CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

25 January 2018

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

Venue Training Room, Ground Floor, Civic Centre, St Peter's Square, Wolverhampton WV1 1SH

Membership

Chair Cllr Jasbir Jaspal (Lab)
Vice-chair Cllr Wendy Thompson (Con)

Labour	**Conservative**
Cllr Greg Brackenridge	Cllr Patricia Patten
Cllr Hazel Malcolm	
Cllr Elias Mattu	
Cllr Peter O'Neill	
Cllr Phil Page	
Cllr Martin Waite	

Quorum for this meeting is four Councillors.

Information for the Public

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Contact Earl Piggott-Smith
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Agenda

Part 1 – items open to the press and public

Item No. *Title*

MEETING BUSINESS ITEMS

1 **Apologies**

2 **Declarations of Interest**

3 **Minutes of previous meeting (16 November 2016)** (Pages 3 - 8)
[To approve the minutes of the previous meeting as a correct record.]

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

DISCUSSION ITEMS

5 **CAMHS Transformation Plan Refresh 2017-20** (Pages 9 - 14)
[Margaret Courts,Children's Commissioning Manager,Wolverhampton CCG, to present report detailing a refresh of the CAMHS Local Transformation Plan]

6 **Oral Health Needs of Older Adults** (Pages 15 - 20)
[Dr Kate Warren,Consultant in Public Health, to present report on oral health needs of older adults living in care homes, adults receiving domiciliary care and adults with disabilities oral health]

7 **Update report on the Public Health Outcomes Framework and changes to the Public Health Service** (Pages 21 - 36)
[John Denley, Director of Public Health, to present report]

8 **Dementia Friendly Community - Briefing Paper** (Pages 37 - 42)
[Susan Eagle, Commissioning Officer,to present briefing paper]

9 **Patient Mortality Rates (report to follow)**
[Dr Jonathan Odum, Medical Director, RWHT, to present report]

CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

Minutes - 16 November 2017

Attendance

Members of the Health Scrutiny Panel

Cllr Greg Brackenridge
Cllr Jasbir Jaspal (Chair)
Elizabeth Learoyd
Cllr Hazel Malcolm
Cllr Peter O'Neill
Cllr Patricia Patten
Cllr Wendy Thompson (Vice-Chair)
Cllr Martin Waite

In Attendance

Steven Marshall	Wolverhampton CCG
Jeremy Vanes	The Royal Wolverhampton NHS Trust
Debra Hickman	The Royal Wolverhampton NHS Trust

Employees

John Denley	Director of Public Health
Earl Piggott-Smith	Scrutiny Officer
Alison Shannon	Finance Business Partner

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies**
Apologies for absence were received from Councillors Mattu and Page.

2 **Declarations of Interest**
There were no declarations of interest.

3 **Minutes of previous meeting**
Corrections

Neeraj Maholtra to be added as attending the meeting.

4 **Matters Arising**
Agenda Item 8: Wolverhampton Integrated End of Life Care Strategy

David Watts, Director of Adult Services, updated the panel on progress of the pilot to introduce red bag in care homes.

Agenda Item 9: Walsall Clinical Commissioning Group

The Scrutiny Officer updated the panel on progress of comments made about changes to hospitals stroke services and shared a copy of the response from Walsall CCG to the issues highlighted. The panel agreed to monitor the progress of plans to reconfigure stroke services. The panel commented on a discussion where a reference was made about consultation and whether it was genuine as changes were already being made now. The panel agreed to note the comment.

5 **Draft Budget and Medium Term Financial Strategy 2018-19 to 2019-20**

Finance Business Partner (People), introduced the draft budget report 2018-2019. The panel members comments would be consolidated with comments from other panels and presented to Scrutiny Board to agree a final draft response that would be presented to Cabinet.

The Finance Business Partner (People) invited panel members to also comment on the approach to the budget consultation process. The Finance Business Partner (People) outlined the plans to identify £14.8 million of budget reductions and income generation to address the projected deficit in 2018-2019. The Finance Business Partner (People) added that a series of
public meetings were arranged to explain the budget proposals and to invite comments. The members of the public also had the opportunity to submit comments online.

The Finance Business Partner (People) explained that there were no new savings proposals that fell within the remit of the Health Scrutiny Panel detailed in the draft budget report. The Finance Business Partner (People) briefed the panel on the planned reduction in the public health grant for 2018-2019 and that further reductions in the grant were expected. The public health grant is currently awarded as a ring-fenced payment from the Department of Health. The Finance Business Partner (People) explained that an overspend of £376,000 for Public Health for 2017-2018 was predicted at quarter on in order to address the recurrent budget pressures and review was being undertaken across Public Health including a restructure and commissioned services. A report will be presented to Cabinet on 29 November 2017 on findings of a review of commissioned services delivered by Public Health with recommendations for new priorities for the service.

The Director of Public Health, outlined plans for restructuring of the public health service and the vision for promoting the development of a public health focused organisation in the future. The Director of Public Health commented on the contribution of the policies and financial resources of other Council departments in contributing towards improving public and well-being and the change in the role of a restructured service from funding a number of traditional services, such as stop smoking, to looking at the factors that impact on the health of the local population and which encourage healthier life choices.

The panel requested that it would be useful to have information about quality of life, measures such as breastfeeding rates, to provide evidence to be able to assess the impact of the policies.

The Director of Public Health explained that there was a public health outcome framework and agreed to present the information to a future meeting for panel. The Director of Public Health explained that the new approach was focused on achieving lasting behaviour change and improving current health measures.

The panel queried the plans to achieve a balanced budget for public health service, given the overspend and the use of £1.7million reserves. The Finance Business Partner (People) explained that a financial recovery plan for quarter one has been developed to bring the budget back into balance. The panel were advised that public health service would not be required to repay the funding allocated from reserve for 2017-2018.

The panel queried if a feasibility study had been taken on the changes outlined for changing the priorities of the service and the restructure of the workforce to deliver the new programme of work. The Director of Public Health commented that current approach was not delivering sustained changes in health outcomes and that it was important to recognise the impact of environment and importance of employment in helping to deliver better results. The Director of Public Health added that the new approach was aimed at building resilience among the population.

The panel queried the public response to the consultation events. The Finance Business Partner (People) responded that the events were widely publicised but public response had been lower than in previous years.

The panel discussed performance indicators for public health. The Director of Public Health agreed to present information to show how the performance of Wolverhampton compares statistically against national averages to a future meeting.

Resolved:

The panel agreed to receive a report from the Director of Public Health to detail the performance of Wolverhampton against national indicators to a future meeting of the panel.

6 **Public Health Service - presentation**

John Denley, Director of Public, gave a presentation which outlined a new approach to role of public health. The approach is based on the view that improving public health and meeting statutory priorities is the responsibility of the whole organisation and not the small specialist public health service. The Director of Public Health listed the factors that influenced the health of a population and stated that health service provision only makes a small contribution – lifestyle factors e.g. smoking, diet and socio-economic factors, e.g. employment, income had much greater impact on the health of a population.

The Director of Public Health commented on the slow progress in reducing differences in life expectancy at a ward level and argued that the role of the service must be to support all three council directorates to deliver the statutory public health responsibilities of the authority.

The Director of Public Health commented on evidence which challenged the effectiveness of services typically offered by public health service such as smoking cessation where the focus was not on addressing the causes of the behaviour but on designing services to meet the need. The Director of Public Health added that the

new approach will mean reducing the delivery of services and focus on making changes at the population level.

The Director of Public Health commented on proposed changes to the commissioning of services and create services that people can user to use and build community resilience and move away from the delivery of services. The role of public health in the future will be to influence the work of other agencies such as hospital and Wolverhampton CCG in achieving the priorities detailed in the corporate plan.

The panel discussed the issue of drugs and alcohol preventative services and the implications for other agencies such as GPs if public health service reduces its provision. The was concern expressed that the proposals need to be discussed with other partners as the changes are likely to affect areas differently if funding for stop-smoking services is stopped. The panel discussed the high number of fast food outlets concentrated in certain parts of the city and the challenge for the Council in wanting to reduce the number empty shops and the impact of such premises on health. The panel discussed the important role of planning control on the public realm.

The panel queried the risks of the approach in reducing the provision of support services at a time of high demand. The Director of Public Health responded that the issue of fast food outlets and there is a need for the Council to consider the balance between creating a business environment and promoting better health. The Director of Public Health discussed the evidence about the factors that support behaviour change and the importance of raising aspirations to persuade people reduce levels of smoking and drinking. The Director of Public Health commented on the importance of raising the aspiration of young people in order improve future life chances.

The panel accepted the need for change to reduce the gaps in life expectancy but there was concern about the loss of public health skills if the plan were introduced – the panel added that it would not want to lose the experience and skills and would like to see more details about the plans. The Director of Public Health agreed to bring a further report on the proposals to a future meeting of the panel.

The Director of Public Health agreed to provide current Public Health Outcomes Framework for Wolverhampton with an update on performance against key indicators.

The panel welcomed the report.

Resolved:

1. The Director of Public Health to present report detailing Public Health Outcomes Framework for Wolverhampton and an update on performance to a future meeting.

2. The Director of Public Health to present report on proposed changes to public health service to a future meeting of the panel.

7 **The Royal Wolverhampton NHS Trust – Quality Accounts 2017/18 (report to follow)**

Debra Hickman – Deputy Chief Nurse, The Royal Wolverhampton NHS Trust (RWHT), presented an update on progress against priorities detailed in the Quality Accounts 2017/18 report.

The Deputy Chief Nurse advised the panel that the hospital had a recent visit from the Care Quality Commission who inspected the Urgent Care Centre, receiving a 'good' rating.

Jeremy Vanes, Chair (RWHT) advised the panel that the hospital agreed to be filmed for the tv series Junior Doctors. The hospital has no editorial control over filming but considered there were real benefits to being involved in the programme. The Chair advised the panel that progress is being made to recruit two non- executive directors.

The Deputy Chief Nurse advised the panel that the priorities for the hospital have remained the same for two years. The issue of staffing levels is a significant priority but progress was being made. The hospital has placed significant attention on recruiting and retaining staff with the required skills and experience. The action plans linked to the priorities are regularly audited. The Deputy Chief Nurse made the comments about progress against priorities.

Priority 1: Nurse staffing levels

The Deputy Chief Nurse commented that reducing the number of nursing vacancies remains a challenge for the hospital. The hospital arranged a series of overseas trips in the past to find nurses but have not done so recently given national changes to requirements for registration. The hospital wants to continue to encourage local recruitment and have adopted different approaches to finding replacement staff.

The Deputy Chief Nurse commented that the issue of Brexit cannot be evidenced as impacting on recruitment for the hospital. However, there is evidence of European recruits leaving the hospital to pursue opportunities further south of the country. The Deputy Chief Nurse reported that the hospital has made significant impact on improving attendance at work following a review of the approach to managing sickness.

Priority 2: Safer Care

The Deputy Chief Nurse advised the panel that 95% is the national target benchmark for 'harm free' care. This is a point prevalence measure identifying prevalence of pressure injuries, falls, medication and infections associated with urinary catheters at a given point in time. The panel were advised of work that is being done nationally to reduce the number of patient falls. The Deputy Chief Nurse advised the panel of the work done to identify high risk patients and provide the right interventions to support patients; however this is a challenge at night time when less staff are available to observe patients at risk of falls.

The panel queried the reasons for the high number of reported medication incidents. The Chair explained that the procedures for prescribing medicines are clear but are not followed and the challenge for the hospital is understanding the reasons for this. The Deputy Chief Nurse commented on a move to electronic prescribing as way forward for reducing the number of incidents. In addition, work is being done to identify 'hot spot' areas across the hospital where more action is needed.

Priority 3: Patient Experience and Satisfaction

The Deputy Chief Nurse advised the panel of the analysis of complaints and the Friends and Family Test (FFT). The Deputy Chief Nurse commented that the FFT is a “blunt’ measure of the performance of the hospital and work is being done to get a more rounded view of what the public think about the quality of the services provided. The panel commented that there was shared concern about customer feedback as experience suggests that two groups of people will comment – those people who are very angry or upset about the service and those people who are very happy about the service – it was important to get a representative sample of views to be able to judge the performance of the hospital.

The panel welcomed the report.

Resolved:

The panel agreed to note the progress towards meeting the RWHT priorities.

The meeting closed at 3.30pm

Agenda Item No: 5

Health Scrutiny Panel

25 January 2018

Report title	CAMHS Transformation Plan Refresh 2017
Report of:	Margaret Courts, Wolverhampton CCG
Portfolio	Public Health and Wellbeing

Recommendation(s) for action or decision:

The Health Scrutiny Panel is recommended to:

1. Receive and note the CAMHS Transformation Plan Refresh 2018.

1.0 Introduction

1.1 For the Health Scrutiny Panel to receive an update of the CAMHS Transformation Refresh 2017.

1.2 The CAMHS Transformation Refresh was published in October 2017 and fully assured by NHS England with minimal additions required.

2.0 Background

2.1 Following the initial CAMHS Local Transformation Plan submission in October 2015, the plan was revised in November 2016 and the implementation plan was developed to transform services across the city for children and young people with Emotional Mental Health and Wellbeing difficulties, including specialist CAMHS.

2.2 The Local CAMHS Transformation plan was refreshed and submitted to NHS England on 31st of October 2017 to demonstrate the journey travelled since the initial Local Transformation plan was developed in 2015, the challenges which exist and actions still to be taken. It was closely aligned with developments in HeadStart to ensure that it compliments and supports the Phase Three test and learn model as well as linking with the transformation of children's services where there is an increase in focus on early intervention and prevention services. The refreshed plan also indicates the funds that are available from the CCG and the intentions for investment of this funding until 2021/22. The plan was give full assurance by NHS England on submission with minimal additions required and has now been published on the CCG and CWC website.

3.0 Progress

3.1 Progress against the original plan has been significant and there has been an increase in the workforce for CAMHS from 41.31 WTE in 2014/15 to 63.77 WTE this year 2017/18. There is now an all age Eating Disorder service as well as an Early Intervention in Psychosis service in existence both of whom are commissioned in partnership with Sandwell and West Birmingham CCG. There is a Single Point of Access for all referrals into specialist CAMHS which will be developed from April 2018 to include the new Emotional Mental Health and Wellbeing Service. Also as part of the investment into the services a 136 suite has been commissioned at Penn Hospital which is specifically for CYP although it is currently being registered for use with the CQC. BCPFT have supported their Children and Young People to co-produce their website (http://www.blackcountryminds.com) which provides information in many ways about what they do, what they provide, how to refer, self-help items and a bit of fun section – all developed with the Children and young people who have been through CAMHS. This website has been included in the HeadStart online support platform. There is a new Emotional Mental Health and Wellbeing service which is currently funded by the CCG as a pilot but will be jointly procured by the CCG and CWC from April 2018.

3.2 The financial implications detailed below are applicable to Wolverhampton Clinical Commissioning Group.

2017/18 Plan Figure		2018/19 Plan Figure		2019/20 Plan Figure		2020/21 Plan Figure		2021/22 Plan Figure
105,660		107,667		109,713		112,675		114,703
		145,000		147,755		151,745		154,476
				100,000		102,700		105,459
						197,000		200,546
105,660		252,667		357,468		564,120		574,274

The financial implications detailed below are applicable to City of Wolverhampton Council. The funding here comprises of the current anticipated funding for CAMHS child and Family, Inspire and Key team as well as the contribution for the Emotional Health and Wellbeing service and funding provided from HeadStart for 3 years for this service.

2017/18 Plan Figure		2018/19 Plan Figure		2019/20 Plan Figure		2020/21 Plan Figure		2021/22 Plan Figure
457,480		457,480		457,480		457,480		457,480
125,000		125,000		125,000		125,000		125,000
		125,000		125,000		125,000		
582,480		707,480		707,480		707,480		582,480

The future potential investment from Wolverhampton CCG and the City of Wolverhampton Council which will impact on Wolverhampton Children and Young People Mental Health services from 2017 /18 onwards is identified above. Agencies in Wolverhampton will be working together to ensure best use of existing as well as new resources, so that all available funds are used to support improved outcomes in line with the vision of Future in Mind monies and with support from some of the funding from HeadStart, particularly in relation to the workforce development component.

3.3 The table below identifies how the funding received above will be used to transform Children and Young People's Mental Health 2017 – 2021.

Year Plan Figure	**Available from Where?**	**Service to be invested in**
2017/18 £105,660	Growth monies from Future in Mind - £5,660 to be used for spot purchasing HSB assessments as	£100,000 to be invested in Emotional Mental Health & Wellbeing –

	well as £9330 not spent on EPP uplift – now recurrent.	recurrent
2018/19 £145,000	Additional funding from EPP uplift not required and money left from last year = £15,000 additional – both identified above	£70,000 Possible for STP crisis – required recurrently £63,500 Possible online digital counselling service – required recurrently if agreed £27,000 PRU CAMHS link worker – required recurrently if evaluation is successful. [1] This funding is only for 7 months from Sept 2018 as funding until then has already been given to BCPFT due to late recruitment of staff Sept 2017 – funding was provided for a full year affect.
2017/19 £262,500 – funding provided from NHS England for CYP IAPT training – 2 instalments already received. (Oct'17)	This funding has been ear marked for CYP IAPT training/backfill which this needs to be arranged either by finding courses or staff who can be recruited to train to ensure the services commissioned to deliver NHS community services are able to deliver evidence based interventions.	CYP IAPT services for training and /or backfill only – **NOT TO BE USED TO COMMISSION ACTUAL SERVICES FOR CYP**
2019/20 £100,000	When all services that have been invested in from previous years, are taken into account at full year effect, there is approximately £70,000 for	£70,000 possibly to be invested in Neurodevelopmental services to support the

[1] It is acknowledged that this amount is in excess of that agreed at beginning of year but it is only £500 and this can be found via savings on CCG's contributions to EPP placements following change in way funding is agreed.

	investment in other services. (approx. £30,000 of amount is needed to fund the PRU CAMHS link worker in full if evaluation is successful and it meets its objectives.	ASD strategy for CYP – this may be appropriate to scope LD consultant for CAMHS which could be commissioned across Sandwell and Wolverhampton depending on numbers.
2020/21 £197,000	There is approximately £197,000 for investment in services going forward and it is felt that investment in primary care workers for CYP should be considered at this time once other services have been reviewed and redesigned if necessary	£197,000 potentially for investment for primary care workers and possibly for Core CAMHS and Crisis and Home Treatment Teams. Also some of this funding will have to be identified to undertake additional CYP IAPT training. Final decisions will be taken when existing services are reviewed and evaluation undertaken.

4.0 Next Steps

4.1 The next steps for the CAMHS transformation plan refresh are to implement the plan as identified in APPENDIX 3 – Action Plan with Key Performance Indicators from page 73-75 of the embedded document.

4.0 Impact on Health and Wellbeing Strategy Board Priorities

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

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

5.0 Decision/Supporting Information (including options)

6.0 Implications

Please detail any known implications in relation to this report:

- Financial implications – Detailed above in relation to the CCG.
- Legal implications N/A
- Equalities implications N/A
- Environmental implications N/A
- Human resources implications – There will be a requirement for the current workforce to work differently in a number of areas to realise a whole system approach.
- Corporate landlord implications N/A
- Risks N/A

7.0 Schedule of background papers

7.1 The background papers (CAMHS Transformation Plan refresh 2017) relating to this report can be inspected by clicking the following link or contacting the report writer:

Wolverhampton CCG
Wolverhampton Science Park,
Glaisher Drive,
Wolverhampton,
WV10 9RU
margaret.courts@nhs.net
T: 01902 444210 or 07818 522198

Agenda Item No: 6

CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

25 February 2018

Report title	Oral health needs of older adults living in care homes, adults receiving domiciliary care and adults with disabilities	
Cabinet member with lead responsibility	Councillor Paul Sweet, Public Health and Wellbeing	
Wards affected	All	
Accountable director	Mark Taylor, People Directorate	
Originating service	Public Health	
Accountable employee(s)	John Denley Tel Email	Service Director Public Health & Wellbeing 01902 551497 John.denley@wolverhampton.gov.uk
Report to be/has been considered by	People Leadership Team 15 January 2018	

Recommendation(s) for action or decision:

The Panel is recommended to:

1. Receive the report as requested and identify any further opportunities to promote and develop oral health of older adults, particularly those living in care homes, receiving domiciliary care, or those with learning difficulties.

Recommendations for noting:

The Panel is asked to note:

1. The good joint working on oral health between the City of Wolverhampton Council, the Wolverhampton Community Dental Service, and Public Health England.
2. Good performance in care homes around oral health assessment and excellent levels of access to routine dental care.
3. Inequalities in oral health between people in receipt of care, and the general population.

1.0 Purpose

1.1 Health Scrutiny Panel previously requested a report on oral health in the City of Wolverhampton. Whilst oral health has implications across all ages this report addresses older adults, particularly those living in care homes, receiving domiciliary care and those with learning difficulties as this is a vulnerable group that has had recent local and national focus. Oral health in children was discussed at scrutiny panel in April 2017.

2.0 Background

2.1 The Health and Social Care Act (2012) amended the National Health Service Act (2006) to confer responsibilities on local authorities for health improvement, including oral health improvement, in relation to the residents in their areas.

2.2 Local authorities are statutorily required to provide or commission oral health promotion programmes and provide or cooperate with oral health surveys in order to facilitate the:

- assessment and monitoring of oral health needs,
- planning and evaluation of oral health promotion programmes,
- planning and evaluation of the arrangements for the provision of dental services, and
- reporting and monitoring of the effects of any local water fluoridation schemes covering their area.

2.3 Oral health surveys are carried out as part of the Public Health England dental public health intelligence programme.

2.4 Wolverhampton is included in a West Midlands scheme to fluoridate the drinking water. The water from our two main suppliers is fluoridated and therefore the majority of Wolverhampton residents can access fluoridated water.

2.5 Wolverhampton Special Care Dental Service provides services to key vulnerable groups across Wolverhampton, sometimes via a mobile dental van, as contracted through NHS England. This includes oral health improvement activity with specific clientele and vulnerable groups using a dedicated oral health promotion worker with further oral health promotion qualifications and working with areas most in need, as identified from survey evidence and undertaking targeted community work.

The Wolverhampton Special Care Dental Service sees individuals with severe learning difficulties, severe mental health problems, severe autistic spectrum disorders and those with physical disabilities. Most adults with learning difficulties, receiving domiciliary care or living in care homes will not fulfil the criteria to be able to access the Special Care Dental Service, therefore it is important to support access mainstream services.

3.1 Oral health of older adults in care homes

3.1.1 2.2% of the population in Wolverhampton live in care homes or care establishments (approximately 5645 people). The West Midlands Care Home Dental Survey in Care Homes was completed in 2011. It provides important evidence about the oral health of care home residents in Wolverhampton, and the rest of the West Midlands:

- Care home residents in the West Midlands were twice as likely to have dental caries compared to non-care home residents aged 65-74 in the 2009 Adult Dental Health Survey.
- 30.8% of care home residents in the West Midlands brushed their teeth twice per day compared to 75% of non-care home residents surveyed in the Adult Dental Health Survey.
- Around a quarter (25.8%) of residents needed help brushing their teeth.

3.1.2 The survey suggested that care homes in Wolverhampton had relatively good access to routine dental appointments: 100% of those surveyed who tried to get a dental appointment from care homes in Wolverhampton in the previous six months were able to get one, compared to 87.8% across the West Midlands.

However, urgent care access was a problem for many in Wolverhampton; 17.9% of care home managers reported that they had no access to urgent care in Wolverhampton (compared with 15.4% across West Midlands). There is a perceived lack of training on how to access urgent care in the West Midlands, which is consistent with national data.

3.1.3 Wolverhampton care homes compare well to the rest of the West Midlands; they had the highest level of oral health admission assessments in the West Midlands according to the West Midlands Oral Health Survey (71.4% of care homes in Wolverhampton compared to 61.3% in West Midlands). Without an oral health admission assessment, residents' oral health may be overlooked, which risks causing substantial harm. 98.2% of care homes surveyed in Wolverhampton included oral health in their care plans – the highest in the West Midlands.

3.1.4 Digital advice packs with links to resources were sent to care homes in November 2017. This included links to training videos for staff, online e-learning for staff, the National Institute for Health and Care Excellence (NICE) Oral Health Risk Assessment Tool and NICE Guidelines for Older Adults in Care Homes.

3.2 Oral Health in Older Adults Receiving Domiciliary Care

3.2.1 There is limited information about the oral health of those receiving domiciliary care in Wolverhampton, and no survey data from the West Midlands. A recent national survey of adults in contact with domiciliary dental care revealed they were

- Less likely to brush their teeth twice per day than adults in the general population (43% vs. 75%).

- More likely to complain of pain or a problem in their mouths (14% vs. 9%)

3.2.2 Domiciliary care providers in Wolverhampton are commissioned to support (if required) with brushing teeth or dentures and aid with oral hygiene as appropriate; however, there is no requirement for them to undertake an oral health risk assessment.

3.3 Oral Health in Adults with Learning Disabilities

3.3.1 In Wolverhampton:

- 59.2 per 1000 people have moderate learning difficulties, and 5.34 per 1000 people having severe learning difficulties.
- This is significantly higher than the England average of 28.6 per 1000 with moderate learning difficulties and 3.8 per 1000 with severe learning difficulties.

There is no survey data on adults with learning disabilities in Wolverhampton. Some studies have indicated that those with learning disabilities have worse oral health compared to the general population, so it can be expected that this is reflected in Wolverhampton.

4.0 Future developments

The following is recommended to improve the oral health of older adults in Wolverhampton:

- Support vulnerable adults to access mainstream services if they do not qualify for the Special Care Dental Service
- Ensure care homes are aware of resources and support
- Ensure low sugar foods in care homes are available in care homes
- Encourage GPs to prescribe sugar-free liquid medications if applicable
- Undertake an oral health survey of older adults in care homes decennially
- Liaise with social care to introduce regular oral health assessments and education for staff and residents as part of contracts for care homes and domiciliary care

5.0 Financial implications

5.1 Funding for Public Health is provided to the Council by the Department of Health in the form of a ring-fenced grant. The total allocation for 2017-2018 is £21.3 million. Any costs associated with oral health needs will be contained within this overall allocation. [MI/08012018/K]

6.0 Legal implications

6.1 The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012, Part 4 of the Regulations specifies the functions to be exercised by local authorities in relation to dental public health in England.

Local authorities should:

- provide or secure the provision of oral health promotion programmes as deemed necessary for the area
- provide or secure the provision of oral health surveys to:
- assess and monitor oral health needs
- plan and evaluate oral health promotion programmes
- plan and evaluate arrangements for provision of dental services
- monitor and report on the effect of water fluoridation programmes
- participate in any oral health survey conducted or commissioned by the Secretary of State.

RB/08012018/Q

7.0 Equalities implications

7.1 This report highlights inequalities in oral health by age, disability and socioeconomic status and makes recommendations to reduce these inequalities.

8.0 Environmental implications

8.1 None

9.0 Human resources implications

9.1 None

10.0 Corporate landlord implications

10.1 None

11.0 Schedule of background papers

11.1 None

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Agenda Item No: 7

CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

25 January 2018

Report title	Update report on the Public Health Outcomes Framework and changes to the Public Health service	
Cabinet member with lead responsibility	Councillor Paul Sweet Public Health and Wellbeing	
Wards affected	All	
Accountable director	Mark Taylor, People	
Originating service	Public Health	
Accountable employee(s)	John Denley Tel Email	Director of Public Health 01902 550148 john.denley@wolverhampton.gov.uk
Report to be/has been considered by	People Leadership Team	15 January 2018

Recommendation(s) for action or decision:

The Panel is recommended to:

1. Support the Director of Public Health's vision for new ways of working.

Recommendations for noting:

The Panel is asked to note:

1. The City of Wolverhampton is an area of high need for Public Health as confirmed by the Public Health Outcomes Framework.

2. Many of the areas that need to be addressed on the Public Health Outcomes Framework cannot be addressed by the Public Health Service alone and require systems thinking and partnership action.

1.0 Purpose

1.1 To update the panel on the Public Health Outcomes Framework (PHOF) tool provided by Public health England to help monitor performance of public health outcomes in the city of Wolverhampton and to inform the panel of the proposed new public health vision going forward.

2.0 Background

2.1 The PHOF sets out desired outcomes and indicators that enable us to understand how well public health is being improved and protected. It concentrates on two high-level public health indicators life expectancy and healthy life expectancy, and groups further indicators into four domains that cover the full spectrum of outcomes that cover all stages of life. These domains are as follows: improving the wider determinants of health, health improvement, health protection, and health care public health and preventing premature mortality.

2.2 The PHOF is accessed via an online portal which presents data for the indicators in the framework for the most recent period available and accompanying benchmarking and trend data where possible. Inequalities data are also provided where these are available. The tool is updated as part of a quarterly update cycle in August, November, February and May, the latest data was released on the 7 November 2017.

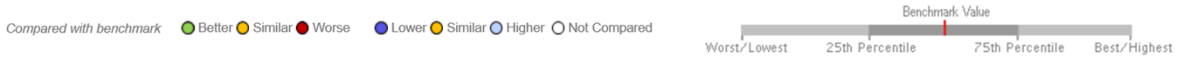
2.3 The public health service is currently going through a significant restructure which is intended to be completed for the start of next financial year. The restructure is necessary to balance the budget (since 2014/15 the public health funding grant has been cut by 17%) and to deliver the new vision for public health.

3.0 Progress

3.1 In summary the city of Wolverhampton is an area of high need as identified by the PHOF. Across the 4 domains of the PHOF there are a number of key indicators that we will need to tackle if we are to improve the public health of the population to ensure people live longer and healthier lives. Many of these issues are the result of intergenerational problems that require new ways of working to address. The new vision for public health seeks to refocus our efforts on how to make significant changes that will improve these outcomes for the long-term health of our population.

3.2 The graphic on the following page shows a spine chart with the performance in the city of Wolverhampton for the overarching indicators of the PHOF. The city of Wolverhampton has significantly lower levels of life expectancy and healthy life expectancy for both males and females. Performance for these indicators is in the lowest quartile of performance nationally.

PHOF Overarching indicators



Indicator	Period	Wolves			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
0.1i - Healthy life expectancy at birth (Male)	2013 - 15	–	-	56.4	62.4	63.4	54.0		71.1
0.1i - Healthy life expectancy at birth (Female)	2013 - 15	–	-	59.5	63.2	64.1	52.4		71.1
0.1ii - Life expectancy at birth (Male)	2013 - 15	–	-	77.4	78.7	79.5	74.3		83.4
0.1ii - Life expectancy at birth (Female)	2013 - 15	–	-	81.4	82.7	83.1	79.4		86.4
0.1ii - Life expectancy at 65 (Male)	2013 - 15	–	-	17.6	18.4	18.7	15.8		21.4
0.1ii - Life expectancy at 65 (Female)	2013 - 15	–	-	20.2	20.9	21.1	18.8		23.9

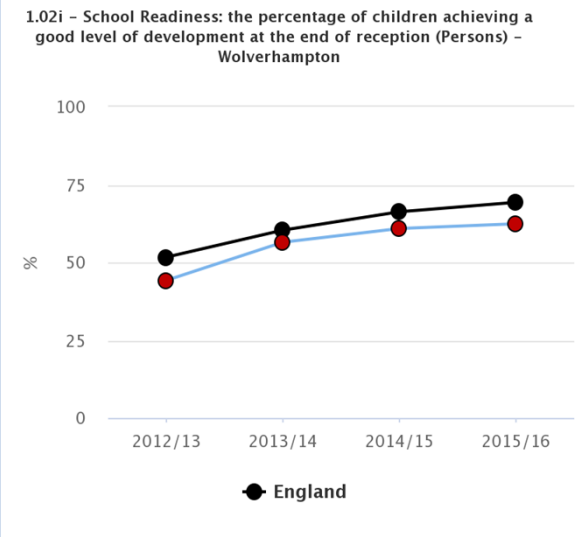
3.3 When compared to national performance across all the domains the PHOF shows that the city of Wolverhampton is an area of high Public Health need. Of the 196 indicators within PHOF the city of Wolverhampton is performing better than the England average for 21, similar to national for 70 and worse than national for 105.

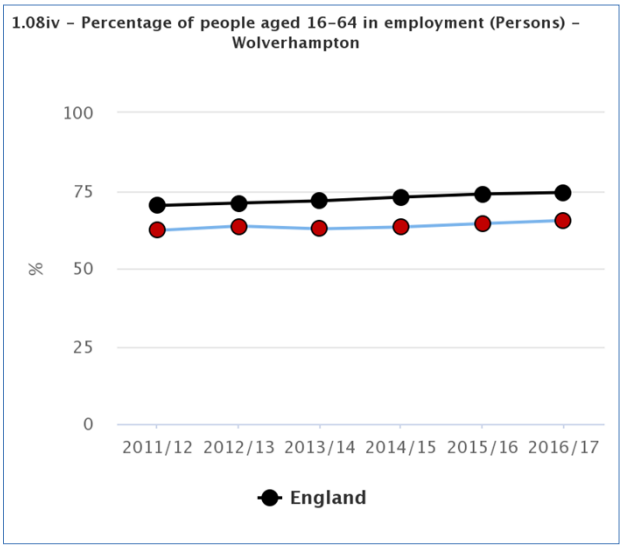
PHOF comaparison to national by domain

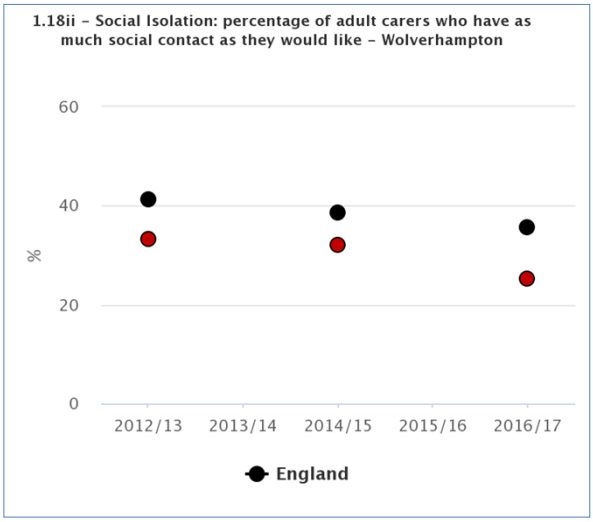
Domain	Indicators with data	Better than national	Similar to national	Worse than national	Not compared
Overarching	6			6	
Wider determinants	43	13	13	17	10
Health improvement	62	4	20	38	2
Health protection	21	3	7	11	3
Healthcare and premature mortality	64	1	30	33	1
Overall	**196**	**21**	**70**	**105**	16
Percentage overall		**11%**	**36%**	**54%**	

3.4 The full set of indicators that make up the PHOF can be found in the appendix, or via the online indicator portal available at https://fingertips.phe.org.uk/profile/public-health-outcomes-framework. The following charts present performance on key areas needed for improvement in the city of Wolverhampton.

3.4.1 Under the wider determinants domain in PHOF we have focused on school readiness, employment and social isolation in carers. Both school readiness and employment levels have been improving however a significant gap to national average remains for both. Both these indicators are key to boosting social mobility within the city. Social isolation in careers as measured by the percentage of carers who feel they have the social interaction is worsening in the city of Wolverhampton and remains significantly lower than the national average.

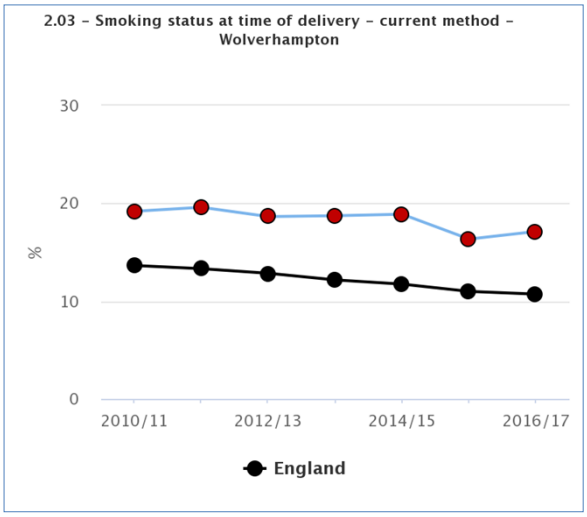


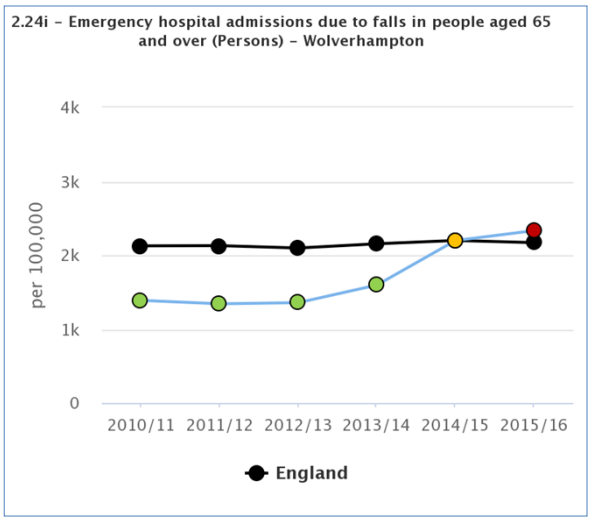


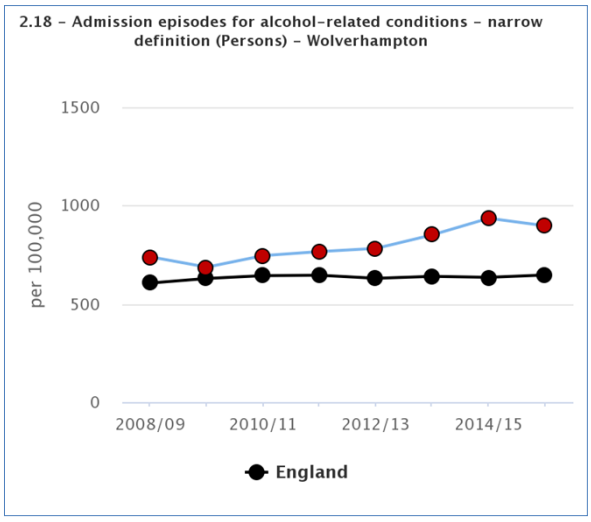


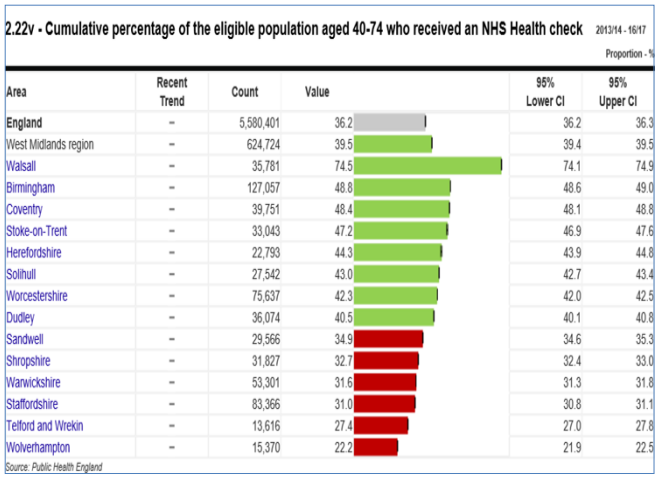
3.4.2 The health improvement domain contains many risk factors that contribute to poor health outcomes. We have chosen smoking, admissions due to falls/alcohol and health checks uptake to illustrate areas the council can have the most impact on improving health. associated with poor health. Although smoking levels are falling in the city of Wolverhampton significant gap remains to the national average. Admissions due to falls have previously been at much lower levels than they are currently with a large increase taking place from 2013/14 to 2015/16. Alcohol admissions in the city of Wolverhampton continue to increase further away from the

national average and remain significantly higher. Whilst health check uptake in the city of Wolverhampton is the lowest of anywhere in the west midlands.









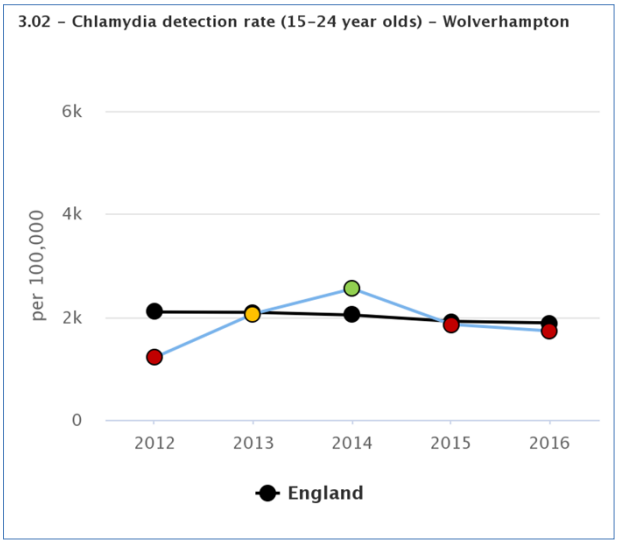
2.22v - Cumulative percentage of the eligible population aged 40-74 who received an NHS Health check 2013/14 - 16/17

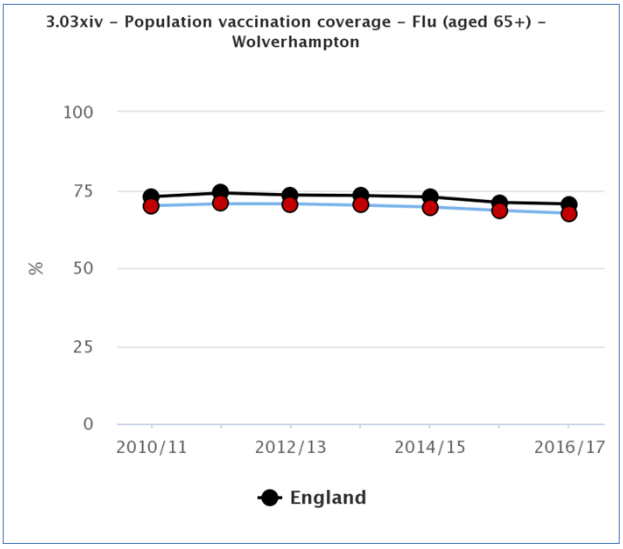
Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	-	5,580,401	36.2	36.2	36.3
West Midlands region	-	624,724	39.5	39.4	39.5
Walsall	-	35,781	74.5	74.1	74.9
Birmingham	-	127,057	48.8	48.6	49.0
Coventry	-	39,751	48.4	48.1	48.8
Stoke-on-Trent	-	33,043	47.2	46.9	47.6
Herefordshire	-	22,793	44.3	43.9	44.8
Solihull	-	27,542	43.0	42.7	43.4
Worcestershire	-	75,637	42.3	42.0	42.5
Dudley	-	36,074	40.5	40.1	40.8
Sandwell	-	29,566	34.9	34.6	35.3
Shropshire	-	31,827	32.7	32.4	33.0
Warwickshire	-	53,301	31.6	31.3	31.8
Staffordshire	-	83,366	31.0	30.8	31.1
Telford and Wrekin	-	13,616	27.4	27.0	27.8
Wolverhampton	-	15,370	22.2	21.9	22.5

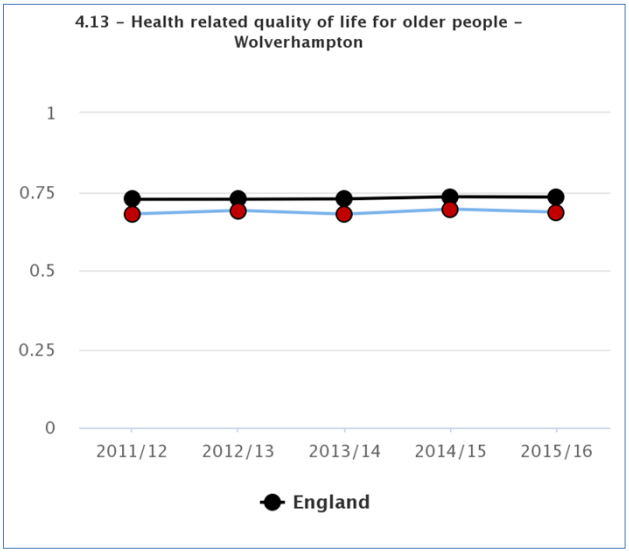
Source: Public Health England

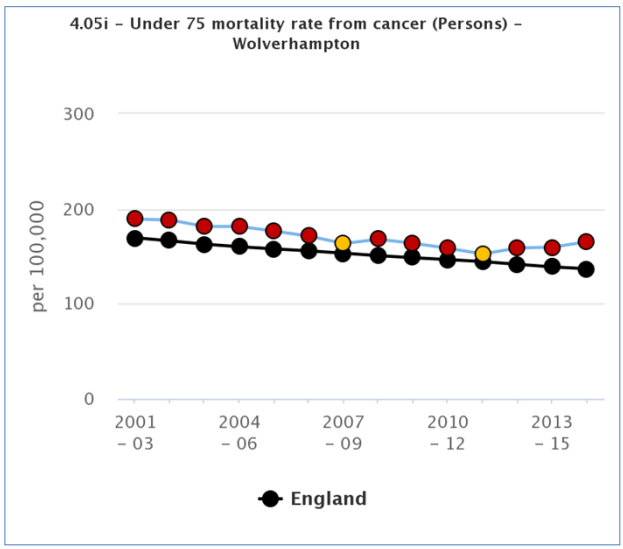
3.4.3 The indicators under the health protection domain that we have chosen to highlight are chlamydia detection rates and flu vaccine uptake. Chlamydia detection rates in the 15-24 population have fallen from 2014 when they hit the target of 2.3k per 100k for the first time. They have subsequently fell back to being significantly below the national average. Flu vaccine coverage in the 65+ population has fallen slightly over the last 3 years and remains consistently lower than the national average.





3.4.4 The heath care and premature mortality section of the PHOF concentrates on the later stages of people's lives. Two key indicators from this domain are health related quality of life for older people and premature mortality from cancer. For both of these measures the city of Wolverhampton is performing significantly worse than the national average. Cancer mortality has increased in recent years whilst quality of life for older people has fallen slightly.





3.5 The current way of working is not going to have a significant impact on the performance on PHOF that we require to make a difference to the health of people in the city of Wolverhampton. We need to move away from being a provider of services that do not have the desired population effect and move to a more preventative approach.

A good education, a stable good quality job, a decent home and living in a thriving community are strongest factors that will determine someone's health and wellbeing over their lifetime - and even before they are born.

If we get these factors right, coupled with access to good quality health and care services, they have the most significant bearing on the lifestyle choices people make and quality of life they live.

Repositioning public health in the local government in 2013 provided an unprecedented opportunity to impact on these factors and over the past five years some firm foundations have been established to build upon.

More recently, key local partners have come together to form a view their ambition for the City of Wolverhampton. The vision - New Horizons - Our vision for the City of Wolverhampton in 2030 - has created the opportunity to rethink and realign our approach to improving the health of the city at a population level, whereby we move away from traditionally providing behaviour change services to individuals and focus more on making a difference to the factors that influence our behaviour.

3.6 The City of Wolverhampton Council's (CWC) vision for public health is that by 2030;

- Our residents have a great start to life
- Our residents live longer, healthier, lives
- The gap in life expectancy will have narrowed between the most and least healthy
- Our communities are protected from harm, major incidents and other preventable health threats

To achieve these, we will aspire to be a 'Public Health Council' whereby:

- Everything we directly deliver, buy or the policies we make through the City of Wolverhampton Council (CWC) will maximise the impact on the health and wellbeing of our residents.
- We will provide leadership across the wider 'system' to promote prevention of ill-health, particularly targeting our most disadvantaged.
- We will deliver prevention and better health outcomes through supporting stronger integration of services, including those that extend beyond the NHS and social care.
- We will ensure we deliver our statutory duties.

4.0 Financial implications

4.1 Funding for Public Health is provided to the Council by the Department of Health in the form of a ring-fenced grant. The total allocation for 2017-2018 is £21.3 million and 2018-2019 is £20.8 million. Any costs associated delivering the Public Health Outcomes Framework and changes to the service will be contained within this overall allocation. [MI/08012018/T]

5.0 Legal implications

5.1 None RB/08012018/E

6.0 Equalities implications

6.1 Equalities analysis has been undertaken for the restructure and the review of commissioned services.

7.0 Environmental implications

7.1 None

8.0 Human resources implications

8.1 A staffing restructure is underway to meet the requirements of the new ways of working.

9.0 Corporate landlord implications

9.1 None

10.0 Schedule of background papers

10.1 None

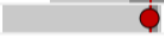
Appendix 1 PHOF Wider determinants domain

Compared with benchmark Better Similar Worse | Lower Similar Higher Not Compared

Benchmark Value
Worst/Lowest | 25th Percentile | 75th Percentile | Best/Highest

Indicator	Period	Wolves			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
1.01i - Children in low income families (all dependent children under 20)	2014	↓	17,975	30.2%	23.2%	19.9%	41.9%		6.8%
1.01ii - Children in low income families (under 16s)	2014	↓	15,775	31.0%	23.5%	20.1%	39.2%		7.0%
1.02i - School Readiness: the percentage of children achieving a good level of development at the end of reception (Persons)	2015/16	–	2,222	62.4%	67.1%	69.3%	59.7%		78.7%
1.02i - School Readiness: the percentage of children achieving a good level of development at the end of reception (Male)	2015/16	–	1,001	54.3%	59.6%	62.1%	51.2%		73.1%
1.02i - School Readiness: the percentage of children achieving a good level of development at the end of reception (Female)	2015/16	–	1,221	71.1%	74.8%	76.8%	67.5%		85.0%
1.02i - School Readiness: the percentage of children with free school meal status achieving a good level of development at the end of reception (Persons)	2015/16	–	444	54.8%	54.2%	54.4%	41.0%		72.1%
1.02i - School Readiness: the percentage of children with free school meal status achieving a good level of development at the end of reception (Male)	2015/16	–	186	45.6%	46.5%	45.8%	29.5%		68.6%
1.02i - School Readiness: the percentage of children with free school meal status achieving a good level of development at the end of reception (Female)	2015/16	–	258	64.2%	62.2%	63.5%	47.7%		80.4%
1.02ii - School Readiness: the percentage of Year 1 pupils achieving the expected level in the phonics screening check (Persons)	2015/16	↑	2,636	79.0%	80.7%	80.5%	74.5%		89.1%
1.02ii - School Readiness: the percentage of Year 1 pupils achieving the expected level in the phonics screening check (Male)	2015/16	–	1,313	75.4%	77.0%	76.9%	70.5%		88.1%
1.02ii - School Readiness: the percentage of Year 1 pupils achieving the expected level in the phonics screening check (Female)	2015/16	–	1,323	82.9%	84.6%	84.3%	78.7%		92.6%
1.02ii - School Readiness: the percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check (Persons)	2015/16	↑	529	70.3%	70.4%	68.6%	53.2%		84.2%
1.02ii - School Readiness: the percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check (Male)	2015/16	–	259	64.6%	64.7%	63.6%	46.6%		84.0%
1.02ii - School Readiness: the percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check (Female)	2015/16	–	270	76.9%	76.5%	74.0%	56.8%		100%
1.03 - Pupil absence	2015/16	↓	564,055	4.65%	4.58%	4.57%	5.50%		3.23%
1.04 - First time entrants to the youth justice system	2016	↓	128	545.4	398.5	327.1	739.6		97.5
1.05 - 16-18 year olds not in education employment or training	2015	↓	320	3.4%	4.3%	4.2%	7.9%		1.5%
1.06i - Adults with a learning disability who live in stable and appropriate accommodation (Persons)	2015/16	→	304	66.1%	67.9%	75.4%	41.9%		94.4%
1.06i - Adults with a learning disability who live in stable and appropriate accommodation (Male)	2015/16	→	196	67.8%	67.6%	74.9%	40.6%		94.2%
1.06i - Adults with a learning disability who live in stable and appropriate accommodation (Female)	2015/16	→	108	63.2%	68.3%	75.6%	43.6%		96.1%
1.06ii - Adults in contact with secondary mental health services who live in stable and appropriate accommodation (Persons)	2015/16	–	-	79.7%	72.5%	58.6%	1.6%		92.6%
1.06ii - Adults in contact with secondary mental health services who live in stable and appropriate accommodation (Male)	2015/16	–	-	72.3%	71.2%	57.4%	1.3%		92.1%
1.06ii - Adults in contact with secondary mental health services who live in stable and appropriate accommodation (Female)	2015/16	–	-	89.9%	74.0%	60.0%	0.6%		93.5%
1.07 - People in prison who have a mental illness or a significant mental illness - current method	2016/17	–	-	-	-	-	-	*Insufficient number of values for a spine chart*	-

Wider determinants domain continued……

1.07 - People in prison who have a mental illness or a significant mental illness - historic method	2013/14	–	-	-	-	5.55%	-	*Insufficient number of values for a spine chart*	-
1.08i - Gap in the employment rate between those with a long-term health condition and the overall employment rate	2016/17	–	-	28.1	28.7	29.4	38.8		12.3
1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate (Persons)	2015/16	–	-	62.7	65.9	68.1	77.8		48.3
1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate (Male)	2015/16	–	-	69.3	71.8	73.0	83.0		47.4
1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate (Female)	2015/16	–	-	55.8	60.3	63.6	74.8		38.4
1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate (Persons)	2015/16	–	-	57.5	60.6	67.2	78.4		53.6
1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate (Male)	2015/16	–	-	64.1	68.6	73.7	84.2		62.2
1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate (Female)	2015/16	–	-	50.8	52.4	60.8	73.1		43.8
1.08iv - Percentage of people aged 16-64 in employment (Persons)	2016/17	↑	104,300	65.4%	71.4%	74.4%	60.9%		82.4%
1.08iv - Percentage of people aged 16-64 in employment (Male)	2016/17	↑	56,400	71.1%	77.7%	79.5%	62.2%		89.0%
1.08iv - Percentage of people aged 16-64 in employment (Female)	2016/17	↓	47,900	59.7%	65.1%	69.5%	54.1%		80.9%
1.09i - Sickness absence - the percentage of employees who had at least one day off in the previous week	2014 - 16	–	-	1.8%	2.0%	2.1%	4.0%		0.9%
1.09ii - Sickness absence - the percentage of working days lost due to sickness absence	2014 - 16	–	-	1.0%	1.2%	1.2%	2.6%		0.4%
1.10 - Killed and seriously injured (KSI) casualties on England's roads	2013 - 15	–	217	28.6	33.9	38.5	74.0		11.8
1.11 - Domestic abuse-related incidents and crimes - current method	2015/16	–	-	23.5	23.6	22.1	9.4		38.4
1.11 - Domestic abuse - historic method	2014/15	–	-	22.4	20.3	20.4	5.5		33.8
1.12i - Violent crime (including sexual violence) - hospital admissions for violence	2013/14 - 15/16	–	712	85.4	44.2	44.8	133.4		9.1
1.12ii - Violent crime (including sexual violence) - violence offences per 1,000 population	2015/16	↑	4,591	18.1	17.0	17.2	6.7		36.7
1.12iii- Violent crime (including sexual violence) - rate of sexual offences per 1,000 population	2015/16	↑	437	1.7	1.7	1.7	0.9		3.5
1.13i - Re-offending levels - percentage of offenders who re-offend	2014	→	691	26.1%	25.0%	25.4%	20.0%		35.0%
1.13ii - Re-offending levels - average number of re-offences per offender	2014	↑	2,299	0.87	0.82	0.82	0.56		1.38
1.13iii - First time offenders	2016	–	892	350.6	239.8	218.4	68.3		440.1
1.14i - The rate of complaints about noise	2014/15	↓	1,940	7.7	5.7*	7.1*	72.9		2.2
1.14ii - The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime	2011	–	11,880	4.8%	4.1%	5.2%	20.8%		0.8%
1.14iii - The percentage of the population exposed to road, rail and air transport noise of 55 dB(A) or more during the night-	2011	–	16,820	6.7%	7.5%	8.0%	42.4%		1.2%
1.15i - Statutory homelessness - Eligible homeless people not in priority need	2016/17	↑	237	2.3	1.1*	0.8	9.6		0.0
1.15ii - Statutory homelessness - households in temporary accommodation	2016/17	→	60	0.6	1.1*	3.3	37.5		0.0
1.16 - Utilisation of outdoor space for exercise/health reasons	Mar 2015 - Feb 2016	–	-	27.6%	17.7%	17.9%	5.1%		36.9%
1.17 - Fuel poverty	2015	↓	15,158	14.6%	13.5%	11.0%	18.2%		6.7%
1.18i - Social Isolation: percentage of adult social care users who have as much social contact as they would like	2016/17	–	-	50.9%	46.1%	45.4%	34.5%		52.9%
1.18ii - Social Isolation: percentage of adult carers who have as much social contact as they would like	2016/17	–	87	25.2%	36.9%	35.5%	21.5%		55.0%

Appendix 2 PHOF Health improvement domain

Compared with benchmark Better Similar Worse Lower Similar Higher Not Compared

Indicator	Period	Wolves			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
2.01 - Low birth weight of term babies	2015	→	106	3.5%	3.3%	2.8%	4.8%		1.3%
2.02i - Breastfeeding - breastfeeding initiation	2014/15	→	2,191	64.4%	66.8%	74.3%	47.2%		92.9%
2.02ii - Breastfeeding - breastfeeding prevalence at 6-8 weeks after birth - current method	2015/16	–	1,160	32.4%	*	43.2%*	18.0%		76.5%
2.02ii - Breastfeeding - breastfeeding prevalence at 6-8 weeks after birth - historical method	2014/15	–	1,068	*	*	43.8%	19.1%		81.5%
2.03 - Smoking status at time of delivery - current method	2016/17	↓	585	17.1%	11.8%	10.7%	28.1%		2.3%
2.03 - Smoking status at time of delivery - historical method	2016/17	↓	585	17.1%	11.4%*	10.5%	28.1%		2.3%
2.04 - Under 18 conceptions	2015	↓	142	31.9	23.7	20.8	43.8		5.7
2.04 - Under 18 conceptions: conceptions in those aged under 16	2015	→	25	6.0	4.3	3.7	8.6		0.9
2.05ii - Proportion of children aged 2-2½yrs offered ASQ-3 as part of the Healthy Child Programme or integrated review	2015/16	–	1,881	*	83.7%	81.3%*	-	*Insufficient number of values for a spine chart*	-
2.06i - Child excess weight in 4-5 and 10-year olds - 4-5 year olds	2015/16	→	810	25.3%	23.3%	22.1%	30.1%		14.3%
2.06ii - Child excess weight in 4-5 and 10-year olds - 10-11 year olds	2015/16	↑	1,160	40.3%	36.6%	34.2%	43.4%		22.9%
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	2015/16	→	479	97.6	110.4	104.2	207.4		53.5
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years)	2015/16	→	202	111.8	139.1	129.6	254.2		56.0
2.07ii - Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years)	2015/16	↑	452	138.0	126.1	134.1	280.2		72.0
2.08i - Average difficulties score for all looked after children aged 5-16 who have been in care for at least 12 months on 31st March	2015/16	–	-	14.2	14.1	14.0	17.6		10.2
2.08ii - Percentage of children where there is a cause for concern	2015/16	–	93	36.6	38.4	37.8	55.6		20.5
2.09i - Smoking prevalence at age 15 - current smokers (WAY survey)	2014/15	–	-	7.6%	7.0%	8.2%	14.9%		3.4%
2.09ii - Smoking prevalence at age 15 - regular smokers (WAY survey)	2014/15	–	-	5.9%	4.9%	5.5%	11.1%		1.3%
2.09iii - Smoking prevalence at age 15 - occasional smokers (WAY survey)	2014/15	–	-	1.7%	2.0%	2.7%	7.6%		0.6%
2.09iv - Smoking prevalence at age 15 years - regular smokers (SDD survey)	2016	–	-	-	-	7%	-	*Insufficient number of values for a spine chart*	-
2.09v - Smoking prevalence at age 15 years - occasional smokers (SDD survey)	2016	–	-	-	-	8%	-	*Insufficient number of values for a spine chart*	-
2.10ii - Emergency Hospital Admissions for Intentional Self-Harm	2015/16	–	694	268.7	208.9	196.5	635.3		55.7
2.11i - Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults) - current method	2015/16	–	-	47.8%	56.1%	56.8%	41.6%		66.6%
2.11i - Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults) - historical method	2015	–	-	43.9%	48.8%	52.3%	36.5%		62.8%
2.11ii - Average number of portions of fruit consumed daily (adults) - current method	2015/16	–	-	2.46	2.65	2.63	2.24		3.12
2.11ii - Average number of portions of fruit consumed daily (adults) - historical method	2015	–	-	2.26	2.43	2.51	2.11		2.93
2.11iii - Average number of portions of vegetables consumed daily (adults) - current method	2015/16	–	-	2.35	2.62	2.68	2.23		3.11
2.11iii - Average number of portions of vegetables consumed daily (adults) - historical method	2015	–	-	1.89	2.14	2.27	1.70		2.60
2.11iv - Proportion of the population meeting the recommended "5-a-day" at age 15	2014/15	–	-	49.6%	51.1%	52.4%	39.9%		67.6%
2.11v - Average number of portions of fruit consumed daily at age 15 (WAY survey)	2014/15	–	-	2.36	2.33	2.39	2.01		3.26
2.11vi - Average number of portions of vegetables consumed daily at age 15 (WAY survey)	2014/15	–	-	2.30	2.35	2.40	1.86		2.92
2.12 - Percentage of adults (aged 18+) classified as overweight or obese - current method	2015/16	–	-	68.0%	63.9%	61.3%	73.4%		42.7%
2.12 - Percentage of adults (aged 16+) classified as overweight or obese - historical method	2013 - 15	–	-	66.3%	66.8%	64.8%	76.2%		46.5%

Health improvement domain continued……

2.13i - Percentage of physically active adults - current method	2015/16	–	-	55.5	62.5	64.9	53.9		73.7
2.13i - Percentage of physically active adults - historical method	2015	–	-	49.9%	55.1%	57.0%	44.8%		69.8%
2.13ii - Percentage of physically inactive adults - current method	2015/16	–	-	27.9	24.1	22.3	32.5		14.1
2.13ii - Percentage of physically inactive adults - historical method	2015	–	-	35.2%	30.9%	28.7%	43.7%		17.5%
2.14 - Smoking Prevalence in adults - current smokers (APS)	2016	–	-	16.5%	15.4%	15.5%	24.2%		7.4%
2.15i - Successful completion of drug treatment - opiate users	2016	↓	52	5.1%	5.7%	6.7%	2.4%		17.4%
2.15ii - Successful completion of drug treatment - non-opiate users	2016	→	62	27.7%	35.4%	37.1%	18.1%		60.6%
2.15iii - Successful completion of alcohol treatment	2016	↑	226	40.6%	38.2%	38.7%	17.3%		70.9%
2.15iv - Deaths from drug misuse	2014 - 16	–	32	4.4	4.3	4.2	20.1		1.2
2.16 - Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison	2016/17	–	83	32.8%	31.5%	30.3%	8.8%		73.8%
2.17 - Recorded diabetes	2014/15	↑	16,890	8.1%	7.3%	6.4%	3.7%		8.9%
2.18 - Admission episodes for alcohol-related conditions - narrow definition (Persons)	2015/16	–	2,078	897	728	647	1,163		390
2.18 - Admission episodes for alcohol-related conditions - narrow definition (Male)	2015/16	–	1,243	1,114	908	830	1,427		509
2.18 - Admission episodes for alcohol-related conditions - narrow definition (Female)	2015/16	–	835	698	566	483	918		274
2.19 - Cancer diagnosed at early stage (experimental statistics)	2015	–	482	50.7%	52.1%	52.4%	41.6%		60.4%
2.20i - Cancer screening coverage - breast cancer	2016	↓	17,763	71.2%	75.8%	75.5%	57.2%		84.0%
2.20ii - Cancer screening coverage - cervical cancer	2016	↓	45,423	68.1%	71.8%	72.7%	55.5%		81.4%
2.20iii - Cancer screening coverage - bowel cancer	2016	–	17,116	52.0%	57.3%	57.9%	40.9%		66.4%
2.20iv - Abdominal Aortic Aneurysm Screening - Coverage	2015/16	–	995	78.0%	79.3%	79.9%	57.5%		87.2%
2.20v - Diabetic eye screening - uptake	2015/16	–	-	-	81.3%	83.0%	-	*Insufficient number of values for a spine chart*	-
2.20vii - Infectious Diseases in Pregnancy Screening - HIV Coverage	2015/16	–	-	-	98.7%	99.1%	-	*Insufficient number of values for a spine chart*	-
2.20viii - Infectious Diseases in Pregnancy Screening - Syphilis Coverage	2015	–	-	-	97.7%	98.2%	-	*Insufficient number of values for a spine chart*	-
2.20ix - Infectious Diseases in Pregnancy Screening - Hepatitis B Coverage	2015	–	-	-	97.4%	98.1%	-	*Insufficient number of values for a spine chart*	-
2.20x - Sickle Cell and Thalassaemia Screening - Coverage	2015/16	–	-	-	99.2%	99.1%	-	*Insufficient number of values for a spine chart*	-
2.20xi - Newborn Blood Spot Screening - Coverage	2015/16	–	3,034	99.2%*	97.6%*	95.6%*	70.2%		99.8%
2.20xii - Newborn Hearing Screening - Coverage	2015/16	–	3,322	98.1%	99.0%	98.7%	95.1%		99.9%
2.20xiii - Newborn and Infant Physical Examination Screening - Coverage	2015/16	–	-	-	95.8%	94.9%	-	*Insufficient number of values for a spine chart*	-
2.22iii - Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check	2013/14 - 16/17	–	50,616	73.1%	87.0%	74.1%	23.0%		100%
2.22iv - Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check	2013/14 - 16/17	–	15,370	30.4%	45.3%	48.9%	20.5%		100.0%
2.22v - Cumulative percentage of the eligible population aged 40-74 who received an NHS Health check	2013/14 - 16/17	–	15,370	22.2%	39.5%	36.2%	15.1%		89.0%
2.23i - Self-reported wellbeing - people with a low satisfaction score	2015/16	–	-	7.6%	4.3%	4.6%	-	*Insufficient number of values for a spine chart*	-
2.23ii - Self-reported wellbeing - people with a low worthwhile score	2015/16	–	-	6.4%	3.4%	3.6%	-	*Insufficient number of values for a spine chart*	-
2.23iii - Self-reported wellbeing - people with a low happiness score	2015/16	–	-	10.0%	8.2%	8.8%	13.9%		4.9%
2.23iv - Self-reported wellbeing - people with a high anxiety score	2015/16	–	-	15.5%	18.6%	19.4%	30.6%		11.9%
2.24i - Emergency hospital admissions due to falls in people aged 65 and over (Persons)	2015/16	–	1,060	2,332	2185	2169	3,426		1,237
2.24i - Emergency hospital admissions due to falls in people aged 65 and over (Male)	2015/16	–	335	1,872	1748	1733	3,116		825
2.24i - Emergency hospital admissions due to falls in people aged 65 and over (Female)	2015/16	–	725	2,646	2489	2471	3,859		1,535
2.24ii - Emergency hospital admissions due to falls in people aged 65 and over - aged 65-79 (Persons)	2015/16	–	304	1,010	1004	1012	1,726		586
2.24ii - Emergency hospital admissions due to falls in people aged 65 and over - aged 65-79 (Male)	2015/16	–	118	838	814	825	1,628		354
2.24ii - Emergency hospital admissions due to falls in people aged 65 and over - aged 65-79 (Female)	2015/16	–	186	1,161	1173	1177	1,891		789
2.24iii - Emergency hospital admissions due to falls in people aged 65 and over - aged 80+ (Persons)	2015/16	–	756	6,166	5610	5526	8,353		3,126
2.24iii - Emergency hospital admissions due to falls in people aged 65 and over - aged 80+ (Male)	2015/16	–	217	4,869	4457	4367	7,719		2,124
2.24iii - Emergency hospital admissions due to falls in people aged 65 and over - aged 80+ (Female)	2015/16	–	539	6,954	6306	622[illegible]			3,664

Appendix 3 PHOF Health protection domain

Compared with benchmark Better Similar Worse | Lower Similar Higher Not Compared

Benchmark Value
Worst/Lowest | 25th Percentile | 75th Percentile | Best/Highest

Indicator	Period	Wolves			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
3.01 - Fraction of mortality attributable to particulate air pollution	2015	–	-	5.0%	4.8%	4.7%	6.7%		3.2%
3.02 - Chlamydia detection rate (15-24 year olds) <1,900 1,900 to 2,300 ≥2,300	2016	↑	565	1,725	1714	1882	813		4,938
3.02 - Chlamydia detection rate (15-24 year olds) (Male)	2016	→	185	1,105	1145	1269	521		3,901
3.02 - Chlamydia detection rate (15-24 year olds) (Female)	2016	↑	374	2,337	2305	2479	1,116		5,558
3.03i - Population vaccination coverage - Hepatitis B (1 year old)	2015/16	–	-	*	*	*	-	-	-
3.03i - Population vaccination coverage - Hepatitis B (2 years old)	2015/16	–	-	*	*	*	-	-	-
3.03ii - Population vaccination coverage - BCG - areas offering universal BCG only	2015/16	–	-	*	-	*	-	-	-
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old) <90% 90% to 95% ≥95%	2015/16	↓	3,080	92.3%*	94.3%	93.6%	70.4%		98.9%
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old) <90% 90% to 95% ≥95%	2015/16	↓	3,235	94.0%*	96.2%	95.2%	73.0%		99.2%
3.03iv - Population vaccination coverage - MenC <90% 90% to 95% ≥95%	2015/16	–	-	*	*	*	-	-	-
3.03v - Population vaccination coverage - PCV <90% 90% to 95% ≥95%	2015/16	↓	3,070	92.0%*	94.2%	93.5%	75.5%		99.1%
3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old) <90% 90% to 95% ≥95%	2015/16	→	3,134	91.1%*	93.1%	91.6%	65.2%		97.5%
3.03vi - Population vaccination coverage - Hib / Men C booster (5 years old) <90% 90% to 95% ≥95%	2015/16	↓	2,971	85.9%*	93.1%	92.6%	68.2%		97.7%
3.03vii - Population vaccination coverage - PCV booster <90% 90% to 95% ≥95%	2015/16	↑	3,139	91.3%	93.0%	91.5%	67.1%		97.6%
3.03viii - Population vaccination coverage - MMR for one dose (2 years old) <90% 90% to 95% ≥95%	2015/16	↑	3,146	91.5%*	93.1%	91.9%	69.3%		97.7%
3.03ix - Population vaccination coverage - MMR for one dose (5 years old) <90% 90% to 95% ≥95%	2015/16	↑	3,260	94.2%*	95.6%	94.8%	71.1%		98.9%
3.03x - Population vaccination coverage - MMR for two doses (5 years old) <90% 90% to 95% ≥95%	2015/16	↑	3,015	87.1%*	89.1%	88.2%	56.5%		98.6%
3.03xii - Population vaccination coverage - HPV vaccination coverage for one dose (females 12-13 years old) <80% 80% to 90% ≥90%	2015/16	–	1,303	92.1%	85.4%	87.0%	68.4%		97.3%
3.03xiii - Population vaccination coverage - PPV <65% 65% to 75% ≥75%	2016/17	↑	27,494	65.4%	68.5%	69.8%	49.4%		80.7%
3.03xiv - Population vaccination coverage -Flu (aged 65+) <75% ≥75%	2016/17	↓	30,039	67.5%	70.1%*	70.5%	48.6%		78.1%
3.03xv - Population vaccination coverage - Flu (at risk individuals) <55% ≥55%	2016/17	↓	15,221	47.4%	49.5%*	48.6%	36.2%		61.2%
3.03xvi - Population vaccination coverage -HPV vaccination coverage for two doses (females 13-14 years old) <80% 80% to 90% ≥90%	2015/16	–	1,276	91.8%	86.0%	85.1%	43.7%		99.1%
3.03xvii - Population vaccination coverage -Shingles vaccination coverage (70 years old) <50% 50% to 60% ≥60%	2015/16	–	982	51.9%	55.5%	54.9%	25.6%		68.8%
3.03xviii - Population vaccination coverage -Flu (2-4 years old) <40% 40% to 65% ≥65%	2016/17	–	3,661	32.5%	38.2%*	38.1%	19.2%		52.4%
3.04 - HIV late diagnosis <25% 25% to 50% ≥50%	2014 - 16	–	39	47.6%	44.1%	40.1%	80.0%		18.2%
3.05i - Treatment completion for TB	2015	→	41	82.0%	83.1%	83.4%	-	*Insufficient number of values for a spine chart*	-
3.05ii - Incidence of TB	2014 - 16	–	180	23.6	12.7	10.9	69.0		1.3
3.06 - NHS organisations with a board approved sustainable development management plan	2015/16	→	3	75.0%	55.8%	66.2%	25.0%		100%
3.08 - Adjusted antibiotic prescribing in primary care by the NHS ≤ mean England prescribing (2013/14) > mean England prescribing (2013/14)	2016	–	158,909	1.06	1.12	1.08	1.44		0.67

Appendix 4 Healthcare and premature mortality domain

Compared with benchmark Better Similar Worse Lower Similar Higher Not Compared

Benchmark Value
Worst/Lowest 25th Percentile 75th Percentile Best/Highest

Indicator	Period	Wolves			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
4.01 - Infant mortality	2014 - 16	–	58	5.6	6.0	3.9	7.9		1.6
4.02 - Proportion of five year old children free from dental decay	2014/15	–	1,508	72.2%	76.6%	75.2%	43.9%		85.9%
4.03 - Mortality rate from causes considered preventable (Persons)	2014 - 16	–	1,575	239.6	196.1	182.8	330.0		129.7
4.03 - Mortality rate from causes considered preventable (Male)	2014 - 16	–	971	307.3	250.8	230.4	413.7		162.8
4.03 - Mortality rate from causes considered preventable (Female)	2014 - 16	–	604	175.7	145.4	138.5	254.4		97.6
4.04i - Under 75 mortality rate from all cardiovascular diseases (Persons)	2014 - 16	–	624	106.5	78.0	73.5	141.3		45.6
4.04i - Under 75 mortality rate from all cardiovascular diseases (Male)	2014 - 16	–	418	145.7	109.3	102.7	189.8		68.1
4.04i - Under 75 mortality rate from all cardiovascular diseases (Female)	2014 - 16	–	206	69.0	48.0	45.8	96.0		26.1
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Persons)	2014 - 16	–	381	65.4	49.7	46.7	94.9		24.3
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Male)	2014 - 16	–	277	97.4	75.6	70.4	136.5		42.2
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Female)	2014 - 16	–	104	35.0	24.8	24.3	55.6		8.9
4.05i - Under 75 mortality rate from cancer (Persons)	2014 - 16	–	964	165.3	141.9	136.8	195.3		100.0
4.05i - Under 75 mortality rate from cancer (Male)	2014 - 16	–	521	184.3	158.8	152.1	222.3		92.4
4.05i - Under 75 mortality rate from cancer (Female)	2014 - 16	–	443	147.6	126.0	122.6	180.0		90.5
4.05ii - Under 75 mortality rate from cancer considered preventable (Persons)	2014 - 16	–	552	94.8	81.9	79.4	128.6		56.5
4.05ii - Under 75 mortality rate from cancer considered preventable (Male)	2014 - 16	–	310	109.9	90.1	85.9	139.0		53.0
4.05ii - Under 75 mortality rate from cancer considered preventable (Female)	2014 - 16	–	242	80.7	74.2	73.4	119.5		51.3
4.06i - Under 75 mortality rate from liver disease (Persons)	2014 - 16	–	201	32.8	20.9	18.3	44.7		9.8
4.06i - Under 75 mortality rate from liver disease (Male)	2014 - 16	–	127	42.5	27.1	23.9	56.8		8.5
4.06i - Under 75 mortality rate from liver disease (Female)	2014 - 16	–	74	23.6	14.9	12.8	32.7		5.6
4.06ii - Under 75 mortality rate from liver disease considered preventable (Persons)	2014 - 16	–	183	29.9	18.6	16.1	41.9		8.7
4.06ii - Under 75 mortality rate from liver disease considered preventable (Male)	2014 - 16	–	116	38.8	24.5	21.5	54.8		8.5
4.06ii - Under 75 mortality rate from liver disease considered preventable (Female)	2014 - 16	–	67	21.4	12.8	10.9	29.2		5.5
4.07i - Under 75 mortality rate from respiratory disease (Persons)	2014 - 16	–	240	41.3	35.4	33.8	70.2		18.1
4.07i - Under 75 mortality rate from respiratory disease (Male)	2014 - 16	–	144	51.3	41.6	39.2	78.1		22.7
4.07i - Under 75 mortality rate from respiratory disease (Female)	2014 - 16	–	96	32.1	29.6	28.7	69.0		11.2
4.07ii - Under 75 mortality rate from respiratory disease considered preventable (Persons)	2014 - 16	–	125	22.0	19.1	18.6	46.7		8.0
4.07ii - Under 75 mortality rate from respiratory disease considered preventable (Male)	2014 - 16	–	69	25.3	21.8	20.8	48.2		8.0
4.07ii - Under 75 mortality rate from respiratory disease considered preventable (Female)	2014 - 16	–	56	19.0	16.6	16.5	45.8		4.9
4.08 - Mortality rate from a range of specified communicable diseases, including influenza (Persons)	2014 - 16	–	138	19.8	12.4	10.7	22.0		5.1
4.08 - Mortality rate from a range of specified communicable diseases, including influenza (Male)	2014 - 16	–	64	21.4	13.9	11.6	23.2		5.6
4.08 - Mortality rate from a range of specified communicable diseases, including influenza (Female)	2014 - 16	–	74	18.7	11.3	9.9	21.0		3.8

Healthcare and premature mortality domain continued……

4.09i - Excess under 75 mortality rate in adults with serious mental illness	2014/15	–	-	478.8	400.7	370.0	570.4		164.8
4.09ii - Proportion of adults in the population in contact with secondary mental health services	2014/15	–	8,126	4.7%	5.6%	5.4%	14.5%		2.7%
4.10 - Suicide rate (Persons)	2014 - 16	–	66	10.1	10.0	9.9	18.3		6.1
4.10 - Suicide rate (Male)	2014 - 16	–	56	17.4	15.9	15.3	27.7		8.4
4.10 - Suicide rate (Female)	2014 - 16	–	10	3.0	4.4	4.8	11.3		2.3
4.11 - Emergency readmissions within 30 days of discharge from hospital (Persons)	2011/12	–	3,376	11.9%	11.8%	11.8%	14.5%		8.8%
4.11 - Emergency readmissions within 30 days of discharge from hospital (Male)	2011/12	–	1,664	12.1%	12.2%	12.1%	14.9%		8.7%
4.11 - Emergency readmissions within 30 days of discharge from hospital (Female)	2011/12	–	1,712	11.7%	11.5%	11.5%	14.7%		8.3%
4.12i - Preventable sight loss - age related macular degeneration (AMD)	2015/16	↓	42	98.4	88.4*	114.0	403.9		11.8
4.12ii - Preventable sight loss - glaucoma	2015/16	→	12	9.9	9.6*	12.8	39.2		4.0
4.12iii - Preventable sight loss - diabetic eye disease	2015/16	→	6	2.8	2.3*	2.9	-	*Insufficient number of values for a spine chart*	-
4.12iv - Preventable sight loss - sight loss certifications	2015/16	↓	89	35.0	33.0*	41.9	109.1		5.7
4.13 - Health related quality of life for older people	2015/16	–	-	0.685	0.719	0.733	0.642		0.799
4.14i - Hip fractures in people aged 65 and over (Persons)	2015/16	–	325	710	619	589	820		391
4.14i - Hip fractures in people aged 65 and over (Male)	2015/16	–	101	562	449	416	669		259
4.14i - Hip fractures in people aged 65 and over (Female)	2015/16	–	224	806	740	710	962		439
4.14ii - Hip fractures in people aged 65 and over - aged 65-79 (Persons)	2015/16	–	76	251	262	244	375		164
4.14ii - Hip fractures in people aged 65 and over - aged 65-79 (Male)	2015/16	–	25	178	185	168	-	*Insufficient number of values for a spine chart*	-
4.14ii - Hip fractures in people aged 65 and over - aged 65-79 (Female)	2015/16	–	51	315	331	311	506		202
4.14iii - Hip fractures in people aged 65 and over - aged 80+ (Persons)	2015/16	–	249	2,042	1652	1591	2,311		953
4.14iii - Hip fractures in people aged 65 and over - aged 80+ (Male)	2015/16	–	76	1,675	1212	1136	1,881		706
4.14iii - Hip fractures in people aged 65 and over - aged 80+ (Female)	2015/16	–	173	2,229	1924	1868	2,611		1,175
4.15i - Excess winter deaths index (single year, all ages) (Persons)	Aug 2015 - Jul 2016	–	102	12.3	15.6	15.1	27.9		-0.7
4.15i - Excess winter deaths index (single year, all ages) (Male)	Aug 2015 - Jul 2016	–	52	12.7	14.9	13.9	37.7		-9.2
4.15i - Excess winter deaths index (single year, all ages) (Female)	Aug 2015 - Jul 2016	–	50	11.9	16.3	16.2	35.5		-11.4
4.15ii - Excess winter deaths index (single year, age 85+) (Persons)	Aug 2015 - Jul 2016	–	27	8.3	15.8	17.7	47.0		-11.7
4.15ii - Excess winter deaths index (single year, age 85+) (Male)	Aug 2015 - Jul 2016	–	21	17.4	14.2	17.5	54.5		-19.0
4.15ii - Excess winter deaths index (single year, age 85+) (Female)	Aug 2015 - Jul 2016	–	6	3.0	16.8	17.8	64.2		-14.1
4.15iii - Excess winter deaths index (3 years, all ages) (Persons)	Aug 2013 - Jul 2016	–	367	15.3	18.3	17.9	28.9		7.4
4.15iii - Excess winter deaths index (3 years, all ages) (Male)	Aug 2013 - Jul 2016	–	145	12.1	15.8	15.4	35.2		0.9
4.15iii - Excess winter deaths index (3 years, all ages) (Female)	Aug 2013 - Jul 2016	–	222	18.7	20.7	20.2	32.3		2.9
4.15iv - Excess winter deaths index (3 years, age 85+) (Persons)	Aug 2013 - Jul 2016	–	157	17.5	24.1	24.6	39.9		4.9
4.15iv - Excess winter deaths index (3 years, age 85+) (Male)	Aug 2013 - Jul 2016	–	53	15.2	22.8	23.3	56.5		-5.3
4.15iv - Excess winter deaths index (3 years, age 85+) (Female)	Aug 2013 - Jul 2016	–	105	19.0	24.9	25.3	48.4		8.1
4.16 - Estimated dementia diagnosis rate (aged 65+)	2017	–	2,204	73.4%	65.6%	67.9%	53.8%		90.8%

≥ 66.7% (significantly) similar to 66.7%
< 66.7% (significantly)

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Briefing Note

Agenda Item No: 8

CITY OF WOLVERHAMPTON COUNCIL

Title: Dementia Friendly Community

Prepared by: Susan Eagle - Commissioning Officer

Date: 25th January 2018

Intended audience: Internal ☐ Partner organisation ☐ Public ☒ Confidential ☐

Purpose or recommendation

The purpose of this briefing note is to inform all stakeholders that the Alzheimer's Society has granted the City of Wolverhampton Council, Dementia Friendly Community status (DFC) for 2017/18 on 5 December 2017.

Councillors are invited to attend a celebration event on 31 January 2018 at Wolverhampton Art Gallery.

Please contact Earl Piggott-Smith on earl.piggot-smith@wolverhampton.gov.uk for further details.

1.0 **Overview**

The City of Wolverhampton had previously achieved recognition as a Dementia Friendly Community in 2014. To retain the status, the Alzheimer's Society require continuous improvements and will review evidence that the necessary work is being continued.

The recognition is officially defined as "working towards" by the Alzheimer's Society as not all areas within a community can be classified as dementia friendly.

An on-line application to be recognised as working towards becoming a Dementia Friendly Community 2017/18 was made to the Alzheimer's Society on 5 December 2017 by the Wolverhampton Dementia Action Alliance. (The Alliance has successfully brought together dozens of local organisations that want to become more dementia friendly, including retailers, businesses, the emergency services, religious groups, and education providers).

The Alzheimer's Society 'status' is a recognition of all the good work done by partners in the Alliance who have undertaken actions to become dementia friendly. The intention is to retain the status through self - assessment each year.

The Alzheimer's Society define a Dementia Friendly Community as follows:

> *A city, town or village where people with dementia are understood, respected and supported, and confident they can contribute to community life. In a dementia-friendly community people will be aware of and understand dementia, and people with dementia will feel included and involved and have choice and control over their day-to-day lives.*

The creation of Dementia Friendly Communities was a priority stated in the Prime Minister's Challenge on Dementia in 2012. The focus on improving services for people with dementia supports the City of Wolverhampton Council's aims to reduce isolation, promote independence, and enable communities to use our assets that can support vulnerable people and their families.

2.0 **Criteria to be recognised as a Dementia Friendly Community**

All communities that register for the Dementia Friendly Communities recognition process will be formally working towards meeting the foundation criteria for being dementia friendly.

There are seven areas to provide evidence against to achieve the recognition. The criteria Dementia Friendly Community status are as follows:

- Implement a local structure
- Identify a person or people to take responsibility for driving forward the work to support your community to become dementia friendly - work with organisations
- Have a plan to raise awareness in all sectors
- Have a strong voice for people with dementia
- Raise the profile to increase reach and awareness to different community groups
- Focus the plan on key areas
- Have a plan in place for self – assessment and review

A community that registers for the recognition process is committing to meeting each criterion but they are expected to interpret them from a local perspective - to fit the size, type, stage of progression and resources available. As part of the process a community will asked to describe what they are working towards, and the actions they intend to take.

3.0 Progress

The Alzheimer's Society states that a Local Dementia Action Alliance (DAA) should bring together regional and local members to improve the lives of people with dementia in their area.

The DAA is the local vehicle to develop Dementia Friendly Communities. A local Alliance can be established at any level, be it a village, city, county or even a region. The Wolverhampton Dementia Action Alliance is made up of organisations that operate across the City and who are working towards creating a dementia friendly community to improve the lives of people living with dementia and their carers.

Since February 2017 the Commissioning team have focussed on reviewing and re-energising the DAA by strengthening the structure, engaging new members, and driving the dementia agenda.

The Commissioner, Susan Eagle, has sought to engage with all organisations and maintain regular contact to ensure dementia remains a priority area of work across the City. The DAA now boasts a strong multi-agency membership of approximately 30 organisations who are either active or supporting members. Please see Appendix 1 for members that are involved in the Wolverhampton DAA.

To become a member of this Local Dementia Action Alliance, organisations sign up to the National Dementia Declaration and submit a short action plan setting out how they will work towards delivering the outcomes outlined in the declaration. Once this has been submitted successfully, the organisation will be considered a member of the Dementia Action Alliance.

The DAA is co-ordinated by the commissioner Susan Eagle and chaired by the Visiting Professor of Health Management and Leadership, University of Wolverhampton, Jon Crockett. Cabinet Member for Adult Services Councillor Sandra Samuels OBE is also a member and supports the DAA to engage with local organisations.

The Councils Communication team have supported the work of the DAA through regular tweets and a press release to raise awareness of the DAA and recruit new members. This led to new organisations including, West Midlands Pension Fund, FMC Power Solicitors Firm and Mid Counties CO-OP signing up to make a difference.

The Commissioner has engaged with a variety of organisations to highlight the benefits of becoming dementia friendly to their customers and staff.

The Dementia Action Alliance deliver against an Action Log that covers the eight priority areas defined by the Alzheimer's Society. The areas are:

1. Arts, culture, leisure, and recreation
2. Businesses and shops
3. Children, young people and students
4. Community, voluntary, faith groups and organisations
5. Fire and Police
6. Health and social care
7. Housing
8. Transport
9. Other

Key actions in each of these areas are assigned to partners to ensure development across the community.

Develop a strong voice for people with dementia living in your communities

The Dementia Action Alliance have achieved this through engaging with carers, public and people living with dementia. A specific carers and service user group is being developed to mirror the Dementia Action Alliance following engagement with carers and people living with dementia.

The commissioner has raised the profile of the engagement work that invites people living with dementia, their carers, and professionals to have their say about dementia services in Wolverhampton. This work will inform Wolverhampton's Joint Strategic Needs Analysis and in turn inform the redesign of future services where possible. This work is recognised by the DAA and is promoted through members.

Raise the profile to increase reach and awareness to different groups in the community.

The Dementia Action Alliance have linked with Lichfield Diocese and more recently have engaged with Wolverhampton Interfaith group. The focus is to ensure all faith and community groups have an opportunity to become dementia friends, and in turn raise awareness in their own places of worship and community groups. This is a focus area as nationally and locally; black and minority groups are underrepresented in the engagement activities available.

The Commissioner has also worked with the Alzheimer's Society to deliver Dementia Friends sessions to all Council staff. The opportunity was advertised on City People and the first session has reached full capacity, with 25 people booked on for January 2018. This has proved a successful engagement method to raise awareness across all groups including: front of house staff, music

teachers, staff from BME backgrounds and staff affected by dementia in some way. These sessions will continue throughout the year.

4.0 Examples of the work undertaken by DAA members

An example of additional work carried out over the last ten months by DAA members is highlighted in the table below.

Priority Area	**Activity**
Arts, culture, leisure, and recreation	The Library Information service have completed their own action plan that includes dementia friendly staff and provision of prescription books for people diagnosed with dementia.
	The Grand Theatre and Arena Theatre front of house staff are receiving dementia friend's awareness sessions from FMC Power Solicitors firm.
	Joint work is being undertaken between WV Active and the University to understand the impact of physical activity on dementia.
Businesses and shops	The membership of the DAA is increasing and currently includes ASDA, CO-OP and smaller retailers such as Gatsby Emporium have completed their own Action Plan on-line.
	ASDA's community champion has implemented a slow lane for shoppers, organised bag packs and attends community groups.
	CO-OP is supporting the local independent Alz Café as their chosen charity and have also implemented training to store managers to share with their staff. Several fund-raising activities have also been undertaken.
	Plans are underway to recruit shops within the Mander Centre and increase the number of dementia friendly staff, including security guards.
	Lloyds and HSBC have dementia friends in place as part of their vulnerable persons strategy. Links are made to the Councils vulnerable support team, who raised awareness of fraud and finance protection within the banks during dementia awareness week, May 2017.
Children, young people, and students	West midlands Fire Service have agreed to include dementia awareness as part of their Cadet programme to engage with young people.
	The University has made the dementia module compulsory for all nurses. The University hosts a website and attracts funding to carry out research projects.
	The Memory Matters Service piloted work with a Wolverhampton school to design dementia friendly resources that were suitable for children.

	Lichfield Diocese Dementia Champion member attended five schools and delivered dementia awareness sessions in assemblies. The training was delivered to over 700 children in total. There are plans to continue this in 2018.
Community, voluntary, faith groups and organisations	Lichfield Diocese have invested to support churches and the wider community to become dementia friendly. Dementia Friends sessions have been delivered by Lichfield Diocese to schools, churches, pharmacists and temples.
	Wolves Community Trust are an active member and have committed to raise awareness through their work with TWIRL and a Diabetes group, with staff becoming dementia friends.
	The Alzheimer's Society worked with the Wolves team who filmed a video of their players raising awareness for dementia. This is available on YouTube.
	Age UK are members of the DAA and committed to raise awareness throughout their contacts and networks.
Fire and Police	West Midlands Fire Service and Police are members. Their focus is to ensure community officers and vulnerable safety officers are dementia friends and raising awareness throughout the community.
Health and social care	The Royal Wolverhampton NHS Trust and Black Country Partnership Foundation Trust are members and regularly attend the DAA and have a set of actions to implement within their organisations that are above and beyond their everyday business. The Royal Wolverhampton NHS Trust have invested in a reminiscence room and Black Country Partnership have plans to train all front of house staff across all sites.
	The City of Wolverhampton Council hosted the DAA to hold an awareness event during Dementia Awareness Week in May 2017. The event was held at Bob Jones Community Centre and attracted over 100 people from the public, carers and service users. The event was a huge success with 21 stall holders displaying how they can support people living with dementia and their carers.
	Work is underway to attract practice managers across Wolverhampton.
Housing	Wolverhampton Homes are an active member and are rolling out dementia friends awareness sessions to staff through a dementia e-learning package to over 700 staff.
	The DAA will seek to strengthen and expand members from the housing sector.
Transport	The DAA seek to include dementia awareness into taxi firms, Centro and transport services.

5.0 Next Steps

- To host a celebration event with local awards for Dementia Action Alliance members on 31 January 2018.
- To continue engaging members at the Dementia Action Alliance, both existing and new.
- To continue delivering actions in each of the eight areas.

- To focus on raising awareness within the transport and museum sector.
- To meet the criteria of self-assessment as given by the Alzheimer's Society to retain status.
- To report future updates to the People Leadership Team.

For further information please contact:

Sarah Smith
Head of Strategic Commissioning – People Directorate
01902 555318
sarah.smith@wolverhampton.gov.uk