worcestershire
countycouncil

Worcestershire County Council

Supplement Pack

Health and Well-Being Board
Tuesday, 24 September 2019, 2.00 pm, Council Chamber, County Hall

Agenda

Agenda produced and published by Simon Mallinson, Head of Legal and Democratic Services, County Hall, Spetchley Road, Worcester WR5 2NP

To obtain further information or a copy of this agenda contact Kate Griffiths, Committee Officer on Worcester (01905) 846630 or email: KGriffiths@worcestershire.gov.uk

All the above reports and supporting information can be accessed via the Council's website

Date of Issue: Monday, 16 September 2019

This page is intentionally left blank

Worcestershire Safeguarding Children Board

Annual Report 2018/19

Foreword by Derek Benson, Independent Chair of the Worcestershire Safeguarding Children Board

It is my pleasure to introduce the Annual Report for the Worcestershire Safeguarding Children Board (WSCB) for 2018/19. This will be the last such report published by the WSCB under current arrangements before responsibility for local safeguarding transfers to the named Safeguarding Partners in September 2019. Plans for the new arrangements have been carefully considered and the Safeguarding Partners; the Local Authority, West Mercia Police and the Clinical Commissioning Groups for Health, will collectively take the lead in a partnership that remains focussed in its commitment to achieving the best possible outcomes for the children and young people of Worcestershire.

The purpose of Local Safeguarding Children Boards has been to co-ordinate effective safeguarding arrangements across the statutory and voluntary sector agencies, and it is vital that the three Safeguarding Partners maintain that breadth of involvement. They are already actively engaged in partnership activity across the county and are well sighted on the good practice that exists. The strength of the existing arrangements is due to the shared determination of that broad range of partners that come together as the WSCB to ensure children are safeguarded and whose wellbeing is actively promoted. It is essential that the rich diversity of opinion and experience is maintained going forward.

The activity of the Board has been effectively and diligently coordinated and supported by the Business Unit, and I would like to record my appreciation for their ongoing energy, enthusiasm and professionalism.

The Annual Report provides updates on what has been achieved during 2018/19 and includes information on progress against local priorities, developments in safeguarding and how learning has been shared and incorporated into practice. This is achieved through detailed performance data from partners, a comprehensive audit and assurance programme and importantly, feedback and input from service users including children and young people.

Throughout the last year as well as preparing for the transition to the new arrangements, the WSCB has worked to deliver a number of key priorities; implementing a strategy and supporting toolkit to tackle Neglect, better understanding and supporting activity to address the widening issues of exploitation, and seeking assurance and promoting Early Help in Worcestershire. Much of this activity will continue into 2019/20.

Another key element of the Board's work has been the ongoing support for Children's Services in its improvement journey, whilst continuing to monitor the outcomes for children and young people. There are clear signs of progress and this will remain a priority area as the newly constituted Partnership takes shape.

Safeguarding has never been more important and we, as individuals and partners, must remain focussed in our efforts to provide those better outcomes for children and young people in Worcestershire.

Contents

1. Introduction

What is the Worcestershire Safeguarding Children Board (WSCB)?

WSCB is the key statutory body overseeing multi-agency child safeguarding arrangements across Worcestershire. Our work is governed by the statutory guidance in 'Working Together to Safeguard Children 2015'.

Section 14 of the Children Act 2004 sets out the statutory objectives of Local Safeguarding Children Boards, which are:

- To co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in their area; and
- To ensure the effectiveness of what is done by each such person or body for those purposes.

Purpose of the Annual Report

Statutory legislation requires the Independent Chair of the Safeguarding Board to publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the area it covers. This report relates to the preceding financial year. The report will be submitted to the Chief Executive and Leader of the Council, the local Police and Crime Commissioner and the chair of the Health and Well-Being Board.

The report aims to provide a rigorous and transparent assessment of the performance and effectiveness of local services. It identifies areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action.

Vision Statement

All children and young people in Worcestershire are safe and thriving

Mission Statement

Working in partnership to keep all children and young people safe and thriving within an environment where safeguarding is everybody's business and intervention and support is timely and right for individuals and families.

WSCB Values

- Respect for children, young people and their families
- Making a positive difference to the lives of children and young people
- Working together in partnership
- Collective and mutual challenge between partners to keep children safe

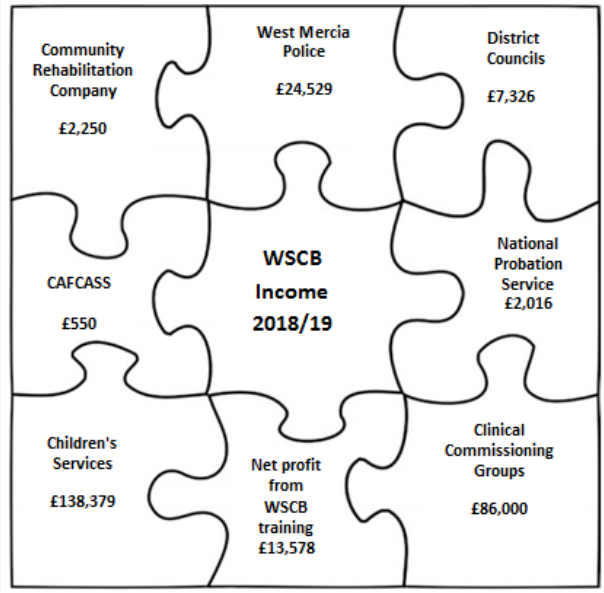
- Involving communities at a local level
- Valuing and responding to diversity

WSCB Membership & Structure

Membership of WSCB is statutory for a number of partners as outlined in Working Together (2015). A full list of member partner agencies can be found at Appendix 1

The WSCB Structure is located at Appendix 2

Financial Contributions



New Multi-Agency Safeguarding Arrangements

The Children and Social Work Act 2017 replaces Local Safeguarding Children Boards (LSCBs) with new local safeguarding arrangements, led by three safeguarding partners (the local authority, police, and clinical commissioning groups). LSCBs must continue to carry out all of their statutory functions, until the point at which safeguarding partner arrangements begin to operate in a local area. The Worcestershire Safeguarding Children Partnership will be implemented by 1 September 2019. More information can be found at: https://www.safeguardingworcestershire.org.uk/changes-to-safeguarding-children-arrangements-from-1st-september/

2. Context

2.1 Context & Local Demographics

The largely rural county of Worcestershire is situated in the West Midlands. It has a population of 588,400 and 75% of residents live within the main towns and urban areas. According to figures released by Worcestershire County Council the county population has been increasing by an average of approximately 3,800 people per annum over the last 5 years, and the rate of growth is increasing.

Age

Worcestershire has a resident population of approximately 116,900 children and young people aged 0 to 17, making up 20% of the total population. Over the next ten years trend-based projections suggest that the population of 0 to 17 year olds will increase by 4,900 (4.2%) with variations between age groups. The population of 10 to 15 year olds is projected to increase by over 10% while the population of 16 to 17 year olds is projected to increase almost 14%.

Ethnicity

10% of the population aged 0 to 17 is classified as belonging to an ethnic group other than White British. The largest group is Asian or Asian British and the next largest is children from a mixed heritage background. English is spoken as an additional language by over 6,400 school pupils (8.0%). Polish, Urdu and Punjabi are the most commonly recorded spoken community languages in the area.

Areas of Deprivation

The Indices of Deprivation use several measures including income, employment, education, health, barriers to housing and services, crime, and living environment. These are weighted and combined to create an overall Index of Multiple Deprivation. In Worcestershire deprivation scores vary with the highest score at 75.6 in one area of Worcester City and 2.4 in another. Most of the high deprivation areas are in the urban areas of Worcester, Wyre Forest and Redditch, with some areas of deprivation also present in the towns of Evesham, Malvern, Droitwich and Stourport - On - Severn. The average for the county is 17.7, ranked as 111 out of 152 Local Authority areas (1 being the most deprived).

Local Authority Provision

At the end of March 2018 there were a total of 695 Children in Need (CIN), 798 Looked After Children (LAC) and 415 children with Child Protection Plans. (2017 comparison figures in table below.)

Local Authority Provision	March 2018	March 2019
Child in Need Plans (A Child in Need is one that has been assessed under Section 17 of the Children Act 1989 as being unlikely to maintain a reasonable level of health or development or whose health or development is likely to be impaired without the provision of services; or a child who is disabled)	695	594

Looked After Children (a child who is being looked after by the Local Authority is known as a child in care)	798	842
Child Protection Plans (children require a Child Protection Plan if they are judged to be suffering, or likely to suffer, significant harm)	415	404

2.2 Partnership Working

Linkages with other Strategic Boards

The WSCB Independent Chair is directly accountable to the Chief Executive of Worcestershire County Council and works closely with the Director of Children, Families and Communities, attending the Children & Families Overview and Scrutiny Panel when available.

The work of the WSCB fits within the wider context of the Worcestershire Health and Well-Being Board (HWB), the Safer Communities Board (SCB) and the Worcestershire Safeguarding Adults Board (WSAB). Work with WSAB, facilitated by the Independent Chair, focusses on areas of safeguarding which span both Boards in order to improve communication and reduce complexity for partner agencies. Examples are sexual exploitation, domestic abuse and Female Genital Mutilation (FGM).

The Board also works closely with the Worcestershire Forum Against Domestic Abuse and Sexual Violence with regard to the impact of domestic abuse on children.

Links to other strategies

Special Educational Needs and/or a Disability (SEND) Strategy which sets out partnership duties and will be delivered through an action plan to be overseen by the local authority's Children with SEND Improvement Board.
www.worcestershire.gov.uk/info/20541/we_are_listening/1616/our_send_strategy

Children and Young People's Plan 2017-21 which provides a framework for all agencies and organisations working with children, young people and families to make the necessary impact to improve lives. www.worcestershire.gov.uk/download/downloads/id/8306/worcestershire_children_and_young_peoples_plan_booklet.pdf

Joint Health and Well-Being Strategy 2016 – 21 which is a statement of the Health and Well-Being Board's vision and priorities based on the Joint Strategic Needs Assessment and the views of key stakeholders.
www.worcestershire.gov.uk/download/downloads/id/7051/joint_health_and_well-being_strategy_2016_to_2021.pdf

Early Help Strategy 2017 – 2020 which sets out how agencies should work together to provide additional support to children and families.
www.worcestershire.gov.uk/downloads/file/8802/worcestershire_early_help_strategy_2017_to_2020

3. Strategic Priorities

3.1 Implementation of Neglect Strategy

Worcestershire has a significantly higher rate of neglect per 10,000 population (34.00 in 2017) than for both statistical neighbours (21.6) and England (26.3). 79% of all current Child Protection Plans are for Neglect which is significantly higher than the national average. Nearly three quarters of new Contacts or Referrals where neglect is a factor relate to children under 10 years old. More than half of all social work assessments result in no further action being taken by Children's Social Care, with one quarter proceeding to a Child in Need or Child Protection Plan.

Three Multi-Agency Case File Audits (MACFAs) have been undertaken on cases where children were experiencing neglect in 2014 (MACFA 14), 2017 (MACFA 26) and 2019 (MACFA 31). The findings from the most recent audit will serve as a benchmark against which the safeguarding partners will be able to evaluate progress.

Key aspects of practice which have been identified from the MACFAs and also from case reviews undertaken nationally are:

- Need to include the parents' histories and parental risk factors as part of the assessment of their ability to change
- Evidence required that inter-agency neglect guidance is being followed by agencies
- Over-focus on the needs of the parents
- Need to listen to children and young people about their lived experience and evidence how this has impacted on decision making
- Need for increased focus on the roles of 'invisible males'
- Need to avoid drift and delay in decision making
- Tendency towards 'start again syndrome' following changes of worker/service
- Importance of chronologies and processes for sharing them between agencies
- Importance of engaging with wider family members when assessing and working with parents who not demonstrating the necessary changes
- Tendency towards professional over-optimism about co-operation and the ability of some parents to sustain improvements
- Need for SMART objectives in Plans with time scales and contingency plans evidenced

The WSCB approved its Neglect Strategy in December 2018 which can be located at: https://www.safeguardingworcestershire.org.uk/wp-content/uploads/2019/06/Worcestershire-Neglect-Strategy-2018-2020.pdf

The aims of the Strategy are to develop shared definitions and language, and a consistent approach to screening across the Partnership with examples of appropriate responses at different levels of need. The revised pathway for responding to neglect concerns, spanning early help through to child protection, and a toolkit for use by frontline practitioners when working directly with families are to be launched at targeted events in June 2019. Young people and practitioners had been consulted on some of the tools and their feedback used to improve the tools. Attendees at the launch events will be specifically nominated by their strategic leads to support the embedding of the pathway and toolkit within their own workforce. The toolkit can be located at: http://westmidlands.procedures.org.uk/local-content/xkjN/neglect-tools-and-pathways/?b=Worcestershire

The Board agreed that neglect would continue to be a strategic priority into 2019/20 so that the impact of the Neglect Strategy could be evaluated.

3.2 Protecting Children and Young People from Exploitation

WSCB has a Child Sexual Exploitation (CSE) Strategic Group as one of its sub-groups and a CSE Operational Group which reports directly to the Strategic Group. During the year the focus on CSE has expanded to include other forms of exploitation and contextual safeguarding. 'GET SAFE' is the Worcestershire partnership title for the identification and management of multi-agency support and protection for children and young people at risk of **G**ang-related activity, Sexual **E**xploitation, **T**rafficking, Modern day **S**lavery, **A**bsent and Missing, **F**orced Marriage, Honour Based Violence and Female Genital Mutilation, and Criminal **E**xploitation.

These extra-familial forms of abuse and harm require a timely, well co-ordinated, multi-agency response, including information sharing, to ensure risks are quickly identified and responded to at both an early help and high-risk level of need. The GET SAFE Triage being developed at the Worcestershire Safeguarding Hub will play a key role in ensuring these activities are happening across the different levels of need and evaluating the outcomes to inform future responses. The intelligence this multi-agency Triage will gather will help inform Worcestershire's problem profile of Criminal Exploitation and inform future disruption activities and tactical responses.

After some significant delay a CSE Problem Profile was produced by West Mercia Police and this now needs to be regularly updated and broadened out to include other areas of the GET SAFE (exploitation) agenda.

A CSE multi-agency dataset has been agreed and work continues to populate it with input from Partners. There have been continued challenges in accessing Police data following their change of data system. This dataset needs to be developed to include a wider set of Key Performance Indicators (KPIs) to reflect the GET SAFE agenda.

Towards the end of the year an outline GET SAFE Action Plan was drafted and work is currently being undertaken with Partners to agree the detail.

A MACFA was undertaken during the year looking at partner agencies' use of the CSE Screening Tool. Headline findings were that the tool is in need of review and no longer fit for purpose, it is not being used systematically to screen for risk of CSE but rather when there are already CSE concerns, practice is inconsistent and there is a lack of analysis of risk once indicators have been identified. A review of the CSE screening tool is to be undertaken by the GET SAFE Operational Group.

More information is available at:
https://www.safeguardingworcestershire.org.uk/wscb/professionals/cse/

3.3 Seeking Assurance and Promoting Effective Early Help

A key development during the year has been the publication of the revised Early Help Pathway identified as a gap in last year's annual report. The Board's Improving Frontline Practice Group was a helpful mechanism for consultation with Partners and it supported circulation of communications through the WSCB newsletter, core training programme and Practitioner Network meetings.

It was clarified that co-ordination of delivery of the Early Help Strategy action plan would sit under the Children and Young People Strategic Partnership sub-group of the Health and Well-being Board.

WSCB was sighted on audits undertaken during the year which looked at the effectiveness of the Early Intervention Family Support (EIFS) service. The quality of assessments was found to be good and the Signs of Safety strengths-based approach was being embedded. Aspects of practice requiring improvement included reflective practice, management oversight and the inclusion of parents and wider family. Feedback from parents was very positive about their experience.

Assurance was provided to the Board from commissioners for both Public Health and Children's Community Health regarding the respective quality assurance frameworks in place for early help services delivered by Providers.

Two MACFAs were completed during the year looking at early help cases. Some examples of good practice were identified where high levels of intensive support had been provided by Family Support Workers. There were questions raised in two of the cases about whether early help at Level 3 was the correct level of intervention given the complexity of needs and risks being presented at the time. There was evidence of good recording of the child's voice in records and in the work undertaken in four of the six cases, and the quality of Plans had improved on the findings from previous MACFAs with Lead Professionals identified in all of the cases (May 2019).

A MACFA undertaken in September 2018 looked at the application of thresholds by partner agencies and the quality of referrals made to the Family Front Door (FFD). Nineteen referrals from a range of agencies were reviewed in detail. It is possible to provide only limited assurance based on the findings that partner agencies fully understood the threshold for intervention by Children's Social Care and there was found to be significant variation in the quality of referrals being made. Responses from staff at the FFD were of consistently good quality, with improvement only required regarding informing referrers of outcomes. During the year changes were made to referral processes which separated out referrals for early help and social work services, with online referral forms providing more guidance for referrers about what is required. It is anticipated that these changes will lead to improved quality of future referrals and support practitioners in distinguishing between the different levels of need.

The Board sought feedback from practitioners on their understanding of early help using a snap survey. The majority of respondents were schools representing one fifth of all education establishments in Worcestershire. The vast majority of respondents said they were at least 'fairly' confident in working in a multi-agency context and confirmed that they accessed the Levels of Need Guidance and found it useful. Most indicated that specific training on being a Lead Professional and completion of an Early Help Assessment would be helpful.

It is not possible for the Board to provide assurance about the wider early help offer made by universal services due to the fact that there is no mechanism in place currently to capture this information.

3.4 Voice of the Child

Voice of the Child is one of the practice issues considered in the Board's MACFA process with auditors asked to specifically consider how effectively the 'voice' of the child was sought, recorded and considered by the partner agencies involved. Across the four MACFAs completed during the year it was found that practice is variable in terms of listening to and giving consideration to the views of children and young people. In the most effective cases the child's voice and lived experience had been explored by practitioners, including

the impact on them of parental needs or vulnerabilities and risk factors, and then used to inform planning.

During the year WSCB adapted a series of prompt questions for practitioners to consider when seeking to understand what a day in the life of a baby, pre-school child, primary age child or teenager looks like. The 'A Day in My Life' prompts form part of the Neglect Toolkit but could be used in all aspects of direct work with a children or young people. The Board consulted with pupils from middle and secondary schools and feedback informed development of the tools.

An example of the prompt questions is located at:
http://westmidlands.procedures.org.uk/assets/clients/6/Worcestershire%20Downloads/Worcestershire%20neglect%20tools/A%20Day%20in%20My%20Life%20(teenager).pdf

3.5 Critical Friends to the Children's Social Care Service Improvement Plan (SIP)

The WSCB has been updated at every Board meeting on the Service Improvement Plan performance indicators and also on outcomes from Ofsted monitoring visits. Meetings with Critical Friends were discontinued during the year after the Board agreed that progress was being evidenced and Board members were able to provide ongoing scrutiny and challenge through the Board and its sub-groups.

Feedback following Ofsted monitoring visits noted that the quality of support offered to children in care and care leavers has improved since the last inspection of children's services in November 2016, whilst acknowledging that many of the positive changes were at that time (April 2018) very recent and not all children and young people in Worcestershire were yet receiving consistently appropriate support. It was noted by inspectors that the local authority was making satisfactory progress to improve services with good progress being made in the area of assessment and quality assurance. Progress in other areas at that time (July 2018), such as planning for children, was more variable and required further focused work. Inspectors also noted that there had been progress in improving services for children and young people vulnerable to child sexual exploitation and those who go missing, although it was considered that Worcestershire's strategic approach to other forms of exploitation was at that time (January 2019) under-developed.

Last year WSCB noted the significance of the development of a new operating model for children's social care and implementation of the Signs of Safety approach to practice. This year has seen the embedding of Signs of Safety across the partnership and the Board has ensured that tools developed to support aspects of practice, such as the Neglect Toolkit, reflect this approach. In addition, work has continued towards the launch of Worcestershire Children First, the Alternative Delivery Model for Children's Social Care to be launched on 1 October 2019.

3.6 Establish new arrangements for the Safeguarding Partnership

The three named Safeguarding Partners (Chief Executive of Worcestershire County Council, Chief Constable of West Mercia Police, and Accountable Officer for the Clinical Commissioning Groups) have been represented by their respective Board members in discussions regarding the new multi-agency safeguarding arrangements. A proposal was presented at an exceptional Board meeting on 21 January 2019 followed by a period of

consultation. The proposed changes were approved at the Board meeting held on 13 March 2019. There will be a period of transition until the new Worcestershire Safeguarding Children Partnership (WSCP) is fully implemented on 1 September 2019.

Further information is available at: https://www.safeguardingworcestershire.org.uk/wp-content/uploads/2019/06/Worcestershire-Safeguarding-Children-Partnership-Plan-FINAL.pdf

3.7 Consolidate findings from Serious Case Reviews (SCRs) into learning which leads to improved practice

Work has been completed by the Serious Case Review and the Improving Frontline Practice sub-groups of the Board to develop a summary of key messages from three SCRs completed during the year. A communications plan to ensure dissemination of learning and key messages was presented to the March Board meeting and has now been implemented.

The Board commissioned the Geese Theatre Company to develop a dramatic piece to be performed for frontline practitioners at a local theatre in June 2019. Three key messages were portrayed in the dramatic scripting around the lives of two fictitious families: any amount of alcohol can impact negatively on parenting, professional dynamics can make it hard for your voice to be heard, and the importance of understanding the child's lived experience and not to assume that a quiet or withdrawn child has nothing to say. Other key messages from the SCRs were summarised in a briefing to be made available to practitioners on the day.

In addition to the Geese Theatre Company production two targeted learning events were planned for July 2019 aimed at frontline practitioners and managers who were placed well professionally to support the embedding of learning across their organisation's workforce. The purpose is to consider what actions frontline practitioners and managers can take to share the learning with staff and to ensure that systems and processes support the improvement of practice in these specific areas of practice.

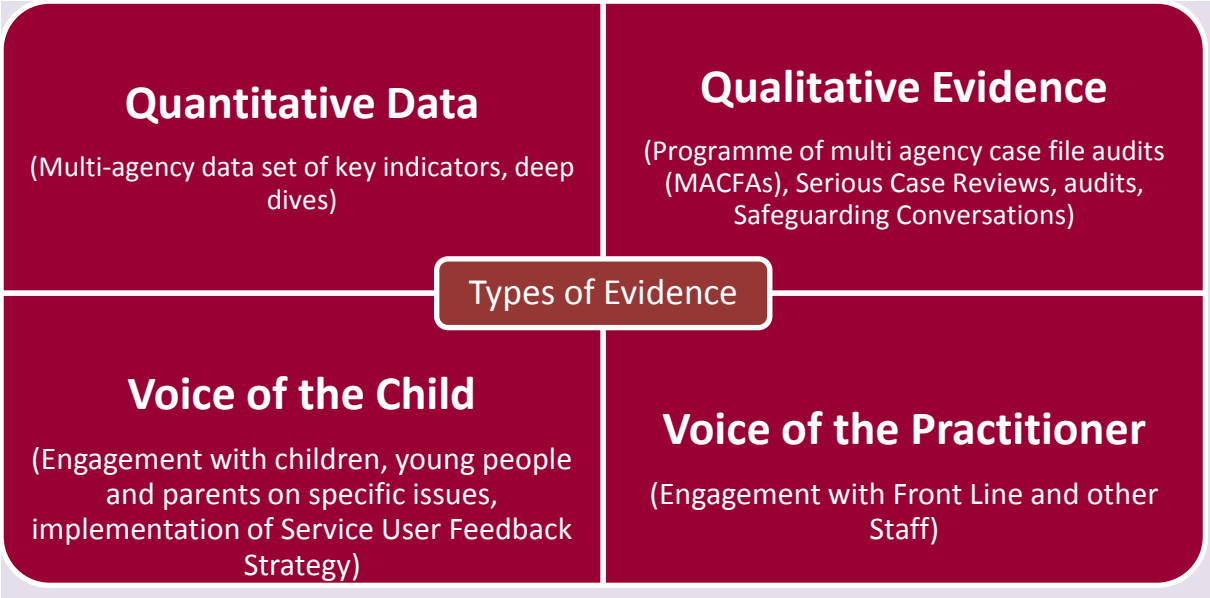
The Learning and Improvement Briefings which support the communications plan are located at: https://www.safeguardingworcestershire.org.uk/learning-development/training-c/learning-improvement-briefings/

The Worcestershire Safeguarding Children Partnership will monitor the impact of the embedding of learning over time through audits and data analysis.

4. Effectiveness, Learning and Improvement

4.1 Monitoring Effectiveness

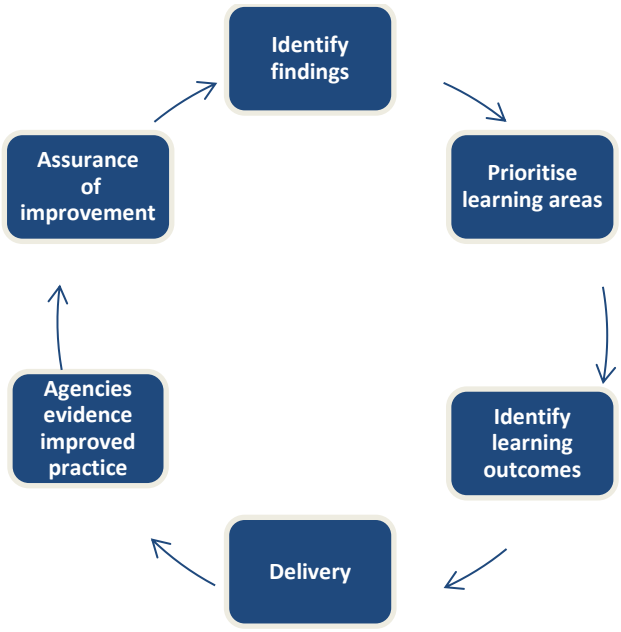
The WSCB evidence base for monitoring the effectiveness of safeguarding arrangements in Worcestershire for children and young people during this period has included a combination of:



The WSCB Learning and Improvement Framework consolidates learning from a range of activities including:

- Child Death Reviews
- Serious Case Reviews and case reviews
- Multi Agency Case File Audits (MACFAs)
- Audits
- Safeguarding Conversations
- Domestic Homicide Reviews and Safeguarding Adults Reviews (where appropriate)

The diagram below demonstrates the Learning and Improvement cycle:



4.2 Quantitative Data

The Board maintains a multi-agency dataset of high level key performance indicators which it scrutinises to identify areas of performance which require further interrogation. This year the data has been streamlined to ensure full scrutiny.

Key headlines from the data are:

11,300 Contacts to the Family Front Door, an increase of 13% compared to last year
Number of Looked After Children has increased from 798 last year to 842
Number of open Section 17 assessments has increased from 386 to 597
Number of Section 17 assessments completed has reduced from 4953 last year to 4429
Number of open Section 47 (child protection) assessments has increased from 90 to 103
Number of open Child in Need Plans has reduced from 695 last year to 594
Number of open Child Protection Plans has reduced from 415 last year to 404

4.3 Qualitative Assurance Activity

In 2018/19 the following quality assurance audits were completed:

4.3.1 Section 11 Audit (statutory partners)

The Section 11 (S11) Audit is a self-assessment by partner agencies of the extent to which they are fulfilling their safeguarding responsibilities. The S11 Audit provides assurance that safeguarding arrangements are in place across the WSCB partnership or, where improvements are required, plans are in place to address them. WSCB conducts a full S11 audit every two years. In 2017/18 the Board utilised a new audit template devised by a working party from across the West Midlands.

This year the Board can provide assurance that partner agencies continue to report progress against outstanding actions.

4.3.2 Child Sexual Exploitation (CSE) Self-Assessment

Partner agencies were asked to assess themselves against the standards established by the Board. This audit enabled WSCB to benchmark compliance by agencies in this area and compare the results to an audit undertaken in 2017. Improvement has been shown in that no agencies now deem themselves to be inadequate in any area, however there are still areas for improvement reflected in the recommendations.

4.3.3 Section 175/157 audit (schools and colleges)

Response to this annual audit was excellent with 100% of establishments returning their audits. This is the first time that this has been achieved in Worcestershire and demonstrates strong engagement with safeguarding by schools.

This audit evidences a high level of safeguarding activity across education settings in Worcestershire and the importance of a whole school approach which includes a focus on staff development and learning opportunities. 47 Schools have been supported with the self-assessment by the County Council's Education Safeguarding Adviser

Communication between WCC and schools has improved with the provision of network meetings, training and designated Safeguarding Champions.

It is expected that Operation Encompass, where schools are informed the next morning about domestic abuse incidents, is welcomed and should have a positive impact on the emotional support made available to children and young people.

4.3.4 Multi-Agency Case File Audits (MACFAs)

MACFAs are in-depth audits of a small sample of cases facilitated by an independent Auditor commissioned by the Board. Four MACFAs were undertaken during the year and the learning is covered elsewhere in this report. Any child protection issues identified by the review process are immediately picked up by the relevant agency and actioned. Learning is taken back to individual agencies to inform practice and is also included in multi-agency core safeguarding training delivered by the Board.

The MACFA panel invited individual schools to participate in the process where appropriate and this has enabled better understanding of the child's lived experience for all partner agencies.

.

4.3.5 Safeguarding Conversations

Safeguarding Conversations are a process developed by WSCB where Board members meet with frontline practitioners to discuss how performance and practice issues impact upon the delivery of a multi-agency plan and subsequent outcomes for a child or young person. Two Safeguarding Conversations were held during the year and three Board members attended including the Director of Children, Families and Communities, the Vice Chair of the Safeguarding Board and the Designated Doctor.

The Safeguarding Conversations were based on Neglect and Step-up/Step-down processes in line with WSCB priorities. In both cases there was found to be evidence of good joint working between agencies. Other aspects of good practice included the collation of full family histories, good quality supervision for staff, evidence of early help support offered by school and health professionals and a contingency plan in place to respond to fluctuating parental mental health. There was evidence of confusion, however, amongst practitioners about how to access early help provision, a lack of information in one case about a parent's new partner and general concern about the lack of availability of suitable mental health services.

4.4 Child Death Overview Panel (CDOP)

The Child Death Overview Panel (CDOP) has a statutory responsibility to collect and analyse information about the deaths of all children who live in Worcestershire to identify any safety and welfare matters along with wider public health or safety concerns. The Panel analyses the collated information to classify each death, identify any 'modifiable factors' that may have contributed to the death of the child and make recommendations regarding interventions to reduce the risk of similar deaths. Although there may only be a small number of deaths from a particular cause in a given year, cumulative data and liaison with other CDOPs in the West Midlands may reveal trends and common factors.

During 2017/18 CDOP received Notification of 25 Child Deaths, the lowest since CDOP processes began in 2008. However, during 2018/19, 38 Notifications were received which is closer to the norm over the last 11 years.

CDOP and its Sub-Groups met on 7 occasions and undertook 23 Child Death Reviews during the year. Modifiable Factors were present in 10 of the deaths and included lack of parental supervision, maternal smoking and obesity, and fatal road traffic collisions involving inexperienced teenage drivers.

Other issues coming to Panel included several incidents relating to health care, questions relating to teenage suicide along with the review by Public Health of Infant Mortality in Worcestershire. This found no statistically significant change over a 10yr period [2006 to 2016]

A thorough analysis of Child Death Reviews categorised as 'Sudden Unexpected Unexplained Death' relating to children aged under 2 years was undertaken. It is concerning to learn that there has been a significant rise in Baby Deaths with Modifiable Factors including excessive alcohol consumption coupled with bed-sharing and smoking. This trend has been shared within the West Midlands CDOP Network and wider data analysis is underway including review of the current Safer Sleeping initiatives

The Panel Manager has continued to participate extensively in the plans for the implementation of the 'New Arrangements for Child Death Review' and presented suggested minor modifications to current local operational practices to the September and December Worcestershire CDOP meetings. It is good to reflect that many of the proposed National Changes to the Child Death Review processes have been the culture in Worcestershire for many years.

Considerable attention has also had to be paid to managing the backlog of Child Death Notifications received, especially those managed through the new Perinatal Mortality Review process; to ensure that Child Death Reviews are completed as promptly as post-death processes permit.

From September 2019 Child Death Reviews become the responsibility of the Child Death Partners (Local Authority and Clinical Commissioning Groups) and Public Health is taking the lead for Worcestershire County Council. The decision has been taken to develop a joint CDOP with Herefordshire. Further information is available at: http://www.worcestershire.gov.uk/downloads/file/11281/child_death_review_plan

4.5 Serious Case Reviews (SCRs) and Case Reviews

The Serious Case Review Group considers cases where there may be multi-agency learning to decide whether the criteria for a SCR are met. During the year three cases were considered and, following scoping, were not considered to meet the criteria for a Serious Case Review. If the criteria for a SCR are not met, consideration is given to conducting a case review. No case reviews were initiated during the year.

Two Serious Case Reviews were completed during the year, however it was evident that one of the cases did not meet the criteria and was subsequently down-graded to a case review with the agreement of the National Panel. Learning will be published when parallel processes, such as inquests, criminal proceedings or other formal review processes, have been completed. Recommendations for agencies and the Board have been implemented prior to publication.

Working Together 2018 details how SCRs should be undertaken once the new multi-agency safeguarding arrangements are in place. Under the new legislation and supporting guidance,

these will in future be called 'Child Safeguarding Practice Reviews', with Serious Case Reviews being undertaken by the National Panel if the case is of particular national interest or is complex.

Worcestershire has actively participated in a West Midlands 'Early Adopter' programme to develop a regional framework for Rapid Reviews (scoping process to make a decision about further action) and Child Safeguarding Practice Reviews.

Two Rapid Reviews have been undertaken since the implementation of the new Rapid Review process in June 2018, both achieved within the prescribed time scale of 15 days.

4.6 Single Agency Inspections

Agencies reported that the following inspections had taken place during 2018/19:

- Worcestershire Acute Hospitals NHS Trust – CQC Inspection, January, 2019 and a NHSI peer review visit undertaken on 11th March, 2019. Progress on the implementation of actions and sustained improvements required following the CQC visits are monitored through the Trust's monthly Safeguarding Committee attended by the Head of Safeguarding or their Deputy. Developments undertaken over 2018/19 period has moved WHAT from a position of offering limited assurance, to that of being able to offer the Trust Board and the CCGs moderate assurance in relation to the safeguarding agenda.
- West Mercia Police were part of a peer inspection at the beginning of 2019 undertaken by Her Majesty's Inspectorate of Constabularies and Fire and Rescue Services (HMICFRS). The inspection looked at elements of vulnerability and safeguarding and engaged with operational and strategic staff and partners.
- Swanswell, a sub group of Cranstoun who deliver drug and alcohol services, received a CQC inspection at their base in Worcestershire.
- Children's Social Care had several Ofsted monitoring visits which are all available on the Ofsted website.
- Hereford and Worcester Fire and Rescue services had an inspection in 2018. The inspection assessed how effectively and efficiently Hereford & Worcester Fire and Rescue Service prevents, protects the public against and responds to fires and other emergencies. It also assesses how well it looks after the people who work for the service.
- The local area SEND (Special Educational Needs and Disabilities) inspection was completed in March 2018 https://files.api.ofsted.gov.uk/v1/file/2773973 The WSCB has been sighted on the written Statement of Action which was developed following the inspection and has received assurance that work streams are progressing. Ofsted continues to monitor implementation of the Statement of Action.

4.7 Communications

During 2018/19 WSCB has engaged in a wide range of communication activities to raise awareness of safeguarding issues and raise the profile of the Board. Communications have been directed towards members of the public, parents and carers, children and young people, and practitioners from across the partnership.

- **Website**

One of the major communications projects has been the development of a new Safeguarding Worcestershire website. A joint project with Worcestershire Safeguarding Adults Board, the website replaced the previous WSCB webpages hosted by Worcestershire County Council. The joint website will provide an opportunity to showcase cross cutting issues such as Transition, Domestic Abuse, Mental Capacity Act and Exploitation, as well as supporting the 'Think Family' approach. It is due to go live on 1st May 2019.

Other communication activities in 2018/19:

- **Newsletter**: four issues of the Board newsletter, Safeguarding Matters, have been published on the board website and circulated across the partnership.
- **Practitioner Network**: the network provides a quarterly forum for local practitioners from across the partnership to meet and share information and best practice in relation to safeguarding issues. The network acts as a consultation and reference group to support the Board.
- **Awareness Days**: The Board has widely circulated briefings and materials to support national awareness days on issues such as Child Sexual Exploitation and Internet Safety.
- **Learning & Improvement Briefings** (LIBs): During the year the board published two further LIBs on MACFA Messages and Consent & Confidentiality. A further four LIBs have been developed for circulation in the spring of 2019 covering key messages from local Serious Case Reviews.

4.8 Engagement with front line practitioners

Practitioner Network

The WSCB Practitioner Network is the interface between safeguarding practice and safeguarding strategy. The network provides the Board with a practitioner's view of the reality of safeguarding children and young people in Worcestershire. Practitioners meet quarterly and represent a wide variety of organisations involved with safeguarding. The network is a dynamic process, not only serving to promote best practice, but also as a conduit to convey views and concerns back to the Board.

This forum is used to disseminate learning and to take feedback from practitioners on a range of specific issues. In 2017/18 the Practitioner Network was consulted on Learning and Improvement Briefings, Levels of Need Guidance and an Early Help survey.

Specific presentations were made to the Practitioner Network on:

- Worcestershire Children First
- Illegal money lending and the impact on safeguarding children and young people
- Signs of Safety
- Domestic Abuse
- Working Together 2018
- Car Wash App – The Clewer initiative in relation to modern slavery
- Operation Encompass
- Worcestershire Parenting Services
- The impact of contemporary issues on children and young people's mental health

4.9 Engagement with Children, Young People and Families

A social work student from the University of Worcester worked with WSCB during the year to support the Service User Feedback agenda and engagement with young people. She has brought a young person's perspective and challenge to discussions.

This year the Board consulted directly with young people on the development of a toolkit to support the Neglect Strategy. The young people provided excellent feedback and the tools were made more young people friendly as a result.

Agencies are asked to report on their approach to Service User Feedback (SUF) as part of the Section 11 Audit. It is noted that the Youth Justice Service has an excellent method of collating and using feedback from young people to develop its services.

4.10 Policies & Procedures

Worcestershire is part of a consortium of nine Local Safeguarding Children Boards from the West Midlands who share the online multi-agency safeguarding children procedures located at: http://westmidlands.procedures.org.uk/ It is two years since these procedures went live and during this period all of the policies have been reviewed to ensure they are up to date.

In addition, Worcestershire has developed its own pathways and tools which sit in the local section of the procedures. Key pieces of work this year have been the development of a local Female Genital Mutilation (FGM) Pathway, Child in Need Guidance and the Neglect Toolkit.

4.11 Evaluating the effectiveness of training

During the year 842 people attended a range of multi-agency courses delivered by WSCB. Courses included Targeted training (1, 2 & Refresher), Supervision training, CSE Awareness Raising and Management of Allegations. WSCB multi-agency training is attended by a wide range of agencies, in particular schools, the Worcestershire Health and Care NHS Trust and staff who work for the Children, Families & Communities Directorate of Worcestershire County Council.

WSCB multi-agency training continues to be delivered to a very high standard as evidenced by on the day and impact evaluations. 96% of people attending the training completed an `on the day' evaluation which shows that people rate the quality of the training and effectiveness of the teaching as good or very good. Those who attended said that their knowledge and confidence in working in safeguarding had improved.

Impact evaluations completed three months after the course suggest that attending the training had:

- Improved working practices
- Positively impacted on supporting families and children
- Improved awareness of safeguarding

E-learning was less well used this year with 996 practitioners accessing online courses (down 28% compared with last year). There has been a year-on-year reduction in demand and the Board took the decision cease delivery of e-learning from April 2019. It will instead signpost agencies to alternative providers where they can purchase online courses directly.

5. Formal Summary Statement of the arrangements to ensure that children are safe in Worcestershire

Worcestershire Safeguarding Children Board has a responsibility to form an annual overall judgment on safeguarding arrangements and their effectiveness. Based on the Board's quality assurance activity and the learning to come from it, and giving consideration to inspection findings during the year, it can make the following formal summary statement in respect of 2018/19:

Engagement with the work of WSCB has remained strong, evidenced by Board members chairing sub-groups and ensuring actions are completed to implement the Business Plan. Attendance at Board meetings remains good and response to audits is generally positive. There have been fewer changes to Board membership than in previous years which has supported continuity and full engagement. Contributory partners have, despite competing financial demands, maintained funding for the Board. There remains evidence of a strong multi-agency commitment to learning and improvement across the WSCB partnership.

During 2018/19 the Board has continued to be sighted on the work being undertaken by Children's Social Care to improve services for children in need of help and protection, including early help, through its comprehensive Service Improvement Plan. In addition, Ofsted have continued to monitor progress through quarterly monitoring visits. As a result of feedback received from Ofsted and the local authority's own Quality Assurance and Performance Information, the Service Improvement Plan has been reviewed and priorities re-focussed. The Board was satisfied with the regular updates provided from the Director of Children, Families and Communities and with commentary and analysis regarding performance information provided by the Assistant Director (Safeguarding).

Operation Encompass is a national initiative which was launched in Worcestershire in November 2018 where notifications about domestic abuse incidents are communicated the next morning to schools via the portal. The WSCB supported this initiative by providing money to pay for administration capacity for one year. Informal feedback is that schools welcome this information as it places them in a position where they can put a child's presentation into context and provide emotional support to children if necessary.

The Levels of Need (Thresholds) guidance, approved by the Board in March 2016, has been updated during the year to include a revised Early Help Pathway. Previously this had been a significant gap. An understanding of the local early help offer and pathway is critical to ensuring that practitioners are able to make appropriate decisions about how families access timely support and when to make a referral to Children's Social Care. Previously feedback received by the Board indicated that practitioners were unclear about the early help offer and their part in delivering it, and about the process for accessing services for families. Changes to the referral process made in November 2018 for accessing Early Intervention Family Support (EIFS) or Targeted Family Support (TFS) have provided greater clarity for practitioners about the differences between Level 3 and 4 interventions and the process for accessing services when early help support at Level 2 is not sufficient. In December 2018 the Board was informed that early help support requests had nearly doubled with most coming from schools. It is anticipated that the development of locality working in districts will further support the partnership approach. Through its sub-groups the WSCB played a part in

providing feedback on the Early Help Pathway and in disseminating information across the Partnership.

Two key areas of multi-agency activity during the year have been development of the GET SAFE agenda, which has broadened out the focus from Child Sexual Exploitation to other aspects of exploitation, and the Neglect Strategy and launch of the Neglect Toolkit. Next year will see the CSE Strategic and Operational Groups widen their respective remits as exploitation remains a key priority for the new Worcestershire Safeguarding Children Partnership, and the development of a GET SAFE Action Plan 2019-21 will support this important area of multi-agency safeguarding. Evaluation of the impact of the Neglect Toolkit on practice and development of our understanding of neglect in Worcestershire will also be a priority during the coming year.

Summary statement of overall effectiveness

The Board concluded that the body of evidence from data, audits, its own learning and inspection findings demonstrates that clear progress is being made in the provision of support and protection for children and young people in Worcestershire. The anticipated full inspection of local authority services by Ofsted in 2019 will hopefully confirm this position.

Further assurance is required as to the effectiveness of the wider early help offer, albeit it is recognised that the quality of provision by local authority commissioned providers is good. In order for children and families to receive the right services at the right time there needs to be a good understanding of the Early Help Pathway and the threshold for statutory intervention by Children's Social Care. The Board acknowledges the good work done to develop the Worcestershire Early Help Pathway which, along with changes made to referral processes, provides greater clarity for practitioners about their role in delivering lower level early help and about accessing services at higher levels of intervention.

The Board acknowledges the tremendous effort made by the Local Authority, in collaboration with partners, to make tangible improvements to services for children and young people in Worcestershire. It recognises, however, that further work is required for safeguarding services to be consistently good and hands over to the new Worcestershire Safeguarding Children Partnership to provide the support and challenge as the improvement journey continues in 2019/20.

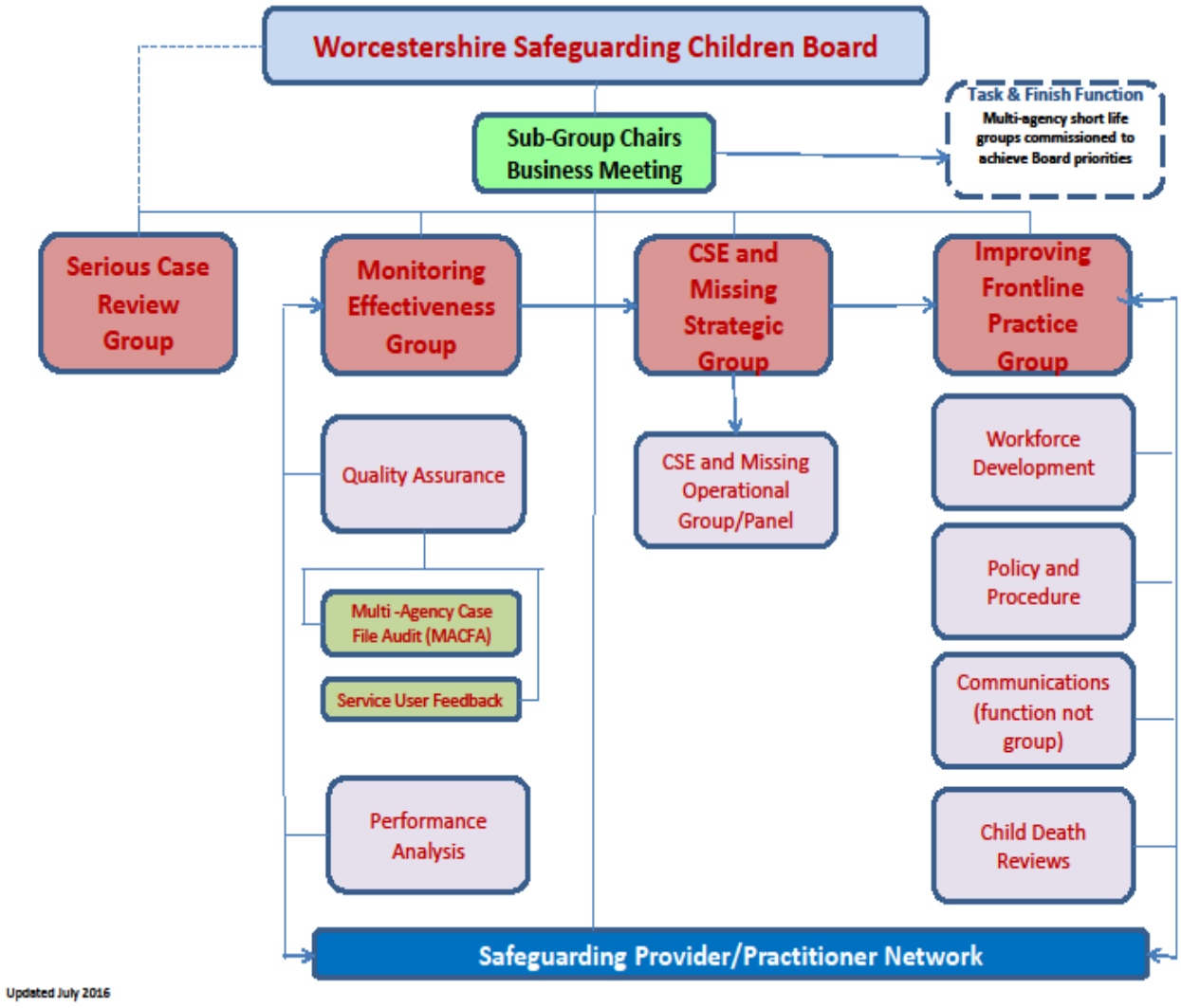
Footnote: Ofsted completed a full inspection of Children Social Care services in June 2019. Inspectors recognised that considerable progress has been made in many areas in improving the quality of services for children and families since the inspection in 2016. The report acknowledges that outcomes for many children and their families are better and that there is evidence of a "sustained trajectory of improvement". Following the inspection the judgement from Ofsted is that all service areas 'require improvement to be good'. In 2016 all areas were judged to be inadequate other than adoption.

Appendix 1 WSCB Membership 2018/19

Agency	Name	Role
Independent	Derek Benson	Independent Chair
Worcestershire County Council	Catherine Driscoll	Chief Executive
	Tina Russell	Assistant Director (Safeguarding)
	Sarah Wilkins	Assistant Director (Early Help and Commissioning)
	Nick Wilson	Assistant Director (Education and Skills)
	Frances Howie	Director of Public Health
	Sarah Cox	Quality and Safeguarding Manager, Adult Social Care
Young Solutions	Michael Hunter	Chief Executive (representing Community Voluntary Sector)
CAFCASS	Julie Shaw	Service Manager
Heart Of Worcestershire FE College	Julia Breakwell	Vice Principal (representing FE Colleges)
Bromsgrove and Redditch District Council	Kevin Dicks	Chief Executive (representing District Councils)
Worcestershire Health and Care NHS Trust	Michelle Clarke	Director of Quality (Executive Nurse)
NHS Worcestershire Clinical Commissioning Groups	Lisa Levy	Chief Nurse and Director of Quality
	Ellen Footman	Designated Nurse
	David Lewis	Designated Doctor
West Midlands Ambulance NHS Trust	Robert Cole	Head of Clinical Practice
Worcestershire Acute Hospitals NHS Trust	Vicky Morris	Deputy Chief Nursing Officer
Herefordshire and Worcestershire Youth Justice Service	Keith Barham	Head of Service
West Mercia Police	Damian Pettit	Superintendent, South Worcestershire
Warwickshire and West Mercia Community Rehabilitation Company	Nina Kane	Head of Service, Worcestershire and Herefordshire
National Probation Service	Jackie Stevenson	Head of Service, West Mercia

Hereford and Worcester Fire and Rescue Service	Nathan Travis	Chief Fire Officer
St Peters C of E First School	Tracey O'Keefe-Pullen	Head Teacher (representing First and Primary Schools)
St Egwins Middle School	Nick Pullen	Head Teacher (representing Middle Schools)
Waseley Hills High School	Alan Roll	Head Teacher (representing Secondary Schools)
King's School	Matthew Armstrong	Head Teacher (representing Independent Schools)
Riversides School	Paul Yeomans	Head Teacher (representing Special Schools)
Magic Moments Nursery	Natalie Burford	Proprietor (representing Early Years)

Appendix 2 WSCB Structure



Appendix 3 End of Year Finance Position

	Board Budget	Training Delivery	SCR	Partnership Fund	Total
	Expenditure £				
Salaries **	174,810				174,810
Independent Chair	26,257				26,257
SCRs and Case Reviews			9,235		9,235
Performance resources *	16,842				16,842
Administration and business costs	40,367				40,367
Training Expenditure (excluding salaries)		28,629			28,629
E-Academy (E-learning)		14,016			14,016
Partnership Fund expenditure				29,388	29,388
Total Expenditure	**258,267**	**42,645**	**9,235**	**29,388**	**339,544**
	Income £				
Agency Contributions					
WCC - 50%	(138,379)				(138,379)
Health - 35%	(86,000)				(86,000)
Police - 10%	(24,529)				(24,529)
National Probation Service - 0.9%	(2,016)				(2,016)
Community Rehabilitation Company - 0.9%	(2,250)				(2,250)
CAFCASS - 0.4%	(550)				(550)
District councils - 2.5%	(7,326)				(7,326)
Core training, Early Years and GP		(42,410)			(42,410)
Income from E-Learning		(13,813)			(13,813)
Partnership Fund				(0)	(0)
Total income	**(261,051)**	**(56,223)**	**(0)**	**(0)**	**(317,273)**
Net Expenditure	(2,774)	(13,578)	9,235	29,388	22,271
Holding account b/f as at 1 April 2018	(18,700)	(88,360)	(27,360)	(39,200)	(173,620)
Holding account as 31st March 2019	(21,474)	(101,938)	(18,125)	(9,812)	(151,349)

Appendix 4 Performance Data

1. Journey of the Child

1.1 Initial Contact

- There were just over 11,300 contacts to the Family Front Door in the full year, an increase of 10% on last year and an average of 942 per month.
- Percentages of Contacts by source are: Police 43%, Schools 12%, Health 14%, Individual 8%, Local Authority Services 6%, Others 16%.
- Percentages of Contacts by outcome are: Social Care referral 48%, Early Help 26%, No further action 26%.
- Accepted referrals to Children's Social Care services were approximately 430 per month (last year not comparable).
- Repeat referrals within 12 months have decreased slightly to 21% (last year was 22%).
- Open Section 17 assessments have increased to 597 (last year was 386).
- Open Section 47 assessments have increased to 103 (last year was 90).
- Section 17 timeliness improved to 82% (last year was 73%).
- Initial Child Protection Conference timeliness improved to 77% (last year was 74%).

. .

1.2 Early Help

- There have been 1288 Early Help Assessments completed (last year was 1162), with the number open reduced to 113 (last year was 145). There are 533 open Early Help workflows (last year was 436), which equates to 900 individuals with a Targeted Family Support worker (last year was 879).
- Recently there has been a monthly average of 26 step downs from social care (last year was 25) and 7 step ups to social care (last year was 7).

1.3 Children with a Child in Need Plan

- Children with open Child in Need Plans has reduced to 594 (last year was 695).
- Child in Need figures for Worcestershire are in line with our statistical Neighbours in rates per 10,000.

1.4 Children with a Child Protection Plan

- Children with a Child Protection Plan have reduced to 404 (last year was 415).
- Duration of Child Protection Plans have shortened with 88% now shorter than 12 months compared to 65% at the end of March 2018.
- Number of children subject to a Plan for longer than 18 months has increased to 16 (last year was 7).
- The rate of Child Protection Plans per 10,000 has reduced to 35 (last year was 36). Nationally this was 45 for 2018.

1.5 Looked After Children

- Number of Looked After Children has increased to 842 (last year was 798).

- The rate of Looked After Children per 10,000 has increased to 72 (last year was 69). Nationally this was 64 for 2018.

1.6 Children who are Care Leavers

- There are currently 359 care leavers open for services, of whom 87% are classed as 'in touch' with the service (last year was 88% and National 93%), 89% are known to be in suitable accommodation (last year was 89%), care leavers not in suitable accommodation has reduced to 4% (last year was 10%) and those classed as not known is 7%.Work within the Through Care service business plan and with the corporate parenting board is prioritising suitable accommodations.

1.7 Children in Private Fostering

A privately fostered child is defined as a child under the age of 16 (18 if disabled) who is cared for and provided with accommodation by someone other than the parent, a parent who is not the biological parent but has parent responsibility, a close relative such as a brother, sister, aunt, uncle, grandparent or step parent. A child who is looked after in their own home by an adult is not considered to be privately fostered.

- There are 11 private fostering arrangements in place (last year was 15). An average of 77% of fostering visits were within timescale (last year was 66%).

1.8 Unaccompanied Asylum Seeking Children (UASC)

Unaccompanied Asylum Seeking Children are children who have travelled to the UK alone, or become separated from anyone with parental and/or care responsibilities for them. Children seek asylum because they have a genuine need for protection and are in search of safety. Under sections 17 and 20 of the Children Act 1989 Local Authorities have a duty to provide support to these children.

- 33 children were accepted as UASC during the year, all aged from 13-17 years. The total now placed in Worcestershire is 38 (last year was 24), 27 of which are in foster care and 11 in semi-independent accommodation.

1.9 Children with a disability

The Children with Disabilities Team offer services to those children and young people requiring additional resources in respect of their disability, where the disability has a profound impact on the child or young person's life. Other services available are those provided by health, education, play and youth services as well as community resources provided by voluntary agencies.

- The number of children allocated to the specific disability team increased to 437 (last year was 413), with 271 being subject to a short breaks plan, 51 on a Child in Need Plan, 42 being looked after and 10 on a child protection plan.

1.10 Children Missing Education and Electively Home Educated Children

When a child is on a school roll but not attending and they cannot be traced, the Local Authority must try to find the child. Parents have the right to educate their children at home as long as they provide an education that is sufficient and suitable for their child's needs and aptitudes. There is a requirement on Local Authorities to annually monitor the suitability of education provided to children educated at home. Schools have to inform their Local Authority if a child is removed from roll to be home educated and the guidance has extended this requirement to academies and independent schools.

- The number of children registered as missing education was 57 with 287 under current enquiry.
- The number of children being electively home educated has increased to 742 (last year was 694).
- Both of these continue to be a key focus for Education and Skills.

1.11 Children at risk of offending

The Youth Justice Service aims to prevent offending and re-offending by children and young people under the age of 18 by providing a variety of interventions and support. These can include preventative provisions and diversionary activities, so that young people can have more fulfilling lives, families are strengthened, and communities feel safer and more harmonious.

There has been no information received from West Mercia Police in relation to the number of children charged and detained by the police or those held in police custody overnight for four hours or more.

1.12 Children and Health

The Child and Adolescent Mental Health Service (CAMHS) provides support to children and families where the young person is experiencing significant mental health difficulties. The team includes psychiatrists, psychologists, psychotherapists, mental health nurses, family therapists and therapeutic social workers.

- Referrals have increased to 210 per month (last year was 200) for the Child and Adolescent Mental Health Service in 2018/19. The numbers on waiting lists for an initial appointment have reduced significantly to below 150 (last year was 318), whilst waiting times have reduced to under 5 weeks (last year was 6 weeks).

1.13 Missing Children

The aim is to reduce the incidence of all children and young people going missing and if they do, to reduce the risk of them suffering harm and recover them to safety as soon as possible. We do this through partnership working, information sharing, problem solving and performance management. A child or young person will be categorised as 'Missing' when their whereabouts cannot be established and/or the circumstances are out of character and the context suggests the person is subject of a crime or at risk of harm to themselves or another.

Introduction of Missing Children Officers in Feb 18 has shown a significantly positive impact on the number of missing children incidents and on the numbers of individual children involved in incidents through 18/19. Timeliness of Welfare Return Interviews has significantly improved since embedding of this new role. There has been a decrease in missing children incidents and children involved in incidents by approximately 50%.

2. WSCB Strategic Priorities

2.1 Children subject to Neglect

- 79% of all Child Protection Plans have neglect as a category (last year was 65%).
- 19% of all Child in Need Plans have neglect as a factor (No comparable figure for last year).
- 36% of all Child Protection Plans have neglect as a factor (No comparable figure for last year).
- 32% of all Looked After Children have neglect as a factor (No comparable figure for last year).

The rise in the number of children subject to plans for neglect is reflective of increasing awareness and proactive action to identify Neglect as a serious issue of harm to children. Informal work was completed with managers in year and the formal WSCB Neglect Strategy and Toolkit was launched towards year end. The reduction in the use of the category of emotional abuse is reflective of work done with chairs and partners to ensure the Child Protection threshold is clear to parents and partners.

2.2 Children witnessing Domestic Abuse

- There was a monthly average of 218 contacts with Domestic Abuse as a factor (No comparable figure for last year).
- There was a monthly average of 127 Section 17 assessments with Domestic Abuse as a factor (No comparable figure for last year).
- 30% of all Child in Need Plans have domestic abuse as a factor (Last year was 35%).
- 45% of all Child Protection Plans have domestic abuse as a factor (Last year was 48%).
- 30% of all Looked After Children have domestic abuse as a factor (Last year was 31%).
- West Mercia Police remain unable to report data in respect to children with repeated domestic abuse offences.

2.3 Children vulnerable to and experiencing Child Sexual Exploitation (CSE)

- Monthly CSE referrals have increased to 34 (last year was 32).
- The current number experiencing CSE is 12 (last year was 16).
- The current number vulnerable to CSE is 164 (last year was 155).
- 3% of all Child in Need Plans have CSE as a factor (No comparable figure for last year).
- 2% of all Child Protection Plans have CSE as a factor (No comparable figure for last year).
- 3% of all Looked After Children have CSE as a factor (No comparable figure for last year).

Appendix 5 Glossary

CAFCASS	Children and Families Court Advisory and Support Service
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Groups
CDOP	Child Death Overview Panel
CiN	Child in Need
CME	Children Missing Education
CPC	Child Protection Conference
CPP	Child Protection Plan
CQC	Care Quality Commission
CRC	Community Rehabilitation Company
CSC	Children's Social Care
CSE	Child Sexual Exploitation
EH	Early Help
EHA	Early Help Assessment
EHE	Elective Home Education
FGM	Female Genital Mutilation
HACT	Health and Care NHS Trust
HMIC	Her Majesty's Inspectorate of Constabulary
HWB	Health and Well-Being Board
ICPC	Initial Child Protection Conference
IMD	Index of Multiple Deprivation
LAC	Looked after Child
LGA	Local Government Association
LSOAs	Lower Layer Super Output Area
MACFA	Multi Agency Case File Audit
MEG	Monitoring Effectiveness Group
NPS	National Probation Service
SCR	Serious Case Review
SUDIC	Sudden, Unexpected Deaths in Infants and Children
WCC	Worcestershire County Council
WFADA & SV	Worcestershire Forum Against Domestic Abuse and Sexual Violence
WMP	West Midlands Police
WSAB	Worcestershire Safeguarding Adults Board
WSCB	Worcestershire Safeguarding Children Board
YABS	Youth Advisory Board (Safeguarding)
YJS	Youth Justice Service

Worcestershire Safeguarding Children Board

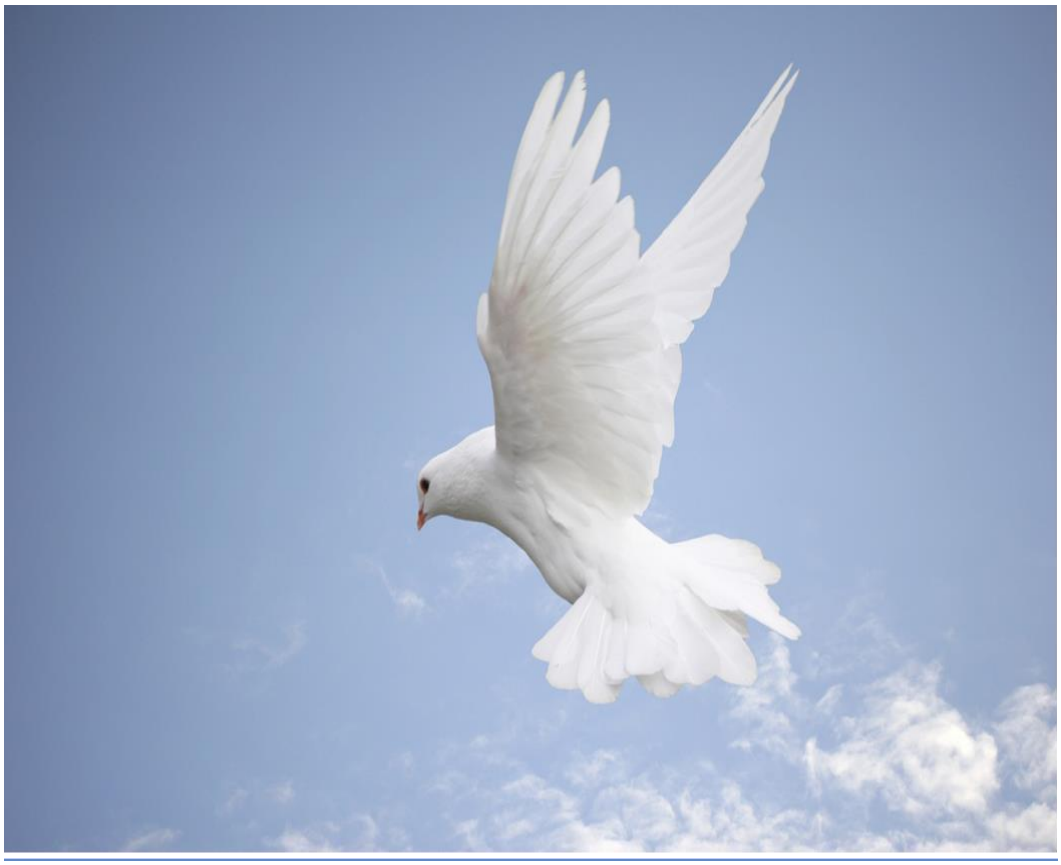
www.safeguardingworcestershire.org.uk

Worcestershire Health and Care NHS
NHS Trust

The Child Death Review Process For Worcestershire

Final Annual Report

01 April 2018 to 30 September 19



Contents

Foreword and Introduction

We present the Final Worcestershire Child Death Overview Panel's (WCDOP) Report, which illustrates the evolution of the Child Death Review process with ever increasing opportunities to identify areas for improvement and development of services for children in Worcestershire.

The Worcestershire CDOP continues to be effective in fulfilling its statutory function, as part of the responsibilities of the local safeguarding Children Board, to review the deaths of every child under the age of 18 years residing in the county; the key purpose of this is to learn lessons and reduce the incidence of preventable child deaths in the future.

WCDOP has contributed directly to the work of Worcestershire Safeguarding Children Board, which historically has been the statutory partnership for ensuring that agencies work in effective collaboration to safeguard and promote the welfare of children to produce positive outcomes for children and their families.

The Child Death Review process has now been in existence for eleven years following its inception in April 2008. Since that time, the statutory guidance has been updated with the publication of Working Together to Safeguard Children in March 2010, with minor revisions in 2013, 2015 and 2017.

Further substantial revision was published in Autumn 2018 along with Child Death Review Statutory and Operational Guidance [England] giving detail of the new statutory arrangements for Child Death Review, as referenced in the Children and Social Work Act of 2017. Subsequent to this; there are changes underway with regard to the future organisation and management of Child Death Review.

From 01 October 2019 Herefordshire and Worcestershire Child Death Overview Panels will be in combination thus this report will document activity to the closure of WCDOP.

WCDOP Chair and Manager wish to thank all WCDOP participants for their unstinting support of our activity since 2008 and to celebrate our many achievements in undertaking activity to improve and develop services for children in Worcestershire.

WCDOP Data Summary 2018/19

- Between 1st April 2018 and 30th September 2019, Panel received a total of **51** [36/15] Death Notifications of Worcestershire resident children. 37 of these were notified in 2018/19. Information with regard to the deaths of 13 non-residents also needed to be managed

- **55%** of notifications were **male** with **45% female**

- **75 %** of deaths recorded were of **children aged less than 1 year**

- **17** Child Deaths were managed [in whole or in part] through the Joint Agency Response [JAR] processes

- Since 2008, the average number of annual notifications received is **37**

Child Deaths Reviewed by Panel, 2018 - 19

- From 2008-2019 Worcestershire CDOP has reviewed **380** child deaths; **93%** of all received **Notifications [411]**

- WCDOP has been most fortunate to have a very experienced independent chair to lead **9** members of Panel representing a range of agencies including 3rd Sector, West Mercia Police, WCC Children's Social Care, WCC Local Safeguarding Board, NHS WH&C Paediatrics, NHS WAHT Paediatrics and Safeguarding CCG

- During the last 3 years there have been many personnel changes in representing agency participants but Panel has **over a third of its membership** who have served for over **5 years**

- Both WCC Legal Services and WMAS support WCDOP, participating as and when their expertise is requested.
  Panel was keen to further expand participation and, with WSCB support, recruited a participant from Education

- Between 1st April 2018 and 30th September 2019 Panel, Perinatal and Life Limited Sub-Groups met on **9** occasions to successfully review **37 cases;** [ref Figure 1]

- Modifiable Factors were identified in **43%** of cases

- During this period, the Perinatal Mortality Review Tool has been introduced to support reviews of all baby deaths.
  While we receive very prompt reports following reviews undertaken locally, we have experienced some challenges with the forwarding of these reports from tertiary centres, but this is being resolved.
  This, coupled with delays in post-death processes such as Post Mortem and or Inquest has added to delays in bringing cases for review at Panel

Figure 1 Worcestershire CDOP Activity Since 2008

Data Breakdown for Child Deaths Reviewed by Panel in 2018/19 will be found in Appendix 1b

	Child Deaths Reviewed by WCDOP 2008-09	Child Death Reviewed by WCDOP 2009-10	Child Death Reviewed by WCDOP 2010-11	Child Death Reviewed by WCDOP 2011-12	Child Death Reviewed by WCDOP 2012-13	Child Death Reviewed by WCDOP 2013-14	Child Death Reviewed by WCDOP 2014-15	Child Death Reviewed by WCDOP 2015-16	Child Death Reviewed by WCDOP 2016-17	Child Death Reviewed by WCDOP 2017-18	Child Death Reviewed by WCDOP 2018-19	Pending Child Death Reviews	Child Deaths Reviewed	Notifications of Child Deaths Received
2008 – 09	11	21											32	32
2009 - 10		23	18	3	1	1							46	46
2010 – 11			18	16	1		1+1*						36+1	36
2011 – 12				10	23								33	33
2012 – 13					15	23	2	1	1		1		43	43
2013 - 14						14	21	1		1			37	37
2014 – 15							23	19			1		43	43
2015 – 16								14	21	2	1		38	38
2016 – 17									15	8	2	1	26	27
2017 – 18										14	11		25	25
2018 – 19											21	29	21	51
Totals	**11**	**44**	**36**	**29**	**40**	**38**	**47+1***	**35**	**36**	**25**	**37**	**31**	**380**	**411**

NB

* '2010-11' / Column 'Child Deaths Reviewed 2014-15' relates to a Child Death reviewed by Panel a 2nd time

Learning from Child Death Review

Of the **37** Child Deaths reviewed by the CDOP in during this period, **16 deaths** were considered to have **'Modifiable Factors'**

This term indicates that the Panel has identified one or more factors which in combination, **may** have contributed to the death of the child and, by means of locally, regionally, or nationally achievable interventions, could be modified to reduce the risk of future child deaths

Modifiable Factors Identified during the review of Perinatal Deaths:

- Smoking in Pregnancy
- Obesity: BMI 35^{+}
- Sub-optimal Health Care Management

Modifiable Factors Identified during the review of Child Deaths:

- Sub-optimal Health Care Management
- Smoking in Pregnancy
- Smoking in the Home Environment
- Alcohol in tandem with Bed and Sofa -Sharing with a Baby
- Failures in Multi-Agency Information Sharing
- Dangerous car driving by teens

The Child Death Review, CDR, process generates learning points and recommendations from overviews by the Panel. A comprehensive action plan matrix is maintained to record, update, and monitor the actions and to establish completion.

Actions enacted include:

- Encouraging the exploration of improved pathways concerning the management of pre-pregnancy planning in relation to smoking cessation and obesity, factors which can make examination and assessment of pregnancy difficult, particularly abdominal examination and which show a definite link to adverse outcomes Indeed 25% of Worcestershire women present to book Midwifery Care with a BMI of 30+ and although this is not as high risk as BMIs of 35+, it is a trend that is suggested could be addressed via a Public Health Campaign i.e. 'Get Fit B4 U Get Pregnant' including the appreciation of obesity in parents as a risk factor for their maternity progress and subsequent children's health

- Subsequent to PSG review, learning and amendments to training, policies and practises have been cascaded within the Informal CDOP Network in England.

- Following robust PSG procedures have uncovered and linked many factors of concern; Police and Children's Services are invited to reviews, as appropriate, and subsequent exploration of safeguarding action is undertaken including more thorough multi-agency information sharing.

- Sharing the frequently occurring issues of environmental stresses including overcrowding and deprivation.

- Encouraging the appropriate management of pregnancy and the deployment of Advanced Care Plans for babies with known Life Limited conditions; with the inclusion of Mothers in 'PAGE Study', **P**renatal **A**ssessment of **G**enomes & **E**xomes, which strives to gain a better understanding of genetic variants causing developmental problems during Pregnancy and aims to improve prenatal diagnostics, allowing better genetics-derived prognoses & more informed parental counselling in the future.

- Ensuring good support for families with signposting from the Acute Health Trust Bereavement Midwifery Team to commissioned bereavement support in Worcestershire provided by Acorns, Kemp, St Richards and Primrose Hospices.

- Recommending high quality integrated multi-agency working in relation to many children with life limiting or terminal conditions.

- WCDOP Manager facilitating the development of improved communication pathways between Tertiary and Local professionals for both babies and children including follow-up appointments for parents following a necessary transfer to a Tertiary Centre.
  Many examples of excellent collaborative working between WCDOP Manager and Worcestershire Acute Health Trust Midwifery, Obstetrics and Neonatology facilitate; managing information flow and ensuring all available documentation is shared.

- Drawing attention to the continuing problems encountered when significant numbers of new-born babies and mothers have to be transferred, both in-utero and ex-utero, to other hospitals with Level 1 specialist neonatal services in locations where neonatal cots are available since there is no provision for this level of care in Worcestershire.
  Coupled with issues around locating cots at Tertiary Centres, an agreement in the West Midlands for all in-utero transfers to be automatic to Birmingham Women's Hospital continues to be explored?

- Commending the high quality of care and family support provided by Acorns Hospice and the Orchard Service for children and their families both in the palliative stage of their care and continuing after the death of the child.

Developments and Initiatives

Review of West Mercia SUDIC Policy

The document "Sudden Unexpected Death in Infancy and Childhood" is a report which gives multi-agency guidelines for subsequent care and investigation of such cases. This report was generated by a working group, chaired by Baroness Helena Kennedy QC, convened by The Royal College of Pathologists, endorsed by The Royal College of Paediatrics and Child Health and was published late November 2016.

Subsequent to this the West Mercia Protocol for Sudden, Unexpected Deaths in Infants and Children [WM SUDIC Protocol] was reviewed in 2018 to ensure advice from the above report is incorporated into the local practices for the management of Rapid Response deaths, now referenced as Joint Agency Response Deaths [JARs].

This document was ratified by WSCB in March 2019.
However, following the publication of Working Together to Safeguard Children 2018 and Child Death Review Statutory and Operational Guidance [England], this Protocol will require alignment to the detail of the published 'new arrangements

Safer Sleeping Initiative

The Worcestershire Safer Sleeping Risk Assessment Form has been operational since October 2013. All new born babies now have an in-depth review of their sleeping arrangements and a discussion of risks pertinent to them, to enable parents and carers to make informed decisions about how to care for their baby during sleep time.

Following interest from the West Midlands Parent Held Record Group in the Worcestershire Safer Sleeping Initiative, a safer sleeping pro-forma was devised which is now included in the Health Visiting 'Red Book' and implemented throughout the West Midlands region.

This initiative has now been further adopted by Child Health agencies in several areas of England.

During 2017/18, for the first time since the inception of WCDOP, **NO** child deaths were categorised as 'sudden and unexpected deaths in infancy'. Is this testament to the efficacy of the Safer Sleeping Initiative?

However, our celebration was short lived as over the last 18 months there has been a significant rise in baby deaths related to unsafe sleeping practices; in particular both bed and sofa sharing with a baby in tandem with alcohol use in smoking households.

With reference to Figure 2, it is notable, with the exception of 2013/14, that the incidence of Modifiable Factors [red notation] in relation to Category 10 CDRs for children aged less than 1 yr. declined following the introduction of the Worcestershire Safer Sleeping Guideline.

NB
4 of the 6 deaths reviewed in 2013/14 with noted Modifiable Factors died during 2012/13; before the implementation of the Safer Sleeping Guideline.

Figure 2

Data Breakdown for WCDOP Historical Category 10 Data [Children aged less than 1 year]

Category of Death	10. Sudden unexpected, unexplained death [data re children aged less than 1 yr]

Year of Review	Modifiable Factors Identified	No Modifiable Factors Identified
2008/09	1	0
2009/10	1	2
2010/11	2	0
2011/12	3	0
2012/13	0	0
2013/14	**6**	1
2014/15	2	0
2015/16	2	0
2016/17	1	0
2017/18	0	0
2018/19	**6**	0

Totals	**25**	3

Following review at WCDOP, a number of cumulative concerns became apparent suggesting a need for further exploration of the current Safer Sleeping Guideline.

Public Health and the Acute Trust WCDOP participants have shared these concerns with their agencies and, in partnership, are exploring:

- Can the Safe Sleep message be improved?
- Is the message fully understood by parents?
- Is it consistently and well-delivered by professionals?

We are confident the newly combined H&W CDOP and Child Death Review Partners will be keen to support this on-going activity to progress outcomes and recommendations accordingly.

Joint Agency Response

There have been significant personnel changes to the Joint Agency Response Team with a new appointment to the Lead SUDIC Nurse role in 2017, which is now established.
There has been a recent appointment to the Administrator post which is bedding in.

During the last 18 months 17 deaths have been managed through the JAR processes as set out in the WM SUDIC Protocol;
An audit of these deaths has been undertaken to ensure the protocol is being followed appropriately. Some key learning points identified continue to include:

- ✓ All children who have died should be transported to Acute Hospital Emergency Department so that a full review and SUDIC samples can be obtained.
  This did not happen in 3 cases

- ✓ SUDIC process was not followed at an Emergency Department at an out of county hospital.
  This has been raised by the Lead SUDIC nurse with the safeguarding team at the hospital who were already aware that this was an issue for the hospital.
  This is being addressed through planned links with a neighbouring hospital with a paediatric department

- ✓ Initial history was not taken in A&E in a further 3 cases, one where the death occurred overseas, and 2 where the death occurred on intensive care units.
  The Joint Agency Response Protocol was followed in these cases with initial information sharing meetings held to plan future actions and support for the families

- ✓ Multi-agency Information Sharing Meetings have been held for all children with consistent attendance by GPs when the venue is the GP's surgery

Acute Trust Bereavement Midwifery Team

The Panel is delighted to share that its persistent endorsement of the Department of Health recommendation for the CCG supported appointment and deployment of a Bereavement Midwife is having synergistic effect on child death bereavement support and future pregnancy planning.

Indeed, such is the efficacy of this role that since 2018, 2 additional members of staff have been recruited to provide 9 full time equivalent days per week of specialist Bereavement Midwifery Services to families..

Following Child Death Reviews at PSG, the Worcestershire Acute Health Trust [WAHT] Bereavement Midwifery Team has been proactive in cascading learning with colleagues with many notable positive outcomes for women and babies such as:

- √ Addressing the issue of Early Booking for Mothers with multiple miscarriages or Pre-Term Delivery History; Local Midwifery Audit has recognised that women with history of early pregnancy losses are now seen at an earlier stage in subsequent pregnancies.

- √ Raising the Obstetric and Paediatric cognizance of consultant promotion of Post Mortems (PM) with parents; although not always giving exact Cause of Death a PM outcome may rule out particular issues & support future pregnancy planning.

- √ The amendment of Midwifery Policy to address non-attendance at any antenatal appointments.

- √ The development of a local 'Neonatal Palliative Care Guideline'; to support parents in cases of known Life Limited conditions i.e. Edwards Syndrome & issues of organ donation.

- √ Ensuring that women who have undergone surgical cervical procedures are clearly aware of the time delay required between surgery and conception since in such instances there is higher risk of cervical incompetence

- √ Addressing the issues around local management of post mortem examination of placentas.

- √ Establishing clear and comprehensive feedback meetings, both locally and at tertiary centres, where the pregnancy, delivery, post-partum care, baby death, bereavement support and future conception and pregnancy planning is discussed and addressed.
  Subsequent to the meeting parents receive written correspondence with a copy to GP.

Perinatal Mortality Review Tool

A collaboration led by MBRRACE-UK has been appointed by the Healthcare Quality Improvement Partnership [HQIP] to develop and establish a national standardised Perinatal Mortality Review Tool [PMRT].

The PMRT has been designed with user and parent involvement to support high quality standardised Perinatal Reviews. The aim of the PMRT programme is to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales.

The tool supports:

- Systematic, multidisciplinary, high quality reviews of the circumstances and care leading up to and surrounding each Stillbirth and Neonatal Death, and the deaths of babies who have required neonatal care but die in the post-neonatal period.

- Active communication with parents to ensure they are told that a review of their care and that of their baby will be carried out and how they can contribute to the process.

- A structured process of review, learning, reporting and actions to improve future care.

This tool was adopted by WAHT in the final quarter of 2017/18 to support the well-established WAHT Perinatal Morbidity Mortality Meetings, PMMMs; now re-named PMRT meetings.

However, whereas a Form C was completed following PSG meetings and used to inform and support local Perinatal Morbidity and Mortality Reviews, we have established themed PSG meetings post-PMRT to review a Draft Form C of all available collated information from agencies involved along with both the locally and, when appropriate, tertiary completed PMRTs.

We now have formal information sharing agreements in place with most Tertiary Centres to support the prompt forwarding of completed PMRT Proformae.
Also, at the request of regional HM Coroners, we have introduced formal information sharing procedures to support the prompt forwarding of Post Mortem reports.
Both of these actions should address the recent delays in bring cases for more prompt PSG review.

Often there are outcomes arising from the PSG Child Death Review which are in addition to issues highlighted at PMRT review since information is provided by a wider data set which may include CSC, Police and GP input. Also the exclusively medical nature of the PMRT does not address categorisation or the identification of modifiable factors. As before, learning and improvements are disseminated accordingly.

We look forward to sharing our excellent practice of Themed Panel Management of perinatal/neonatal deaths with our new Herefordshire CDOP colleagues

Review Proforma 'Form Cs'

Adapted Form Cs to support the review of SUDIC, Perinatal/Neonatal and Suicide Deaths were initially introduced in 2012/13 and have been further improved to provide more effective tools to identify risk factors pertinent to the review of particular deaths and Themed Panel meetings [PSG & LL/LT Groups]

By request, these proformae have been shared within the CDOP Network England with some adapted and used as published templates to support the 'new arrangements' for Child Death review processes

Review Proforma 'Form Bs'

The adapted Form Bs and exemplars have also been further been improved to aid ease of information sharing and completion.
However, although some professionals, particularly in Worcestershire, are keen to share information and provide a variety of documentation to support review, it is very challenging when Tertiary Centres do not promptly forward information.
We look forward to the adoption of the ECDOP IT package along with the new styles of Agency Reporting Proformae which we hope will address this issue.

Advanced Care Plans

Advanced Care Plans known as ACPs were developed by a multi-disciplinary team of West Midlands Healthcare Professionals [inclusive of the WH&C NHS Trust Lead for Orchard Service] led by a Consultant Paediatric Intensivist from Birmingham Children's Hospital and introduced in the West Midlands region in 2012

The purpose of the ACP is to provide a vehicle through which the challenging questions around the death of a child can be approached and managed with Parents and, in many instances, inclusive of the child or teen concerned

It is far from a one-off document, completed and stored away.
The ACP is re-visited through the child's palliative stage of care and often reflects the changing attitude and approach of the family involved to the death of their child; often demonstrating an evolving approach to DNAR care and post-death activity such as use of the special cooled bedroom at Acorns along with funerary preferences.

In 2019 it is rare indeed for the death of a Worcestershire child who has been Life Limited or Life Threatened not to have been supported by this device which is testament to the professionals' excellent interaction and engagement with families providing guidance and support through these challenging decisions

Other Developments and Initiatives:

- The active participation of WCDOP in the pooling of initiatives and child death information through an informal England-wide CDOP Network.

  Learning noted elsewhere is further shared at WCDOP including concerns raised by a Coroner regarding a baby death related to bath seat deployment and supervision

- Further improvements to the Worcestershire Child Death Leaflet to explain the WCDOP processes along with a second leaflet providing details of helping organisations to support bereaved families.

  These leaflets are provided for all bereaved parents by either a Health Care Professional known to the family, Acorns or the Worcestershire Acute Health Trust Bereavement Midwife Team and are published on our website.

- An excellent working relationship between WCDOP and the Acute Trust Bereavement Midwifery Team is now well established to support information gathering to support review along with communication and feedback from PSG to bereaved families and advice for future pregnancy planning.

- WCDOP has established a bespoke approach to working with bereaved families and provides feedback from the WCDOP Child Death Review processes at the direction of the Chair.
  We look forward to further refining this parental interaction through the adoption of 'Key Workers' as referenced in the 'new arrangements' for future CDR management.

- Thematic Perinatal/Neonatal Reviews [including those requiring a JAR] continue to be undertaken by a well-established sub-group of Panel: the Perinatal Sub-Group (PSG). This group is hosted at Worcester Acute Trust Hospital with committed participation by Neonatology and Obstetric Consultants along with the Bereavement Midwife and is led by Panel Deputy Chair with other agencies invited as appropriate to the CDRs undertaken.

  75% of PSG reviews are completed within 6 months of death so ensuring parents receive timely feedback and support with conception and future pregnancy planning.

- Thematic reviews of children who have died following Life Limited/Life Threatened condition continue to be undertaken by a well-established sub-group of Panel, the LL/LT Sub-Group (LL/LTG). This group is hosted at Acorns Hospice for the Three Counties and is led by Panel Chair with agencies invited as appropriate to the CDRs undertaken.

- Most WCDOP reviews have been completed as quickly as the necessary information available to inform the review and other pre CDOP processes (PM, Inquest etc.) are concluded so as to provide timely feedback to families and support the implementation of recommended actions. However, as previously mentioned, increasingly, there are cases outstanding for very lengthy periods owing to delays in relation to the new post child death review activity like PMRTs or PM and inquest activity.

- Effective communication between Panel and Acute Health Trust Paediatrics is now established with a nominated Consultant Paediatrician joining each WCDOP meeting. The strong relationship between CDOP and the Acute Health Trust is further positively reinforced through other activity e.g. exploration of the Safer Sleeping Guideline.

- Panel has established effective communication to and from WSCB in terms of accountability and looks forward to this further development through the new CDR Partners.

- Panel has also developed effective relationships with Worcestershire Health and Well-being Board and Public Health through active participation and information flow via the Public Health representation at WCDOP and IFPG meetings.

- Membership of both the West Midlands and the proactive England CDOP Network which actively promotes the sharing of good practice and initiatives along with data sharing and data analysis.

- Working with Birmingham University to support the provision and implementation of in-service training of healthcare professions re Child Death Review.

Future Activities

Changes to the Processes of Child Death Review

We are delighted that much of our well-established practice at WCDOP, undertaken as established culture, is incorporated into the recent Governments publications to support the improved review of Child Deaths in England:

'Working Together to Safeguard Children 2018'
and

'Child Death Review Statutory and Operational Guidance [England]'

These publications provide detail regarding the 'New Arrangements' for Child Death Review in England.

The implementation of these new roles, processes and procedures is in hand by the Child Death Review Partners from the 5 CCGs and 2 LAs of Herefordshire and Worcestershire with a CDOP agreed and functional from 01 October 2019.

Other Activities Which Child Death Review Partner s May Wish to Pursue Could Include:

- Re alignment of the SUDIC Protocol to the new government Child Death Review publications

- Asking what could CDR Partners undertake to reduce smoking during pregnancy and smoking by parents with young families?
  Promoting pre-pregnancy education i.e. 'Get Fit B4 U Get Pregnant' campaign addressing obesity, smoking and incompetent cervix issues with women planning a future pregnancy.

- Improvement to the Safer Sleeping Risk Assessment Form to include obesity along with smoking, drinking alcohol and bed/sofa sharing, which are discussed with parents as key risks for SIDS.

- ✓ Asking what could CDR Partners undertake to raise awareness of alcohol consumption and its effects on decision making particularly with regard to child care?
  As Anti-Drink Drive culture is well established by millennials and the dangers of drinking alcohol and driving are clearly acknowledged, so does it follow that the dangers of drinking alcohol and caring for a child could likewise be addressed?
  It is possible to change established cultures; twenty years ago, we relied on plastic checkout bags to manage our shopping home - now we all provide our own shopping bags …….

- ✓ Widening membership of the H&W CDOP to include the participation of a faith group representative to strengthen the multi-agency nature of Child Death Review.

- ✓ The devising of an advice pack for Schools 'Experiencing a Child Death' has been explored with Public Health and WCC Safeguarding Advisor

- ✓ Producing a Leaflet in partnership with the Fire Service raising awareness of safety at "Sleepovers "

Appendix 1a DfE / Dept. Health Child Death Review Data

Owing to the changes in Child Death Review processes at Government level WCDOP, along with all CDOPs in England, was advised [March 2018] that data from 2017/18 would be collected to support comparative analysis; with further detail to follow ……

This data was collected by Dept. Health in March 2019.

Subsequent to this, Child Death Data for 2018/19 was collected in July 2019.

However, it is noted that no comparative national Child Death Data has been published by Government since August 2017.

The documents detailing 'New Arrangements' for Child Death Review references the future management and publication of comparative of Child Death Data through the recently launched National Child Mortality Database [NCMD].

Appendix 1b Data Breakdown for Cases Reviewed by Panel 2018/19

NB
As previously stated, this report references data for the period 01 April 18 to 30 September 2019 [18 months] to the close of WCDOP activity

Figure 3: Breakdown of Child Death Reviews completed by CDOP 2017/18 arranged by Category of Death and indicating No Modifiable Factors / Identified Modifiable Factors

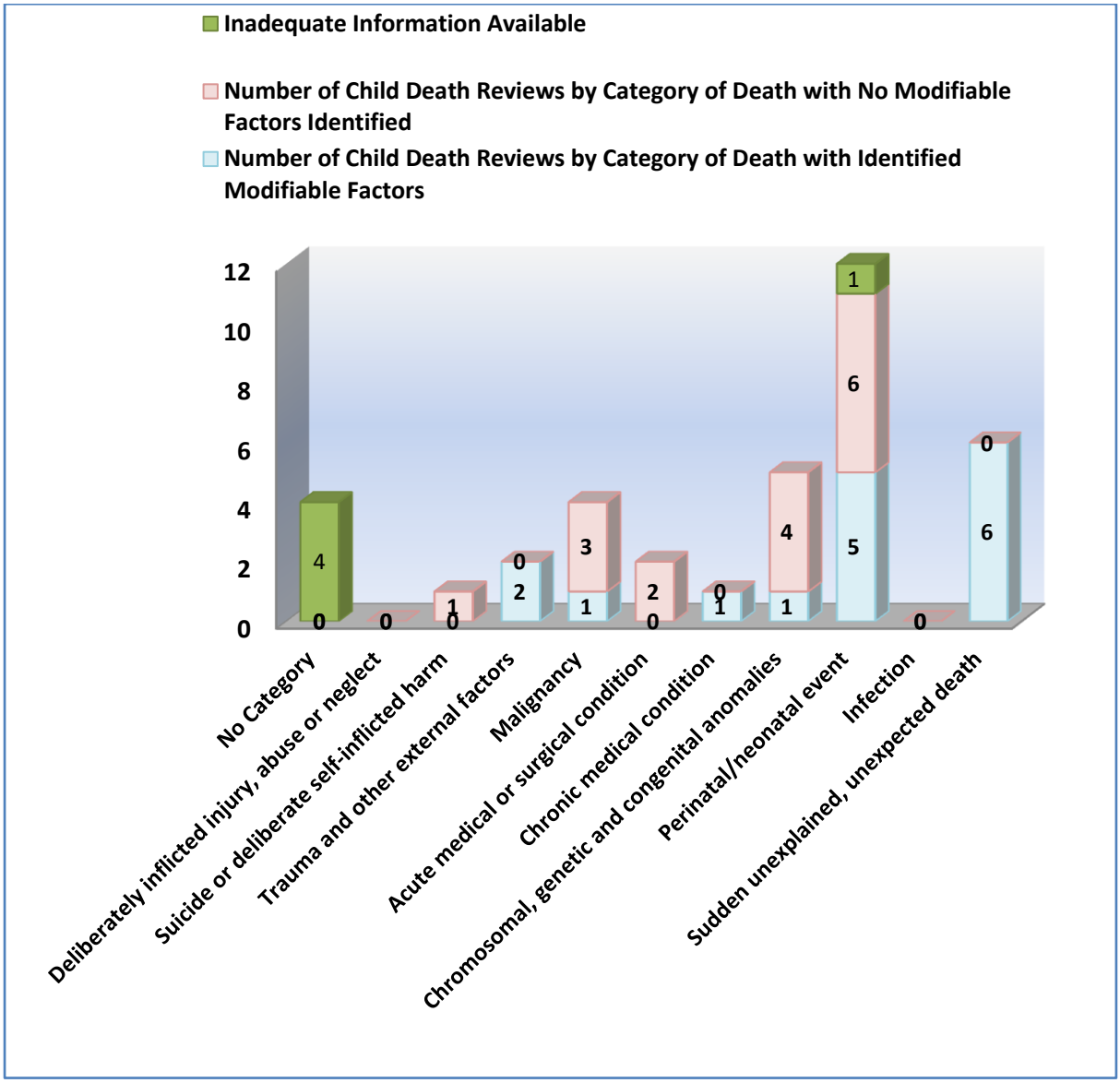


Figure 4: Breakdown of Child Death reviews completed in 2017/18 arranged by Location of the Child Death

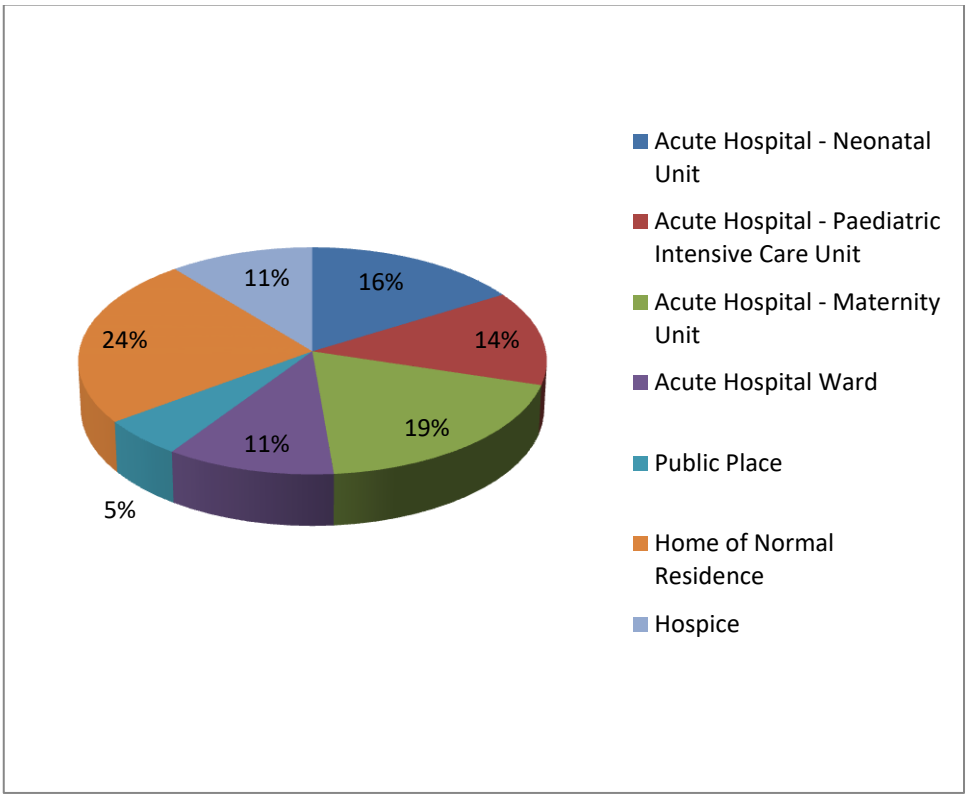
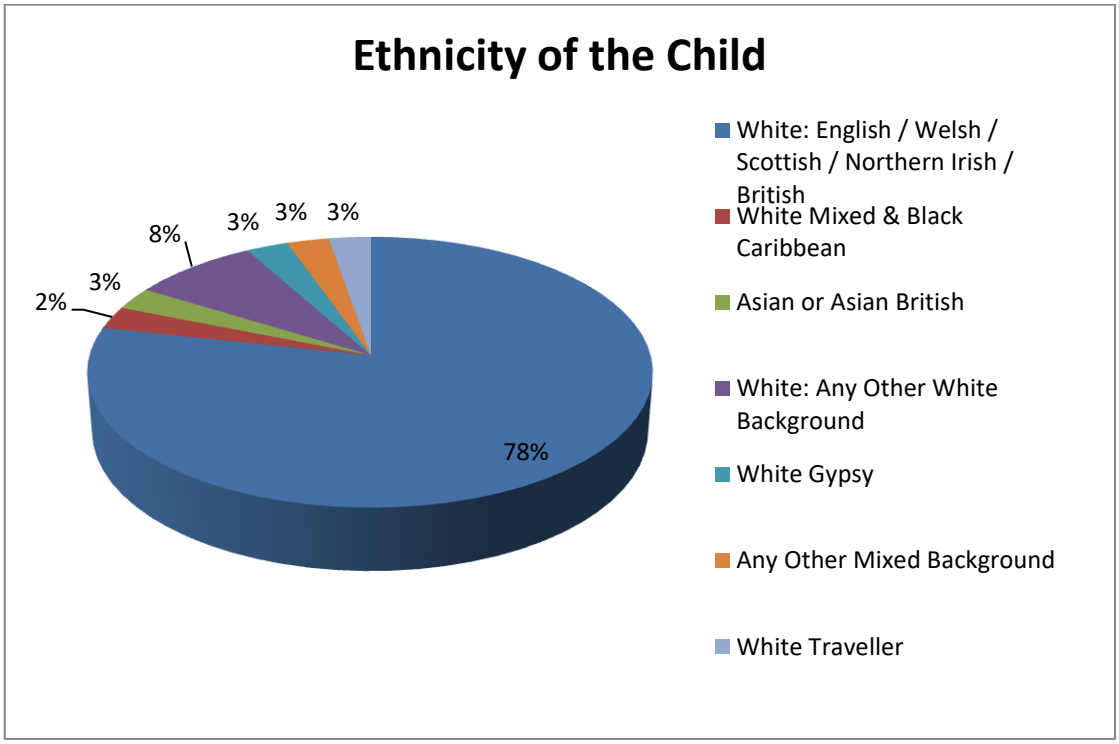


Figure 5: Breakdown of the 25 Child Death reviews completed by CDOP 2018/19 arranged by Ethnicity



Appendix 1c Cumulative data 2008 – 2019

Figure 6: Number of Child Deaths in Worcestershire

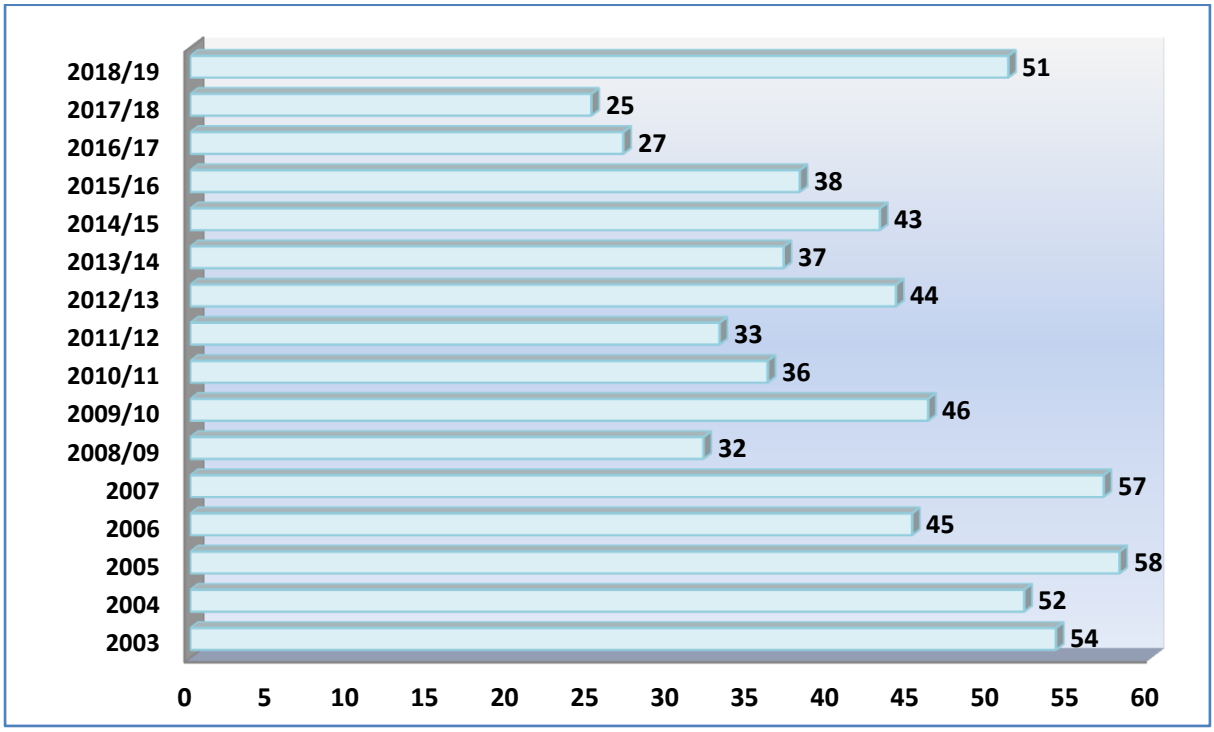
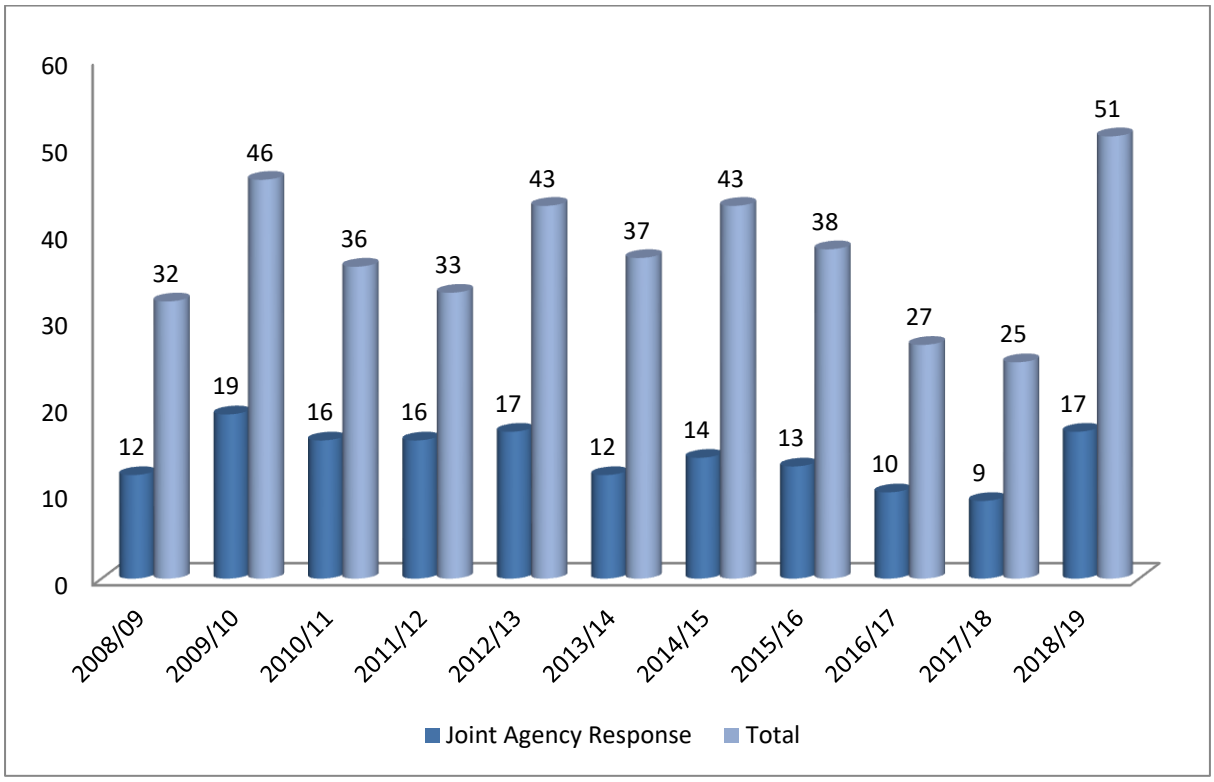


Figure 7: Breakdown of Notifications received 2008/09 to 2017/18 by Child deaths managed as Joint Agency Response Deaths



The data for 2013/14 to 2017/18 would indicate a reduction of deaths reported to Panel that were managed as JARs compared to the previous years

Figure 8: Child Deaths in Worcestershire 2008/09- to 2017/18 by age at Death and by Gender

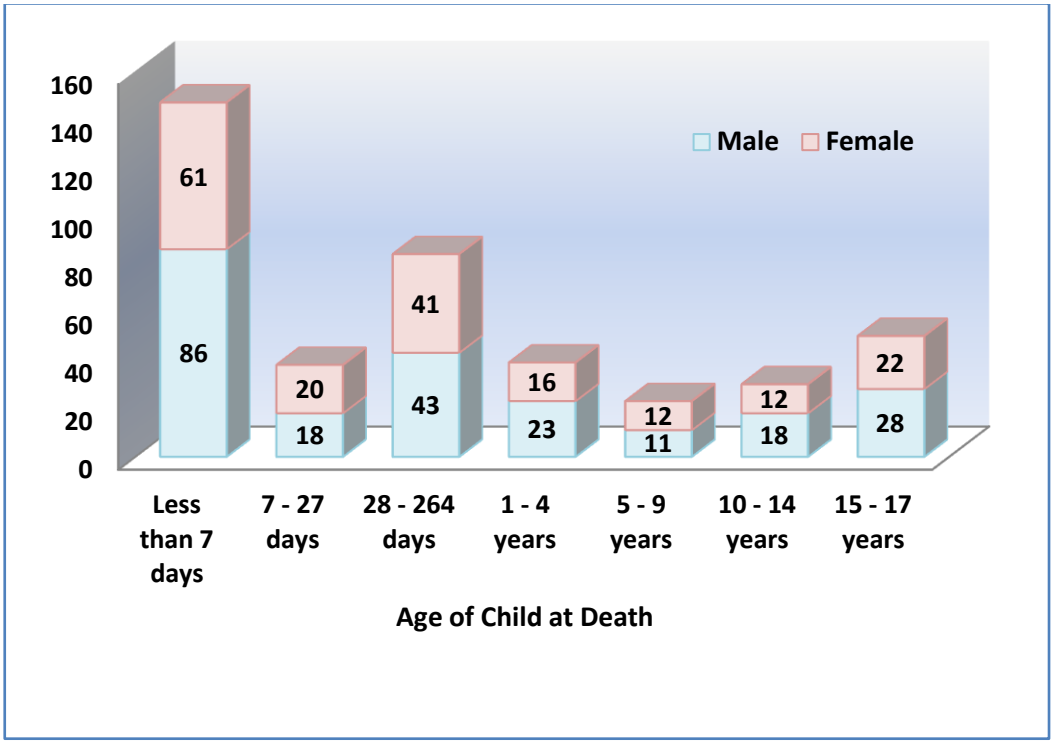
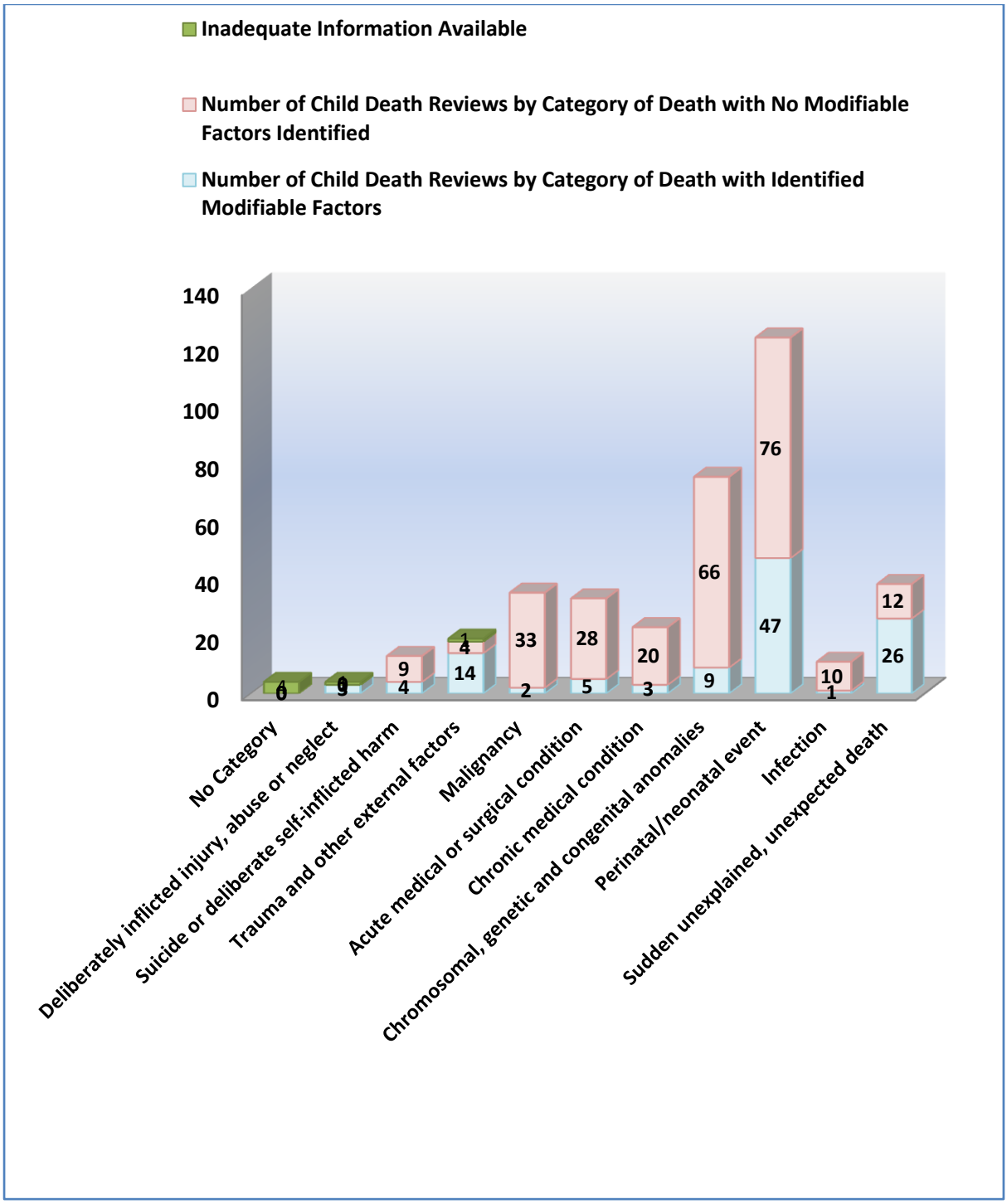


Figure 9: Child Deaths Reviewed Identified as Having Modifiable Factors, 2008 to 2019



This page is intentionally left blank

Worcestershire Safeguarding Adults Board

Annual Report 2018/19

Worcestershire Safeguarding Adults Board

Document version: V1

Document Control

- **Ratified by WSAB** Virtual Sign off By Chair 10.09.19
- **Date revision due** Not required

Revision History

Date	Version	Changes made	Author
10.09.19	V1	Published Version	Bridget Brickley

Contact: Worcestershire Safeguarding Adults Board Manager

Location: Worcestershire Safeguarding Adults Board website

Contributors to the development of the document

Name	Organisation
Derek Benson	WSAB Independent Chair
Rachel Watkins	WSAB Board Co-ordinator
Simon Davis	Worcestershire County Council
Sarah Cox	Worcestershire County Council
Suzanne Hardy	Worcestershire Health and Care NHS Trust
Ellen Footman	Clinical Commissioning Group
Deborah Narburgh	Worcester Acute Hospitals NHS Trust
Emma Whitworth,	West Mercia Police
Mary Nettle	Independent representative (People with Living Experience)
Richard White	Independent Sector Representative

Actions

Required Actions	Date
Sign Off	September 2019
Placed on website	September 2019

Contents

Chairs Foreword

Since the Care Act 2014 the Worcestershire Safeguarding Adults Board (WSAB) has led partnership activity to oversee and scrutinise the safeguarding of adults with care and support needs in the county.

This continues to be a high priority for a broad range of partner agencies and organisations from across the statutory and voluntary sectors, and I would like to place on record my appreciation for their commitment, diligence and determination to secure better outcomes for some of the most vulnerable people in our communities.

Safeguarding is critically important and is best approached through agencies coming together with shared ambition, shared information and joint programmes of action. 2018/19 has seen the partnership in Worcestershire continue to strengthen with engagement of not only the key partners but crucially from service users, carers and their advocates, who now all have an active place and voice on the Board. The voice of those who have care and support needs and use the services of the partner organisations is essential in understanding what is happening, what is required and how they are affected by the services provided.

This is reflected in the priorities of the Business Plan; Is 'Making Safeguarding Personal' properly understood and embedded in practice; Are the requirements of the Mental Capacity Act consistently applied; and are referrals into Social Care made at the right time, with the right information and leading to the right action and outcome? The WSAB will continue to seek assurance that arrangements in Worcestershire are appropriate and effective by working with colleagues from the Worcestershire Safeguarding Children Board, the Health and Wellbeing Board, the Community Safety Partnerships and professionals from across the partnership. The financial and resourcing issues faced by partners remain a risk to service provision and the WSAB must remain vigilant to the impact of such pressures.

I firmly believe that a collective approach is most effective in safeguarding people with care and support needs, and the WSAB will remain committed to maintaining a strong and inclusive partnership in Worcestershire.

Derek Benson
Independent Chair of Worcestershire Safeguarding Adults Board

1.0 Introduction

Annual Review 2017-18

In line with the Care Act (2014) guidance on Annual Reports the purpose of this report is to:

- Clearly state what the Worcestershire Safeguarding Adults Board (WSAB) and its members have done to carry out its objectives and strategic plan;
- Set out how the Board is monitoring progress against policies and intentions to deliver its strategic plan;
- Provide information on safeguarding adult reviews (SARs). Reporting on what has been done to act on the findings of completed reviews.

This report is set out in four parts:

- Chapter 2 Background – Why we are here, what we set out to do and how we do it
- Chapter 3 Review of Activities – What we have done
- Chapter 4 Safeguarding Activity and Performance – The difference this has made
- Chapter 5 Next Year's Priorities – Our work going forward

2.0 Background

2.1 Purpose of the Board

A Safeguarding Adult Board's primary role is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who:

- *have needs for care and support (whether or not the local authority is meeting any of those needs) and;*
- *are experiencing, or at risk of, abuse or neglect; and*
- *as a result of those care and support needs are unable to protect themselves from either the risk of, or the experience of abuse or neglect*

Worcestershire Safeguarding Adults Board's (WSAB) vision is to provide assurance that adults with care and support needs are safeguarded from abuse or neglect. WSAB Partners work together to ensure that people who have care & support needs are empowered or kept safe from abuse or neglect and that where abuse occurs, partner organisations respond effectively and proportionately, whilst adhering to the principles of Making Safeguarding Personal.

The work of the Board is underpinned by the six safeguarding principles as defined in the Care Act (2014) which are:

- **Empowerment** - Personalisation and the presumption of person-led decisions and informed consent.
- **Prevention** - It is better to take action before harm occurs.
- **Proportionality** - Proportionate and least intrusive response appropriate to the risk presented.
- **Protection** - Support and representation for those in greatest need.
- **Partnership** - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- **Accountability** - Accountability and transparency in delivering safeguarding.

The application of the safeguarding principles supports a person-led and outcome-led approach to safeguarding, known as Making Safeguarding Personal (MSP). The WSAB plays a key role in ensuring that an MSP approach is embedded across all agencies within Worcestershire.

2.2 Board Membership

The Board is made up of several key partner organisations in Worcestershire including:

- Worcestershire County Council Directorate of Adult Services
- West Mercia Police
- NHS Redditch and Bromsgrove Clinical Commissioning Group
- NHS South Worcestershire Clinical Commissioning Group
- NHS Wyre Forest Clinical Commissioning Group
- Worcestershire Health and Care NHS Trust
- Worcestershire Acute Hospitals NHS Trust
- National Probation Service
- Regulatory Services
- Worcestershire Voices
- Representative from Worcestershire Housing Strategic Partnership
- Representative from Care Homes Association
- Representative from Carer reference group
- Representative from Advocacy Reference Group
- Representative from People with Living Experience (PwLE) Reference Group
- Lead Councillor for Adult Social Care
- Public Health

Other organisations in the County providing services to adults with care and support needs continue to work in partnership with the Board to promote adult safeguarding and support the work of the sub-groups.

2.3 Annual Budget and Financial Contribution

The 2017/18 annual budget for the Board was £133,267. Alongside staff and administration, this funds the cost of Safeguarding Adult Reviews (SAR) and supports the delivery of objectives. The annual budget is established through a financial contribution from key partner agencies. The name of the agency and their contribution; shown as a percentage of the overall cost, is set out in table 2.1 below:

Table 2.1 – Financial Contribution by Statutory Partners

Agency Name	% Contribution
Worcestershire County Council	41.94
NHS South Worcestershire Clinical Commissioning Group	22.49
NHS Redditch/Bromsgrove Clinical Commissioning Group	13.50
West Mercia Police	13.07
NHS Wyre Forest Clinical Commissioning Group	9

There was an under-spend for this financial year of £37K. Alongside this there was cumulative under-spend from previous years of £49K, amounting to the Board now having reserves of £90K.

This build-up of reserves dates back to a decision made several years ago to increase the Board budget following an overspend due to the cost of completing a large number of SARs that year, alongside anticipation of increased staff cost. It took a while to recruit to some posts and the cost for SARs over subsequent years was lower than predicted.

The Board have now agreed that the future Budget will revert back to its original sum of £117,000. In addition a refund of 49K will be proportionately returned to partners contributing to this budget. The remaining surplus will be used to offset any future SAR overspend alongside supporting a number of areas of work which have been identified for additional development, including building analytical capability, training and communication. The Board will also review future contributions against planned committed expenditure to ensure that this surplus is not replicated in future years.

2.4 Delivery Model

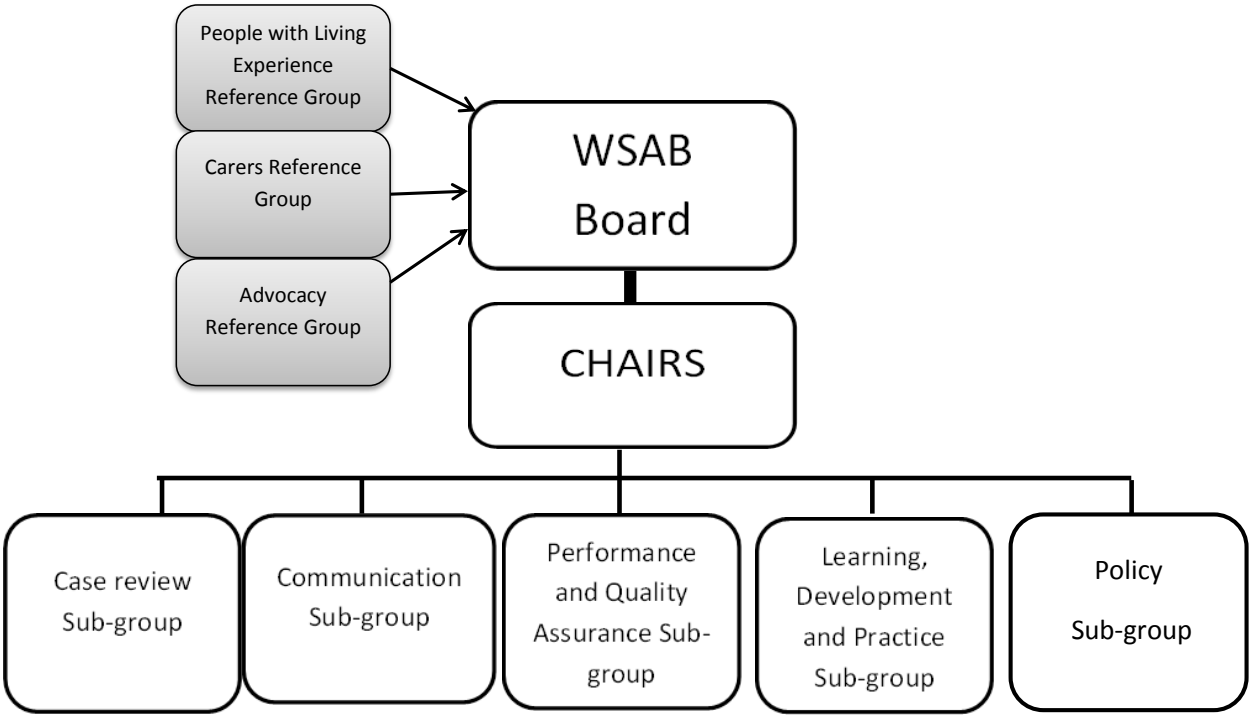
Implementation of the Business Objectives is achieved through the work of the Board and its five sub-groups (Fig 2.4). Each year annual business objectives are developed based on emerging themes from the data, findings from local and national reviews and a review of previous Board Priorities identified each year at a Board Strategy Day.

Issues are also identified and raised at the Board via three reference groups, which represent the interests of people with care and support needs, their careers and families.

There is a representative from each of these reference groups on the Board attending the Strategy Day.

The sub-groups develop individual implementation plans which outline the activities different stakeholders will undertake to ensure that the annual business objectives will be met. These are reviewed on a quarterly basis.

Fig 2.4 WSAB Structure



2.5 Business Objectives

There were four key objectives identified in the 2018-19 business plan. Table 2.5 gives a summary of the annual objectives and details achievements and any barriers and challenges to progress.

Table 2.5 - Achievements and Challenges

WSAB Objective	Achievements and Challenges
1. To improve awareness across all stakeholders of what safeguarding is. (Section 42 Criteria).	**Achievements:** • Reviews of a number of policies have been undertaken during the year alongside the development of professional guidelines (see section 3.2.6); • Improvement plans which were identified though the previous year's Annual Assurance Assessment, were reviewed to ensure that relevant actions were undertaken;

WSAB Objective	Achievements and Challenges
	• Learning briefings are now systematically being produced and disseminated when a SAR is completed; • The SAR protocol has been updated to reflect modifications in the SAR process, including the monitoring of action plans and evidencing the impact of learning; • Additional workshops were held on Mental Capacity Act and Section 42 criteria, for those unable to attend the oversubscribed annual SARs learning event of 2017/8; • Links were made into local Homelessness Forums to develop awareness of when Section 42 criteria could be utilised for this group of people and support the development of preventative actions; • A voluntary sector Task and Finish group was established to develop awareness of the application of Section 42 criteria and support the development of early interventions through a strength based approach to problem solving; • The Communication Sub-group is now being led by the Board Chair following a review of membership and terms of reference. **Challenges** • Whilst procurement processes meant that the joint website with Worcestershire Safeguarding Children's Board was not finalised during 2018/9, it was competed early in the next business year and is now active. • It was not possible to complete the update of the new training strategy as the publication of the revised intercollegiate document by the Royal College of Nursing supported by National Health Service England (NHSE) took place later than anticipated; This action has been carried over into the 2019/20 Business plan • The review of the Adult Safeguarding Competency framework has also not been completed due to the delay in the publication of the NHSE intercollegiate document. This action has been carried over into the 2019/20 Business plan
2. Demonstrate that we are listening to people and gathering their views.	**Achievements** • There is now representation at the Board from the three reference groups identified in the Boards Engagement Strategy, Carers, Advocacy and People with Living Experience; • Sub-groups now have wider and active representation from the voluntary sector and district councils • The People with Living Experience reference group is being developed, with the support of Onside Advocacy, to ensure that there is a wide range of representation from people who have different care and support needs; • Following the request from a Voluntary Sector task and finish

WSAB Objective	Achievements and Challenges
	group a Safeguarding Network has been established which will meet bi-annually. This network is action focused and current areas it is exploring include the development of a strength based approach in localities and joint safeguarding training approaches **Challenges** • The old website format did not allow for easy editing, once the new website is established this will enable this objective to develop further, alongside the development of the Safeguarding Network.
3. To seek assurance that stakeholders are continuously improving knowledge and practice in relation to Making Safeguarding Personal (MSP), the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).	**Achievements** • Improvement plans, which were identified though the previous year's Annual Assurance Assessment, were reviewed to ensure that relevant actions were undertaken; • The dashboard, which was established to measure the WSAB progress towards meeting its measurable objectives, is presented at the quarterly Board meetings; • An audit was undertaken to review the safeguarding policies and processes in place in day care organisations which have no legal requirements to meet local or national quality standards. **Challenges** • There have been limited opportunities to review organisations' improvement plans, so these three areas (MSP, MCA and DoLs will remain a priority in the 2019/20 Business Plan.
4. To embed cross cutting work with Worcestershire Safeguarding Children's Board (WSCB) (and other relevant partnership Boards) to ensure there are improvements in professional practice, particularly in relation to professional curiosity and transition arrangements.	**Achievements** • The WSAB continued to liaise with WSCB to ensure that key policies and procedures are in place and embedded in practice for young people approaching adulthood, who remain vulnerable to abuse and neglect; • The Chair of the Case Review Subgroup is Vice Chair of the Children's Boards SCR Subgroup and vis versa to ensure that the groups work together and learning is shared; • The SAR referral and decision template has been modified to align it with WSCB documentation; • This year's Safeguarding Adults Review (SAR) annual learning event focused on Domestic Abuse and Coercive Control in relation to people with care and support needs. The event was supported by the Domestic Abuse lead from the Health and Wellbeing Partnership, alongside an academic lead on Domestic Abuse from the University of Worcester; • A process is now in place to ensure there is better communication on reviewing cases where there is an overlap between the need for a SAR and a Learning Disability Mortality Review (LeDeR).

3.0 Review of Activities 2018/19

3.1 Care Act Requirements

Care Act Guidance requires Safeguarding Adults Boards and the statutory partners to provide an account, through the Annual Report, of how they ensure that Care Act duties are both effective and meaningful so as to ensure that local safeguarding systems and processes reflect the vision, principles and requirements of the Act.

3.2 Work of the Board

A major part of the early work undertaken by the WSAB sub-groups was to ensure partner agencies were all implementing the Care Act (2014) requirements. As the Board processes have evolved, a number of issues which require more in-depth focus have been identified and been taken forward as priorities. These have predominantly focussed on Mental Capacity Act, Making Safeguarding Personal and Section 42 enquiries along with specific issues identified in Safeguarding Adults Review (SARs).

Board processes are now well established and structures to engage with people who have experience of health and social care services, their carers and advocates are now in place. The work around engagement will continue to be developed and embedded over the next business year, with additional focus on developing links and early intervention approaches with the voluntary sector.

3.2.1 Safeguarding Adults Reviews (SAR)

SARs are commissioned when:

- there is reasonable cause for concern about how WSAB members or other agencies providing services, worked together to safeguard an adult,

and

- The adult has died, and WSAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died)

or

- The adult is still alive, and WSAB knows or suspects that the adult has experienced serious harm.

Safeguarding Adult Boards are also free to arrange for a review in any other situations involving an adult in its area with needs for care and support. In this case the WSAB would only consider a review if there are clearly identified areas of learning, practice improvement or service development that have the potential to significantly improve the provision of care and support and this cannot be achieved by other review procedures. The capacity of the sub-group and agencies to manage such a review would also have to be considered.

A SAR is a multi-agency review process which seeks to determine what relevant agencies and individuals involved could have done differently, that could have prevented harm or a death from taking place in order to prevent future harm or death from occurring.

The purpose of a SAR is to critically review;

- The services provided and establish if these had been provided in accordance with current policies, procedures and professional standards;
- If these policies and procedures enabled the services required to work together to ensure the services are delivered to the benefit of the individual;
- And importantly to identify any area where if any matter had been completed differently the outcome would have been to the advantage of the individual.

During 2018/19 there were 8 referrals requesting consideration for a Safeguarding Adult Review (SAR) to be undertaken. Five of these resulted in the recommendation that a SAR should be commissioned and due to the time of referral have been carried over to be completed during 2019/20. Three of these were in relation to the death of a person living in the open, often described as as a rough sleeper. It was agreed that the review into their death should be undertaken through a thematic review, and include the findings from an independent review by Worcester City Council into a similar death two years previously.

Of the remaining referrals, one resulted in single agency actions being recommended the other two referrals required no additional actions,

Work was also completed on two SARs which were carried over from 2017/18, both of which are now published and can be found on the Board's website via the following link:

Hold down the ctrl key and click on the link *SARs Link*

3.2.2 SARs: Changing Practice through Learning and Action

Action plans for each SAR are drawn up identifying where change in practice is required. The progress of the implementation of the action plans is carefully managed by agencies and monitored the WSAB. Domestic abuse and coercive control were issues identified in both of the SARs published during 2018/9. Key learning themes from these SARs include:

- Ensuring staff understand that many circumstances are both safeguarding situations and domestic abuse, with a range of legal options to work with victims;

- Ensuring safeguarding policies, protocols and procedures explain the link to domestic abuse and vice versa;

- Ensure that staff are trained to identify and deal with domestic abuse in the form of coercive and controlling behaviour, abuse in same sex relationships and domestic abuse suffered by adults at risk;

- Consider the development integrated training that covers both safeguarding and domestic abuse rather than treating them as separate issues;

There were also further recommendations on ensuring that guidance is clear on how staff and organisations need to share and review historical information, including previous assessments.

Where the criteria for a SAR and a Domestic Homicide Review are met, learning actions are overseen by both the Safeguarding Adults Board and the relevant Community Safety Partnership. The Board also links with the Domestic Abuse Forum which is coordinated by Public Health. Recommendations from these reviews would be discussed and implemented through these processes.

3.2.3 Learning Event

In January 2019 we held our annual learning event. This year the focus was on learning in relation to cases where Domestic Abuse or Coercive Control was a significant factor following the publication of two Joint SARs and Domestic Homicide Reviews on people with care and support needs, alongside a Safeguarding Adult Review into a person with learning difficulties who was subjected to coercive control by a family member. The author of this SAR gave a presentation into the learning from this case and a statement prepared by the subject of the report, was read by an advocate who was providing ongoing support.

The event also provided a number of learning opportunities including a presentation from a senior lecturer from the University of Worcester on the prevalence of Domestic Abuse and Coercive Control amongst people with care and support needs; Awareness raising sessions by a public health lead on identifying Coercive Control and Domestic Abuse, workshops focusing on participants identifying what they would do in relation to local case studies; Signposting advice on support available including information from a solicitor and local domestic abuse services.

3.2.4 Annual Assurance Statement

Member organisations of Safeguarding Adults Boards are required to undertake an annual assurance review of how they have worked to meet the Care Act requirements and deliver the Boards priorities. Partner organisations assess themselves against a set of standards and provide evidence to support these statements. The WSAB then challenge

organisations to provide additional evidence, where appropriate.

In the previous business year (2017/18) the assessment framework was revised to take a more in-depth focus on areas which were identified as reoccurring themes through SARs and performance measures. The framework was redesigned to elicit evidence of effective practice and processes that are in place to embed the following in each organisation, alongside any plans to develop and improve future practice:

- Appropriate use of Mental Capacity Assessments;
- Safeguarding process leading to a Section 42 inquiry;
- Incorporation of the values of Making Safeguarding Personal as a key element of all Safeguarding discussions and recordings.

Overall most organisations, who are members of WSAB, were found to be addressing and working well towards meeting the requirements of these areas. However some gaps or challenges were identified and actions were being put in place to address these.

At the beginning of the 2018/19 business year the stakeholders provided an update on these improvement plans and progress towards meeting these three standards. All the actions identified had been activated, these included introduction and development of training; improved guidance; review of processes and awareness raising. Alongside these some organisations also undertook audits and surveys to assess how well these processes and principles were embedded in practice.

Improvements were found in a number of areas, particularly in relation to developing the understanding of safeguarding processes and incorporating the values of Making Safeguarding Personal. For example an audit undertaken within WHCT found an increase in identifying outcomes and similarly a competency assessment undertaken by Worcestershire County Council found good standards in safeguarding knowledge amongst staff. However in some areas understanding the principles and processes of the Mental Capacity Act and undertaking assessments remained a challenge.

3.2.5 WSAB – Board Governance and Development

The WSAB continued to build on the robust governance processes which were already in place. Notable work and changes for 2018/19 include:

- Ongoing development of Performance Management Framework to measure progress against Board objectives;
- Review and changes to sub-groups to reflect the development and progress of the Board work;
- Development of the People with Living Experience reference group to ensure that a diverse range of experiences are reflected in the work of the Board;

- Formation of a Voluntary Sector Task and Finish group to explore the development of early interventions and prevention actions through strength based locality work.

As part of the WSAB's commitment to improve engagement with people who have experienced safeguarding and service provision, the Board receives regular presentations from people with experience of adult health and social care services. This provides an opportunity for WSAB members to widen their understanding, including what it means to be in receipt of services and the impact that these experience have on the recipients; as well as identifying any service issues which may need greater assurance.

3.2.6 WSAB Publications and Guidance

Policies which were required through the implementation of the Care Act are now in place. A process of reviewing these has been established, During 2018/19 the following guidance was reviewed and changes were made:

- Multi-Agency Self-Neglect Guidance

New guidance was developed to support residential and domiciliary care settings to minimise the risk of a person going missing and key actions to take if someone does go missing

All documents can be found on the WSAB website:

Hold down the ctrl key and click on the link WSAB website

3.3 Organisational Contributions

Statutory Partners, as outlined in section 2.3, have continued to ensure that they build on their Safeguarding work and responsibilities. Organisational activities and achievements which have supported the delivery and development of the four WSAB objectives include:

Objective 1 To improve awareness across all stakeholders of what safeguarding is.

- Regular meetings are held between Safeguarding Leads to disseminate key messages, with a focus on key topics and learning from SARs; (WHCT, WMP, CCG/GP Practices);
- The CCGs' seek assurance from NHS commissioned services that recommendations from local and national reviews/inquiries are implemented across the health economy. In turn the CCG report to NHS England (NHSE) /NHS Improvement (NHSI) to provide assurance that they are commissioning high quality, safe, effective & sustainable care;

- The CCG Safeguarding Team undertake Quality Assurance visits in conjunction with the CCG Quality Team and Adult Social Care colleagues when safeguarding concerns have been raised;
- Continual development of training to ensure that learning around safeguarding is embedded and understood by staff within the partner organisations alongside commissioned providers; (WHCT, PH, WAHT, WCC, WMP, CCG);
- Within the WAHT levels of safeguarding training take up have improved significantly over the last year ;
- Bespoke safeguarding training in place for key front line staff, including GP's,nurses and midwives (CCG, WAHT, WHCT);
- Lunch & Learn sessions have been introduced for WCC staff these have includes sessions on Safeguarding, including question and answer sessions;
- WAHT have developed a Safeguarding Training Directory to inform staff of the levels of training required, competencies and where training can be accessed;
- WAHT undertook a full review and update of the Trust intranet pages to include WSAB SAR learning briefs;
- Closer working links have been developed between the Adult Safeguarding Team and Area Teams (WCC);
- Principles of Signs of Safety are being embedded into practice to further develop MSP (WCC);
- WCC has developed a safeguarding protocol with West Mercia Women's Aid;
- Quarterly and weekly safeguarding newsletters and briefings (WHCT, CCG).

Objective 2: Demonstrate listening to adults and gathering their views

- Work has been undertaken with service user and carer groups to ascertain their views around issues such as safeguarding (WHCT);
- Patient stories go to the WHCT Board , these can have a safeguarding element and patients have attended to share their experience;
- The Neighbourhood Teams now have experts by experience on the Alliance Boards.(WHCT);
- WHCT undertook an audit of MSP which showed an increased consultation with the adult prior to a safeguarding concern being reported;
- Discussions and awareness raising around safeguarding is delivered as part of the engagement activity with service users through a wide array of forums and networks (CCG);
- WCC have developed an outcome survey which is now sent out to people when a safeguarding enquiry is completed;
- WCC Safeguarding Team and the 3 Conversation Development Practitioners are actively supporting the development of a Safeguarding network group by the Board;
- WCC performance is above the national average in relation to MSP and MCA application;

- Guidance has been produced on MCA Frequently Answered Questions, Working with Lasting Powers of Attorney, Practice Advice and MCA (WCC);
- Patient Experience Report are shared with the WHAT, WHCT and CCG Safeguarding Committees on a quarterly basis;
- WHAT launched its Patient, Carer, and Community Engagement Plan

Objective 3: To seek assurance that stakeholders are continuously improving knowledge and practice in relation to Making Safeguarding Personal (MSP), the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

- A rolling programme of refresher Level 3 Safeguarding Adults training which has been commissioned by the CCG includes Making Safeguarding Personal, the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS);
- MCA and DoLS training is essential for all registered professionals within the WHCT and has a compliance rate of 94.30% at the end this reporting period. This is in excess of the 90% target set by the CCGs;
- A base line assessment has been undertaken against the NICE Guidelines of the use of Decision Making and Mental Capacity. This showed 83% compliance with best practice. An action plan has been developed and will be completed during 2019/20. (WHCT);
- Considerable work has been undertaken to improve the recording of assessments of mental capacity and best interest decisions in community hospitals in relation to Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions, including an e-learning tool.(WCHT);
- Bespoke sessions have been delivered to teams where audit or internal reviews indicate a need to increase understanding and implementations of the Mental Capacity Act principles. (WHCT);
- The CCG is currently piloting an MCA tool for GP practices using their electronic patient record system .
- The CCG quality assures applications to the Court of Protection where there is a deprivation of liberty in respect of domestic settings, supported living and shared lives schemes. Feedback from the applications is shared with practitioners in order to improve the quality of the information provided and therefore services to people;
- WCC has delivered presentations and reflective practice session on MCA and DoLs to their staff and a variety of forums and organisations including, Student Social workers, Homelessness Forums; GP's;
- SAR actions have included producing practical MCA guidance for staff and running reflective learning sessions;(WCC);
- Development of a staff video in relation to MCA & DoLS –this video is mandatory for all Healthcare Assistants working within the Trust and has also been uploaded to the Trust intranet training pages and incorporated into training delivered by the Trust Dementia team.(WAHT);
- Staff knowledge check audit undertaken –including MCA & DoLS (WAHT).

Objective 4: To embed cross cutting work with Worcestershire Safeguarding Children's Board (and other relevant partnership Boards) to ensure there are improvements in professional practice, particularly in relation to professional curiosity and transition arrangements.

- Representation at both the WSAB and Worcestershire Safeguarding Children's Board is undertaken by the same person in many partner organisations to ensure greater joined up work and continuity. (CCG, WCC);
- A partners portal has been developed as part of the MASH process (WCC);
- WHCT and WAHT have Safeguarding champions to ensure that support and advice can be clearly provided across both children's and adult services;
- WHCT, WAHT and CCGs have Integrated Safeguarding Teams supporting work across the adult and children's safeguarding agendas;
- A monthly meeting of the Integrated Safeguarding Committee takes place to ensure that senior leadership have oversight over work streams and safeguarding matters (CCG, WAHT and WHCT);
- WAHT held a domestic abuse and coercive control awareness raising event for staff. They now have covert items to be given to victims with contact details for West Mercia Women's Aid;
- Participation in the Domestic Abuse Triage, CSE and Missing Triage and DRIVE as part of the Safeguarding Hub (WCC, WHCT);
- WAHT promoted the Worcestershire Understanding Extremism & Radicalisation Toolkit which is available on Trust intranet as a staff resource;
- WAHT supported the Home Office Female Genital Mutilation National Campaign during October.

These are just a selection of the feedback provided by partners to evidence how they have supported the board in meeting the priorities in 2018-2019

4.0 Safeguarding Activity and Performance 2018/19

4.1 Care Act (2014)

The data in this report is based on the definitions of safeguarding criteria as set out in the Care Act (2014).

4.2 Number and Source of Concerns

Since the Care Act criteria were introduced in 2015, the number of concerns reported has seen a steady decrease (Table 4.1). Analysis suggested that the high level of reports were initially due to incorrect referrals. This was addressed through a number of measures including raising awareness on what constitutes a safeguarding concern which will meet section 42 criteria, (outlined in section 2.1 of this report), alongside reviewing the pathway for reporting care quality concerns. There was also a particular focus on services which consistently had high levels of inappropriate reporting.

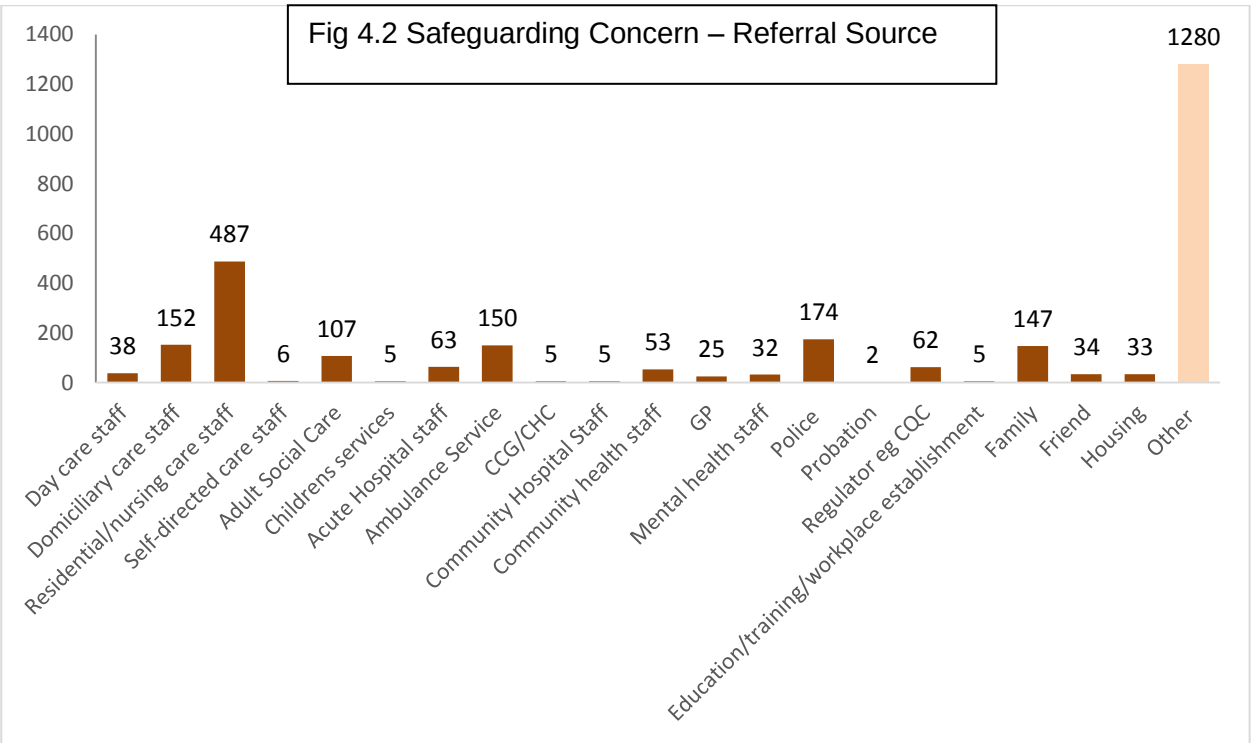
Table 4.1 – **Concerns dealt with under safeguarding 2017/18**
Source: Safeguarding Adults Collection
(compared to the previous three years)

	2015-16	2016-17	2017-18	**2018-19**
Concerns Reported	2653	2342	1942	**2202**
High Risk	99	65	79	**69**
Section 42 applies (meets criteria)	343	328	325	**318**
Percentage of concerns reported where Section 42 Applies		15%	18%	**15%**

In the previous year (2017-18) there was increase in the percentage of concerns which met Section 42 criteria last year, from 15%, to 18%. Analysis suggested that the high level of reports received prior to this year was in part due to incorrect referrals. Such referrals are likely to produce a low conversion rate. This was addressed through a number of measures, including raising awareness on section 42 safeguarding criteria. There was a particular focus on services which consistently had high levels of inappropriate reporting.

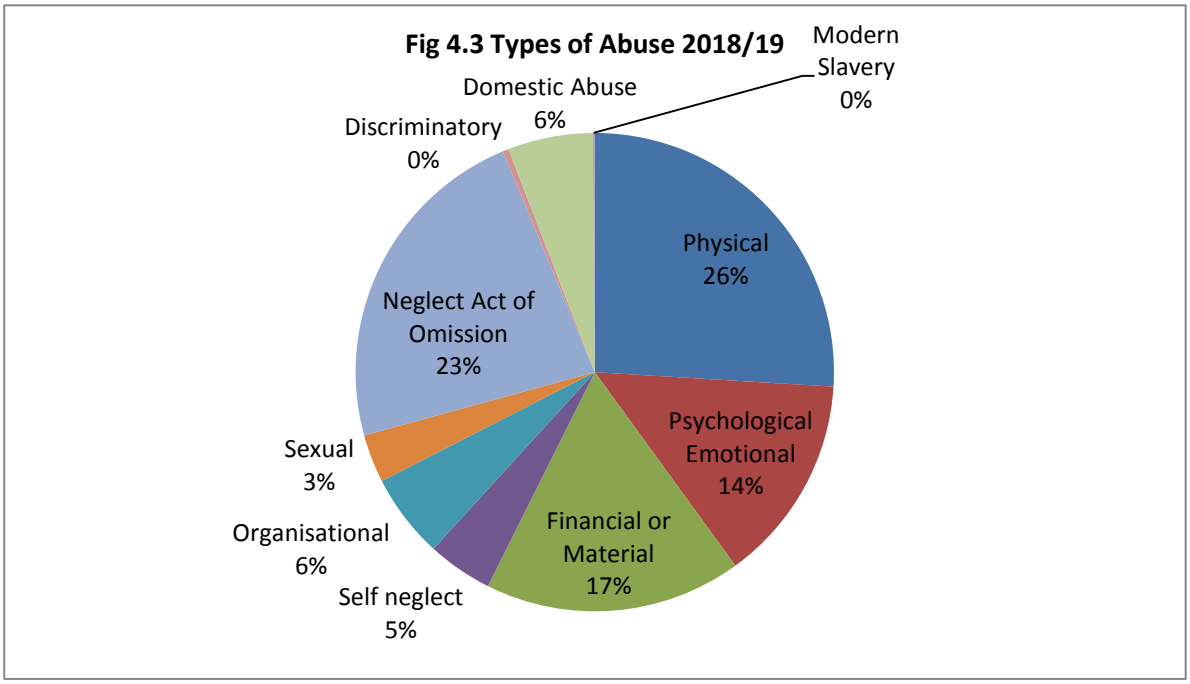
However this year it has returned to 15%, which is why awareness raising Section 42 criteria is still a key priority for the Board. It is also important to acknowledge that some of those which do not meet the criteria still require some level of support or signposting. Whilst this is often addressed through the Local Authority Safeguarding team this has an impact on their capacity. Ensuring that there is an effective pathway addressing cases which do not meet the criteria is therefore also a priority for the Board.

As with the previous year the highest numbers of concerns were raised by residential care and nursing homes followed by the police, ambulance service, domiciliary care providers and families(fig 4.2). Those recorded as 'other' include a broad spectrum of people and organisations not categorised within the current recording system.



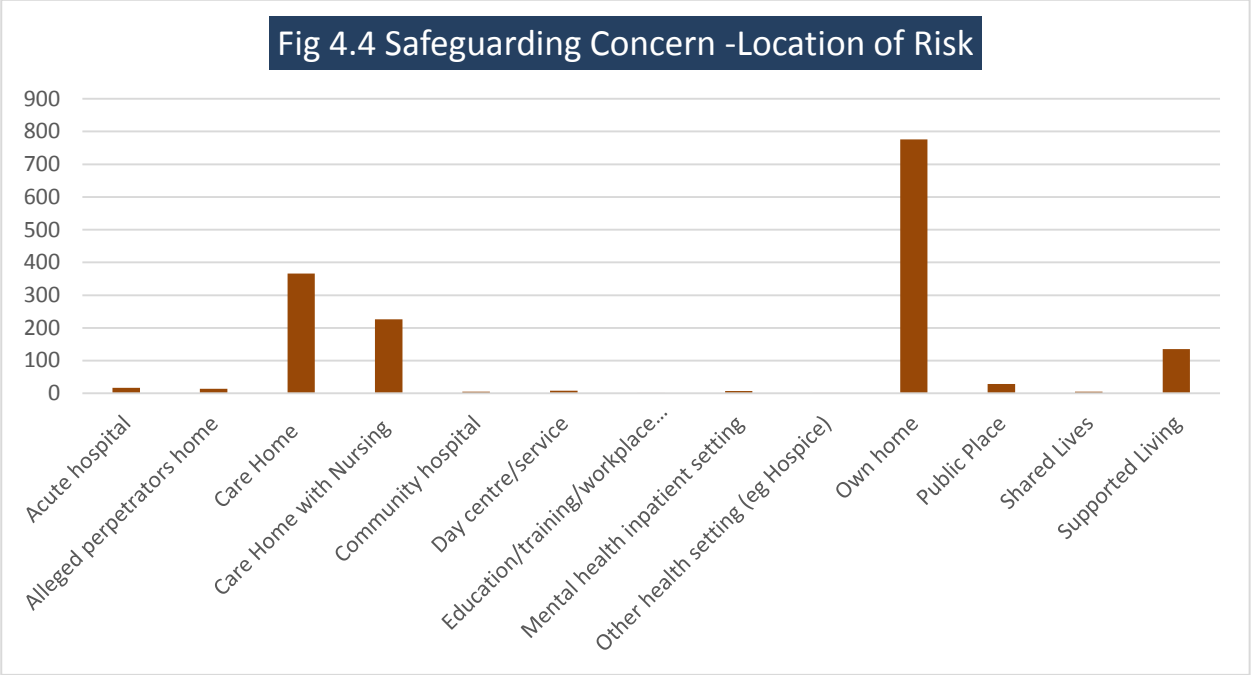
4.3 Type of Abuse

The different types of abuse recorded have remained similar levels over the last three years. (Fig 4.3) Physical abuse remains the highest type of abuse, closely followed by neglect. The next highest levels are financial and psychological abuse. These follow the national picture, so understanding and addressing the circumstances where these types of abuse could take place, alongside developing early interventions through effective pathways which prevent such cases are a priority for the WSAB.



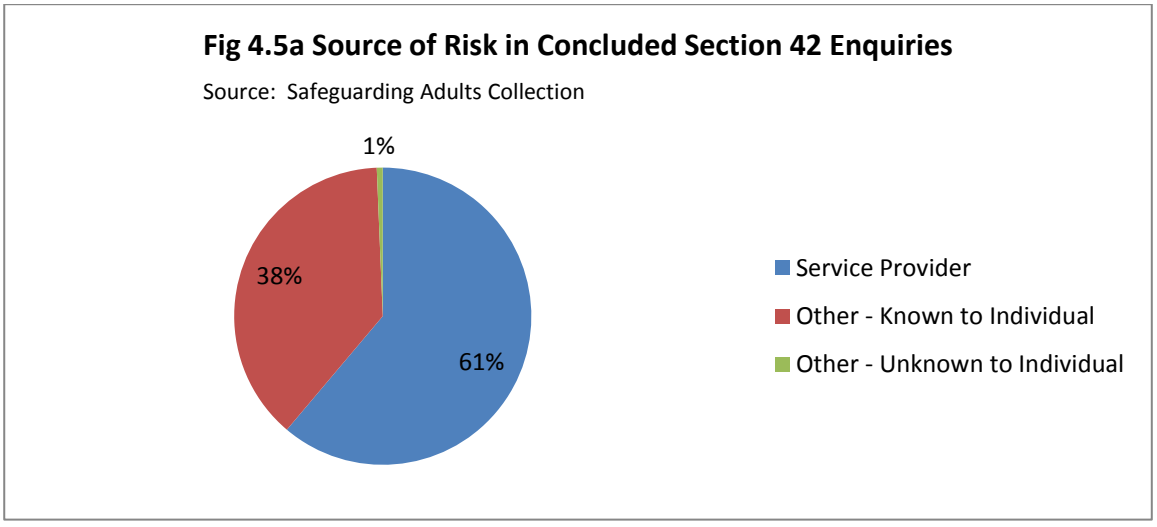
4.4 Location of Risk

Data on the location again shows a similar pattern to previous years. The majority of safeguarding concerns, where a decision has been made that they meet the section 42 criteria, have taken place in the adult's own home. (Fig 4.4) As with the previous year, Care and Nursing Homes continue to be the next highest location.



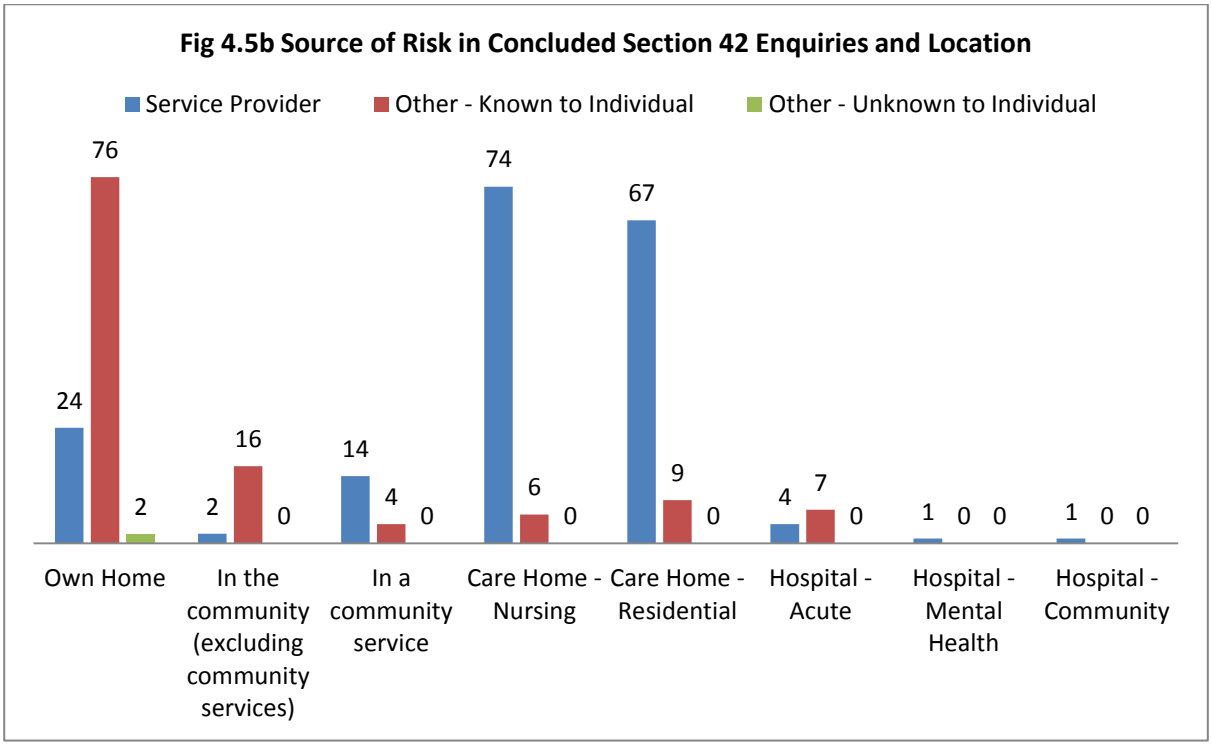
4.5 Source of Risk

In those cases which met the Section 42 criteria and the enquiry had been completed well over half (61%) of the person who presented the risk, was someone who worked for a service being received by the person with care and support needs. The remainder were people who were known to the individual, such as a family member, friend or neighbour (Fig 4.5a).



In terms of the location of the abuse in concluded enquiries, the combination of residential and nursing homes were the location where more incidents occurred, and the source of the risk was predominantly someone working within that services. This is because within these settings there is a culture of reporting safeguarding conerns. Also there are more staff present who are likely to witness incidents,

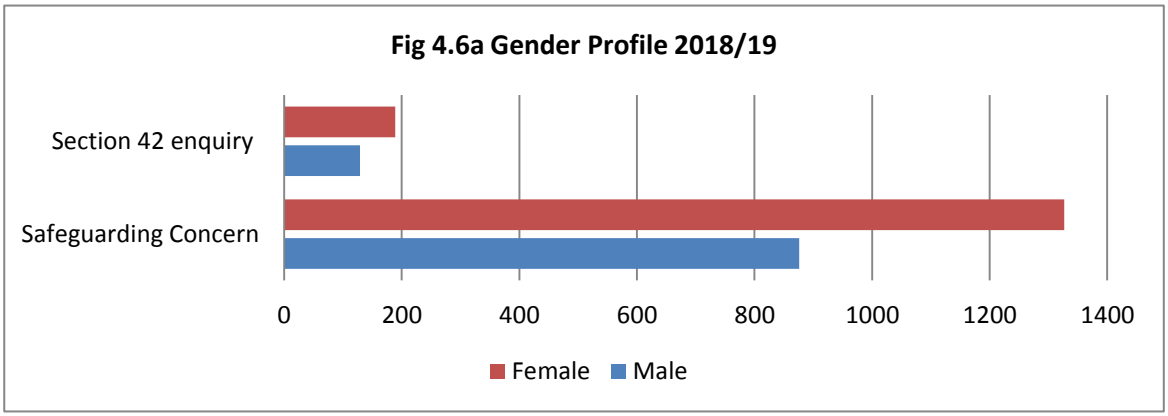
The next most prevalent location was the persons own home, however the biggest risk here was someone known to the individual for example a family member, friend or neighbour. (fig 4.5b)



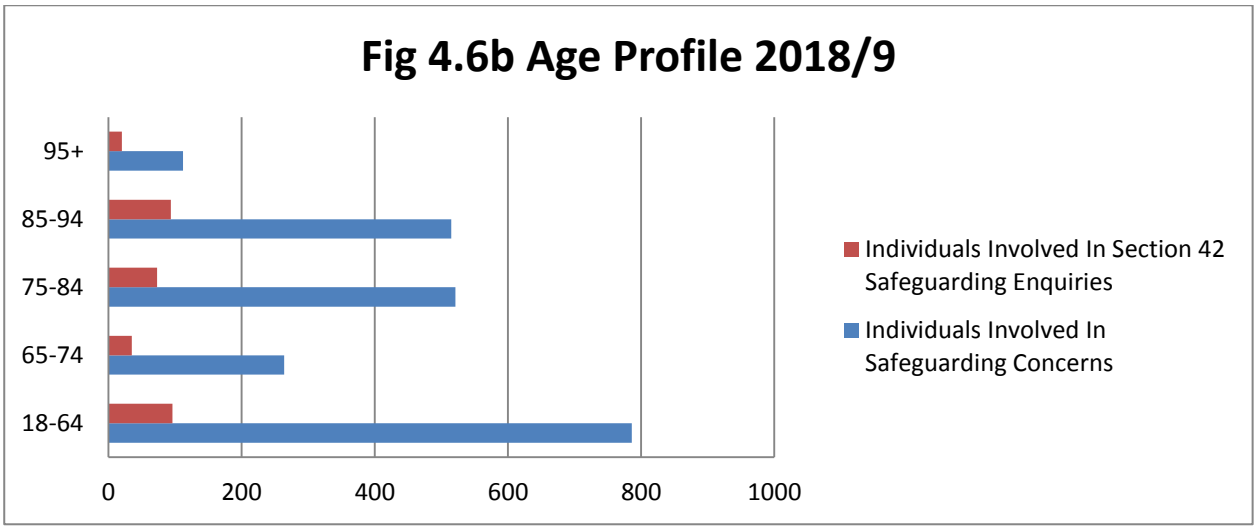
4.6 Demographic Profiles

Gender and Age

As with the previous year, the number of cases which are raised as a safeguarding concern and those which subsequently meet the safeguarding section 42 criteria is higher for women than for men (fig 4.6a).

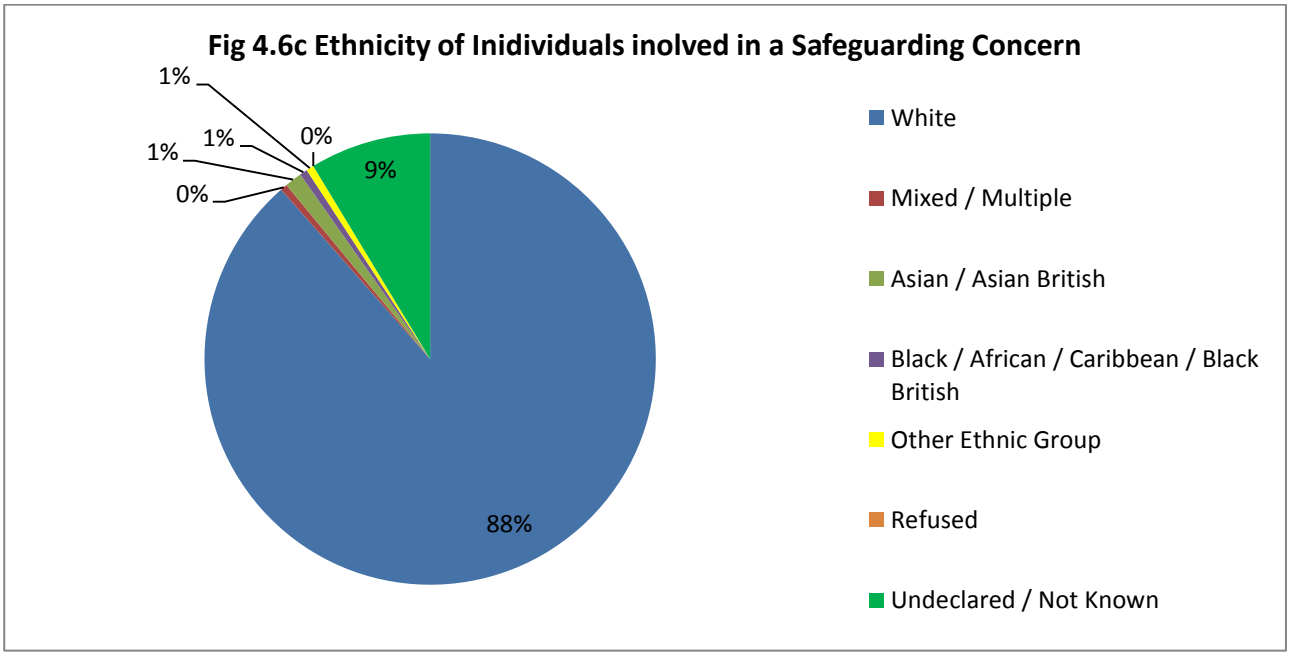


The age profile of concerns raised (fig 4.6b) shows that there are more concerns raised amongst the 28 to 64 age group. However those which meet the Section 42 criteria in this age group reduces significantly and is at a similar level to some of the older groups (85-94).



Ethnicity

Ethnicity also follows the same pattern as previous years. Of those individuals who were referred as a safeguarding concern during 2018/9 88% were white (fig 4.6c). Representation in the other groups was as low as 1%. The percentage of safeguarding concerns for all BME groups combined is 3% which is lower than the 7.6% of BME groups identified as living across the county in the last census. This could be due to underreporting within these communities. However, there is also a relatively significant number where the ethnicity is either not recorded or not stated (9%). So there could be some inaccuracies in recording amongst this group.



4.7 Making Safeguarding Personal

Embedding this person centred approach is an ongoing priority for the WSAB.
Of the completed enquiries this year, 61% of the people being supported identified an outcome. Whilst this is a decline compared to previous years this is because an issue was identified in the process of recording the outcomes during the previous year (2016/7). The information management system had previously allowed outcomes to be added later as the enquiry progresses. This meant that the outcome may not always have been identified by the person being supported at the beginning of the process.

This has now been rectified and table 4.7 shows the type of outcomes which people wanted to achieve through the enquiry process and whether these were felt to be met.

Table 4.7 Making Safeguarding Personal – Desired outcomes achieved

Desired Outcome	Achieved %	Set	Achieved
To be and feel safe	87%	133	116
To know that disciplinary action has been taken	79%	81	64
To have exercised choice	52%	31	16
To get new friends	0%	0	0
To maintain a key relationship	58%	38	22
To maintain control of the situation	22%	60	13
To be involved in making decisions	73%	51	37
To know where to get help	43%	14	6
To know that this won't happen to anyone else	75%	102	64
To have help to recover	70%	27	19
To have access to justice or an apology	53%	32	17
To achieve any other outcome	78%	9	7

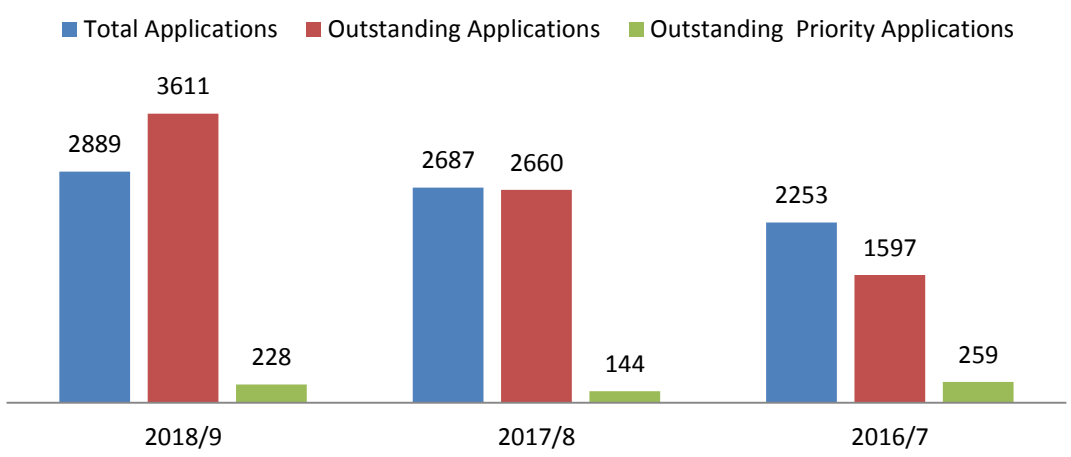
4.8 Deprivation of Liberty Safeguards (DoLS)

The ruling in the Cheshire West case in 2014 significantly increased the level of applications locally and nationally. As a consequence, alongside applications made during each financial year, there was also a significant carry over of outstanding cases from the year before this decision. This accounts for the combined higher level of assessments undertaken or started compared to the number of applications made during the year.

In order to manage this situation, alongside the increased workload which has resulted, Worcestershire has streamlined areas of the administration process and reviewed how cases are prioritised to ensure that resources are targeted at those who are most in need or vulnerable.

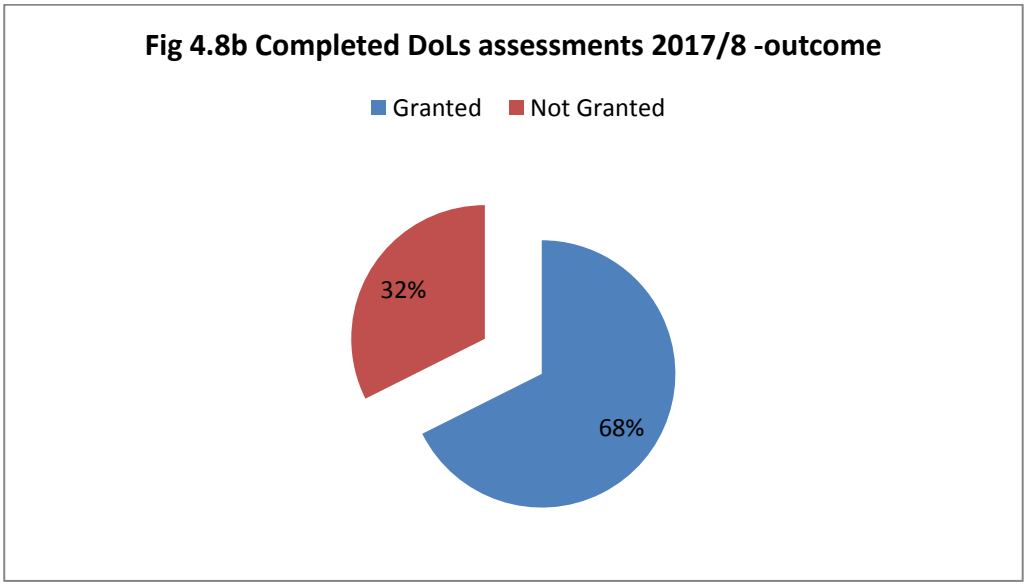
The total number of Deprivation of Liberty Safeguards applications made during 2018/9 was 2889 (Fig 4.8a), a slight increase compared to the previous year. Whilst this had some bearing on the increase in outstanding applications, including the priority applications, other factors also had an impact. There was a short period when there was an unexplained increase in applications. Whilst these have now returned to the expected level, this combined with reduced capacity in the team on a few occasions, had an impact on the level of applications which could be assessed.

Fig 4.13 Number of DoLs referrals and outstanding applications (comparison by year)



During the year a total of 1701 assessments were completed during the year , of which 68% of the applications were granted, compared to 79% the previous year (Fig 4.8b). Those which were not granted will include people who died before an assessment was made or those which did not meet the requirements.

Fig 4.8b Completed DoLs assessments 2017/8 -outcome



5.0 Priorities for 2019/20

In January 2019 the Board held its annual Strategy Day to evaluate the impact of activities over the last year and identify business objectives for the forthcoming year. The activity required to deliver Care Act (2014) duties and requirements, alongside exploring performance data was analysed and key themes, which emerged through engagement and consultations, alongside information from organisational audits and surveys were reviewed.

Based on this information the following priorities were identified for the forthcoming year:

1. Ensure that there is an effective pathway for addressing and preventing safeguarding concerns (particularly in relation to Making Safeguarding Personal, Mental Capacity Act and application of Section 42 Criteria);
2. The development of Joint working with the Children's Board;
3. Addressing the risks of exploitation amongst adults with care and support needs.

These have been used to complete the Annual Business Plan for 2019/20 and aligned to the relevant sub-groups to ensure that objectives are achieved.

KEY to Acronyms

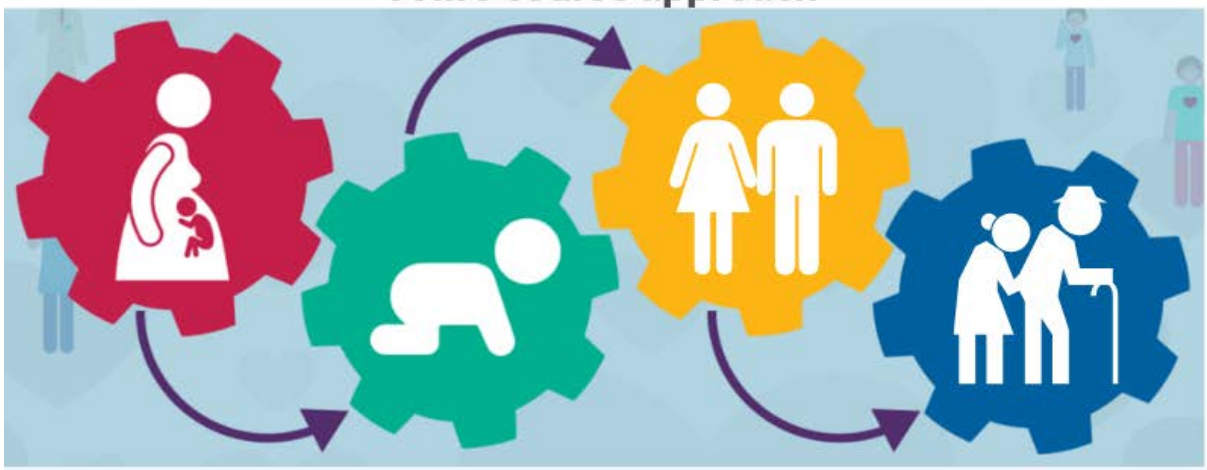
CCG	Clinical Commissioning Group
CSE	Child Sexual Exploitation
DoLS	Deprivation of Liberty Safeguards
DNACPR	Do Not Attempt Cardio Pulmonary Resuscitation
GP	General Practitioner (Doctor)
LeDeR	Learning Disability Mortality Review
MCA	Mental Capacity Act
MSP	Making Safeguarding Personal
NHS	National Health Service
NHSE	National Health Service England
NICE	National Institute for Health and Care Excellence
PH	Public Health
SAR	Safeguarding Adults Review
WCC	Worcestershire County Council
WAHT	Worcestershire Acute Hospital Trust
WHCT	Worcestershire Health and Care Trust
WMP	West Mercia Police
WSAB	Worcestershire Safeguarding Adults Board
WSCB	Worcestershire Safeguarding Children's Board

This page is intentionally left blank

worcestershire county council

Joint Strategic Needs Assessment Annual Summary 2019

A life course approach



Prepared by: Directorate of Public Health
Date: September 2019
Version: 1.0
Review Date: September 2020

NHS Wyre Forest Clinical Commissioning Group

NHS Redditch and Bromsgrove Clinical Commissioning Group

NHS South Worcestershire Clinical Commissioning Group

Contents

Executive Summary

1. The JSNA process collectively paints the 'big picture' view of current and future health, wellbeing and care needs of people in Worcestershire. This section summarises key findings from the JSNA annual summary report, which has been presented using a 'life course' approach.

2. Worcestershire is a relatively affluent county with a growing economy. The Worcestershire economy grew between 2012 and 2017 and the Worcestershire Enterprise Partnership is listed as one of the top five performing LEPs in the country by the Office for National Statistics. This is good news as there is a strong association between income and health.

3. Compared to England, Worcestershire performs well on many measures of health and wellbeing. Life expectancy, an overarching indicator, is higher than the England average for both females and males, and deaths from causes considered preventable are significantly lower in Worcestershire than England. However, where measures are better than England this shouldn't stifle ambition to continue to improve them.

4. Where Worcestershire performs better than England, this can mask underlying differences in outcomes between the most and the least affluent residents. This leads us to continue seeing preventable, unfair and unjust differences in health that arise from the unequal distribution of social, environmental and economic conditions.

5. The following table summarises topics that may be an issue in Worcestershire and worthy of further investigation or action.

Table 1. Potential Issues in Worcestershire

Newly identified issues include:	Persistent issues include:
Inequalities in life expectancy at birth are increasing for males and females – more deprived people are living shorter lives than the least deprived people	**Antibiotic Prescribing in Primary Care** has been consistently higher than England, but is showing a declining trend
Killed or Seriously Injured on the Roads is showing an upwards trend and this rise needs to be understood fully to implement appropriate action.	**Air Quality** is linked to poor health outcomes, and there are persistent areas of poor air quality in Worcestershire
Cancer Screening is significantly better than England, yet there is a possible declining trend and wide variation in uptake between GP practices.	**Inequality in School Readiness** between the least affluent and more affluent children in Worcestershire is persistently worse than England average.

Emergency Re-admissions are showing an upward trajectory as with England, some of which may be avoidable.	**Educational Outcomes** for those with free school meal status compared with more affluent children in Worcestershire is persistently worse than England average
Smoking in Pregnancy has shown an upward trajectory in the last two years which increases risk of health problems for mothers and babies.	**Children Needing Social Care** are continuing to rise
Excess Weight in Adults is trending upwards, and significantly higher in Worcestershire than England.	**Children's Oral Health** inequality has increased in recent years, with the most deprived children having poorer oral health than the least deprived children.
	Breastfeeding Initiation rates are poor compared with England
	Deaths from Drugs Misuse is showing an upward trend and system action is needed to tackle this rise.

A Growing and Ageing Population

6. The population of Worcestershire in 2019 is estimated to be 592,057 people. The population is projected to increase by 26,443 people in the next ten years. This is an increase of 4.5%.

7. Worcestershire has an ageing population and this trend is projected to continue. In future years there is expected to be a large increase in the number of older people and in particular in the very oldest age groups.

8. Worcestershire has an ageing population and this trend is projected to continue. In future years there is expected to be a large increase in the number of older people and, in particular, the very oldest age groups.

Housing as a Determinant of Health

9. Measures to improve someone's home or housing circumstances can be effective in reducing demand for health and social care services and are an important means of improving health outcomes.

10. With the Worcestershire population projected to increase, a significant number of additional homes will be needed, of the right type, in the right place and with the right amenities.

11. The condition of the housing stock is important, and data suggests that some areas of Worcestershire have a higher proportion of non-decent housing than the nation as a whole.

Social Care Services

12. In Worcestershire social care services are delivered by Worcestershire County Council.

13. Approximately 27,000 referrals were received by Adult Services and 1,799 safeguarding concerns were reported to the council in 2017/18.

Learning Disabilities

14. 1,440 adults with a learning disability receive long-term support from the council and over 350 adults with a learning disability live in supported living units to help them be more independent.

15. People with learning disabilities experience inequalities across many areas of their lives and particularly in relation to their health. They have more healthcare needs and life expectancy for people with learning difficulties is much lower than for the overall population. Reducing this gap is a key priority for Worcestershire.

Starting Out: Mothers, Babies, Children, Young People, Early Help and Prevention

16. Worcestershire has a high percentage of mothers smoking at the time of delivery (12.5% compared to 10.8% England average) and a consistently higher rate of premature births.

17. The rate of infant mortality has decreased for the latest period and is now similar to the national average (against a backdrop of increasing infant mortality seen in 2018)

18. Growing up in poverty damages children's health and wellbeing, adversely affecting their future health and life chances. The latest figures suggest that there are 16,250 children living in poverty related to low income in Worcestershire.

19. In Worcestershire children who live in low-income families are less likely to have reached a good level of development before they start school than children from better off families. There is a 21 percentage-point gap compared with a 15 percentage-point gap nationally.

20. In 2018 there were 868 children with autism known to Worcestershire schools. This is a lower rate than England and the average rate for similar local authorities. There could be a number of reasons for this which may warrant further investigation.

21. Childhood vaccination saves lives. For a vaccination programme to be effective the rate of uptake needs to be 95%. Worcestershire has historically performed better than the England average for childhood immunisations. However, for the last two

years, rates have been falling and they are below the 95% target coverage rate for many types.

22. The rate of vaccination for Measles, Mumps and Rubella (MMR) in Worcestershire has fallen and is now at 92.2%, and there is wide variation across GP practices. This is lower than the rate required to limit disease spread.

23. In educational attainment, there is a 10 percentage-point difference in GCSE attainment between boys and girls, with 60% of boys obtaining a grade 4 or above in English and Maths compared to 70% of girls.

24. Around 170 young people aged 16 to 24 were accepted as homeless in 2017/18. This is a higher rate than the England average.

25. 146 young people aged 10-17 were first-time entrants into the Youth Justice System in 2018. This is higher than the rate for England as a whole but there has been a downward trend year-on-year since 2015.

26. In Worcestershire the rate of Alcohol Specific Hospital Admissions for under 18s is similar to the England average (31.9 vs 32.9 per 100,000). After a period of falling rates year-on-year since 2006-7 rates have remained relatively static over the last two periods.

27. In Worcestershire the rate of self-harm in children and young people is lower than for England as a whole and this has been the case for the last couple of years.

Being Well: Health of Adults

28. Worcestershire has a similar rate of physically active adults to England.

29. It is estimated that 65% of adults in Worcestershire are carrying more weight than is healthy. This is higher than the national estimate.

30. In Worcestershire the overall rate of smoking has been declining and it is estimated that currently around 12% of adults smoke. This is lower than the national rate.

31. Smoking is still a major driver of avoidable differences in health between groups of people. Almost a quarter (24%) of Worcestershire residents who work in routine or manual occupations are thought to smoke. This is twice the proportion who smoke in the overall adult population.

32. Each year around 48 people die prematurely from alcoholic liver disease in Worcestershire.

33. In Worcestershire it is estimated that 80.1% cases of diabetes have been diagnosed. This is similar to the national rate.

34. Between 2014 and 2019 around 50% of eligible people aged 40-70 received an NHS England Check. This is higher than the national rate. Analysis suggests lower uptake

where the need is greatest - in people who live in the most deprived areas of Worcestershire.

35. Waiting times for, and the proportion of people completing alcohol treatment, are both better in Worcestershire than nationally.

36. In Worcestershire the proportion of people who successfully complete drug treatment has increased.

37. Worcestershire is currently seeing high levels of deaths from drug misuse. The rate has been increasing for a number of years.

38. Worcestershire generally has good sexual health outcomes with lower rates of sexually transmitted infections (STIs), HIV, unintended pregnancies and abortions than England. However, there are differences by district.

39. Most cervical cancer is thought to be caused by Human Papilloma Virus (HPV). A vaccine for HPV is available and there is a national vaccination programme with the potential to prevent many cases of HPV-related cancers. In Worcestershire the uptake of the vaccine is above the target coverage rate of 90% for the first dose but below it for uptake of the second.

40. Although Worcestershire has higher rates of screening coverage than England as a whole the recent trend in breast and cervical cancer screening has been downward and many Worcestershire practices are not meeting national targets.

Ageing: People Aged 65 Years and Over

41. Although Worcestershire performs well on many measures that relate to ageing there are some exceptions, these include fuel poverty and the rate of dementia diagnosis.

42. Approximately 29,000 households in Worcestershire (11.5%) are living in fuel poverty, this is above the national rate. The issue disproportionately affects older people. Nationally, a fifth of households affected by fuel poverty have household members that are all over 60. If Worcestershire follows this pattern 5,000 households would fall into this category.

43. In Worcestershire dementia will be a significant issue in future years as the population in the oldest age groups grows.

44. The number of people with dementia in Worcestershire is forecast to increase by 56% between 2019 and 2035 from 9,560 to 14,905.

45. The estimated dementia diagnosis rate for those aged 65 and over in 2018 at 59.7% was lower than the England level (67.5%). A timely diagnosis helps people living with dementia, their carers and healthcare staff to plan ahead and work together to improve health and care outcomes.

46. Falls are often the reason that someone has to leave their own home. There are over 2,300 falls per year in the over 65s in Worcestershire.

47. 13,287 people registered with Worcestershire GPs are recorded as having had a stroke or transient ischaemic attack (TIA).

48. Deaths due to stroke are higher than nationally.

49. Nearly half of older people in Worcestershire have an illness that affects their daily activities. This equates to 63,000 people currently and numbers are projected to increase by 38% in the next 15 years.

50. Depression is estimated to affect 11,630 people over the age of 65 in Worcestershire.

51. The number of people aged 65 and over living alone in Worcestershire is estimated to be 15,160 males and 28,350 females. It is expected that these numbers will rise by 36% for both genders. Whilst living alone does not always mean someone is lonely it can clearly be a contributory factor.

52. It is estimated that in 2019, 20,110 people aged 65 and over were providing unpaid care in Worcestershire, this is forecast to grow by 28% to 25,670 by 2035.

Introduction

This report provides a high-level summary of health and wellbeing information for Worcestershire. The report aims to highlight potential health and wellbeing issues which may need further investigation and action as well as providing an update on Health and Wellbeing Board priorities. The audience for this report is wide ranging and includes decision makers, commissioners and anyone with an interest in health and wellbeing in Worcestershire.

The structure of this year's annual summary has been revised to summarise information on wider determinants of health (including economy, environment, housing, community crime and safety), and sets out to provide current information on indicators across the 'life course', including:

- Starting out: mothers, babies, children, early help and prevention
- Young people
- Adults
- Ageing: people over 65 years

The report also sets out a brief description of district level issues and provides 'infographics' for most chapters which are new for this year's report.

The report also sets out a brief description of district level issues and provides 'infographics' for most chapters which are new for this year's report.

About the Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment (JSNA) is a statutory duty of the Health and Wellbeing Board. The local JSNA is an ongoing process which seeks to provide a strategic overview of health and wellbeing for Worcestershire. This overview includes the wider factors that are key to the population's health and wellbeing, for example, education, employment, environment, income and crime to name just a few. It is also important that the JSNA identifies future health and wellbeing needs.

Both the local authority and the NHS have duties under the Health and Social Care Act 2012 to have regard to reducing health inequalities and the JSNA is an important means of fulfilling this duty.

This report should be read in conjunction with other JSNA publications which provide more in-depth analysis on specific topics and together build a comprehensive picture of health and wellbeing needs for Worcestershire. More detailed information on specific topics, including needs assessments, can be found on the JSNA website.[1]

There are several elements to Worcestershire's JSNA process:

1. A multi-agency JSNA working group to collectively agree priorities and oversee the production of JSNA outputs

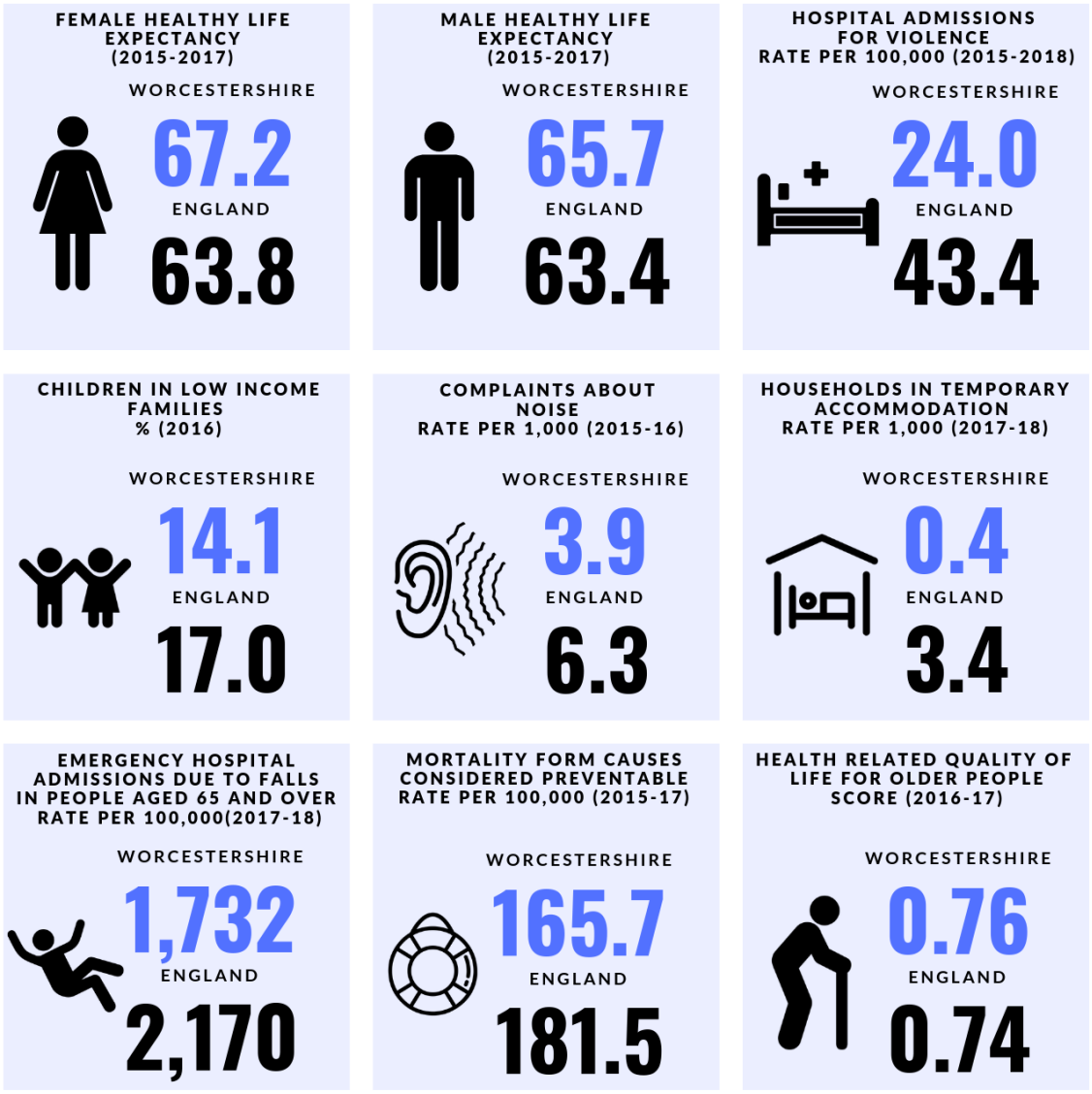
[1] http://www.worcestershire.gov.uk/info/20122/joint_strategic_needs_assessment

2. Multi-agency contributions to understanding the health and wellbeing of Worcestershire residents
3. Provision of information and intelligence to the Health and Wellbeing Board, commissioners and the public about health and social care needs
4. Production and publication of briefings, profiles and needs assessments (published at http://www.worcestershire.gov.uk/jsnapublications)
5. Production and publication of up to date interactive information dashboards through the JSNA website (including dashboards to support the Health and Wellbeing Board's priorities)
6. Production of a JSNA Annual Summary

Where Worcestershire Performs Well

In general, the population of Worcestershire is healthy and there are many health-related measures where Worcestershire performs consistently better than the national average (Figure 1 and Appendix). However, there are some pockets of Worcestershire where people's health is not good and the average masks inequality. To take one example, although on average Worcestershire has a lower proportion of children in low income families than England as a whole, this is not the case in Wyre Forest District.

Figure 1. Where Worcestershire Performs Well



Data Source: Public Health England, Public Health Outcomes Framework
Images from the Noun Project ("Falling" by Andrew Doane, "Life Saver" by Nicole Macdonald, "Accommodation" by Symbolon, "Children" by Musmellow, "Noise" by Peter K., "Leaves" by Rivercon, "Old" by 1516, Hospital by ibrandify)
All other images from Canva.com

Newly Identified and Persistent Issues

Public Health England produce **The Public Health Outcomes Framework**.[2] This is a set of measures that provides a vision for the public's health by supporting two overarching aims, namely:

- Increased years lived in good health termed Healthy Life Expectancy
- Reduced differences in life expectancy and years lived in good health between communities

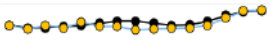
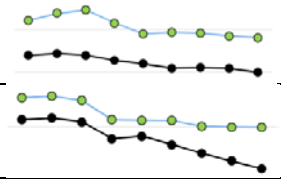
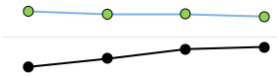
The Public Health Outcomes Framework has been used to help identify topics that may be an issue in Worcestershire and worthy of further investigation or action.

Table 2 summarises topics newly identified as issues for Worcestershire and gives the reason for their selection. Table 3 summarises issues identified in the previous JSNA Annual Summary and that remain a concern. More detailed information for each issue is available in the body of this report and signposting is provided.

Table 2: Newly Identified Issues

Issue	Trend[3]	Reason for Inclusion
Inequalities in life expectancy at birth - female		There is a social gradient in life expectancy. People living in deprived areas have shorter lives than those who live in more affluent areas. For females in particular this difference has increased in recent years and it is now larger than in 2010-12. For males, although the difference is similar to 2010-12, there is some evidence of a widening gap since 2012-14.[4] See p99 for more information.
Inequalities in life expectancy at birth - male		

[2] https://fingertips.phe.org.uk/profile/public-health-outcomes-framework
[3] Black line = England, Green = statistically better than England, Yellow= statistically similar to England, Red = statistically worse than England, Purple/Mauve = not compared.
[4] Life expectancy at birth is calculated for each deprivation decile of lower super output areas (LSOAs) within each area and then the slope index of inequality (SII) is calculated based on these figures. The SII is a measure of the social gradient in life expectancy

Killed or Seriously Injured (KSI) on the Roads		The rate of people killed or seriously injured on Worcestershire roads has been increasing. It is now similar to the England average and if the trend continues it may become worse. See p52 for more information.
Deaths from Drugs Misuse		The rate of deaths from drug misuse in Worcestershire is increasing. This is not what would be expected in a relatively wealthy county like Worcestershire. See p92 for more information.
Cancer screening Breast		Overall, Worcestershire has higher cancer screening rates than England. However, for breast and cervical cancer rates are declining and there are differences in screening uptake between individual GP practices with some practices have lower uptake than the England average. It is important to note that for breast and cervical cancer the national screening target is 80%. Taking this into consideration, a high proportion of practices across Worcestershire are not meeting the target, despite showing as performing better than the England average.
Cancer screening Cervical		
Cancer screening Bowel		

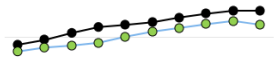
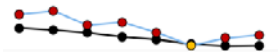
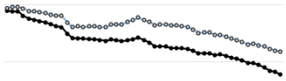
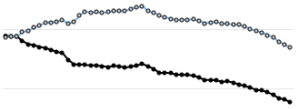
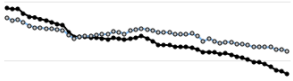
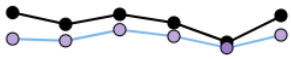
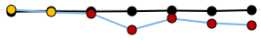
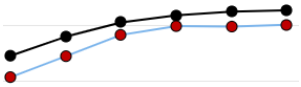
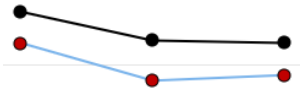
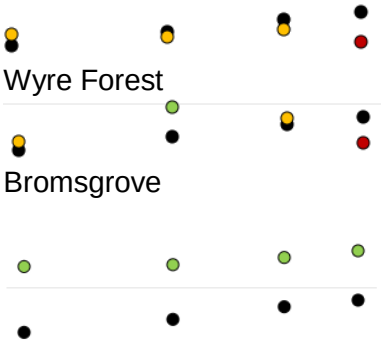
		See p95 for more information.
Emergency Re-admissions		Nationally, the rate of emergency re-admissions has been increasing. This trend has also been seen locally and all Worcestershire Clinical Commissioning Groups (CCGs) have seen an increase in emergency hospital re-admissions since 2013. See p54 for more information.
Smoking in Pregnancy		The rate of women smoking during pregnancy in Worcestershire is higher than the England average. Until 2015/16 there had been a downward trend, in line with the national picture, however, since then the rate has started to increase again. See p59 for more information.
Excess weight in adults		It is estimated that the majority (65%) of adults in Worcestershire have excess weight. In the past this estimate was similar to England but it is now higher and may be increasing still. See p87 for more information.

Table 3: Persistent Issues

Issue	Trend	Reason for Inclusion
Antibiotic Prescribing in Primary Care	South Worcestershire CCG  Redditch and Bromsgrove CCG  Wyre Forest CCG 	In Worcestershire antibiotics are prescribed in primary care at a higher rate than nationally. However, sustained improvement on this measure is being seen in all three Clinical Commissioning Groups (CCGs). See p19 for more information.
Air Quality	Fine Particulate Matter: 	In Worcestershire there are persistent hot spots for poor air quality - particularly in Worcester City. As a largely rural county Worcestershire also has agricultural activities that generate particulate matter that can contribute to this issue.
Breastfeeding initiation		Worcestershire has lower rates of women who start breastfeeding within two days of giving birth than the national average and this has been the case for some time. Rates are lowest amongst younger mothers, mothers of white ethnicity and

		those living in more deprived localities - particularly in Wyre Forest and Redditch. See p62 for more information.
Inequality in School Readiness		Locally in 2017/18 only half of children who were eligible for free school meals had reached a good level of development by the time they started school. This is in comparison to 71.2% of all children. See p68 for more information.
Educational Outcomes	GCSE Attainment for Pupils with Free School Meal Status 	**Key Stage 1:** Disadvantaged children - those eligible for free school meals - performed poorly in all areas compared to the England average for this group of children. **Key Stage 2:** In 2018 all areas of Worcestershire, with the exception of Bromsgrove, had lower percentages of pupils who reached the expected standards in reading, writing and mathematics than nationally. Percentages were even lower for children who were disadvantaged (eligible for free school meals). **GCSE Results (KS4):** In Worcestershire a higher proportion of

		pupils achieved a grade 4 or above in GCSE Maths and English than in England overall. But, disappointingly, we are still seeing disadvantaged children having poorer educational outcomes in Worcestershire when compared to the same group of children in England, although there has been an improvement since 2017. See p70 for more information.
Children Needing Social Care		The numbers of children who receive additional help or protection from Children's Social Care is continuing to rise. See p74 for more information.
Children's Oral Health	Proportion of five years olds free from dental decay: Worcester  Wyre Forest Bromsgrove	Inequality in children's oral health has increased in recent years. There are differences by council district, with Worcester and Wyre Forest districts emerging as having poorer oral health for children than other districts. See p78 for more information.

Review of Issues Identified in 2018

Antibiotic Prescribing in Primary Care

Data on antibiotic prescribing in Primary Care is available for a rolling 12-month period. The data is adjusted to account for the characteristics of the population to allow fair comparison between areas. A lower value is better.[5]

Table 4 shows that although all Worcestershire CCGs met an NHS England target of 1.161 items prescribed per STAR-PU at the end of 2018/19 they did not meet a more aspirational 0.965 target.

Table 4. Twelve Month Total Number of Prescribed Antibiotic Items Per STAR-PU March 2019

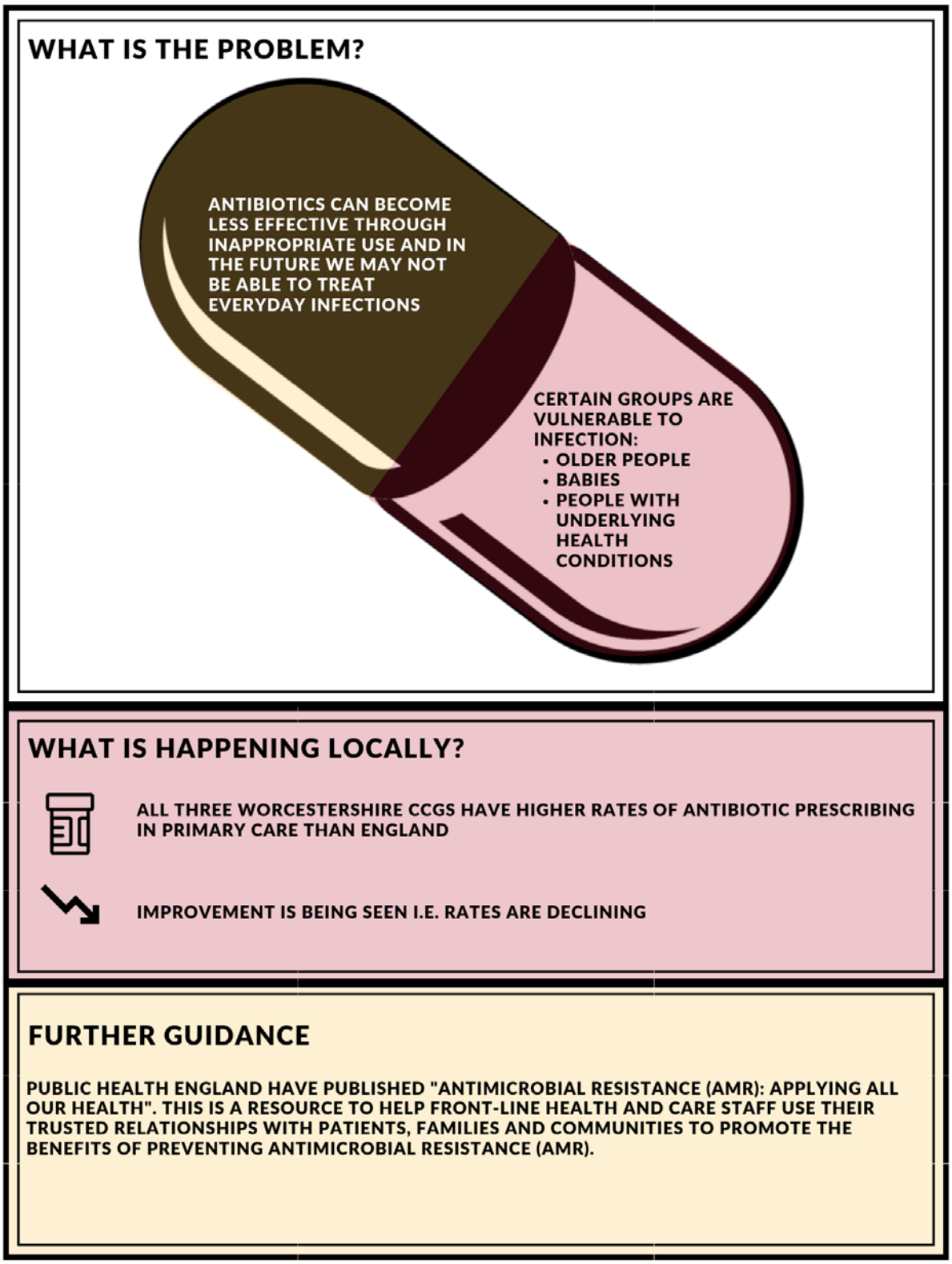
Area Name	Value	Compared to goal*
England	0.95	Green
West Midlands	0.98	Amber
NHS Redditch And Bromsgrove CCG	1.14	Amber
NHS South Worcestershire CCG	1.03	Amber
NHS Wyre Forest CCG	1.03	Amber

Source: Public Health England, AMR Local Indicators Profile.[6]

[5] STAR-PU is weighted units adjusted by the age and sex of patient distribution of each practice. An item is an antibiotic (from British National Formulary Section 5.1) that is prescribed in a primary care setting. The lower the value, the fewer antibiotics have been prescribed.

[6] Available at: https://fingertips.phe.org.uk/profile/amr-local-indicators *The value (items per STAR-PU) is benchmarked against the Quality Premium 2017/19 scheme target of equal to or below England 2013/14 mean performance value of 1.161 items per STAR-PU and an additional reduction of value equal to or below 0.965 items per STAR-PU (England's 2015/16 mean performance) for 2018/19.

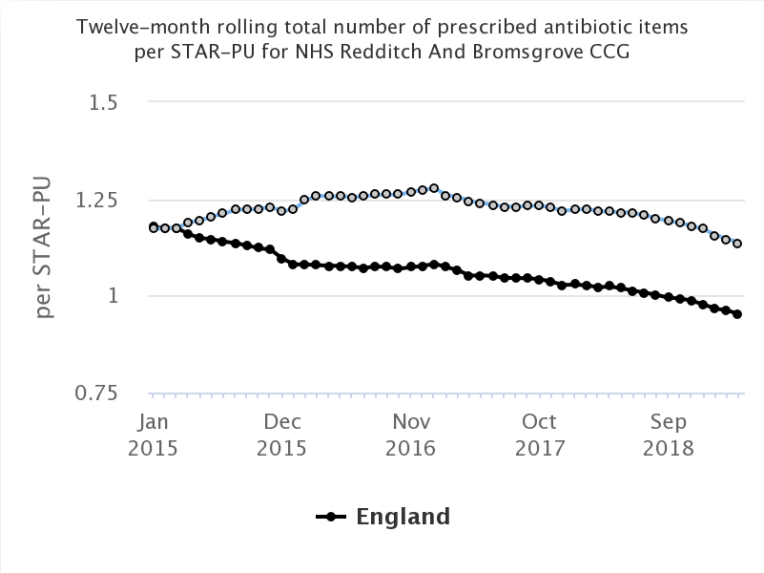
Figure 2. Antibiotic Prescribing in Primary Care



Graphic created by the Public Health Team using Canva and images from the NounProject.com ("Pill" by Rick, "Pills" by Evgeny Filatov and "Decrease" by dilakuscan).

In March 2019, compared to 10 similar CCGs Redditch and Bromsgrove CCG had the highest 12-month rate of antibiotic prescribing in primary care. However, since January 2017 there has been consistent improvement. Of Redditch and Bromsgrove's similar CCGs, Vale Royal CCG has seen the steepest decline in antibiotic prescribing rate in primary care.[7]

Figure 3. Twelve-Month Rolling Total Number of Prescribed Antibiotic Items Per STAR-PU. Redditch and Bromsgrove CCG.

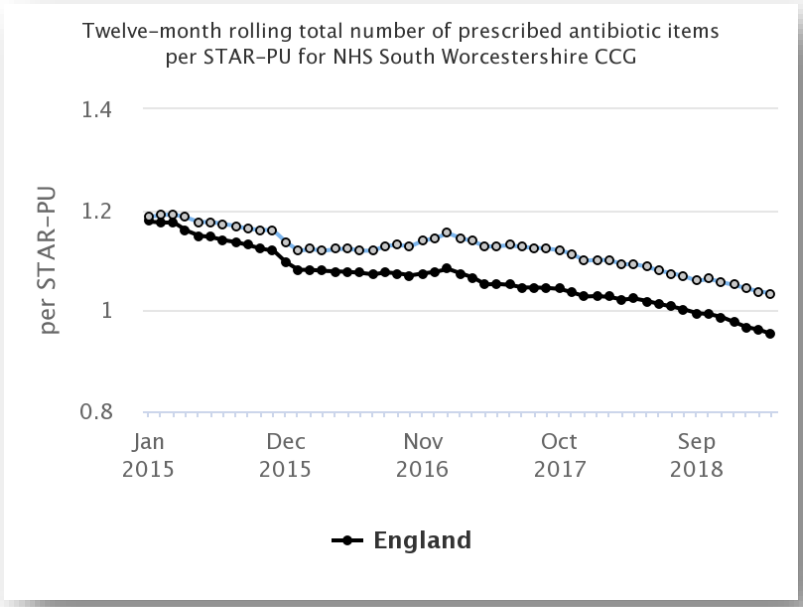


Source: Public Health England, AMR Local Indicators Profile.[8]

Since March 2017 South Worcestershire CCG has seen a steady decline in antibiotic prescribing in primary care although it still has a rate which is higher than the NHS England target rate. The rate of decline is like that of similar CCGs.

[7] From 2015/16 onwards out-of-hours antimicrobial prescribing for the whole county has been reported into the R&B CCG cost centre. This extra volume of prescribing without an associated countervailing patient cohort denominator continues to skew the R&B picture.
[8] Available at: https://fingertips.phe.org.uk/profile/amr-local-indicators

Figure 4. Twelve-Month Rolling Total Number of Prescribed Antibiotic Items Per STAR-PU. South Worcestershire CCG.

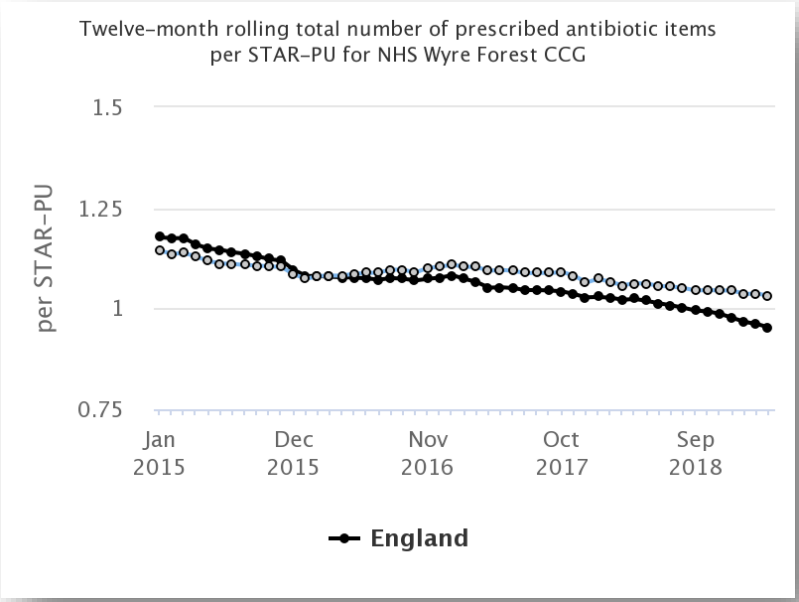


Source: Public Health England, AMR Local Indicators Profile.[9]

Since May 2017 Wyre Forest CCG has also seen a steady decline in the rate of antibiotic prescribing in primary care but the rate is still higher than the NHS England target rate and amongst Wyre Forest's similar CCGs West Lancashire has seen a steeper decline.

[9] Available at: https://fingertips.phe.org.uk/profile/amr-local-indicators

Figure 5. Twelve-Month Rolling Total Number of Prescribed Antibiotic Items Per STAR-PU. Wyre Forest CCG.



Source: Public Health England, AMR Local Indicators Profile.[10]

Best Practice

This year the Department of Health and Social Care published a five-year action plan for antimicrobial resistance (2019-2024) which supports a 20-year vision. The plan sets out the actions needed across all sectors to respond to the challenge.[11]

In June 2019 Public Health England updated Antimicrobial Resistance (AMR): applying All Our Health.[12] This is a resource which will help front-line health and care staff use their trusted relationships with patients, families and communities to promote the benefits of preventing antimicrobial resistance).

Key Areas of Work

The Worcestershire CCGs Medicines Commissioning Team continue to monitor antimicrobial prescribing in primary care, provide GP practices with access to prescribing

[10] Available at: https://fingertips.phe.org.uk/profile/amr-local-indicators

[11] HM Government (2019). Tackling antimicrobial resistance 2019–2024. The UK's five-year national action plan. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/784894/UK_AMR_5_year_national_action_plan.pdf

[12] Public Health England (2019). Antimicrobial resistance (AMR): applying All Our Health. Available at: https://www.gov.uk/government/publications/antimicrobial-resistance-amr-applying-all-our-health/antimicrobial-resistance-amr-applying-all-our-health

support software to facilitate compliance with local guidance, distribute regular prescribing messages via newsletters and report concerns to individual practices and host providers where they arise.

The widespread use of broad-spectrum antibiotics (co-amoxiclav, cephalosporins and quinolones) outside of a limited range of specific clinical indications is associated with an increase in antimicrobial resistance. The proportion of prescribed items of these antibiotics compared to the overall number of prescribed antibiotic items over a rolling 12-month period is another key NHS England measure. The NHS England target for this is for the proportion to be below 10%.

GP practices in South Worcestershire CCG were identified as being outliers with respect to this measure and were asked to perform a comprehensive audit during quarter one of 2018/19. The audit required them to interrogate prescribing of broad-spectrum antibiotics with respect to local guidance and then produce and submit individual action plans to address non-compliance with guidance. As a result of this audit South Worcestershire CCG figures for this measure fell over the next few months as indicated in the Table 5 and now lie below the NHS England target of 10%.

Table 5. Proportion of Antibiotics Prescribed in South Worcestershire CCG that were Broad-Spectrum

12 MONTH PRESCRIBING TO END	APRIL 18	MAY 18	JUNE 18	JULY 18	AUG 18	SEP 18	OCT 18
% co-amoxiclav, cephalosporins and quinolones	**10.36**	**10.36**	**10.28**	**10.23**	**10.16**	**10.06**	**9.94**

Source: Worcestershire CCGs Medicines Commissioning Team

12-month rolling co-amoxiclav, cephalosporin and quinolone figures for the three Worcestershire CCGs are given in the Table 6. Note all CCGs have hit the 10% target.

Table 6. Proportion of Antibiotics Prescribed in Worcestershire CCGs that were Broad-Spectrum (March 2019; 12-month Rolling Figures)

Clinical Commissioning Group	% co-amoxiclav, cephalosporins and quinolones
REDDITCH & BROMSGROVE	8.48
SOUTH WORCESTERSHIRE	9.29
WYRE FOREST	7.73

Source: Worcestershire CCGs Medicines Commissioning Team

Moving forward, it is anticipated that further audits and workstreams will be undertaken.

Air Quality

Poor air quality is a major public health risk, ranking alongside cancer, heart disease and obesity. It shortens lives and damages quality of life for many people.

Both short and long-term exposure to air pollution can affect health. Short-term exposure to elevated levels of air pollution can cause a range of health impacts, including effects on lung function, exacerbation of asthma, increases in respiratory and cardiovascular hospital admissions and mortality. Long-term exposure reduces life expectancy, mainly due to cardiovascular and respiratory diseases and lung cancer.[13]

Many pollutants affect air quality, but the five most damaging pollutants are:

- Particulate Matter (PM2.5),
- Ammonia,
- Sulphur Dioxide,
- Nitrogen Dioxide (NO_2) and
- Non-Methane Volatile Organic Compounds (NMVOCS)

Pollutants can travel long distances and combine with each other to create different pollutants. Of the five pollutants listed above, data is available for PM2.5 and NO_2 in a format that allows comparisons to be made.

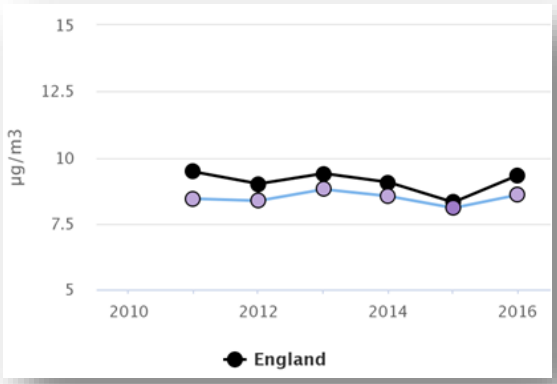
Fine Particulate Matter (PM2.5)

Annual concentration of human-made fine particulate matter (PM2.5) in Worcestershire is 8.6 micrograms per cubic metre (µg/m^3). This means Worcestershire has better than average air quality by this measure (it is in the second-best quintile in England).

However, the average PM2.5 concentration varies across the county. The highest concentration is recorded in Bromsgrove at 9.1 µg/m^3, this is followed by Redditch (8.9 µg/m^3), Worcester (8.8 µg/m^3), Wychavon (8.4 µg/m^3), Wyre Forest (8.3 µg/m^3) and Malvern Hills (7.8 µg/m^3).

[13] Public Health England. Health Matters: Air Pollution Nov 18. Available at: https://www.gov.uk/government/publications/health-matters-air-pollution/health-matters-air-pollution

Figure 6. Air Pollution: Fine Particulate Matter - Worcestershire



Source: Public Health England, Public Health Outcomes Framework

Nitrogen Dioxide (NO_2)

Worcestershire has small pockets, called Air Quality Management Areas (AQMAs) where the local air quality is unlikely to meet the Government's national NO_2 thresholds.[14] Across the county, there are seven AQMAs including three in Bromsgrove, one in Worcester, one in Wychavon and two in Wyre Forest. In June 2019 the whole area within the political boundary of Worcester City was declared an AQMA.

In 2017, 0.3% of the Worcestershire population was living in an AQMA, which is higher than the England average of 0.2%. The changes to the Worcester AQMA have contributed to an increase in this figure.

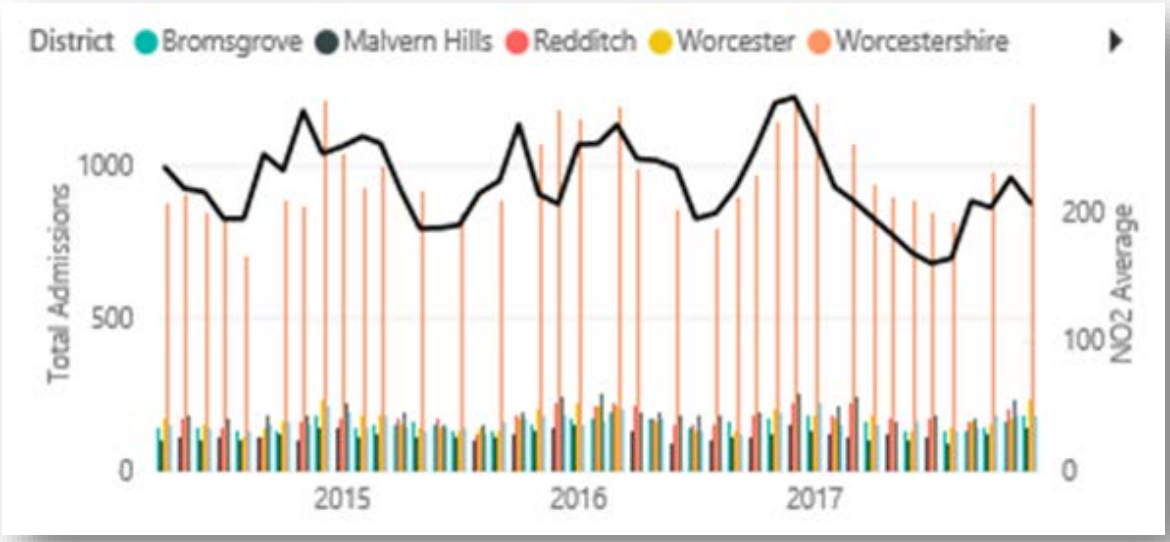
Recently the Worcestershire Public Health Team studied the strength of association between average NO_2 levels and hospital admissions for conditions amenable to poor air quality[15] and cardio-vascular admissions[16]. The results of this investigation are shown in Figure 7.

[14] There are two air quality objectives for nitrogen dioxide. The long-term objective is 40 µg/m3 averaged over a year and the short-term objective is 200 µg/m3 averaged over one hour.

[15] ICD 10: 100-109

[16] ICD 10: J00-J99

Figure 7. Total Admissions and NO_2



In 2016 there was a strong association between NO_2 levels and hospital admissions at county level and in 2017, data for Bromsgrove, Wychavon, Malvern and Redditch showed a strong association between hospital admissions and NO_2 concentrations.

The Clean Air Strategy published in January 2019 sets out comprehensive actions required across all parts of government and society to improve air quality.[17]

Public Health England has published a review of actions providing local practitioners and policy-makers with an indication of the range of interventions that can be used to address problems arising from different sources of air pollution.[18] A partnership group to consider the implementation of these actions at a local level has recently been set up by the Public Health Team.

[17] Department of Environment, Food and Rural Affairs. Clean Air Strategy 2019. Available at: https://www.gov.uk/government/publications/clean-air-strategy-2019
[18] https://www.gov.uk/government/publications/improving-outdoor-air-quality-and-health-review-of-interventions

The Worcestershire Picture

Population, Economy, Environment, Housing, Community, Crime and Safety

Worcestershire is a county in the West Midlands made up of six districts: Bromsgrove, Malvern Hills, Redditch, Worcester, Wychavon and Wyre Forest. This section provides an overview of Worcestershire in terms of population, economy, environment, community, housing and crime and safety in order to better understand the factors that influence people's health.

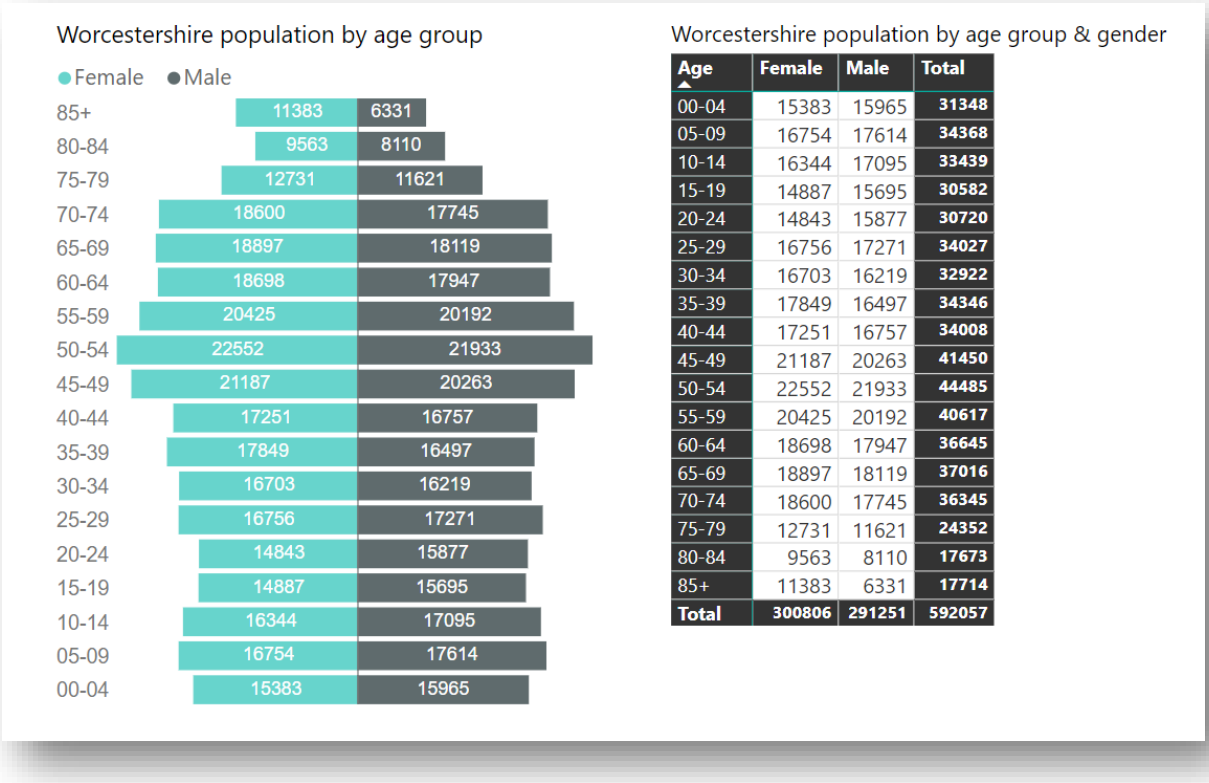
Population

The current population of Worcestershire is estimated to be around 592,057 - an increase of 0.6% from the previous year based on the ONS mid-year 2018 population estimates. Overall the population growth has slowed compared to the previous year.

Wychavon district has the largest proportion of the total population in the county and Malvern Hills the smallest. Wyre Forest and Worcester have similar populations (101,062 and 101,891 respectively).

Worcestershire has an ageing population and a large proportion of the population is in the 45 plus age groups (Figure 8). By 2035 this age structure is expected to translate into a large increase in the older age groups and, in particular, the very oldest age groups (Figure 9).

Figure 8. Worcestershire Population Estimate

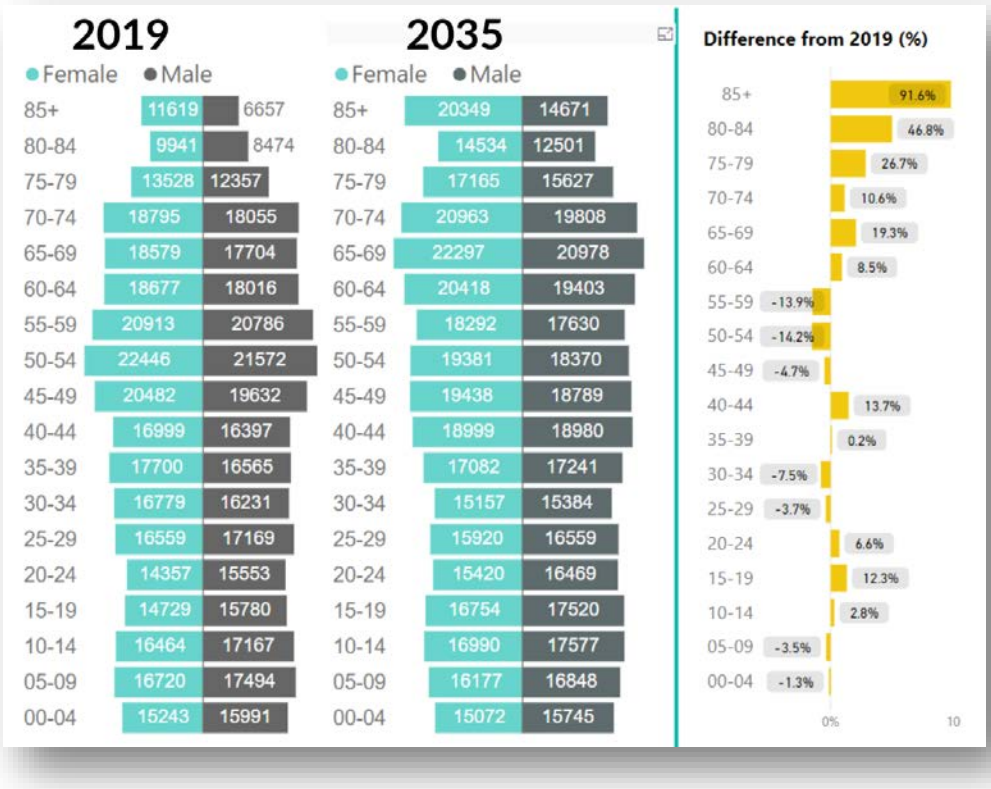


Worcestershire population by age group & gender

Age	Female	Male	Total
00-04	15383	15965	**31348**
05-09	16754	17614	**34368**
10-14	16344	17095	**33439**
15-19	14887	15695	**30582**
20-24	14843	15877	**30720**
25-29	16756	17271	**34027**
30-34	16703	16219	**32922**
35-39	17849	16497	**34346**
40-44	17251	16757	**34008**
45-49	21187	20263	**41450**
50-54	22552	21933	**44485**
55-59	20425	20192	**40617**
60-64	18698	17947	**36645**
65-69	18897	18119	**37016**
70-74	18600	17745	**36345**
75-79	12731	11621	**24352**
80-84	9563	8110	**17673**
85+	11383	6331	**17714**
Total	**300806**	**291251**	**592057**

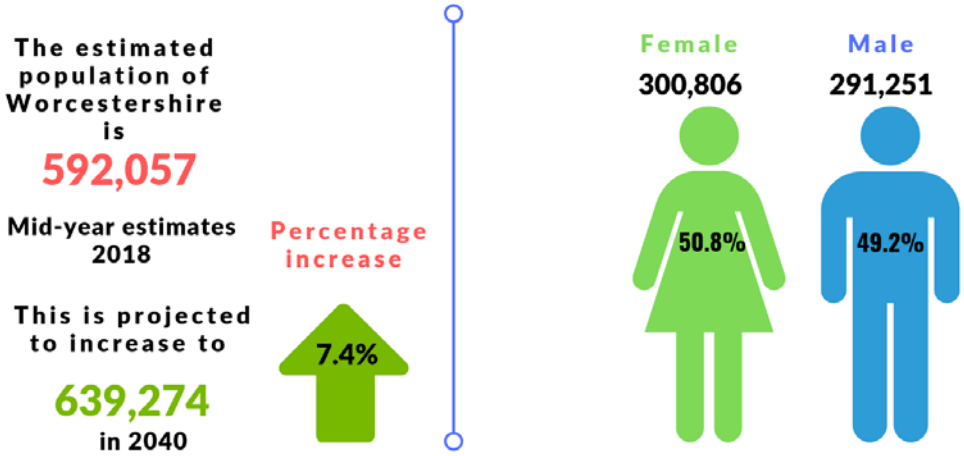
Source: Worcestershire Public Health Team based on Office for National Statistics population estimates Mid-Year 2018

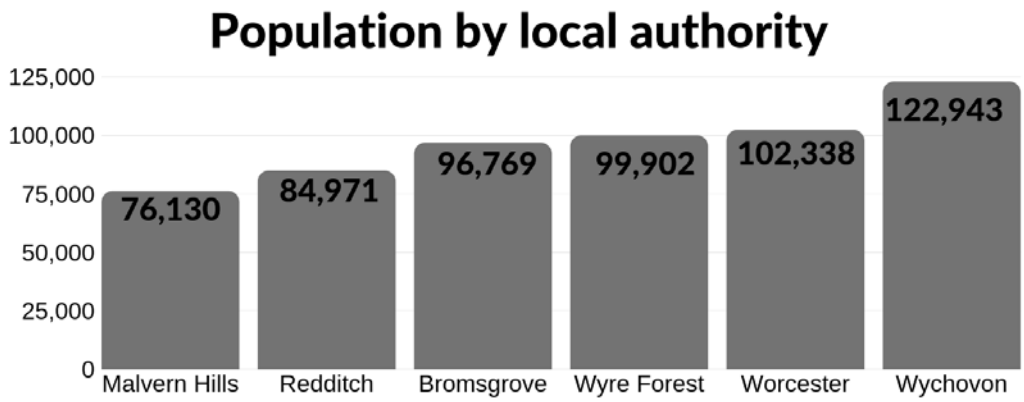
Figure 9. Projected Population Based on 2018 Mid-Year Population



Source: Worcestershire Public Health Team based on Office for National Statistics population projections Mid-Year 2018

Figure 10. Worcestershire's Population: Key Facts





01 **0-19 Age Group**
Between 20-24% of the population in each of the six districts are children and young people. Redditch has the highest percentage at 24%.

02 **20-64 Age Group**
More than half of the population (50-60%) in each of the districts are adults. Worcester has the highest percentage at 60%

03 **65 plus Age Group**
Between 17-29% of the population in the six districts are older people.
Malvern Hills has the highest percentage at 29%

Worcestershire has a predominantly white population (95.7%)
7060 people with an ethnicity of Mixed (1.2%)
14,121 people with an ethnicity of Asian (2.4%)
2,353 people with an ethnicity of Black (0.4%)
1,765 people with an ethnicity of Other (0.3%)

Data source: Public Health England, Public Health Outcomes Framework
All images from: Canva.com

NHS Wyre Forest Clinical Commissioning Group
NHS Redditch and Bromsgrove Clinical Commissioning Group
NHS South Worcestershire Clinical Commissioning Group

Economy

There is a strong association between income and health with many health outcomes improving incrementally as income rises.[19]

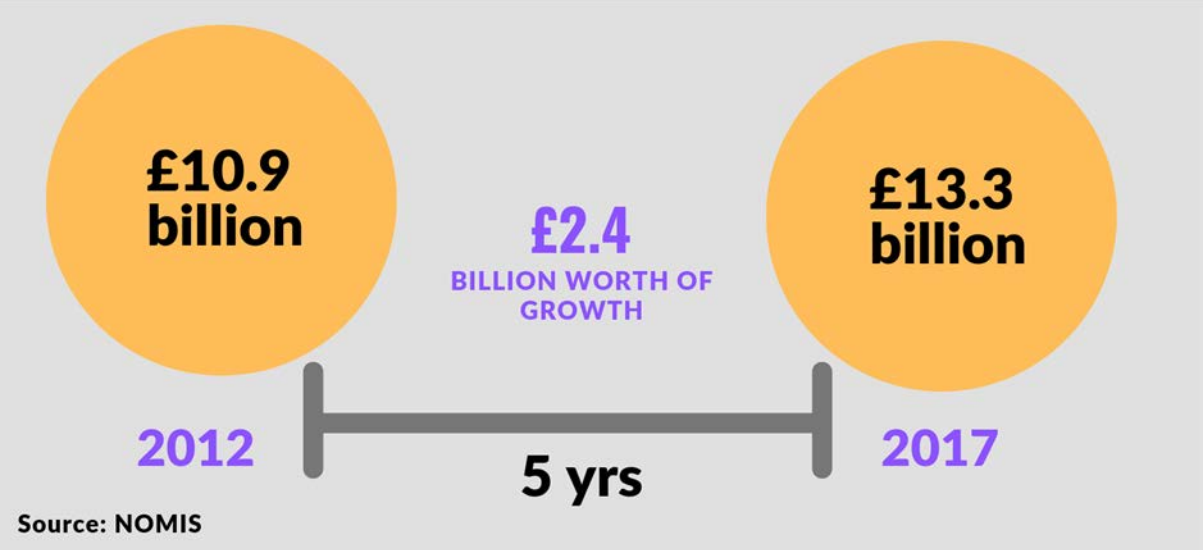
Employment is one of the most important determinants of physical and mental health. The long-term unemployed have a lower life expectancy and worse health than those in work.[20] Unemployment does not just affect individuals, but lack of income, may influence a child's early development and educational opportunities, which in turn can affect their future employment opportunities and income.[21]

The contribution of Worcestershire's economy to Gross Domestic Product (GDP) can be quantified by measuring Gross Value Added (GVA).[22] Two approaches can be used to calculate GVA:

- GVA P - The production approach estimates the value of an output (goods or services) less the value of the inputs used in the production process for each economic unit.
- GVA I - The income approach measures the incomes of individuals (e.g. wages) and corporations (e.g. profits) in the production of outputs (goods or services).

[19] Public Health England: Social Determinants of Health https://www.gov.uk/government/publications/health-profile-for-england/chapter-6-social-determinants-of-health#fn:18
[20] Bartley M, Ferrie J, Montgomery SM. (2005) Chapter 5: Health and labour market disadvantage: unemployment, non-employment and job insecurity. Social Determinants of Health 2nd Edition. Oxford University Press: Oxford.
[21] Joseph Rowntree Foundation. (2014) How Does Money Influence Health? Accessed 12 August 2019

Figure 11. Gross Value Added (GVA)



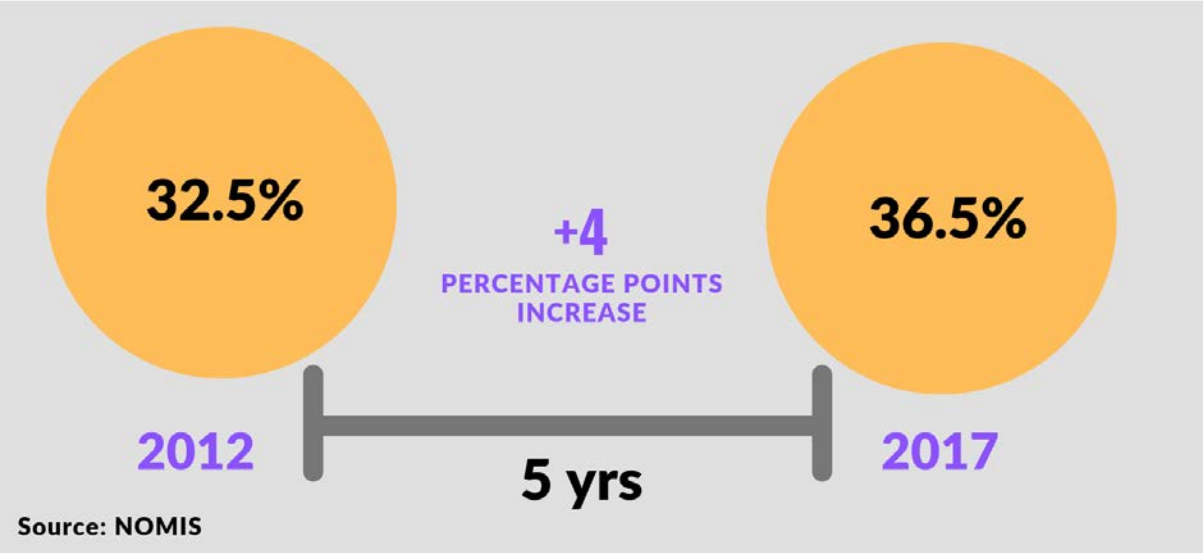
The total output of the Worcestershire economy grew by 22% between 2012 and 2017. This equates to about 4.4% yearly growth.

Figure 12. GVA per hour worked

The value translates to approximately 2.5% average annual increase over 5 years.

Worcestershire Local Enterprise Partnership (LEP) is listed by the Office for National Statistics as one of the top five performing LEPs by real GVA growth since 2009.[23]

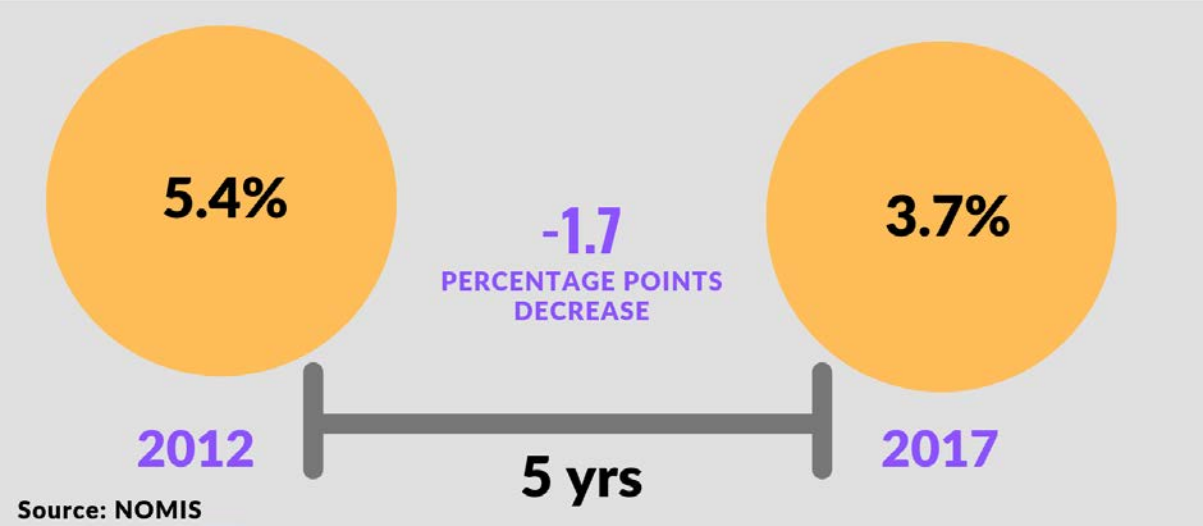
Figure 13. Workforce skills NVQ level 4 plus



Employers require specific skills sets to maximise productivity. NVQ level 4 is a suitable qualification required by the workforce to fulfil the objective of a highly skilled knowledge economy. The percentage of the workforce who had skills at NVQ level 4 plus improved by 4 percentage points between 2012 and 2017.

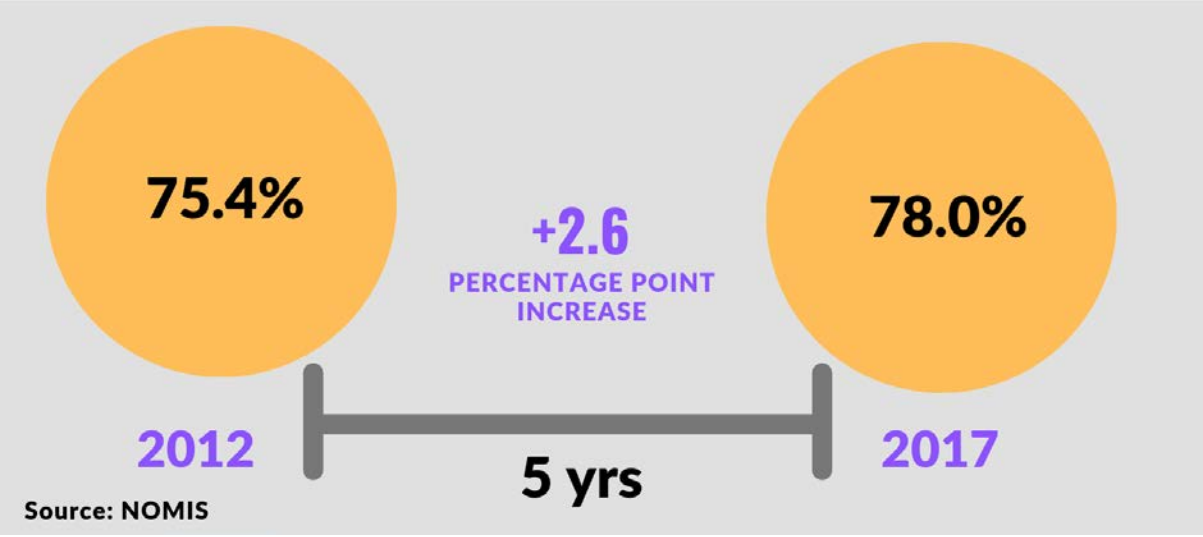
[23] https://www.ons.gov.uk/economy/grossvalueaddedgva/bulletins/regionalgrossvalueaddedbalanceduk/1998to2017

Figure 14. Unemployment-Worcestershire



Unemployment is associated with an increased risk of ill health and mortality. Between 2012 and 2017 unemployment in Worcestershire decreased by 45.9%.

Figure 15. Employment-Worcestershire



The percentage of people in employment has been increasing and was consistently better than the England average over the five-year period 2012-2017.

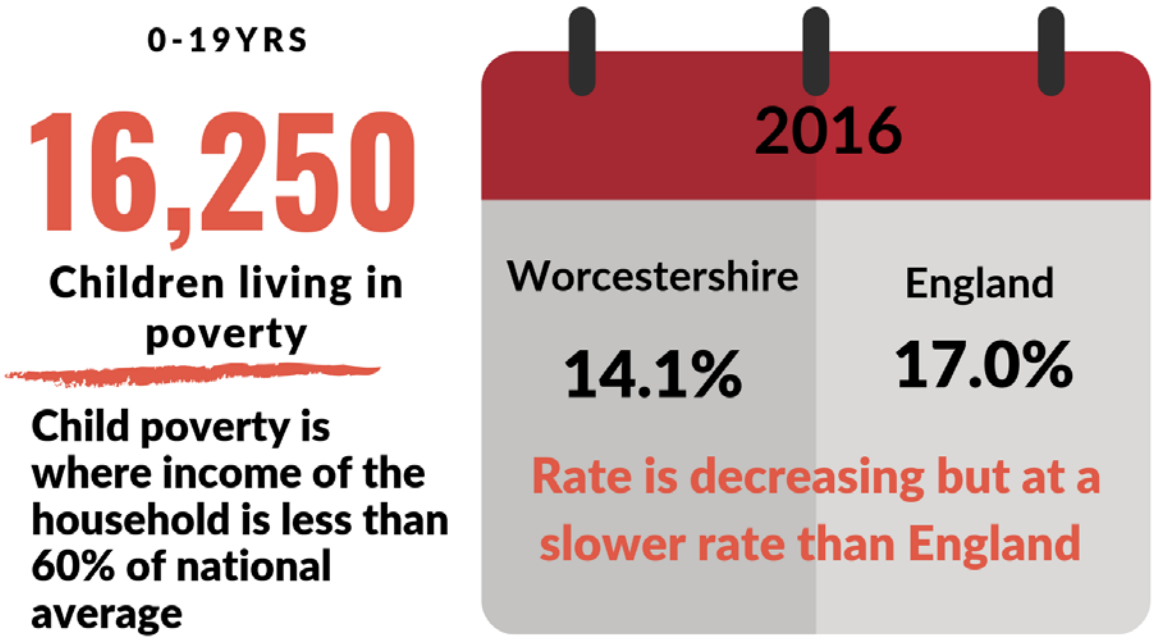
Child Poverty

Growing up in poverty damages children's health and wellbeing, adversely affecting their future health and life chances. Ensuring a good environment in childhood, especially early childhood, is important. A considerable body of evidence links adverse childhood circumstances to poor child health outcomes, future adult ill health and premature mortality. There is also a wide variety of evidence to show that children who live in poverty are exposed to a range of risks that can have a serious impact on their mental health. Reducing the numbers of children who experience poverty should improve these adult health outcomes and increase healthy life expectancy.[24]

The latest available figures show that in Worcestershire 14.1% of children live in poverty related to low income. Compared to similar local authorities, Worcestershire is worse than the average (which is 13%).

The rate is decreasing although at a slower pace than England.

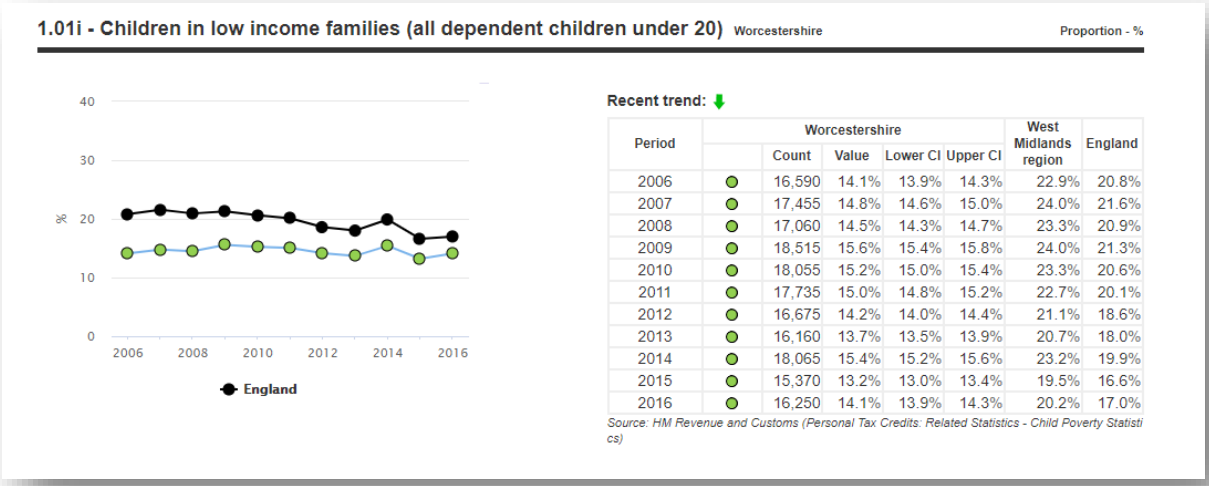
Figure 16: Children in Low Income Families (All Dependent Children Under 20) 2016



Infographics created by the Public Health Team using : Canva.com
Data source: Public Health England

[24] Marmot Review report – 'Fair Society, Healthy Lives: https://www.local.gov.uk/marmot-review-report-fair-society-healthy-lives

Figure 17. Trend for Worcestershire - Children in Low Income: Under 20



1.01i - Children in low income families (all dependent children under 20) Worcestershire — Proportion - %

Recent trend:

Period	Worcestershire					West Midlands region	England
		Count	Value	Lower CI	Upper CI		
2006		16,590	14.1%	13.9%	14.3%	22.9%	20.8%
2007		17,455	14.8%	14.6%	15.0%	24.0%	21.6%
2008		17,060	14.5%	14.3%	14.7%	23.3%	20.9%
2009		18,515	15.6%	15.4%	15.8%	24.0%	21.3%
2010		18,055	15.2%	15.0%	15.4%	23.3%	20.6%
2011		17,735	15.0%	14.8%	15.2%	22.7%	20.1%
2012		16,675	14.2%	14.0%	14.4%	21.1%	18.6%
2013		16,160	13.7%	13.5%	13.9%	20.7%	18.0%
2014		18,065	15.4%	15.2%	15.6%	23.2%	19.9%
2015		15,370	13.2%	13.0%	13.4%	19.5%	16.6%
2016		16,250	14.1%	13.9%	14.3%	20.2%	17.0%

Source: HM Revenue and Customs (Personal Tax Credits: Related Statistics - Child Poverty Statistics)

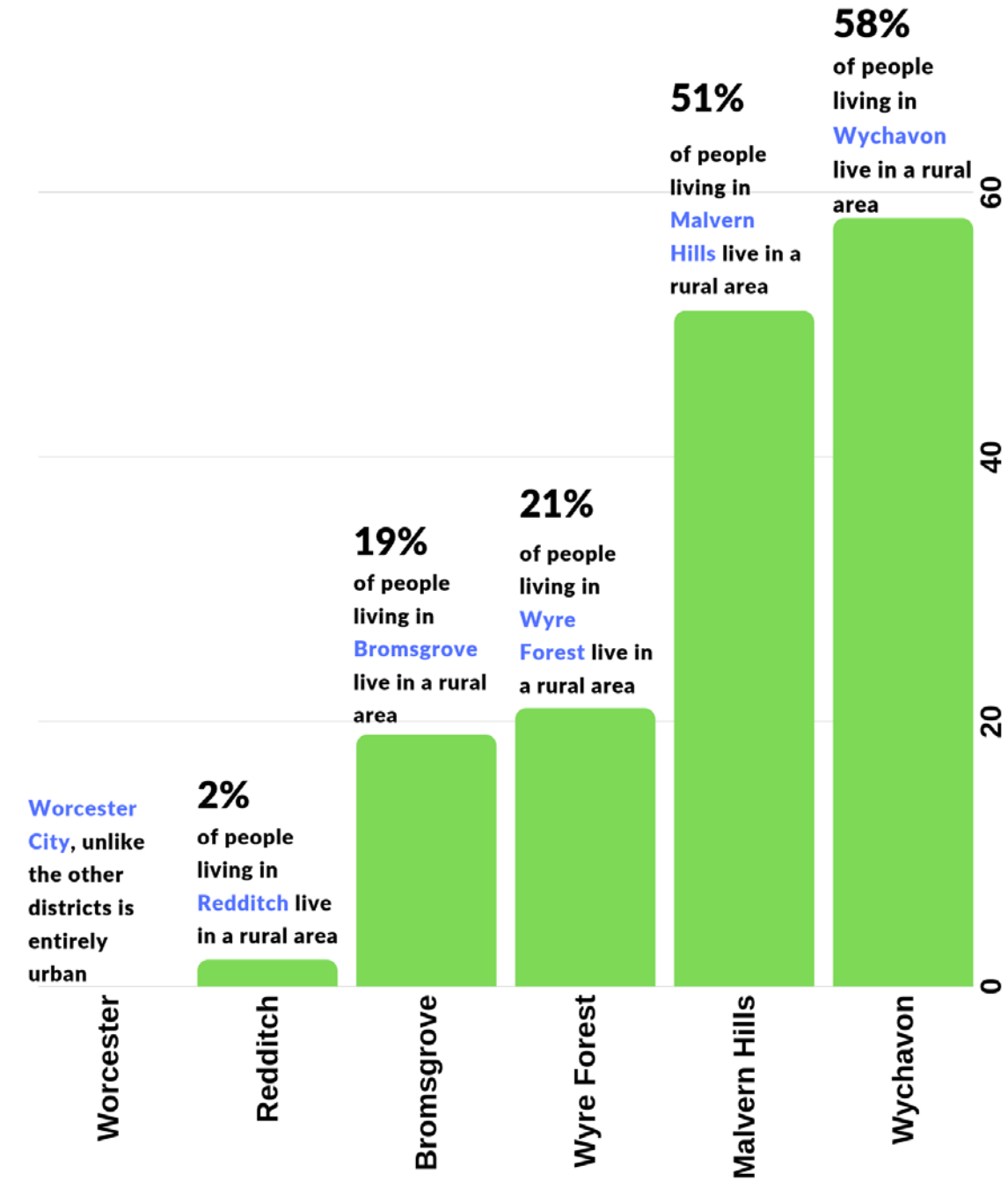
Source: Public Health England

Environment

Worcestershire has safe high-quality green spaces that are utilised for sports and leisure. The county possesses a variety of accessible natural environment in and around towns and cities, including parks, canals and nature areas and countryside including farmland, woodland, hills and rivers. These provide a great way of getting out in the fresh air, exercising and making new friends.

The proportion of the population who live in a rural area varies greatly between districts. Malvern Hills and Wychavon are the two Worcestershire districts which have the largest proportion of their population living in a rural area and Redditch and Worcester have the lowest proportion.

Figure 18. Percentage of People Who Live in a Rural Area



Graph developed using :Canva.com

Community

There is growing recognition that although disadvantaged social groups and communities have a range of complex and inter-related needs, they also have assets at the social and community level that can help improve health and strengthen resilience to health problems.[25]

To build social capital and utilise community-based assets to improve health and well-being, local authorities can:

- Support volunteering opportunities,
- Focus upon reducing social isolation,
- Support creation of informal social networks through groups and activities
- Map and develop community assets.[26]

The 2017-2018 Director of Public Health Annual Report for Worcestershire, **'Prevention is Better than Cure**', advocates engaging with local communities to build local health assets by bringing people together, with the support of all sectors, to build resilient communities with informed residents who can help themselves and each other.[27]

The report points to the use of asset-based approaches across the county to strengthen community engagement and contribute towards positive health and well-being. These approaches seek to bolster well-being at individual and community levels, helping to increase resilience to the wider corrosive effects of the social determinants of health and risky behaviours.[28]

Recognising assets helps value community strengths and ensure everyone has access to them. It builds on the positives and ensures that health action is co-produced equally between communities and services.

Public health England have produced guidance on community-centered approaches targeting the following:

- Community Strengthening
- Volunteer and Peer Roles
- Collaborations and Partnerships
- Access to Community resources[29]

---

[25],[6,7] The Kings Fund: https://www.kingsfund.org.uk/projects/improving-publics-health/strong-communities-wellbeing-and-resilience

[27] Director of Public Health Report 2018 http://www.worcestershire.gov.uk/info/20122/joint_strategic_needs_assessment/1498/jsna_director_of_public_health_annual_reports

[29] Public Health England Guidance: https://www.gov.uk/government/publications/health-matters-health-and-well-being-community-centred-approaches/health-matters-community-centred-approaches-for-health-and-well-being

Loneliness and social isolation are a risk factor particularly amongst the elderly population.

In Worcestershire only half (49%) of adult social care users have as much social contact as they would like. A similarly low figure of adult carers have as much social contact as they would like (38.4%). Although, Worcestershire is not unusual as these rates are similar to what is seen nationally.

Housing

"Interventions to improve the home or housing circumstances can be effective in preventing and reducing demand for health care and social care. To be successful we need everyone to think 'home and health'. Collaboration between local professionals - from environmental health and housing to allied health, public health and social care - is central to integrate housing as a means to improve health outcomes and reduce health inequalities".

Professor Kevin Fenton, National Director of Health and Wellbeing at Public Health England

Housing contributes to people's health and well-being.[30] A healthy home is one that enables individuals to:

- manage their own health and care needs, including long-term conditions
- live independently, safely and well in their own home for as long as they choose
- complete treatment and recover from substance misuse, tuberculosis or other ill health
- move on successfully from homelessness or another traumatic life event
- access and sustain education, training and employment
- participate and contribute to society

With the population projected to increase, particularly amongst the elderly age groups, the challenge for Worcestershire is finding a balance between demand and supply. The annual delivery rate across the county will need to be approximately 2,600 per year from 2021 to 2030 to deliver both the required numbers and any short fall from previous delivery. This is an unprecedented number for the county.

Currently all districts, apart from Bromsgrove and Redditch, are delivering over their accumulated targets. Bromsgrove and Redditch have under-delivered by approximately 1,600 homes since 2011.

The Housing stock condition information from 2011 indicates that Malvern Hills, Wyre Forest and Wychavon had a higher proportion of non-decent housing than that seen nationally. This is linked to houses being older properties and owner occupier's inability to address issues despite positive economic growth over the same period.[31]

[30] Dahlgren G, Whitehead M (1991*). Policies and strategies to promote social equity in health,* Stockholm Institute for Further Studies
[31] Worcestershire County Council: http://www.worcestershire.gov.uk/info/20044/research_and_feedback/673/worcestershire_county_economic_summary

Figure 19. Relating Housing to Health and Wider Effects

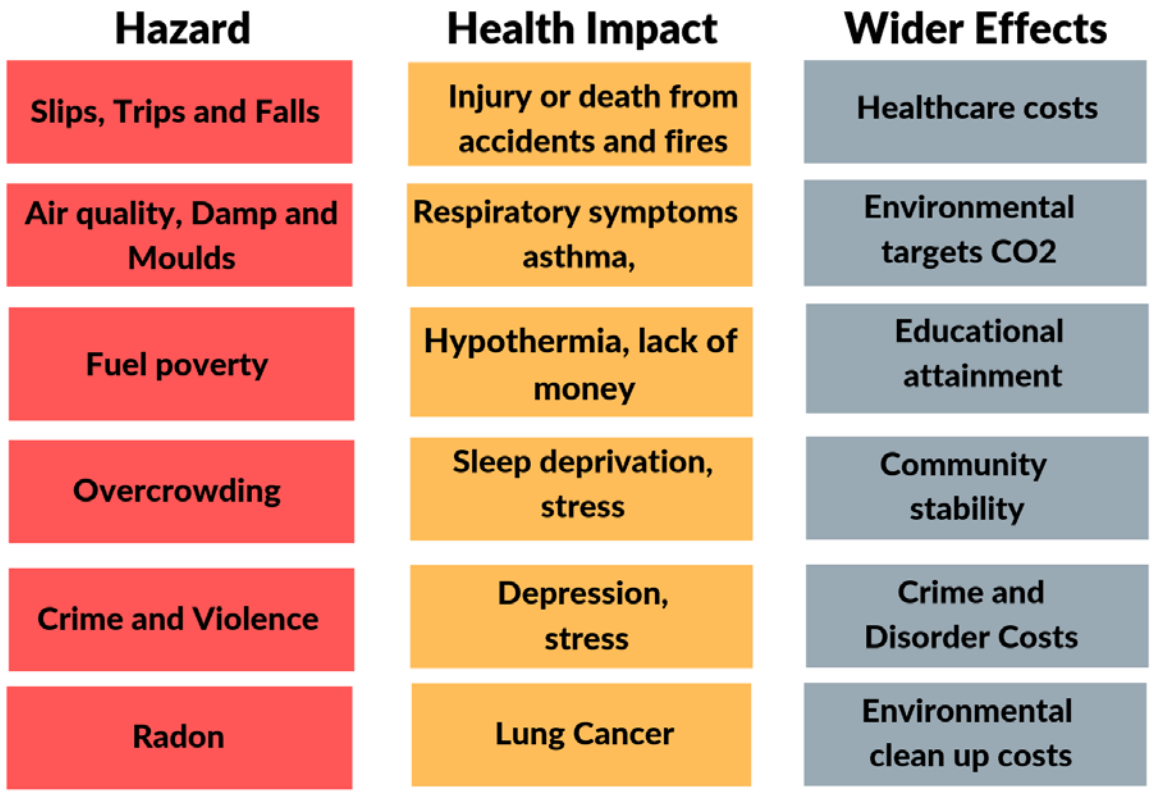
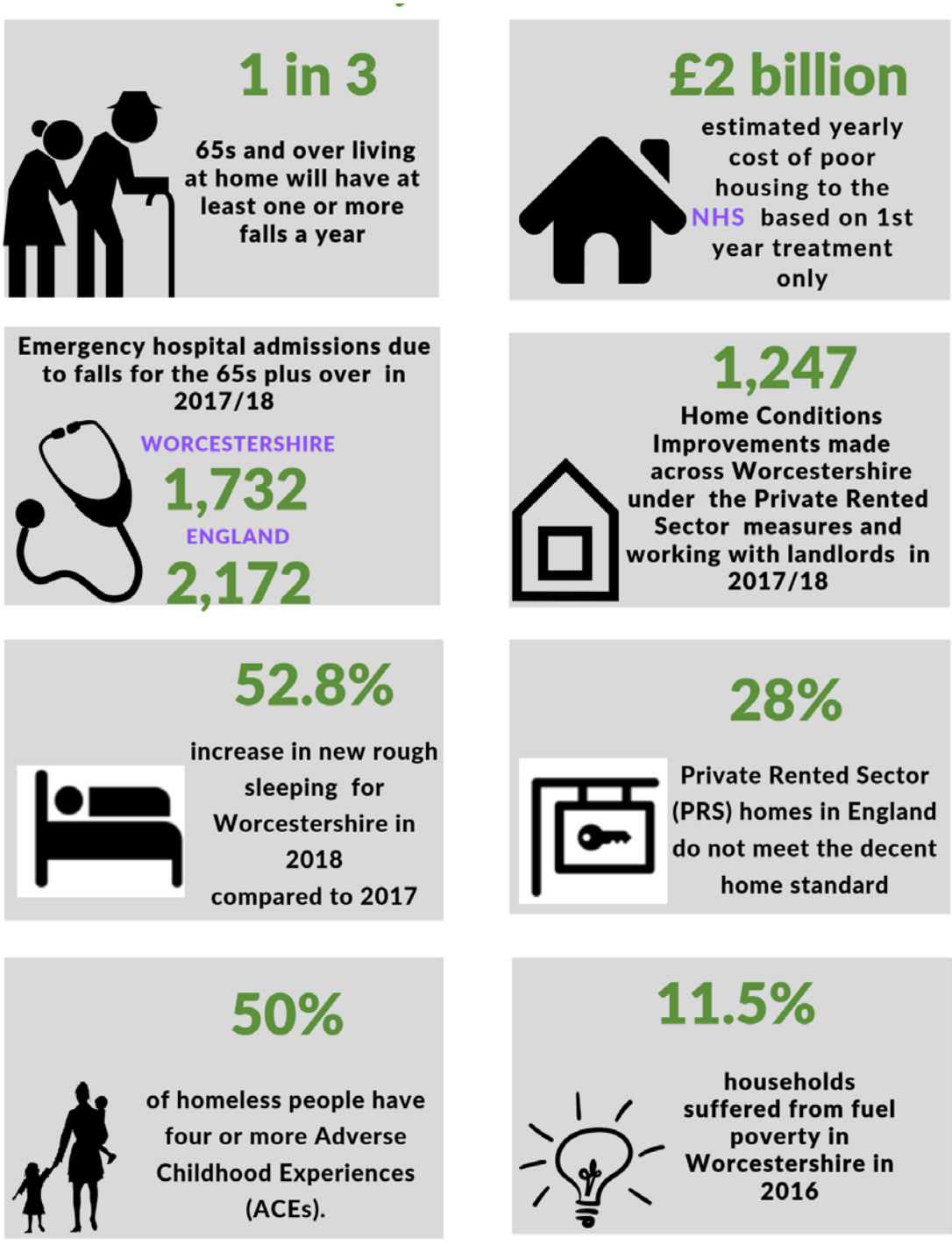


Figure 20**. Housing Stats and numbers**



Created by Public Health Team using: Canva.com
Data source: Public Health England

In Worcestershire the rate of homeless young people (18-24) is 0.68 per 1,000. This is significantly higher than the England average (0.52 per 1,000). There is an improving trend with numbers of homeless young people reducing from 186 in 2016/17 to 170 in 2017/18[32].

[32] PHE, https://fingertips.phe.org.uk/search/homeless#page/0/gid/1/pat/6/par/E12000005/ati/202/are/E10000034

Violent Crime (Including Sexual Violence)

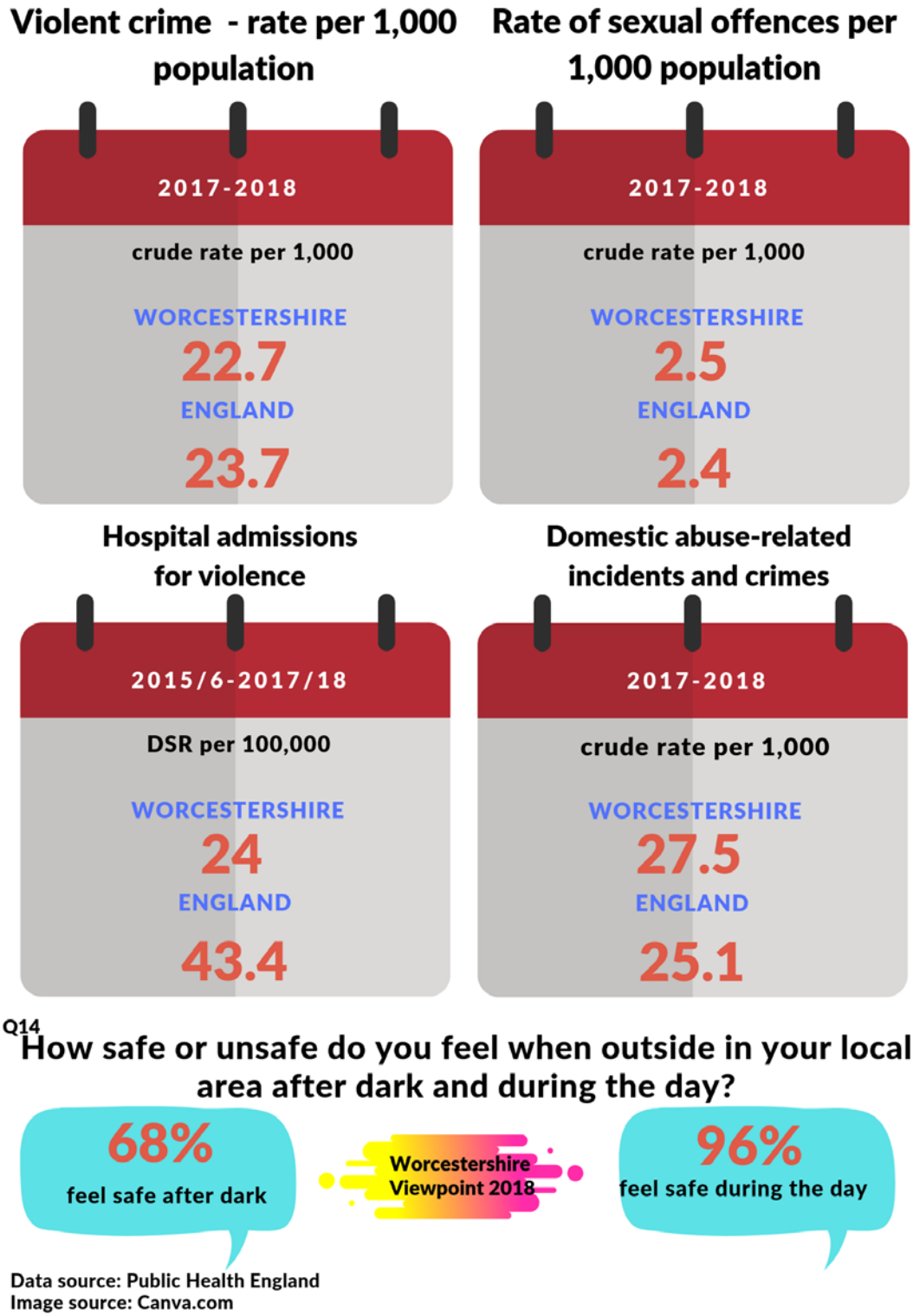
Crime is an important feature of deprivation that has major effects on individuals and communities.[33] Worcestershire has a deprivation score of -0.28 which means that it is safer on average than England.[34]

Crime data is often semi-anonymized and put into broad crime categories that include one of the following 12 types: anti-social behaviour, burglary, other crime (consisting of shoplifting, drugs, criminal damage and arson, public disorder and weapons, other theft), robbery, vehicle crime, and violent crime.[35]

Violence and abuse are closely connected to other issues such as poor health, child poverty, social exclusion and economic and educational disadvantage. The Worcestershire Domestic Violence Strategy 2017-20 seeks to address all forms of violence and abuse regardless of age, gender and sexual orientation.

[33] PHE: https://fingertips.phe.org.uk/search/crime#page/6/gid/1/pat/6/par/E12000005/ati/102/are/E10000034/iid/92635/age/-1/sex/-1
[34] England-wide crime deprivation distribution scores range from -3.23 to 3.28 with a mean value of 0. The further away the score is from zero in the negative direction the safer the place and the further away the score is in the positive direction the more unsafe.
[35] UK crime stats: http://www.ukcrimestats.com/Subdivisions/CTY/2246/

Figure 21. Crime: Key Facts



Data source: Public Health England
Image source: Canva.com

Autism

Autism Spectrum Disorder (ASD) is a life-long developmental disability that affects how a person communicates with and relates to other people, and how they experience the world around them. Prevalence studies of ASD indicate that 1.1% of the population may have autism. This equates to approximately 726,447 people in the UK.[36]

National data shows that boys are much more likely to be diagnosed with autism than girls.[37] Special Educational Need (SEN) data shows boys are four and a half times more likely to have a primary or secondary need of ASD compared to girls.

There are no estimates of the overall numbers of people with ASD in Worcestershire, using the national prevalence of 1.1% and population estimate for 2018, this would mean that there are estimated to be approximately 6,513 people living in Worcestershire with ASD. However, schools do submit data on the number of children recorded as having ASD as a primary SEN to the Department of Education.

National data collected by the Special Educational Needs and Disability school census, shows that there were 868 children in Worcestershire in 2018 who had autism and who were known to schools. This is a rate of 10 per 1,000 population which is significantly lower than both the England average of 13.7 per 1,000 population and the average for similar local authorities to Worcestershire (CIPFA nearest neighbours) which is 12.7 per 1,000 population. The data is likely to be an under-estimate of the actual numbers as it refers only to children with ASD as a primary type of need and does not include independent schools.

A profile of Special Educational Needs and Disabilities (SEND)[38] in Worcestershire was produced in 2018. The latest published data shows that Worcestershire had a proportion of children with ASD as a primary need in primary, secondary and special schools of 7.6%. This is significantly lower than both England at 8.6% and the West Midlands at 8.8%. Comparisons with similar local authorities reveal there is some variation. Both Warwickshire at 11.1% and Suffolk at 12.0% had a significantly higher proportion of children with ASD as a primary need than Worcestershire but Gloucestershire has a significantly lower proportion at 4.7%. There could be a number of reasons for this which may warrant further investigation including under-diagnosis of ASD in Worcestershire, inappropriate referrals, or issues relating to service access.

A profile of Special Educational Needs and Disabilities (SEND) in Worcestershire was produced in 2018. The latest published data shows that Worcestershire had a proportion of children with ASD as a primary need in primary, secondary and special schools of 7.6%. This is significantly lower than both England at 8.6% and the West Midlands at 8.8%. Comparisons with similar local authorities reveal there is some variation. Both

36 NHS Digital. Estimating the Prevalence of Autism Spectrum Conditions in Adults - Extending the 2007 Adult Psychiatric Morbidity Survey. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/estimating-the-prevalence-of-autism-spectrum-conditions-in-adults/estimating-the-prevalence-of-autism-spectrum-conditions-in-adults-extending-the-2007-adult-psychiatric-morbidity-survey

37 National Children's Bureau (2016) Gender and children and young people's emotional and mental health: Manifestations and responses: a rapid review of the evidence. [Online]. Available from: http://www.going4growth.com/downloads/NCB_evidence_review_-_gender_and_CYP_mental_health_-2.pdf

38 Worcestershire County Council (2018) 2018 Profile on Special Educational Needs and Disabilities, [Online], Available from: http://www.worcestershire.gov.uk/download/downloads/id/10643/2018_children_with_send_profile.pdf

Warwickshire at 11.1% and Suffolk at 12.0% had a significantly higher proportion of children with ASD as a primary need than Worcestershire but Gloucestershire has a significantly lower proportion at 4.7%. There could be several reasons for this which may warrant further investigation including under-diagnosis of ASD in Worcestershire, inappropriate referrals, or issues relating to service access.

Learning Disabilities

People with learning disabilities experience inequalities across many areas of their lives and particularly in relation to their health. These health inequalities often start early in life and result, to an extent, from barriers they face in accessing timely, appropriate and effective health care. This can be due to a number of reasons including: lack of transport links, staff not understanding learning disability, failure to recognise a person with learning disability is unwell, inadequate after care or follow-up and not enough involvement allowed from carers.

Health Care Needs

People with learning disabilities have more healthcare needs than the general population. Approximately half of people with learning disabilities will have at least one significant health problem. Rates of epilepsy and dementia are higher in people who have learning disabilities than in the general population. Over 20 times higher for epilepsy and four times higher for dementia.[39]

People with learning disabilities are also more likely to have difficulties with eating, drinking and swallowing (dysphagia) and because of this they are more likely to experience respiratory infections.

Reducing the Life Expectancy Gap

Life expectancy for people with learning disabilities is much lower in comparison to the overall population; 18 years lower for females and 14 years lower for males. Reducing this life expectancy gap is a key priority area for Worcestershire's Sustainability and Transformation Partnership (STP) and also part of Worcestershire's Learning Disability Strategy.

Life expectancy for people with learning disabilities is much lower in comparison to the overall population; 18 years lower for females and 14 years lower for males. Reducing this life expectancy gap is a key priority area for Worcestershire's Sustainability and Transformation Partnership (STP) and part of Worcestershire's Learning Disability Strategy.

The Learning Disability Mortality Review (LeDeR) Programme has been in place across Worcestershire since the summer of 2017. The aim of the programme is to reduce premature mortality and address identified health inequalities for people with a learning disability. When someone with a learning disability dies a review is undertaken to help clarify contributory factors for the causes of death; identify variation and best practice; and identify key recommendations where there is opportunity to influence outcomes.

[39] The rate of dementia is 22% compared to 6% in the general population.

A multi-stakeholder steering group, that includes commissioners, providers, family carers and Public Health, consider the recommendations arising from each review and agree local action. During 2019 five Priority Action Work Groups have started to focus on responding to key themes identified following case review analysis. A web-based information hub is in development in Worcestershire to support the steering group to share progress and learning.

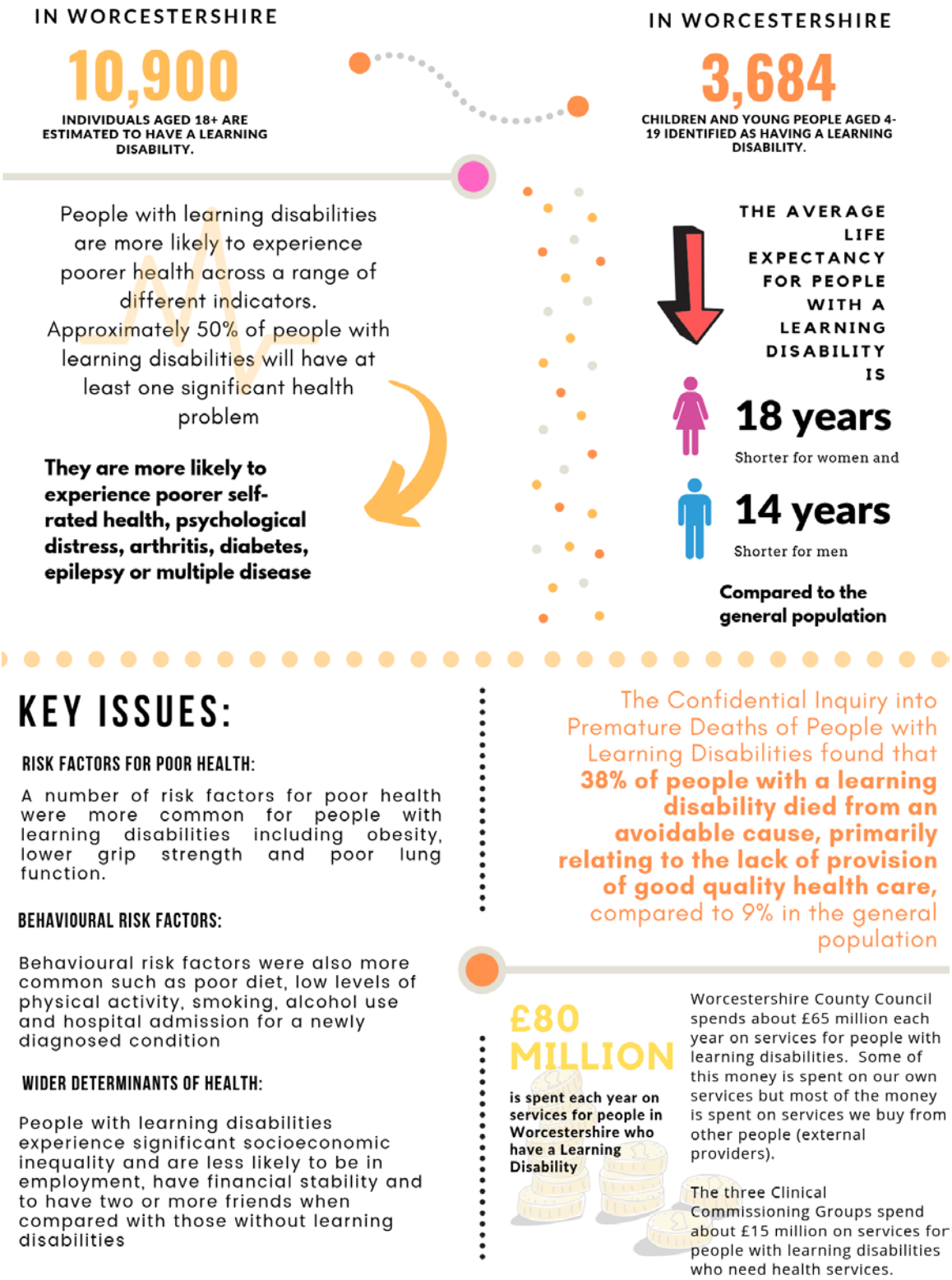
The latest LeDeR Annual Report identified that nationally the causes of death most frequently recorded were pneumonia (25%), aspiration pneumonia (16%) and sepsis (7%). These are all conditions which are potentially treatable if caught in time.

A particular concern raised by the report was the identification of diagnostic over-shadowing - misreading symptoms of illness as being due to a person having learning disabilities rather than a treatable medical condition. This can be symptomatic of a lack of understanding, or a disregard for people with learning disabilities; an attitude that devalues their lives, makes ill-founded assumptions about their quality of life, and perpetuates health and other inequalities. Unconscious bias remains in the provision of care for people with learning disabilities. For example, some people had their cause of death recorded as 'learning disabilities' and others had the rationale for a Do Not Attempt Cardiopulmonary Resuscitation (DNA CPR) order as being 'learning disabilities' or an associate condition.

Learning Disability Briefings can be found on the JSNA website.[40]

[40] Available at: http://www.worcestershire.gov.uk/info/20122/joint_strategic_needs_assessment/1473/jsna_publications_by_category

Figure 22. Learning Disabilities in Worcestershire: Key Facts



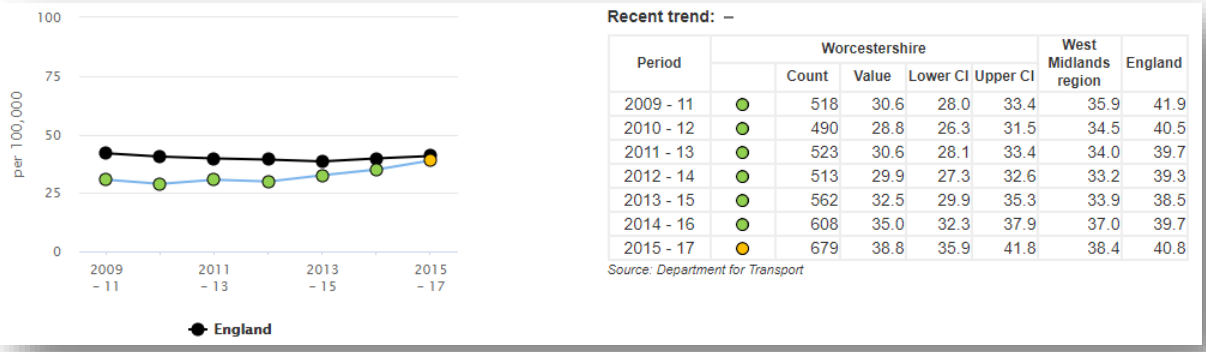
Data sources: 2019 Briefing on Health and Care of People with Learning Disabilities, 2018 Briefing on Learning Disabilities, Worcestershire County Council JSNA http://www.worcestershire.gov.uk/info/20122/joint_strategic_needs_assessment
Graphic created by Public Health Team using Canva

NHS Wyre Forest Clinical Commissioning Group
NHS Redditch and Bromsgrove Clinical Commissioning Group
NHS South Worcestershire Clinical Commissioning Group

Killed or Seriously Injured on the Roads

Since 2012 the rate of people Killed or Seriously Injured (KSI) on Worcestershire roads has gradually increased and is now similar to England. If the increasing trend continues the rate may become worse than the England average.

Figure 23. Killed or Seriously Injured (KSI) on Roads – Worcestershire, Rate Per 100,000



Recent trend: –

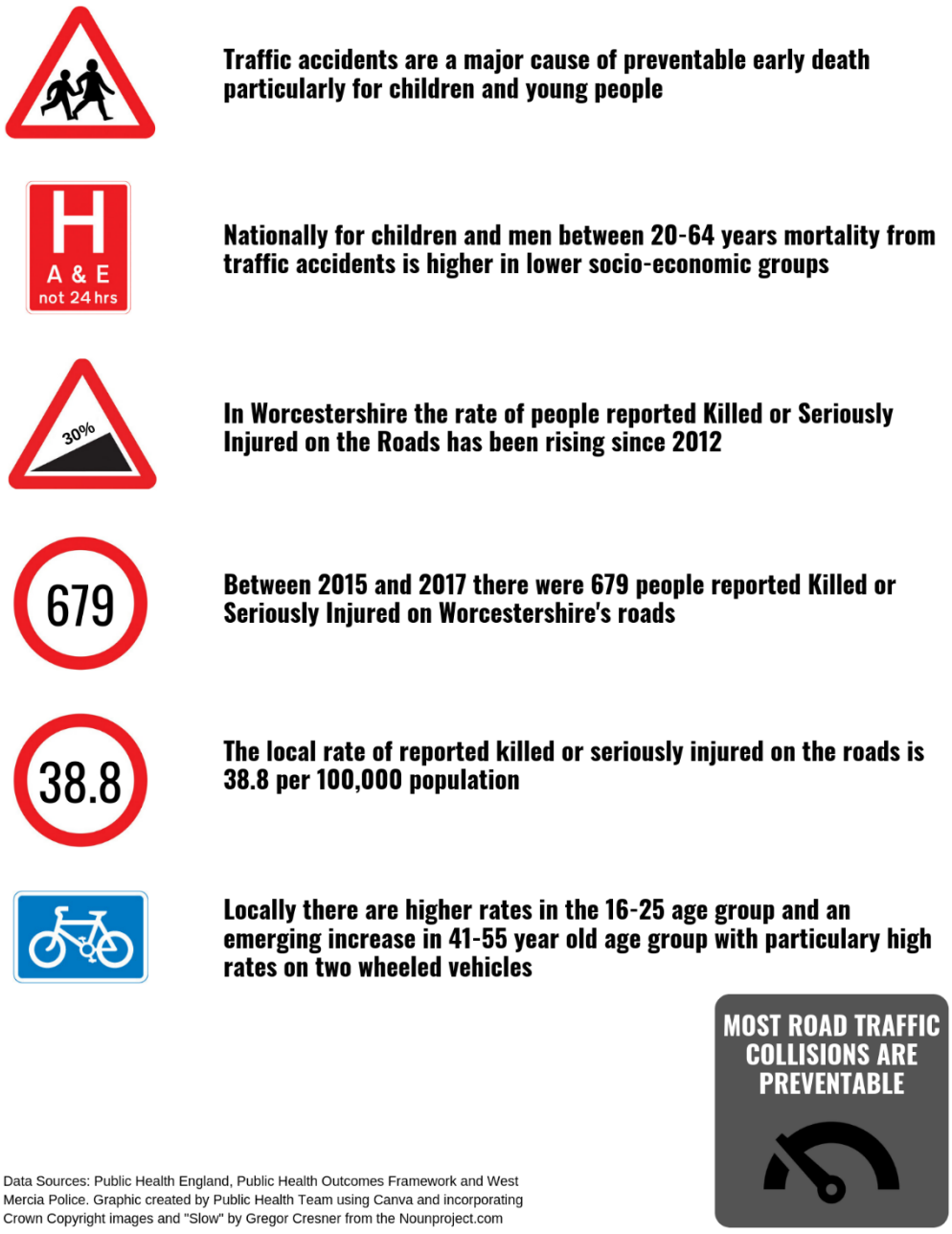
Period		Worcestershire Count	Value	Lower CI	Upper CI	West Midlands region	England
2009 - 11		518	30.6	28.0	33.4	35.9	41.9
2010 - 12		490	28.8	26.3	31.5	34.5	40.5
2011 - 13		523	30.6	28.1	33.4	34.0	39.7
2012 - 14		513	29.9	27.3	32.6	33.2	39.3
2013 - 15		562	32.5	29.9	35.3	33.9	38.5
2014 - 16		608	35.0	32.3	37.9	37.0	39.7
2015 - 17		679	38.8	35.9	41.8	38.4	40.8

Source: Department for Transport

Source: Public Health England, Public Health Outcomes Framework, 19/06/19 (Data: Department for Transport). Key: Green= better than the England rate, Yellow=similar to the England rate.

Road traffic collisions can be avoided through improved education, awareness, road infrastructure, traffic law enforcement and vehicle safety.

Figure 24. Killed or Seriously Injured on the Roads: Key Facts



Emergency Hospital Re-admissions within 30 Days[41]

Figure 25. Emergency Hospital Re-admissions: Key Facts

NHS Digital publish statistics on emergency re-admissions within 30 days of discharge from hospital. These are available by Clinical Commissioning Group (CCG).

The indicator will be reported annually and is a percentage adjusted by various factors to allow comparisons to be made between CCGs.

Nationally, the rate of emergency re-admissions has been increasing. This trend has also been seen locally and all Worcestershire Clinical Commissioning Groups (CCGs) have seen a significant increase in emergency re-admissions since 2013.

This indicator requires careful interpretation and should be considered alongside information from other indicators and alternative sources such as patient feedback, staff surveys and similar material.

Graphic created by the Public Health Team using Canva. Images from the nounproject.com: "Repeat" by Puput Nugroho, "Increase" by Vectorstall, "Emergency" by Logan and "Investigation" Adrien Coquet

Table 7. Percentage Emergency Re-admissions within 30 Days of Discharge (Indicator 3.2)

Period	England	Redditch and Bromsgrove CCG	South Worcestershire CCG	Wyre Forest CCG
2013/14	12.5	11.3 (10.8-11.8)	11.6 (11.2-12.0)	11.1 (10.5-11.8)
2014/15	12.8	11.9 (11.5-12.5)	12.1 (11.7-12.5)	10.6 (10.0-11.3)
2015/16	13.2	13.3 (12.8-13.8)	12.4 (12.0-12.8)	12.2 (11.5-12.9)
2016/17	13.3	14.1 (13.5-14.6)	13.0 (12.5-13.4)	12.7 (12.0-13.4)
2017/18	13.8	14.1 (13.6-14.7)	13.1 (12.7-13.5)	12.8 (12.1-13.5)

Source: NHS Digital[42]

Further work to understand these figures is needed.

[42] https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework/current/domain-3-helping-people-to-recover-from-episodes-of-ill-health-or-following-injury-nof/3b-emergency-readmissions-within-30-days-of-discharge-from-hospital

Care of Adults

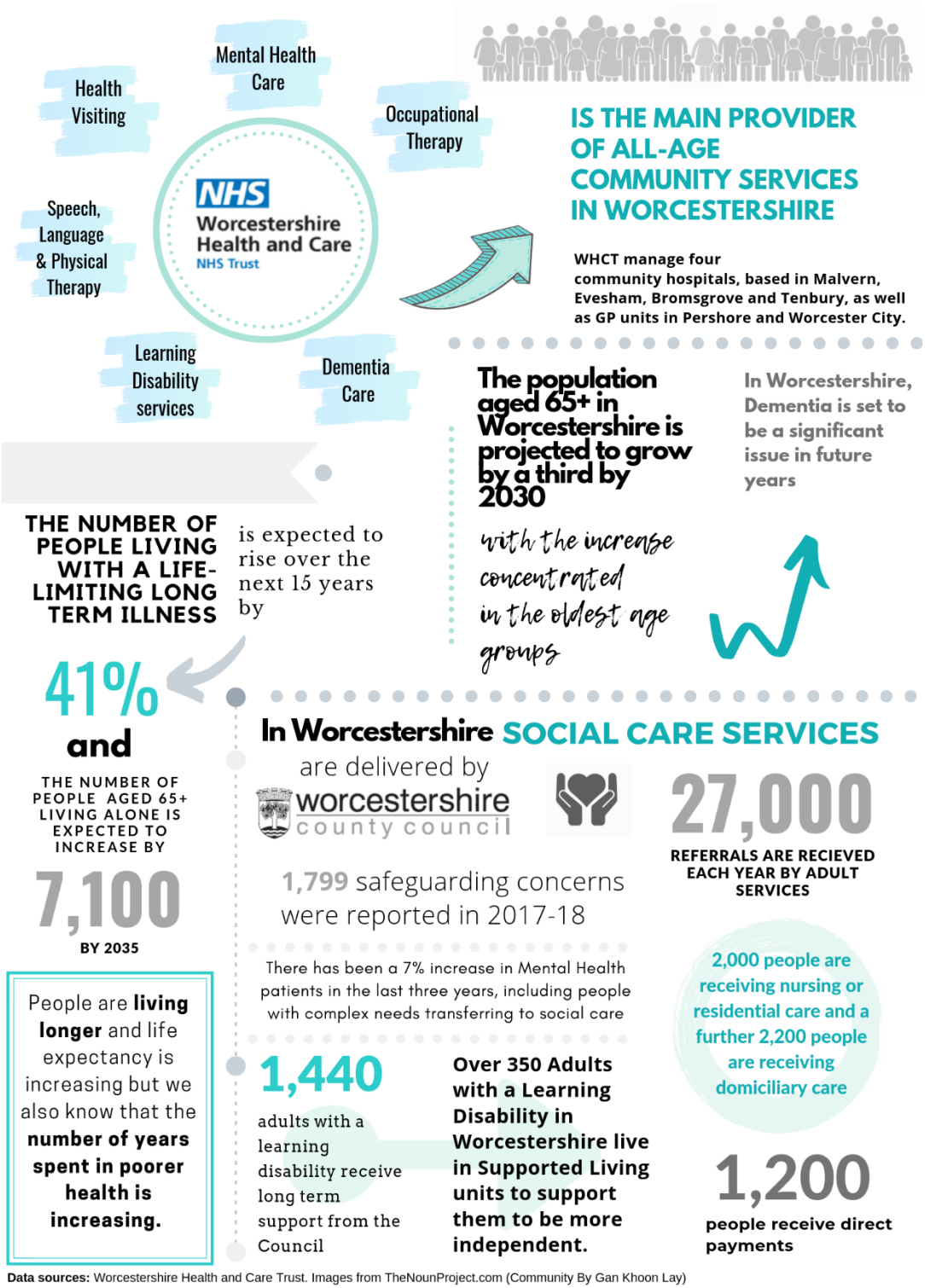
Worcestershire Health and Care Trust (WHCT) is the main provider of all-age community services. These include health visiting, speech and language and physical and mental health care for children and young people. The trust provides a range of services for adults and older people, including occupational therapy, physiotherapy, dementia care and learning disability services. WHCT manage four community hospitals, based in Malvern, Evesham, Bromsgrove and Tenbury, as well as GP units in Pershore and Worcester City. WHCT employs around 4,000 staff and is rated 'Good' by the Care Quality Commission.

The recent development of integrated neighbourhood teams is aligned with the implementation of the Adult Social Care 'Three Conversation Model' and adult Social Care continues to work closely with all partners in the ongoing development of the Sustainability and Transformation Programme (STP) for Herefordshire and Worcestershire.

Worcestershire County Council supports carers through the commissioning and provision of overnight short break services and has invested, with health, £1.87m to the Carers' Hub. The Carer's Hub is delivered by Worcestershire Association of Carers, who recorded 12,500 carers in the County during 2017/18.

There has been an approximate 7% growth in Mental Health patients over the last three years. This includes people with complex needs transferring to social care.

Figure 26 Care of Adults in Worcestershire: Key Facts



Data sources: Worcestershire Health and Care Trust. Images from TheNounProject.com (Community By Gan Khoon Lay)
Graphic created by Public Health Team using Canva

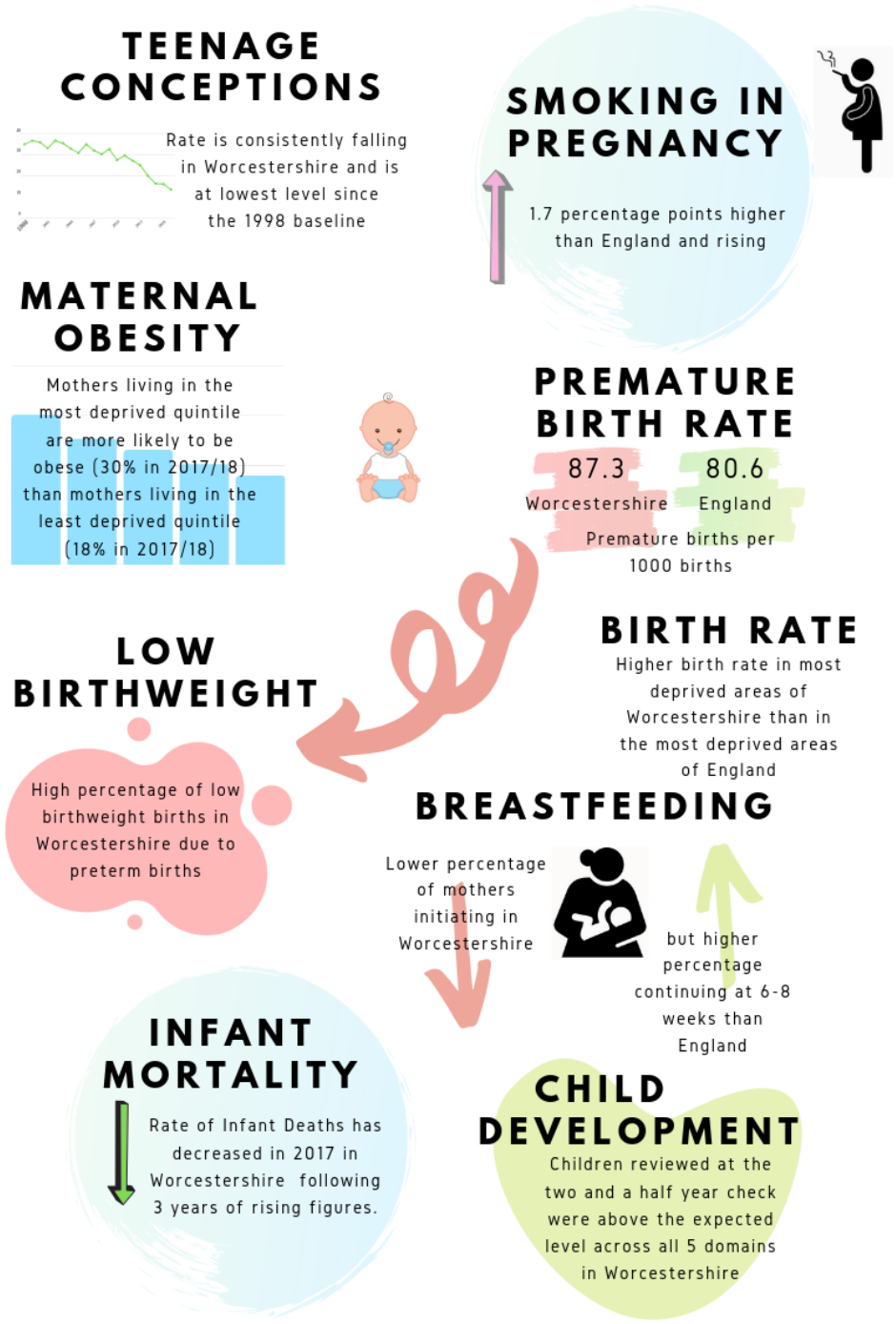
NHS Wyre Forest Clinical Commissioning Group

NHS Redditch and Bromsgrove Clinical Commissioning Group

NHS South Worcestershire Clinical Commissioning Group

Starting Out: Mothers, Babies, Children, Young People, Early Help and Prevention

Figure 27. Starting Out in Worcestershire: Key Facts

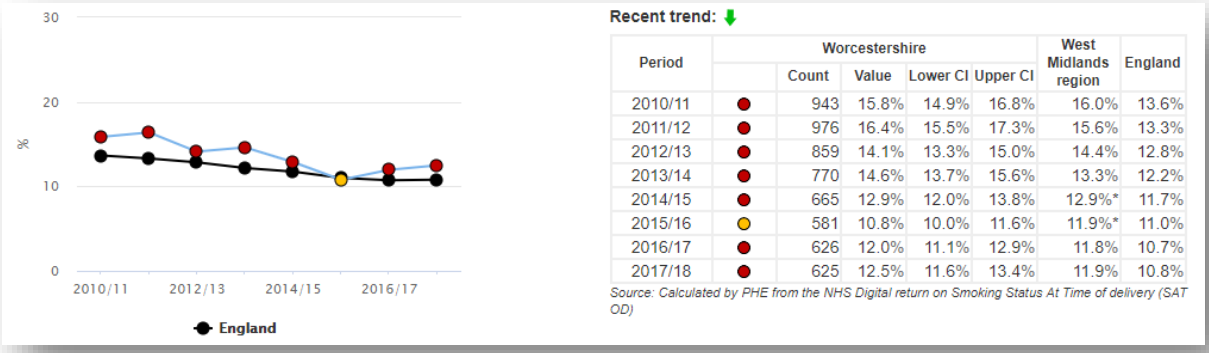


Created with Canva by the Public Health Team, images courtesy of the Noun Project (Pregnant Woman Smoking by Gan Khoon Lay, Breastfeeding by Luis Prado)

Smoking in Pregnancy

Smoking is still the single biggest identifiable risk factor for poor birth outcomes. Figure 28 shows the proportion of mothers smoking at the time of delivery. Until 2015/16 there had been a downwards trend for Worcestershire, in line with the national picture, however, since then the rate has started to increase again. In 2017/18, the percentage of mothers who are smoking at the time of delivery is higher than England at 12.5% (625 women). This overall rate hides local variation. When split by district, five out of the six districts have similar percentages, between 11.5% and 11.9%. These rates are slightly higher than the England average but only Wyre Forest has a rate that is consistently significantly higher than the national average at 15.6% (160 women).

Figure 28: Smoking Status at Time of Delivery - Worcestershire



Recent trend: ⬇

Period		Worcestershire Count	Value	Lower CI	Upper CI	West Midlands region	England
2010/11	●	943	15.8%	14.9%	16.8%	16.0%	13.6%
2011/12	●	976	16.4%	15.5%	17.3%	15.6%	13.3%
2012/13	●	859	14.1%	13.3%	15.0%	14.4%	12.8%
2013/14	●	770	14.6%	13.7%	15.6%	13.3%	12.2%
2014/15	●	665	12.9%	12.0%	13.8%	12.9%*	11.7%
2015/16	●	581	10.8%	10.0%	11.6%	11.9%*	11.0%
2016/17	●	626	12.0%	11.1%	12.9%	11.8%	10.7%
2017/18	●	625	12.5%	11.6%	13.4%	11.9%	10.8%

Source: Calculated by PHE from the NHS Digital return on Smoking Status At Time of delivery (SATOD)

Source: Public Health England, Fingertips, Local Tobacco Profiles

Provisional analysis of 2018/19 indicates that the rate has risen once again across Worcestershire and is likely to be over 13%.

The Tobacco Control Plan for England includes a target to reduce the prevalence of smoking in pregnancy in England to 6% or less by 2022.

Smoking in pregnancy was also highlighted in the Chief Medical Officers Annual Report of 2018 which has resulted in a recommendation that NHS England and Local Authorities commit to halving existing inequalities in smoking in pregnancy by geography by 2024.

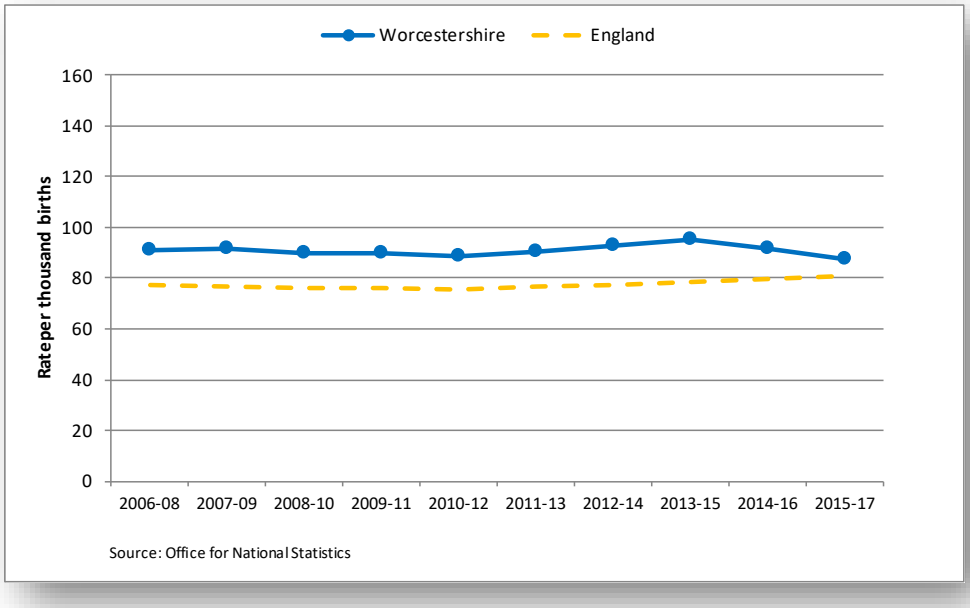
In order to try and achieve these ambitious targets locally Public Health have been working closely with the Local Maternity System (LMS) and Worcestershire Acute Hospitals Trust (WAHT) who are committed to lowering smoking in pregnancy rates, both at booking and time of delivery. A Sustainability and Transformation Partnership (STP)-wide workstream is focussed on implementing a system-wide approach to review current pathways and systems to improve outcomes for pregnant women. In 2019 WAHT will be piloting the use of public health Maternity Support Workers (MSWs) to proactively provide face-to-face smoking cessation support and pharmacotherapy for pregnant women and members of their household. The face-to-face, midwifery-based service will be working closely with the

existing telephone support service, to offer choice and a greater level of joined up support for pregnant smokers.

Premature Births

Globally premature birth is the leading cause of death for children under the age of five. There are greater health risks for premature births and the earlier the birth the greater the risk. Worcestershire has historically had a higher premature birth rate than England (Figure 29). Preventing deaths and complications from pre-term birth starts with a healthy pregnancy, healthy diet and optimal nutrition. There is substantial evidence that smoking in pregnancy can lead to premature births.

Figure 29: Premature Birth Rate - Worcestershire[43]



Following a number of years of high rates in Worcestershire, a local audit of premature births was carried out in 2018 in conjunction with the local acute trust. Findings are currently being analysed and have been passed back to the Acute Trust for their comments.

Low Birthweight

Low birthweight is an important public health measure as it indicates whether the baby was able to grow as expected while in the womb. Being born at low birthweight is an

[43] Definition: Number of births at less than 37 weeks gestation per 1,000 total births.

important marker along the trajectory of early child development, indicating an increased risk of poor health outcomes from birth onwards.

The percentage of all births in Worcestershire with a recorded birth weight under 2,500g has consistently been higher than the national average. However, this figure includes premature births - which are likely dominating the statistics. If we look at another indicator for low birthweight, low birthweight at full-term of pregnancy, this interpretation is further strengthened as Worcestershire has consistently had a lower percentage than England.

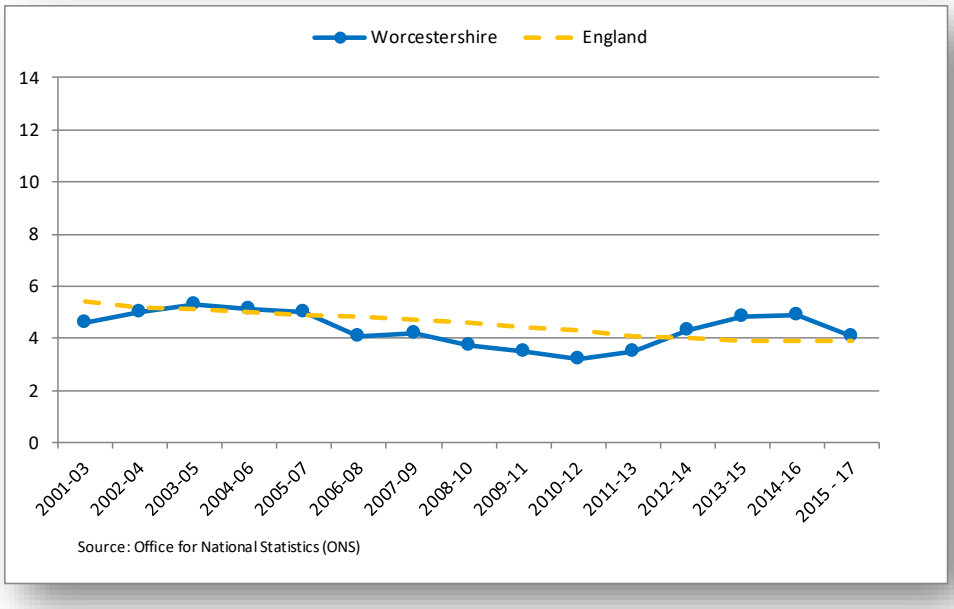
Infant Mortality

Infant mortality covers all deaths within the first year of life. The majority of these are neonatal deaths which occur during the first month and the main cause is related to prematurity and pre-term birth, followed closely by congenital abnormalities. Nationally and in Worcestershire, the number of infants who die is relatively small and subject to considerable variation from year to year. As a result, the data are often considered on a three-year rolling average basis.

The infant mortality rate in Worcestershire increased during the period 2012 to 2016 and became, for the first time, statistically significantly higher than the England average for the period 2014 to 2016. This was in contrast to the national decrease during the same period. The rate has since decreased for the period 2015 to 2017 and is now similar again to the England average. Caution should be applied when interpreting these figures because numbers are small.

The infant mortality rate in Worcestershire increased during the period 2012 to 2016 and became, for the first time, statistically significantly higher than the England average for the period 2014 to 2016. This was, in contrast to the national decrease during the same period. The rate has since decreased for the period 2015 to 2017 and is now similar again to the England average. Caution should be applied when interpreting these figures because numbers are small.

Figure 30. Infant Mortality Rate - Worcestershire[44]



Breastfeeding

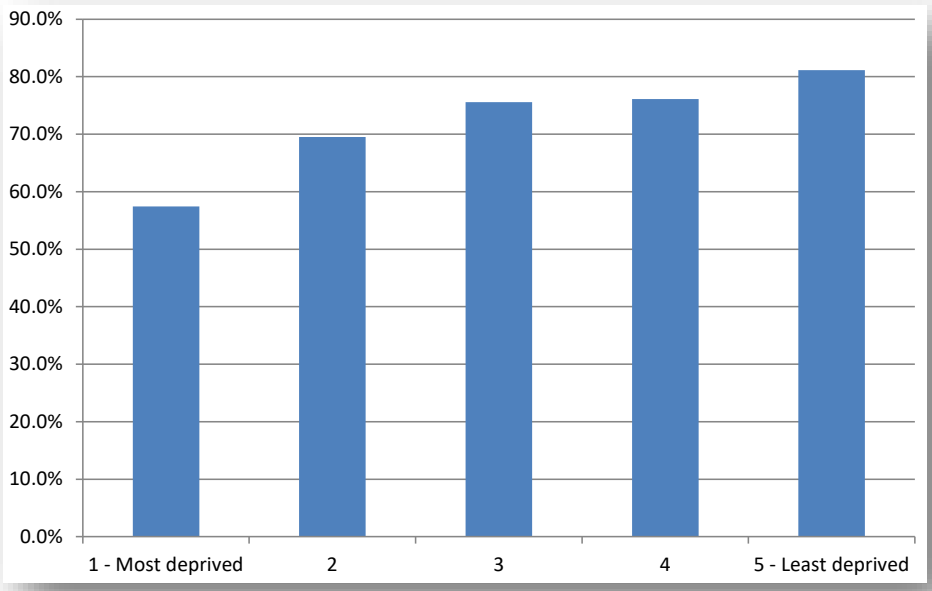
Breastfeeding provides the best possible nutritional start in life for a baby, protecting the baby from infection and offering important health benefits for the mother. The government's advice is that infants should be exclusively breastfed, receiving only breastmilk for the first 6 months of life.

In Worcestershire, breastfeeding initiation rates (breastfeeding within 48 hours of delivery) have been lower than the national average. However, locally the Trust has suggested that the figures submitted nationally are missing some records and that the true figures are higher.

Local analysis has shown that breastfeeding rates are lowest amongst younger mothers, mothers of white ethnicity and those living in more deprived localities. Breastfeeding initiation in Worcestershire is lowest in Wyre Forest and Redditch Districts. Figure 31 highlights the relationship of breastfeeding initiation rates to deprivation.

[44] Definition: Deaths under one year of age per 1,000 live births

Figure 31: Breastfeeding Initiation by IMD - Worcestershire (2017/18)



Source: NHS Digital/Maternity Dataset/Bespoke Public Health Analysis

The national definition of breastfeeding initiation for statistical purposes has recently changed and trusts are now monitored on a 'First Feed' definition. Currently trusts are struggling to provide the information to NHS Digital and consequently data is not very reliable. The Worcestershire figures that are available, are still looking on the low side. Encouraging mothers to continue breastfeeding exclusively until the child is 6 months old is a priority. In Worcestershire, once breastfeeding has started, maintenance rates are consistently good compared to national figures and the breastfeeding rate at 6-8 weeks has increased over the last 3 years. Encouragingly, there has also been an improvement on this measure for infants from more deprived areas.

Excess Weight in Childhood

In England, the height and weight of children in Reception and Year 6 is measured in school settings and the Body Mass Index (BMI) calculated via the National Child Measurement Programme (NCMP). In Worcestershire this is undertaken by the School Health Service. The results from the annual NCMP survey are used both nationally and locally to support the planning and delivery of services for children.

In Worcestershire, 22.4% of children in Reception year were classified as having excess weight in 2017/18. Encouragingly this is the lowest percentage since recording began back in 2007. These results whilst encouraging still mean that more than 1 in 5 children starting school are overweight. By year 6, the number with excess weight has risen to almost 1 in 3 children.

These overall numbers mask some real differences. In both age groups boys are more likely to be overweight than girls and children living in the most deprived areas of Worcestershire have higher rates of excess weight than those living in the least deprived areas. The gap between the most and least deprived areas increases with the age of the child.

Childhood Immunisation

Vaccination is one of the most important public health interventions because it stops people from becoming ill, stops spread of infection and ultimately saves lives. For a vaccination programme to be effective vaccination coverage (how many people have the vaccination) needs to be high, this is set at 95%. At a 95% coverage rate, transmission of disease is significantly reduced, which means less outbreaks of infection and also has the added benefit of protecting those who cannot be vaccinated, such as people undergoing treatment for cancer, the very young, or those who are immunocompromised, this is called herd immunity. Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Coverage is closely linked to levels of disease.

In England, the highest coverage rates were 2012-13, across the majority of childhood vaccinations, rates have been declining year on year, which is a concerning trend. In 2017-18, coverage declined in nine of the 12 routine vaccinations measured at ages 12 months, 24 months or five years in England compared to the previous year[45].In 2017-18, DTaP/IPV/Hib coverage at 12 months declined for the fifth year in a row, decreasing 1.6% since 2012-13 and is at its lowest since 2008-09. However, coverage at 24 months has remained above the 95% target since 2009-10[45]. Coverage for the Measles Mumps and Rubella (MMR) vaccine as measured at two years decreased in 2017-18 for the fourth year in a row. Coverage for this vaccine is now at 91.2%, the lowest it has been since 2011-12[45].There were 971 laboratory confirmed cases of measles during 2018, this is three times higher than 2017, where there were 259 cases[46]. Now is not a time for complacency, this summer in 2019, the U.K lost the measles elimination status, which had been held for three years due to falling vaccination rates and ongoing outbreaks.

Worcestershire has historically performed better than the England average for childhood immunisations. However, for the last two years, rates have been falling and they are below the 95% target coverage rate for many types.

The MMR coverage for the first dose (children 2 years and younger) has declined over the past 2 years in Worcestershire with current coverage of 92.4%, but remains significantly better than the England average.

The MMR coverage for the first dose (children 5 years and younger) has increased significantly since 2012/13, and has remained stable over the last 2 years with current coverage of 97.3%. This is significantly better than England and meets the coverage target of 95%.

[45] NHS Digital (2018) Childhood Vaccination Coverage Statistics- England 2017-18, [Online], Available from: https://digital.nhs.uk

[46] Public Health England (2019) Measles cases in England: January to December 2018, [Online] Available from: https://www.gov.uk/government/publications/measles-mumps-and-rubella-laboratory-confirmed-cases-in-england-2018/measles-cases-in-england-january-to-december-2018

The MMR coverage for 2 doses (children 5 years and younger) has increased significantly since 2012/13, and has remained stable over the last 2 years with current coverage of 92.2%. This is significantly better coverage than England.

There is also wide variation across GP practice areas. To take Measles, Mumps and Rubella (MMR) at first dose 2 years as an example across Worcestershire in 2017-18:

- A quarter (25.6%) of GP Practices in Worcestershire were below the England average (17 out of 66).
- The best performing practice had a 100% coverage rate and at the worst performing practice the rate was 76.3%.
- This means that for MMR at 2yrs (1st dose) 446 children are considered to be at risk because they have not been immunised.

Figure 32. Childhood Immunisation: Key Facts

VACCINATION SAVES LIVES AND PROMOTES GOOD HEALTH

Focus on.....

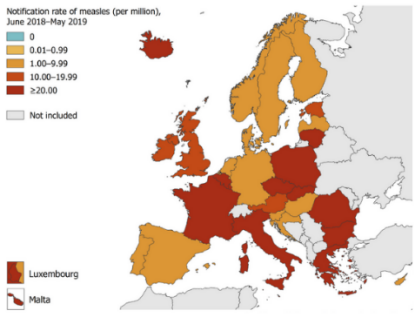
MEASLES

is a highly infectious disease which can only be controlled by vaccination.

Why does it matter?

01 **Vaccination Rates are Falling**

across the World, UK and Europe. This means that the virus is able to transmit more easily



Source: https://www.ecdc.europa.eu

02 **Falling vaccination rates have led to more outbreaks**

In the UK in 2018, there were 991 cases of measles. Compared to 284 in 2017.

03 **The MMR vaccination rate has fallen significantly in Worcestershire**

In England, the MMR vaccination is given in 2 doses - thefirst dose is given at 12-13 months, and the second dose is given at 3 yearsand 4 months.

First dose MMR at Age 2 has declined over the past 2 years in Worcestershire with current coverage of 92.4%, but remains significantly better than the England average.

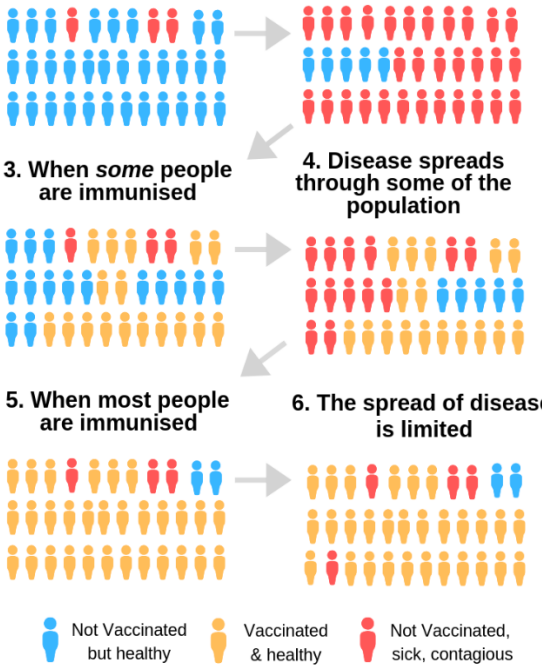
2nd dose MMR at Age 5 has increased significantly since 2012/13, and has remained stable over the last 2 years with current coverage of 92.2%. This is significantly better coverage than England.

After clean water. vaccination is the most effective public health intervention in the world.

Public Health England, 2018

How does vaccination work?

1. When *no one* is immunised
2. Disease spreads rapidly through the population
3. When *some* people are immunised
4. Disease spreads through some of the population
5. When most people are immunised
6. The spread of disease is limited



Not Vaccinated but healthy

Vaccinated & healthy

Not Vaccinated, sick, contagious

FOR A VACCINATION PROGRAMME TO BE EFFECTIVE THE UPTAKE RATE NEEDS TO BE

95%

at this level, protection is also provided for people who cannot be vaccinated

including babies or those with a weakened immune system, such as people undergoing cancer treatment.

This is called Herd Immunity

Data sources: Public Health Outcomes Framework, https://fingertips.phe.org.uk, COVER Immunisation Statistics, www.gov.uk, Herd Immunity Diagram adapted from https://medium.com/@gidmk/herd-immunity-is-pretty-cool-adbc52630f9f
Graphic created by Public Health Team using Canva

NHS Wyre Forest Clinical Commissioning Group

NHS Redditch and Bromsgrove Clinical Commissioning Group

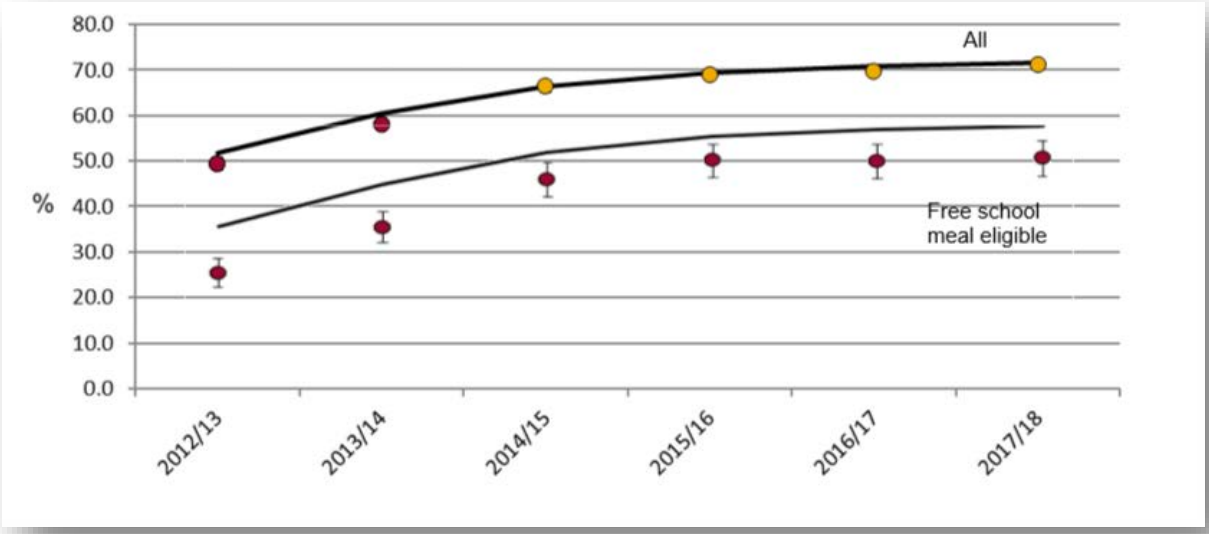
NHS South Worcestershire Clinical Commissioning Group

School Readiness

School readiness is a key measure of early years development across a wide range of developmental areas. Children from deprived backgrounds are more at risk of poorer development and the evidence shows that differences by social background emerge early in life.

The gap in school readiness between free school meal eligible children and other children continues to be an issue in Worcestershire and in Worcestershire this gap is persistently larger than the national gap. In 2017/18 the proportion of 4-5 year olds in Worcestershire who achieved a good level of development was 71.2% (similar to the national average). However, the proportion of 4-5 year-olds eligible for free school meals with a good level of development was significantly lower at 50.1%.

Figure 33. Children with Free School Meal Status Achieving a Good Level of Development at the End of Reception - Worcestershire[47]



Data Source: Public Health England

[47] Notes 1. District and county data is not official data but should be reasonably accurate. 2. Green is significantly better than England, red=significantly worse than England.

Table 8. Trends in the Percentage Point Gap in Children Achieving a Good Level of Development who are Free School Meal Eligible and all Children - England and Worcestershire

Year	Worcestershire	England
2012/13	22.8	15.5
2013/14	22.1	15.6
2014/15	20.8	15.1
2015/16	19.5	14.9
2016/17	20.4	14.7
2017/18	21.1	14.9

Source: Public Health England

Table 9 shows that Wyre Forest, Bromsgrove and Wychavon have the lowest percentage achieving a good level of development for free school meal eligible pupils, while all districts except Worcester have a bigger gap between non free school meal eligible and free school meal eligible children.

Table 9. Percentage with Good Level of Development by Free School Meal Eligibility - Worcestershire Districts (2017/18)

District	% GLD for those not eligible for FSM	% GLD for those eligible for FSM	Gap
Bromsgrove	75	49	26
Malvern Hills	79	53	26
Redditch	71	53	18
Worcester	70	57	13
Wychavon	76	51	25
Wyre Forest	73	41	32
Worcestershire	74	50	24
England	74	57	17

Source: Calculated from SFR data. England data calculated from Public Health England Health Profiles

Educational Outcomes

Key Stage 1 (KS1): Worcestershire has an equal or higher percentage of pupils reaching the expected standards for all four areas tested at KS1 level. This masks the poor performance of children eligible for free school meals who, in all areas, have considerably lower performance than the England averages for this cohort of children.

Key Stage 2 (KS2): All areas of Worcestershire, with the exception of Bromsgrove, had lower percentages than the national average of pupils who reached the expected standards in reading, writing and mathematics in KS2 in 2018. These percentages were even lower for children who are classed as disadvantaged or eligible for free school meals.

KS4 results (GCSEs): Across the general population in Worcestershire a higher percentage achieved a grade 4 or above in English and Mathematics GCSEs than the average across England. In the new grading system, students are graded 9 (highest) to 1 (lowest) where a grade 4 is equivalent to a 'C' in the previous scale. However, disappointingly we are still seeing disadvantaged children having poorer educational outcomes in Worcestershire when compared to the same cohort of children in England, although there has been an improvement since 2017

How Does Worcestershire Compare to England?

When looking at inequalities across a number of different pupil characteristics and each of the Key Stages, there is variation in comparison to the England average.

Worcestershire performs higher than the England average for KS1 writing, maths and science for pupils who English is not their first language and for children receiving Free School Meals achievement at KS4 is higher than the national average.

Children Looked After (CLA), Children in Need (CiN), Children with SEND support and those with an EHCP/Statement all performed lower than the national average.

Figure 34. Attainment at Each Key Stage by Pupil Characteristics for Worcestershire (2017-18)

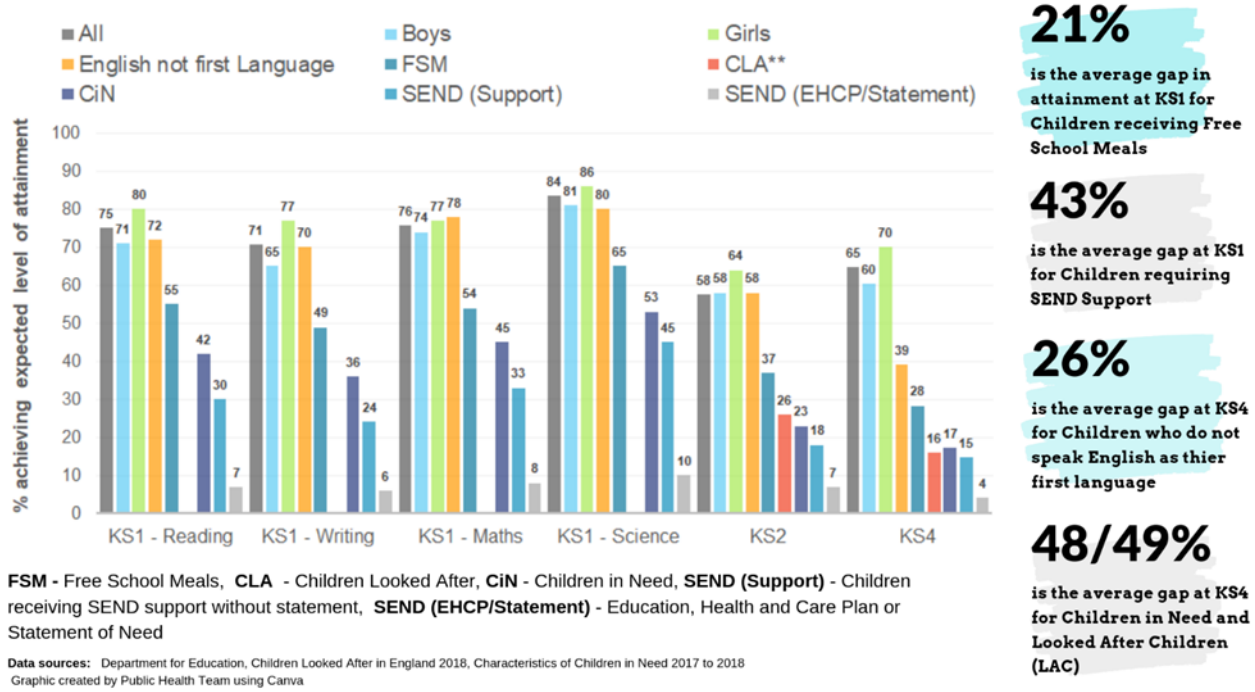
	KS1- Reading		KS1 Writing		KS1 Maths		KS1 - Science		KS2		KS4	
Pupil Characteristics	W	E	W	E	W	E	W	E	W	E	W	E
All	75	75	71	70	76	76	84	83	58	65	65	64
Boys	71	71	65	63	74	75	81	80	58	61	60	61
Girls	80	80	77	77	77	77	86	85	64	69	70	68
English not first Language	72	73	70	69	78	75	80	79	58	65	39	43
FSM	55	60	49	53	54	63	65	69	37	46	28	22
CLA**		51		42		49		58	26	35	16	18
CiN	42	48	36	41	45	49	53	57	23	34	17	19
SEND (Support)	30	33	24	25	33	36	45	46	18	24	15	17
SEND (EHCP/Statement)	7	13	6	9	8	13	10	15	7	9	4	5

Better than England
Worse than England

W = Worcestershire, E = England

Data sources: Department for Education, Schools Pupils and their Characteristics 2018, Children Looked After in England 2018, Characteristics of Children in Need 2017 to 2018

Figure 35. Attainment at Each Key Stage by Pupil Characteristics for Worcestershire (2017-18)



FSM - Free School Meals, **CLA** - Children Looked After, **CiN** - Children in Need, **SEND (Support)** - Children receiving SEND support without statement, **SEND (EHCP/Statement)** - Education, Health and Care Plan or Statement of Need

Data sources: Department for Education, Children Looked After in England 2018, Characteristics of Children in Need 2017 to 2018
Graphic created by Public Health Team using Canva

Gender: Gender differences in education are present at all stages of education, on average boys consistently perform lower compared to girls across all key stages. The difference in attainment gap between boys and girls in Worcestershire at KS1 was highest for reading (9%) and writing (12%), and lowest for science (3%) and mathematics (5%). Difference in attainment was lowest at KS2 (6%) and highest at KS4 (10%).

Ethnicity: Attainment gap at each of the Key Stages is variable across different ethnic groups. At KS1 reading and writing children of Asian, Mixed and Black ethnicity, perform higher than average. Children of Chinese ethnicity perform lower than average in reading (11%) and writing (7%). The attainment gap for Science and mathematics is much smaller at around 2-5% lower for children of mixed/black/Asian and Chinese ethnicity. At KS4 there are more pronounced differences with children of black ethnicity having a gap 23% lower than average and children of Chinese ethnicity having a gap 28% higher than average.

English Not First Language: "First Language" is the language to which a child was initially exposed during early development and continues to be exposed to in the home or in the community. In Worcestershire, children who do not have English as their first language, perform similar at KS1 and KS2, but at KS4 they have a gap that is lower by 26%

Free School Meals: Children from poorer backgrounds are more at risk of poorer development and the evidence shows that differences by social background emerge early in life. Although the gap is closing and improving each year there is still a difference of attainment gap when compared to the Worcestershire average around 21% at KS1 and 37% at KS4.

Children Looked After (CLA): The attainment gap between children in care and the Worcestershire average was 32% at KS2 and 49% at KS4. The reasons for this are complex but include, placement instability which has been strongly linked to school instability[48] and can be particularly disruptive to learning and achievement.

Children in Need: Nationally, one in ten pupils would have been a child in need at some point. The issues faced include, persistent absenteeism and more likely to be excluded. Children with more complex factors, such as those in need of social care services were 50% less likely to achieve a strong pass in English and Maths GCSEs[49]. The attainment gap between children in need and the average for Worcestershire was 48% at KS4.

SEND: (Support or EHC/Statement): In Worcestershire, children receiving SEND support without a statement of need, have an attainment gap at all key stages, for example

[48] Children's Commissioner (2018) Stability Index 2018 – Overview and Findings, [Online], Available from: https://www.childrenscommissioner.gov.uk/wp-content/uploads/2018/05/Childrens-Commissioners-2018-Stability-Index-Overview.pdf

[49] Department for Education (2019) Children in need of help and protection [Online], Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/809108/CIN_review_final_analysis_publication.pdf

KS1 (43%) and KS4 (50%) compared to the average. For children with a statement of need or EHC plan the gap is much wider, for example KS1 (69%) and KS4 (61%).

Special Educational Needs and Disabilities (SEND)[50]: In Worcestershire in 2018, there were a total of 13,450 (15.4%) children with a Special Educational Need and Disability. This was higher than the national average (14.6%). 10,959 were receiving SEN support and 2,491 had a statement of need or EHCP plan. The proportion of children in Primary School with a SEND was higher (14.7%) than England (13.8%). For all children with a SEND, Speech Language and Communication Needs were higher (43.0%) compared to the national average (29.8%).

Analysis of local data in 2017 identified that there appeared to be a strong relationship between SEND status and deprivation, with the highest levels in the most deprived areas. There appears to be a strong association with deprivation for the following SEND categories: Social, emotional and mental health difficulties, Speech, language and communication needs and Moderate learning difficulties.

Special Educational Needs and Disability (SEND) and Education, Health and Care Plans (EHCPs).

In Worcestershire, the proportion of children with no Special Educational Needs (SEN) support who achieved a good level of development by the end of reception was the same as the England average at 76%. For children in Worcestershire with SEN support this was 32% overall, nationally this was 28%. Data was not available for those children with a SEN statement or Education, Health and Care Plan (EHCP) plan.[51] However, we know that nationally this is around 4% for children who have a statement or EHCP plan.

[50] Further information can be found in the SEND Profile - Further information can be found in the SEND Profile - http://www.worcestershire.gov.uk/info/20122/joint_strategic_needs_assessment/1473/jsna_publications_by_category/2

[51] An education, health and care (EHC) plan is for children and young people aged up to 25 who need more support than is available through special educational needs support. EHC plans identify educational, health and social needs and set out the additional support to meet those needs.

Children Needing Social Care

The numbers of children who receive additional help or protection from Children's Social Care is continuing to rise. Numbers of children looked after (CLA) and those subject to child protection plans (CPP) have continued to increase. For the first time in a four-year period there has been a reduction in the number of children assessed as children in need (CIN).

Children in Care (Children Looked After)

Under the Children Act 1989, a child is looked after by a local authority if he or she falls into one of the following categories: is provided with accommodation for a continuous period of more than 24 hours, is subject to a care order, placement order or has one of a number of youth justice legal statuses.

- There has been an increase in the number of children in care in Worcestershire between 2017[52] (767) and 2018[53] (793).
- The rate of children in care has increased and since 2016 and since this time the rate has been higher than the England average.
- Worcestershire has a higher proportion of children in care with a Special Educational Need (59.9%) than England (55.5%).
- GCSE attainment for children in care in Worcestershire[54] (16.0%) is similar to the England average (13.8%), but there is a significant gap between this group of children and all children overall in Worcestershire where the proportion of young people achieving 5 GCSEs A*-C was 60.9%.

Children in Need

- In 2018, the rate per 10,000 children aged under 18 identified as being 'in need' following referral to social services in Worcestershire (535.4) was lower than the England rate (635.2).
- There were a higher proportion of children with a disability identified as being a child in need (17%; 561) compared to the England average (12.3%).
- Worcestershire has a higher proportion of cases that were open for two years or more (44%; 1,483) compared to the England average (31%). Worcestershire has a higher proportion of cases that were open for two years or more (44%; 1,483) compared to the England average (31%).

Child Protection

Worcestershire has a higher proportion of cases that were open for two years or more (44%; 1,483) compared to the England average (31%). Worcestershire has a higher proportion of cases that were open for two years or more (44%; 1,483) compared to the England average (31%). At an initial child protection conference, the decision will be made

[52] As at 31/03/2017
[53] As at 31/03/2018
[54] Definition of numerator: Number of children who have been looked after continuously for at least 12 months as at 31 March (excluding those children in respite care) at end of Key Stage 4 in schools maintained by the local education authority achieving 5 or more GCSEs at grades A* to C or equivalent, including English and maths GCSE.

as to whether the child needs to become the subject of a child protection plan. When a child becomes the subject of a plan, the initial category of abuse is recorded. There has been an decrease in the number of children who were subject to a child protection plan between 2017[52] (517) and 2018[53] (424). Worcestershire has a higher proportion of cases that were open for two years or more (44%; 1,483) compared to the England average (31%).

Worcestershire has a higher proportion of cases that were open for two years or more (44%; 1,483) compared to the England average (31%). Worcestershire has a higher proportion of cases that were open for two years or more (44%; 1,483) compared to the England average (31%). At an initial child protection conference, the decision will be made as to whether the child needs to become the subject of a child protection plan. When a child becomes the subject of a plan, the initial category of abuse is recorded. There has been a decrease in the number of children who were subject to a child protection plan between 2017 (517) and 2018 (424). Worcestershire has a higher proportion of cases that were open for two years or more (44%; 1,483) compared to the England average (31%).

Figure 36. Vulnerable Children in Worcestershire

	2018	%
Children Looked After*	793	0.7
On Child Protection Register*	682	0.6
Children in Need*	3386	2.9
Vulnerable Children (Other)	36984	31.4
Total vulnerable	**41845**	**35.5**
Total Children (0-17)	117783	

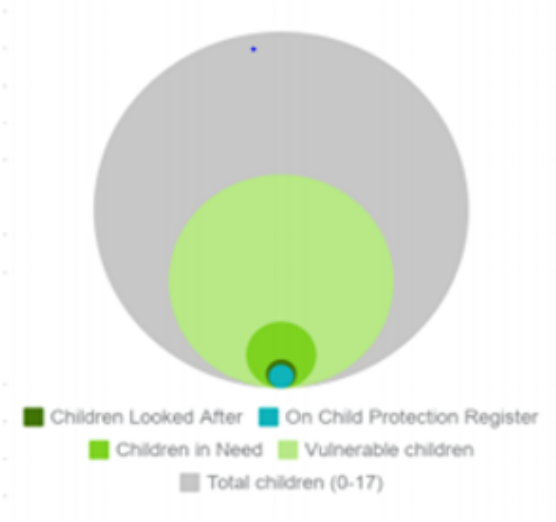
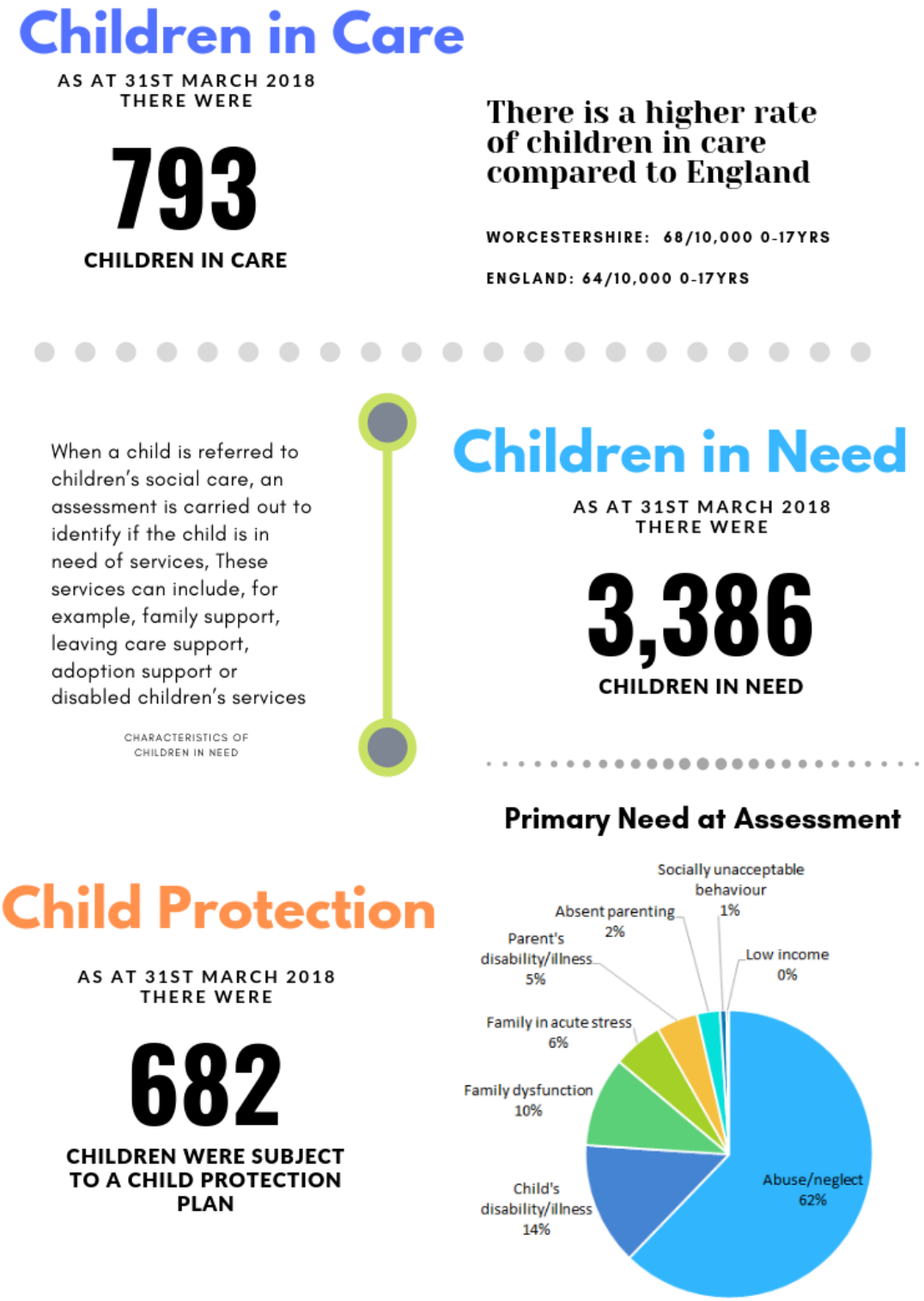


Figure 37. Children Needing Social Care: Key Facts



Data sources: Department for Education, Children Looked After in England 2018, Characteristics of Children in Need 2017 to 2018
Graphic created by Public Health Team using Canva

NHS Wyre Forest Clinical Commissioning Group
NHS Redditch and Bromsgrove Clinical Commissioning Group
NHS South Worcestershire Clinical Commissioning Group

Children's Oral Health

Tooth decay is the most common oral disease among children in England – affecting one in four children by the time they start school - and it is the most common reason for hospital admission for children aged 5 to 9 years old - yet it is largely preventable. The Government Green Paper, **'Advancing our Health: Prevention in the 2020s'**, states that "to give our children a good start in life, we need to do much better on oral health".

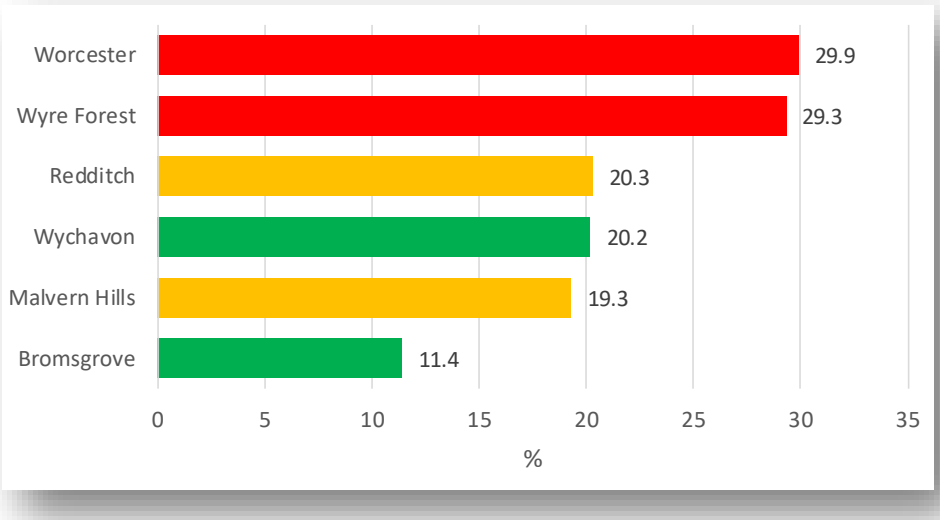
Overall, dental health for 5-year olds in Worcestershire is better than the national average. In 2016/17, 21.8% of 5-year olds in Worcestershire had evidence of tooth decay. This is statistically significantly lower than the England value of 23.3%.

The average number of decayed, missing or filled teeth (DMFT) was 0.62 in Worcestershire in 2016/17, significantly better than England (0.78).

However, inequalities within the county have become increasingly evident in recent years. There are differences in oral health across the county by Council District, with Worcester City and Wyre Forest emerging as having poorer oral health for children and the best area for child oral health being Bromsgrove district. In Worcestershire one in five children enter school with evidence of tooth decay.

The chart below highlights dental decay in 5-year olds in Worcestershire districts in 2016/17. The percentage of 5-year olds with any dental decay varies by district, and the two worst areas, Worcester and Wyre Forest, have seen increases between 2014/15 – 2016/17 (from 27.3% to 29.9%, and 23.6% to 29.3% respectively).

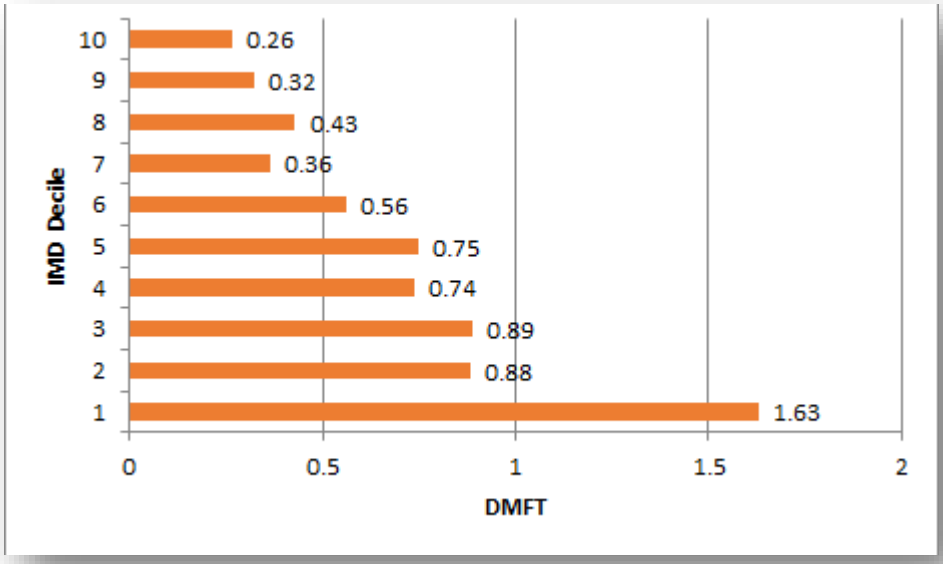
Figure 38. Percentage of Five-Year Olds With any Dental Decay (2016/17)



Source: Dental Public Health Epidemiology Programme for England: oral health survey of five-year-old children 2017

Part of the variation observed between districts is due to differences in deprivation levels. There is a clear relationship between child oral health and deprivation. Figure 39 shows that the average number of decayed missing and filled teeth per child varies considerably by deprivation of residence. The average in decile 1 (the most deprived decile) is nearly double that in decile 2, while for the remaining deciles the variation is less marked, but still present.

Figure 39: Average Number of Decayed Missing and Filled Teeth per Child by Deprivation Decile – Worcestershire (2016/17)



Source: Dental Public Health Epidemiology Programme for England: oral health survey of five-year-old children 2017 Notes: IMD deciles refer to the deprivation rank of the area of residence, IMD1 refers to areas in the 10% most deprived nationally, IMD10 refers to the 10% least deprived. DMFT=decayed, missing and filled teeth

A number of actions are underway to tackle poor oral health in children in Worcestershire including:

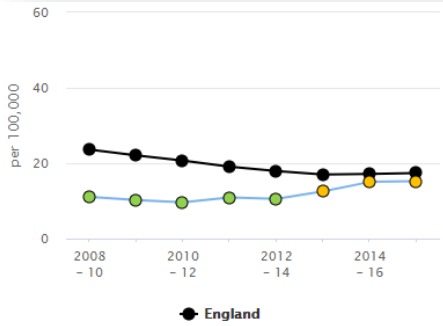
Several actions are underway to tackle poor oral health in children in Worcestershire including:

- A supervised tooth brushing scheme and provision of toothbrushes and toothpaste in Worcester City, an area with high levels of tooth decay.
- Support to NHSE and PHE oral health campaigns, for example ‘A little trip to the dentist’, which encourages parents to take their babies to the dentist even before their first teeth appear, in order to familiarise them with the surgery.
- Promotion of good oral health through social media and other channels.
- Review of the Community Dental Service.

Children Killed or Seriously Injured on the Roads

The rate of Killed or Seriously Injured (KSI) on the roads in children is similar to England. Historically, in Worcestershire this rate has been better than the national average but since 2008 the national rate has fallen whilst the local rate has not.

Figure 40. Children (0-15) Killed or Seriously Injured (KSI) on the Roads, Crude Rate per 100,000 Population



Recent trend: –

Period		Worcestershire Count	Value	Lower CI	Upper CI	West Midlands region	England
2008 - 10		36	11.1	7.8	15.3	23.2	23.6
2009 - 11		31	10.2	7.0	14.5	22.5	22.1
2010 - 12		29	9.6	6.4	13.8	22.2	20.7
2011 - 13		33	10.9	7.5	15.3	21.0	19.1
2012 - 14		32	10.6	7.2	14.9	19.4	17.9
2013 - 15		38	12.5	8.8	17.2	18.6	17.0
2014 - 16		46	15.0	11.0	20.1	19.1	17.1
2015 - 17		47	15.2	11.2	20.2	19.6	17.4

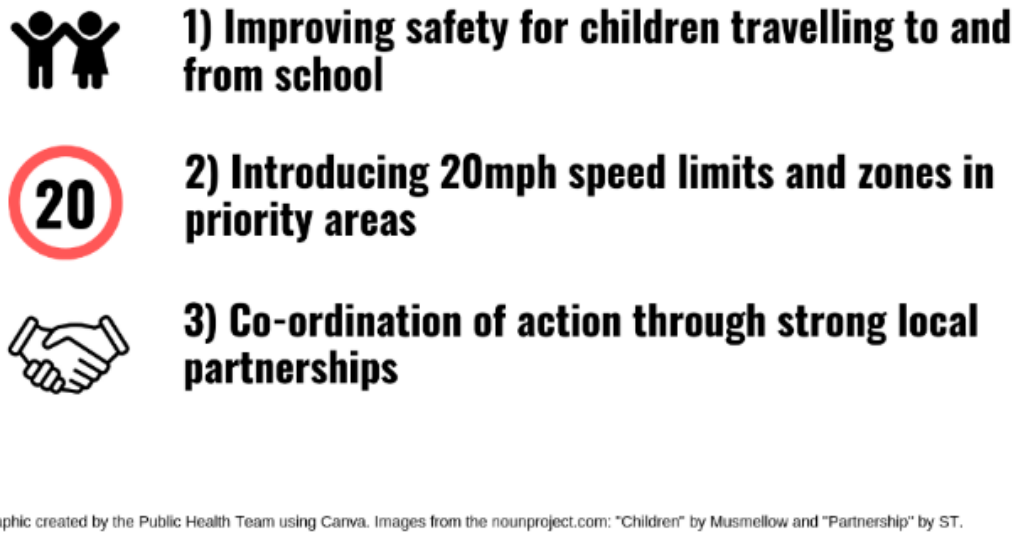
Source: Department for Transport (DfT), Road accidents and safety statistics.

Source: Public Health England, Public Health Outcomes Framework, 19/06/19. Data source Department for Transport (National Statistics). Green= better than the England rate, Yellow=similar to the England rate.

Public Health England in partnership with ROSPA and the Child Accident Prevention Trust (CAPT) have produced guidance on reducing unintentional injuries on the roads among children and young people under 25 years.[55] Priority actions from this guidance are summarised in Figure 41.

[55] Public Health England, ROSPA and Child Accident Prevention Trust (2018). Reducing unintentional injuries on the roads among children and young people under 25 years. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/695781/Reducing_unintentional_injuries_on_the_roads_among_children_and_young_people_.pdf

Figure 41. Priority Actions for Reducing Injuries on the Roads for Children and Young People.



Not in Education, Employment or Training (NEET)

Young people who are not in education, employment or training are at greater risk of a range of negative outcomes, including poor health, depression or early parenthood. The Government recognises that increasing the participation of young people in learning and employment not only makes a lasting difference to individual lives but is also central to the Government's ambitions to improve social mobility and stimulate economic growth.[56]

Worcestershire has a significantly lower proportion of young people who are Not in Education, Employment or Training (NEET). Between 2016 and 2017 there was an increase from 4.7% to 5.1%. This means there were 30 more young people who were NEET. This contrasts with Worcestershire's three most similar local authorities: Warwickshire, Gloucestershire and Suffolk, who all saw numbers of NEET reduce during this period.

These figures mask inequalities, however, with 45% of care leavers in Worcestershire who were Not in Education, Employment or Training (NEET) in 2017 compared to 5.1% of the overall population. This is a worse percentage than both England as a whole and our statistical neighbours. Only 4% of care leavers entered higher education by the age of 19 compared to 39% of the general population.

These figures mask inequalities, however, with 45% of care leavers in Worcestershire who were Not in Education, Employment or Training (NEET) in 2017 compared to 5.1% of the overall population. This is a worse percentage than both England as a whole and our statistical neighbours. Only 4% of care leavers entered higher education by the age of 19 compared to 39% of the general population.

Mental Health of Children and Young People[57]

Nationally it is estimated that 50% of those with a lifetime mental illness will experience symptoms by the age of 14 and 75% will experience symptoms by the age of 24. Around 10% of children aged 5-16 suffer from a clinically significant mental health illness and just 25% of children who need treatment, go on to receive it.

There are differences by gender, boys aged 11-15 are 1.3 times more likely to have a mental illness compared to girls aged 11-15 years.

In a national report, Mental Health of Children and Young People in England (2017) it is estimated that in the UK:

- Around one in eight (12.8%) children and young people had a diagnosable mental health disorder.
- The prevalence for Emotional Disorders was 5.8% for children aged 5-15 years, this increased significantly for ages 17-19 where around one in four girls (22.4%) had an emotional disorder, of this proportion, around half had also self-harmed.

[56] Public Health England (2019) Indicator Definitions and Supporting Information: 16-17 year olds not in education, employment or training, [Online] Available from: https://fingertips.phe.org.uk Indicator No: 93203
[57] Worcestershire County Council (2018) Early Help Needs Assessment, [Online], Available from: http://www.worcestershire.gov.uk/info/20122/joint_strategic_needs_assessment/1473/jsna_publications_by_category/2

- Around 1 in 20 young people had self-harmed (5.5%). Rates of self-harm were over twice as high in girls in comparison to boys (7.3% compared to 3.6%). Increasing to around one in five in girls aged 17-19 (21.5%) and one in ten for boys aged 17-19 (9.7%).
- Around one in three (34%) children with an emotional disorder had ever self-harmed or attempted suicide.
- Mental health disorders were found to be associated with low income, parental mental health, adverse life events, lower levels of social support and participation and less healthy family functioning.
- An association was found between daily social media use and having a mental health disorder. Those with a disorder were more likely to use social media on a daily basis and for longer periods of time, compared to those without.
- In the last year one in five children and young people aged 11 to 19 had been bullied online in the past year, rates were higher in girls (25.8%) in comparison to boys (16.7%) and those young people with a mental disorder were twice as likely to have experienced this as those without a disorder.

Young People and Homelessness

Homelessness has a serious impact on both the young people affected and the wider society. Young people describe their lives as being 'on hold' while they are homeless, making it much harder for them to achieve their goals and ensure their own well-being. Homeless young people are much more likely to be not in education, employment or training. Homeless young people often experience a disrupted education. Poverty and desperation mean some homeless young people turn to crime, which further decreases the chances of them finding work and escaping their situation. Homeless young people are also more likely to be victims of crime, as their situation puts them at risk of exploitation, particularly if they become homeless at a very young age. The often chaotic and unstable lives of homeless young people mean that poor physical and mental health is common, as is substance misuse (Centrepoint)[58].

Young people can become homeless when parents/relatives are no longer willing to accommodate them. Another key reason involves the person living in a hostel or sleeping rough. In Worcestershire there were 170 young people aged 16-24 who were accepted as homeless in 2017-18. The rate in Worcestershire is higher than the England average (0.68 compared to 0.52 per 1,000 households). A full profile on homelessness in Worcestershire was produced by the Public Health Team.[59]

[58] Public Health England (2018) Indicator Definitions and Supporting Information: Homeless Young People aged 16-24, Available from: fingertips.phe.org.uk
[59] Available here: http://www.worcestershire.gov.uk/info/20122/joint_strategic_needs_assessment

Young Offenders

Children and young people at risk of offending or within the youth justice system often have greater mental health needs than other young persons.[60] In Worcestershire there were a total of 146 young people aged 10-17 who were a first-time entrants into the Youth Justice System in 2018. The rate of young people entering the Youth Justice System for the first time is higher in Worcestershire (284.8 per 100,000) when compared to England (238.5 per 100,000) but there has been a downward trend year-on-year since 2015.

Under 18 Alcohol Related Hospital Admissions

Nationally, consumption rates of alcohol are falling in the 16-24 age group and of all the age groups they are the least likely to drink alcohol, however, when they do, they are more likely to drink to excess compared to other age groups.

In Worcestershire the rate of Alcohol Specific Hospital Admissions for under 18s is similar to the England average (31.9 vs 32.9 per 100,000). After a period of falling rates year-on-year since 2006-7 rates have remained relatively static over the last two periods.

Self-Harm

In England, hospital admissions for self-harm in children have increased in recent years, with admissions for young women being much higher than admissions for young men. With links to other mental health conditions such as depression, the emotional causes of self-harm may require psychological assessment and treatment.[61]

In Worcestershire, the rate of admissions for self-harm for children and young people aged 10-24 years in 2017-18 was lower (344.1 DSR per 100,000 population) than the England average (421.2 DSR per 100,000 population) and this has been the case for the last two financial years.

[60] Public Health England (2018) Indicator Definitions and Supporting Information: First time entrants to the Youth Justice System Available from: fingertips.phe.org.uk

[61] Public Health England (2018) Indicator Definitions and Supporting Information: Hospital admissions as a result of self-harm (10-24 years), Available from: fingertips.phe.org.uk

Being Well: Health of Adults

Physical Activity

Regular physical activity has many health benefits - it can reduce the risk of a range of conditions (Table 10).[62]

Table 10. Health Benefits of Regular Physical Activity

Disease Risk	Risk Reduction
Hip fractures	68%
Type 2 diabetes	40%
Cardiovascular diseases	35%
All-cause mortality	30%
Colon cancer	30%
Depression	30%
Dementia	30%
Breast cancer	20%

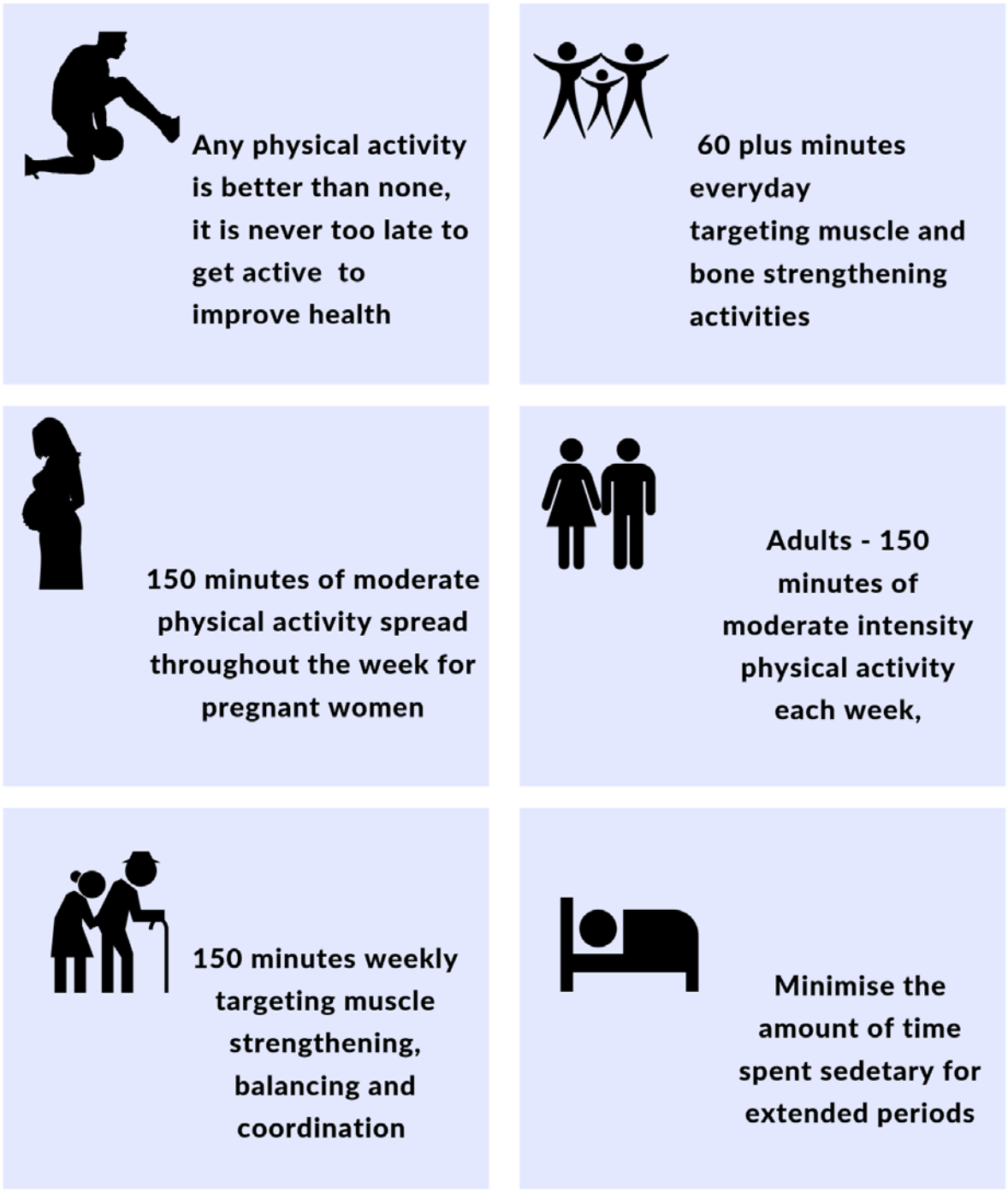
Source: Public Health England

Currently 66.6% of adults in Worcestershire are estimated to be physically active.[63] This is similar to the England average.

[62] Physical Activity: Applying all our health-https://www.gov.uk/government/publications/physical-activity-applying-all-our-health/physical-activity-applying-all-our-health

[63] From Sport England's Active Lives Survey. The number of respondents aged 19 and over, with valid responses to questions on physical activity, doing at least 150 moderate intensity equivalent (MIE) minutes physical activity per week in bouts of 10 minutes or more in the previous 28 days expressed as a percentage of the total number of respondents aged 19 and over.

Figure 42. Physical Activity Guidelines



Graphic created by Public Health Team using : Canva.com

Weight

Excess weight is a significant public health concern which results in long-term negative social, psychological and physical ill-health often leading to poor quality of life and reduced life expectancy. Common health conditions associated with obesity in adults include: type 2 diabetes, hypertension, coronary artery disease and stroke, respiratory effects and cancers.

In adults, a simple index of weight-for-height called Body Mass Index (BMI) is used to classify overweight and obesity. The World Health Organisation defines overweight and obesity in adults as follows:

- Overweight is a BMI greater than or equal to 25; and
- Obesity is a BMI greater than or equal to 30.

In 2017/18, according to the Sport England Active Lives Survey, the percentage of adults in Worcestershire estimated to be overweight or obese rose to 65%. This is higher than the England value of 62%.

Looking at obesity specifically, all three Worcestershire Clinical Commissioning Groups (CCGs) have higher recorded rates than England and related to this there has been an upward trend in recorded diabetes for all three.

Smoking

Smoking is the most important cause of preventable ill health and premature mortality in the UK. It is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease and is also associated with cancers in other organs, including lip, mouth, throat, bladder, kidney, stomach, liver and cervix.

In Worcestershire 11.8% of people are estimated to be smokers. This is lower than the England average. The estimated proportion of the population who smoke has fallen in recent years both nationally and locally.

Smoking is a major driver of avoidable differences in health between groups and people who work in routine and manual occupations have a much higher odds of smoking than those in managerial and professional posts.

Locally, it is estimated that 23.5% of people in routine and manual occupations smoke. This is twice the proportion of all adults estimated to smoke which is 11.8%.

Figure 43. Smoking: Key Facts

NHS Wyre Forest Clinical Commissioning Group

NHS Redditch and Bromsgrove Clinical Commissioning Group

NHS South Worcestershire Clinical Commissioning Group

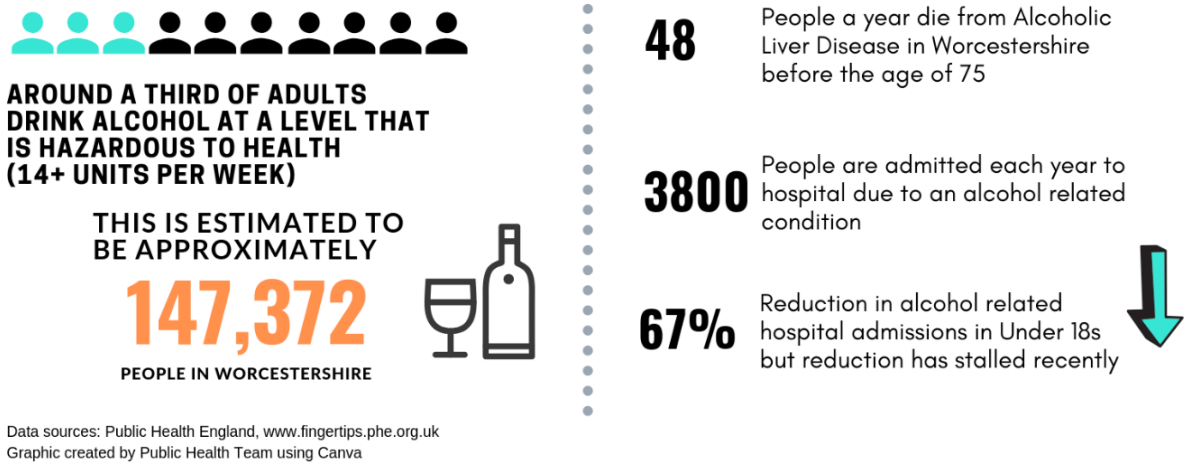
Alcohol

Alcohol can have a significant impact upon an individual both physically and psychologically. Drinking above the recommended levels increases the risk of certain types of cancer including liver, breast and oral. It is a risk factor for liver disease, heart disease, depression, suicide, unsafe sex and injuries. Harmful drinking also has wider effects including impacts upon children and families, domestic and partner violence, employment, housing, crime, violence and road traffic accidents.

In Worcestershire, hospital admissions for alcohol related conditions are similar to the national rate. In 2017/18 there were 3,820 admissions which is a standardised[64] rate of 629 per 100,000 people.

The rate of people dying prematurely (aged under 75) from alcoholic liver disease in Worcestershire is also similar to the national rate. During 2015-17 there were 144 premature deaths due to alcoholic liver disease which is a standardised rate of 8.7 per 100,000 people.

Figure 44. Alcohol: Key Facts



[64] Adjusted for the age and gender characteristics of the population to allow comparison with other areas.

Substance Misuse (including treatment for alcohol addiction)

Drug misuse has the potential to cause a wide range of harms to the individual, those close to them, and wider society. This includes impacts on individuals physical and mental health and increased risk of unemployment, homelessness and criminal activity.

Treatment

In Worcestershire, 1,390 adults accessed structured drug treatment in 2017-18.

When engaged in treatment, people use alcohol and illegal drugs less, commit less crime, improve their health, and manage their lives better. This clearly benefits both the individual and the local community. Preventing unplanned drop out and keeping people in treatment long enough to benefit contributes to improved outcomes. As people progress through treatment, the benefits to them, their families and their community start to accrue.

Since 2015 Swanswell Charitable Trust (part of Cranstoun Group) have delivered an integrated substance misuse service across Worcestershire and during this time the proportion of drug users successfully completing treatment has increased significantly.

Alcohol Treatment

People who need alcohol treatment need prompt help if they are to recover from dependence and keeping waiting times short will play a vital role in supporting recovery from alcohol dependence.

In Worcestershire in 2017-18, 99.9% of all people waiting for treatment were seen within 3-6 weeks of being referred. This was slightly higher than the national average of 98%. In 2015, 26% of people successfully completed alcohol treatment. In 2017, this had increased to 45% and the proportion of people completing alcohol treatment was higher than the England average for the first time in a six-year period.

Drug Treatment

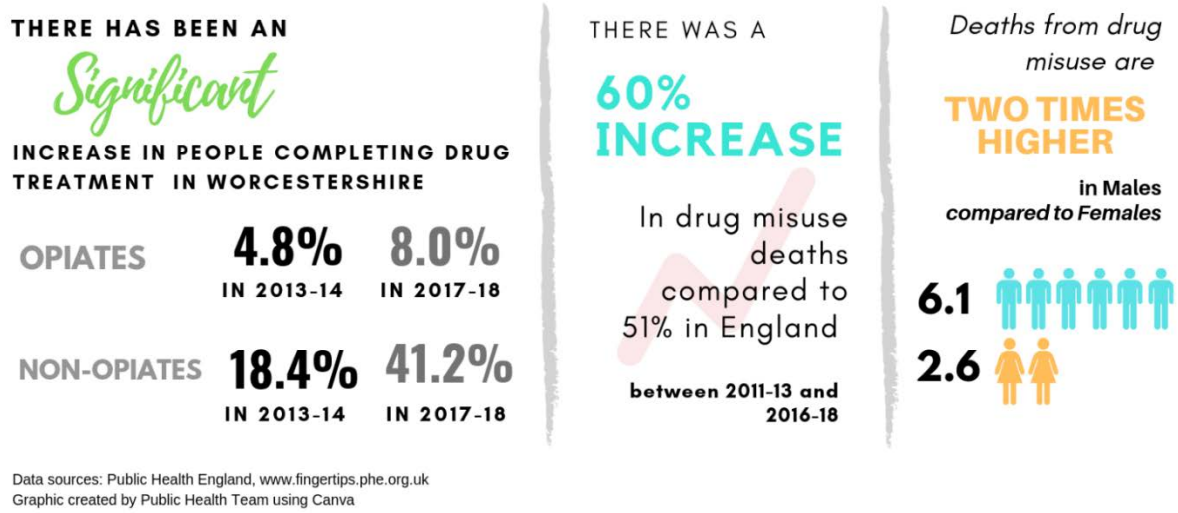
Service users accessing drug treatment are often divided in to two categories, opiate users, people who are dependent on or have problems with opiates (mainly heroin) and non-opiates, people who have problems with non-opiate drugs, such as cannabis, crack and ecstasy.

In Worcestershire, it is evident that the percentage of opiate users successfully completing drug treatment and not representing to treatment within 6 months has increased from 4.8% in 2014/15 to 8.0% in 2017/18. This improvement has ensured Worcestershire's performance, against a Public Health Outcome Framework measure, has improved from being worse than the national average to being better. In a comparable timeframe, the England performance has decreased, from 7.4% in 2014/15 to 6.5% in 2017/18.

The percentage of non-opiate users successfully completing drug treatment and not representing to treatment within six months has increased from 30.3% in 2014/15 to 42.1% in 2017/18. During this time, the England average has decreased from 39.2% in

2014/15 to 36.9% in 2017/18. The Worcestershire performance for non-opiate is now also better than the national average.

Figure 45. Drugs: Key Facts



Deaths from Drugs Misuse

Locally, both the rate and number of deaths from drugs misuse has been increasing for a number of years. This is also the case nationally but in Worcestershire it is unexpected.[65]

In Worcestershire there were a total of 72 deaths from drug misuse in the period 2016-18. The rate was 4.3 per 100,000 which is similar to the national rate of 4.5.

During this period the rate of deaths from drugs misuse was over two times higher in males than in females (6.1 vs 2.6 per 100,000 respectively). There were also differences at district level. The highest numbers of deaths from drug misuse were in Worcester and Wyre Forest districts which saw 17 deaths each.

Between 2011 and 2018 the number of deaths from drug misuse increased by 60% in Worcestershire. However, between 2014 and 2018 the rate and numbers have shown little change. It is too early to say if this represents a slowdown in the rise.

A national inquiry into drug deaths conducted by Public Health England identified two factors that might contribute to the rising drug deaths:

- Increase in availability and purity of heroin
- Ageing heroin users

Many heroin users started to use heroin in the 1980s and 1990s and are now experiencing cumulative physical and mental health conditions that make them more susceptible to overdose. A majority of these users may not be engaging in drug treatment where they could be protected.

Worcestershire has a large population of older drug users in treatment, who may experience a number of health issues consistent with older-age drug use. There is a need for a whole system approach and aligned commissioning, addressing health inequalities and providing better access to supportive physical healthcare and psychiatric care, along with other support which could include housing and employment. There is also a need to address the reasons why people are not accessing treatment and make treatment more attractive to this cohort.

[65] The definition of a drug misuse death is one where either the underlying cause is drug abuse or drug dependence, or the underlying cause is drug poisoning and any of the substances controlled under the Misuse of Drugs Act 1971 are involved as well as deaths from drug abuse and dependence. These figures include accidents and suicides involving drug poisonings as well as complications of drug abuse (such as deep vein thrombosis or septicaemia from intravenous drug use (Office for National Statistics (2018) Deaths related to drug poisoning in England and Wales Deaths related to drug poisoning in England and Wales: 2017 registrations, [Online], Available from: www.ONS.gov.uk).

Sexual Health

Sexual health outcomes in Worcestershire continue to be largely better than the national average.

The rate of all new sexually transmitted illness (STI) diagnoses, excluding diagnoses of chlamydia for under 25s, in Worcestershire for 2018 was 417 per 100,000 population. This is less than half the national rate of 851. The rate has been improving since 2014 when the rate was 569.

Late diagnosis of HIV has a significant effect on outcomes. In Worcestershire late diagnosis of HIV has shown a considerable improvement in recent years – the rate was 43.9% in 2015-17 - a fall from 60.9% in 2011-13 (the national level is 41.1% and the target is 50%).

Prescribing of long-acting reversible contraception (LARC) is better than the national rate (56.7 per 1,000 in 2017 compared to 47.4 for England). This method of contraception is highly effective as it does not rely on daily compliance and is more cost effective than condoms or the pill.

There are differences by district, and within the county sexual health outcomes are poorer in Worcester and Redditch districts, with higher STI and teenage conception rates and lower rates of contraceptive and long-acting reversible contraception (LARC) prescribing compared to other districts.

In comparison Wyre Forest has similar STI and teenage conception rates as the rest of the county and has high rates of contraception and LARC prescribing.

The Worcestershire JSNA Briefing on Sexual Health, 2016 provides more detailed information on sexual health outcomes.[66]

Sexual Health

Worcestershire generally has good sexual health outcomes. There are lower rates of sexually transmitted infections (STIs), HIV, unintended pregnancies and abortions than England and high rates of prescribing of all methods of contraception.

There are differences by district, and within the county sexual health outcomes are poorer in Worcester and Redditch districts, with higher STI and teenage conception rates and lower rates of contraceptive and long-acting reversible contraception (LARC) prescribing compared to other districts.
In comparison Wyre Forest has similar STI and teenage conception rates as the rest of the county and has high rates of contraception and LARC prescribing.

The rate of all **new sexually transmitted illness** (STI) diagnoses (excluding diagnoses of chlamydia for under 25s) in Worcestershire for 2018 is 417 per 100,000 population,

[66] http://www.worcestershire.gov.uk/info/20122/joint_strategic_needs_assessment/1473/jsna_publications_by_category/8

which **is less than half the national rate** of 851. It has been improving since 2014, when the rate was 569 (Public Health England).

Human Papilloma Virus (HPV) Vaccination Programme

Globally, Human Papilloma Viruses (HPV) are responsible for 5% of cancers worldwide. HPV is thought to be responsible for over 99% of cervical cancer as well as 90% of anal, about 70% of vaginal and vulvar cancers and more than 60% of penile cancers.

In the UK a national programme for HPV Vaccination started in 2008. Since that time 10 million girls have been given the vaccination - over 80% of women aged 15-24 years. It is estimated that by 2058 in the UK the HPV vaccine currently being used may have prevented up to 64,138 HPV-related cervical cancers and 49,649 other HPV-related cancers.[67]

The HPV vaccination is delivered in two doses. The first dose is a priming dose and the second dose is required for full protection. In Worcestershire uptake of the HPV Vaccination for first dose has improved significantly in the last two years from 84.8% in 2015-16 to 90.3% in 2017-18, which is above the national target coverage rate of 90%.

For second dose HPV vaccination, the rate is above the England average at 85.8% but still below the 90% target coverage rate.

The HPV vaccination rate in Worcestershire is lower than Warwickshire (our most similar local authority according to CIPFA) but uptake rates are higher than Gloucestershire and Suffolk (second and third most similar authorities).

From September 2019, the HPV vaccination will be offered routinely to all boys in Year 8.

[67] Public Health England (2019) Press Release: HPV Vaccine could prevent over 100,000 cancers [Online], Available from: https://www.gov.uk/government/news/hpv-vaccine-could-prevent-over-100-000-cancers

Screening

Cancer Screening

The main NHS cancer screening programmes are for bowel, breast and cervical cancers. The current rates of cancer screening coverage in Worcestershire are:

- Bowel (60-74 years) 61.9%
- Breast (53-70 years) 79.0%
- Cervical (25-64 years) 74.9%

(2018, Public Health England)

Although Worcestershire has higher rates of screening coverage than England as a whole the recent trend in breast and cervical cancer screening has been downward and many Worcestershire practices are not meeting national targets.
Although Worcestershire has higher rates of screening coverage than England as a whole; the recent trend in breast and cervical cancer screening has been downward and many Worcestershire practices are not meeting national targets.
The national screening target for breast and cervical cancer is set at 80% coverage and for bowel cancer screening the target is 60% coverage.

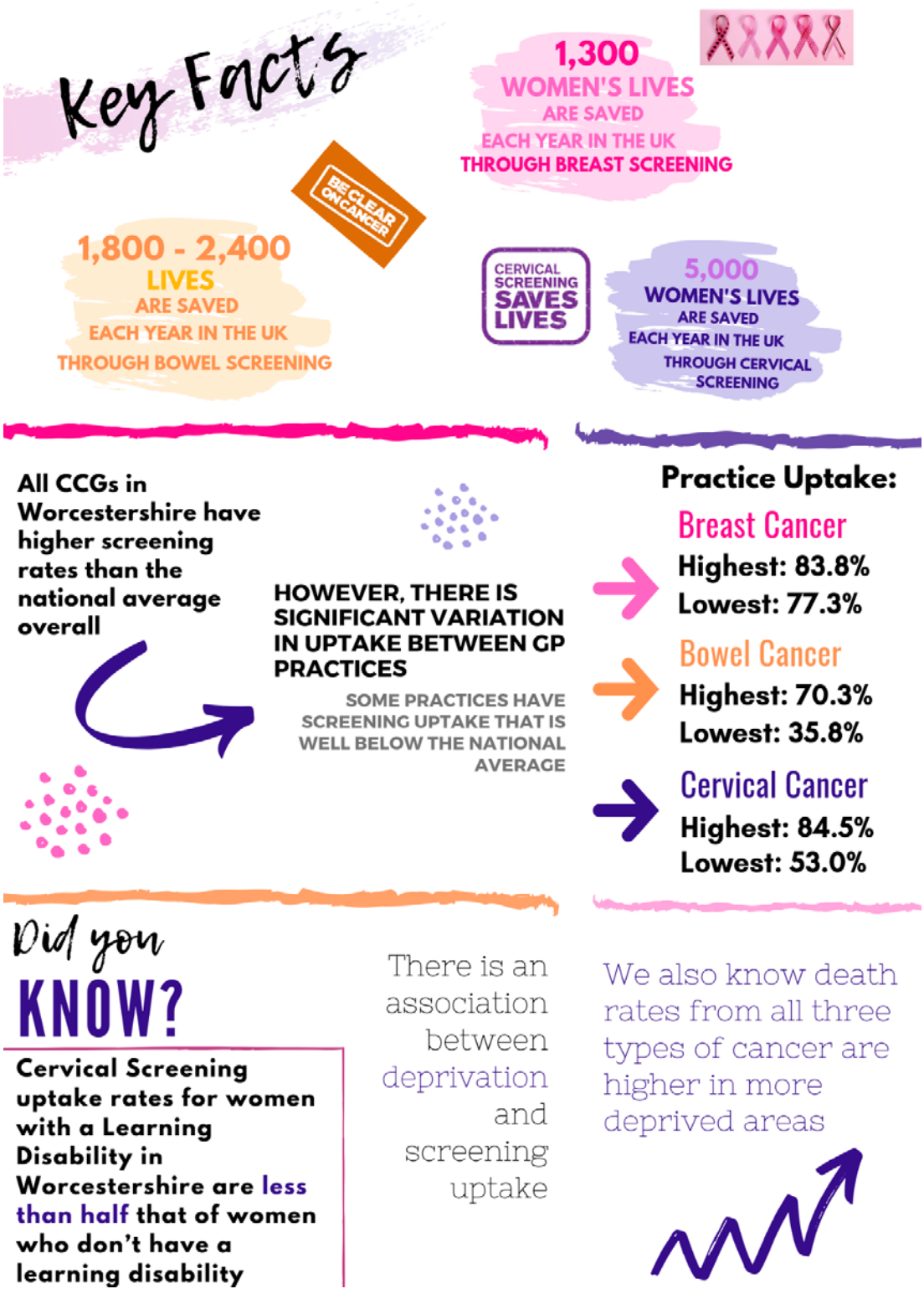
Cervical Cancer Screening: 55 out of 70 (78.6%) practices in Worcestershire did not meet the national screening target of 80%. This means across Worcestershire, a total of 7,384 screens are required to meet the target.

Breast Cancer Screening: 55 out of 70 (78.6%) practices in Worcestershire did not meet the national screening target of 80%. This means across Worcestershire, a total of 3,117 screens are required to meet the target.

Bowel Cancer Screening: 21 out of 70 (30.0%) practices in Worcestershire did not meet the national screening target of 60%. Across all of the CCG areas in Worcestershire, the national screening target of 60% was met in 2017-18. This demonstrates there is practice level variation.

Bowel Cancer Screening: 21 out of 70 (30.0%) practices in Worcestershire did not meet the national screening target of 60%. Across all of the CCG areas in Worcestershire, the national screening target of 60% was met in 2017-18. This demonstrates there is practice level variation.

Figure 46. NHS Cancer Screening Programme: Key Facts



NHS Wyre Forest Clinical Commissioning Group

NHS Redditch and Bromsgrove Clinical Commissioning Group

NHS South Worcestershire Clinical Commissioning Group

Abdominal Aortic Aneurysm (AAA) screening

Abdominal Aortic Aneurysm (AAA) screening aims to reduce AAA related mortality among men aged 65 to 74. Worcestershire currently has a higher screening rate for AAA than England as a whole. The current rate of coverage is 86.4% and there has been little change in this rate for a number of years.

Diabetes

Diabetes can cause complications that include cardiovascular, kidney, foot and eye diseases. Approximately 90% of cases are Type 2 diabetes which is partially preventable by lifestyle changes (exercise, weight loss, and healthy eating). Earlier detection of Type 2 diabetes followed by effective treatment reduces the risk of developing complications.

In Worcestershire it is estimated that 80.1% cases of diabetes have been diagnosed. This is similar to the national rate.

NHS Health Checks

The NHS Health Check is a health check-up for adults in England aged 40-74. It is designed to spot early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia. As people age, they have a higher risk of developing one of these conditions. An NHS Health Check helps find ways to lower this risk.

It is estimated 89,400 (49.8%) of the eligible population aged 40-74 in Worcestershire received an NHS Health Check between 2014/15 and 2018/19. This is higher than the national rate which was 43.3%.

Analysis of local data suggests lower take up of health checks in populations living the most deprived areas of Worcestershire. Yet the need in these areas is greatest as amongst this group we see a higher than average diagnosis rate for all the major health conditions identified by health checks.

Living Longer and in Good Health

Life Expectancy and Healthy Life Expectancy

Life expectancy at birth for both females and males living in Worcestershire is higher than the England average. It is currently 83.9 years for females and 79.9 years for males. However, these figures don't tell the whole story.

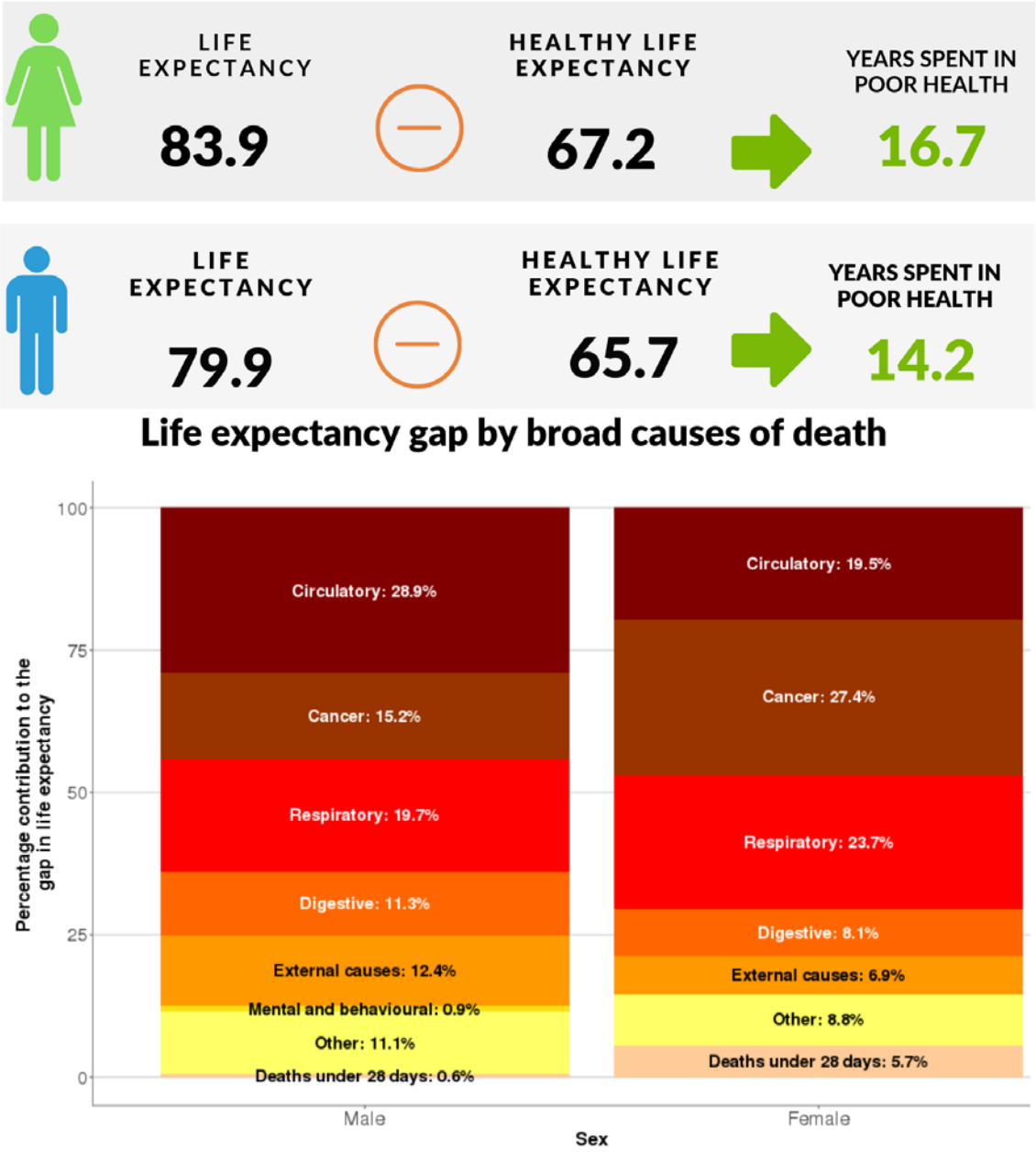
The difference between the number of years someone could be expected to live in good health, healthy life expectancy, and total life expectancy is sometimes referred to as the 'Window of Need'. In Worcestershire the 'Window of Need' is 16.7 years for females and 14.2 years for males.

There is also a difference in Life Expectancy at Birth according to where someone lives. Life Expectancy at Birth is 7.6 years lower for males and 6.2 years lower for females who live in the most deprived areas of Worcestershire compared to those who live in the least deprived areas.[68] For females in particular inequality in life expectancy at birth has increased in recent years and it is now higher than in 2010-12. For males although the indicator is statistically similar to the figure in 2010-12 there is evidence of an increasing trend since 2012-14. It is for this reason that inequality in life expectancy at birth has been highlighted as an issue to be explored.

The life expectancy gap by broad causes of death provides useful data on living longer and premature mortality.

[68] This measure is also referred to as the Slope Index of Inequality.

Figure 46: Inequalities in Life Expectancy



Underlying causes

01 **Deprivation**
The 7 domains of deprivation included in the index are: income, education, employment, health, crime, barriers to housing and living environment.

02 **Inequality**
Simply an unfair situation in society when some people have more opportunities, money, access to health services etc. than other people.

Created by Public Health Team using : Canva.com
Data source: Public Health England

NHS Wyre Forest Clinical Commissioning Group
NHS Redditch and Bromsgrove Clinical Commissioning Group
NHS South Worcestershire Clinical Commissioning Group

Ageing: People Aged 65 Years and Over

Worcestershire has a relatively large proportion of people aged 65 and over. The proportion of older people varies by district. Malvern Hills has the highest proportion (27.9%) and Worcester (17%) and Redditch (18.2%) the lowest.

The number of older people is predicted to increase by nearly a third between 2019 and 2035. The rise is expected to be fastest in those aged 85 or over where the number is set to almost double (increase by 92%). This will have implications for the future provision of health and social care services in Worcestershire.

The population of ethnic minority older people in Worcestershire is small at 966 or just under 1% of the total population aged 65 and over in 2011 (the latest year for which data is available).

Worcestershire population estimates and projections for older people are available from the JSNA website.[69]

Worcestershire performs better than England for many public health measures which relate to ageing. The exceptions to this are fuel poverty and dementia diagnosis rate.

In the following section key public health issues facing older people in the county are summarised. These include:

- Physical Health - falls, stroke
- Living Conditions - social isolation, caring, fuel poverty
- Mental Health – dementia, depression
- Long-term illness
- Frailty
- Demand for health and social care

Physical Health

Falls

Falls are the largest cause of emergency hospital admissions for older people and are a major cause of people moving from their own home to long-term nursing or residential care.

There are approximately 2,300 falls per year in the over 65s in Worcestershire which result in an emergency hospital admission. The rate is lower than the England rate (1,730 per 100,000 compared to 2,170 per 100,000 in 2017/18).[70]

[69] Available at: http://www.worcestershire.gov.uk/info/20122/joint_strategic_needs_assessment

[70] Public Health England, Public Health Outcomes Framework

Influenza

Influenza is a highly infectious viral illness. A vaccination is offered to people who are at greater risk of developing serious complications if they catch it. Over 65s are a priority group for receiving influenza vaccination.

In the 2017/18 flu season, 74.7% of people aged 65 and over in Worcestershire were immunised, which is just below the national target value of 75%.

Stroke

13,287 people registered with Worcestershire GPs are recorded as having had a stroke or transient ischaemic attack (TIA). This is 2.2% of patients which is higher the national figure of 1.8%.

Stroke deaths in Worcestershire occur at a higher rate than nationally (the Standardised Mortality Ratio is 110.5). Worcestershire ranks 4th worst of 16 similar local authorities on this measure.[71] Three quarters of stroke deaths occur after the age of 65.

One of the factors underlying high stroke mortality is atrial fibrillation. Atrial fibrillation (AF) increases the risk of stroke by a factor of five, and strokes caused by AF are often more severe, with higher mortality and greater disability. AF is under-diagnosed and under-treated: up to a third of people with AF are unaware they have the condition and even when diagnosed inadequate treatment is common – large numbers do not receive anticoagulants or have poor anticoagulant control. Table 11 shows that Worcestershire has high prevalence of both stroke and atrial fibrillation.

Table 11. Stroke and Atrial Fibrillation Prevalence by CCG, 2017/18

Key Facts	Redditch and Bromsgrove CCG	South Worcestershire CCG	Wyre Forest CCG	Worcestershire	England
Atrial fibrillation QOF prevalence (similar CCGs)	2.1% (2.3%)	2.5% (2.5%)	2.5% (2.5%)	2.4%	1.9%
Estimated prevalence of atrial fibrillation	2.6%	3.0%	3.2%	2.9%	2.4%
Stroke QOF prevalence (similar CCGs)	2.0% (2.0%)	2.1% (2.2%)	2.7% (2.1%)	2.2%	1.8%

Source: NCVIN stroke profiles

[71] CIPFA Nearest Neighbours

Limiting Long-term Illness

Limiting long-term illness is defined as an illness that affects daily activities. It is estimated that nearly half (47%) of older people in Worcestershire have a limiting long-term illness. This equates to 63,000 people and this number is forecast to increase by 38% between 2019 and 2035.

Frailty

Frailty is a syndrome associated with, but not directly related to, age. It is characterised by a deterioration of function where an apparently minor event, for example, an infection or change in medication may result in a striking and disproportionate change in health state. A cold under normal circumstances is frustrating but not debilitating but for someone living with frailty this could cause deterioration with the onset of drowsiness, confusion, worsening mobility and an increased risk of falling, breaking a bone and being admitted to hospital.

People living with frailty are dependent on devices, home adaptations or people around them to remain independent. Those living with severe frailty are fully dependant on others for most or all activities.

Changes to the GP contract in 2017/18 introduced routine frailty identification for patients who are 65 and over. It targets a small number of key interventions (falls assessment, medicines review and promotion of the additional information in the summary care record) at those most at risk of adverse events including hospitalisation, nursing home admission and death. Early identification coupled with targeted support can help older people living with frailty to stay well and live independently for as long as possible.

The changes to the GP contract may result in new data being published on frailty, and we expect to report on this in future.[72]

Mental Health

The number of people with dementia in Worcestershire is forecast to increase by 56% between 2019 and 2035 from 9,560 to 14,905. This is a bigger increase than that expected for England (51%).[73]

A key priority is improving the diagnosis rate for dementia. A timely diagnosis enables people living with dementia, their carers, and healthcare staff, to plan accordingly and work together to improve health and care outcomes. The estimated dementia diagnosis

[72] See https://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/ for further information.

[73] Projecting Older People Population Information (POPPI) projections. Available from: https://www.poppi.org.uk/

rate[74] for those aged 65 and over in 2018 was lower than the England level at 59.7% (England = 67.5%).

Depression in later life can be a major cause of ill health and can have a severe effect on physical and mental wellbeing. Older people are particularly vulnerable to factors that can lead to depression such as bereavement, physical disability and illness and loneliness. Depression is estimated to affect 11,630 people aged over 65 in Worcestershire (2019; POPPI).

Living Conditions

Social Isolation

In Worcestershire it is estimated that 15,160 males and 28,350 females aged 65 and over are living alone. By 2035 these numbers are expected to rise by 36% for both genders.[75] While there is no direct relationship between living alone and loneliness, it is clearly a contributory factor.

Only half (49%) of adult social care users in Worcestershire have as much social contact as they would like (Public Health England estimates).

Fuel Poverty

Fuel poverty is driven by three main factors: income, current cost of energy and energy efficiency of the home. A household is considered to be fuel poor if they have required fuel costs that are above average and, were they to spend that amount, they would be left with a residual income below the official poverty line.[76]

Health effects of fuel poverty can include: respiratory conditions, mental health and studies have shown that more than one in five (21.5%) excess winter deaths in England and Wales are attributable to the coldest quarter of housing.[77]

Approximately 29,000 households in Worcestershire (11.5%) are living in fuel poverty, this is above the national rate which is 11.1%.[78] The issue disproportionately affects older people given, for example, the link between cold homes and respiratory conditions. Nationally, a fifth of households affected by fuel poverty have household members that are all over 60 (older people households). If Worcestershire followed this pattern 5,000 households would fall into this category.

[74] The rate of persons aged 65 and over with a recorded diagnosis of dementia per person estimated to have dementia given the characteristics of the population in Worcestershire.
[75] Projecting Older People Population Information (POPPI) projections. Available from: https://www.poppi.org.uk/

[76] JSNA Briefing on Fuel Poverty (2016), Worcestershire County Council
http://www.worcestershire.gov.uk/download/downloads/id/9407/2016_briefing_on_fuel_poverty.pdf
[77] (UCL Institute of Health Equity (2011). The Health Impacts of Cold Homes and Fuel Poverty. Available from: http://www.instituteofhealthequity.org/resources-reports/the-health-impacts-of-cold-homes-and-fuel-poverty/the-health-impacts-of-cold-homes-and-fuel-poverty.pdf)
[78] Public Health England, Public Health Outcomes Framework.

Unpaid Care

It is estimated that in 2019, 20,110 people aged 65 and over were providing unpaid care in Worcestershire, this is forecast to grow by 28% to 25,670 by 2035 (a person is a provider of unpaid care if they look after or give help or support to family members, friends, neighbours or others because of long-term physical or mental ill health or disability, or problems related to old age). Over a third of older people (7,345, 36.5%) in Worcestershire providing unpaid care are doing so for 50 or more hours a week.[79]

[79] Projecting Older People Population Information (POPPI) projections. Available from: https://www.poppi.org.uk/

Demands on the Health and Social Care System

Table 12 illustrates the potential effect of population change on the numbers of older people with key health conditions. The numbers are projected to increase by 28%-56% between 2019 and 2035. This increase in numbers is likely to lead to a substantial rise in the demand for social care and health services in future years.

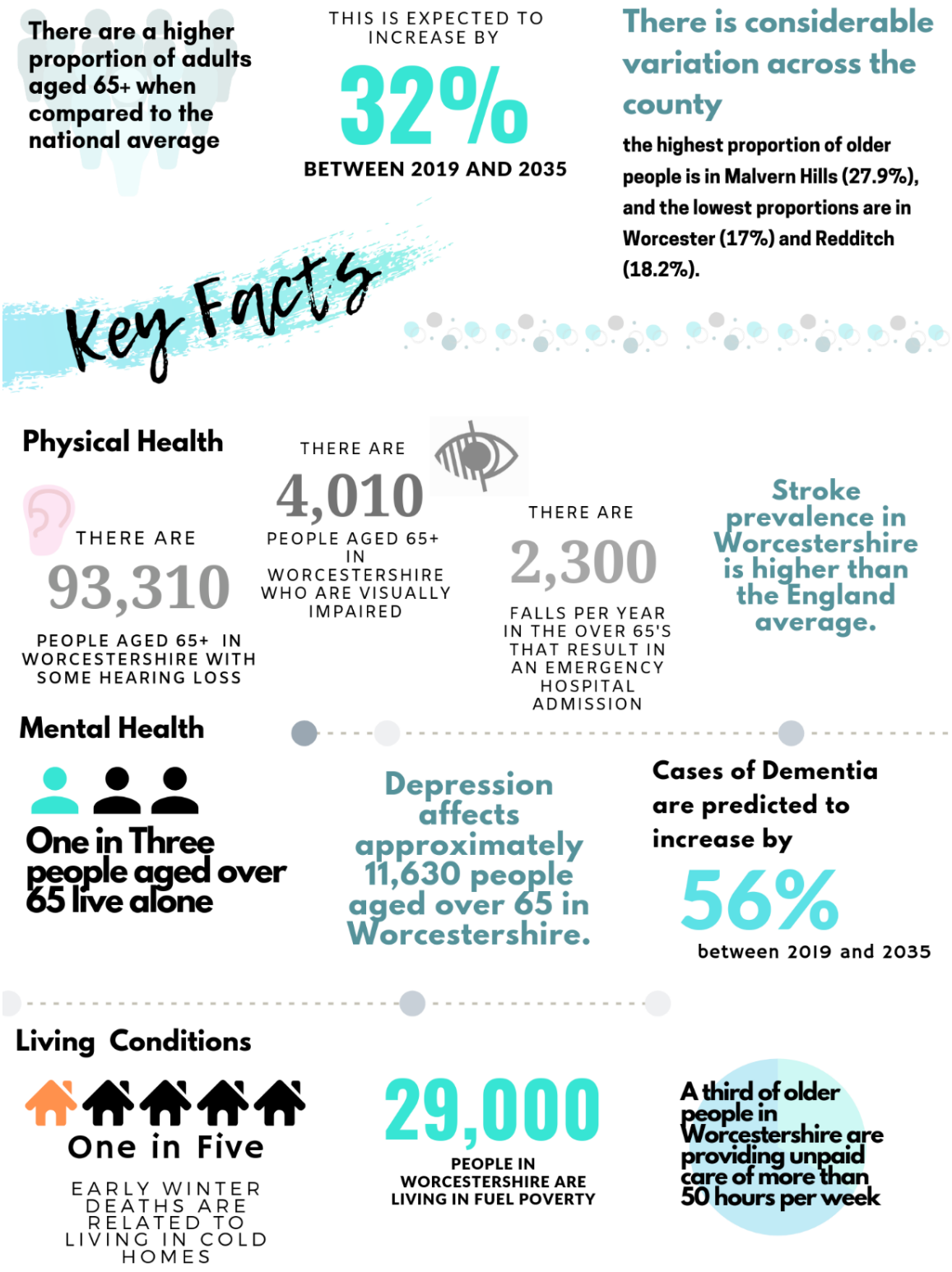
Table 12. Projected Numbers of Older People with Key Health Conditions

Condition	2019	2035	% change
Dementia	9560	14910	56%
Depression	11630	15330	32%
Living alone	43500	59180	36%
Limiting Long term illness	62910	66960	38%
Mobility	24780	36310	47%
Hearing loss (moderate or severe)	93310	144810	55%
Visual impairment (75+)	4010	6070	51%
Stroke	3170	4280	35%
Bronchitis/Emphysema	2300	3040	32%
Provision of unpaid care	20110	25670	28%

Source: POPPI[80]

[80]Projecting Older People Population Information system, Aug 2019. All age 65+ unless otherwise stated. Definitions of above available at www.poppi.org.uk (these may differ from other sources).

Figure 47. Older People's Health in Worcestershire: Key Facts



Data sources: Public Health England, www.fingertips.phe.org.uk, Images from theNounProject.com, (Blind by Bluu)
Graphic created by Public Health Team using Canva

Wyre Forest Clinical Commissioning Group

Redditch and Bromsgrove Clinical Commissioning Group

South Worcestershire Clinical Commissioning Group

Worcestershire Districts

This section summarises key population information, health outcomes and issues of potential concern for each of the six Worcestershire districts.

Population

Table 13. Worcestershire Districts: Key Population Facts

District	Population (2018)	Deprivation	Inequalities* (male, years) (Eng=9.4)	Inequalities* (female, years) (Eng=7.4)
Bromsgrove	98,662	In 20% least deprived districts in England. A few relatively deprived areas	8.2	6.8
Malvern Hills	78,113	Several pockets of relative deprivation (Pickersleigh)	7.4	2.9
Redditch	84,989	Significant pockets of relative deprivation (central, Winyates)	12.2	10
Worcester	101,891	Significant pockets of relative deprivation (central and NE)	8.4	2.7
Wychavon	127,340	Some pockets of relative deprivation	7.1	6.5
Wyre Forest	101,062	Significant pockets of relative	8.4	11.7

		deprivation (Kidderminster)		

*life expectancy gap in years between most and least deprived areas, red denotes significantly higher than England, green significantly lower

Bromsgrove

- Bromsgrove has a lower proportion of younger people aged 20-39 and higher proportion of adults aged 40 plus compared to England.
- 10.2% of children living in low income households in 2016 (1,605).
- 3.8% of people living in Bromsgrove are from an ethnic minority group, compared to 13.2% in England.
- The gap between the richest and poorest areas in Bromsgrove for premature deaths in males has widened since 2011-13. The inequality gap is larger for men than for women.

Malvern Hills

- Malvern Hills has the highest proportion of people aged 65 and over (27.9%) in comparison to other Worcestershire districts and England (18.2%).
- 14.4% of children living in low income households in 2016 (1,575).
- 3.9% of people living in Malvern Hills are from an ethnic minority group, compared to 13.2% in England.

Redditch

- Redditch has the highest proportion of children and young people aged 0-19 (23.7%) in comparison to other Worcestershire districts.
- 15.6% of children were living in low income households in 2016 (2,620).
- 9.4% of people living in Redditch are from an ethnic minority group, compared to 13.2% in England.
- For premature deaths in males the gap between the richest and poorest areas in Redditch has widened since 2011-13.

Worcester

- Higher proportion of people in 20-29 year old age group (16%) in comparison to Worcestershire (11%) and England (13%).
- 16.5% of children living in low income households in 2016 (3,135). This is not statistically significantly different to the England value (17%), following a ten year period in which it was significantly lower.
- 2.8% of people living in Worcester are from an ethnic minority group, compared to 13.2% in England.
- For premature deaths the gap between the richest and poorest areas in Worcester in males has widened since 2011-13.

Wychavon

- Wychavon has a higher proportion of people aged 65 and over (24.8%) in comparison to Worcestershire overall (22.5%).
- An estimated 1.1% of people living in Wychavon are from an ethnic minority group, compared to 13.2% in England.
- There were 11.8% of children living in low income households in 2016 (2,315).
- For premature deaths in males the gap between the richest and poorest areas in Wychavon has widened since 2011-13.

Wyre Forest

- Wyre Forest has a higher proportion of people aged 65 and over (24.6%) in comparison to Worcestershire overall (22.5%).
- 18.1% of children living in low income households in 2016 (3,050). This is statistically significantly higher than the England value of 17%, following four years in which it was not significantly different.
- 1.7% of people living in Wyre Forest are from an ethnic minority group, compared to 13.2% in England.
- For premature deaths in females the gap between the richest and poorest areas in Wyre Forest has widened since 2011-13.

Areas of Concern

Table 14 summarises those indicators in the Public Health Outcomes Framework for which at least one district is significantly worse than the national average.

Table 14: District Level Issues of Concern

Figures in red are significantly worse, green significantly better and amber not significantly different to England.

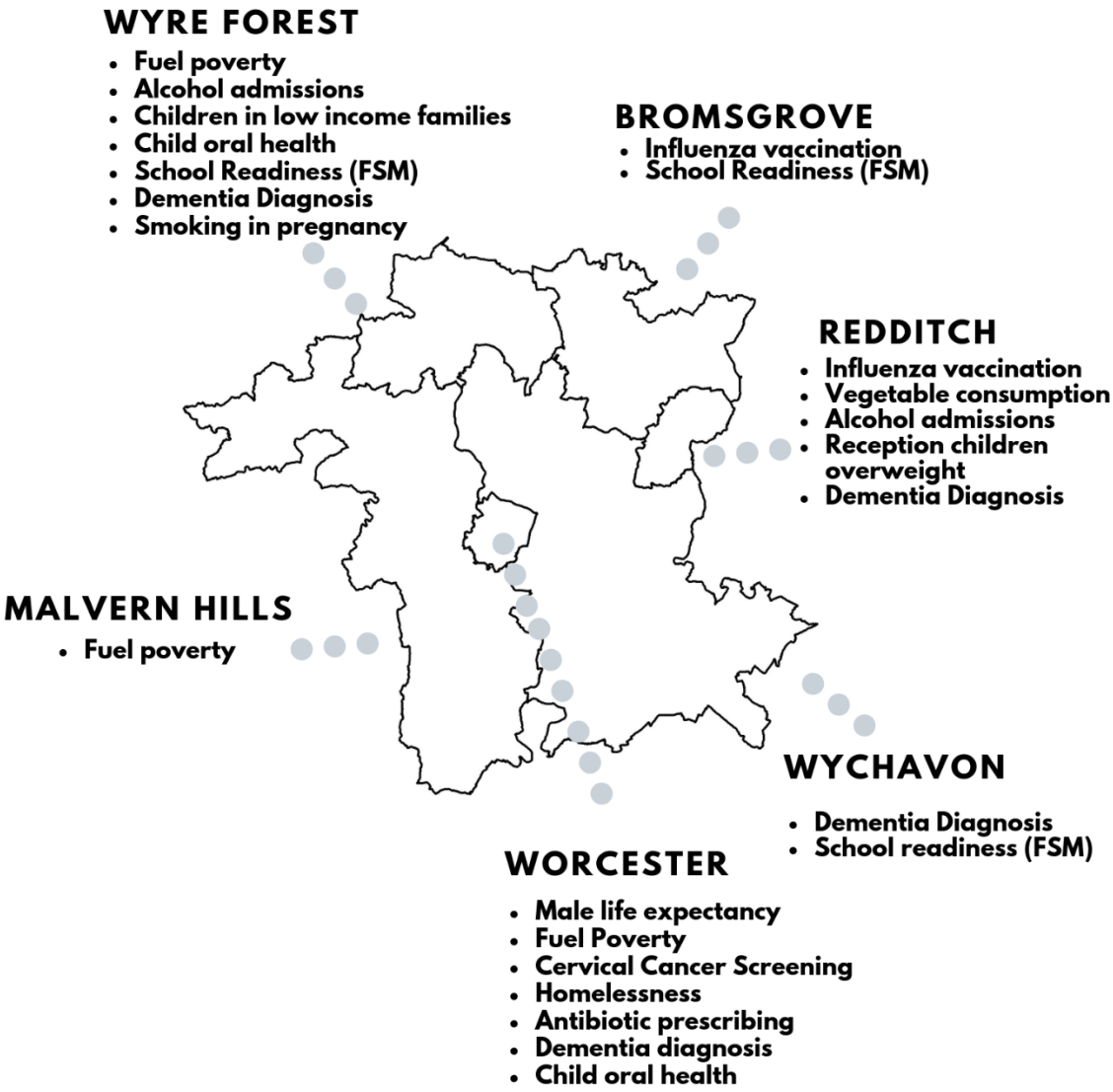
Indicator	Period	England	Bromsgrove	Malvern Hills	Redditch	Worcester	Wychavon	Wyre Forest
Population vaccination coverage - Flu (aged 65+) %*	2018/19	75	73.3	74.9	73.3	74.9	74.9	74.9
Proportion of five-year-old children free from dental decay %	2016/17	76.7	88.6	80.7	79.7	70.1	79.8	70.7
School readiness (free school meal eligible) %*	2017/18	57	49	53	53	57	51	41
Cervical Cancer Screening Coverage %	2018	71.4	79.3	77.6	71.4	70.7	75.8	74.9
Estimated Dementia Diagnosis Rate (65+) %	2019	68.7	68.4	63	59	58.9	51.9	59.8
Life Expectancy (male) years	2015-17	79.6	79.9	81.0	79.2	78.6	81.0	79.4
Alcohol Related Admissions per 100,000	2017/18	632.3	572.8	576.8	780.3	640.6	549.8	696.5

Statutory Homelessness-not in priority need, rate per 1,000	2017/18	0.8	N/A	N/A	0.4	2.8	0.8	0.7
Antibiotic prescribing (per STAR-PU)	2018	0.99	1	1.04	1.04	1.3	1.05	1.04
Smoking status at time of delivery %	2017/18	10.8	11.9	11.5	11.9	11.5	11.5	15.6
Children in low income families %	2016	17.0	10.2	14.4	15.6	16.5	11.8	18.1
Reception Year children overweight (including obesity) %	2017/18	22.4	19.9	20.4	25.3	20.7	22.7	24.8
Fuel Poverty %*	2016	11.1	10	12.6	10.6	12.7	10.7	12.5
Portions of vegetables consumed daily	2017/18	2.65	2.61	2.75	2.48	2.57	2.95	2.48

*officially not RAG rated, these are PH calcs **STAR-PU is adjusted prescribing units

Source: Public Health Outcomes Framework.

Figure 48. Measures Significantly Worse Than England



*FSM=free school meal eligible.

Source: Public Health Outcomes Framework

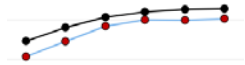
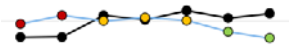
Health and Wellbeing Board Priorities

The Worcestershire Health and Wellbeing Board Joint Health and Wellbeing Strategy 2016-21 identifies three priorities which apply to all ages:

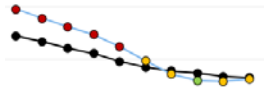
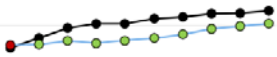
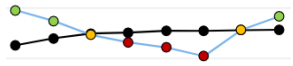
- keeping the population active
- preventing alcohol harm
- maintaining good mental health and well-being

A refreshed strategy is due to be published in April 2021. The following section provides an update on key indicators relating to current priorities.

Mental Health and Wellbeing

Indicator	England	Worcs	Baseline (Including period)	Trend
Satisfaction with life measure (National Wellbeing Survey) - 2014-15	4.6%	3.3%	No change (No updated data)	
School readiness: the percentage of children with free school meal status achieving a good level of development at the end of reception - 2017-18	56.6%	50.1%	45.7% (2014-15)	
Hospital admissions as a result of self-harm (10-24 years) - 2017-18	421.1	341.1 DSR per 100,000	409.9 (2014-15)	
Referrals to Child and Adolescent Mental Health Services (CAMHS) - 2017-18	N/A	3405	2266 (2016-17)	
Diagnosis rate for people with dementia (aged 65+) - 2018	67.9%	61.0%	New indicator (no trend available)	
Health related quality of life for people with long-term conditions - 2016-17	0.757	0.737 (No significance levels reported)	No change (No updated data)	
% adult social care users who have as much social contact as they would like to - 2017-18	46.0%	49.0%	50.5% (2014-15)	
Proportion of adults in contact with secondary mental health services - 2014-15	5.4%	4.0%	No change (No updated data)	

Alcohol

Indicator	England	Worcs	Baseline (Including period)	Trend
Age standardised rate of mortality considered preventable from liver disease in those aged under 75 -2015-17	16.3	15.3 (DSR per 100,000)	15.2 (2012-14)	
Alcohol specific hospital admission - Under 18 year olds -2015/16 - 17/18	32.9	31.9 (Crude rate per 100,000)	36 .0 (2012/13-2014/15)	
Persons admitted to hospital due to alcohol-specific conditions -2017-18	570	391 (DSR per 100,000)	446 (2014-15)	
Persons admitted to hospital due to alcohol-related conditions (Broad) -2017-18	2224	2022 (DSR per 100,000)	1855 (2014-15)	
Persons admitted to hospital due to alcohol-related conditions (Narrow) -2017-18	632	629 (DSR per 100,000)	641 (2014-15)	
% of those in treatment who successfully completed treatment -2017	38.9%	45.5%	31.6 (2014-15)	

Keeping Active at Every Age

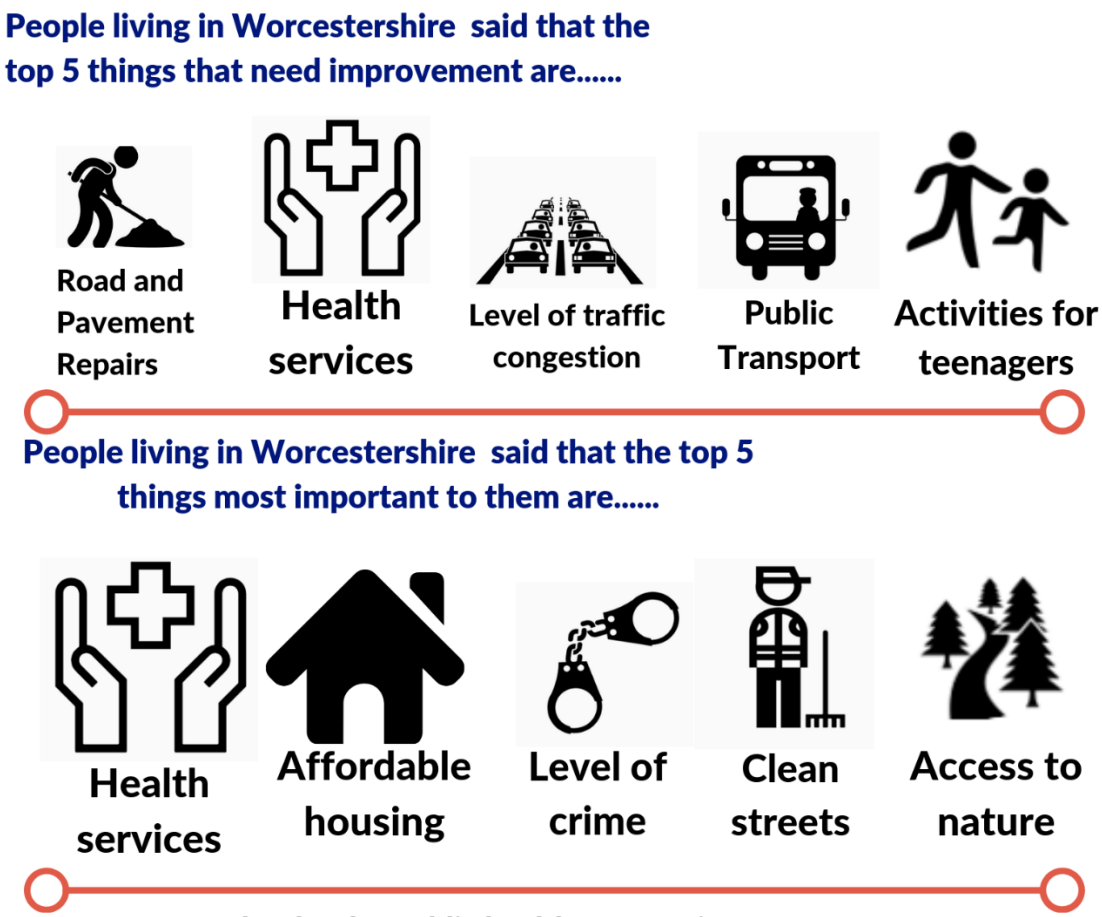
Indicator	England	Worcs	Baseline (Including period)	Trend
Age standardised rate of mortality from all cardiovascular diseases under 75 - 2015-17	72.5	64.0 (DSR per 100,000)	69.4 (2012-14)	
% children aged 4-5 years classified as overweight or obese - 2017-18	22.4%	22.4%	22.7% (2014-15)	
% children aged 10-11 years classified as overweight or obese - 2017-18	34.2%	33.8%	30.5% (2014-15)	
Physical activity measures for children and young people - % of 15 year olds physically active for at least one hour per day seven days a week - 2014-15	13.9%	15.7%	14.8% (2014-15)	No change (No updated data)
Cycling & walking travel measures for adults - proportion of residents who do any walking or cycling, for any purpose, at least once per month by local authority - 2014-15	87.1%	86.6%	86.8% (2013-14)	No change (No updated data)
% of adults achieving 150 minutes of physical activity per week. - 2017-18	66.3%	66.6%	68.3% (2015-16)	
% of adults classified as inactive - 2017-18	22.2%	21.1%	20.9% (2015-16)	
Numbers of older people taking up strength and balance training (attended at least one class) - 2018-19	-	752	469 (2015-16)	Increase from 658 in 2017-18
Numbers of people taking part in health walks - 2018-19	-	1374 (approx)	916 (2015-16)	8% increase compared to 2017-18
Numbers of people training as volunteers for health walks - 2018-19	-	71	42 (2015-16)	Increased by 10 compared to 2017-18

Local Views

Viewpoint Survey

Worcestershire County Council Viewpoint is a resident panel for research and consultation. Panel members complete an annual survey to track views on the local area and council services and may be invited to take part in other research and consultation activities through the year. Key findings from the 2018 survey are shown in Figure 49.

Figure 49. Viewpoint Survey 2018: Key Results



- Health services are viewed by Worcestershire residents as important and needing improvement

Healthwatch Reports

Healthwatch Worcestershire is an independent consumer champion giving the public, patients and users of publicly funded health and social care services in Worcestershire a voice. Since the last JSNA Annual Summary, Healthwatch Worcestershire have published the following reports:

Service User and Carer Experience of the Mental Health Home Treatment Service – March 2019

In 2016 Worcestershire Health and Care Trust approved a new model of support for adults with mental health issues. The new model aimed to be more community based, recovery focussed, allow people to maintain control and independence and reduce the risk of people needing to be admitted to a mental health ward.

Healthwatch were keen to explore the patient experience of the re-designed service in relation to: care planning and crisis planning, information and support and carer experience. People and their carers who had been discharged from the service were surveyed. All participants were also given the opportunity to meet if they wished to discuss their experience in person.

Healthwatch found overall a high level of service user satisfaction with the Mental Health Home Treatment service amongst respondents. However, they also identified areas for improvement and were able to make a number of recommendations including:

- greater consistency of staff members visiting service users at home,
- provision of a patient discharge summary,
- increase awareness of how to make a complaint,
- provision of information to carers about carer support groups/organisations.

As a result, the Worcestershire Health and Care Trust are introducing new shift patterns for Home Treatment Team staff to enable greater consistency of home visits. PALS information leaflets are routinely provided to service users along with carer support information to carers and discharge summaries are now provided in plain language.

Further positive actions are being taken in response to other recommendations in the report. The full report and responses to recommendations and actions to be taken can be found via the following link: https://www.healthwatchworcestershire.co.uk/service-user-and-carer-experience-of-the-mental-health-home-treatment-plan-march-2019/

Children and Young People's Mental Health Report – March 2019

This report focussed on experiences of accessing mental health for children and young people.

Healthwatch conducted surveys and engagement work with both parents and carers and children and young people themselves.

Overall the findings suggested that more information is needed for parents, carers and young people about the support available and how this is accessed. There is also a need to ensure there is sufficient support available, increased awareness and support in

schools, reduced waiting times for Child and Adolescent Mental Health Services and appropriate support for children and young people with Autism Spectrum Conditions.

The report and responses to the recommendations and actions to be taken can be found via the following link: https://www.healthwatchworcestershire.co.uk/children-and-young-peoples-mental-health-report-march-2019/

Going to the Dentist – February 2019

This work sought to explore the reasons why people might not attend the dentist as frequently as recommended.

Two surveys were completed; one of adults and one of children and young people. Healthwatch also spoke to people with learning disabilities, sight loss, those who were homeless or living in temporary accommodation, college students and parents of children under five.

Overall there were many positive messages from the work, but Healthwatch also identified some issues which may result in less frequent attendance at dental check-ups including:

- cost,
- lack of information,
- confusion over charging,
- fear and
- in some cases difficulty in finding an NHS dentist locally.

Drawing on what people had told them Healthwatch made a number of recommendations about how people's experience could be improved.

The report, and the responses to the recommendations and actions to be taken, can be found via the following link: https://www.healthwatchworcestershire.co.uk/going-to-the-dentist-in-worcestershire/

The report, and the responses to the recommendations and actions to be taken, can be found via the following link: https://www.healthwatchworcestershire.co.uk/going-to-the-dentist-in-worcestershire/

NHS Long-Term Plan Healthwatch Engagement Report 2019

The NHS launched its long-term plan in January 2019 setting out the vision for the next ten years.

Healthwatch Herefordshire and Healthwatch Worcestershire spent time from March to June 2019 gathering views across both counties on local NHS priorities in the plan to help shape how the local NHS system implements the visions of the plan, to make it a reality for our local services. The Report will now be used by the NHS across both counties to shape an implementation plan for the next few years, that will determine the planning and delivery of NHS services. It can be found via the following link: https://www.healthwatchworcestershire.co.uk/nhs-long-term-plan/

Further Information and Feedback

This report has been written by Worcestershire County Council's Public Health Team with guidance and support from the Joint Strategic Needs Assessment Working Group.

We welcome your comments and questions - please do contact us.

This document can be provided in alternative formats such as large print, audio recording or Braille.

Contact for comments, questions and alternative formats: Janette Fulton, Tel: 01905 843359, Email: jfulton@worcestershire.gov.uk

Appendix 1

Where Worcestershire Has Performed Consistently Better Than England – Full List of Indicators

The following table shows Public Health Outcomes Framework Indicators where Worcestershire has performed consistently better than England since 2014 (i.e. for 5 years or more) and where there is no evidence of a worsening trend.

Table 15 Public Health Outcomes Framework Indicators Where Worcestershire Performs Consistently Better Than England

Indicator	Worcestershire	England
Female Healthy Life Expectancy (2015-17)	67.2 years	63.8 years
Male Healthy Life Expectancy (2015-17)	65.7 years	63.4 years
Female Life expectancy at 65 (2015-17)	21.5 years	21.1 years
Male Life Expectancy at 65 (2015-17)	19.0 years	18.8 years
Children in low income families (all dependent children under 20, 2016)	14.1%	17.0%
Hospital admissions for violence (2015/16 to 17/18; Directly Standardised Rate)	24.0 per 100,000	43.4 per 100,000
The rate of complaints about noise (2015/16)	3.9 per 1,000	6.3 per 1,000
Households in temporary accommodation (2017/18)	0.4 per 1,000	3.4 per 1,000
Abdominal Aortic Aneurysm Screening – Coverage (2017/18)	86.4%	80.8%
Emergency hospital admissions due to falls in people aged 65 and over (2017/18)	1,732 per 100,000	2,170 per 100,000
Population vaccination coverage MMR for one dose (5 years old, 2017/18)	97.3%	94.9%
TB Incidence (three-year average, 2015-17)	3.1 per 100,000	9.9 per 100,000
Mortality form causes considered preventable (2015-17, Directly Standardised Rate)	165.7 per 100,000	181.5 per 100,000
Premature mortality; cardiovascular disease (2015-17, Directly Standardised Rate)	64.0 per 100,000	72.5 per 100,000

Premature mortality; respiratory disease (2015-17, Directly Standardised Rate)	28.0 per 100,000	34.3 per 100,000
Health related quality of life for older people (2016/17)	0.758 Mean Score	0.735 Mean Score

This page is intentionally left blank

Worcestershire Health and Well-being Board

JSNA Profile on Housing and Health

Information Lead:	Janette Fulton	Version:	0.13
Written By:	Cameron Russell	Date:	06/09/2019
Review Date:	31/08/22		

Executive Summary

1. Context

1.1. **There is a new drive to promote closer working between housing and health through the 2018 document *Improving Health and Care through the home: A National Memorandum of Understanding*. This has emerged from a greater recognition of the relationship between housing and health.**

The document sets out:

- A shared commitment to joint action across sectors.
- Principles for joint working.
- The framework for designing and delivering healthy homes, communities and services.
- Success criteria to deliver and measure impact.

1.2. Other recent major national initiatives which link housing with health include:

- Building regulations/ Energy Performance Certificates (EPC) guidelines- changes to improve accessibility of homes and energy efficiency.
- Homelessness legislation- increased duties for local authorities.
- Planning for Health - Health Impact Assessment.

2. The link between housing and health

2.1. **Housing is one of the wider determinants of health- the broad social and economic circumstances that together determine people's health and well-being.**

2.2. There are significant risks to an individual's physical and mental health associated with living in dwellings including:

- A cold, damp, or otherwise hazardous home (an unhealthy home) - 11.5% of Worcestershire households are in fuel poverty (2016).
- A home that doesn't meet the household's needs due to risks such as being overcrowded (2.7% of Worcestershire households in 2011) or inaccessible to a disabled or older person (an unsuitable home).
- A home that does not provide a sense of safety and security including precarious living circumstances and/or homelessness (an unstable home). 677 people in Worcester were statutory homeless in 2016/17. Homelessness and rough sleeping can result in multiple adverse physical and mental health impacts.

2.3. Evidence from research is strongest for cold homes and fuel poverty having adverse effects on both mental and physical health.

3. Demographic change and housing affordability

3.1. **With strong population growth expected in the future, building of new homes may struggle to keep up. The potential consequences of this are limitations on economic growth and reducing housing affordability. Both nationally and locally we have seen worsening affordability of housing.**

3.2. The total population of Worcestershire is forecast to increase by 38,000 (6.4%) by 2035.

3.3. The Worcestershire population is ageing. A large proportion of the Worcestershire population is in the middle-aged and older age groups and by 2035 this is projected to translate into a large increase of the number of people in the older age groups and, in particular, the very oldest age groups. For example, by 2035 the 65-69 population is forecast to increase by 19% while the number of people aged 85 or over. is set to increase by 92%.

3.4. Housing affordability affects where people live and work, and factors that influence health, including the quality of housing available, poverty, community cohesion, and time spent commuting. In common with the rest of the country, Worcestershire districts have seen a considerable decrease in the affordability of housing relative to earnings since 1999. However, the figures have plateaued somewhat in recent years, possibly due to the ongoing effect of the economic downturn. Further details are on p19.

4. Key indicators

4.1. **The Worcestershire figures for most public health indicators related to housing are similar to England. However, we might expect a relatively affluent county such as Worcestershire to have better values.**

4.2. Homeless young people is the only public health indicator which is significantly worse than England. Fuel poverty, overall homelessness and housing affordability measures are slightly worse than England.

*Table 1: Key housing and health indicators**

	Period	Worcestershire	Trend	England
Fuel Poverty	2016	11.5%	Improving	11.1%
Overcrowded Households	2011	2.7%	-	4.8%
Discharge from Hospital (65+)	2017/18	81.4%	Improving	82.9%
Statutory Homelessness (rate per 1000)	2017/18	2.7	Flat	2.4
Homelessness (young people aged 16-24)	2017/18	0.68	Improving	0.52
Housing Affordability Ratio	2016	8.1	-	7.2

Source: Public Health Outcomes Framework

* A full set of housing and health indicators can be seen on page 48.

5. Housing stock condition

5.1. **There is a considerable proportion of non-decent housing in Worcestershire, ranging from 26.6% in Redditch to 44.0% in Malvern Hills (2011). Non-decent housing is identified in terms of hazards to health and thermal comfort.**

5.2. Stock condition information from 2011 indicates that Malvern Hills (44.0%), Wyre Forest (37.9%) and Wychavon (38.0%) had a higher proportion of non-decent housing than that seen nationally. While the proportion of households in private accommodation classified as vulnerable was lower than the England value of 20.3% in all Worcestershire districts, the highest rates were in Wyre Forest (19.7%), Redditch (19.6%) and Worcester (18.5%).

6. Warm and healthy homes

6.1. **The strongest evidence on the link between housing and health relates to fuel poverty and energy efficiency. Interventions in this field, targeted on the most deprived and vulnerable households, are likely to have a significant effect on the health of the population.**

6.2. Fuel poverty impacts a) the direct effects of living in a cold home and b) the indirect effect of carbon emissions on air quality which result from poor energy efficiency.

6.3. Fuel poverty is worse than nationally in Malvern Hills, Worcester and Wyre Forest. Cold homes have been linked to excess winter deaths, cardio-vascular illness, respiratory illness and falls in the home. Older people face particular susceptibility to

such outcomes. Beyond physical health, there is evidence to suggest a significant link between cold homes and poor mental health (anxiety and depression).

6.4. Interventions in Worcestershire include programmes to improve central heating and encourage tariff switching.

7. Older people

7.1. Housing and health issues which are pertinent to older people include falls prevention, accessibility of buildings, discharge for hospital, mental health and helping people to die at home.

7.2. Housing can play a potential role in falls prevention. Home Assessment and Modification (HAM) is a service in which relevant experts risk assess a person's usual residence to identify environmental hazards and carries out actions to reduce these. Typical environmental hazards are loose mats, poor lighting and no handrails.

7.3. Accessibility of buildings. The benefits of adapting the home are recognised as an effective way to improve the health and wellbeing of older people, and disabled adults and children. A more accessible home environment can improve independence, reduce risk and reduce reliance on assistance.

7.4. Discharge from hospital. The proportion of older people who were still at home 91 days after discharge has been improving in Worcestershire in recent years but is still below the national rate.

7.5. The Prime Minister's Challenge on Dementia 2020[1] includes an ambition for increased numbers of people with dementia being able to live longer in their own homes when it is in their interests to do so, with a greater focus on independent living.

7.6. Helping People to be Cared for and Die at Home[2]. Championing the role of social housing and supporting the development of frontline housing staff to respond to this agenda.

8. Homelessness and rough sleeping

8.1. **Overall homelessness is close to the national rate, but for young people Worcestershire has a relatively high rate of statutory homelessness. The economic recession saw statutory homelessness in the county peak in 2011, since then it has fallen, but it still remains above pre-2011 levels.**

[1] Department of Health and Social Care, 2015.

[2] Housing LIN (Learning and Improvement Network), Feb 2016, *End of Life Care: Helping people to be cared for and die at home*

8.2. Official figures from the Ministry of Housing, Communities and Local Government, indicate that there were 53 people sleeping rough in Worcestershire in Autumn 2018. This is a considerable increase from the 25 people recorded in Autumn 2017 (the figures do tend to fluctuate from year to year).

8.3. Homeless people are at increased risk of a wide range of health problems related to physical health, mental health and substance misuse (usage of illegal and prescribed drugs, and of tobacco and alcohol).

8.4. Physical health problems include circulatory and respiratory conditions, joint aches and pains and poor oral health. There is evidence that many homeless people have two or more long-term conditions (LTCs), a situation known as 'multimorbidity'.

8.5. The Homelessness Reduction Act 2017 increased the scope of duties of local authorities towards the homeless. Proposed changes to legislation and benefits are likely to have an impact on official homeless numbers.

9. Planning for health

9.1. **Good health includes physical, mental and social wellbeing. Support for good health, including health care services provision, requires the application of best practice in a range of areas, including planning.**

9.2. Positive measures include:

- Planning for built and natural environments that provide suitable living conditions, encourage good physical and mental health and wellbeing, and prevent people becoming ill.
- Ensuring access to facilities that promote, provide and encourage healthier lifestyle
- choices or that deal with ill health, and a means of getting to those facilities.
- Providing health-promoting environments to support recuperation when people do fall ill.

9.3. National guidance on planning for health[3] has been published online by the Ministry of Housing, Communities and Local Government. In addition, Public Health England have a Healthy Places Programme[4] which supports the development of healthy places and homes.

9.4. Health Impact Assessment (HIA) is a tool to assess the potential health implications on a population of a planning proposal. HIAs ensure that the effects of development on both health and health inequalities are considered and addressed during the

[3] *The role of health and wellbeing in planning*, 2014, Ministry of housing, Communities and Local Government, https://www.gov.uk/guidance/health-and-wellbeing
[4] https://www.gov.uk/government/publications/phe-healthy-places/healthy-places

planning process. HIAs are currently being produced systematically in South Worcestershire and increasingly so across the north of the county.

Recommendations

If action is not taken to improve the quality and availability of homes, the pressure on decreasing health and social care budgets is likely to increase.

Further work, in diverse areas, has been identified in the recommendations of this report. Areas include: Warm and healthy homes, the ageing population, homelessness and rough sleeping, falls prevention and planning for health. To take this forward will require effective joint working across agencies.

Recommendations	Lead Organisation(s)
Joint working in Housing and Health	
1. To take forward locally the objectives in the National Memorandum of Understanding. Stakeholders should use evidence and information to inform plans, strategies and commissioning at a local level. This will help to ensure that home and housing circumstances and their effect on health and wellbeing are suitably considered.	Health and Wellbeing Board Worcestershire Strategic Housing Partnership
2. To support the development of a joint preventative approach that maintains people's independence at home, reduces hospital admissions and provides effective discharge from hospital.	Health and Wellbeing Board, Worcestershire Strategic Housing Partnership
Warm and healthy homes	
3. Fuel poverty is a major issue affecting the county, there will be a need to build upon interventions in Worcestershire to address thermal comfort and low incomes.	Warmer Worcestershire network (WCC, District Councils, Act on Energy Age UK Hereford and Worcester Fire and Rescue Service, Public Health Practitioners, Care and Repair) Integrated Care for Older People (ICOPE) in Worcestershire

Recommendations	Lead Organisation(s)
Ageing population	
4. There is a need to ensure readiness for future increases in the number of older people and single person households. Action is required to improve the quality, suitability and availability of homes.	WCC (Adult Social Care/Public Health), Worcestershire Strategic Housing Partnership/ local planning authorities
Homelessness and rough sleeping	
4. Ensuring that needs of homeless people are included in Joint Strategic Needs Assessments to inform local planning and commissioning.	WCC Public Health
6. Ensuring awareness amongst policy makers of severity and nature of health problems for homeless people.	Health and Wellbeing Board, Worcestershire Strategic Housing Partnership
7. Improving access to health services for homeless people through joint working between local agencies.	Health and Wellbeing Board, Worcestershire Strategic Housing Partnership
8. Continuing to work in partnership in line with Worcestershire Homelessness and Rough Sleeping Strategy.	Worcestershire Strategic Housing Partnership
Falls prevention	
9. Services (in house and commissioned) to collaborate across health, social care and housing to ensure that a prevention focus with information, advice and adaptation services is available across the County.	WCC Public Health, Worcestershire Strategic Housing Partnership
Children and young people	
10. Joint working to reduce unintentional injuries using the NICE guidance[5]. Including: • Collecting information. • Determining and addressing barriers to creating a safe home environment. • Getting the community involved using 'community champions'. • Carrying out home safety assessments. • Supplying and installing home safety equipment.	Worcestershire Children First, environmental health, Fire and rescue services, Health visiting

[5] https://www.nice.org.uk/guidance/ph30

Recommendations	Lead Organisation(s)
Planning for Health	
11. Wyre Forest District Council, Redditch Borough Council and Bromsgrove District Council to consider adopting a similar approach to that set out in the South Worcestershire Planning for Health SPD.	WCC Public Health and district council planning authorities
12. Further develop planning processes conducive to health and wellbeing, using tools such as Health Impact Assessments and the Public Health England Healthy Places Programme.	WCC public health, WCC planning and district council planning authorities

Acknowledgements

We acknowledge and thank members of the Housing and Health Working Group, including:

- Worcestershire County Council representatives.
- District council representatives.
- NHS: Redditch and Bromsgrove, South Worcestershire and Wyre Forest Clinical Commissioning Groups.
- Worcestershire Healthwatch.

Table of Contents

Full Report

Background

This is the first Worcestershire JSNA report which looks in depth at the overall relationship between housing and health. It builds on the 2018 Homeless Health Profile.

Our home environment affects our well-being, risk of disease and demands on health and care services. We need warm, safe and secure homes to help us to lead healthy, independent lives and to recover from illness.

People living in poor housing conditions directly affects demand on health services. The Building Research Establishment (BRE) suggested the cost of poor housing to the English NHS was £2 billion per annum and this figure is based on first year treatment costs only.[6]

In March 2018, Public Health England published *Improving Health and Care through the home.* This is a national Memorandum of Understanding (MoU) which was signed by over 25 government bodies and organisations in the health, social care and housing sector.[7] The MoU aims to maximise opportunities to embed the role of housing in joined up action on improving health and better health and social care services. It sets out:

- A shared commitment to joint action across sectors.
- Principles for joint working.
- The framework for designing and delivering healthy homes, communities and services.
- Success criteria to deliver and measure impact.

The MoU states that "local Health and Well-being Boards have a duty to understand the health and well-being of their communities, the wider factors that impact on this and local assets that can help to improve outcomes and reduce inequalities. The inclusion of housing and housing circumstances, for example, homelessness in Joint Strategic Needs Assessments, should inform the Health and Well-being Strategy and local commissioning". This profile has been produced to help satisfy this requirement and is intended to form part of an evidence-base around housing and health in Worcestershire which can be drawn upon by stakeholders.

[6] BHE (2015), *Cost of Poor Housing Briefing,* https://www.bre.co.uk/filelibrary/pdf/87741-Cost-of-Poor-Housing-Briefing-Paper-v3.pdf

[7] Public Health England (2018),. *Improving Health and Care through the home: A National Memorandum of Understanding.* PHE publications gateway number 2017861 https://www.gov.uk/government/publications/improving-health-and-care-through-the-home-mou

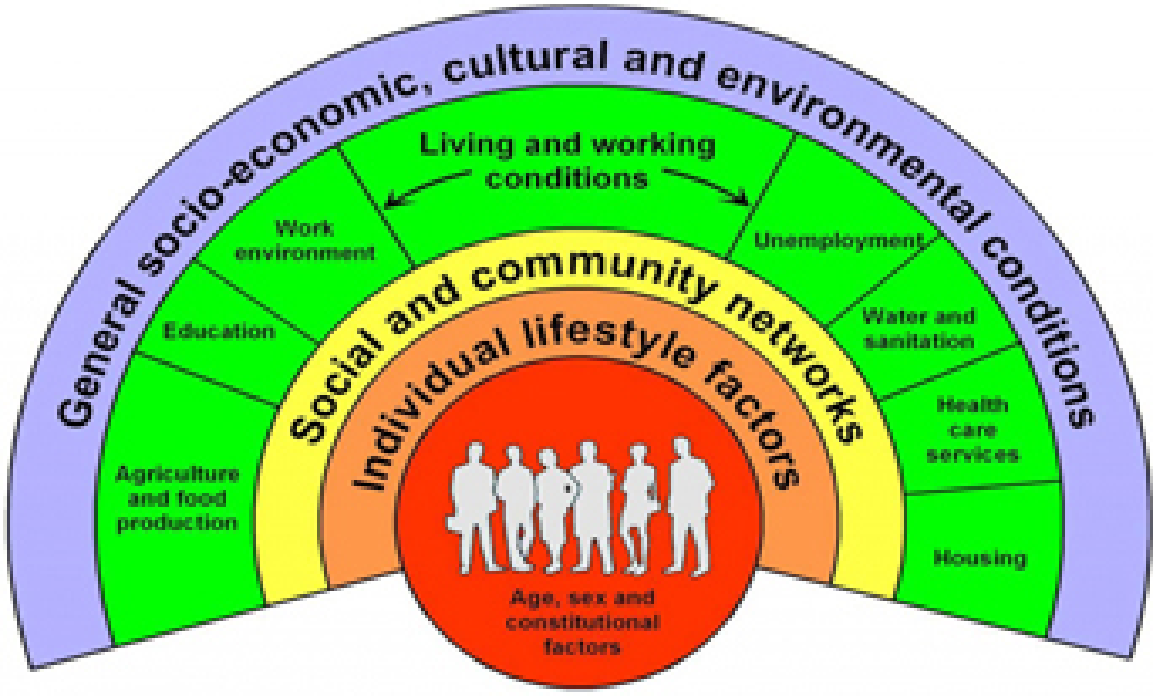
This report focusses on the following topics and their relevance to vulnerable groups of people such as the homeless, older people, people with long-term conditions including mental ill health or learning and physical disabilities, and families with young children:

- Insecure housing, such as temporary accommodation and homelessness.
- The condition of the housing stock.
- Fuel Poverty.
- Homes that do not meet household needs due to size, amenities, location or affordability.

The Link Between Housing and Health

The broad social and economic circumstances that together determine people's health and well-being are known as the 'wider determinants of health'. Figure 1 shows housing as part of the living and working conditions which affect people's health and well-being.

Figure 1 The Dahlgren and Whitehead Model of Health Determinants



Source: Dahlgren and Whitehead (1991)[8]

[8] Dahlgren G, Whitehead M (1991*). Policies and strategies to promote social equity in health,* Stockholm Institute for Further Studies

Public Health England have provided a useful summary which neatly encapsulates the links between housing and health:

There are risks to an individual's physical and mental health associated with living in:

- A cold, damp, or otherwise hazardous home (an unhealthy home).
- A home that doesn't meet the household's needs due to risks such as being overcrowded or inaccessible to a disabled or older person (an unsuitable home).
- A home that does not provide a sense of safety and security including precarious living circumstances and/or homelessness (an unstable home).

The right home environment protects and improves health and well-being and prevents physical and mental ill health. It also enables people to:

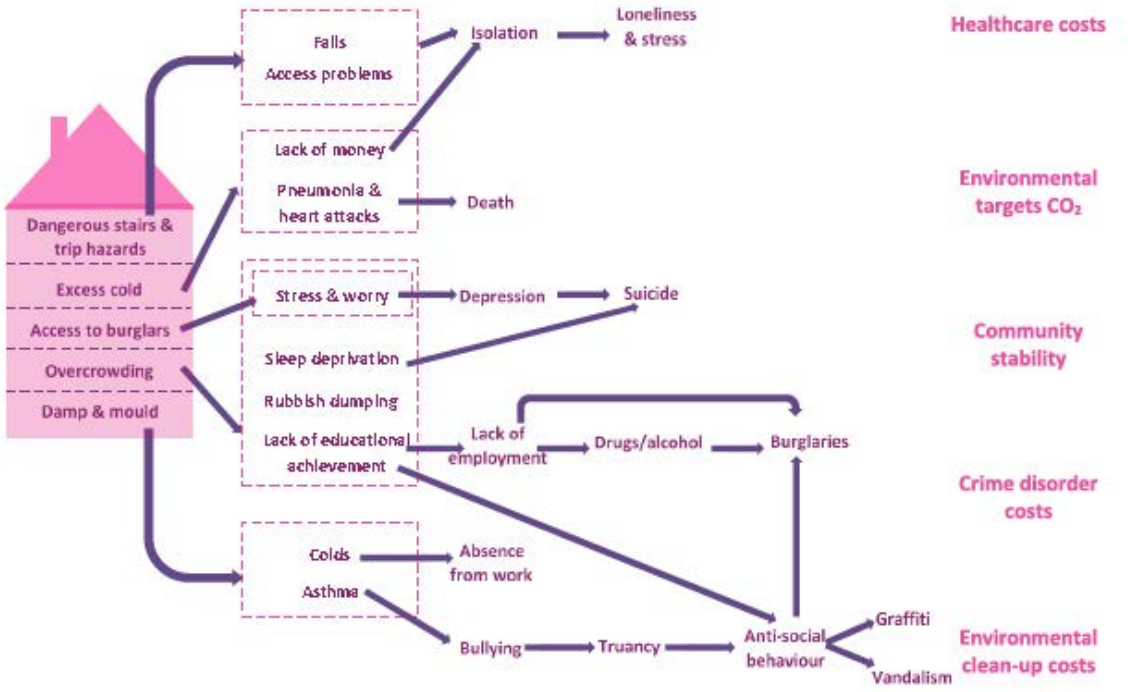
- Manage their own health and care needs, including long-term conditions.
- Live independently, safely and well in their own home for as long as they choose.
- Complete treatment and recover from substance misuse, tuberculosis or other ill health.
- Move on successfully from homelessness or other traumatic life event.
- Access and sustain education, training and employment.
- Participate and contribute to society.

Source: Public Health England 'Improving Health Through the Home' (2017)[9]

[9] https://www.gov.uk/government/publications/improving-health-through-the-home

Figure 2 shows the complex relationship between housing hazards and health. Hazards shown include dangerous stairs and trip hazards, excess cold, access to burglars, overcrowding and damp and mould. These are shown as leading to adverse outcomes including falls, loneliness, stress, pneumonia, heart attacks, depression and suicide.

Figure 2 Relating Housing Hazards to Health



Source: Wyre Forest Health Impact Assessment[10]

The most significant housing hazards and their associated health effects linked to poor housing have been identified in a systematic review[11] and are outlined below:

Significant housing hazards*

Air Quality (particles and fibres causing death among the very ill)
Conditions of warmth and humidity
Radon
Slips, trips and falls
Noise
House dust mites
Environmental tobacco smoke
Fires

*Seriousness of hazard assessed and ranked by number of people affected, seriousness of effect and strength of evidence

[10] BRE (2016). *Wyre Forest Health Impact Assessment*. BRE.

[11] Thomson H, Thomas S, Sellström E, Petticrew M. Housing Improvements for Health and Associated Socio-Economic Outcomes: A Systematic Review Campbell Systematic Reviews 2013:2

Associated health effects

Respiratory symptoms, asthma, lung cancer
Depression and anxiety
Injury or death from accidents and fires
Hypothermia
Skin and eye irritation
General physical symptoms

What is known about housing in England?

The Health Profile for England 2017 combines data to give a broad picture of the Health of People in England[12]. Some important housing-related findings from the report were:

- In 2013, a fifth of dwellings (21% or 4.8 million homes) failed to meet the decent homes standard[13], which is a reduction of 2.9 million homes since 2006 when around a third of homes (35% or 7.7 million) failed to meet the standard.
- Significant expansion of the private rented sector in the last 20 years (from 10% to 19%) has provided an additional 2.5 million homes. However, **this sector had the highest proportion of non-decent homes**. The social rented sector had the lowest proportion of non-decent homes (15%) and almost a fifth (19%) of owner-occupied homes failed to meet the standard. Conditions in the private rented sector are still behind, but the situation has been improving, falling from 47% of non-decent homes in 2006 to 28% in 2014. More families with children are using the private sector where homes are less likely to meet the decent homes standard.
- With the shortage of housing in the social rented sector, due in part because of a lack of affordable housing, **more low-income families are relying on private sector accommodation**, where homes are less likely to be affordable and meet the decent homes standard.
- Fuel poverty is the condition of being unable to afford to keep one's home adequately heated for comfort, and this is one of the factors associated with a reduced quality of health. In England, 10.6% of households were fuel poor in 2014. However, **a social gradient in fuel poverty exists where those on lower household incomes are more likely to be at risk of fuel poverty**, contributing to social and health inequalities.
- In 2014, 12.6% of households living in the most deprived local authorities were living in fuel poverty, compared to just 7.6% of households in the least deprived local authorities. **Households living on low income are more likely to live at lower temperatures.** Living at lower temperature is linked to a range of negative health outcomes including **cardiovascular** and **respiratory disease** and contributes to **excess winter deaths** across England.

[12] Public Health England. *Health Profile for England 2017*. Available at: https://www.gov.uk/government/publications/health-profile-for-england
[13] The criteria for the decent homes standard are as follows: it must meet the current statutory minimum standard for housing; it must be in a reasonable state of repair; it must have reasonably modern facilities and services; it must provide a reasonable degree of thermal comfort

What is known about Worcestershire?

Population Characteristics

Understanding the size and characteristics of the population is vital when it comes to planning and delivering services.

The following section describes the characteristics of the current and future population of Worcestershire. For District and Ward break downs and the most up to date figures a live 'data dashboard' is available on the Joint Strategic Needs Assessment (JSNA) Website[14].

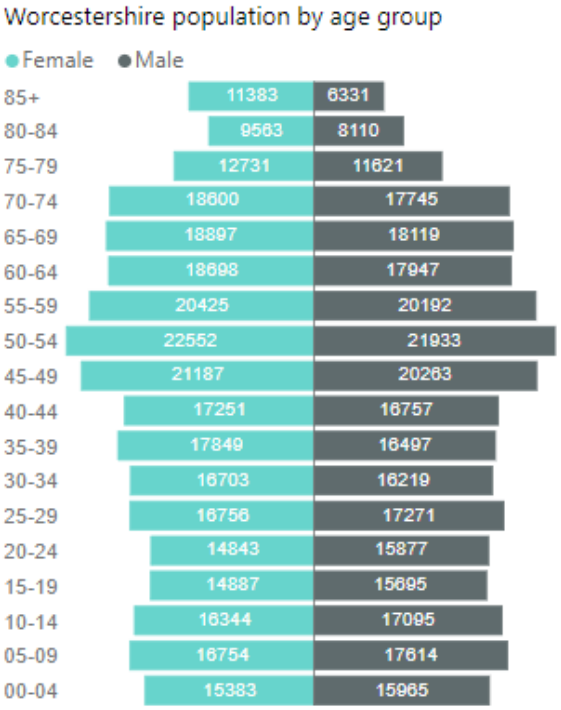
The current population of Worcestershire in 2018 is estimated to be 592,057[15] and this figure is projected to rise to 630,508 by 2035 according to ONS projections. This is an increase of approximately 38,500, which may be an underestimate as these national projections do not sufficiently take account of local housebuilding.

[14] http://www.worcestershire.gov.uk/info/20122/joint_strategic_needs_assessment
[15] Office for National Statistics (ONS) 2017 Mid-Year Estimate

Figure 3 shows the current age structure of the Worcestershire population.

The Worcestershire population is ageing. A large proportion of the Worcestershire population is in the middle-aged and older age groups and by 2035 this is projected to translate into a large increase the number of people in the older age groups and, in particular, the very oldest age groups - as can be seen from Figure 4.

Figure 3: 2018 Age structure of the Worcestershire population

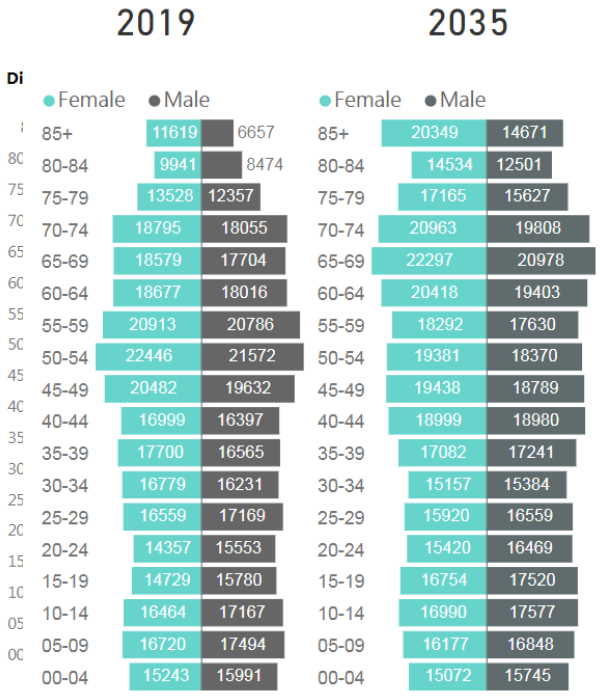


Worcestershire population by age group & gender

Age	Female	Male	Total
00-04	15383	15965	31348
05-09	16754	17614	34368
10-14	16344	17095	33439
15-19	14887	15695	30582
20-24	14843	15877	30720
25-29	16756	17271	34027
30-34	16703	16219	32922
35-39	17849	16497	34346
40-44	17251	16757	34008
45-49	21187	20263	41450
50-54	22552	21933	44485
55-59	20425	20192	40617
60-64	18698	17947	36645
65-69	18897	18119	37016
70-74	18600	17745	36345
75-79	12731	11621	24352
80-84	9563	8110	17673
85+	11383	6331	17714
Total	300806	291251	592057

Data from ONS mid-year population estimates

Figure 4 Population Projections for Worcestershire, 2019-2035



Household Composition

Office for National Statistics (ONS) projections show that nationally one-person households are projected to increase by 26% by 2041. Most of the growth in one-person households is projected to take place among households headed by older people. By 2041, there will be more people living alone who are aged 65 years and over than those who are less than 65 years old.

A similar pattern is seen for Worcestershire with particularly high growth rates in single person households for older age groups. Between 2019 and 2039, the number of all one person households is projected to increase by 20%, while the growth rate for over 65s is 44%. Reflecting the national trend, by 2039 most single person households in Worcestershire will be aged 65 and over (Table 2).

Table 2: Single Person Household projections, Worcestershire 2019-2039

Group	2019	2039	Change
Male under 65	23312	23140	-1%
Male 65 and over	12795	18661	46%
Female under 65	15733	15135	-4%
Female 65 and over	23882	34021	42%
All under 65	39045	38275	-2%
All 65 and over	36677	52682	44%
All single person households	75722	90958	20%

Source: Office for National Statistics

Dwelling Projections

The number of homes planned is available from local plans (Table 3).

Table 3 Homes Planned (from adopted local plans)

South Worcestershire Development Plan 2006	2030 = 28,400 homes
Bromsgrove District Plan 2011	2030 = 7,000 homes
Redditch Borough Plan 2011	2030 = 6,400 homes
Wyre Forest Core Strategy 2006	2026 = 4,000 homes
Total	45,800

Homes Delivered

From 2011 to mid-2017, 11,268 homes had been delivered. 2,408 homes were delivered in 2016/17.

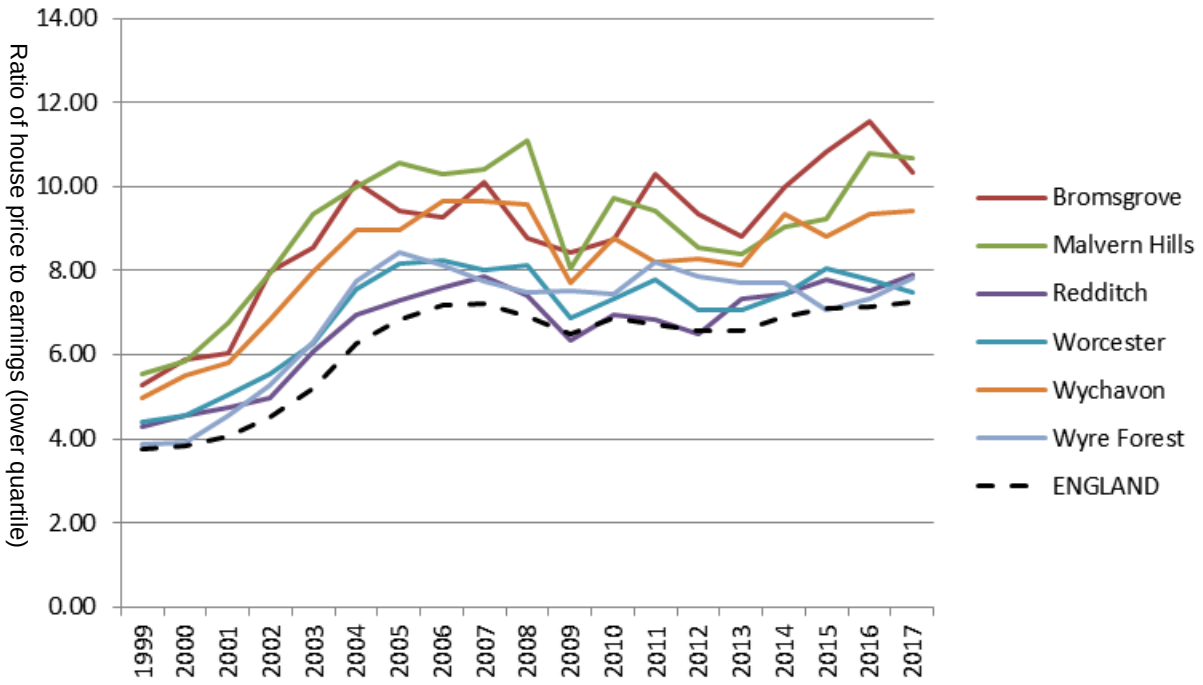
Currently all districts, with the exception of Bromsgrove and Redditch, are delivering over their accumulated targets. Bromsgrove and Redditch have under-delivered by approximately 1,600 homes since 2011.

The annual delivery rate across the county will need to be approximately 2,600 per year from 2021 to 2030 to deliver both the required numbers and any short fall from previous delivery, which is an unprecedented number for the county.

Housing Affordability

The economic situation of households is a key determinant of their ability to secure healthy and secure accommodation. Housing affordability affects where people live and work, and factors that influence health, including the quality of housing available, poverty, community cohesion, and time spent commuting.

Figure 5 Housing Affordability in Worcestershire; Ratio of Lower Quartile House Price to Lower Quartile Earnings[16]



Source: Office for National Statistics

Figure 5 shows how house prices relate to earnings for Worcestershire residents who earn the least (a ratio of the lowest 25% of house prices to lowest 25% of earners) termed the 'Housing Affordability Ratio'. The housing affordability ratio has remained consistently higher in Worcestershire districts compared to England. This means that in Worcestershire houses are less affordable for people whose earnings are in the lowest 25% of all earnings.

In common with the rest of the country, Worcestershire districts have seen a considerable decrease in the affordability of housing relative to earnings since 1999. However, the figures have plateaued somewhat in recent years.

Since 1999, Worcestershire has largely followed the national trend of housing becoming less affordable. However, there has been a noticeable slowdown in rate of increase since the impact of the economic downturn of 2008.

[16] The affordability ratios are calculated using Office for National Statistics (ONS) House Prices Statistics [1] (based on Land Registry data) and earnings from the Annual Survey of Hours and Earnings [2]. The earnings relate to the respondent's place of residence rather than place of work. This means that affordability in commuter areas reflects the earning power of commuters.

Households in Receipt of Housing Benefit

Table 4 shows the rate of housing benefit claimants by Worcestershire district. The highest rate of Housing Benefits claimants is in Wyre Forest District, the lowest is Bromsgrove District.

All districts have a housing benefit claimant rate that is significantly lower than England.

Table 4 Households in Receipt of Housing Benefit, April 2018

Area	No of Households on Housing Benefit	Rate per 10,000 Households
Bromsgrove	3,504	868
Malvern Hills	3,758	1,105
Redditch	4,855	1,377
Worcester	6,408	1,456
Wychavon	6,047	1,137
Wyre Forest	6,817	1,518
England	4.2 million	1,809

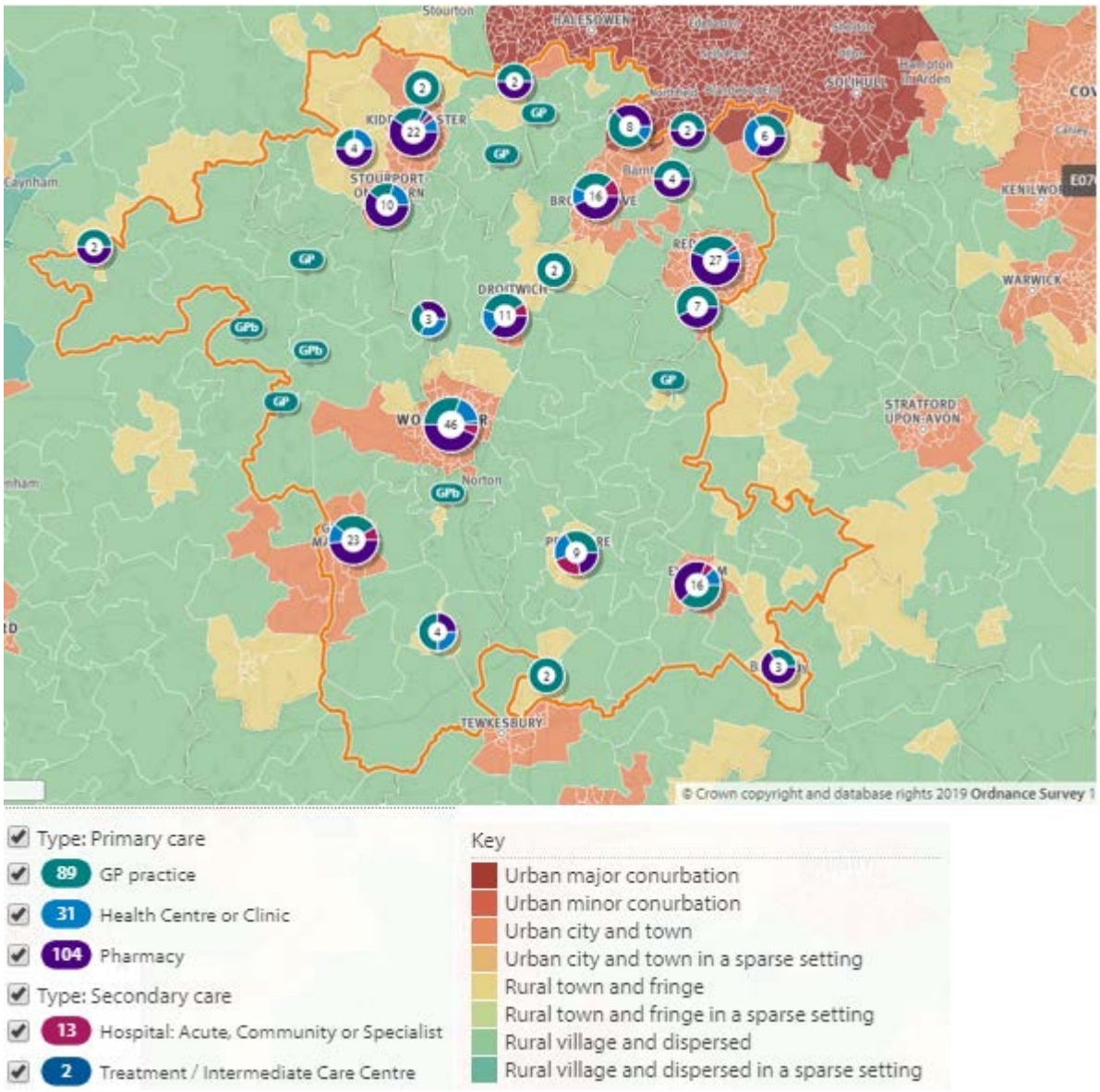
Source: Department of Work and Pensions (Stat-Xplore)

Access to Services

Worcestershire is predominantly rural but has some significant urban districts. The location of housing can affect access to local services.

As Figure 6 shows, most health services in the county are located in urban areas, which can present issues for those living in rural areas, particularly when access to a car is not available. Worcestershire has 64% of households with access to GPs within 15 minutes by public transport or walking compared to the England average of 81%.[17]

Figure 6: Map of Rural/Urban Classification and Health Service distribution in Worcestershire



Source: Public Health England SHAPE tool. Available at: https://shapeatlas.net.

[17] Worcestershire JSNA Briefing on Rural Health (forthcoming)

Housing Stock Condition

Non-Decent Housing

A decent home meets the following four criteria:

a. It meets the current statutory minimum for housing[18].
b. It is in a reasonable state of repair.
c. It has reasonably modern facilities and services.
d. It provides a reasonable degree of thermal comfort.

Figure 7 shows some stock condition information from 2011. It indicates that Malvern Hills, Wyre Forest and Wychavon had a higher proportion of non-decent housing than that seen nationally. While the proportion of households in private accommodation classified as vulnerable was lower than England in all Worcestershire districts, the highest rates were in Wyre Forest, Redditch and Worcester.

Figure 7 Stock Condition in Worcestershire, 2011

Authority	% non-decent dwellings	% of households in private accommodation classified as vulnerable	% of households classified as vulnerable and living in a non-decent property
Bromsgrove	33.0%	14.5%	5.1%
Malvern Hills	44.0%	15.1%	6.9%
Redditch	26.6%	19.6%	5.9%
Worcester	32.8%	18.5%	7.0%
Wychavon	38.0%	15.5%	6.1%
Wyre Forest	37.9%	19.7%	8.1%
England	35.8%	20.3%	7.9%

Source: Worcestershire Strategic Market Assessment 2012

More recent data on stock condition is available for Wyre Forest and Worcester City council districts:

Wyre Forest District (2016)

There are an estimated 9,127 category 1 hazards in Wyre Forest's private sector stock, of which 1,413 are within the privately rented sector. The owner-occupied sector contains the greatest number of category 1 hazards requiring an estimated £17.6 million to mitigate. The most common hazards are falling on stairs (3,631 hazards), excess cold (2,438 hazards) and falls associated with baths (662 hazards) (see Table 5).

The estimated total cost of mitigating all these hazards is £20.6 million with £3 million in the private rented sector.
In Wyre Forest District it is estimated that poor housing conditions are responsible for over 327 harmful events requiring medical treatment every year.

[18] The Housing Health and Safety Rating System (HHSRS) is a risk-based evaluation tool to help local authorities identify and protect against potential risks and hazards to health and safety from any deficiencies identified in dwellings. It was introduced under the Housing Act 2004 and applies to residential properties in England and Wales.

If these hazards are mitigated then the total annual savings to society are estimated to be £17.5 million, including £1.5 million of savings to the NHS in the cost of treating accidents and ill-health.

Table 5 The estimated number of category 1 hazards by tenure and estimated number of instances requiring medical intervention in Wyre Forest, private sector stock (IMD lowest 20% is across all stock)

Housing hazard type	Total Private Stock	Owner Occupied	Private rented	IMD lowest 20%	Estimated number of instances requiring medical intervention
Falls on stairs etc.	4,307	3,631	676	700	135
Excess cold	2,769	2,438	331	186	15
Falls associated with baths etc.	786	662	123	128	44
Falling on level surfaces etc.	652	549	102	106	36
Falls between levels	242	171	71	86	24
Fire	88	62	26	31	2
Damp and mould growth	60	42	17	21	30
Flames, hot surface etc.	41	29	12	15	7
Entry by intruders	39	27	11	14	13
Food safety	35	25	10	13	6
Personal hygiene, sanitation and drainage	32	23	9	11	5
Collision and entrapment	30	21	9	11	5
Crowding and space	25	18	7	9	3
Electrical hazards	19	13	5	7	1
Domestic hygiene, pests and refuse	3	2	1	1	1
Total	9,127	7,715	1,413	1,338	327

Source: Wyre Forest Health Impact Assessment

The English Housing Survey produces national data on dwelling condition. Applying national trends to the stock profile of Wyre Forest would suggest that around 19.8% of dwelling stock is non-decent, which is slightly lower than the national average of 20.6%. The number of dwellings likely to fail the minimum standard of decent homes criteria is estimated to be 11.0% (compared with 11.9% nationally).

Worcester City District

Findings from the Worcester City Private Stock Condition Survey 2015 are summarised below.[19]

The findings of data examined as part of the report indicate that some 14,000 dwellings are non-decent - failing at least one of the four Decent Homes Standard criteria. This equates to 31.7% of the total private housing stock within Worcester which is slightly higher than the national average of 27% as identified from the English Housing Survey 2010-11 (Table 6). There has been an increase in the overall number of non-decent dwellings following the previous survey undertaken in 2004 by 10%, some 5,150 dwellings.

Table 6: Decent Homes Standard Failures, Worcester

Headline Result	Worcester 2004	Worcester 2014	National EHCS 2007	National EHD 2010-11
Overall Decent Homes Standard Failures	21.4%	31.7%	34.6%	27.0%
Fail Part A: HHSRS	27%		23.5%	17.0%
Fail Part B: Disrepair	6.2%		7.3%	5.6%
Fail Part C: Modern Facilities and Services	<1%		2.9%	2.3%
Fail Part D:	15%		14.9%	9.9%

Source: Worcester City Private Stock Condition Survey 2015

In social housing, Decent Homes failures have reduced steadily over the last 10 years due to targets set by the Government that must be met by social landlords. However, in the private rented sector, there are no legislative targets to enforce; and this increased level of failure indicates that property maintenance and the rate of component renewals have slowed – most likely due to the cost of carrying out such works, the impact of the economic downturn and there being no meaningful sanction to do otherwise (it should be noted that the 2004 Worcester City District survey used different criteria for the assessment of Decent Homes which relied on a very basic “fitness standard” and the 2014 figure, together with the updated 2010–2011 English Housing Survey figures are more relevant).

[19] Michael Dyson Associates, (Sept 2015), *Worcester City Private Stock Condition Survey*

Redditch and Bromsgrove

Findings from the most recent stock condition survey (produced from BRE stock modelling) in Redditch and Bromsgrove are shown in Table 7. They indicate that most decent home failures are due to the Housing Health and Safety Rating system, while thermal comfort issues are significant, accounting for around half of all decent homes standard failures.

Table 7 Proportion of private housing stock dwellings failing at least one of the four Decent Homes Standard criteria.

Failure Type	Number of dwellings	%
Overall Decent Homes Standard Failures	Bromsgrove	36
	Redditch	30
Fail Part A: HHSRS (Housing Health and Safety Rating System)	Bromsgrove	24
	Redditch	19
Fail Part B: Disrepair	Bromsgrove	8
	Redditch	7
Fail Part C: Modern Facilities and Services	Bromsgrove	1
	Redditch	1
Fail Part D: Thermal Comfort	Bromsgrove	17
	Redditch	16

Source: BRE Stock Modelling (2009)[20]

Overcrowding

The Parliamentary Office of Science and Technology (POST) published a report on health in private rented housing (2018) which summarises the evidence on the health effects of overcrowding and lack of space:

A 2005 survey by Shelter showed that most families living in overcrowded homes said their living conditions affected their mental health, stress, privacy and sleep quality. Concerns about children's physical health, as well as their ability to play and study, were frequently raised. The Housing Health and Safety Rating System also refers to the increased risk, from overcrowding and lack of space, of accidents, infectious diseases, condensation and mould. Living in overcrowded housing negatively affects children, including being associated with respiratory issues.[21]

[20] Bromsgrove District & Redditch Borough Councils – BRE Stock Modelling

[21] Parliamentary Office of Science and Technology *POSTnote on health in private rented housing* (2018)

Local data from the Census of Population 2011 shows that the extent of overcrowding[22] is statistically significantly lower in Worcestershire and districts than nationally, but there is considerable variation by local authority district.

Figure 8: Proportion of Overcrowded Households (2011)

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	1,060,967	4.8	4.8	4.8
Worcestershire	–	6,366	2.7	2.6	2.7
Bromsgrove	–	691	1.8	1.7	1.9
Malvern Hills	–	588	1.8	1.7	2.0
Redditch	–	1,541	4.4	4.2	4.7
Worcester	–	1,310	3.1	3.0	3.3
Wychavon	–	1,175	2.4	2.2	2.5
Wyre Forest	–	1,061	2.5	2.3	2.6

Source: Census

Warm and Healthy Homes

Fuel poverty is a major issue which links housing and health.

The independent Fuel Poverty Review report[23] suggested that a conservative estimate of the number of excess winter deaths caused by living in low temperatures due to fuel poverty would be 1 in 10; this equates to 2,700 people per year, more than die on the roads each year. In addition, fuel poverty contributes to a much larger number of incidents of ill-health and demands on the NHS and a wider range of problems of social isolation and poor outcomes for young people.

Fuel poverty can impact on health and well-being through a) the direct effects of living in a cold home and b) the indirect effect of carbon emissions on air quality which result from poor energy efficiency.

Beyond physical health, the Fuel Poverty Review also reports that there is evidence to suggest links between low temperatures and poor mental health, between cold homes and social isolation amongst adults and between low indoor temperatures and truancy, educational attainment and anti-social behaviour amongst adolescents.

Evidence shows that improved health is most likely when housing improvements are targeted at those with poor health and inadequate housing conditions, in particular inadequate warmth.[24]

[22] Overcrowding is defined as a household having one or more fewer bedrooms than the standard requirement

[23] Getting the measure of fuel poverty Final Report of the Fuel Poverty Review John Hills CASE report 72 ISSN 1465-3001 March 2012

[24] Thomson H, Thomas S, Sellström E, Petticrew M. *Housing Improvements for Health and Associated Socio-Economic Outcomes: A Systematic Review* Campbell Systematic Reviews 2013:2

Under the "Low Income, High Cost" measure published by Public Health England, households are fuel poor where:

- They have required fuel costs that are above average (the national median level).
- Were they to spend that amount, they would be left with a residual income below the official fuel poverty line.

The key elements in determining whether a household is fuel poor or not are:

- Income.
- Fuel prices.
- Fuel consumption (which is dependent on the dwelling characteristics and the lifestyle of the household).

Various factors might lock households in to high energy costs including:

- A low standard of energy efficiency.
- A lack of access to capital to make the necessary improvements (or to move to a more energy-efficient property).
- Vulnerable people may be less likely to take advantage of cost savings through switching energy tariff or supplier.
- Pre-payment tends to be available on relatively expensive standard tariffs only.

Figure 9 shows that 28,694 (11.5%) of households suffered from fuel poverty in Worcestershire in 2016, slightly above the national average of 11.1%. While there has been some fluctuation, fuel poverty levels in Worcestershire have tended to be above the national level since 2011 (Figure 10).

A briefing on fuel poverty was published in 2016 as part of the Joint Strategic Needs Assessment (JSNA).[25]

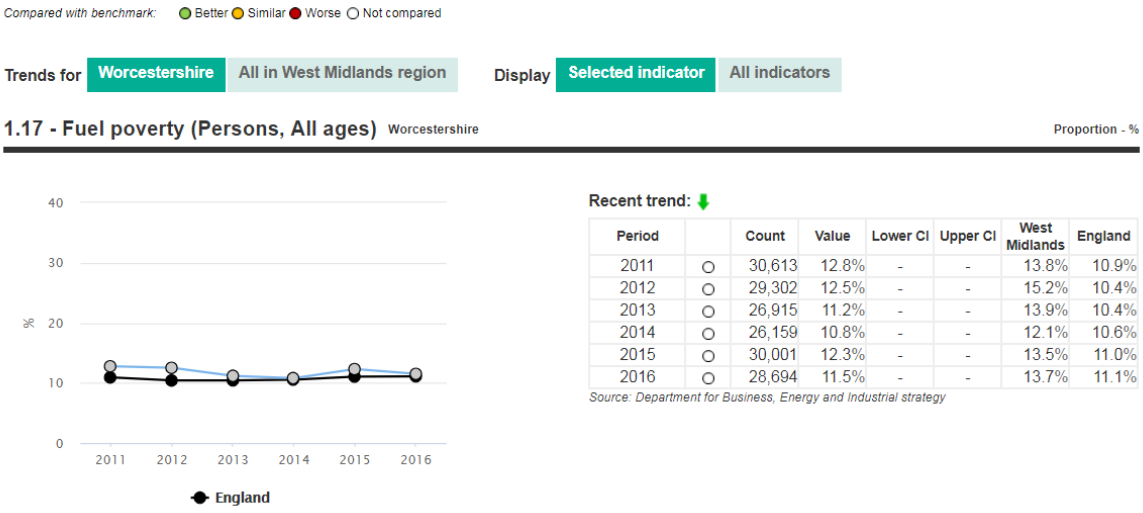
Figure 9: Percentage of households in fuel poverty, Worcestershire districts 2016

1.17 - Fuel poverty 2016

Area	Count	Value
England	2,550,565	11.1
Worcestershire	28,694	11.5
Bromsgrove	3,978	10.0
Malvern Hills	4,244	12.6
Redditch	3,820	10.6
Worcester	5,548	12.7
Wychavon	5,521	10.7
Wyre Forest	5,583	12.5

Source: Department for Business, Energy and Industrial strategy

Figure 10: Percentage of households in fuel poverty, Worcestershire 2011-2016



Recent trend: ↓

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2011	○	30,613	12.8%	-	-	13.8%	10.9%
2012	○	29,302	12.5%	-	-	15.2%	10.4%
2013	○	26,915	11.2%	-	-	13.9%	10.4%
2014	○	26,159	10.8%	-	-	12.1%	10.6%
2015	○	30,001	12.3%	-	-	13.5%	11.0%
2016	○	28,694	11.5%	-	-	13.7%	11.1%

Source: Department for Business, Energy and Industrial strategy

[25] http://www.worcestershire.gov.uk/download/downloads/id/9407/2016_briefing_on_fuel_poverty.pdf

The numbers in fuel poverty represent a significant issue, and in Worcestershire a number of initiatives have been put in place to address it. For example, the Emergency Central Heating Offer (ECHO): Access to funding secured to repair or replace broken gas central heating for low income households; the Warm Homes fund, which enables low income households to receive a gas central heating system for the first time; and the Worcestershire Energy Switch, in which Worcestershire County Council promoted a collective energy switch which took place in October 2018. This encouraged households to seek a better energy tariff to reduce their energy bills.

All of these countywide schemes have engaged local energy charity Act on Energy to coordinate the customer focussed energy advice. Alongside engagement for the programmes, Act on Energy also offer additional support for applicants such as advice on fuel debt, additional energy efficiency measures such as insulation and onward referrals for additional support such as home fire safety checks with Herefordshire and Worcestershire Fire and Rescue Service.

Energy Performance Certificates (EPC)

An Energy Performance Certificates (EPC) is an asset rating and explains how energy efficient a building is and its impact on the environment. Dwellings are rated on a scale of A-G where an A rating is the most energy efficient. Homes which are rated more highly should have a lower impact through their Carbon Dioxide (CO_2) emissions. The Certificate will also include recommendations on methods by which the occupier can improve their home's energy efficiency which can save money and help preserve an environment conducive to human habitation (DECC, 2012).

Energy Performance Certificates (EPC) are drawn up by accredited energy assessors. They show how energy efficient a property currently is, and how energy efficient it could be if certain improvements were made.

The Energy Efficiency (Private Rented Property) (England and Wales) Regulations 2015 establish a minimum level of energy efficiency for privately rented property in England and Wales[26]. This means that:

- Landlords who are re-letting a self-contained property must supply an EPC to any prospective renter. The EPC must be commissioned before a property is marketed.
- From April 2018, landlords of privately rented domestic and non-domestic property in England or Wales must ensure that their properties reach at least an Energy Performance Certificate (EPC) rating of E before granting a new tenancy to new or existing tenants.
- From 01 April 2020, landlords must not continue letting a relevant domestic property which is already let if that property has an EPC rating F or G (as shown on a valid EPC for the property).

[26] Department for Business, Energy and Industrial Strategy, *The Domestic Private Rented Property Minimum Standard,* 2019, www.gov.uk/beis

Table 8 gives a breakdown of EPCs issued by Council District in Worcestershire over the period 2008-2018

Energy Performance Certificates (EPC) Rating

Table 8: Energy Performance Certificates (EPC) Rating, Worcestershire Districts, 2008-2018

Local Authority	Number of Lodgements	A	B	C	D	E	F	G	% F or G
Bromsgrove	27644	0%	13%	23%	39%	18%	5%	1%	6.2%
Malvern Hills	24146	0%	12%	20%	34%	22%	10%	3%	12.9%
Redditch	23961	0%	7%	31%	44%	15%	3%	1%	3.6%
Worcester	33007	0%	8%	25%	41%	20%	4%	1%	5.9%
Wychavon	39622	0%	19%	21%	35%	16%	6%	2%	8.1%
Wyre Forest	28226	0%	7%	24%	40%	21%	6%	2%	8.4%
England & Wales	18378820	0%	10%	27%	39%	18%	5%	1%	6.4%

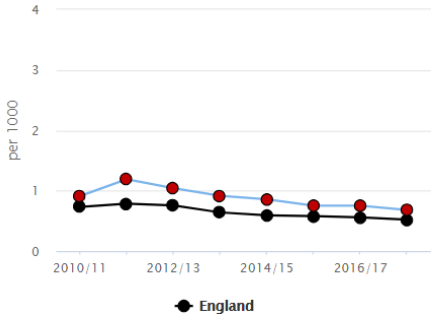
NB. A property may have more than one EPC recorded, some properties don't have an EPC.

Homelessness and Housing Insecurity

Homelessness and housing insecurity are important issues affecting health and inequalities. Data from Public Health England indicates that:

- The rate of homelessness applications in Worcestershire in 2015/16 was 4.9 per 1,000 (1,198 households), this is similar to the national rate of 5.0 per 1,000.
- The family homelessness rate in 2017/18 is 1.9 per 1,000 (472 households), similar to the rate of for England of 1.7 per 1,000.
- The homeless young people aged 16-24 rate in 2016/17 is 0.68 per 1,000 (170 people), which is significantly higher than the national level of 0.52 per 1,000. Figure 11 shows that the rate in Worcestershire has been persistently above national levels in recent years.

Figure 11: Homeless young people aged 16-24, Worcestershire 2010/11-2017/18, Crude Rate



Recent trend: ⬇

Period		Count	Value	Lower CI	Upper CI	West Midlands region	England
2010/11	●	217	0.91	0.79	1.04	1.29	0.73
2011/12	●	285	1.19	1.05	1.33	1.27	0.79
2012/13	●	251	1.04	0.92	1.18	1.19	0.75
2013/14	●	222	0.92	0.80	1.04	1.01	0.64
2014/15	●	209	0.85	0.74	0.98	0.91	0.59
2015/16	●	185	0.75	0.65	0.87	0.83	0.58
2016/17	●	186	0.75	0.65	0.87	0.81	0.56
2017/18	●	170	0.68*	0.58	0.79	0.69*	0.52

Source: Department for Communities and Local Government

- In 2017/18 the Worcestershire county rate of eligible homeless people 'not in priority need' was 0.9 per 1,000 households (240 people) similar to the England average (0.8 per 1000 households).
- There is a significantly lower than national rate of statutory homeless households in temporary accommodation recorded in Worcestershire in 2016/17 (100 households, 0.4 per 1000 households, England rate is 1.4 per 1000 households). This is a good outcome as people living in temporary accommodation have high rates of some infections and skin conditions; and children have high rates of accidents.

Rough Sleeping

The Government's Rough Sleeping Strategy 2018 sets out a requirement for a multi-agency approach to meeting the ambition of ending rough sleeping by 2027 and is a focus for partnership activity in Worcestershire. The health problems of rough sleepers were highlighted in the previous JSNA health and homelessness profile in 2018.

Official figures from the Ministry of Housing, Communities and Local Government [27], indicate that there were 53 people sleeping rough in Worcestershire in Autumn 2018. This is a considerable increase from the 25 people recorded in Autumn 2017 (the figures do tend to fluctuate from year to year).

[27] https://www.gov.uk/government/statistics/rough-sleeping-in-england-autumn-2018

In 2018 Worcestershire County Council published a Joint Strategic Needs Assessment Profile on Homelessness.[28] The key findings are given below:

- Homelessness covers a wide spectrum of housing situations and defining homelessness is not straightforward. Official data based on statutory homelessness are only part of the story. Counting homeless people is a challenge and hidden homelessness an issue.
- Homelessness is an important concern in Worcestershire. Many indicators are close to the national level. The economic recession saw statutory homelessness in the county peak in 2011, since then it has fallen, but it still remains above pre-2011 levels.
- Homeless people are at increased risk of a wide range of health problems related to physical health, mental health and substance misuse (usage of illegal and prescribed drugs, and of tobacco and alcohol).
- Physical health problems include circulatory and respiratory conditions, joint aches and pains and poor oral health. There is evidence that many homeless people have two or more long-term conditions (LTCs), a situation known as 'multimorbidity'.
- The Worcestershire Homeless Health Audit 2017 found the majority, 87%, of the sample were smokers. This is a similar proportion to national studies of similar homeless groups and is much higher than the general population prevalence of 17%. Amongst those who were drinking, the average units consumed per day was 11 which is much higher than the officially recommended limit of 14 units per week.
- Access to health services is an issue nationally and locally with significant proportions of homeless people facing barriers to access and/or insufficient treatment. This may have an effect on the diagnosis of chronic health conditions. For example, the Worcestershire Homeless Health Audit 2017 found diabetes was reported at a rate well below that recorded in the overall population, which suggests there may be under-diagnosis of this condition amongst this homeless population.
- The Homelessness Reduction Act 2017 increased the scope of duties of local authorities towards the homeless. Proposed changes to legislation and benefits are likely to have an impact on homeless numbers.

[28] Worcestershire County Council (2018),*JSNA Homeless Health Profile*

Housing for Older People

The population of older people in Worcestershire is set to increase in the future. Two key documents illustrate the links between housing and health for older people, and these are briefly summarised below:

Housing Learning and Improvement Network (Housing LIN): Dementia and housing: an assessment tool for local commissioning[29]

The Prime Minister's Challenge on Dementia 2020[30] includes an ambition for increased numbers of people with dementia being able to live longer in their own homes when it is in their interests to do so, with a greater focus on independent living.

The tool is intended to support a collaborative assessment between public health professionals and commissioners working in local authority adult social care, planning and housing departments, Clinical Commissioning Groups as well as providers of housing and housing-related services, and communities of interest. It describes three inter-related elements of housing:

- Physical environment, this can enable or disable health and wellbeing and housing conditions can support or undermine good health.
- Housing related services and interventions, these might include housing management and tenancy sustainment, housing-related support, or home-from-hospital services.
- People and networks, working with people with dementia, local authority and health commissioners and a range of providers, as well as multi-agency groups, voluntary sector, local networks and communities, to ensure that the person with dementia and their family and/or carers are at the centre of any support, and that agencies work in an integrated way.

[29] Housing LIN (Learning and Improvement Network), May 2016, *Dementia and Housing: An assessment tool for local commissioning,*
[30] Department of Health and Social Care, 2015.

Housing LIN: Helping People to be Cared for and Die at Home[31]

Championing the role of social housing and supporting the development of frontline housing staff to respond to this agenda. For example:

- Avoiding the harms for those affected by death and dying- increased mental health issues, physical illnesses.
- Reducing risk of increased mortality & morbidity for bereaved.
- Maximising quality of remaining life, and;
- Developing healthy environment- and infrastructures.

However, in a survey undertaken by the Local Government Information Unit[32] less than a quarter of respondents agreed that housing departments, and by extension social landlords, work closely with the NHS and social care on end of life provision, despite their often crucial role in supporting quality of life outcomes.

Falls Prevention

Housing can play a potential role in falls prevention. A review by Public Health England[33] identified interventions for home assessment and modifications as being potentially cost effective, alongside six other types of intervention such as strength and balance programmes.

Home Assessment and Modification (HAM) is a service in which relevant experts risk assess a person's usual residence to identify environmental hazards and carries out actions to reduce these. Typical environmental hazards are loose mats, poor lighting and no handrails.

NICE guidance[34] states:

"Older people who have received treatment in hospital following a fall should be offered a home hazard assessment and safety intervention/modifications by a suitably trained healthcare professional. Normally this should be part of discharge planning and be carried out within a timescale agreed by the patient or carer, and appropriate members of the health care team…Home hazard assessment is shown to be effective only in conjunction with follow-up and intervention, not in isolation".

[31] Housing LIN (Learning and Improvement Network), Feb 2016, *End of Life Care: Helping people to be cared for and die at home*
[32] LGIU, *The role of the local authority in end of life care* (2012)
[33] Public Health England, *A structured literature review to identify cost-effective interventions to prevent falls in older people living in the community* (2018)
[34] https://www.nice.org.uk/guidance/cg161

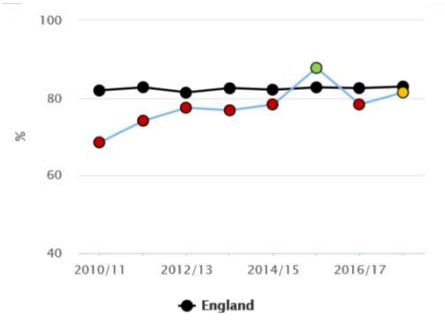
Discharge from Hospital

The NHS Outcomes Framework includes a key indicator that is relevant to the link between housing and health/social care. It measures the extent to which older people are helped to recover their independence after illness or injury.

This is the proportion of older people (aged 65 and over) discharged from acute or community hospitals to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. This is expressed as a percentage.

Figure 12 shows that the proportion of older people who were still at home 91 days after discharge has been improving in Worcestershire in recent years but is still below the national rate.

Figure 12: Proportion of older people who were still at home 91 days after discharge from hospital (age 65+), 2011/12-2017/18



Recent trend: ↑

Period		Worcestershire Count	Value	Lower CI	Upper CI	West Midlands region	England
2010/11		185	68.5%	62.8%	73.8%	81.9%	81.9%
2011/12		395	74.1%	70.7%	78.1%	81.1%	82.7%
2012/13		395	77.5%	73.6%	80.9%	77.9%	81.4%
2013/14		430	76.8%	73.1%	80.1%	82.4%	82.5%
2014/15		445	78.3%	74.5%	81.3%	80.0%	82.1%
2015/16		458	87.7%	84.6%	90.3%	80.2%	82.7%
2016/17		419	78.3%	74.6%	81.6%	80.2%	82.5%
2017/18		398	81.4%	77.7%	84.6%	79.7%	82.9%

Source: Information Centre for Health and Social Care, ASCOF

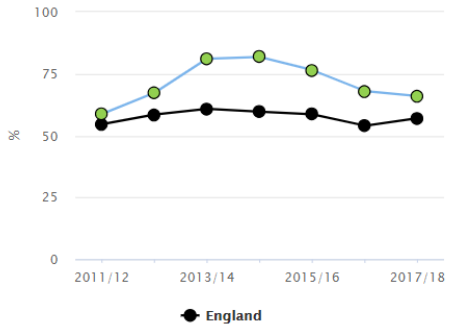
Source: NHS Outcomes Framework (indicator 3.6i)

Adults with Mental Health Needs

Housing Service Commissioners and providers have a key role in improving mental health outcomes - providing both settled housing and the services people need to maintain their homes as independently as possible. They can support people at risk of mental ill health to build resilience, as well as providing specialist support for people with mental health problems.

In Worcestershire the proportion of adults in contact with secondary mental health services living independently, with or without support, is 66% which is above the national average of 57% (Figure 13).

Figure 13: Proportion of adults in contact with secondary mental health services living independently, with or without support, Worcestershire 2011/12-2017/18



Recent trend: –

Period		Count	Value	Lower CI	Upper CI	West Midlands region	England
2011/12		-	58.7%	55.6%	61.7%	51.2%	54.6%
2012/13		-	67.3%	64.0%	69.9%	60.3%	58.5%
2013/14		-	81.1%	77.9%	83.9%	72.2%	60.8%
2014/15		-	81.8%	78.8%	84.4%	71.2%	59.7%
2015/16		-	76.5%	73.2%	79.5%	72.5%	58.6%
2016/17		-	68.0%*	64.5%	71.3%	45.0%*	54.0%*
2017/18		-	66.0%	62.5%	69.3%	55.0%	57.0%

Source: NHS Digital. Measures from the Adult and Social Care Outcomes Framework, table 1H. (Resources)

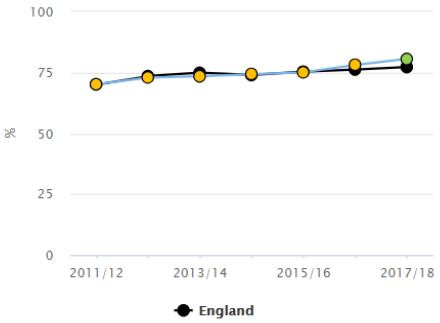
Source: Public Health Outcomes Framework, indicator “Adults in contact with secondary mental health services who live in stable and appropriate accommodation”. Figure heading is taken from ASCOF name as this is a better description.

Adults with a Learning Disability

The proportion of adults with a primary support reason of learning disability support who live independently in their own home or with their family in Worcestershire is 80.6%, which is statistically significantly higher than the national value of 77.2% (Figure 14). This indicator has been improving at a faster rate in Worcestershire than nationally. The nature of accommodation for people with a primary support reason of learning disability support has a strong impact on their safety and overall quality of life and the risk of social exclusion. Maintaining settled accommodation and providing social care in this environment promotes personalisation and quality of life prevents the need to readmit people into hospital or costly residential care.

Worcestershire's performance in relation to this indicator is linked to our Supported Living Strategy. We aim to maximise the number of people with disabilities who are living in supported living. This enables individuals to have their own tenancies or to become home owners, with the flexibility to move house or change their support provider if they wish, thus helping people to maximise their independence.

Figure 14: Proportion of adults with a primary support reason of learning disability support who live independently, in their own home or with their family, Worcestershire 2011/12-2017/18



Recent trend: ↑

Period		Count	Value	Lower CI	Upper CI	West Midlands region	England
2011/12		930	70.2%	67.7%	72.6%	65.4%	70.0%
2012/13		970	72.9%	70.5%	75.3%	66.0%	73.5%
2013/14		970	73.5%	71.0%	75.8%	68.9%	74.9%
2014/15		949	74.3%	71.8%	76.6%	64.7%	74.0%*
2015/16		962	75.1%	72.7%	77.4%	67.9%	75.4%
2016/17		1,001	78.1%	75.8%	80.3%	70.3%	76.2%
2017/18		1,030	80.6%	78.3%	82.7%	72.3%	77.2%

Source: NHS Digital. Measures from the Adult and Social Care Outcomes Framework, table 1G.

Source: Public Health Outcomes Framework indicator "Adults with a learning disability who live in stable and appropriate accommodation". Figure heading is taken from ASCOF name as this is a better description.

Accessible Housing

The benefits of adapting the home are recognised as an effective way to improve the health and wellbeing of older people, and disabled adults and children. A more accessible home environment can improve independence, reduce risk and reduce reliance on assistance.

New requirements on new build developments mean there are likely to be basic accessibility features in all new builds.[35]

While it is difficult to assess levels of need for adaptable housing in Worcestershire, we do have figures on the numbers of housing adaptations carried out.

[35] The Building Regulations 2015 edition incorporating 2016 amendments, HM Government

Disabled facilities grants are provided by local authorities to people who are disabled and need to make changes to their home, for example to:

- Widen doors and install ramps.
- Improve access to rooms and facilities – e.g. stairlifts or a downstairs bathroom.
- Provide a heating system suitable for their needs.
- Adapt heating or lighting controls to make them easier to use.

Home Improvement Agency

Home Improvement Agencies are local organisations that help older, disabled and vulnerable people to live a good life for longer. They offer reliable information and advice and support people to make modifications to their homes as their health and needs change through later years.

The Home Improvement Agency in Worcestershire provides advice and assistance to people to help them remain living independently in their home. They also provide the Disabled Facilities Grants on behalf of the 6 Local Housing Authorities and minor adaptations on behalf of the County Council.

Table 9: Home Improvement Agency (HIA) New Service User Characteristics in 2017/18 (based on cases closed)[36]

	Bromsgrove	Malvern Hills	Redditch	Worcester	Wychavon	Wyre Forest	Total
Total Cases (number of sets of work)	188	149	142	127	180	209	995
Total Clients Analysed below	160	119	101	107	135	178	800
Older people (60 & Over) in total	111	80	64	76	86	125	542
No health information recorded	12	12	14	6	6	17	67
Older people with mental health problems including Dementia	4	1	5	1	3	3	17
Frail elderly	4	6	2	2	2	1	17
Mental health problems not older person	0	0	0	0	0	1	1
Learning disabilities (all ages)	3	5	5	3	3	5	24
Physical and sensory disabilities (all ages)	138	102	79	96	118	155	688
Other (Chronic Ill Health) (all ages)	6	4	2	3	7	3	25
TOTAL Health Issues	278	210	171	187	225	310	

[36] Please note: These figures are only available from cases where an OT has visited and provided the health information. There will be duplicate figures where someone has more than one health issue they will be entered under both headings.

Table 10: Disability Related Benefit Claimants in 2018

	Bromsgrove	Malvern Hills	Redditch	Worcester	Wychavon	Wyre Forest	Total
No. of Disability Living Allowance claimants (May 2018)	1770	1690	2117	2467	2757	2757	13558
Number of Personal Independence Claimants (Dec 2018)	2264	1705	2952	2591	2880	3658	16050
No. of Employment and Support Allowance claimants (May 2018)	1910	2026	2340	3444	3039	3673	16432

Table 11: Disabled Facilities Grants (DFGs) in 2017/18

	Bromsgrove	Malvern Hills	Redditch	Worcester	Wychavon	Wyre Forest	Total
No of people assessed for adaptations	267	189	182	180	236	273	1327
No. of DFGs approved	113	85	90	89	127	130	634
Average value of DFGs given (over £1,000)	£6,156	£5,757	£8,028	£7,068	£6778	£5,729	

NB. the first line is the number assessed for an adaptation either minor or a DFG and the second row is the number of DFGs approved – there is usually quite a high drop out rate as people aren't eligible (it is a means tested grant) or don't want to proceed with the work.

Children and Young People

National Institute for Health and Care Excellence (NICE) guidance on unintentional injuries for children and young people aged under 15 highlights some areas in which housing and health agencies can usefully collaborate.[37] NICE make the following recommendations:

Recommendation 1: Prioritising households at greatest risk

Determine the types of household where children and young people aged under 15 are at greatest risk of unintentional injury based on surveys, needs assessments and existing datasets (such as local council housing records).

The guidance refers to types of household and housing where children and young people aged under 15 are at greatest risk of unintentional injury. Identification of these 'Priority Households' could include those with children aged under 5, families living in rented or overcrowded conditions or families living on a low income. It could also include those living in a property where there is a lack of appropriately installed safety equipment, or one where hazards have been identified through the Housing Health and Safety Rating System (HHSRS).

The process of systematically identifying potential hazards in the home, evaluating the risks and providing information or advice on how to reduce them is described here as a Home Safety Assessment. Other terms commonly used to describe the same process include 'Home Risk Assessment' and 'Home Safety Check'. It may be carried out by a trained assessor or by parents and other householders, using an appropriate checklist.

[37] https://www.nice.org.uk/guidance/ph30

Recommendation 2: Working in partnership

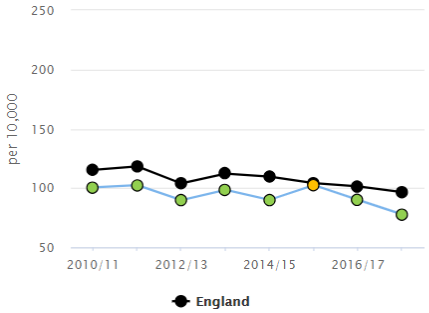
Establish local partnerships with relevant statutory and voluntary organisations or support existing ones. Partners could include: local community and parent groups, organisations employing health and social practitioners who visit children and young people in their homes (for example, health visitors), child care agencies, others with a remit to improve the health and well-being of children aged under 15, local umbrella organisations for private and social landlords, those involved in lifestyle and other health initiatives.

In the guidance, areas in which housing and health can work together are:

- On collecting information on specific households where children and young people aged under 15 may be at greatest risk of an unintentional injury.
- determining and addressing barriers to creating a safe home environment, for example, the cost of equipment, cultural norms, issues of trust or a lack of control over the home environment may all be barriers to installing safety equipment.
- getting the community involved (as outlined in NICE Public Health Guidance 9 'Community Engagement'). For example, local 'community champions' could be used to promote home safety interventions and help practitioners gain the trust of householders.
- carrying out home safety assessments and supplying and installing home safety equipment, in line with recommendation.

Data from Public Health England shows that Worcestershire performs better than the national average for hospital admissions caused by unintentional and deliberate injuries in children, and figures have been improving in line with the national trend (Figure 15).

Figure 15: Hospital admissions caused by unintentional and deliberate injuries in children (0-14), Worcestershire, 2010/11-2017/18, Crude Rate per 10,000



Recent trend: ⬇

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2010/11		944	100.6	94.3	107.3	117.1	115.2
2011/12		958	102.4	96.0	109.1	120.5	118.3
2012/13		842	89.8	83.8	96.0	106.3	103.9
2013/14		928	98.4	92.2	105.0	116.4	112.2
2014/15		852	90.1	84.1	96.3	112.3	109.6
2015/16		976	102.4	96.1	109.0	110.4	104.2
2016/17		871	90.0	84.1	96.2	106.6	101.5
2017/18		762	77.7	72.3	83.4	103.4	96.4

Source: Hospital Episode Statistics (HES)

Source: Public Health Outcomes Framework

Planning for Health

National guidance on planning for health[38] has been published online by the Ministry of Housing, Communities and Local Government in recognition of the fact that the built and natural environments are major determinants of health and wellbeing. In addition, Public Health England have a Healthy Places Programme[39] which supports the development of healthy places and homes with the aim of ensuring that health inequalities are considered and addressed when planning, developing and improving the built environment and in enabling people to have a place they can call 'home'.

The guidance suggests that local planning authorities should ensure that health and wellbeing, and health infrastructure are considered in local and neighbourhood plans and in planning decision making.

At a more local level, The Planning for Health in South Worcestershire Supplementary Planning Document (SPD)[40], covers the local planning authorities of Malvern Hills District Council, Worcester City Council and Wychavon District Council. It was prepared in partnership with the Strategic Planning team and the Directorate of Public Health

It includes this useful summary:

Good health includes physical, mental and social wellbeing. Support for good health, including health care services provision, requires the application of best practice in a range of areas, including planning.

Positive measures include:

- *Planning for built and natural environments that provide suitable living conditions, encourage good physical and mental health and wellbeing, and prevent people becoming ill.*
- *Ensuring access to facilities that promote, provide and encourage healthier lifestyle choices or that deal with ill health, and a means of getting to those facilities.*
- *Providing health-promoting environments to support recuperation when people do fall ill.*

The Planning for Health SPD was written by Worcestershire County Council strategic planning section in conjunction with Public Health, with the purpose of ensuring consistent links are made between public health policy and approaches and the planning policy framework and development control activity that takes place at a District Council level. The SDP in itself is not a formal policy document but is intended to support the Planning Authorities to consider Public Health issues in a consistent manner across Worcestershire.

[38] *The role of health and wellbeing in planning*, 2014, Ministry of housing, Communities and Local Government, https://www.gov.uk/guidance/health-and-wellbeing
[39] https://www.gov.uk/government/publications/phe-healthy-places/healthy-places
[40] *"Planning for Health in South Worcestershire"* Adopted September 2017 Supplementary Planning Document

A Health Impact Assessment (HIA) is a tool to predict the health implications on a population of a planning proposal. HIAs ensure that the effects of development on both health and health inequalities are considered and addressed during the planning process. The SPD recommended the use of HIAs for specified planning proposals in South Worcestershire.[41]

The Public Health department at Worcestershire County Council is working with planners to develop a health and planning policy for South Worcestershire which will strengthen the SPD. It is also looking at developing a health SPD in Wyre Forest District.

Key Issues for Planning and Health

In this section we draw upon the national and local guidance referred to above to summarise some key issues linking planning and public health.

1. Sustainable Development

Sustainable development is about meeting the needs of the present without compromising the ability of future generations to meet their own needs

Achieving sustainable development means that the planning system has three overarching objectives, all of which are wider determinants of public health:

- An economic objective – to help build a strong, responsive and competitive economy
- A social objective – to support strong, vibrant and healthy communities,
- An environmental objective – to contribute to protecting and enhancing our natural, built and historic environment

2. Good Quality Adaptable Housing

Developing good quality adaptable housing that is suitable for all generations could include, for example, a reduction in health and social care costs. Additionally, the built environment, through the design of housing and supportive community spaces, is providing opportunities for social participation and community engagement.

[41] Residential and mixed use sites of 25 dwellings or more, Employment sites of 5 ha or more,
Retail developments of 500 square metres or more. The following should be screened to determine need for an HIA:
Restaurants & cafés, Drinking establishments, Hot food takeaways, Betting shops and pay-day loan shops

3. Age-Friendly Environments

Older people require supportive and enabling living environments to compensate for the physical and social changes associated with ageing.

The provision of accessible open spaces and walkable neighbourhoods can also encourage and facilitate increased physical activity amongst the elderly. The provision of safe, well-lit, segregated and walkable routes connecting local green spaces and essential amenities could improve the likelihood of those with dementia continuing their everyday lives as part of the community.

The provision of accessible open spaces and walkable neighbourhoods can also enable social interaction and connect people with places and other people.

4. Community Facilities

Community facilities play an increasingly important yet often undervalued role in providing for the wellbeing of the community and the facilitation of social contact. Ensuring that people do not feel the negative impacts of social exclusion is an important consideration in terms of both their physical and mental health and general well-being. Such facilities can encourage companionship, a sense of identity and belonging.

5. Green Space

Access to a network of high-quality open spaces and opportunities for sport and physical activity is important for the health and well-being of communities. An active life is important for physical and mental health and wellbeing.

6. Active Travel

Effective spatial planning can reduce the need to travel by car to the workplace, schools, shopping or leisure facilities by ensuring that new dwellings are located in areas where such facilities are readily available, or where alternative transport modes are in place.

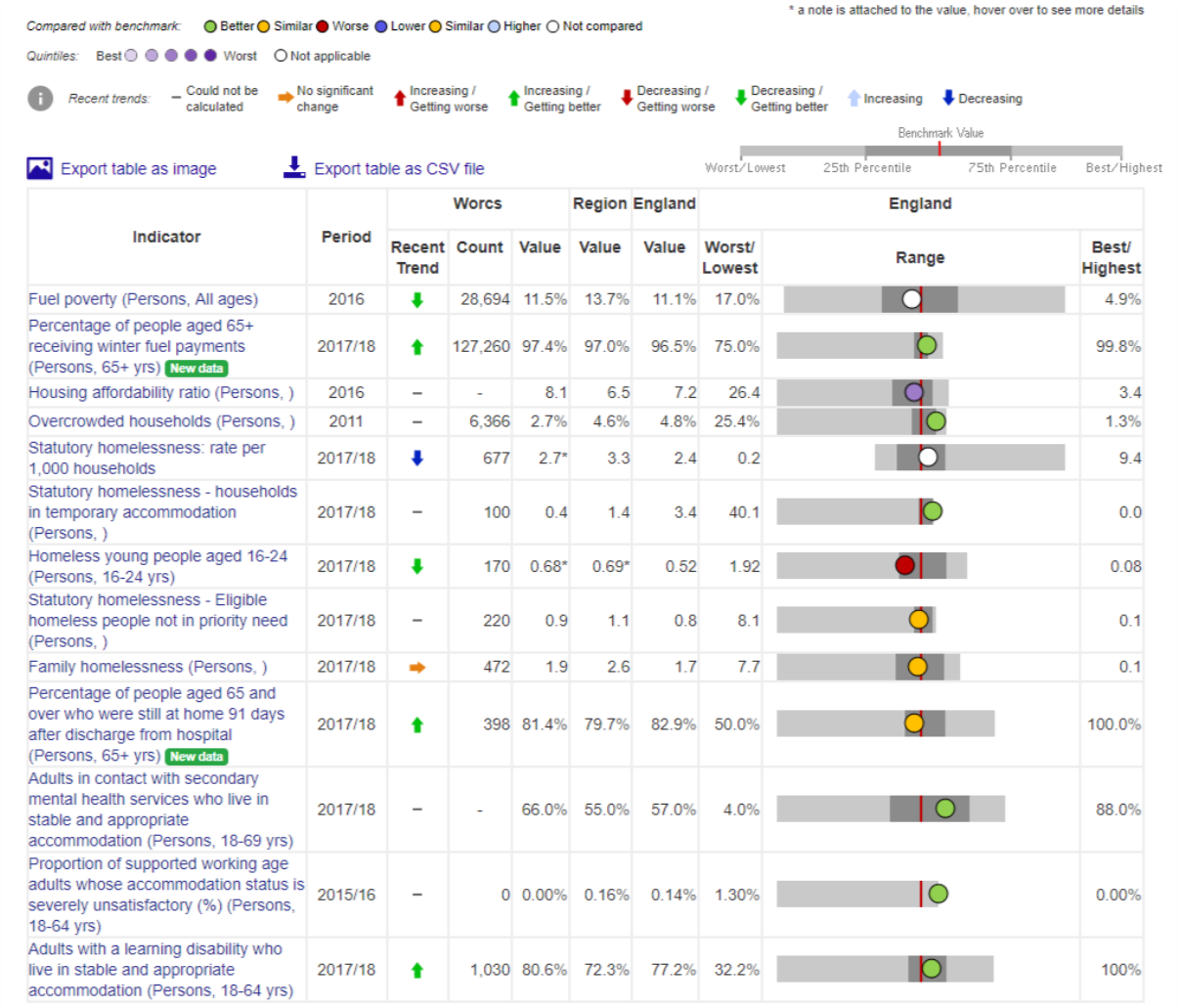
7. Encouraging Healthier Food Choices

City and town centres offer a wide range of services to meet the needs of their residents and visitors and in many cases allow them to enjoy a high standard of living. However, the prevalence, availability and location of some of these services, such as hot food takeaways, can encourage unhealthy consumption. A more positive aspect of cities and towns is the opportunity to encourage healthy eating through the use of allotments and food growing areas for the resident population.

How Does Worcestershire Compare?

This section reports a selection of indicators from the Public Health England Fingertips Tool which are relevant to housing and health. Figure 16 provides data on selected key performance indicators.

Figure 16 Worcestershire Data on the Key Performance Indicators Related to Housing and Health



Indicator	Period	Worcs			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Fuel poverty (Persons, All ages)	2016	↓	28,694	11.5%	13.7%	11.1%	17.0%		4.9%
Percentage of people aged 65+ receiving winter fuel payments (Persons, 65+ yrs) New data	2017/18	↑	127,260	97.4%	97.0%	96.5%	75.0%		99.8%
Housing affordability ratio (Persons,)	2016	–	-	8.1	6.5	7.2	26.4		3.4
Overcrowded households (Persons,)	2011	–	6,366	2.7%	4.6%	4.8%	25.4%		1.3%
Statutory homelessness: rate per 1,000 households	2017/18	↓	677	2.7*	3.3	2.4	0.2		9.4
Statutory homelessness - households in temporary accommodation (Persons,)	2017/18	–	100	0.4	1.4	3.4	40.1		0.0
Homeless young people aged 16-24 (Persons, 16-24 yrs)	2017/18	↓	170	0.68*	0.69*	0.52	1.92		0.08
Statutory homelessness - Eligible homeless people not in priority need (Persons,)	2017/18	–	220	0.9	1.1	0.8	8.1		0.1
Family homelessness (Persons,)	2017/18	→	472	1.9	2.6	1.7	7.7		0.1
Percentage of people aged 65 and over who were still at home 91 days after discharge from hospital (Persons, 65+ yrs) New data	2017/18	↑	398	81.4%	79.7%	82.9%	50.0%		100.0%
Adults in contact with secondary mental health services who live in stable and appropriate accommodation (Persons, 18-69 yrs)	2017/18	–	-	66.0%	55.0%	57.0%	4.0%		88.0%
Proportion of supported working age adults whose accommodation status is severely unsatisfactory (%) (Persons, 18-64 yrs)	2015/16	–	0	0.00%	0.16%	0.14%	1.30%		0.00%
Adults with a learning disability who live in stable and appropriate accommodation (Persons, 18-64 yrs)	2017/18	↑	1,030	80.6%	72.3%	77.2%	32.2%		100%

Source: Public Health England Fingertips (user defined table)

The following indicators are significantly better than England:

- Winter Fuel Payments.
- Statutory homelessness in temporary accommodation.
- Overcrowded households.
- Adults in contact with secondary mental health services who live in stable and appropriate accommodation.
- Adults in contact with mental health services in settled accommodation.
- Proportion of supported working age adults whose accommodation status is severely unsatisfactory.

Statistical significance is not measured for the Housing Affordability Ratio, but this has been consistently higher than nationally for some time, as discussed earlier.

The rate of homeless young people aged 16-24 in 2017/18 was significantly above the national level at 0.68 per 1,000 population compared to 0.52 in England.

Current Risks and Challenges

- Growing mismatch between housing supply and demand and consequent issues of affordability and housing shortages.
- Homelessness and rough sleeping could get worse.
- Fuel poverty levels will remain at their current levels or even increase as housing stock deteriorates.
- Increased demands on health and social care system.
- Costs to the NHS and Social Care increase.

If action is not taken to improve the quality and availability of homes the pressures on decreasing health and social care budgets is only going to increase. The evidence available suggests that interventions to alleviate fuel poverty may be particularly effective.

Best Practice

A comprehensive review of evidence linking housing improvement and health was published in 2013[42]. The report found that:

- Improvements to housing conditions can lead to improvements in health.
- Improved health is most likely when the housing improvements are targeted at those with poor health and inadequate housing conditions, in particular, inadequate warmth.
- Area based housing improvement programmes, for example programmes of housing-led neighbourhood renewal, which improve housing regardless of individual need may not lead to clear improvements in housing conditions for all the houses in a neighbourhood. This may explain why health improvements following these programmes are not always obvious.
- Improvements in warmth and affordable warmth may be an important reason for improved health. This in turn may also lead to reduced absences from school or work. Improvements in energy efficiency and provision of affordable warmth may allow householders to heat more rooms in the house and increase the amount of usable space in the home.
- An overview of the best available research evidence suggests that housing which promotes good health needs to be an appropriate size to meet household needs and be affordable to maintain a comfortable indoor temperature.
- Housing investment which improves thermal comfort in the home can lead to health improvements, especially where the improvements are targeted at those with inadequate warmth and those with chronic respiratory disease.

[42] Thomson H, Thomas S, Sellström E, Petticrew M. Housing Improvements for Health and Associated Socio-Economic Outcomes: A Systematic Review Campbell Systematic Reviews 2013:2

The Housing Learning and Improvement Network (Housing LIN) [43] published some valuable guidance in 2016 which shows how housing improvements can contribute to outcomes in public health and adult social care.

The tool, *Developing Your Local Housing Offer for Health and Care*, provides charts to help to clarify how housing and related support services can deliver the specific outcomes required of health and care partners through the national frameworks. It does this by:

- Identifying the relevant outcomes in the national frameworks (across health, public health and social care).
- Identifying housing services and related support solutions that provide housing-based solutions/contribute to health and well-being outcomes.
- Signposting to existing national evidence that gives background evidence and modelling the key elements that the offer should contain, updated to reflect the latest work coming from the health and housing MoU.
- Linking to tools that can help to: demonstrate demand, quality of services, efficiencies and outcomes (economic and social impacts).

[43] CIH and the Housing LIN (Learning and Improvement Network, Developing Your Local Housing Offer for Health and Care, 2016

Key Publications

Public Health England (PHE)

Improving Health Through the Home: MoU
https://www.gov.uk/government/publications/improving-health-through-the-home/improving-health-through-the-home

End of Life Care: Helping People to be Cared for and Die at Home
https://www.housinglin.org.uk/Topics/type/End-of-Life-Care-Helping-people-to-be-cared-for-and-die-at-home/

Developing your Local Housing Offer for Health and Care: Targeting Outcomes
https://www.housinglin.org.uk/Topics/type/Developing-your-local-housing-offer-for-health-and-care/

National Institute for Health and Care Excellence (NICE)

Excess Winter Deaths and Illness and the Health Risks Associated with Cold Homes (NG6)
https://www.nice.org.uk/guidance/ng6

Dementia Resource for Carers and Care Providers (QS30)
https://www.nice.org.uk/about/nice-communities/social-care/tailored-resources/dementia/statement-7

Unintentional Injuries in the Home: Interventions for Under 15s Public Health Guideline (PH30)
https://www.nice.org.uk/guidance/ph30

Who Might Find This Report Useful?

- The Worcestershire Health and Well-being Board.
- Housing and planning authorities.
- Housing Providers.
- Housing, care and support providers.
- The voluntary and community sector.

Data Notes

Organisations who carried out the original collection and analysis of the data bear no responsibility for its further analysis or interpretation.

Further Information and Feedback

This report has been written by Worcestershire County Council's Public Health Team. We welcome your comments on these reports and how they could better suit your requirements, please do contact us with your ideas.

This document can be provided in alternative formats such as large print, audio recording or Braille.

Contact for comments and alternative formats: Janette Fulton, Tel: 01905 843359, Email: jfulton@worcestershire.gov.uk

SEND Data Report – January – March 2019

SEND Performance Framework

In order to fully support the SEND Improvement plan there was a requirement to produce a conceptual Performance Framework. This provides one specific source of robust performance measurables which relate back directly to the Worcestershire Statement of Action. Following an extensive initial list which contained both measurable and position statements, the framework has been refined to include only measurable data collected either Annually or Quarterly. The framework will improve throughout 2019/20 as metrics continue to be collected and monitored with relevant actions to improve and support the SEND action plan.

The table below shows the respective work streams included:

Work stream	Title	Owners	Details
1	The Local Offer	Penny Richardson Sally Anne Osbourne	***Accurate, Available and useful to enable access to help and information at the earliest opportunity.*** Measurables include :Provision of places. Mostly in relation to documentation and updating details and changes of the Local Offer
2	Embedding the Graduate Response	Gabrielle Stacey Phillipa Coleman	***Improve and embed the Graduated Response so needs are identified at the earliest point with appropriate support*** Measurables include : Aged 0-25 - All Educational Outcomes, Attendance, Exclusions, Post 16
3	Assessment and Planning	Penny Richardson Liz Staples Louise Levett	***Children and Young People's needs are assessed and met in a timely and purposeful manner*** Measurables include: Education and Health Care plan assessments and timeliness. Attainment in Adulthood (Post 25 years)
4	Joint Commissioning and Leadership	Sarah Wilkins Lucy Noon Steve Larking	***Children and Young People's needs are understood and resources applied so they get what they need when they need it*** Measurables include: All metrics in regards to Health
5	Workforce and Engagement	Laura Folkers Steve Larking Steph Courts	***Children and Young People's needs are supported by a workforce that achieves the best possible outcomes, through effective engagement and coproduction. A multiagency workforce shares a culture which promotes inclusive practice, equipped through knowledge and skills*** No specific measurables

.

The following table shows an overall summary of all current performance measurables:

SEND Dashboard Summaries		Improved on last year and/or better than National (where available)	Improved on last year and/or behind national (where available)	Not Improved and worse than national	Unable to RAG / RAG would be inappropriate / Data to follow
Statement of Action Key Concern	**Number of metrics**	**Green**	**Amber**	**Red**	**Grey**
Academic Outcomes	12	1	2	5	4
Vulnerability Characteristics	9	4	1	4	0
Education Health Care Plans	2	1	0	1	0
Health	7	0	0	1	6
Placement / Provision	28	0	0	1	27
Post 16	4	2	0	1	1
Worcestershire Totals	**62**	**8**	**3**	**13**	**38**

Supporting Commentary

Recently issued DfE data deals with placement data and changes in EHCP numbers. A separate presentation will reflect on changes between 2017 and 2018 Calendar years – these are the periods used by the DfE that enable comparison with other LAs.

Work Stream 1 – Penny Richardson

Placement / Provision - Penny Richardson

Annually collected Performance Indicators for SEND Improvement Board

Key Performance Indicator	Worcs Annual 2016/17 (End of Sept 17)	Worcs Annual 2017/18 (End of Sept 18)	National 2017/18
% of children with EHCPs placed in mainstream education provision (Maintained, Academy, RP & units)	30.1	26.4	39.1
% of children with EHCPs placed in resourced provision and units	5.2	3.9	5.1
% of children with EHCPs placed in state-funded special school	45.6	43.5	34.8
% of children with EHCPs placed in NMISS	3.3	3.9	4.9
% of children with EHCPs placed in all special	48.9	47.4	39.7
% of children with EHCPs attending alternative provision/Pupil referral unit at point of issue	0.3	0.2	0.7
% of children with EHCPs attending post-16 FE institution (mainstream & Sixth-form college)	14.5	15.8	12.4
% of children with EHCPs attending post-16 FE institution (specialist)	1.6	2.7	1.3
% of children with EHCPs attending post-16 FE institution (other FE)	0.2	0.3	0.8
% of pupil population with EHCPs	2.7	2.9	2.9
% of pupil population with EHCPs (Primary)	0.8	0.8	1.4
% of pupil population with EHCPs (Secondary)	1.4	1.4	1.6
% of pupil population with SEN Support	12.5	12.6	11.7
% of pupil population with SEN Support (Primary)	13.2	13.9	12.4
% of pupil population with SEN Support (Secondary)	11.5	10.8	10.6
% of pupil population with SEN (Primary)	14	14.7	13.8
% of pupil population with SEN (Secondary)	13	12.2	12.3
% of children with first time EHCPs placed in mainstream education provision (Maintained, Academy, RP & units)	39.8	42.9	61.6
% of children with first time EHCPs placed in resourced provision and units	2.4	3.7	4.6
% of children with first time EHCPs placed in state-funded special school	49	39.2	20.4
% of children with first time EHCPs placed in NMISS	1.9	5.3	3.3
% of children with first time EHCPs placed in all special	51	44.5	23.7
% of children with first time EHCPs attending alternative provision/Pupil referral unit at point of issue	2.4	0.3	1.8
% of children with first time EHCPs attending post-16 FE institution (mainstream & Sixth-form college)	1	5.9	4.2
% of children with first time EHCPs attending post-16 FE institution (specialist)	2.4	1.1	0.4
% of children with first time EHCPs attending post-16 FE institution (other FE)	0.5	0.8	0.5

Quarterly collected Performance Indicators for SEND Improvement Board

Key Performance Indicator	Worcs Annual 2016/17 (End of Sept 17)	Worcs Annual 2017/18 (End of Sept 18)	End of Q1 (Dec)	End of Q2 (Mar)
Number on a waiting list for specialist provision / Unable to place	Not available	26	31	55
% of mainstream schools that have undertaken a self-review of their SEND provision in the previous 2 years	Data not Received	Data not Received	Data not Received	Data requested 25.06.19

Supporting Commentary

Recently issued DfE data deals with placement data and changes in EHCP numbers. This enables comparisons to be made across LAs and with the national position, drawing on the national SEN2 data returns. The following table shows the Jan 2019 position.

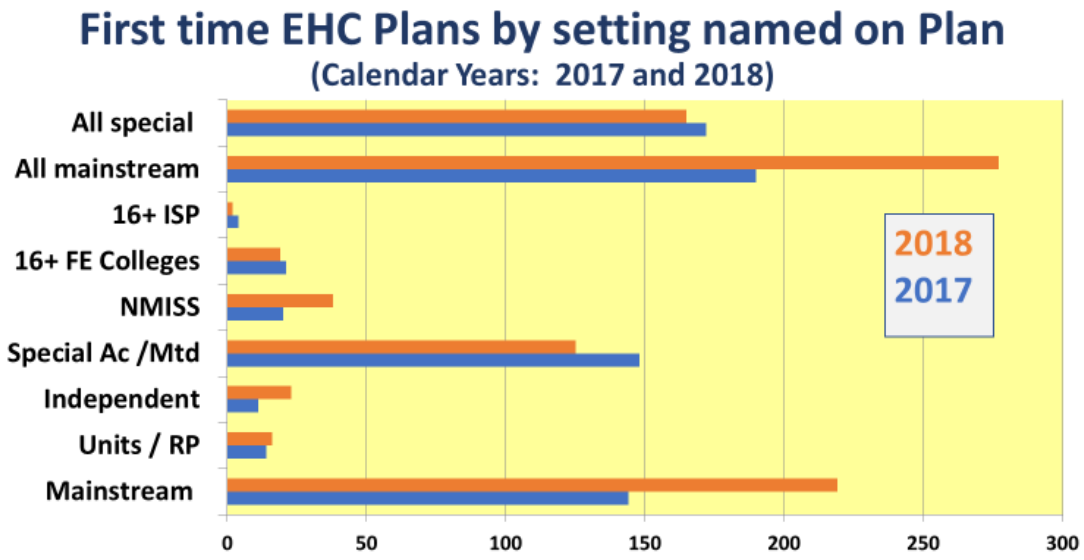
Table WS1.1 - January 2019 - % of pupil population with EHC Plans or at SEN Support			
	National	**Regional**	**Worcestershire**
% of pupil population with EHCP	3.1	3.1	3
% pupil population - SEN Support (& % increase from Jan 18)	11.9 (+0.2%)	12.6 (+0.1%)	12.6 (+0.3%)
Primary mainstream - % with EHCP	1.6	1.2	1.0
Primary mainstream - % at SEN Support	12.6	13.4	14.4
Primary mainstream - % All SEND	14.2	14.6	15.3
Secondary mainstream - % with EHCP	1.7	1.4	1.5
Secondary mainstream - % SEN Support	10.8	11.6	10.9
Secondary mainstream - % All SEND	12.4	13.1	12.3
Total SEND (incl sp schools in LA area)	14.9	15.7	15.9

The % of pupils with EHC Plans is slightly lower than the national and regional averages. However, the percentage growth in those at SEN support has grown to the same level as the regional position.

Whilst the percentage of those with EHC Plans in mainstream primary schools is lower than the national position, the % at SEN Support and the % of all primary aged pupils with SEND (SEN Support and Plans) is higher. In secondary mainstream, the % at SEN support is lower and for EHC Plans higher than the regional position. The overall (primary, secondary and special) % pupils with SEND is higher than both the national and regional position.

In Worcestershire the balance between placements of first time EHC Plans in mainstream and special changed. The strategic intention was to rebalance the placement profile of those with EHC Plans.

Chart - WS1.2



More comparative analysis will be prepared to show national and regional differences.

Numbers of pupils waiting for specialist provision

These numbers do not relate to pupils out of school. The waiting relates to outstanding consultations following parental preference and includes more than one consultation for a number of pupils. The metric needs to be re-titled to make sure its descriptor is not misleading. It is more an indicator of demand for special school and the complexities of satisfying the legal requirement to consult with schools in specific circumstances. Numbers change throughout the year and are influenced by annual review, phase transition, first time Plans, transfers of pupils from another LA into Worcestershire. In 2017/18 academic year, 137 pupils were provided with a new special school place. In 2018/19 academic year, by May 2019, 58 pupils had been provided with a special school place with 64 for whom placement options were being considered.

Work Stream 2 – Gabrielle Stacey

Academic Outcomes - Gabrielle Stacey

Annually collected Performance Indicators for SEND Improvement Board

Key Performance Indicator	Worcs Annual 2016/17 (End of Sept 17)	Worcs Annual 2017/18 (End of Sept 18)	National 2017/18
% of children achieving a good level of development - SEND support	26%	32%	28%
% of children achieving a good level of development - with an EHCP	4%	3%	5%
% of pupils reaching expected standard in Reading, Writing, Maths KS1 teacher assessments - SEND support	20%	19%	21%
% of pupils reaching expected standard in Reading, Writing, Maths KS1 teacher assessments - with an EHCP	4%	4%	7%
% of pupils reaching the expected standard RWM at KS2 - SEND support	16%	18%	24%
% of pupils reaching the expected standard RWM at KS2 - with an EHCP	10%	7%	9%
Average Attainment 8 score per pupil at the end of KS4 - SEND support	30.8	31.8	32.2
Average Attainment 8 score per pupil at the end of KS4 - with an EHCP	12.6	11.0	13.5
% of KS4 pupils with SEND support going to or remaining in education and employment or training opportunities	91%	Not published yet	88%
% of KS4 pupils with an EHCP going to or remaining in education and employment or training opportunities	89%	Not published yet	91%

Quarterly collected Performance Indicators for SEND Improvement Board

Key Performance Indicator	Worcs Annual 2016/17 (End of Sept 17)	Worcs Annual 2017/18 (End of Sept 18)	End of Q1 (Dec)	End of Q2 (Mar)
% of children who have had early years developmental checks	Data not Received	Data not Received	Data not Received	93.1%
% of children not meeting developmental milestones	Data not Received	Data not Received	Data not Received	9.7%

Vulnerability Characteristics - Gabrielle Stacey

Quarterly collected Performance Indicators for SEND Improvement Board

Key Performance Indicator	Worcs Annual 2016/17 (End of Sept 17)	Worcs Annual 2017/18 (End of Sept 18)	End of Q1 (Dec)	End of Q2 (Mar)
Overall attendance - EHCP pupils	88.3%	88.3%	88.3%	88.7%
Overall attendance - SEND Support pupils	91.4%	91.5%	91.9%	92.5%
Permanent exclusions - EHCP Pupils	25	14	5	8
Permanent exclusions - SEND Support pupils	57	62	20	28
Fixed term exclusions (>=5 days) - EHCP Pupils	34	16	4	7
Fixed term exclusions (>=5 days) - SEND Support pupils	58	44	31	47
Number of Children Missing Education with an EHCP	2	4	4	4
Number of Children Missing Education with SEND Support	14	8	14	19
Number of Young people with a EHCP open to the Youth Justice Service team	9	10	5	5

Post 16

Annually collected Performance Indicators for SEND Improvement Board - Gabrielle Stacey & Penny Richardson

Key Performance Indicator	Worcs Annual 2016/17 (End of Sept 17)	Worcs Annual 2017/18 (End of Sept 18)	National 2017/18
% of 16-17 year olds with SEND in education or training (Gabrielle)	91%	Not published yet	89%
% of 19 year olds with an EHCP qualified to Level 2 including E&M (Gabrielle)	13%	15%	15%

Supporting Commentary

- Key Stage 2 outcomes in Worcestershire have been below national figures for the last few years for ALL pupils, including key groups. Outcomes are improving over time but not rapidly enough to close the gap with national comparators
- Historically, there have been lower expectations in schools for the attainment of pupils with EHCP – this is still evident in many schools
- Achievement data for small cohorts of pupils with SEND in small, rural schools are not deemed to be 'significant' with the school's overall data outcomes and comparison to national figures is therefore not meaningful. However, collectively, these small cohorts equate to a significant number of Worcestershire pupils and therefore impact more adversely on LA data
- Attainment for pupils at SEN Support has increased from 2017 across all Key Stages with the exception of KS1. This may be due to increased focus on SEND locally, particularly since the Local Area inspection

- Although attainment at KS2 is not strong compared to national figures, this demonstrates an upward 3 year trend. Progress measures for pupils with EHCP demonstrate significant improvements over time; in 2018, progress measures were in line with or exceeded national comparators i.e. pupils with EHCPs are making better progress across KS2 but from lower starting points
- The percentage of children who have undergone EY developmental checks is available in this quarter for the first time. Over time this will allow for trend analysis and a greater understanding of the measures needed to achieve 100% in this area.
- This is also the case with the metric describing the % of children who are not yet meeting developmental milestones.
- The percentage of 19 year olds with an EHCP qualified to Level 2 including English and Maths has improved from 2016/17 and is in line with national data.
- Attendance of both EHCP and SEND support pupils has risen slightly in the last quarter.
- If current rates of permanent exclusions of both EHCP and SEND support pupils continue there is likely to be a decrease compared to 17/18. This is also the case for fixed term exclusions of EHCP students. Fixed term exclusions of SEND support students have increased.
- The number of SEND support pupils missing education has increased relative to 17-18.

Factors which may be influencing trends:

Supports

- Heightened focus on achievement of pupils with SEND from LA officers and partner services leading to improved attainment and progress
- Increased lines of communication from LA to schools to ensure expectations are clear e.g. Assistant Director letters to schools, SEN communications via Children's Services Portal, clearer and consistent messages to schools from a wide range of services though support and training; SENCo Seminars etc.
- Increased opportunities for partnership working across services to deliver improved services to schools and ensure a coordinated approach
- Coordinated work between the Prime Post 16 team and WCC (including SEN casework) ensures that individual post 16 students at risk of NEET are identified.
- Missing Mondays has introduced robust identification and tracking of Children Missing Education. This may account for the increase in SEND support pupils identified as such over the last two quarters.

Challenges

- Funding – discussions with school leaders make reference to lack of sufficient funding to effectively meet needs, clearly a national and local issue
- Higher frequency of complex needs in mainstream schools mirrored with a reduction in preventative services to schools over time (national and local issue)
- Teacher workload impacts on capacity and well-being – recruitment and retention (national and local issue)

Work Stream 3 – Penny Richardson

Education and Health Care Plans - Penny Richardson

Quarterly collected Performance Indicators for SEND Improvement Board

Key Performance Indicator	Worcs Annual 2016/17 (End of Sept 17)	Worcs Annual 2017/18 (End of Sept 18)	End of Q1 (Dec)	End of Q2 (Mar)
% of new EHCPs issued within 20 weeks	21%	14%	17%	13%
% of EHCP decisions made in 16 weeks	37%	60%	38%	53%

Post 16

Annually collected Performance Indicators for SEND Improvement Board - Gabrielle Stacey & Penny Richardson

Key Performance Indicator	Worcs Annual 2016/17 (End of Sept 17)	Worcs Annual 2017/18 (End of Sept 18)	National 2017/18
% of Adults with a learning disability in paid employment (Penny)	6.8%	6.5%	Not applicable
% of Adults with a learning disability living at home (Penny)	79.2%	80.5%	Not applicable

Supporting Commentary

There are three stages in the EHC assessment process that are subject to statutory timelines:

(i) Following a request / referral for EHC assessment the decision on whether to assess must be made within 6 weeks.

So far in 18/19 academic year, of 556 requests, 99% of decisions have been made on time. 27% of requests were from parent carers. Of the 556 requests, 66% led to Assessment.

Numbers of requests for assessment are up by 29% since 17/18, and numbers of assessments by 37%.

(ii) By 16 weeks, the assessment must be complete, and a decision made on whether or not to issue an EHC Plan. In March and April 72% and 76% respectively of decisions were made on time. In May, performance dropped to 68%. (Numbers of cases in May were up at 47, compared to 32 and 34 in the two previous months.)

(iii) By 20 weeks, EHC Plans should be finalised. In January 2019, 7% were completed on time. By March this had increased to 43% and by June to 53%. This increased performance is directly related to increased numbers of caseworkers supported with coaching and training.

Work Stream 4 – Phillipa Coleman

Health - Phillipa Coleman

Quarterly collected Performance Indicators for SEND Improvement Board

Key Performance Indicator	Worcs Annual 2016/17 (End of Sept 17)	Worcs Annual 2017/18 (End of Sept 18)	End of Q1 (Dec)	End of Q2 (Mar)
Rate per 10,000 population referrals to CAMHs	214	211	251	Not Published yet
% of Looked After Children with SEND with up to date Health Assessments	Not available	68%	74%	81.9%
% of children seen for Choice Assessment within 8 weeks of CAMHs referral	Reporting starts from April 2019			
% of children seen for Partnership appointment within 18 weeks of their referral to CAMHs	Reporting starts from April 2019			
% of children seen for Physiotherapy services within 18 weeks of referral	Reporting starts from April 2019			
% of children seen for Occupational therapy services within 18 weeks of referral	Reporting starts from April 2019			
% of children seen for Speech and Language therapy services within 18 weeks of referral	Reporting starts from April 2019			

Supporting Commentary

The percentage of looked after children with up to date Health Assessments continues to improve and RAG rating has therefore improved from red to amber.

The indicators about waiting times for CAMHS shown in the table above are forthcoming ones and therefore data is not yet available to report on them. However, at the end of March 2019 the CAMHS indicator was for at least 99% of children to be seen within 18 weeks of referral and the service achieved 100% compliance.

There is also good compliance for children being seen within 18 weeks of referral to other therapy services, for which the target is 95% compliance. This was exceeded for all children's therapy services at March 2019, being achieved for 100% of referrals to occupational therapy, 99% to physiotherapy and 98% to speech and language therapy.