoL refers to those aspects of people's quality of life that are relevant to, and are the focus of, social care interventions and the scoring indicates the level of unmet need reported by the respondents.
-SCR QoL in Wolverhampton is above the England and West Midlands average, indicating that there is less unmet social care needs within the local population.
-However the gap between male and female SCR QoL is increasing and there is a fall in SCR QoL overall since 2011/12.
-This indicates that there appears to be more unmet social care needs for men compared to women and since 2011/12, there has been an overall increase in the level of unmet needs within the local population

Indicative Commissioning Needs

'-Commissioned services should aim to assess how the service provided has improved the quality of the life of the service user.

There is a lack of data for Social care related quality of life for children as the adult social care survey does not collect children's data.

References

1. Adult Social Care Outcomes Framework
2. Personal Social Services Research Unit (PSSRU); Adult Social Care Outcomes Toolkit; accessed at http://www.pssru.ac.uk/ascot/
3. Health and Social Care Information Centre Accessed at http://www.hscic.gov.uk/

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Agenda Item No: 11

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

27 April 2016

Report title	Infant Mortality Scrutiny Review Update	
Cabinet member with lead responsibility	Councillor Sandra Samuels Public Health and Wellbeing	
Wards affected	All	
Accountable director	Linda Sanders, People	
Originating service	Public Health	
Accountable employee(s)	Ros Jervis	Service Director Public Health and Wellbeing
	Tel	01902 551372
	Email	Ros.jervis@wolverhampton.gov.uk
Report to be/has been considered by	Public Health Senior Management Team Meeting	4 February 2016
	People Leadership Team	8 February 2016
	Scrutiny Board	1 March 2016

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1. Consider progress made to implement the recommendations from the Infant Mortality Scrutiny Review that concluded in March 2015.

1.0 Purpose

1.1 The purpose of this report is to update the Board on the implementation of the recommendations of the Infant Mortality Scrutiny Review that was undertaken from July 2014 to March 2015 to gather evidence in relation to the high rate of infant mortality in Wolverhampton.

2.0 Background

2.1 The National Child Health Profiles published in March 2014 indicated that Wolverhampton had the highest rate of infant mortality in England. The average rate of infant mortality between 2010 and 2012 was 7.7 deaths per 1,000 live births compared to the England average of 4.3 deaths per 1,000 live births.

2.2 This high rate of infant mortality raised concerns across health and social care organisations and resulted in the convening of a multi-agency infant mortality working group in May 2014.

2.3 A Health Scrutiny Review commenced in July 2014 to assess the effectiveness of current and future work aimed at addressing modifiable factors that are the main causes of infant mortality in Wolverhampton. The review group met on seven occasions to consider written and verbal evidence from local and regional organisational and professional representatives.

2.4 The detailed consideration of the evidence presented to the Review group resulted in the development of twelve recommendations outlined in the executive report found in appendix one.

2.5 All review recommendations were approved by Cabinet on 22 July 2015 and the Health and Wellbeing Board on 7 October 2015.

3.0 Infant Mortality Scrutiny Review Update February 2016

3.1 There has been good progress on the implementation of the recommendations arising from the Infant Mortality Scrutiny Review. Overall there has been strong multi-agency commitment to delivering the recommendations and collective partnership working to improve outcomes, underpinned by the infant mortality working group.

3.2 The twelve recommendations produced following the infant mortality review are divided into three specific areas:

- The importance of co-ordinating local efforts to tackle the underlying causes of infant mortality in Wolverhampton
- A strategic and co-ordinated response to tackle the modifiable causes of infant mortality in Wolverhampton and also respond to the challenges of dealing with the effects of poverty and deprivation

- Changing practices and policies and apply learning based on reliable evidence as to their impact and effectiveness in reducing the rate of infant mortality.

3.3 The concise detail of progress against the recommendations is documented in appendix one. In summary:

3.3.1 *Co-ordinating local efforts*

- Additional carbon monoxide monitors were purchased in December 2015 to support screening in pregnancy at every antenatal visit and at key contacts in early infancy
- 1983 pregnant women were screened between April 2015 and January 2016
- 405 referrals were received by the Healthy Lifestyle Service; this represents 20% of the women screened
- There was a 20% (81) uptake of referrals from the antenatal clinic
- There has been a steady reduction in the proportion of women smoking at the time of delivery over the first two quarters of 2015/16 (16.9 and 16.6 respectively). Previous annual percentage 18.8 (2014/15).
- A postnatal parent education programme, 'Reducing the Risk' commenced in January, funded by Public Health and delivered by the neonatal unit. This programme is for parents with premature infants and other vulnerable mothers in Wolverhampton referred from midwifery services. The aim is to teach parents basic life support skills, promote breast feeding and safe sleeping alongside dietary advice and smoking cessation.

3.3.2 *Dealing with the effects of poverty and deprivation*

A stakeholder event is planned for 14/15 March 2016 to promote safe sleeping practices, supported by the Lullaby Trust. Local risk factors for modifiable causes of infant mortality will be shared at the event alongside progress on delivery of the recommendations of the infant mortality action plan.

3.3.3 *Changing practices and policies*

- Careful consideration is being given to the implementation of a smoke-free site at Royal Wolverhampton NHS Trust hospitals to take into account how a policy can be enforced without compromising staff safety. Further work is required and will be informed by an audit of practice against smoking cessation guidance produced the National Institute of Health and Care Excellence (NICE).
- A specific programme to deliver Making Every Contact Count (MECC) training was developed by the Healthy Lifestyles Service and training disseminated widely within the acute trust setting for individuals working with pregnant women and new mothers.

4.0 Scrutiny Board Recommendation

4.1 The Infant Mortality Scrutiny Review Update for February 2016 was presented to the Scrutiny Board on 1 March 2016. The Board requested that the review was closed subject to receiving an annual update on the implementation of the recommendations.

5.0 Financial implications

5.1 There are no explicit funding implications arising from implementation of the recommendations of the Infant Mortality Scrutiny Review. All costs associated with the Infant Mortality are met from existing budgets within Public Health. [GS/05022016/M].

6.0 Legal implications

6.1 There are no anticipated legal implications associated with the content of this report. RB/0302015/J

7.0 Equalities implications

7.1 An initial equalities analysis screening has not identified any equality issues at this stage. There are no concerns that implementation of the recommendations arising from the Infant Mortality Review could adversely affect people differently or not meet the needs of certain groups. Inequalities were highlighted during the review process and the recommendations were developed to ensure that these inequalities were addressed.

8.0 Environmental implications

8.1 There are no environmental implications related to this report.

9.0 Human resources implications

8.1 There are no anticipated human resource implications related to this report.

10.0 Corporate landlord implications

10.1 This report does not have any implications for the Council's property portfolio.

11.0 Schedule of background papers

11.1 Scrutiny Review of Infant Morality – Final Report, 21 May 2015.

This report was presented to:

- Cabinet on 22 July 2015
- Health and Wellbeing Board 7 October 2015

Appendix 1
Section one: Executive response - Scrutiny Review of Infant Mortality

The importance of co-ordinating local efforts to tackle the underlying causes of infant mortality in Wolverhampton

Recommendation 1

1. The Service Director- Public Health and Wellbeing to be responsible for collating a coordinated response from the officers responsible for to the following recommendations listed below. The Service Director to advise Scrutiny by presenting a report to Scrutiny Board with details of progress in implementing all the accepted recommendations and necessary follow up action, as appropriate, where accepted recommendations have not been implemented. The Scrutiny Board report to be presented to the Infant Mortality Working Group for information and comment:

a) Royal Wolverhampton NHS Trust to coordinate a response from the maternity, healthy lifestyles living and health visiting services which details specific actions aimed at increasing the percentage of pregnant women setting a smoking quit date, indicating where the results are either not known or lost to follow up. The report to include details of the take-up rate of nicotine replacement therapy and the number who have set a quit date.

b) Royal Wolverhampton NHS Trust to coordinate a report from maternity, healthy living lifestyles and health visiting services on progress in the use and results of carbon monoxide testing of pregnant women at every contact. The report to include feedback from pregnant women recorded as smoking and subsequently referred, about their experiences of the stop smoking service.

c) Royal Wolverhampton NHS Trust to present a report on a review of effective interventions aimed at reducing the numbers of women smoking during and after pregnancy.

d) The lead officer for infant mortality at Wolverhampton Clinical Commissioning Group (CCG) to report on current commissioning arrangements and the extent to which services for pregnancy and infancy are delivering the right mix of enhanced and targeted interventions for pregnant women, particularly vulnerable women considered to be at risk.

e) A report on the benefits of providing a Pepi-Pod crib or similar alternative cot in Wolverhampton. A report of the potential value of using a mobile phone app for parents and parents-to-be with personalised information and content approved by doctors and midwives that spans from pregnancy right through to the first six months after birth. The schemes, if introduced, should be initially targeted a vulnerable women and the findings published with recommendations about a possible future roll out across the City.

f) The Service Director – Public Health and Wellbeing to work with lead officers from key partners to for infant mortality at Wolverhampton CCG to detail proposals to discuss proposals to make best use of available local intelligence in order to help with the early identification better of identify vulnerable pregnant women mothers and provide appropriate targeted interventions that can support them and contribute to the overall aim of reducing the numbers of infant deaths. The findings to be shared with the Wolverhampton Health and Wellbeing Board, and Wolverhampton CCG Governing Body and the Infant Mortality Working Group.

g) To invite Directors of Public Health across the West Midlands region to share examples of best practice in respect of delivering an effective smoking cessation programme to pregnant women and to discuss further opportunities to promote the adoption of best practice across the region.

h) The Service Director – Public Health and Wellbeing and the Chair of the Child Death Overview Panel (CDOP) to jointly report on progress in recruiting staff to collate current and future statistics. Analysis of comparative data at a regional level to be included in future annual reports.

i) The Chair of the Child Death Overview Panel (CDOP) to publish the annual report for Wolverhampton to be published prominently on the Council's website and also the findings shared with key local agencies to promote good practice and improve the quality of local intelligence.

j) The Service Director- Public Health and Wellbeing to report on outcome of review of the national funding formula for 2016/17. (The formula is used to calculate the number of health visitors that an area needs to deliver safe and effective services.)

Comment		Timescale/progress so far	Officer Responsible
	1a-c **Accepted** The draft scrutiny report was presented to the Infant Mortality Working Group (IMWG) on Friday 8 May 2015. Representatives across the whole working group were present, including representatives in relation to recommendations 1a – 1c.	1b. CO monitors have been purchased for midwifery and health visiting services and training will be delivered to support delivery. A more detailed response by responsible organisations/services will be required at the Infant Mortality Working Group (IMWG) at the November 2015 meeting.	Ros Jervis, Service Director, Public Health and Wellbeing (SDPHW)

	Everyone is aware of the need to respond collectively to these recommendations regarding quit rates, use of carbon monoxide monitors (CO), nicotine replacement therapy and the use of stop smoking services in general by pregnant women.	**February 2016 Update: 1a-c** • CO monitors are being used by midwifery, health visiting and healthy lifestyles service. Additional monitors were ordered in December 2015. • 1983 women were screened between April 2015 and January 2016 • 405 referrals were received by the Healthy Lifestyle Service; this represents 20% of the women screened • There was a 20% (81) uptake of referrals from the antenatal clinic • More detailed information on stop smoking services in pregnancy is contained with the Healthy Lifestyle Service report in section six.	
	1d **Accepted** The executive nurse (EN) for the CCG alongside the Designated Doctor for Child Deaths (DDCD) will respond in detail to this recommendation. ***Manjeet Garcha*** has provided a detailed response to the recommendation – see section two.	A more detailed response by responsible organisations/individuals will be required at the IMWG at the November 2015 meeting. **February 2016 Update** It is acknowledged that local intelligence can come from many sources; this intelligence should be disseminated across services to ensure appropriate consideration is given to the impact on relevance of the information on care needs along with any additional education required by providers. In addition, General Practitioners are the primary point of access for pregnant women to maternity services. There is guidance in place for GPs and this is being added to the new GP pathway system currently being implemented in Primary Care. Information sharing between the patients GP and midwife has also been discussed with the Practice Manager Lead/Forum and mechanism are in place. A report has been produced by the CCG and is detailed as an update in section four.	Manjeet Garcha Executive Lead for Nursing and Quality- Wolverhampton CCG

	1e **Accepted** Public Health to undertake an evidence review in relation to available information relevant to use of: i. pepi-pod or alternatives ii. phone applications for personalised information Cost effectiveness will be evaluated where possible	A more detailed response will be reported by Public Health to the IMWG at the November 2015 meeting. **February 2016 Update** (i) Pepi-pod: An evidence review of pepi-pod was completed and the key findings were that the pepi-pod is an infant sleep space culturally tailored for the Maori population and delivered as part of a wider programme to support vulnerable families to prevent sudden unexplained deaths in infancy (SUDI) and may not be easily transferable for use within Wolverhampton. There is no published evidence of the effectiveness of the use of the pepi-pod and some evidence of an increased risk of SUDI with the use of other infant sleeping equipment. A randomised control trial is currently in progress in New Zealand comparing the pepi-pod to another sleeping device. The results will be available late 2016 and will be reviewed to assess effectiveness and cost effectiveness within a UK setting (ii) Phone applications: Whilst there has not been a formal evaluation of 'phone applications for pregnancy and infancy, the application produced by Best Beginnings has received multiple endorsements from key professional bodies such as Royal College of Midwives; Royal College of Obstetrics and Gynaecology and the Faculty of Public Health. The application has been produced in collaboration with health care professionals and is actively promoted locally and used by some mothers.	Ros Jervis (SDPHW)
	1f **Accepted** Public health working alongside EN for CCG, maternity and children services will review the vulnerable women's pathway. There is also a proposed task and finish group to discuss and develop a conception to	A more detailed response by responsible organisations/services will be required at the IMWG at the November 2015 meeting. **(Please read in conjunction with recommendation 2)** **February 2016 Update** Detailed report presented at the May 2016 IMWG to include action against the linked recommendations 1f, 2 and 6. This can	Manjeet Garcha Executive Lead for Nursing and Quality- Wolverhampton CCG

	age five pathway which will also address vulnerability) ***Manjeet Garcha*** has provided a detailed response to the recommendation – see section three.	then be reported to either the Health Scrutiny Board or HWBB (or both).	
	1g **Accepted** Public Health to work with Public Health England on a regional basis in terms of gathering and sharing good practice that supports women to stop smoking during pregnancy and to continue not to smoke after delivery.	A more detailed response will be reported by Public Health to the IMWG at the November 2015 meeting. **February 2016 Update** Regional documents to support smoking cessation during and after pregnancy have been produced by Public Health England and circulated to all relevant organisations.	Ros Jervis (SDPHW)
	1h & 1i **Accepted** Public health working alongside the Chair of the Child Death Overview Panel (Joint) to report on the review currently being undertaken which will be completed by end June 2015.	A more detailed response by the Chair of the Child Death Overview Panel will be required at the IMWG at the November 2015 meeting. CDOP agree to publish the annual report through the WSCB. **February 2016 Update** The Annual report from the Child Death Overview panel is due at the end of January/beginning of February 2016 and once available will be forwarded for publication on the Council website	Chair of the Child Death Overview Panel
	1j **Accepted** SDPHW has submitted a response to the consultation on the national funding formula for 2016/17. A national response is awaited.	It is possible that a national response will be published in December 2015. **February 2016 Update** As of 2 February 2016, a national response is still awaited.	Ros Jervis (SDPHW)

Recommendation 2 Wolverhampton Clinical Commissioning Group (CCG) and the Service Director - Public Health and Wellbeing to agree a programme of work that supports enhanced targeted interventions for high risk families or vulnerable mothers with new babies identified by maternity services; including advice on contraception to avoid unplanned early repeat pregnancy, and support pregnancy spacing. This should include post natal support in the first few weeks of life aimed at parent education and support to reduce the risk of infant death after discharge from the neonatal unit/post natal ward.		
Comment	**Timescale/progress so far**	**Officer Responsible**
Accepted Public Health working alongside EN for CCG, maternity and children services will review the vulnerable women's pathway. There is also a proposed task and finish group to discuss and develop a conception to age five pathway which will also address vulnerability.	A more detailed response by responsible organisations/services will be required at the IMWG in November 2015. (**This must be read in conjunction with recommendation 1f**) **February 2016 Update** A postnatal parent education programme, 'Reducing the Risk' commenced in January, delivered by the neonatal unit. This programme is for parents with premature infants and other vulnerable mothers in Wolverhampton referred from midwifery services. The aim is to teach parents basic life support skills, promote breast feeding and safe sleeping alongside dietary advice and smoking cessation. Detailed report to be presented at the May 2016 IMWG to include action against the linked recommendations 1f, 2 and 6.	Ros Jervis (SDPHW)

Recommendation 3

The Black Country clinical representative of West Midlands Maternity and Children's Strategic Clinical Network in discussion with representatives of SSBC Newborn and Maternity Networks to jointly present a report to the Infant Mortality Working Group regarding care pathways for anticipated extreme preterm births.

The report to include an update on work towards improving survival rates for this cohort and also progress on the outcome of discussions with West Midlands Ambulance Services about improving care pathways for intrauterine transfers of pregnant women in preterm labour. The overall aim of the policy is for pregnant women in preterm labour to be taken to the most appropriate hospital for the safe delivery and on-going care of their baby.

Comment	Timescale/progress so far	Officer Responsible
Accepted This recommendation will be addressed via the Black Country SCN lead update on infant mortality which will incorporate current discussions on intrauterine transfers across the network.	A final report will be presented to the IMWG in November 2015 with a view to a future joint presentation to the Health Scrutiny Panel. **February 2016 Update** A meeting of the Black Country Strategic Clinical Network was held on 26 January 2016 and the outcome of discussions will be reported at the May 2016 meeting of the Infant Mortality Working Group.	Ros Jervis (SDPHW) alongside either a representative of the SCN or Tilly Pillay, Neonatal Lead, The Royal Wolverhampton NHS Trust (RWT)

Recommendation 4 The review group endorse the recommendations of the Infant Mortality Working Group Action Plan 2015 – 2018. A joint report to be presented by the lead officer for infant mortality at Wolverhampton CCG and Public Health to the Wolverhampton Health and Wellbeing Board on a six monthly basis on progress and achievements against recommendations accepted in the Infant Mortality Action Plan. The Service Director - Public Health and Wellbeing to ensure the action plan is reviewed and updated to include emerging risks and further services changes. The findings to be shared with all key partner agencies.		
Comment	**Timescale/progress so far**	**Officer Responsible**
Accepted Update on the IMWG action plan will be presented to the Wolverhampton Health and Wellbeing Board (WHWB).	Update to be completed within two weeks of the May 2015 IMWG and forwarded as an agenda item to be considered for a forthcoming HWBB meeting. Careful consideration needs to be given regarding reporting progress against infant mortality actions (mechanisms and timescales) to various interested parties. **February 2016 Update** The Infant Mortality Action plan is reviewed at each working group meeting and actions updated and circulated to the group. An update was presented to the HWBB on 2 December 2015.	Ros Jervis (SDPHW)

A strategic and co-ordinated response to tackle the modifiable causes of infant mortality in Wolverhampton and also respond to the challenges of dealing with the effects of poverty and deprivation.

Recommendation 5 The findings and progress of the Infant Mortality Working Group to be shared with organisations with a special interest in reducing the number of child deaths, for example, the CDOP, SANDS, BLISS and the Lullaby Trust for comment. Representatives to be invited to comment on progress and invited to share learning locally and nationally on further improvements in the co-ordination of care from a neonatal setting, to home and whether there are any specific recommendations to build on good practice.		
Comment	**Timescale/progress so far**	**Officer Responsible**
Accepted A workshop event to be developed at the end of the calendar year and presented in 2016 to allow monitoring of progress and assessment of improvements.	Workshop discussed at IMWG November 2015 meeting with the proposal for the event to be delivered before March 2016. **February 2016 Update** Plans are in place to hold a stakeholder event on 14/15 March 2016 to promote safe sleeping practices (supported by the Lullaby Trust) and share the progress on the Infant Mortality Action Plan recommendations.	Ros Jervis (SDPHW)

Recommendation 6 The Service Director – Public Health and Wellbeing to draft terms of reference and agree membership for a task and finish group to review vulnerable pregnant women's care pathway. Representatives of Wolverhampton Integrated Substance Misuse Service (Recovery Near You) need to participate in a review of the effectiveness of the current working arrangements for supporting women referred to the service; particularly those involving drugs, alcohol, domestic abuse or long term mental health issues. A report of the findings to be reported to the Health and Wellbeing Board and Scrutiny Board.		
Comment	**Timescale/progress so far**	**Officer Responsible**
Accepted A task and finish group will be established to address this complex recommendation, with representatives from CCG, Public health, LA children services and Recovery Near You (and possibly others) This work is a fundamental component of the vulnerable women's pathway and therefore will also link to recommendation 1f and 2. Helen Kilgallon, Recovery Near You, representative of Wolverhampton Integrated Substance Misuse Service, provided a detailed response to the recommendation – see section five.	Detailed report to be presented at the May 2016 IMWG to include action against the linked recommendations 1f, 2 and 6.	Ros Jervis (SDPHW) and Manjeet Garcha Executive Lead for Nursing and Quality Wolverhampton CCG

Changing practices and policies and apply learning based on reliable evidence as to their impact and effectiveness in reducing the rate of infant mortality.

Recommendation 7 Royal Wolverhampton NHS Trust to provide a detailed response to the NICE published guidance that all NHS hospitals and clinics should become completely smoke-free zones and to set out detailed proposals for implementation and a timetable for achieving this to be presented to a meeting of the Health and Wellbeing Board.		
Comment	**Timescale/progress so far**	**Officer Responsible**
Accepted Discussions are being held between the Medical Director and the Healthy Lifestyles Service manager regarding progressing this recommendation. Public Health will be presenting the Infant Mortality Action Plan (as approved by HWBB) to the Royal Wolverhampton NHS Trust (RWT) Board on 1 June 2015.	Proposed update at the IMWG meeting in November 2015 **February 2016 Update** The Infant Mortality Action Plan was presented to the RWT Trust Board on 1st June 2015. It was highlighted that a number of Trusts in the West Midlands had implemented a smoke-free site policy. However, following discussion the consensus of the Board was that the implications of such a move for RWT required careful consideration, not least the means of enforcing such a measure without compromising staff safety. No further progress has been made to date, but an audit of the NICE guidance PH 26 Smoking: stopping in pregnancy and after childbirth is proposed for discussion at the May 2016 meeting of the IMWG.	Anne Mcleod, Manager Healthy Lifestyles Service, RWT

Recommendation 8 The lead officer for infant mortality at Wolverhampton CCG to consider the availability of genetic screening and counselling support across Wolverhampton and to raise awareness generally of the service. The findings to be presented to the Health Scrutiny Board**.**		
Comment	**Timescale/progress so far**	**Officer Responsible**
Accepted Genetic screening and counselling support is commissioned from Birmingham Women's Hospital NHS Trust on a regional basis. We are not aware of any issues with regards to access or availability of these services however we acknowledge the need to ensure good awareness across the public and professionals; including the conditions that would benefit from these services, how to access services and referral mechanisms.	August – October 2015 **February 2016 Update** Genetic screening and counselling support is commissioned from Birmingham Women's Hospital NHS Trust on a regional basis. We are not aware of any issues with regards to access or availability of these services from professionals and would welcome opportunities to raise public awareness.	Manjeet Garcha, Executive Lead for Nursing and Quality Wolverhampton CCG

Recommendation 9 Service Director - Public Health and Wellbeing, to work with partner agencies to create a public resource document similar to Bradford's 'Every Baby Matters' which explains the risk factors and provides practical advice and support that can help reduce the numbers of avoidable deaths of babies. The resource should be built into any planned public awareness campaigns and include details of the impact of lifestyle behaviours, such as smoking and alcohol that increases the risks of child dying. The document should promote positive health messages and signpost families to sources of available support and useful information.		
Comment	**Timescale/progress so far**	**Officer Responsible**
Accepted A task and finish group to be established to review developing a resource and the feasibility of delivering Making Every Contact Count (MECC) training to key agencies	Task and finish group to be convened in July 2015 **February 2016 Update** A specific programme was developed by the MECC lead within the Healthy Lifestyles Service to include: • key public health messages, • importance of preventative health in reducing infant mortality rates, • local services and referral pathways. The training has been delivered and is currently being updated and rolled out to community midwives, midwifery support workers & family support workers, sonographers, sonographer support workers, health care assistants and reception staff at RWT.	Ros Jervis (SDPHW)

Recommendation 10 All newly elected Councillors to be given a briefing on the issue of infant mortality in Wolverhampton and the practical advice and information they can give when they meet people as part of their work. This should be presented as briefing of the key health messages and the main risks including sofa/bed-sharing, as well as smoking and alcohol in the lifestyle behaviours.		
Comment	**Timescale/progress so far**	**Officer Responsible**
Accepted	Public Health will update the previous member briefing by the end of February 2016 and arrangements will be made for circulation to Councillors.	Earl Piggott-Smith, Scrutiny Officer

Recommendation 11 Service Director - Public Health and Wellbeing, to report on progress in resolving the issue of getting access to personal confidential health data needed to assess the effectiveness of changes introduced to reduce the infant mortality rate.		
Comment	**Timescale/progress so far**	**Officer Responsible**
Accepted Information sharing agreement in progress and proposed infant mortality dashboard content agreed by IMWG	Data should be available by end of July 2015 and populated Infant Mortality dashboard presented at IMWG meeting in November 2015 **February 2016 Update** Maternity data was made available to Public Health via an information sharing agreement in May 2015. The data was used to update the infant mortality briefing and produce an infant mortality dashboard	Ros Jervis (SDPHW)

Recommendation 12 The scrutiny review of infant mortality report to be sent to Wolverhampton CCG, Royal Wolverhampton NHS Trust and CDOP for information and comment and they are invited to give comments on the findings and recommendations. A progress report on those recommendations accepted by the Cabinet is reported to the Wolverhampton Health and Wellbeing Board in 6 months. The report recommendations to be tracked and monitored by Scrutiny Board at the same time.		
Comment	**Timescale/progress so far**	**Officer Responsible**
Accepted	A final report will be sent to representatives when approved. Report sent to all organisations and witnesses who contributed evidence to the review. **February 2016 Update** Director of Public Health presented update report to Health and Wellbeing Board meeting 7 October 2015. An update report to be presented to Scrutiny Board on 1 March 2016.	Earl Piggott-Smith

Section two
Further information: recommendation 1d

Manjeet Garcha Executive Lead for Nursing and Quality- Wolverhampton CCG

Current arrangements

The Royal Wolverhampton NHS Trust is commissioner by Wolverhampton CCG to provide a full and comprehensive maternity service. The service is provided in accordance with all national and local policies in particular NICE guidelines and RCOG standards for maternity care. NHS England's Maternity Pathway payment system is in place which is split into three modules; antenatal, delivery and postnatal. For antenatal and post natal pathways there are three case-mix levels; standard, intermediate and intensive. Intermediate and intensive levels are where women require additional care and or intervention. The delivery element is split by whether or not there are complications and co-morbidities at a level that requires additional care.

Assurance

These pathways are underpinned by NICE guidance and should deliver the appropriate mix of enhanced and targeted interventions. In order to further understand the extent of interventions provided to women across the case-mix levels a multi-disciplinary case note audit is proposed. The aim of the audit will be to provide assurance of appropriate mix of enhanced and targeted interventions as well as provide learning, identify opportunities for training and education, for example.

Initial outline plan

Audit planning – May – June 2015
Undertake audit – July – August 2015
Review outcomes: September 2015
Develop plan: October 2015

Section three
Further information: recommendation 1f

Manjeet Garcha Executive Lead for Nursing and Quality- Wolverhampton CCG

It is acknowledged that local intelligence can come from many sources; this intelligence should be disseminated across services to ensure appropriate consideration is given to the impact on relevance of the information on care needs along with any additional education required by providers. In addition, GPs are the primary point of access for pregnant women to maternity services. There is guidance in place for GPs however; the extent to which this is adhered to is unknown. Further understanding is required of the mechanisms in place across primary care for information sharing between GP and midwife. A survey to gather intelligence followed by education/promotion is opposed.

Survey: June – July 2015
Assess Response: August 2015
Review guidance: September 2015

Section four
February 2016 update: Report on CCG Commissioning Arrangements for Maternity and Child – Infant Mortality

Health Scrutiny Review of Infant Mortality Recommendation 1d
The importance of co-ordinating local efforts to tackle the underlying causes of infant Mortality in Wolverhampton: The lead officer for infant mortality at Wolverhampton Clinical Commissioning Group (CCG) to report on current commissioning arrangements and the extent to which services for pregnancy and infancy are delivering the right mix of enhanced and targeted interventions for pregnant women, particularly vulnerable women considered to be at risk.

Wolverhampton CCG commissions the Royal Wolverhampton NHS Trust (RWT) to provide a full and comprehensive Maternity Service. The service complies will all national and local policies, including NICE guidelines and Royal College of Obstetricians and Gynaecologists (RCOG) Standards for maternity care. The CCG also complies with the NHS England Maternity Pathway Payment system[1] which separates antenatal and postnatal pathways into three case-mix levels; standard, intermediate and intensive. The delivery element is split into two pathways; births where there are not any complications or co-morbidities and those with complications where the pregnant women may require additional care. Pathways attract higher payment tariffs with increased complexity.

All pregnant women are allocated to the appropriate pathway at the antenatal booking appointment, and this is reviewed throughout the pathway to ensure women receive the right level of intervention to meet their needs. Factors considered for allocating women to the intermediate pathway both antenatal and postnatal care, include complex social factors such as age, migrant, refugee, asylum, learning disabilities, safeguarding etc, BMI >=35, or <18 (antenatal only), physical disability, substance misuse including alcohol and medical issues including medical health, hypertension, respiratory, epilepsy, hepatitis and/or previous obstetric history.

Factors considered when allocating women to the intensive pathway include expecting twins, HIV, long-term conditions including Diabetes, chronic heart disease, renal disease and cancer as well as previous fetal congenital anomaly that required specialist medicine.

Each of the Maternity Pathways, developed nationally by RCOG, Department of Health, The Royal College of Midwives and Health Financial Management Association, are expected deliver the appropriate mix of enhanced and targeted interventions.

Current position
The CCG regularly reviews benchmarking information to ascertain the proportion of women in each of the case-mix levels. Patients have, and exercise, choice of where to receive their maternity care and the review includes the local providers that Wolverhampton-registered women choose across the three stages of the pathway; antenatal, intrapartum (delivery) and postnatal. The table below show the activity by risk score (standard, intermediate and intensive) benchmarked against the England average for 2015 and for other trusts (2014).

Table - Maternity PbR pathway - Casemix for Wolverhamption patients 2014 - 2015

Point of Delivery	HRG	National Average %	Commissioners: 06A (WCCG) Sep-15 RL400(RWT)	06A (WCCG) Sept-14 RL400(RWT)	05C Other local Providers RNA00	05Y RBK00	05X RXW00	05N RXW00
Antenatal	INTENSIVE	8.0%	9.3%	7.8%				
	INTERMEDIATE	29.0%	31.1%	33.5%				
	STANDARD	63.0%	59.0%	58.7%				
Postnatal	INTENSIVE	1.0%	0.2%	0.4%				
	INTERMEDIATE	24.0%	15.6%	22.7%				
	STANDARD	75.0%	84.1%	76.9%				
Intrapartum (Delivery)	WITH COMPLICATIONS & COMORBIDITIES	28.6%	22.0%	34.30%				
	WITHOUT COMPLICATIONS AND COMORBITIES	71.4%	78.0%	65.7%				

Key

	In line with national average proportions
	Significantly lower than national average proportions
	Significantly higher than national average proportions

1. www.gov.uk/government/uploads/system/uploads/attachment_data/file/216573/dh_133896.pdf

There have been 1,216 women booked onto the antenatal pathway over the period April to September 2015. The latest data shows that Wolverhampton has a higher proportion of women on antenatal Intensive and intermediate pathways and a lower proportion of standard pathway pregnancies, than the national average. Local factors believed to contribute to this are levels of complex social factors, pregnant women under 20 years, number of women with a BMI >= 35, the level of smokers and the high levels of deprivation in Wolverhampton.

Additional assurance is provided in the form of local and national audits across maternity and neonatal services. RWT undertakes a number of national and local audits both annually and intermittently. National audits such as the Maternal, New and Infant Clinical Outcomes review are completed annually as are the BLISS/neonatal audits, the national Saving Children's lives audit, the latter covers smoking cessation, fetal movement, electronic fetal monitoring and growth charts. It was confirmed that the consultant obstetricians/maternity staff have taken part in local audits on infant mortality and the EMBRACE Confidential enquiry.

Local audits include a postnatal care audit on smoking and pregnancy, RWT follow-up mothers who were smoking at the time of delivery. Original audit was undertaken in November 2014 following the introduction of global CO_2 monitoring. The audit reviewed case files of 40 women as to whether the mother smoked, whether they had received smoking cessation advice during pregnancy and whether they have been offered and taken up CO_2 monitoring. Other forms of audit include the weekly multidisciplinary meetings (Risks assessed) and the monthly Paediatricians meetings with pathologists and other clinicians that discuss any infant deaths and still births.

The CCG is working with RWT to discuss the outcomes and learning from national and local audits, and has the capacity to request additional audit focus should areas of concern be highlighted.

Section five

Helen Kilgallon
Programme Manager
Wolverhampton Substance Misuse Service

In April 2013 a newly commissioned integrated substance misuse service began. This is a partnership with NACRO as prime contractor, Aquarius and BSMHFT as sub-contractors. A recovery model was adapted within the service and a number of posts that were in existence at the previous service were no longer in the new service model. One of the reasons for this was RNY wanted to ensure all staff were skilled to a high level in safeguarding, pregnancy, domestic abuse and mental health and not rely on one particular specialist post.

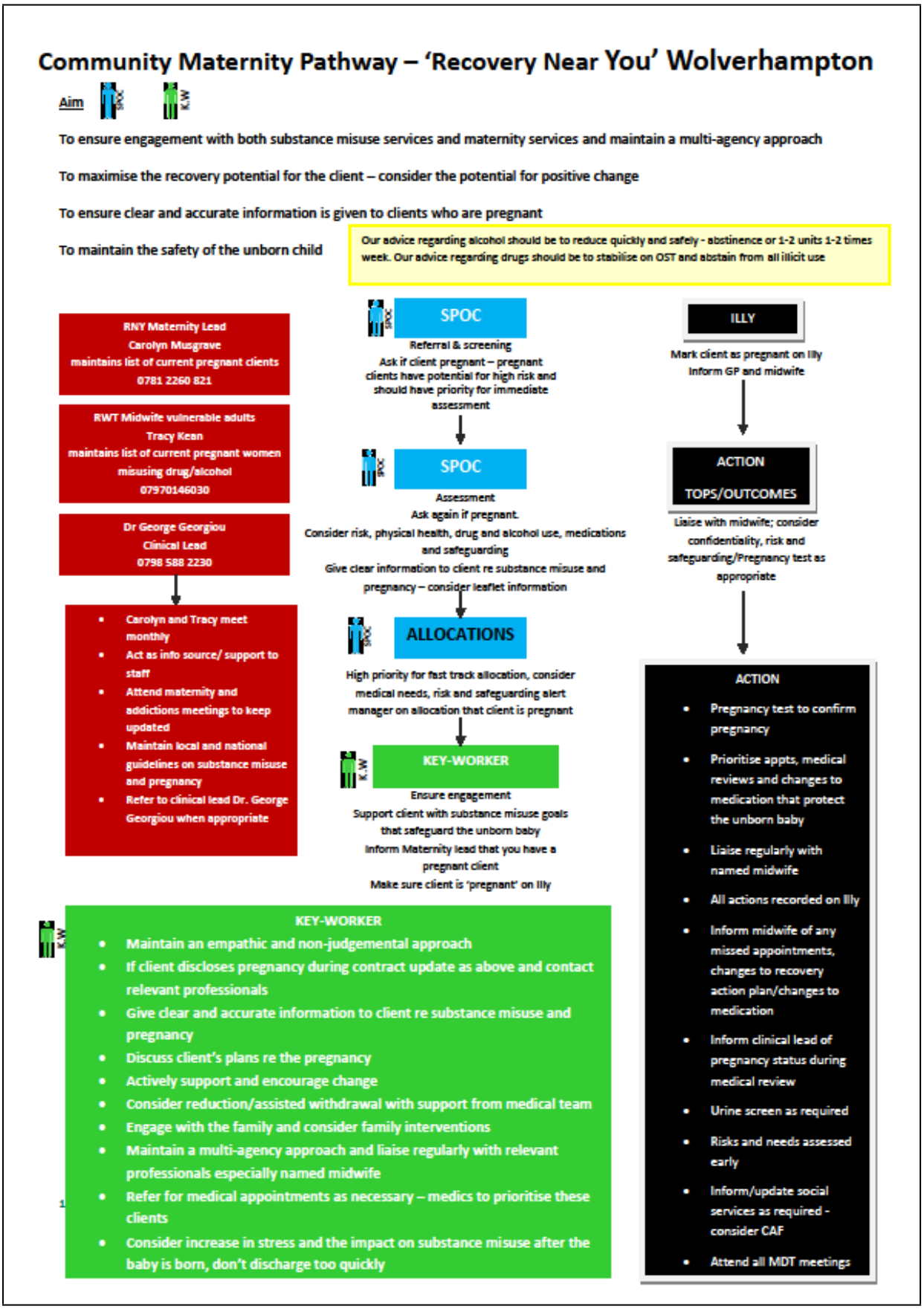
The DALT (drug alcohol liaison team) has been successfully operating within RWT for over 5 yrs. When RNY were awarded the contract leads from DALT and the RNY consultant lead met with maternity as a priority to adapt existing pathways and ensure this particular group of women were given a priority within the service. This pathway has been revisited a number of times to ensure all processes and procedures work smoothly and effectively. I have every confidence that the maternity pathway within RNY and RWT is effective as I know RNY staff sit at maternity meetings, and daily discussions are had with specialist nursing staff within RWT. They can often be seen at meetings at RNY and are a visible presence.

As programme manager I have weekly reports sent to me on all pregnant service users and can view their treatment, attendance and offers of support. I also chair safeguarding meetings where they are discussed. I do not feel that RNY needs to review the process we have currently as they have been working successfully for over 18 months.

I would be more than happy to be part of any processes to look at referral routes into and out of the service i.e. mental health services, and more especially primary care. I feel that this is a particular area where much more work could be done at a very early level as they have access to patients where alcohol screening could be done, offers of smoking cessation, weight management and offers of support for mental health and domestic abuse.

A summary of the community maternity pathway is outlined below:

SPOC- single point of contact
KW- key worker


Community Maternity Pathway – 'Recovery Near You' Wolverhampton
Aim
To ensure engagement with both substance misuse services and maternity services and maintain a multi-agency approach
To maximise the recovery potential for the client – consider the potential for positive change
To ensure clear and accurate information is given to clients who are pregnant
To maintain the safety of the unborn child
Our advice regarding alcohol should be to reduce quickly and safely - abstinence or 1-2 units 1-2 times week. Our advice regarding drugs should be to stabilise on OST and abstain from all illicit use
RNY Maternity Lead
Carolyn Musgrave
maintains list of current pregnant clients
0781 2260 821
RWT Midwife vulnerable adults
Tracy Kean
maintains list of current pregnant women misusing drug/alcohol
07970146030
Dr George Georgiou
Clinical Lead
0798 588 2230
Carolyn and Tracy meet monthly
Act as info source/ support to staff
Attend maternity and addictions meetings to keep updated
Maintain local and national guidelines on substance misuse and pregnancy
Refer to clinical lead Dr. George Georgiou when appropriate
SPOC
Referral & screening
Ask if client pregnant – pregnant clients have potential for high risk and should have priority for immediate assessment
SPOC
Assessment
Ask again if pregnant.
Consider risk, physical health, drug and alcohol use, medications and safeguarding
Give clear information to client re substance misuse and pregnancy – consider leaflet information
ALLOCATIONS
High priority for fast track allocation, consider medical needs, risk and safeguarding alert manager on allocation that client is pregnant
KEY-WORKER
Ensure engagement
Support client with substance misuse goals that safeguard the unborn baby
Inform Maternity lead that you have a pregnant client
Make sure client is 'pregnant' on Illy
ILLY
Mark client as pregnant on Illy
Inform GP and midwife
ACTION
TOPS/OUTCOMES
Liaise with midwife; consider confidentiality, risk and safeguarding/Pregnancy test as appropriate
ACTION
Pregnancy test to confirm pregnancy
Prioritise appts, medical reviews and changes to medication that protect the unborn baby
Liaise regularly with named midwife
All actions recorded on Illy
Inform midwife of any missed appointments, changes to recovery action plan/changes to medication
Inform clinical lead of pregnancy status during medical review
Urine screen as required
Risks and needs assessed early
Inform/update social services as required - consider CAF
Attend all MDT meetings
KEY-WORKER
Maintain an empathic and non-judgemental approach
If client discloses pregnancy during contract update as above and contact relevant professionals
Give clear and accurate information to client re substance misuse and pregnancy
Discuss client's plans re the pregnancy
Actively support and encourage change
Consider reduction/assisted withdrawal with support from medical team
Engage with the family and consider family interventions
Maintain a multi-agency approach and liaise regularly with relevant professionals especially named midwife
Refer for medical appointments as necessary – medics to prioritise these clients
Consider increase in stress and the impact on substance misuse after the baby is born, don't discharge too quickly

Section six

Stopping Smoking in Pregnancy: Health Lifestyle Service report February 2016

The Stop Smoking Service delivers services to the population of Wolverhampton City. Providing they have a GP in Wolverhampton, are receiving health care or live or work in the city.
The service provided to Pregnant Women following the NICE Guidance's below;

- PH26 – Quitting smoking in Pregnancy and child birth.
- PH48 – Smoking Cessation in Secondary Care, Acute, Maternity and Mental Health Services.
- PG45 – Tobacco Harm reduction approaches.

All women in Wolverhampton who book with a midwife and are identified as smoking are referred to the stop smoking service.

- The service will attempt to contact these pregnant women three times, if unable to contact by phone then a letter is sent from the department asking the women to contact the department with information literature included.
- When contact is made, the women is offered a face to face consultation with a trained Stop Smoking Adviser who use motivational interviewing techniques and small goal setting to support the women to set a quit date. (appointments offered in home or community setting)
- Licenced Nicotine Replacement Therapy is then offered and provided to all clients to help reduce the craving to smoke. This is given via a voucher for 2 weeks after which a letter is sent to the clients GP asking then to continue to prescribe the Nicotine Replacement Therapy as advised by the Trained Stop Smoking Adviser.
- Every client is followed up weekly for 6 weeks then every 2 weeks to 12 weeks.
- If they successfully quit smoking they are then contacted monthly by phone or a face to face consultation for the duration of their pregnancy and elapse prevention is offered
- If the client returns back to smoking they are then supported to stop smoking by the above method.
- Relapse prevention is offered at any time.
- The phone number of the adviser is given to all clients; they can be contacted when additional support is required.

Antenatal Service Developments

Staff Training:
Initially it was identified front line staff required training in some key areas relating to improving infant mortality rates;

C0 monitor Training – A Smoking Specialist delivered CO monitor training, including correct use, infection prevention measures, interpreting of results & how to refer into services. This has been delivered to Community Midwives, Midwifery Support Workers & Family Support Workers. CO monitoring at all antenatal visits implemented March 2015 with all pregnant women given printed advice related to the outcome and results recorded in maternity notes.
Smoking Brief Intervention – Smoking specialist has delivered specific smoking cessation brief intervention advice and support to coincide with anyone who uses C0 monitors or discusses lifestyle changes with pregnant women. Anyone who blows over a 4 on the C0 reading gets an opt out referral into the smoking cessation team.

Making every contact count – A specific programme was put together by the MECC lead to include key public health messages, importance of preventative health in reducing infant mortality

rates, local services and referral pathways. This has been delivered and is currently being updated and rolled out to community midwives, midwifery support workers & family support workers, sonographers, sonographer support workers, HCA's & reception staff.

Neonatal Service developments

- Smoking specialist visits Neonatal Unit once weekly. To talk to parents and their families about smoke free homes and offer support to anyone who is interested in attempting a quit attempt.
- Assess smoking status of parents with children on the Neo natal Unit and refer to smoking cessation service. Given advice and support there and then and offered a community referral to follow up.
- Facilitate a weekly informal coffee morning to engage with parents and families.

Table 1: Smoking in Pregnancy Data Quarter 1 2014/15 – Quarter 2 2015/16

	2014/15					2015/16	
	Q1	**Q2**	**Q3**	**Q4**	**Annual**	**Q1**	**Q2**
Set Quit Date	21	33	24	38	**116**	17	38
Quit Smoking	8 (38%)	16 (48%)	11 (46%)	13 (34%)	**48 (41%)**	9 (53%)	14 (37%)
Not Quit Smoking	7 (33%)	9 (27%)	4 (17%)	8 (21%)	**28 (24%)**	2 (12%)	9 (24%)
Loss to Follow-up	6 (29%)	8 (24%)	9 (38%)	17 (45%)	**40 (34%)**	6 (35%)	15 (39%)
Smoking at delivery	19.6%	18.2%	19.6%	19.0%	**18.8%**	16.9%	16.6%

Agenda Item No: 12

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

27 April 2016

Report title	Update on Suicide Prevention	
Cabinet member with lead responsibility	Councillor Sandra Samuels Public Health and Wellbeing	
Wards affected	All	
Accountable director	Linda Sanders People	
Originating service	Public Health and Wellbeing	
Accountable employee(s)	Ros Jervis Neeraj Malhotra Tel Email	Director of Public Health Public Health Consultant (Transformation) 01902 558667 Neeraj.malhotra@wolverhampton.gov.uk
Report to be/has been considered by	People Leadership Team	16 November 2015

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1. Endorse the overall partnership approach taken to suicide prevention.
2. Approve the establishment of a Suicide Prevention Stakeholder Forum.
3. Approve the suicide prevention action plan.
4. Endorse the suicide prevention work as an additional workstream within the crisis concordat programme.

Recommendations for noting:

The Health and Wellbeing Board is asked to note:

1. The suicide prevention needs assessment.
2. Compliance with national requirements for a suicide audit/needs assessment, stakeholder forum and action plan.
3. Early progress made to date on the action plan tasks.

1.0 Purpose

1.1 This report is to inform the Health and Wellbeing Board of the progress made in relation to the requirements outlined in the national suicide prevention strategy *Preventing Suicide in England: A Cross Government Outcomes Strategy to Save Lives*. In particular, progress in relation to the Mental Health and Suicide Prevention Needs Assessment, completed jointly with Wolverhampton Samaritans, the establishment of a multiagency Wolverhampton Suicide Prevention Stakeholder Forum and the development of a Suicide Prevention Action Plan for Wolverhampton.

1.2 In addition to gain the Board's approval for the approach being taken and the action plan, including any comments the Board has to make.

2.0 Background

2.1 In 2012 the government published *Preventing Suicide in England: A Cross Government Outcomes Strategy to Save Lives*. The strategy recommends that local authorities conduct a suicide audit, produce a suicide prevention action plan and set up a multi-agency suicide prevention group. This strategy has been followed up with annual reports – the latest being a two year follow up published in 2015.

2.2 The development of a local suicide action plan is one of the recommendations in the strategy and Public Health England (PHE) has issued guidance for developing a local suicide prevention action plan. However, an All-Party Parliamentary Group (APPG) on Suicide and Self-harm Prevention conducted a survey on Local Suicide Prevention Plans which found that:

- around 30% of local authorities do no suicide audit work;
- around 30% of local authorities do not have a suicide prevention action plan;
- around 40% of local authorities do not have a multi-agency suicide prevention group.

2.3 Suicide prevention should be set into the context of the fact that:

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

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

2.4 Following the public health transfer from the NHS into local government in April 2013, suicide prevention consequently became a local authority led initiative working closely with the police, clinical commissioning groups (CCGs), NHS England, coroners and the voluntary sectors. This report outlines the progress made in Wolverhampton on the

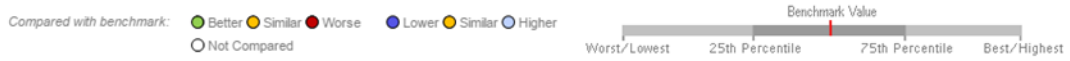
suicide prevention agenda and seeks the board's input into the program and approval of the draft action plan.

2.5 Suicide in Wolverhampton

2.5.1 Suicide is a potentially preventable cause of death and is a significant cause of death in young adults. When someone takes their own life, the effect on their family and friends is devastating and many others involved in providing support and care will also feel the impact. In England, one person dies every two hours as a result of suicide. Table 1 below, from the latest version of the Public Health Outcomes Framework (downloaded 5 April 2016) shows the overall numbers and rates per 100,000 population for suicides and injury undetermined over a three year period from 2012 to 2014. Over this period, there were 64 deaths registered in Wolverhampton (aged 15 and over), the majority (89%) being males. (Note that the Office for National Statistics does not include the under 15s in suicide figures due to the difficulty in determining the cause of death in young people.)

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

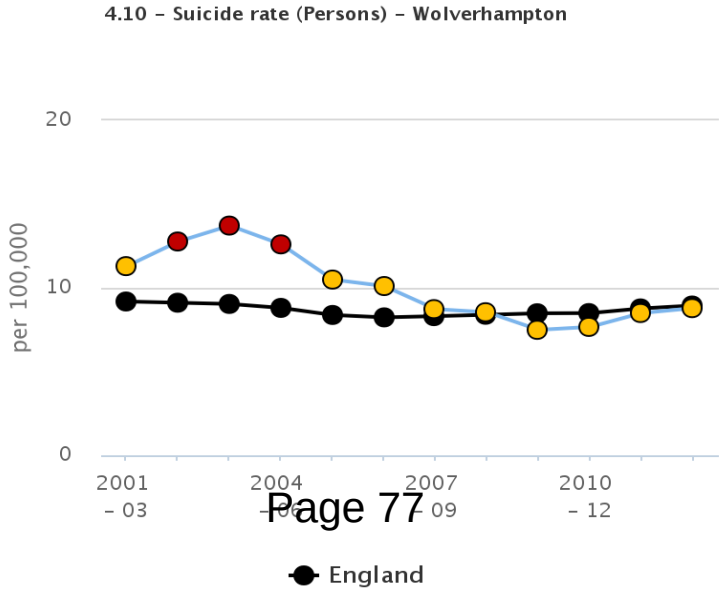
Table 1 Suicide rates in Wolverhampton



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

2.5.3 This increase is reflected in the trend data shown in Figure 1 below where it can be seen that Wolverhampton rates have been decreasing and were lower than the England average but recent trends suggest an increase. This may be due to the effects of the economic downturn or other factors, however, caution must be exercised as suicide rates can show natural fluctuations.

Figure 1 – Trend in suicide rates



Progress made to date

3.1 The following progress has been made on the three elements required in order to meet the national requirements concerning suicide prevention, i.e.:

3.2 **Suicide prevention audit**
A mental health and suicide prevention needs assessment, co-produced with Wolverhampton Samaritans, more than fulfils this requirement by providing a robust evidence base for future suicide prevention work. The executive summary is provided as Attachment 1. This needs assessment was discussed at a special workshop with members of the Wolverhampton Mental Health Stakeholder Forum where members agreed with, and added to, the recommendations of the report. The findings from the needs assessment informed the suicide prevention action plan. At a subsequent meeting of the Mental Health Stakeholder Forum it was agreed that a separate partnership led stakeholder forum was needed to develop and deliver the action plan.

3.3 **Suicide prevention stakeholder forum**
A multi-agency Suicide Prevention Stakeholder Forum has been established to oversee the delivery of the Wolverhampton Suicide Prevention Action Plan 2015. The forum will take a public health approach to suicide prevention. It will bring together key stakeholders in the city to focus action on suicide prevention, address the national strategy and develop and deliver the Wolverhampton Suicide Prevention Action Plan. The group had its first meeting on 10 December 2015 and will meet quarterly.

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

The group is in its early stages of development and is currently exploring how to make links to CAMHS, HeadStart and the wider children's services agenda. This is an ongoing development and the meeting to be held on 7 April will have a focus on suicide and young people including a presentation from PAPYRUS, a national charity for the prevention of young suicide.

3.4 **Suicide prevention action plan**
The suicide prevention needs assessment and additional stakeholder views from the Wolverhampton Mental Health Stakeholder Forum form the basis of the draft Suicide Prevention Action Plan (Attachment 2). The plan is organized by the 6 key areas for action outlined within the *Preventing Suicide in England* strategy. These are:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide

5. Support the media in delivering sensitive approaches to suicide and suicidal behavior
6. Support research and data collection.

The plan complies with the requirements set out in Public Health England's *Guidance for developing a local suicide prevention action plan.*

The action plan is a changing and dynamic document and reflects the progress that has been made in the last 12 months. It will be constantly updated.

To strengthen the work of the forum, the board is asked to endorse the suicide prevention work as an additional workstream within the crisis concordat programme.

3.5 **Action plan progress to date**

The group is in its early days of development, however two areas where progress is being made are reported below:

3.5.1 Key area: reducing the risk of suicide in high risk groups (gatekeeper training)

Action: Ensure that frontline staff, in health and non-health occupations, including the voluntary sector who come into contact with people who are homeless, unemployed, on benefits, socially isolated or otherwise vulnerable are confident and competent in recognising signs of mental distress and know how to support people appropriately and know where to refer onwards if necessary.

3.5.2 Progress: the availability of suicide prevention training has been researched and a programme of safeTALK suicide prevention training has been offered across Wolverhampton organisations.

3.5.3 The safeTALK :Suicide Alertness for Everyone course is a half-day (3.5 hours) training course designed to widen the net of suicide alert helpers to ensure that thoughts of suicide aren't missed, dismissed or avoided. The course gives practical steps to enable everyone to offer immediate help to someone having thoughts of suicide. Two sessions are planned for 21 March 2016 and will be offered to a total of 60 participants.

3.5.4 Action: Workplaces should be encouraged to sign up to policies that support positive mental health, as outlined in NICE guidance 'promoting mental wellbeing at work' (NICE Guidance PH 22)

3.5.5. Progress: We are developing a schedule to help workplaces to support national mental health and suicide awareness days with planned and coordinated action across Wolverhampton. In the meantime, the suicide prevention stakeholder forum and partners has supported the following national awareness days with a range of activities:

- World Suicide Prevention Day – September 10 2015

- Time to Change - Time to Talk day on February 4 2016.

3.5.6 The Time to Change campaign highlighted the fact that many people are still afraid to talk about mental health and suicide. So getting people talking can break down stereotypes, improve relationships, aid recovery and reduce stigma.

3.5.7 To support this campaign an article appeared in City People and leaflets and resources were distributed around the Council (including buildings outside the Civic Centre). The Healthy Lifestyles team had a presence in the Civic Centre foyer to talk about overall healthy lifestyles and provide information about mental wellbeing. In addition, Wolverhampton Community & Wellbeing Hub also had a presence in the Civic Centre Foyer, promoting their service and also offering resources and information on mental wellbeing. The Community & Wellbeing Hub also ran its own Time to Talk event at Epic Café.

4.0 Financial implications

4.1 The Public Health grant for 2015/16 is £21.9 million and any subsequent activity arising from this action plan will be implemented within existing resources. [GS/13042016/X]

5.0 Legal implications

5.1 There are no direct legal implications arising from this report 11042016/S

6.0 Equalities implications

6.1 Some of the most disadvantaged in society are at increased risk of suicide and the needs assessment takes this into consideration and examines their particular needs. A Stage 1 equalities analysis has been completed and forwarded to the Equalities Team on 7 March. A Stage analysis 2 is not needed.

7.0 Environmental implications

7.1 None

8.0 Human resources implications

8.1 None

9.0 Corporate landlord implications

9.1 None

10.0 Schedule of background papers

10.1 People Leadership Team 16 November 2015: Suicide Prevention Needs Assessment and Draft Action Plan

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Attachment 1

Mental Illness and Suicide Prevention: Wolverhampton Needs Assessment 2015

A collaborative project between Wolverhampton City Council Public Health and Wellbeing Team and Wolverhampton Samaritans

Sarah Wilkinson [1], Foundation Year 2 Doctor in Public Health

July 2015

[1] *Contact for enquiries:* Neeraj.Malhotra@wolverhampton.gov.uk

Executive Summary

This needs assessment is a collaborative project between the Wolverhampton Public Health Department and the Wolverhampton Samaritans, and has been based on consultation with local stakeholders working with the wider determinants of mental health. It profiles those adults at high risk of developing mental health disorders, with a particular emphasis on suicide; and maps which services are available to support these high risk groups in Wolverhampton. This will guide focussed outreach by the Wolverhampton Samaritans, inform local commissioning and highlight future areas for study.

Mental, emotional and psychological problems account for more disability than all physical health problems combined in the UK; and mental health problems are estimated to cost £105 billion annually in England. Suicide is the leading cause of death for 20-34 year olds in the UK and each completed suicide during working age costs £1.67 million in England.

90% of people who commit suicide had evidence of a mental illness prior to their death, but only 29.5% had been in contact with secondary statutory mental health services in the preceding 12 months. To reduce suicide at a population level, there should be both suicide-specific interventions and general measures to improve population mental wellbeing and engagement with services, with a view to helping the 60% who go on to complete suicide without being known to formal services.

Key Findings

Suicide is four times more common in men than women and this gap is widening nationally. The highest rates of suicide are in those aged 30 to 59 years – it has been high in the 30 to 44 age group for many years, but there is an upward trend in the 45 to 59 age group that doesn't yet show signs of plateauing. Ethnicity data is not formally collected by coroners. Globally, suicide rates are highest in Eastern Europe, and many Wolverhampton migrants originate from this area. Non-heterosexual sexual orientation is also a risk factor for suicide, with the greatest risk being in homosexual men.

Areas of deprivation are associated with increased suicide rates, and over half of Wolverhampton residents are in the most deprived 20% of the country. The recent recession may exacerbate this. Homelessness is higher in Wolverhampton than nationally, and multiplies the risk of suicide by nine.

Isolation increases the risk of suicide, whereas marriage confers protection against suicide. The risk of suicide is increased by bereavement – especially when a male partner loses their spouse. The risk of suicide in men is four times greater when their partner dies by suicide than by any other cause.

Risk of suicide risk increases with depression severity, and in Wolverhampton the incidence and prevalence of depression is higher than nationally. Mood disorder is the most common psychiatric diagnosis in inpatient suicide. Wolverhampton has a higher alcohol related hospital admission rate than nationally, and heavy drinking confers a three-fold increase in suicide risk. Physical illness also raises suicide risk, particularly in terminal and chronic conditions.

Local stakeholders were consulted through interviews with local organisation working with the wider determinants of mental health and through an online survey distributed to local primary care. This consultation showed that migrants, men and deprived communities were thought to be at the greatest risk of mental health problems locally. In contrast, women are more likely to approach their GP for mental health support. The most commonly reported triggers for mental health crisis were (1) relationships, (2) employment, (3) housing and (4) drugs/alcohol.

The most common concerns with mental health support provision in Wolverhampton currently are (1) waiting times, (2) needing to be referred via GPs, (3) the system being too complicated (particularly with regards to dual diagnosis patients) and (4) language barriers. Waiting times were mentioned by more than 60% of community groups. Although the referral rate is lower for Wolverhampton IAPT than the national average, the waiting times are longer. Although almost half of stakeholders reported needing to be referred by a GP as a barrier to access, Healthy Minds introduced self-referral in late May during the writing of this project.

The greatest supply of services locally is for women and the Asian community. This is in contrast to the areas of need identified by both data and stakeholder consultation. Therefore, the biggest gaps in provision are for men and for migrants. When considering geography, there is a paucity of mental wellbeing support in Bilston, and a lack of third sector mental health support in Whitmore Reans (both of which being highly deprived areas and therefore likely in great need of support).

Key Recommendations

These recommendations have been formulated based on the findings of the report as well as comments from the confirm and challenge workshop of key local mental health stakeholders.

- The mental health service directory should be redesigned to become more easily accessible and to facilitate it being kept up-to-date. It should be well-advertised to the local population.
- Access to low-tier statutory services should not be limited to referral via GPs alone.
  NB. This is currently being superseded by self-referrals for Healthy Minds
- Ways to limit mental health deterioration while awaiting treatment should be explored and the Healthy Minds waiting lists should be monitored during the transition to self-referrals.
- Frontline staff, in health and non health occupations, for example the police, fire and rescue, and those who come into contact with people who are homeless, unemployed, on benefits,

socially isolated or otherwise vulnerable should be confident and competent in recognising signs of mental distress and how to support people appropriately and know where to refer onwards if necessary.

- The need for similar training in the voluntary sector should be assessed, especially amongst those groups providing practical support in those areas and with groups that are at higher risk. Training for frontline staff and others can be provided by the Samaritans, or, if focussing on young adults, by Papyrus. Training packages includes ASSIST, Mental Health First Aid, and STORM.
- How to provide more joined-up support for dual diagnosis patients should be considered.
- Men should be encouraged to engage with mental health support and the provision of male-specific services should be increased.
- More should be done to support the mental health of the migrant community.
- Future commissioning should address geographic imbalances – there is a sparsity of mental wellbeing services in Bilston and of third sector mental health support in Whitmore Reans.
- Local communications teams should ensure that when reporting cases of suicide, local media have access to appropriate guidelines, for example, those produced by the Samaritans, and should work with their media contacts should an incident occur.
- Local authority planning teams should consider suicide prevention by ensuring that new developments and plans do not increase access to the means of suicide and also by designing and maintaining suicide prevention signage. Local authorities could also consider working with other transport partners to identify ways to reduce means of suicide on the transport network. Examples include installation of barriers on bridges, erecting signs, and providing access to telephone hotlines.
- Local pharmacies should be engaged in campaigns, for example to support safe medicine management.
- A campaign to raise awareness of suicide prevention amongst the general public and promote suicide prevention guidance, for example by using MIND's 'supporting someone who feels suicidal' and raising awareness by supporting World Suicide Prevention Day should be considered.
- Wolverhampton organisations should consider signing up to campaigns that challenge mental health stigma, such as 'Time to Change'. http://www.time-to-change.org.uk/
- Workplaces should be encouraged to sign up to policies that support positive mental health, as outlined in NICE guidance 'promoting mental wellbeing at work' (NICE Guidance PH 22) http://www.mind.org.uk/information-support/types-of-mental-health-problems/suicide-supporting-someone-else/#.Vfl5GxFViko
- The emerging issue with new psychoactive substances ('legal highs') should be investigated.
- How best to manage data sharing appropriately between organisations should be investigated, in order to try to allow improved joined up working across the city.

"The best results for mental health promotion, mental illness prevention, and suicide prevention have been achieved by initiatives that […] address a combination of known risk and protective factors, set clear goals, support communities to take action, and are sustained over a long period of time."

Changing Directions, Changing Lives: The Mental Health Strategy for Canada (121)

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Suicide Prevention Wolverhampton Local Suicide Action Plan

1. National strategic setting for developing a local suicide action plan

In 2012 the government published Preventing Suicide in England: A Cross Government Outcomes Strategy to Save Lives[1]. This strategy has been followed up with annual reports – the latest being a two year follow up published in 2015.[2]

The development of a local suicide action plan is one of the recommendations in the strategy and Public Health England (PHE) has issued guidance for developing a local suicide prevention action plan[3]. However, an All-Party Parliamentary Group (APPG) on Suicide and Self-harm Prevention conducted a survey [4] on Local Suicide Prevention Plans which found that:

- around 30% of local authorities do no suicide audit work;
- around 30% of local authorities do not have a suicide prevention action plan;
- around 40% of local authorities do not have a multi-agency suicide prevention group.

Following the public health transfer from the NHS into local government in April 2013, suicide prevention consequently became a local authority led initiative working closely with the police, clinical commissioning groups (CCGs), NHS England, coroners and the voluntary sectors. The 'One Year On' report called on local authorities to

- develop a suicide prevention action plan
- monitor data, trends and hot spots
- engage with local media
- work with transport to map hot spots
- work on local priorities to improve mental health

The draft action plan outlines how these issues will be addressed in Wolverhampton.

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[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf

[2] Preventing suicide in England: Two years on Second annual report on the cross-government outcomes strategy to save lives https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/405407/Annual_Report_acc.pdf

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

[4] The All-Party Parliamentary Group (APPG) on Suicide and Self-Harm Prevention https://www.papyrus-uk.org/repository/documents/editorfiles/appgsp20jan2015.pdf

2. Context for developing a suicide prevention action plan

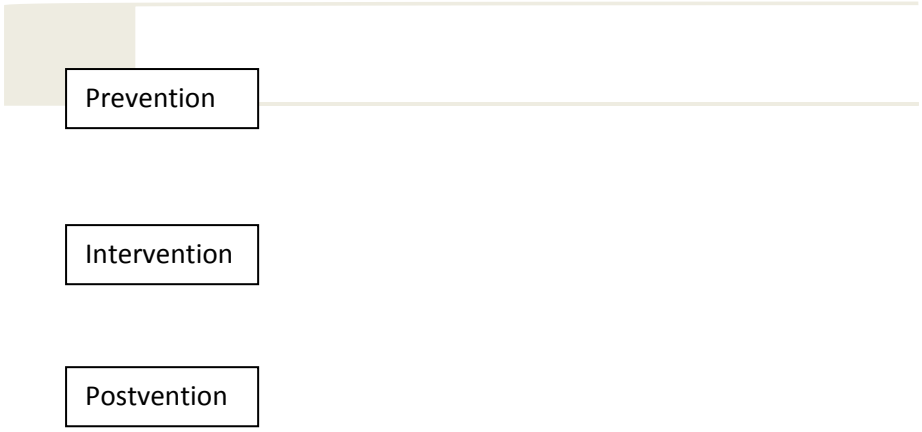
The development of any suicide prevention action plan should be set into the context of the fact that:

- The national data available for England and Wales shows that **only 28%** of suicides occur in people who are in contact with services.
- i.e. **72%** of those who died by suicide were **NOT** in touch with secondary MH services within one year prior to death, highlighting the need for a Public Health approach to Suicide Prevention

The Wolverhampton Suicide Audit 2004-2008[5] showed 57% of suicide victims were not known to mental health services.

Based on this, Figure 1 outlines a three pronged approach to tackling suicide.[6]

Figure 1: A three pronged approach to suicide prevention



Source: – Helen Garnham, Public Health Manager Mental Health

1. **Prevention** - recognises a sliding scale of opportunities to intervene and the need to have a wider programme of work to reach the 72% of those not in contact with services. Key factors in particular include the need to reach those at higher risk, i.e. men, those suffering from alcohol or drug misuse, those unemployment, people with family and relationship problems, or those who are socially isolated

2. **Intervention** - to ensure that all opportunities to prevent suicides within mental health settings are taken and also to push for zero suicides when in care of NHS services[7]
3. **Postvention approaches** recognise the fact that:

[5] Mental Illness and Suicide Prevention: Wolverhampton Needs Assessment 2015
A collaborative project between Wolverhampton City Council Public Health and Wellbeing Team and Wolverhampton Samaritans, July 2015

[6] PHE National Presentation on Six Steps to Suicide Prevention – Helen Garnham, Public Health Manager Mental Health. Public Health England Suicide Prevention Stakeholder Workshop Event 21st October 2015

[7] https://www.gov.uk/government/news/nick-clegg-calls-for-zero-suicides-across-the-nhs

- Those exposed to or bereaved by suicide are up to 3 times more at risk of taking their own lives
- Specific known groups can be targeted for follow up
- There are opportunities to work more closely with local press to entrench responsible reporting approaches in the media
- There are opportunities to work with the voluntary sector for example Bereavement Support Partnership.

Based on this model, PHE has produced a 6 key steps model towards reducing suicide in each local area. These are:

	Key Step	Progress in Wolverhampton
1.	Form a local / sub-regional suicide prevention network	The first meeting of a new group, the Suicide Prevention Stakeholder Forum has been arranged for 10th December 2015. This is following a decision made at the Mental Health Stakeholder Forum that a new, multiagency forum was needed to address the suicide prevention agenda.
2.	Create an action plan	See section 3 below.
3.	Conduct a local / sub-regional suicide audit	A local suicide audit was undertaken in Wolverhampton in 2010 A more comprehensive suicide prevention needs assessment was conducted in July 2015 and which forms the evidence base for the recommendations in the action plan.
4.	Work towards becoming a suicide safer community	To be addressed in action plan
5.	Work towards establishing a postvention service	To be addressed in action plan
6.	Push for Zero suicide approach in local NHS care – both primary and secondary	To be addressed in action plan

3. Wolverhampton Suicide Prevention Action Plan

The following draft action plan is organized by the 6 action plan objectives outlined within the *Preventing Suicide in England* strategy. These are:

Six Key Areas for Action

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

Wolverhampton Suicide Prevention Action Plan

The action plan was drawn up at the mental health stakeholder forum 29th September 2015 and organised into the 6 key areas for action in the national Suicide Prevention Strategy as recommended by PHE

The action plan will be a changing and dynamic document and reflects what has been achieved to date.
An ongoing development of the action plan is to establish links to CAMHS, the HeadStart programme and wider children's services
We will also work to establish the suicide prevention programme as part of the crisis concordat workstream

Short term = within 3 months
Medium term = within 12 months
Long term = over 12 months

Wolverhampton Suicide Prevention Action Plan: Six Key Areas for Action

Timescale (S, M, L term)

1. Reduce the risk of suicide in key high-risk groups - GATE KEEPER TRAINING/ MENTAL HEALTH PROMOTION

	Recommendation	***What should/could be done?***	***By whom?***	**Progress**
1.1	Gatekeeper training Merged 1.1 and 1.2 Frontline staff, in health and non-health occupations, for example the police, fire and rescue, and those who come into contact with people who are homeless, unemployed, on benefits, socially isolated or otherwise vulnerable should	Mental health first aid - Light: half day - Full: two days Terry Rigby Suicide prevention training "who is your mental health	MHFA NM to coordinate e.g. Al, college, housing association, P3, Uni + embed Wolv referral process into the training Need to unpick difference	**Progress Dec 2015** NM to produce a table that scopes different training packages, their advantages and disadvantages and their costs and circulate to members **Progress March 2016 (SW)** A list of training packages produced.

	Recommendation	*What should/could be done?*	*By whom?*	**Progress**
	be confident and competent in recognising signs of mental distress and how to support people appropriately and know where to refer onwards if necessary Scope the need for similar training in the voluntary sector, especially amongst those groups providing practical support in those areas and with groups that are at higher risk. Training for frontline staff and others can be provided by the Samaritans, or, if focussing on young adults, by Papyrus. Training packages include ASSIST, Mental Health First Aid, and STORM. Timescale S - M	champion?" NCFE level II in mental health awareness over 2 months	between mental health first aid and suicide prevention training; identify costs e.g. for groups and level of interest	A programme (2 X sessions) of safeTALK training commissioned and arranged for 21st March 2016. 60 places available. 51 People attended. Notes available including suggested priorities for future action planning.
1.2	The locations of services should be taken into account during future commissioning. This piece of work highlighted that Bilston had a sparsity of mental wellbeing services, while Whitmore Reans had a relative lack of mental health related third sector provision. Timescale S - M	Need to unpick this further	Commissioners across health and council	**Progress Dec 2015** Request members look at what they are doing in these areas. Need to be fed into discussion with commissioners SW NM **Progress March 2016 (SW)** No progress
1.4	The provision of 'drop-in' support, potentially to be provided by the new Mental Wellbeing Hub, should be	Drop in already exits Awareness raising needed on purpose/remit	Emma Smith	**Progress Dec 2015** Recovery House facilitate the drop ins Aiesha follow up with Emma

	Recommendation	***What should/could be done?***	***By whom?***	**Progress**
	clarified and then advertised locally. Timescale S			**Progress March 2016**
1.5	Wolverhampton could look to provide more support for the local migrant community a. What mental health support is available to asylum seekers at each stage of their application should be clarified and communicated to migrants and local providers; b. Future commissioning should consider providing migrant-specific support in a location that feels 'safe' and is not associated with stigma – for example, in the RMC; Timescale S - M	Event in October MH and migrant communities. Piggy back on this for T &F group action plan forthcoming and needs to be followed up	Jackie Mc C LA Comm Emma Smith/ Hub a/b RMC Health Champions T&F group needed	**Progress Dec 2015** Some members attended the October event. Agreed to invite a member of the Refugee and migrant centre to attend the group. Action SW to chase DN re the action plan following the October event **Progress March 2016 (SW)** Follow up meeting held on 29th Feb 2016 and range of actions agreed some of which had cross overs to the suicide prevention action plan, specifically Mental health directory Training Mens' health A member of the RMC has been invited to attend the suicide prevention stakeholder forum
1.6	Wolverhampton organisations should consider signing up to campaigns that challenge mental health stigma, such as		SW and NM to take a look and come up with a plan that is disseminated and	See item 1.7 below

	Recommendation	***What should/could be done?***	***By whom?***	**Progress**
	'Time to Change'. http://www.time-to-change.org.uk/ Timescale S - M		then followed up	
1.7	Workplaces should be encouraged to sign up to policies that support positive mental health, as outlined in NICE guidance 'promoting mental wellbeing at work' (NICE Guidance PH 22) http://www.mind.org.uk/information-support/types-of-mental-health-problems/suicide-supporting-someone-else/#.Vfl5GxFViko Timescale S - M	Join up with workplace health initiative being led by Public Health – starts with the council, university, hospital and college adopting the workplace health charter	SW to talk to Richard Welch	**Progress Dec 2015** Links made to WCC workplace health initiative **Progress March 2016 (SW)** Local initiatives have been undertaken in WCC to support 'Time to Talk day' and World Suicide Prevention day. To support ' Time to Talk' an article appeared in City People and leaflets and resources were distributed around the Council (including buildings outside the Civic). The Healthy Lifestyles team had a presence in the Civic foyer to talk about overall healthy lifestyles and provide information about mental wellbeing. In addition, Wolverhampton Community & Wellbeing Hub also had a presence in the Civic Foyer, promoting their service and also offering resources and information on mental wellbeing. The Community & Wellbeing Hub also ran their own Time to Talk event at Epic Café.
1.8	The mental health directory should be	- Primarily make		**Progress Dec 2015**

	Recommendation	*What should/could be done?*	*By whom?*	**Progress**
	updated to become more easily accessible a. It could be available both as a paper directory and an interactive electronic tool; b. There could be two paper versions – one for service users and another for providers; c. The electronic copy should be easy to navigate according to the user's demographics, issues and the types of service they prefer. Timescale S	electronic so could be downloaded if necessary or view on line - First task is to make existing directory fit for purpose and improve search engine - Make it possible for services to update on a regular basis - Services make links to the directory from their own web sites - Link to WCC WIN	WCC IT SW and NM	NM reported that conversations are happening Agreed Neeraj find out more – investigate with WIN and with CCG **Progress March 2016 (SW)** Directory additionally agreed as a priority by for mental health and migrant communities. SW /SA met with Kuldip Khela re taking this forward on 14th March
1.9	Men should be encouraged to engage with initiatives that improve mental wellbeing • In community places where there is a significant male presence, advertising	- All organisations should make sure that existing services are advertised appropriately and encourage and are accessible for men	All via T&F group This needs some leadership to drive forward NM to talk to media company being used in public health	**Progress Dec 2015** Agreed Neeraj to lead a task and finish group. To tie into the alcohol agenda – reach out to younger men at risk of alcohol harm. Also include Aeisha, Helen Kilgallon and St George's hub

	Recommendation	*What should/could be done?*	*By whom?*	**Progress**
	could be used to address stigma against men expressing their mental health; • People working in community places where there is a significant male presence could be advised/trained to signpost men to relevant mental wellbeing services; • Future commissioning should consider increasing mental wellbeing support services for men. This could take the form of a physical activity, such as football. Delivering two sessions to 20 participants per week is likely to cost £22,830 per year. Timescale S - M	- Those that are socially isolated are at most risk – will not attend so focus on places where they have to go – e.g. banks, job centre - Need to skill up those working in jobcentres etc. in mental health awareness/suicide prevention - Could provide counselling in job centres - Need to be creative to encourage participation Word of mouth can make or break NB – to get people in distress to engage and to encourage identification of those at risk, we need to have support in place – links to an updated directory		**Progress March 2016 (SW)** No progress with setting up T&F group A member of PH team to attend the ManMade conference in June 2016. This conference provides delegates with an overview of innovative and effective ways of supporting men who are finding it difficult to live life. A report will be provided to the Forum to inform the work of the action plan.

	Recommendation	***What should/could be done?***	***By whom?***	**Progress**
1.10	Raise awareness of suicide prevention amongst the general public and promote suicide prevention guidance, for example by using MIND's 'supporting someone who feels suicidal' and raising awareness by supporting World Suicide Prevention Day. Timescale S - M	- Do we need another 'suicide symposium' - Annual public awareness raising event or campaign for general public - Individual stories very powerful - Could link to world suicide prevention day - Raise awareness of suicide prevention in schools	T&F group (include comms reps) prepare for September 2016 event	**Progress Dec 2015** SW to lead a T&F group to lead on a suicide symposium to tie in with the World Suicide prevention day in September. Include Comms leads Steve re Healthy minds website. SW to get this going **Progress March 2016 (SW)** No progress made to date.
1.11	Local pharmacies should be engaged in campaigns, for example to support safe medicine management. – to be included in Healthy Living Pharmacies initiative Timescale S - M	Engage LPC	PH talk to NHS facing team within public health	**Progress Dec 2015** SW had discussed with PH Pharmacy lead. Take forward through Healthy living pharmacies. Change wording of action to reflect this. **Progress March 2016 (SW)** Will be ongoing through Healthy Living Pharmacies and progress is dependent on HLP project timescale

2. Tailor approaches to improve mental health in specific groups

	Recommendation	***What should/could be done?***	***By whom?***	**Progress**
2.1	Access routes for crisis patients should be clarified and communicated to community stakeholder organisations, particularly those who are faced with the situation infrequently Timescale S	Access routes for crisis patients • LA website • BCPFT website • Mental health first aid kit training - laminated sheet	SF	**Progress Dec 2015** Action: SF to be followed up re progress Lee Davies to forward 'Yellow book' to be shared to see if this would help to clarify access routes **Progress March 2016** .
2.3	Ways to limit mental health deterioration while waiting for treatment should be explored a) Training on the recently developed mental health pathways could be delivered to GPs to try to reduce bouncing referrals *b) NB. The recent introduction of GP link workers can also work to this aim* c) Training could also be delivered to trainee	1c Check who delivers 1d In hand	1a CCG) Need to find out what these are and organise team W session with GPs 1b Healthy Minds NM to talk to Steve Scrimshaw 1d Healthy minds NM to talk to Steve Scrimshaw 1e Healthy minds NM to talk to Steve Scrimshaw	**Progress March 2016** SF followed up to clarify 2.3a) re mental health pathways.

	doctors with 4-6 month general practice placements via the weekly teaching programme delivered at New Cross Hospital; d) Waiting lists for Healthy Minds should be monitored during the transition to self-referrals, and long / lengthening waiting times should be addressed; e) Once a patient has been triaged after using their 'Ticket to Recovery', Healthy Minds could inform the GP of the likely waiting time for that service. If a long wait, the GP could arrange an intervening check-up (potentially via phone). Timescale 1a S 1a S 1c			
2.4	The possibility of providing more holistic		SF CCG	**Progress Dec 2015**

	and joined-up support for dual diagnosis patients should be explored. Timescale M		NM to work on joint protocol between substance misuse and mental health services	NM to liaise with Sarah and Steve **Progress March 2016**

3. Reduce access to the means of suicide

	Recommendation	***What should/could be done?***	***By whom?***	**Progress**
3.1	Local authority planning teams should consider suicide prevention by ensuring that new developments and plans do not increase access to the means of suicide and also by designing and maintaining suicide prevention signage Timescale M	LA planning It does matter – Birmingham library	PH to link to LA planning team SW to talk to Richard Welch	**Progress Dec 2015** No progress Action: SW to follow up **Progress March 2016** SW met with Richard White, Wider Determinants Specialist, Public Health who leads on linking public health and planning. Birmingham are developing a toolkit - **The Birmingham Approach to Planning, Development, Health and Wellbeing Toolkit** and it was agreed to suggest an extra criteria in the toolkit to include suicide prevention and mental wellbeing. If agreed, then further detail can be worked up. RW will take this forward, including to the regional meeting on 22nd April.
3.2	Local authorities could also consider working with other transport partners to	Follow up email from network rail	SW to follow up network rail email	**Progress Dec 2015** SW made links with network rail and

	identify ways to reduce means of suicide on the transport network. Examples include installation of barriers on bridges, erecting signs, and providing access to telephone hotlines. Timescale S			invited to attend next meeting Action: SW forward future meeting dates Also agreed to invite British transport police Action for Lee Davies Also invite British waterways Action been invited **Progress March 2016** SA to attend Network Rail event on 10th March and to report back to the Forum

4. Provide better information and support to those bereaved or affected by suicide. BEREAVEMENT SUPPORT – HELP IS AT HAND

	Recommendation	***What should/could be done?***	***By whom?***	**Progress**
4.1	The possibility of providing more suicide bereavement specific support could be explored. Timescale S-M	New guidance from NHSE	SF BCPFT/LA + circulate	**Progress Dec 2015** No progress Action: Follow up SF **Progress March 2016** No progress
4.2	Roll out of 'Help is at hand' bereavement support Timescale S	Follow up from PHE Suicide prevention workshop	SW	**Progress Dec 2015** No progress SW to follow up

				Progress March 2016 Help is at Hand materials are free of charge and are available on batches of 20 copies per order. Need to scope which organizations are using in Wolverhampton. NB – at the SafeTALK training, none of the 51 participants had heard of this resource

5. Support the media in delivering sensitive approaches to suicide and suicidal behavior SUICIDE CLUSTER GUIDANCE

	Recommendation	***What should/could be done?***	***By whom?***	**Progress**
5.1	Local communications teams should ensure that when reporting cases of suicide, local media have access to appropriate guidelines, for example, those produced by the Samaritans, and should work with their media contacts should an incident occur. Timescale S - M	- Training/awareness raising of comms leads - What about with local media too? - How does the local press get hold of stories? - Need to work with local coroner - (NB re coroner – need to record not just ethnicity but sexuality and all protected characteristics)		**Progress Dec 2015** Agreed to try and get a lead from Comms in the council NM/SW ask who would be able to support **Progress March 2016** No progress

6. Support research, data collection and monitoring REAL TIME SUICIDE MONITORING

	Recommendation	***What should/could be done?***	***By whom?***	**Progress**
6.1	The routine collection of ethnicity data could be discussed with the local coroner to understand whether national change is being discussed, and to lobby for change locally. This data will help guide future service provision in an evidence-based manner. Timescale 1. S 2. S-M 3. S - M	1. Revisit the national plan 2. BCPFT capture • Ethnicity • Suicides • Attempted suicides (look into accessing this data) 3. Local coroner: understand how the coroner uses demographic data and what is asked for	DPH DPH + CEO, BCP DPH, CEOs of CCG and LA	**Progress Dec 2015** No progress **Progress March 2016** No progress
6.2	Annual update of suicide outcome briefing /suicide needs assessment Timescale L	Public Health Intel team update suicide briefing	KB (PH Intel)	**Progress Dec 2015** Will provide when new data available. **Progress March 2016** As above
6.3	Explore real time suicide monitoring Timescale S- M	Public Health Intel team follow up from PHE suicide prevention workshop	KB (PH Intel)	**Progress Dec 2015** Progress – pilot sites contacted. Need to follow up **Progress March 2016** Awaiting update from PHE

6th March 2016

Agenda Item No: 14

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

27 April 2016

Report title	Better Care Fund 2016/17 outline plan	
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Wellbeing	
Wards affected	All	
Accountable director	Viv Griffin, Service Director Disability and Mental Health	
Originating service	Adult Services	
Accountable employee(s)	Tony Marvell	People Directorate
	Tel	01902 551461
	Email	Tony.marvell@wolverhampton.gov.uk
Report to be/has been considered by	People Directorate Management Team	11 April 2016
	Integrated Commissioning and partnership Board	21 April 2016
	BCF Programme Board	21 April 2016

Recommendation(s) for noting:

1. To note the progress towards the development of the Section 75 agreement between City of Wolverhampton Council (CWC) and the Wolverhampton Clinical Commissioning Group (CCG).

2. To note the arrangements for final submission to NHS England of the Wolverhampton Better Care Fund 2016/17 delivery plan.

1.0 Purpose

1.1 To advise Health and Wellbeing Board of the progress towards the establishment of a Section 75 Agreement between City of Wolverhampton Council ("CWC") and the Wolverhampton Clinical Commissioning Group ("CCG"), for the purposes of delivering the Better Care Fund in the business year 2016/17.

1.2 To advise Health and Wellbeing Board of the progress for developing the 2016/17 delivery plan. As previously agreed final approval of the 2016/17 BCF delivery plan is delegated to the Chair of the Health and Wellbeing Board, Cllr Samuels and Cllr Mattu with advice from the Transformation Director CCG (Steven Marshall), and BCF Lead for the CWC (Viv Griffin).

2.0 Progress, options, discussion, etc.

Section 75 agreement

2.1 The revenue value of the current proposed pooled fund to be managed via the S. 75 agreement is £54.3 million and consists of £32.6 million (60%) of CCG funded services alongside, £21.7 million council funded services (40%). The council contribution includes £6.4 million representing the NHS transfer to social care ('Section 256 funding). The pooled budget also includes capital grant (Disabled Facility Grant) amounting to £2.4 million which are managed by the council.

2.2 The detailed section 75 agreement includes a risk sharing arrangement (based on the proportion of each partner contribution (CCG 60% and CWC 40%).

2.3 The detailed legal document is currently being drafted by legal teams across CWC and the CCG, and it is expected that this will be in place by May 2016.

2.4 The summary breakdown of the Section 75 is provided in the financial summary of this document.

2016/17 Better Care Fund Delivery Plan

2.5 In the last spending review Government confirmed the intention to move Health and Social Care into a more integrated state by the business year 2019/20, in recognition of the fact that health services cannot operate effectively without good social care. To support Local Authorities to meet growing social care needs government also confirmed an option for local authorities who are responsible for social care to levy a new social care precept of up to 2% on council tax. The additional money raised will have to be spent exclusively on adult social care.

2.6 Government also reconfirmed the Better Care Fund ("BCF") as a key national policy directive for the rest of the current parliament and that the Better Care Fund would be the vehicle used to support that integration. The principle aims of the BCF continue to be the reduction of accident and emergency admissions, improvement to the level of delayed transfers and reduction in the number of care home admissions by investing in joined up health and social care services focused on prevention.

2.7 In December 2015 NHS also published the guidance "Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21"

Which in summary mandates:

- A five year Sustainability and Transformation Plan ("STP"), place-based and driving the Five Year Forward View; and a one year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP

- Place based planning - Planning by individual institutions will increasingly be supplemented with planning by place for local populations, and the agreement of transformation footprints' and the programming of clear deliverables across the STP

2.8 Work across both the Black Country and West Midlands regional areas is underway to jointly agree regional footprints and the Wolverhampton STP.

2.9 On 11 January Department of Health/Department for Communities and Local Government released the BCF policy framework for 2016/17. From this guidance the key points relating to the operation of the BCF in 2016/17 are:

- The National £1 billion payment for the performance element of the Better Care Fund and mandated local targets for the reduction of delayed transfers of care have been removed from BCF arrangements replaced by two new national conditions:

    - Local areas to fund NHS commissioned out-of-hospital services (to ensure continued investment in NHS commissioned out-of-hospital services, which may include a wide range of services including social care).

    - To develop a clear, focused action plan for managing delayed transfers of care (DTOC), including locally agreed targets. The conditions are designed to tackle the high levels of DTOC across the health and care system. Councils, CCGs and NHS providers will have to agree a local target for cutting delayed transfers of care.

- The policy framework provides for more flexibility for Councils and CCGs to put more money into the pool funding arrangement with more flexibility to agree local risk sharing agreements.

- The assurance process for better care fund plans is underway for the 2016/17 period. Assurance plans are not subject to a national assurance process. Instead, local plans are being assessed by regional teams including NHS England and local government officials. Plans will only be approved centrally where areas are designated “high risk”.

2.10 The detailed technical guidance was received in March 2016 (three months later than planned). The moderation process for plans is now underway based on the following time-table:

Date	Requirement
March 2	A spread-sheet return containing plans around Performance indicators
March 21	A draft narrative document and a revised spread sheet return
March 21 – April 5	Regional moderation process
April 5	Feedback from first draft narrative
May 4	Final narrative submission
Mid May	The results of Regional moderation for the final narrative document will be released to Wolverhampton

Plans are being assessed and moderated based on two criteria:

Plan development – which looks at the overall compliance of the submission based against a series of KLOE (“Key line of enquiry”) statements leading to either a low, medium or high rating for individual plans.

Risk assessment – An assessment by the regional assurance team in terms of the overall likelihood that an individual plan will be delivered.

The Wolverhampton plan was submitted in draft form on March 21 which in summary included detailed information surrounding:

- Funding arrangements
- The Wolverhampton strategic plan (5 year view, Vision for Health and Social Care Services 2019/20)
- Risk management
- Governance arrangements

Following regional assessment of the draft Wolverhampton plan, the plan has been rated as “low” for plan development, and “low risk”. This has provided an overall rating for the Wolverhampton plan as “approved with support”.

At the time of this report the programme team are reviewing some areas of the submission in readiness for the final deadline (4 May) with a view to improving the ratings described above for the next submission.

3.0 Financial implications

3.1 The current proposed revenue pooled budget is £54.3 million, of which £21.7 million is a contribution from Council resources and £32.6 million from the CCG. The Section 75 agreement details the risk sharing arrangements for both organisations for any over / under spends with in the pooled budget. In addition to the revenue services pooled budget also includes a capital grant (Disabled Facility Grant) amounting to £2.4 million which are managed by the council.

3.2 The pooled fund requires efficiencies to be realised to fund the council's demographic growth of £2 million.

3.3 The better care policy framework document indicates that "Within the Better Care Fund allocation to Clinical Commissioning Groups is £138 million to support the implementation of the Care Act 2014 and other policies (£135 million in 2015/16)." The 2015/16 figure for Care Act monies of £964,000 has been included within the pooled fund calculation for 2016/17. At the time of signing off the pooled budget the value of the inflationary uplift for the year has yet to be confirmed and therefore this uplift will be agreed by the end of quarter one alongside any other material adjustments for the final 2015/16 outturn.

3.3 The draft pooled budget is broken down into the following work streams:

Work streams	CCG Funded services (£000)	Council Funded services (£000)	Total Services (£000)
Adult Community Services	24,015	18,637	42,652
Dementia	2,586	320	2,906
Mental Health	5,997	2,718	8,715
Total Contribution to Pooled Fund	**32,598**	**21,675**	**54,273**
(Ring Fenced Capital Grants)		2,440	2,440

3.4 The risk sharing arrangements for any over/underspends with the pooled fund and the non-delivery of efficiencies as detailed in section 3.3 will be shared as follows:

	CCG Risk %	Council Risk %
Adults Community Services	56	44
Dementia	89	11

	CCG Risk %	Council Risk %
Mental Health	69	31
Ring Fenced Capital Grant	0	100
Demographic Growth	60	40
Care Act Monies	TBC	TBC

[AS/19042016/D]

4.0 Legal implications

4.1 A Section 75 agreement was in place for the delivery of the BCF plan during 2015/16. A new Section 75 agreement is currently being drafted to cover the period 2016/17.

4.2 Section 75 of the NHS Act 2006 (the “Act”) allows local authorities and NHS bodies to enter into partnership arrangements to provide a more streamlined service and to pool resources, if such arrangements are likely to lead to an improvement in the way their functions are exercised. Section 75 of the Act permits the formation of a pooled budget made up of contributions by both the Council and the CCG out of which payments may be made towards expenditure incurred in the exercise of both prescribed functions of the NHS body and prescribed health-related functions of the local authority.

The Act precludes CCG's from delegating any functions relating to family health services, the commissioning of surgery, radiotherapy, termination of pregnancies, endoscopy, the use of certain laser treatments and other invasive treatments and emergency ambulance services.

[RB/11042016/]

5.0 Equalities implications

5.1 Each individual project within the work streams has identified equality implications, and a full Equality Impact Analysis has been carried at work stream level.

6.0 Environmental implications

6.1 Each individual project within the work streams will identify environmental implications, such as the need to review estates for the co-location of teams and services.

7.0 Human resources implications

7.1 Each individual project within the work streams will identify HR implications. HR departments from both Local Authority and Acute Providers are already engaged in discussions regarding potential HR issues such as integrated working and change of base for staff.

8.0 Corporate landlord implications

8.1 Corporate Landlord (Estates Valuation and Disposals) meets regularly with the Task and Finish Team and is working with the Team to assist and evaluate if any of the assets within the existing NHS and Council Estate is suitable for reuse to support the BCF proposals The BCF programme is currently initiating an additional estates and infrastructure project which will consider accommodation options on a city wide basis.

9.0 Schedule of background papers

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Agenda Item No: 15

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

27 April 2016

Report title	Children's Trust Board Progress Report
Cabinet member with lead responsibility	Councillor Val Gibson Children and Young People
Wards affected	All
Accountable director	Linda Sanders, People
Originating service	Children and Young People
Accountable employee(s)	Emma Bennett Service Director Tel 01902 551449 Email Emma.bennett@wolverhampton.gov.uk
Report to be/has been considered by	PLT 04 April 2016

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1. Support the 2016/17 work programme of the Children's Trust Board

2. Approve the necessary reporting and governance arrangements that are in place to oversee progress of the Children, Young People and Families Plan (2015-25)

1.0 Purpose

1.1 To provide the Board with an update on progress with the Children, Young People and Families Plan (2015-25).

2.0 Background

2.1 The Children's Trust Board has overall governance responsibility of the Children, Young Peole and Families (CYPF) plan 2015-2025. This includes developing and delivering outcomes of the plan and ensuring collective resources of the partners are being effectively and efficiently utilised. The plan wants to achieve an improvement in how healthy and happy children, young people and families living in Wolverhampton are. There are four clear priority areas, these are:

- Child Poverty
- Education, Training and Employment
- Family Strength
- Health

2.2 The work of the Children Trust Board is aligned to the priorities of the Health and Well-being Board; including specifically the wider determinants of health, alcohol and drugs and mental health.

2.3 A performance framework has been developed in order to monitor the success of the priorities and related outcomes outlined in the Children, Young People and Families plan and were agreed in principlel by the Children's Trust Board at a special meeting in May 2015. The performance framework document contains a range of indicators across the four priorities, including, where available, historical data in order to monitor trends and improvements, comparator data, trajectory of performance and where appropriate, RAG ratings.

2.4 As the Board become aware of new developments and emerging issues, the performance framework is adjusted to reflect additional data becoming available and ensuring we use 'meaningful data.'

2.5 With the plan in place, along with other initiatives such as; phase two of Troubled Families, the SEND reforms, organisational changes such as the City of Wolverhampton Children Services transformation and a backdrop of working in times of austerity, a review of the Children's Trust Board structures has been undertaken. This identified a significant overlap of membership, terms of reference and work priorities. To ensure efficiency and effectiveness of resources the Children's Trust Board reduced the number of boards and in particular where boards have significant cross membership and purpose to amalgamate. A structure chart is available in Appendix 1. In addition to this, the Board agreed to disband the Children Trust Executive Group which had the role of performance. This function now sits with the Children Trust Board.

3.0 Progress

3.1 The table below provides a snapshot on progress over the last 12 months

PRIORITY ONE: Reduce the harm caused by child poverty	
Areas of Strength	**Areas for Development**
The proportion of children who live in the areas that are designated as the most deprived as per the IDACI scores that attend good or outstanding schools and the proportion of schools with the highest proportion of those children that are rated good or outstanding is increasing and is significantly better than the West Midlands average.	Attainment for those children who are not eligible for Free School Meals at EYFS is Improving This is below that of comparators.
Attainment for children who are classed as disadvantaged, non-disadvantaged, eligible for Free School Meals and not eligible for Free School Meals is improving across EYFS and KS2 is generally improving and is in line with or better than that of statistical neighbours. The attainment gaps between these groups is also better than comparators.	Attainment for children eligible for Free School Meals at KS4 has fallen and is below that of comparators and the gap between those children and the ones who are not eligible for Free School Meals has increased
The number of families and young people who are homeless remains steady.	The number of families who are being placed in supported accommodation is falling due to those being referred having higher needs and remaining in service longer, affecting the throughput.

PRIORITY TWO: Increase achievement and involvement in education, training and employment Young children are well prepared when they start school	
Areas of Strength	**Areas for Development**
The number of children taking up Terrific for Two's placements is steady. 100% of required places have now been identified.	Children's centre engagement with the most deprived children is improving (61.2%) but remains below the level that Ofsted have determined is 'Good' (65%). This is due to a greater focus on targeted work.
GCSE performance has improved significantly this year and is better than that of statistical neighbours.	There is an improvement in English at KS4 This is still below that of comparators
The average points score of candidates undertaken A-level or equivalent vocational training is better than statistical neighbours, the West Midlands and England averages and Wolverhampton are ranked 14th.	The percentage of young people achieving AAB or better at A-level is below that of comparators.

PRIORITY TWO: Increase achievement and involvement in education, training and employment Young children are well prepared when they start school	
Areas of Strength	**Areas for Development**
For children and young people who are exlcuded from school 91% were found alternative provision by the 6th working day with the average number of days taken to find alternative provision being just four.	
The number of inadequate schools has decreased by one and the number of outstanding schools has increased by one. The overall percentage of schools rated good or outstanding continues to increase.	
The proportion of young people in Education, Employment or Training, overall and within specific vulnerable groups is generally good or improving.	

PRIORITY THREE: Make Families Stronger	
Areas of Strength	**Areas for Development**
The number of Early Help Assessments that are being completed is increasing,demonstrating that families are receiving help sooner which in turn will prevent an escalation to statutory services. The City of Wolverhampton Children's Service transformation. This includes services operating on a universal level, accessible to all families; strengthening families offer, focussing on families with additional need; targets early intervention prevention service who will work with families needing additional intensive support and specialist intensive support services working with families who are at the highest risk of family breakdown.	The proportion of children who were classed as Children in Need over the last 12 months continues to increase, however this is largely due to a sharp rise in numbers between December 2014 and March 2015. The recent reductions in numbers seen throughout the rest of the year means that this indicator should begin to improve significantly from March onwards.
Phase 1 – Troubled Families - 810 Families turned around - Crime, ASB, Absence from school reduced for 683 families. Attendance saving of over £100,000 - 182 adults secured employment for more than six months	The numbers of Looked After Children has significantly reduced from 780 (March 31st 2015) to 659 (March 31st 2016) The number is higher than that of comparators.

PRIORITY THREE: Make Families Stronger	
Areas of Strength	**Areas for Development**
- 31 adults made progress to work **Phase 2** - The number of families identified and engaged on the programme at the end of March 2016 is 517. - Submitted first PBR claim for 12 families	
The rates and numbers of children subject of a child protection plan or Looked After continues to fall and are the lowest that they have been for several years and are demonstrating the effectiveness of the transformation programme.	The number of children who are the subject of a CP Plan for a second or subsequent time is falling, but as a percentage remains higher than comparators - however, this is affected by the reducing CP numbers which can inflate the percentage.

PRIORITY FOUR: Improve the health of children, young people and families	
Areas of Strength	**Areas of Potential Weakness or Concern**
The proportion of children who are overweight is falling particularly in reception year, however, rates remain higher than comparators.	Decrease in women who smoke during pregnancy. This can be attributed by the effect of the implementation of CO monitoring at every antenatal visit and Healthy Lifestyle Service support for smoking cessation in pregnancy. The number is higher than that of comparators.
The percentage of parents and children who are successfully completing substance misuse treatment programmes is increasing and where comparator information is available Wolverhampton is performing better than comparators.	The number of representations to substance misuse treatment programmes is increasing for both children and adults.
- Increase in the number of families supported by the Information Advice and Support Service - SEND strategy has been co-produced, consulted on and ratified. - The Local Offer has been published on Wolverhampton Information Network (WIN) - Partnership working is very strong across education health and care in the delivery of the SEND reforms	

PRIORITY FOUR: Improve the health of children, young people and families	
Areas of Strength	**Areas of Potential Weakness or Concern**
*** The mental health indicators within this priority are currently under review***	

3.2 As the framework becomes more complete and developed, the focus will continue on strengthening commentary and analysis in order to provide further context to the data. This will enable a better assessment of strengths and weaknesses which will assist the Board in identifying areas of good practice and improvements and making recommendations of appropriate actions in order to ensure the successful delivery of the Children, Young People and Families plan.

3.3 On the 8 March 2016 the Board held its annual stakeholders event. When the Children's Trust Board launched the Children Young People & Families Plan, a commitment was made to ensure stakeholders are kept informed on progress. Over 80 delegates attended the event to hear about the progress. The event included the voice of the young people.

4 Next Steps

4.1 The Children's Trust Boad have agreed their focus areas for the next two years. The focus areas will be spotlighted for further, in-depth analysis. These include reducing homelessness, CAMHS transformation, Families in Focus (Troubled Families programme) and post 16 education provision.

Spotlight Focus	Why	What we want to achieve
Reducing youth homelessness	In 2015/16 there was 1026 homeless ness applicants . Of these 246 where in the16-24 age group. The high prevalence of homelessness amongst certain age groups is of particular interest. People between the ages of 18-25 and 16 -54 make up the vast proportion of cases.	Implementation of review recommendations; - Improve access for 16 and 17 year old young offenders to the supported accommodation - Increase internal provision which has evidenced VFM
CAMHS Transformation	There is currently dis jointed work and there is a lack of clear CAMHS pathway. There is a need to improve the quality of experience and outcomes across CAMHS TIERS 1-4 which includes universal, primary, secondary and tertiary care in health and social	The CAMHS Transformational Partnership Board is responsible for the Re-design of the whole service system delivering emotional health, well-

Spotlight Focus	Why	What we want to achieve
	care and initiatives delivered in the range of the City's education establishments, including for engaged and not engaged and excluded children.	being and mental health services to children, young people and their families This includes; - 70% more children and young people accessing CAMHS by 2020. - Aligning the new service system with early help initiatives (i.e. HeadStart), and universal services (i.e. Health Visitors, and Public Health Nurses) - Reduce need for high cost, out of area interventions - Improving access to intervention - Improving transparency and accountability
Families in Focus	Troubled Families National Government Payment by Result Programme • 2840 families to be turned around by 2020 • 483 families targeted by March 2016 Achieving the target will result in financial injection for Wolverhampton in addition to the social and wellbeing improvements.	- Improved outcomes for children, young people, families, partners, LA and the city - Smaller LAC population - More people in work - Children are better educated - Reduction in ASB
Post 16 Education	Wolverhampton students continued to perform strongly in post 16 vocational subjects in 2015 Nationally, the City is ranked 26th (2014 - 19, 2013 - 42, 2012 - 68, 2011 - 79, 2010 - 129, 2009 -145, 2008 - 145) for average point score per entry, (217.4 compared to a national average of 215.9)	- A post-16 strategy which responds to the needs of all learners. - Sufficient places are available with the right offer being available in the City

Spotlight Focus	Why	What we want to achieve
	However, as at January 2016, Wolverhampton has the fifth highest youth unemployment claimant rate, at 5.9%, of all 326 English local authorities.	for Post 16 SEND - Improve progression into education or employment with training - Improve access to impartial information, advice and guidance - Explore new opportunities with university to raise aspirations and engage with children and young people

5.0 Financial implications

5.1 There are no immediate financial implications arising from this report. [AS/30032016/K]

6.0 Legal implications

6.1 There are no immediate legal implications arising from this report.
[Legal Code: TS/13042016/H]

7.0 Equalities implications

7.1 Equalities is embedded within the performance function of the Plan. All accountable organisations will have an equalities strand which must be reported on as part of the performance update. A key element of the plan is reducing inequalities, nationally, regionally and locally in all 4 priority areas.

8.0 Environmental implications

8.1 There are no environmental implications.

9.0 Human resources implications

9.1 There are no human resources implications.

10.0 Corporate landlord implications

10.1 There are no corporate landlord implications.

11.0 Schedule of background papers

11.1 None

APPENDIX 1- Wovlerhampton City Partnerships

Wolverhampton Adult Safeguarding Board
- Better Outcomes
- Performance & Quality
- Information Sharing
- Prevention
- Communication & Engagement
- Workforce Development
- Safeguarding Adult Review

Wolverhampton Children Safeguarding Board
- Executive Committee

- Communication & Engagement
- Serious Case Reviews
- Child Death Overview
- Learning & Development
- Law, Policy & Procedures
- Quality, Performance & Audit
- Sexually Exploited, Missing & Trafficked Young People

- Children Trust Board
- Public Health Delivery Board
- Transformation Commissioning Board

Boards leading on 4 CYP&F Plan priorities, being:
I. Health
II. Child Poverty
III. Family Strength
IV. Education employment and training

Safeguarding Board

Health & Wellbeing Board

Safer Wolverhampton Partnership

City Board

Wolverhampton School Improvement Partnership

Education Board

Young People – Be- Safe Team
Junior Safeguarding Board

-ODOC/ Gangs
- Offender Management
-Domestic Homicide Review Panel

- Neighbourhood Tasking
- Gangs Steering Group
- Channel
- Street Sex Workers

Partnership Business Support
Partnership Tasking
YOT Management Board
Domestic Violence Forum

- Economic Growth Board (more jobs and address barriers to growth)
- Inclusion Board (get more people into work; tackle homelessness & wider detriments of poverty)

Skills and Employment Board

Liaison with key business stakeholders including the Business Champions, LEP and Growth Hub

STATUTORY HEALTH & WELLBEING BOARD

RESPONSIBILITIES; Joint Strategic Needs Assessment, Joint Commissioning Health & Wellbeing Strategy & Health Improvement Plan, GP Consortium accountability, Health Watch, Public Health, overview of Safeguarding, Annual Plans, Support local voice and patient choice.

Wolverhampton Children Trust Board

RESPONSIBILITIES; Developing and delivering outcomes of the Children, Young People & Families Plan 2015-25.
4 strategic priorities; Health, Child Poverty, Family Strength, Education Training & Employment.

Head Start Partnership Board

- Public Health Delivery Board
- Family mental health & Well-being Board
-SEND Partnership

Strengthening Families (Early Help) Board

- Early Help Plan
- The Troubled Families programme (locally known as Families in Focus)
- Families R First (reducing LAC, by enabling children to remain at home)

-0-18 Locality Boards
- Youth Crime Prevention Group

Inclusion Board
(Get more people into work; tackle homelessness & wider determinants of poverty)

-Education Board
-Strengthening families Board

- Skills and Employment Board
- Economic Growth Board (more jobs and address barriers to growth)

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Agenda Item No: 16

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

27 April 2016

Report title	Feedback on the Combined Authority - Mental Health Commission
Cabinet member with lead responsibility	Councillor Elias Mattu - Adults
Wards affected	All
Accountable director	Linda Sanders
Originating service	Disabilities and Mental Health
Accountable employee(s)	Vivienne Griffin
Report to be/has been considered by	

Recommendations for noting:

The Health and Wellbeing Board is asked to note:

1. The progress to date with regard to the Combined Authority – Mental Health Commission.

1.0 Purpose

1.1 The purpose of this report is to update the Health and Wellbeing Board on the progress to date of the Combined Authority – Mental Health Commission and to raise the profile of the work of the Commission.

2.0 Background

2.1 The West Midlands Combined Authority has commissioned research into mental health and its impact on the public sector. It is believed this commission is the first of its type in the country. The Commission is in the process of considering evidence from around the West Midlands region and beyond and it is considering the experiences of real people with real mental health experiences, as well as the knowledge of professional mental health practitioners and mental health organisations.

2.2 The commission is being chaired by Norman Lamb MP, former Minister of State for Care and Support. The Commission has established a panel of experts to drive its work programme including:

Member	**Organisation**
Norman Lamb	Member of Parliament
Paul Anderson	Head of Deutsche Bank, Birmingham Office
Professor Dame Carol Black	Principal of Newnham College Cambridge, Expert Adviser on Health and Work to the Department of Health England and to Public Health England Chairman of Nuffield Trust for health policy
Craig Dearden-Phillips MBE	Founder of 'Stepping Out' venture supporting the formation and growth of new social enterprises in the UK public and voluntary sectors.
Professor Kevin Fenton	Public Health England – Director of Health and Wellbeing
Steve Gilbert	Regional Service User Representative for the Royal College of Psychiatry Member of Mind's Peer Support Advisory Panel
Steve Shrubb	Nurse, Cognitive Behaviour Therapist Development Centre Director Network Director and Mental Health Trust CEO
Professor Swaran Singh	Division of Mental Health and Wellbeing at Warwick University Commissioner for Equality and Human Rights Commission, UK
Dr Geraldine Strathdee	NHS England National Clinical Director for Mental Health

2.3 The Commission has set itself a number of ambitious objectives as follows:

- Assess the scale of mental health problems in the West Midlands and their cost and impact across the whole system.

- Examine best practice elsewhere nationally and internationally in both health and other service areas.
- Establish the relative costs and benefits within the whole system of the application of this best practice to the West Midlands.
- Pilot new ways of working to test effectiveness.
- Make recommendations on how the findings of the Commission can be best taken forward to reform public services in the West Midlands.

3.0 Key Lines of Enquiry and Call for Evidence

3.1 The Mental Health Commission is focused on the following Key Lines Of Enquiry (KLOE):

- Employment
- Housing
- Early Intervention principles
- Criminal justice / troubled individuals
- The role of employers
- Primary Care

3.2 The current phase of the Commission is a call for evidence across the KLOE's with regards to best practice, innovation and what currently works well. This includes the setting up of a citizen's jury panel, a series of stakeholder listening events, a base line audit conducted by School of Social Policy, University of Birmingham of the current mental health footprint and a Criminal Justice stakeholder event.

3.3 Through the Citizen's Jury the Commission is eager to make sure that the opinions of members of the public are central to the work of the Commission, and they are setting up a Citizen's Jury of 20 local people and holding a series of Open Space Listening events. The Jury will explore people's experiences of mental health and wellbeing and start to answer the question '**How can public services help to build wellbeing and keep people mentally well in the West Midlands?'**

4.0 Terms of Reference

4.1 The Commission has adopted the following Terms of Reference:

- Assess scale of issue in West Midlands, cost, impact on public services, economy, communities.
- Review, research and best practice. Establish costs and benefits of application to West Midlands.
- Identify, consider outcome from West Midlands work to improve mental health and wellbeing.
- Recommendations to Government and Combined Authority on:
  - How public services can be transformed to reduce impact on poor mental health and wellbeing, within resources.

- How resources currently spent on mental ill health can be redirected to keep people mentally well and enable recovery.
- Potential for, content of, devo deal for mental health and wellbeing.
- Outcomes to be delivered.

5.0 Key Milestones

5.1 The Commission is working to the following milestones:

- December 2015 - First Commission meeting held and call for evidence including Government and regional/local partners
- January 2016 - Review evidence and agree cost benefit analysis
- April 2016 - Report drafted
- May 2016 - Draft recommendations shared with Government
- June 2016 - Commission reviews and finalises report
- July 2016 - Commission launches report

6.0 Financial implications

6.1 There are no financial implications as a result of this report. GS/18042016/I

7.0 Legal implications

7.1 There are no legal implications as a result of this report. RB/18042016/S

8.0 Equalities implications

8.1 There are no equalities implications as a result of this report.

9.0 Environmental implications

9.1 There are no environmental implications as a result of this report.

10.0 Human resources implications

10.1 There are no human resources implications as a result of this report.

11.0 Corporate landlord implications

11.1 There are no landlord implications as a result of this report.

WEST MIDLANDS MENTAL HEALTH COMMISSION

Why focus on mental health?

- Significant driver of demand for public services
- Has a negative impact on productivity
- Opportunity to improve outcomes for people

Scope

- Covers the population of the three combined authority local enterprise partnerships:
    - 7 metropolitan councils: Wolverhampton, Walsall, Sandwell, Dudley, Birmingham, Solihull, Coventry.
    - Reaching into South Staffordshire, North Worcestershire, Warwickshire.
- Focus predominantly on working age population but recognise importance of getting foundations right in childhood.
- Make recommendations for transformation within the current resource envelope.

Terms of Reference

- Assess scale of issue in West Midlands, cost, impact on public services, economy, communities.
- Review research and best practice. Establish costs and benefits of application to West Midlands.
- Identify, consider outcome from West Midlands work to improve mental health and wellbeing.
- Recommendations to Government and Combined Authority on:
    - How public services can be transformed to reduce impact of poor mental health and wellbeing, within resources.
    - How resources currently spent on mental ill health and can be re-directed to keep people mentally well and enable recovery.
    - Potential for, content of, devo deal for mental health and wellbeing.
    - Outcomes to be delivered.

Key milestones

- December 2016 – Frist Commission meeting held and call for evidence including Government and regional/local partners.
- January 2016 – Review evidence and agree cost benefit analysis
- March 2016 – Commission holds listening event(s)
- April 2016 – Report drafted
- May 2016 – Draft recommendations shared with Government
- June 2016 – Commission reviews and finalises report
- July 2016 Commission launches report

Commission membership

- Norman Lamb MP, Chair of the Commission
- Prof Kevin Fenton, Director of Health and Wellbeing, Public Health England
- Prof Swaran Singh, Head of Mental Health and Wellbeing Division, Warwick Medical School
- Steve Gilbert, Service User
- Dr. Geraldine Strathdee, National Clinical Director of Mental Health, NHS England
- Craig Dearden Phillips, Managing Director of Stepping Out
- Steve Shrubb, Chief Executive, West London Mental Health Trust
- Dame Carol Black, Policy Advisor – work and helath to the government
- Paul Anderson, Managing Director, Deutsche Bank, Birmingham

Combined Authority Leader Champion, Darren Cooper, Sandwell MBC
Supporting Officers:

- Sarah Norman, Lead Chief Executive, Dudley MBC
- Steve Appleton, Project Lead, Steve Appleton, Contact Consulting

Steering Group membership

- Lola Abudu, Public Health England
- Sarah Barnes, Troubled Individuals programme, Solihull MBC
- Stephen Chandler, National ADASS Mental Health Lead
- Dr Aquil Chaudary, Cross Birmingham CCG
- Ruth Cooke, CEO Midland Heart
- Dr Elizabeth England, Sandwell CCG/RCGP Mental Health Lead
- Simon Gilby, Coventry and Warwickshire Mental Health Trust
- Viv Griffin, Wolverhampton Council and West Midlands ADASS and ADCS
- Sarah Jury-Onen, DWP
- Dr Adrian Philips, DPH Birmingham
- Sean Russell, West Midlands Police
- Dr Paul Turner, Birmingham South Central CCG
- Helen Wadley, Birmingham MIND
- Shelly Ward, Prevention of Violence Against Vulnerable People Programme

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Agenda Item No: 17

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

27 April 2016

Report title	Consultation on Joint Autism Strategy
Cabinet member with lead responsibility	Councillor Val Gibson Children & Young People Councillor Elias Mattu Adults
Key decision	Yes
In forward plan	Yes
Wards affected	All
Accountable director	Viv Griffin (Service Director – Disabilities and Mental Health)
Originating service	Disabilities & Mental Health
Accountable employee(s)	Kathy Roper Commissioning Team Manager Tel 01902 555043 Email Kathy.roper@wolverhampton.gov.uk
Report to be/has been considered by	List any meetings at which the report has been or will be considered PLT 11 January 2016 SEB 26 January 2016 Cabinet 24 February 2016

Recommendation(s) for action or decision:

Health and Wellbeing Board is recommended to:

1. Receive the draft Autism Strategy and make comments as part of the consultation process

1.0 Purpose

1.1 The purpose of this report is to present the draft Joint Autism Strategy for consideration and comment as part of the consultation process.

2.0 Background

2.1 This Autism strategy was developed by partners in education, health and social care in the city to making sure that children, young people and adults with autism get the same life chances as people who do not have autism.

2.2 Autism is a lifelong neurodevelopmental condition, it is a 'spectrum' disorder which means that individuals experience it differently and are affected in different ways. There is however some common challenges for people with autism. These include:

- social communication
- social interaction
- social imagination

2.3 The City of Wolverhampton Council and the Clinical Commissioning Group (CCG) are committed to commissioning high quality autism services and working with partner organisations to improve the lives and opportunities for children, young people and adults with autism.

2.4 The purpose of this strategy is to provide a clear plan outlining how support will be delivered in Wolverhampton and to identify objectives and actions which reflect local need and diversity, in line with the vision set out in the national Think Autism 2015 Strategy:

> "All children, adults and older adults with autism are able to live fulfilling and rewarding lives within a society that accepts and understands them. They can get a diagnosis and access support if they need it, and they can depend on mainstream public services to treat them fairly as individuals, helping them make the most of their talents."

2.5 This strategy is a high level document designed to highlight key strategic priorities. There is a risk that stakeholders will not feel that the strategy provides sufficient detail to cover all areas. The implementation of the strategy will therefore be supported by a number of detailed implementation plans that will be influenced by the information gathered during the consultation activities.

3.0 Financial Implications

3.1 There are no financial implications directly associated with this report, however, once the consultation is complete the implementation plans associated with the delivery of the strategy will need to include comprehensive financial plans. The delivery of the new strategy will need to be within the existing financial resources.
[GS/07042016/C]

4.0 Legal Implications

4.1 This strategy supports the City Council and the CCG in the delivery of their statutory duties in relation to the Autism Act 2009 and the supporting national "Think Autism Strategy" 2015. [Legal Code: TS/04042016/A]

5.0 Equalities implications

5.1 There are equalities implications associated with this report as it relates to disabled children and young people. An Equalities Analysis will be completed before consultation commences and updated throughout the consultation process.

6.0 Environmental implications

6.1 There are no environmental implications associated with this report.

7.0 Human resources implications

7.1 There are no human resources implication's associated with this report.

8.0 Corporate landlord implications

8.1 There are no corporate landlord implications associated with this report.

9.0 Schedule of Background Papers

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WCC 1403 03/16

Wolverhampton Joint Autism Strategy 2016-2021

City of Wolverhampton Council and NHS Wolverhampton Clinical Commissioning Group

Wolverhampton NHS
Clinical Commissioning Group

Contents

Introduction

This is a high level strategy designed to support children and adults with autism who live in Wolverhampton.

Autism is a lifelong neurodevelopmental condition, it is a 'spectrum' disorder which means that individuals experience it differently and are affected in different ways. There are however some common challenges for people with autism. *These include:*

- social communication
- social interaction
- social imagination

People with autism can also experience sensory difficulties such as over, or under-sensitivity to sounds, touch, tastes, smells, light or colours. It is also more likely that people who have autism will experience higher levels of stress than someone who does not have autism. This makes mental health problems more likely.

Many people with autism are able to live independent lives. Others may need some support or the ability to access to services in order to achieve their full potential and lead fulfilled and happy lives. Approximately 50% of people with autism have an accompanying learning disability and 30% of people with autism experience mental health issues. Many people can access mainstream services with reasonable adjustments; however, some people may need specialist support to access services positively.

City of Wolverhampton Council and the Clinical Commissioning Group (CCG) are committed to commissioning high quality autism services and working with partner organisations, to improving the lives and opportunities for children, young people and adults with autism.

The purpose of this strategy is to provide a clear plan, outlining how support will be delivered in Wolverhampton and to identify objectives and actions which reflect local need and diversity and to reach the vision together set out in the Think Autism 2015 Strategy:

"All children, adults and older adults with autism are able to live fulfilling and rewarding lives within a society that accepts and understands them. They can get a diagnosis and access support if they need it, and they can depend on mainstream public services to treat them fairly as individuals, helping them make the most of their talents."

For those individuals, who following an assessment of their needs are eligible for social care support, or receive health services, the strategy provides a clear and consistent, joined up approach to support throughout a person's life. It highlights the importance of personalised services and support. Offering individuals more choice and control with a particular emphasis on a clear plan and support when moving from children's to adults' services.

The primary focus of this strategy is to embed autism services and the range of associated support available within our existing provision. This will require the creative and innovative re-shaping and re-design of current services, utilising existing financial resources. It will be achieved by collaborating with local providers to develop more innovative cost effective solutions to community based provision and increase access and availability to local universal services to ensure that both the Council and CCG channel the right resources, at the right time, in the right place, to the right people.

This strategy builds upon earlier work within children's and adults' services, the involvement of customers, carers and other stakeholders, as well as responding to and acting upon national law and guidance.

Statutory responsibilities

This All Age Autism Strategy will be influenced by national and local policy and research, with particular reference to the following:

The National Autism Strategy states that autism services for adults are shaped by the National Autism Strategy for Adults, Fulfilling and Rewarding Lives (2009). *This has five main areas for development:*

- Increasing awareness and understanding of autism
- Developing pathways for diagnosis and personalised needs assessment
- Improving access to support services in the local community
- Helping people with autism into work
- Enabling local partners to plan and develop appropriate services

The refreshed national strategy, Think Autism (2014), maintains a similar focus for development, with three new key proposals.

- Autism Aware Communities
- Autism Innovation Fund
- Better data collection and more joined up advice and information services

Statutory Guidance has been published (2015) to ensure the implementation of the adult autism strategy. It guides local authorities, NHS bodies and NHS Foundation Trusts with regards to what actions should be taken to meet the needs of people with autism living in their area.

It states that local authorities and the NHS:

- Should provide autism awareness training for all staff
- Must provide specialist autism training for key staff, such as GPs and community care assessors
- Cannot refuse a community care assessment for adults with autism based solely on IQ
- Must appoint an autism lead in their area
- Have to develop a clear pathway to diagnosis and assessment for adults with autism
- Need to commission services based on adequate population data.

The Care Act 2014 aims to put people and their carers' in control of their care and support and includes:

- A national minimum eligibility threshold for care and support
- The right to receive a personal budget for people and their carers who meet eligibility criteria
- New rights for carers, including a duty to offer them an assessment and to provide support if they have eligible needs
- A duty for councils to consider the physical, mental and emotional wellbeing of people needing care, and to provide preventative services and support.

General Equality Duty as established by S149 Equality Act 2010 states that public bodies covered by the Equality Act 2010 must develop policies and strategies in line with the requirements of S149 of the Equality Act.

There are three main aims of the General Equality Duty that services must:

- eliminate unlawful discrimination victimisation and harassment
- advance equal opportunities
- and foster good relations

Organisations will be able to demonstrate that they have had "due regard" by having evidence of having considered relevant equalities data in proportionate detail and in a timely manner before key decisions are taken.

This strategy and the services that support people with autism are subject to the perimeters of the Equalities Act.

Vision

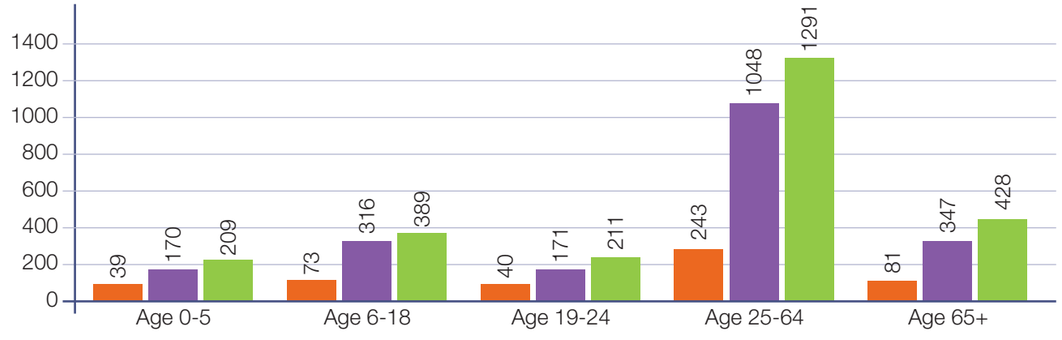
Our vision is a City where people with autism of all ages and regardless of their equalities profile, have the same opportunities as anyone else, can live the life they choose, receive personalised support when they need it, enjoy meaningful activities and be active citizens and members of our community. A City where autistic people feel safe, understood and supported. Where the word autism means the same to every member of our community: 'different .... not less' (Temple Grandin, Ph.D., Professor of Animal Science, diagnosed with High Functioning Autism/Asperger).

Needs Analysis

In order to meet the current and future demand for services and support for people with autism, and in a diverse city like Wolverhampton, it is important to understand the national and local population profile and the prevalence of autism.

Recent studies estimate that the national prevalence is 1 in 100 people have autism. This equates to about 638,000 people in the United Kingdom suggesting that in Wolverhampton there are currently about 2528 people with autism and together with their families make up around 10,000 people in Wolverhampton whose lives are touched by autism every single day. It will also be important that the equalities profile of the diagnosed population is considered in relation to Partner's wider Equality Act responsibilities to ensure that services are offered equitably and that outcomes are not significantly different for reasons unrelated to clinical need.

Between 2011 and 2015, 82 children under the age of 5 and 137 children between the ages of 5 and 18 were diagnosed with autism. Around 75 children and 90 adults, 8 of whom have High Functioning Autism / Asperger's



syndrome are known to the local authority who meet the eligibility criteria for social care services.

Population projections forecast a 4.8% increase in the number of people with autism in Wolverhampton by 2020 and an additional 3.5% rise by 2030. Services will need to adapt to the growing number of people with autism over the coming years.

Based on the local population projection and the prevalence estimate of autism, the graph below shows the estimated number of children, adults and older adults with autism in Wolverhampton.

National and the local data indicate that people aged 55 and over with autism who probably have never received a diagnosis are the least likely of all age groups to access the support they may require. Most people with autism will not require long-term specialist health and social services, but they may need support at certain stages of their life to learn to manage and overcome their social, communication and sensory difficulties. In addition, the lives of people with autism could be significantly enhanced if their needs are known and recognised and those who interact with them have an awareness of the condition.

Only 15% of autistic adults in the UK are in full-time paid employment.

At least one in three adults with autism are experiencing severe mental health difficulties due to a lack of support.

People with autism are more likely to be excluded from school. 27 per cent had been excluded from school and 50 per cent had changed schools apart from normal transitions.

A study found that nearly 1 in 3 people with autism is socially isolated and nearly 40 percent of young adults with autism never saw friends.

Priorities

Priority 1: *To collect clear and consistent data that includes equalities data; and analysis as a fundamental practice across children and adults services*

Priority 2: *Organised information and intelligence sharing across a range of stakeholders*

Strategic Objectives

Based on the Autism Act and the statutory guides, the Wolverhampton profile and the on-going dialogues this strategy sets out eight Strategic Objectives for the forthcoming five years in which we intend to progress to improve the lives of all with autism.

Objective 1

Information, Advice and Support

Outcome

To provide high quality accessible, easy to understand information

The City Council is committed to providing its citizens with good information and support to enable them to get the personalised care they need, make genuine choices and exercise control over their lives and remain independent and well.

City of Wolverhampton Council has, for a number of years, placed great emphasis on providing access to information and advice to its citizens mainly via its public facing services, word of mouth and the giving out of leaflets etc. Since 2009, this philosophy has helped to support and develop the specific requirements of the government policy including the Autism Act 2009 and the Care Act 2014.

The Care Act 2014 formalises many of these requirements and this strategy sets out how the City Council will respond to the new regulations contained within the Act and enhance existing services on offer to anyone who would benefit from them, across the City.

A new Information Portal has been developed www.wolvesnet.info, Wolverhampton Information Network (WIN) brings together existing information and advice resources in a single easy to use database for use by all members of the community. It aims to support the reduction in dependence on council services, by helping people to help themselves. By providing information and advice to people on a range of issues, such as personal finances, healthy living, support groups and things to do It aims to help people remain as independent as possible for longer and to find alternatives to traditional Local Authority support.

As WIN develops and through feedback from users, it has grown to include a range of support and advice services available to the people of Wolverhampton, ranging from support to interest groups. It currently serves the adult population of Wolverhampton, but it is in the process of being upgraded to include Families, Children and the SEND Local Offer to increase its offer to City residents.

Priorities

Priority 1; *To ensure that local information networks such as WIN and the Local Offer have relevant information about Autism.*

Objective 2

Develop a clear and consistent pathway including post diagnostic support

Outcomes

Families will have access to timely diagnostic services that meet NICE guidelines.

Families will be supported through their assessment by the referrer and the diagnostic service, recognising that this is a time of stress for many people.

Children and adults diagnosed with autism will be given support to understand their diagnosis and information about social care provision (including for family carers), educational assessment and support (where appropriate) and information about local and national organisations that can provide further support.

Families (regardless of the outcome of diagnostic assessment) will be signposted by the provider of the assessment to services that may be able to support them and their families in their local community.

Assessments are coordinated by a key worker from the panel, with support from the relevant services.

This section of the document relates to assessment and diagnostic care pathways for people with neurodevelopmental conditions including Autism and other conditions such as Attention Deficit Disorder.

The clinical elements of the diagnostic and assessment services are currently commissioned by the Wolverhampton Clinical Commissioning Group provided following GP referrals.

These services are currently provided by a range of providers including regional based specialist services. In some cases there are shared care arrangements regarding prescribing support and monitoring of medication with GP's and the Black Country Partnership NHS Foundation Trust both in terms of Adult Mental Health Services (AMHS) and Children's and Young Peoples Mental Health Services (CAMHS). This includes CAMHS and AMHS Learning Disability Services.

Adults with learning disabilities are assessed within the specialist learning disability health service, and adults without learning disabilities are referred to a specialist diagnostic service who co-ordinate a multi-disciplinary assessment.

As current diagnostic services are provided in a number of different ways and by different providers this could make it difficult for families and referrers to navigate their way through the system, and could lead to inconsistencies of approach.

Some elements of the children's diagnostic pathway are not formally commissioned and this has led to some inconsistencies in the input by different professional groups into both assessments and the diagnostic panel.

On-going clinical support and treatment of people of all ages with neurodevelopmental conditions and co-occurring mental health needs is also provided by the Black Country Partnership Mental Health NHS Foundation Trust with core principles regarding:

- Strengthening the user and carer voice
- ensuring health support in educational and residential settings
- speedy access to support in a crisis as laid out in our local Crisis Concordat
- care close to home across secondary and tertiary services
- particular attention regarding the application of the care programme approach and management of risks and vulnerabilities
- care pathways and support in primary care
- care pathways and support regarding dual diagnosis (substance misuse) wherein people with neurodevelopmental conditions may have particular risks
- needs and requirements and support during periods of transition

Achieving the timeframes recommended by NICE in terms of assessment completion has been a challenge for both children and adults, and there is no standard core information that is given to families post assessment.

We do not currently have robust ways to determine the difference a diagnosis makes to a family, and whether the outcomes sought through the pathway are met. Adults (and in particular older adults) may not have had an assessment for autism. Their life may have been affected by some of the difficulties associated with autism, but never having been diagnosed they may have been receiving inappropriate support, or no support at all.

Priorities

Priority 1: *In order to develop excellence, consistency and to promote a genuine understanding of the needs of Wolverhampton families we strive to commission one all-age pathway that is embedded across our services, and led by our local commissioned providers of health, social care and education.*

Priority 2: *To ensure that referrers have information about how to support a person who has received a diagnosis, and their family.*

Priority 3: *To ensure that post-assessment information about how to access support is accessible to families.*

Priority 4: *To evaluate the impact of that pathway and work with families to shape the future provision.*

Objective 3

Increasing awareness and understanding of autism

Outcomes

To increase awareness and understanding of autism throughout the city workforce.

People with autism say that they face many difficulties as a result of a lack of understanding about autism.

Mental health and learning disability services will need to ensure that they are making reasonable adjustments for people with autism. We recognise that this will only be possible if all services have autism on their agenda and if the awareness and profile of autism is high.

High quality training not only ensures that all staff have a good understanding of the main characteristics of autism but also equips staff with the knowledge about how to treat people with respect and dignity and enables the team to make reasonable adjustments to take into account the multiple needs issues people with autism may experience.

A well-trained public sector workforce can be the foundation of wider societal changes by improving the way services are planned and delivered.

At present, the City of Wolverhampton Council offers four e-learning materials for its own staff: Autism Awareness, Autism Awareness - Asperger's Syndrome, Autism and Challenging Behaviour and Autism and Education.

There are online e-learning packages available for GPs, health and other public sector services. However, it is recognised that autism

awareness within the general population, as well as the emergency and public services, is likely to be under developed.

There is a need for basic autism awareness training to be available for all staff, whilst specialist training should be provided for professionals in key roles including GPs, social workers, personal assistants, occupational therapists, commissioners and those in leadership roles.

The level and structure of training currently offered could be improved to support staff to identify people with autism. Wolverhampton recognises that staff who have a role in recruitment need an enhanced understanding of the difficulties people with autism face through the process so that reasonable adjustments can be made.

Wolverhampton will aim to actively involve people with autism, their family and carers in the development and delivery of the autism training and refresher programmes. It is anticipated that an increased awareness of public sector staff could support the early identification of the difficulties people with autism face thus increasing their prospect of receiving an appropriate referral, diagnosis and support.

Priorities

Priority 1: *To ensure that various levels of training are developed and delivered, including a specialist autism programme to increase awareness across all relevant agencies and enable key professionals to recognise, assess and support people with autism.*

Priority 2: *To ensure that all commissioned services include requirements for providers to train their staff appropriately so that reasonable adjustments can be made for people with autism.*

Priority 3: *To support services including GP's, hospital, leisure, criminal justice, and housing have appropriately skilled staff to support people with autism so that reasonable adjustments can be made*

Objective 4

Preparing for Adulthood

Outcomes

All young people aged 13- 25 years who are on the autistic spectrum are able to or are supported to make informed decisions about their future.

Young people on the autistic spectrum are in a range of provision both within and outside the city this includes; special schools and mainstream secondary schools and units within the city, the local college, and special schools and colleges outside the city.

Young people should have access to independent and impartial careers education, information, advice and guidance, throughout their preparation for adulthood, from their school, and where appropriate from the Connexions service. Information is also available through the Local Offer for young people and their Parents/Carers.

Support throughout preparing for adulthood is provided through a multi-agency approach underpinned by the principles of person centred planning.

For those young people for whom an Education Health and Care (EHC) plan is appropriate early support to develop vocational profiling leading to a Career Pathway Plan will help inform the outcomes from the completed EHC plan

Advocacy is available through Connexions for all young people and in particular for those over 16 years who may wish to indicate their preferences.

Challenges exist where a young person is not in receipt of an Education Health and Care Plan but is in need of effective careers education information advice and guidance.

Challenges also exist where a young person with autism is not in receipt of an Education Health and Care plan but is in need of wrap around support, particularly in mainstream settings, to enable them to learn and progress and maximize their potential.

Another challenge is the need for young people to be exposed to the demands of an employment setting to successfully navigate their employment pathway.

Priorities

Priority 1: *Young people on the autistic spectrum and who are not in receipt of an Education Health and Care plan are identified early and are fully supported to maximize their potential.*

Priority 2: *All young people on the autistic spectrum who are preparing for adulthood should have access to quality assured work experience to help them prepare for their transition into further education employment or training.*

Objective 5

Lifelong learning, increasing skills and inclusive employment

Outcomes

All exclusion will comply with national guidance and good practice.

All children and young people with autism will attend a school that has a good understanding of their condition, and have skills and resources to meet their needs.

Nationally, 2.8% of children and young people in education have a statement of Special Education Need (SEN) or an Education, Health and Care Plan (EHCP)[1]. Of these 24.5% have an Austism Spectrum Disorder (ASD) identified as their primary area of need, making ASD the most common category of primary need for pupils with a statement/EHCP. 15.4% of pupils are identified as requiring SEN support without having a statement/EHCP. Fewer than 5% of these have ASD identified as a primary need.

In Wolverhampton children and young people with ASD are educated in a range of settings, both mainstream and specialist. Wolverhampton has one special school designated for pupils with ASD as a primary need. There is also a specialist nursery/ KS1 school designated for pupils with ASD or severe learning difficulties. Across all Wolverhampton's special schools there are 105 pupils identified with ASD as a primary area of need, and 56 with ASD as a secondary need. ASD is identified as a category of need for approximately one fifth of the 760 pupils in Wolverhampton special schools.

There is significant variation in the way that children and young people with autism are

affected by their condition. Approximately half have additional learning difficulties, which may sometimes be severe. Others will not have learning difficulties and some may have very advanced cognitive skills. Language skills of children and young people with autism can also vary greatly. For some, spoken language is extremely limited or absent altogether, meaning that they require augmented or alternative methods of communication to help them to understand others and express themselves. Other children and young people with autism may be very fluent talkers, but have difficulties with their use of language in social contexts. Children and young people with autism are also more likely than their peers to experience other developmental conditions such as dyspraxia or attention deficit hyperactivity disorder.

The prevalence of autism and the significant variation across the autism spectrum has implications for education. Firstly, all schools are likely to include pupils on the autism spectrum. Second, however, a "one size fits all" approach to education for pupils with autism will not be appropriate.

There are a number of different evidence-based approaches and frameworks for teaching children and young people with autism. Research does not support the primacy of one approach over others, and tends to suggest that individualised approaches based on the child or young person's needs, incorporating certain core features is most appropriate.

The Autism Education Trust[2] has undertaken research into good practice in education for children and young people with autism. They identified eight themes or features that were important to ensuring good education for pupils with autism:

- High ambitions and aspirations
- Monitoring progress
- Adapting the curriculum
- Involvement of other professionals/ services
- Staff knowledge and training
- Effective communication
- Broader participation
- Stronger relationships with families.

When a child or young person's needs relating to autism are first identified, it is important to ensure a robust, effective and consistent graduated response to meeting those needs. Research shows that access to specialist approaches and expertise are more important in ensuring good education for pupils with SEND than whether pupils are taught in specialist or mainstream provision[3]. It is important to ensure that all educational settings are aware of good practices for supporting pupils, are able to implement these, and are able to access appropriate specialist support (including outreach and therapies) to enable children and young people's needs to be met as early and as locally as possible.

In addition to the difficulties that children and young people with autism may experience in accessing learning, research suggests that they are more likely than others to experience exclusions from school (both formal/legal exclusions and illegal exclusions)[4]. Pupils with autism are also more likely to experience bullying[5]. Therefore, it is a challenge to ensure not only that pupils with autism receive the right support to enable them to access learning and make progress, but also to ensure that they do not experience social exclusion.

There are a small number of children and young people with autism in Wolverhampton with the most complex needs, who may display behaviour that can be challenging, where it has been difficult to make effective educational provision within the city. Some of these pupils will have had a number of different educational placements before the right solution is found. For some their complex needs may make it difficult for them to remain at home all the time, so a residential educational placement is required. It is a challenge to ensure that the right support is available to intervene early when complex needs are identified, to build as much capacity as possible at home and in the school, and to ensure that there is local provision that can meet these pupils' needs.

Leaving school and progressing into further and/or higher education, and on into employment can be a significant challenge for learners with autism. In addition to the academic skills to make these transitions, young people will need to develop social and independence skills to enable them to cope with less structured environments and a broader range of relationships.

People with Autism may require support throughout their life in order to obtain and retain paid work. This support and those who will provide it are shown on the Wolverhampton Supported Employment pathway on the Local offer.

Support is required in schools and at home to raise the possibility of employment with young people. This must be built on as part of Education Health Care plans using vocational profiles, Connexions service involvement and work experience opportunities.

After school each person should have an individual plan to support them towards paid employment and this may involve further training, work experience, an internship and support from job coaches.

Priorities

Priority 1: *Support all educational settings to be autism aware and autism friendly settings, and embed a consistent, evidence-based graduated response to supporting the needs of pupils with autism when these are first identified.*

Priority 2: *Review of SEND educational provision across the city to ensure the availability of inclusive options and in-city provision across the full spectrum of need.*

Priority 3: *Ensure sufficient and consistent access to specialist support services, including outreach and therapies, for all children and young people with autism in all educational settings.*

Priority 4: *Review approaches to education and access to specialist support to ensure that all children and young people access a range of evidence-based approaches and interventions.*

Priority 5: *Work with employment and Access to Work to support people with autism to employment.*

1. *DfE (2015). Statistical First Release: Special Educational Needs in England: January 2015. London: Department for Education.*
2. *Autism Education Trust (2011). What is good practice in autism education? London: Autism Education Trust.*
3. *OFSTED (2006). Inclusion Does it matter where pupils are taught? London: OFSTED.*
4. *National Autistic Society (2003) Autism and Education: the on-going battle. London: NAS.*
5. *Humphrey and Symes (2010). Perceptions of social support and experience of bullying among pupils with autistic spectrum disorders in mainstream secondary schools. European Journal of Special Needs Education - Vol. 25 (1), 77–91.*

Objective 6

Keeping Healthy

Outcomes

People with autism are able to access mainstream primary, acute and specialist health care as required

Children and adults with autism detained or at risk of being detained in secure care are supported by the Transforming Care Programme.

National data indicates that 1 in 3 people with autism will also experience mental health issues. Mainstream health services, including primary acute and mental health should be accessible to all, including those living with autism.

The Wolverhampton Local Transformation Plan for children and young people's mental health and wellbeing is the plan that is driving the reshaping of mental health services for children and young people, and will support young people with autism who are require support with their mental health.

The plan's ambition is to develop and deliver appropriate and bespoke care pathways and evidence based intervention for vulnerable children and young people, ensuring those with autism are not turned away from services and ensuring that they receive care as close to home as is possible.

The NHS England Transforming Care Programme is a new delivery plan which was launched in October 2014 with actions taking place nationally, regionally and locally, each with the intention of making significant longer term improvements which enhance the quality of life for people with learning disabilities and autism who are either at risk of becoming an inpatient or already an inpatient in specialist local mental health hospital, or low, medium or high secure provision.

With a new target of reducing the learning disability and autism inpatient population by 50% by April 2015, CCGs were asked to organise a new programme of reviews. These reviews are called Care and Treatment Reviews (CTRs). They are organised and chaired by the lead commissioner, each is expected to last a full day and comprises of a team including representation from both the local authority and CCG, an independent expert and an expert by experience (a person with a learning disability or a family carer). Each review is expected to consider:-

1. Is the person safe?
2. Is the care and treatment the person is getting good?
3. What are the plans for the future (discharge planning)?
4. Does this person need to be in hospital now?

Wolverhampton has now embedded a system of Care and Treatment Reviews to occur wherever possible pre-admission or as soon after admission as is possible. This will enable all stakeholders to work together to ensure that outcomes are clear and that clear processes are in place to enable effective assessment, treatment and discharge planning for all young people and adults with autism who require specialist health services.

Priorities

Priority 1: *To ensure that all young people and adults with autism have a Care and Treatment review prior to any admission to specialist health care establishments.*

Objective 7

Living well and Increasing Independence (Keeping Safe Criminal Justice, Housing Support,)

Outcomes

To reduce the vulnerability and risk of harm to individuals with autism by creating an autism friendly city.

People with autism are appropriately supported with reasonable adjustments through the criminal justice system whether they are victims, witnesses or suspected of committing a crime.

People with autism who have or who might be at risk of coming into contact with the criminal justice system have access to specialist multi-disciplinary health and social care support and have their needs reviewed regularly.

People with autism and their families have clear information & advice about housing options, including financial information to support financial capability among people with autism and how to manage personal finances and household budgeting.

There is a reduction in the number of people with autism living in residential care because there are a range of other housing and support options available for them.

Keeping Safe - Community safety is a key issue for people with autism. People with autism are more likely to become victims of crimes, bullying (school, workplace, public), hate crime, exploitation (sexual and criminal) and different forms of abuse. Safeguarding children and adults who may be vulnerable is a priority in Wolverhampton.This includes protecting people with autism and their carers within the city or placed out of area.

Independent advocacy, including peer advocacy, is a key way of ensuring safety and support for people living with autism. Some areas have developed a Safe Places scheme which has given people with autism more confidence in the community. The Safe Places scheme in Wolverhampton is designed to support people with a learning disability, however there is scope to extend and develop the scheme to include people with autism.

Criminal Justice – It was identified in “Fulfilling and Rewarding Lives: Evaluating Progress 2011” - adults with autism can face particular difficulties if they come into contact with the criminal justice system. In some cases, this reflects an adult with autism reaching a crisis point. In some others, incidents occur or escalate largely or partially as a result of social and communication difficulties: had the situation been handled differently – and the individual’s autism been recognised – the outcome may have been different.

What’s more, once in the system, adults with autism may make their situation worse through their behaviour – for example, struggling to respond in interviews.

This continues to be an issue in 2015 and further support and joint working with Police and probation services is required to improve the situation for people who come into contact with the criminal justice system.

Housing - When exploring housing options for people with autism, the location of local accommodation and support is an important factor which needs to be considered.

People with autism should be offered a range of housing options including shared living models, as not everyone wants to live alone. It is important that housing and support providers understand the housing needs of people with autism and these are taken into account in housing plans, applications and allocation processes. The Wolverhampton Housing Strategy recognises the housing needs of vulnerable people and is committed to providing a range of housing options, and support to enable vulnerable and disabled people to live independently in our City.

Families of children and young people with disabilities including autism identified that the lack of accessible and affordable transport in the city is a key barrier to them using all of the sports leisure and recreational activities available as a family, and is a barrier to them being active citizens in the city. Adults with disabilities report feeling vulnerable on public transport and this also prevents them going ‘out and about’.

Priorities

Priority 1: *Provide appropriate advice to individuals, carers, staff teams, schools on staying safe by promoting the city’s Safe Places scheme with individuals, carers and more generally within the community.*

Priority 2: *Undertake vulnerability assessments on premises for those living independently.*

Priority 3: *Ensure that the local health and social care services know children and adults with autism who have or who might be at risk of coming into contact with the criminal justice system and ensure that they have access to the same services as the general population (including prevention teams, youth offending teams, liaison and diversion schemes, troubled families schemes and programmes such as those for drug and alcohol misuse) in addition to specialist multi-disciplinary support where appropriate.*

Priority 4: *Work with the Housing Options Team and the Housing Strategy Team to increase the housing options available for people with autism.*

Objective 8

Support for families, parents and carers

Outcomes

Families feel supported to continue in their caring role.

Short breaks providers are skilled to support people with autism.

Carers must be respected as expert care partners and have access to the integrated and personalised services they need to support them in their caring role, and carers need to be supported to stay mentally and physically well and be treated with dignity.

Families, parents and carers say that they want access to good quality information that is provided in a timely way, that is easy to find and relevant to their circumstances.

Parents of children and young people with autism in the city can access the Information Advice and Support Service. Every Local Authority has to provide an Information, Advice and Support Service. This is a statutory requirement, set out in the Children and Families Act 2014.

The Information, Advice and Support Service offers free and impartial information, advice and support on matters relating to a child or young person's special educational needs or

disability including autism from birth to 25 years.

They offer information, advice and support about:-

- Education, health and social care matters and relevant law
- Support available in schools, early years and post 16 settings
- Funding arrangements
- How needs are identified and met
- Disagreements and moving forward
- Exclusion from school

Based on a family's circumstance the team can offer individual support which may include:

- Support at and preparing for meetings
- Help to understand and complete paperwork
- Help to participate in discussions and decision making
- Liaising with other services and organisations
- Looking at positive outcomes

The Information, Advice and Support Service can offer support to families until their family member is 25, which importantly means that families are supported through the transition period.

The Council also has a duty to provide short breaks provision for disabled children and their families, as part of the Children's Act 2008, this includes children with autism. The City Council with the Clinical Commissioning Group funds a range of short breaks services to support parents and carers. These services are provided either in the community, the family home, a residential unit or via a direct payment.

Under the Care Act 2014, carers are entitled to an assessment of their needs in their own right. However, any assessment of carers' needs must be integrated with any services which are to be provided for the person they care for.

Carers often describe feeling isolated, and unsupported. Local peer support groups have proved successful in providing low level support for carers that enable them to continue in their caring role and build social networks.

Wolverhampton Council is in the process of developing a Joint All Age Carers Strategy which will be launched in June 2016. Following consultation this five year strategy will outline the council's approach to supporting unpaid carers of people with Autism.

Priorities

Priority 1: *To work with the Third Sector to develop opportunity within communities to arrange support groups and local and informal networks.*

Priority 2: *To make sure carers of people with autism are offered a carers assessment.*

Priority 3: *To make sure that the parents and carers of people with autism are encouraged and supported to influence and shape future services.*

Conclusion

As mentioned throughout the strategy, how autism is experienced and impacts on an individual can be very varied. It is therefore really important that individuals can access the right support at the right time for them. Whilst producing this strategy, a number of themes emerged. it is clear that people wanted much more awareness and understanding about autism in the community at large and amongst professionals and services. Increased awareness and understanding underpins many of the other themes identified, such as equality of access to services and opportunities, proactive interventions and social inclusion. Specialist themes included the need for a single clear diagnostic pathway, which is something both professionals and people living with autism have called for.

Next Steps

In order to make sure that this draft strategy responds to the needs of people with autism and their family carers/ parents, it will be subject to a period of consultation. The main focus of this consultation will be an Autism Strategy workshop close to National Autism Day on 1st April 2016.

In recognition that people with autism need support from both specialist services and access to universal services that underrated the needs of people with autism, it is proposed that an Autism Action Alliance group is established. This group will have responsibility for the delivery of the strategy and will be made up of a range of stakeholders including people with autism, parents, family carers, and any other organisation that can support the delivery of the strategy. As this is a wide ranging strategy that affects numerous people and organisations, considerations should be given to the appointment of an independent chairperson to chair the Autism Action Alliance. This proposal will also form part of the consultation.

Glossary

Advocate *- An advocate is someone who works with someone to identify what they want, and speaks up for them if they have difficultly doing so themselves*

Assessment *- The way of working out what a person's needs are.*

Carer *- A person who provides unpaid support to a partner, family member, friend or neighbour who is ill or disabled who could not manage without this help.*

Co-produce *- When you as an individual are involved as an equal partner in designing the support and services you receive.*

Commissioning *- How services are planned and paid for and checked that they are of good quality.*

Consultation *- To seek information/views from people about a topic or theme.*

Criminal Justice System *- The system through which people are dealt with who are suspected or found guilty of committing a criminal offence.*

Diagnosis *- The process of finding out the nature and cause of a medical condition through looking at a patient's history and through carrying out medical assessments.*

Direct Payments *- A Direct Payment is money your local authority can give you. It is a different way of getting the support you need. You use it to buy the support you want. Social Services give you the money instead of a service. You spend the money on getting the support you need.*

Eligibility *- When your needs meet your council's criteria for council-funded care and support. Your local council decides who should get support, based on your level of need and the resources available in your area. The eligibility threshold is the level at which your needs reach the point that your council will provide funding. If the council assesses your needs and decides they are below this threshold, you will not qualify for council-funded care.*

GP *- General Practitioner: A doctor whose practice is not limited to a specific medical speciality but instead covers a variety of medical conditions in patients of all ages.*

Outcomes *- In social care, an 'outcome' refers to an aim or objective you would like to achieve or happen – for example, continuing to live in your own home, or being able to go out and about. You should be able to say which outcomes are the most important to you, and receive support to achieve them.*

Personal Budgets *- An amount of money allocated to meet a person's needs identified through a person's self or supported assessment and support plan. This may combine resources from different funding streams to which the individual is entitled but is most often related to meeting social care needs.*

Residential Care *- Care in a care home, with or without nursing, for older people or people with care disabilities who require 24-hour care. Care homes offer trained staff and an adapted environment suitable for the needs of ill, frail or disabled people.*

Safe Places Scheme *- Safe Places are local community places e.g. shops, libraries, cafes which have been set up to help people if they are feeling vulnerable or unsafe by supporting them to call for help from parent/carer or police.*

Safeguarding *- Making sure that adults who may be at risk of harm are not being abused or neglected.*

Sensory *- Problems with working out sensory information such as sounds, sights and smells.*

Signpost *- Pointing people in the direction of information that they could find useful.*

Strategic Objective *- A goal or action which are set to achieve a plan (Strategy)*

Strategy *- A plan*

Supported Living *- Where people live in their own home and receive care and/or support in order to promote their independence.*

Transition *- The process of change a person goes through, for example growing from childhood into adulthood. For people with disabilities this process of reaching adulthood can mean changing the services from which they receive support and this can take place over a long period.*

Wolverhampton Information Network *- Online webpages with information about local organisations, groups and agencies that provide activities, advice, services to people who are looking for services & support.*

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Acknowledgements

Many thanks to everyone who contributed to the writing of this strategy including:

Mental Health Empowerment Service

Voice 4 parents

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WCC Commissioning Teams

Clinical Commissioning Group

Educational Psychology Service

Early Years' Service

Wolverhampton Safety Partnership

Connexions

Library Service

WOLVERHAMPTON CHILDREN'S TRUST

CHILDREN'S TRUST BOARD Agenda Item No: 18

Minutes of meeting held on 1st December 2015

Civic Centre

Item	Notes	Action
	Present Councillor Val Gibson (Chair) – WCC Councillor Pete O'Neill Councillor Claire Darke Ros Jervis – WCC, Public Health Chief Superintendent Simon Hyde – West Midlands Police Andrea Dill Russell– Wolverhampton College Emma Bennett – WCC Mary C Keelan – Secondary Representative, Wolverhampton School Improvement Partnership Cathy Higgins – Consultant Paediatrics Ian Darch - WVSC Cheryl Newton on behalf of Lesley Writtle, BCFPT **Officers in attendance:** Kush Patel – Children's Commissioning Helena Kucharczyk– WCC	
1.	**Welcome, Apologies, Introductions** Apologies were received from: Linda Sanders – WCC Steven Marshall (Vice – Chair) – CCG Lesley Writtle – Black Country Partnership Foundation Trust Gillian Ming - Safeguarding Board Lynn Law – Primary Representative, Wolverhampton School Improvement Partnership. Jeremy Vanes – RWT Julian Kramer – Director of Education Tim Johnson – WCC	
2.	**Declarations of interest:** • None.	

3.	**Minutes of the meeting held on 17th December 2014** • Page 3 – Working well week is 14-18 March • Page 4 - Families in poverty. This is European funding. The bid was titled Building Better Opportunities.	
4.	**Matters Arising** No matters arising	
5.	**CYP&F Performance Framework** HK presented information in regards to the performance framework. The following additional points were noted: **Priority 1 –Child Poverty** Cllr O'Neil reported that the CYP Scrutiny Panel has previously looked at how schools are using their pupil premium. He suggested whether the CTB could look at this issue and best practice. Cllr Gibson proposed she felt the task sat better under the CYP Scrutiny Panel and Julian Kramer, Director of Education should be asked to progress this. The finding will be taken back to scrutiny panel with a summary reported submitted to CTB. **Priority 2** HK highlighted that A level data is now included. **Priority 3** 412 families have been identified, the target is 483. EB confirmed we are on target. HK said that Wolverhampton no longer have the second highest number of LAC. We now have the 4th highest nationally. **Priority 4** RJ reported that despite a reduction in data obesity levels remain high. EB asked about the substance misuse data repeat representation and whether additional analysis is being undertaken to understand the repeats. RJ said she will look into this. **Action: RJ to provide an update.**	**RJ**
6.	**Priority Leads Summary reports** Reports submitted by EB and RJ. EB wanted to clarify the expectations of priority leads. The role of the priority lead is to be the champion of that work steam. The work is often via an existing Partnership Board and the expectation is the priority lead will be the connector between Boards. Cllr Gibson said we need some feedback on the work of the other boards.	

	RJ said Health needs clarification. Currently there are 3 leads identified. EB commented that due to the broad depth of health, 3 leads have been identified. RJ said we could miss the softer outcome work if we only focus on the performance framework. RJ said it would be helpful to have the priority leads highlight report and that would generate discussion. The Board discussed the way forward and agreed that the onus will be on members to raise issues of concern linked to owners of the performance measures and those members who attend other partnership boards rather then continuing with the specific priority lead role. **Action – KP to email members asking for agenda items.** The following questions were raised on the reports submitted. Family Strength – ID asked about Troubled Families and the evidence that it is working. EB confirmed that it is working and there are a number of success stories. Our first payment by result claim has been submitted for Phase 2 for 12 families. EB stressed that we are not really going to see impact for another 12/18 months. In response to what worked in phase 1, EB reported that it was the key worker intensive support. The children re-design is based on that model. The ratio is 10 families to 1 key worker. In the remodelling it has slightly increased to 12 families to 1 key worker. ID asked that links need to be strengthened with the successful European funding bids. Talent Match currently has low referrals from the Children Services **Action ID to identify someone to attend EB management team to brief on Talent Match.**	**KP** **ID**
7.	**Spotlight – Chris Hale and Anthony Walker** Chris Hale provided an overview on the Housing Strategy. PowerPoint presentation is attached. There is high demand for new housing and there is sufficient land in the City for development. The City of Wolverhampton are building 450 new council housing (social Housing) . There is currently a stock of 22000 council housing. It is important that existing stock is kept in good condition. This is managed through the 'decent homes' work. They are working with the private sector to ensure 'decent homes'. If it is below standard, enforcement powers are utilised. It is projected that there will be more private sector stock that public sector stock. Wolverhampton Homes is 3 stars which is the highest rating.	

Homelessness – Anthony Walker (presentation attached)

Additional comments
Larger families are an issue. Seeing more of them. Families with 6 or more children.
If a landlord is struggling, this is a knock on effect for multiple families.

Welfare reforms
External factors – closure of services has a knock on effect to Housing.
Rough sleeping. – The LA response was to get these people engaged in services. Analysis found that it was outside people coming into the City. For some rough sleepers, it's a choice. Wolverhampton is generous with giving money. Need to have alternatives to giving direct money.

Future plans
- Homelessness strategy – look at the key issues. Would like the CTB to be part of this.
- Rent with confidence – looking at star rating for landlords. To put the lower star landlords out of business
- Single accommodation offer – Housing dept. can assist people with finding a property.

Cllr V Gibson asked whether Housing has the authority to enter private sector premises to look at standards. CH said that there is national legislation for use of enforcement power. The power alluded to is in Scotland. We don't have this in England.

CH added that Wolverhampton was on enforcers – BBC I player.

Cllr O'Neil said that the Government agency is tasked with placing asylum seekers/ refuges in hotels or other temporary accommodation.
AW said the agency referred to is G4s who have been contracted.
Cllr O'Neil asked how the placements are being managed.

Question – how are you managing the placements?
AW – worked with them to ensure the suitability accommodation is provided. G4S need to inform the LA on property they wish to procure. This is part of their contract. If they do not do this, the provider can be issued with a penalty.

Decrease in 16-17 homlessness

AD asked about the data showing a reduction in 16/17 year olds being homeless. AD said that the College is seeing an increase in homeless for 16/17/18 compared to previous year.

EB said a review is being undertaken on youth homelessness. A report will be going to the Strategic Housing Board.

Action AD to meet with AW **AD/AW**

	MK suggested broadening this to include schools. ID said that the 2 largest barriers for young people were mental health and inappropriate housing. ID asked what happens when there is a concern about an inadequate property. CH responded that if there is a concern, a team would go out to inspect the property. There is current law, which makes it illegal for a notice to be served as a result of a complaint. Additional questions asked **The number of empty houses?** There aren't many. Bringing back about 200 per year. CH is looking at partnership with a number of good landlords to purchase the poorer properties. **In which areas are is the housing development taking place?** CH said it was happening across the City; In Bilston, Compton, Low Hill to name a few. 25% of new properties have to be affordable homes. **How do you promote the developments?** This is done through social media but the best route is word of mouth.	
8.	**CTB 2015/17 work programme** KP presented the proposed work plan for the next 12 months. The next proposed spotlight is on Education, Employment and Training - **Julian Kramer to be asked to present on narrowing the gap, particularly at KS 4.** **Action – to agree with Linda Sanders and Julien Kramer as to whether the post 16 review is presented to CTB.**	JK EB
9.	**AOB** **CTB Stakeholder Briefing** KP said the date is confirmed for the morning of 07.03.16 at Bilston Town Hall. KP asked for confirmation of speakers. The board agreed the following; Family strength – Emma Bennett Health – What are the big achievements Steve/ Viv and Ros to discuss. Child poverty – Lesley Roberts/ Ian Darch EET – Julian Kramer KP said the young people's voice will most likely be a video. ID suggested Talent Match could contribute to this. **Action – KP to send out invitation again.** - **ID to send Talent Match contact details to KP**	**KP**

	Third Sector ID reported that there is a perception that the third 3rd sector provision is being pushed out. He asked to see how much resources is allocated to the third sector **Action - Cllr Gibson to speak to Cabinet Member of Resources about third sector cuts.**	**ID** **Cllr VG**
10	**Date of Next Meeting:** **TBA**	

Meeting Title:	Integrated Commissioning and Partership Board	**Date of meeting**:	10 March 2016
Attendees:	Helen Hibbs (HH), Linda Sanders (LS), Steven Marshall (SM), Vivienne Griffin (VG), Tony Marvell (TM), Andrea Smith (AS), Claire Skidmore (CS) Ros Jervis (RJ), Helena Kucharzyk (HK)	**Apologies:**	Tony Ivko (TI)
In support:	Savreena Kaur (SK)		

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Agenda Item	Discussion Points	Owner	Date required
Welcome and Introduction	HH welcomed members to the meeting, introductions were made and apologies noted.		
Minutes from previous meeting	The Minutes of the last meeting were agreed as a true and accurate record.		
Matters Arising/ Actions	***Lynne Kitson to set up a meeting for Kathy Roper and Donald McIntosh as an opportunity to discuss developments around the Autism Strategy. –*** LK has set up the meeting. ***Milestones / schedules of the Section 75 Agreement to be mapped out. –*** Section 75 has been completed. ***Clarity is required around the narrative for signposting the service user regarding the Gem Centre since Children's Disability Team have moved out. Viv Griffin to notify service users regarding the changes which have happened at the Gem Centre. –*** VG to look into this. ***SM to send his Excel file of activities to JG to assist in aligning the processes. –*** SM to forward list of read codes (from Mike Hastings. ***The Authority will carry out a piece of work to investigate why there is a steep increase in costs. –*** Alison commented on this during the Finance Update. ***The Autism Strategy will be circulated –*** TM to circulate. ***EB to share the report on the cabinet redesign of Early Help services. –*** SM is happy with the strategy. ***DMcI to let RJ know about future meeting dates with LPC so that she can attend. –*** DmcI provided RJ with future dates.	VG SM TM	15/04/2016 15/04/2016 15/04/2016
BCF Finance Update 15/16	AS reported that in terms of budget pressure care and the support plan across older people services a lot of work has been done to identify the packages and why they have been entered late onto the system – some of which has been linked to outstanding asessments. These have been reassessed and reviewed. Key areas identified were; - A high number are CHC funded. - High costs as well as late costs have been singled out. - As we reduce the number of patients going into residential		

	care, people in domicilary care are more likely to be self funded. - The contribution split hasn't changed vastly. Finance are currently looking into whether the data has shifted from last month and will continue discussion on the risk around figures. AS to keep the board updated.	AS	NM
BCF Planning for 16/17 Submission	The Submission 1 template from NHS England was distributed prior to the meeting. This was a first summary submission. The next submission will be a revised version on the 21st April. Board members to relay any comments ahead of the next submission.		
Big Lottery – Commissioning Partners	Comissioning partners will be identified further down the model once it has been developed. Once a Business Case is complete – CCG as a commissioner will be able to provide potential for the outcome measures. The model will be based around Newcastles current model. There is one component around self improvement and wellbeing. 70% of the payment component is funded by cabinet office, the remaining 30% is funded locally. Isolation and Loneliness contribute to Social Care Costs – Prevention Component. There are a number of links to public health which will be need to be prioritised with the funds remaining – 30% of which will need to be found from the health and social care economy albeit it will need to have some benefit to the commissioning organisation.		
Strategies – Primary Care and Autism	One strategy was identified to support lead on primary care and one to support the social care aspect around it. GP's aligning with RWT. Practices are planning to sub contract services through hospital due to hospitals planning to put extra resource into practices. Public Health have been approached by GP Practices and the GP Federation and Prevention Agenda providing them with information and support around high impact preventions.		
Updates - Childrens/CAMH's Adult Social Care Public Health Health Watch	***Childrens CAMHS –*** The CAMH's transformation Board is crucial to setting up workstreams and programming work over the next few months. Implementation is now commencing and is going reasonably well. ***Public Health –*** Public health have been awarded two bundles of contracts; one of which is for adult weight services,(BME groups and males). An online service has now been introduced to try and engage males. A community interest and organisation service has been commissioned in Dudley which has had some positive outcomes around working with different communities. The other bundle is all community services and contracts with pharmacies which ha much better specifications and change such as needle exchange and supervised consumption. Neeraj Malhotra is leading on the Transformation of Children's Services and is looking to combine this with doing a 0-19 years		

	service with schools. This will need to align with CTS. There will be a consultation exercise during summer. ***Adult Social Care –*** There hasn't been enough engagement during this term. AW is leading from CCG on the Mental Health and Disabilities workstream. SM is also having difficulty with getting people engaged. A draft letter has been sent out by AW to Keith Ireland, The 4 CCG's and Walsall/Dudley Chief Executives. HH to forward the letter which has information around local authorities buying out PFI to LS. LS to circulate the venn diagram created which maps out what the local authority does, what the CCG does and where there is a mutual joint interest.	 HH LS	 15/04/2016 15/04/2016
AOB	None noted		

Actions	**Owner**	**Date Required**
HH to forward the letter which has information around local authorities buying out PFI to LS.	**HH**	**21/04/2016**
LS to circulate the venn diagram created which maps out what the local authority does, what the CCG does and where there is a mutual joint interest.	**LS**	**21/04/2016**
TM to circulate the Autism Strategy – members to bring any queries to the next board.	**TM**	**21/04/2016**
Forward list of read codes (from Mike Hastings to assist with the aligning process.	**SM**	**21/04/2016**
Clarity is required around the narrative for signposting the service user regarding the Gem Centre since Children's Disability Team have moved out. Viv Griffin to notify service users regarding the changes which have happened at the Gem Centre.	**VG**	**21/04/2016**

Distribution: Attendees and apologies
Date Completed: 11 March 2016
Author: Savreena Kaur
Date of next meeting: 21 April 2016
Venue of next meeting: Science Park – Room 4

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Minutes of Public Health Delivery Board 15 March 2016

Time: 10.00 **Public meeting No** **Type of meeting: Internal**

Venue: Bert Williams Leisure Centre, Meeting Room

1. **Present:** Ros Jervis (RJ) (Chair), Joanne Birtles (JB), Glenda Augustine (GA), Karen Samuels (KS), Juliet Grainger (JG), Richard Welch, Katie Spence, Chris Hale (CH) Keren Jones (KJ)

Apologies: , Sharon Sidhu(SS), Ian Darch (ID), Andy Jervis (AJ), Neeraj Malhotra (NM), Donald McKintosh (DM), Andrew Wolverson (AW), Kerry Walters (KW),

Item No.	Agenda Heading	Action
2.	**Minutes of last meeting and matters arising** Page 2 – Children, Young People and Families RJ confirmed that the Key Elements were Smoking / Alcohol / Obesity Page 3 – Commissioning JG confirmed that the Sexual Health contract had been rewarded to RWT & it has been agreed for the Healthy Lifestyles Service to TUPED over to the Local Authority as of 1st October 2016. All agreed that the minutes were a true record.	
3 / 4	RJ asked the group to consider a change of structure to the future board meetings and explained how she felt the PHDB could become an Oversight Group. The work programme was displayed and discussed and sub groups were looked into in more detail. Overall the board felt	

	that work may be being duplicated as the Sub Groups were meeting quarterly along with the PHDB and instead the Delivery Board could be held every 6 months with clear outlooks and plans to feedback and contribute to. The PHDB could also include community groups that could add valuable suggestions and information, the 6 monthly meetings can be used for review, linkage and priority setting for the work ahead – suggested meetings take place February and early September to also develop commissioning intentions. September's meeting to be a workshop for new board members to get an insight as to what the outlook and purpose of the group will be. Mental Health work & targeted community work to be part of the discussion / workshop. An introductory presentation is to be produced and displayed. The 3 overarching principles and 4 priorities will stay the same but will be developed and evolved. RJ will need to share this information with members that are not in attendance today to make sure that they too agree on the structure of the meetings going forward. Membership list to be updated with possible attendees for the September workshop. Next meeting to be held on – Wednesday 14th September 2016 10am – 12pm	**All**