worcestershire
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Health and Well-Being Board
Tuesday, 5 December 2017, Lakeview Room, County Hall - 2.00 pm

Minutes

Present:

Mr J H Smith (Chairman), Ms J Alner, Kevin Dicks, Catherine Driscoll, Mr A I Hardman, Mr M J Hart, Dr Frances Howie, Dr A Kelly, Dr C Marley, Peter Pinfield, Mr A C Roberts, Mrs M Sherrey, Jonathan Sutton, Simon Trickett and David Watkins.

Also attended:

Liz Altay, Philippa Coleman, Sarah Wilkins and Kate Griffiths

463 Apologies and Substitutes

Apologies had been received from Carole Cumino, Gerry O'Donnell and Steve Stewart.

Jonathan Sutton attended for Carole Cumino and David Watkins attended for Gerry O'Donnell.

Catherine Driscoll requested that her item be first on the agenda as she had been asked to attend another meeting.

464 Declarations of Interest

None

465 Public Participation

None

466 Confirmation of Minutes

The minutes were confirmed as a correct record of the previous meeting and were signed by the Chairman.

467 Special Education Needs and Disabilities (SEND) Strategy

Catherine Driscoll, Director of Children, Families and Communities was delighted to commend the Special Educational Needs and Disabilities (SEND) strategy. The Strategy was a partnership approach which dealt with education and health needs and had been completed with the aid of months of discussion with parents and carers.

Sarah Wilkins explained that this was the first time there had been a separate SEND Strategy which responded to the Children and Young People's Plan (CYPP) aim of improving outcomes for vulnerable children. The Strategy had been developed since March 2017 and the Strategic SEND Board had met in September to refine the policy. It

was hoped that the Strategy would be signed off at Cabinet in February 2018.

The Strategy had been developed with the help of data from Public Health and 5 priority areas had been developed:

- Preparing for adulthood
- Integration and operational delivery
- Early intervention
- Workforce development
- A person-centred approach

Marcus Hart, Cabinet Member for Education and Skills endorsed the strategy and commended the fact that it was for wider stakeholders as well as the Local Authority. It was now important that the strategy be put into action.

During the discussion the following points were made:

- The Strategy does not specifically mention looked after children or children in need but they had been considered and were incorporated in the strategy
- Health and well-being members felt that there was quite a lot they could do to help implement the strategy along-side the implementation of accountable care
- Although the strategy was for a number of partners to work together there was not a joint approach to funding and early in the implementation stage funding and the use of resources across the system needed to be agreed
- The strategy sat below the CYPP but Children with SEND needed one holistic plan rather than being dealt with separately by different parts of the system. It was a challenge for system leaders to implement the strategy so that young people wouldn't feel as though a separate step needed to be considered
- It was suggested that the SEND strategy be taken to the Sustainability and Transformation Partnership Workforce Board to ensure consistent implementation
- Housing providers had not been included in the consultations but that would be considered
- There was a risk that implementation takes a long time to occur
- A Local government peer review had taken place. Once the feedback had been received it could be shared with the Board

- The Strategy would be reporting to the Children and Families Strategic Group which was a sub group of the Board so feedback could form part of the feedback from that group,

RESOLVED that the Health and Well-being Board:

a) Noted the vision and priorities of the strategy in relation to the HWB priorities and those of the CYPP and related strategies, and

b) Approved the SEND Strategy and supported the vision and priorities under the HWB vision of improving the lives of Worcestershire's residents as part of the formal governance process.

468 CAMHs Transition Plan

Philippa Coleman explained that the plan was generally known as the CAMHS (Children and Adolescent Mental Health Service) Transformation Plan however CAMHS was just part of the plan. The plan had first been produced two years ago and was now on its second refresh following consultations with Healthwatch, the Youth Cabinet and other stakeholders.

New services had been introduced with £1.1 million extra funding and had led to successes which were shown by a reducing number of young people needing Tier 4 services. The new schemes focussed on earlier and lower level interventions and included on-line and face to face counselling which did not need GP referrals. A community eating disorder service had also been set up and further investment had been made in training.

In the discussion the following points were made:

- Board members were pleased that children's mental health services were moving in the right direction
- Tier 4 beds were for very poorly children who required placements which were often outside Worcestershire. The availability of such placements was getting worse so it was important to improve services in Tiers 1 to 3 which would improve services for children, reduce the demand for Tier 4 further and also save money in the long term,
- There was concern about the referral system as it no longer just had to be from a GP. Referrals could now come from schools and it was felt to be a good thing that referrals could come from

schools who would know the children better than GPs. The CAST (Consultation, advice, support and training) team gave advice and could help parents and schools with the referral process
- Children and parents could make referrals to the on-line service
- Help with eating disorders mainly dealt with bulimia and anorexia but in time that would broaden to other issues
- Most of the £1.1 million in extra funding has gone into prevention services to help with Tiers 2 and 3, and it was noted that this was a good alignment with the prevention priorities within the HWB Strategy and the STP
- Commissioning was carried out by CCGs but they worked closely with health and the Local Authority
- NHS England had already assured the Plan.

RESOLVED that the Health and Well-being Board:

a) Approved the refreshed Transformation Plan and continued to support its development and implementation; and
b) Noted that this transformation plan would be implemented as part of the programme of work under the HWB Strategy priority of improving mental health and well-being.

469 Sustainability and Transformation Partnership Update

Jo-anne Alner explained that NHS England had released staff to support the STP and as a result she would now Chair the Partnership Board.

Various points were raised by the HWB at the Joint Herefordshire and Worcestershire HWB meeting in June 2017 and these were answered in the report:

- The STP reflected the HWB strategy
- Prevention was key across all the STP programmes
- The STP was committed to engagement and had recruited a Community Engagement Officer
- The digital delivery programme was being refreshed and the County Council would be involved in implementation. However those who were not digitally able would not be overlooked
- It was recognised that patients needed to be seen by the right person at the right time so close working between hospitals and social care was important. Social Care spend would have to be taken into account along-side NHS spend

- The HWB would receive updates on plans when they were available. The HWB had already received updates on the Future of Acute Hospital Services and the Local Maternity Systems Plan
- The STP agreed more could be done to work more closely with housing, transport and other partners such as police, fire and District Councillors.

Board members made the following points:

- There were concerns that there were still outstanding questions regarding finances as well as what changes people would actually see to services when they were made 'sustainable'. In particular there were concerns about the impact on social care of the shift away from acute care. People wanted more facts and figures although it was understood that actions may be going on behind the scenes
- It was felt that the language around the STP was difficult to understand, for example people were confused as to the purpose of the Ambulatory Care Unit. It was clarified that the Unit was for GPs to send patients they were concerned about and it was agreed that clear language should be used in future communications
- It was explained that the STP was a partnership which aimed to collectively and collaboratively plan health and social care. It was acknowledged that this was complex, with different accountabilities across the system. At the moment, significant progress was being made in integrating care at team level.

Developing Accountable Care in Worcestershire

Accountable care was a progressive step to change the culture of how care was planned. The STP Partnership Board worked together to plan and deliver health and care services within one budget, with the social care budget out of scope. The planning was done dependent on the needs and budget within a particular area and services from different organisations would be working together for the best outcome. This was different to the previous system which expected to achieve efficiencies through competition.

Accountable care would allow more focus to be on the patient and more control at local level. Place was a layer

of provision of 30-50,000 people. As money was decreasing it was important that prevention was a main consideration.

The Worcestershire approach to Accountable Care was to build on the existing infrastructure which moved the system away from privatisation, rather than towards it as some politicians had feared. The system was organised from the bottom up: for example Droitwich would have a single team made up from staff from all organisations; above that was the individual CCG level then County level.

As Hospital, community services and social care needed to work in the same team it was important to get the integration right. Other services such as housing also needed to be considered and included.

In some areas acute services were taking over GP practices but in this area it was the other way round. CCGs would begin implementation and once the system was more robust it would be explained to the wider public.

As services were being integrated, Board members wondered if providers should be considered as representatives on the HWB.

RESOLVED that the Health and Well-being Board;

a) **Received responses to the points they raised at the Joint Herefordshire and Worcestershire HWB in June 2017;**
b) **Noted the development towards Accountable Care;**
c) **Considered which areas of the plan they would like to receive further detail on from the STP;**
d) **Agreed that a briefing would be held for Councillors on the STP and Accountable Care; and**
e) **Would further consider membership or attendance of providers at the Health and Well-being Board.**

470 Development Meeting update

The last Development Session was held as a data workshop to consider whether existing priorities were fully intelligence led. At the session it was agreed that there was a pattern of clustering of poor outcomes among certain groups which could have been predicted and with the right intervention they could have been avoided. It was felt that the HWB should look at these adverse childhood experiences (ACES) in more detail. It

was also agreed that the Board should further consider Children's road safety.

RESOLVED that the Health and Well-being Board:

a) **Noted the recent workshop following on from the presentation of the Joint Strategic needs Assessment to the October meeting of the Board;**
b) **Agreed for further work to take place to develop a shared understanding of Adverse Childhood Experiences;**
c) **Agreed that further consideration of children's road safety outcomes should take place, and a representative of the Safer Roads Partnership should be invited to a future meeting of the Board to present data to strengthen understanding of priorities in this area.**

471 Adverse Childhood Events (ACES)

Liz Altay gave a presentation (attached) explaining that there was a robust evidence base linking adverse childhood experiences (ACEs) to severe negative health and social outcomes across the life course. The more ACEs a person experiences the worse their outcomes. Multiple ACEs in a family have a high risk of transmitting poor outcomes for the next generation.

Training could be developed for staff so that they make routine enquiries of all their contacts. This would then identify people who were likely to experience poor outcomes and various prevention actions could be put into place to reduce the effect of the negative experiences.

Board members welcomed this approach and those dealing with Children's services could see the importance of such work in breaking the cycle of intergenerational harm.

Chronic homelessness was accepted as a result of suffering ACEs and homeless people were now being asked what happened to you rather than an assumption being made that there was something wrong with them.

Board members accepted that a joined up response was needed and input would be required from all partners including the police.

RESOLVED that the Health and Well-being Board:

a) **Considered and commented on the ACEs briefing presented to the Board;**

b) Should ensure that each organisation represented by the Board attended future ACE events and played an active part in the formulation and delivery of action to prevent and respond effectively to ACEs across the life course.

472 Immunisation Update

This report was for the Board to note that NHS England had agreed to social care workers being eligible for free flu vaccinations rather than having to claim the cost back from their employees. Board Members were requested to take this information back to their organisations, publicise the change and encourage social care workers to have the vaccination.

RESOLVED that the Health and Well-being Board:

a) Notes, supports and advocates the changes in the flu vaccination programme within their organisations; and
b) Commits as organisations to working together to improve flu vaccination uptake within health and social care workers and in the eligible population.

473 Future Meeting Dates

Dates for 2018

Public meetings (All at 2pm)

- 27 February 2018
- 22 May 2018
- 25 September 2018
- 13 November 2018

Private Development meetings (All at 2pm)

- 30 January 2018
- 27 March 2018
- 24 April 2018
- 19 June 2018
- 17 July 2018
- 23 October 2018
- 4 December 2018

The meeting ended at 3.50pm

Chairman …….

Adverse Childhood Experiences

Liz Altay

Adverse Childhood Experiences

- An adverse childhood experience (ACE) describes a traumatic experience in a person's life occurring before the age of 18.

The Ten Adverse Childhood Experiences	
Child	**Parents / household**
• Physical abuse • Sexual abuse • Emotional abuse • Physical neglect • Emotional neglect	• Mother treated violently • Household substance misuse • Household mental illness • Parental separation or divorce • Incarcerated household member

- Robust evidence base linking ACEs to severe negative health and social outcomes across the life course

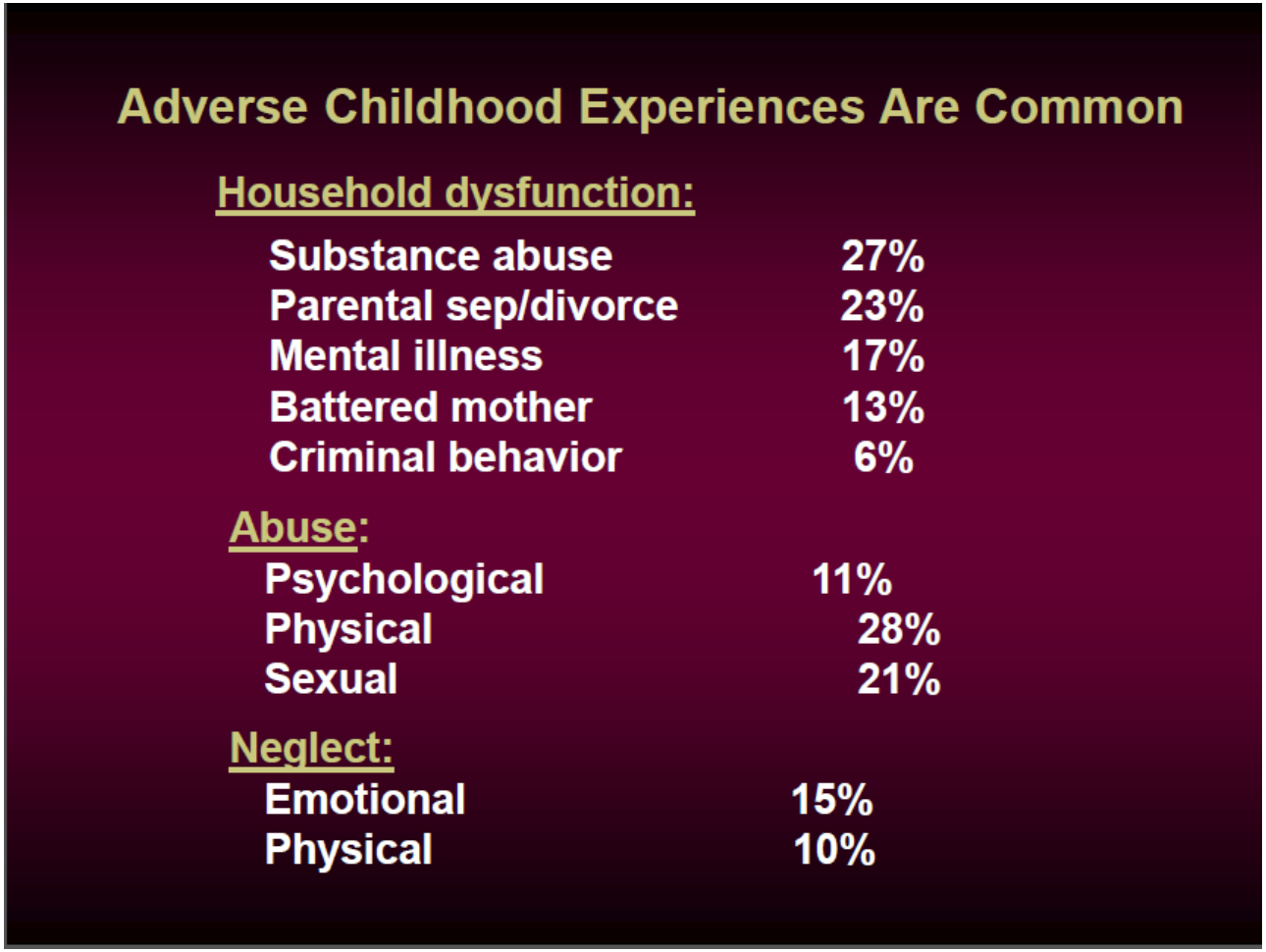
Public Health England

Questions to define health harming behaviours – The ACEs Score Calculator

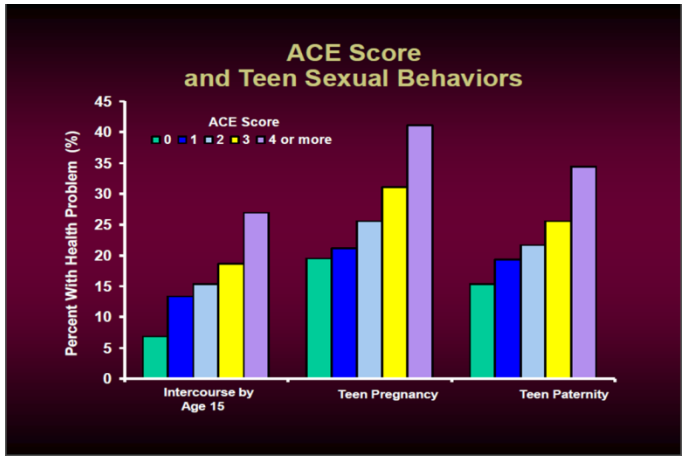
Adverse Childhood Experiences	Definition
Parental separation	Were your parents ever separated or divorced?
Domestic violence	How often did your parents or adults in your home ever slap, hit, kick, punch, or beat each other up?
Physical abuse	How often did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way? This does not include gentle smacking for punishment
Verbal abuse	How often did a parent or adult in your home ever swear at you, insult you, or put you down?
Sexual abuse	How often did anyone at least 5 years older than you (including adults) ever touch you sexually?
	How often did anyone at least 5 years older than you (including adults) try to make you touch them sexually?
	How often did anyone at least 5 years older than you (including adults) force you to have any type of sexual intercourse (oral, anal, or vaginal)?
Mental illness	Did you live with anyone who was depressed, mentally ill, or suicidal?
Alcohol abuse	Did you live with anyone who was a problem drinker or alcoholic?
Drug abuse	Did you live with anyone who used illegal street drugs or who abused prescription medications?
Incarceration	Did you live with anyone who served time or was sentenced to serve time in a prison or young offenders' institution?

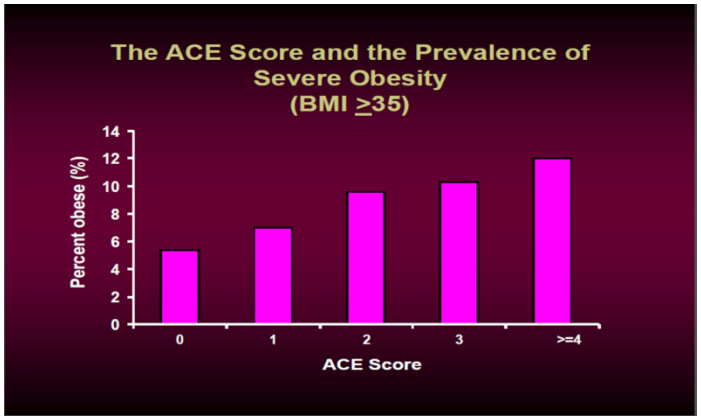
All ACE questions were preceded by the statement "While you were growing up, before the age of 18..."

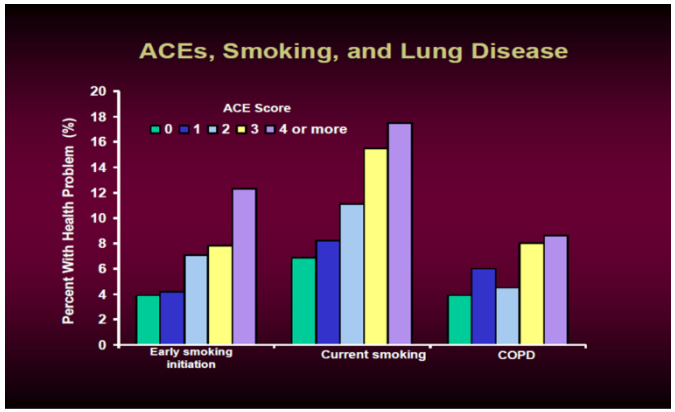
ACEs study USA

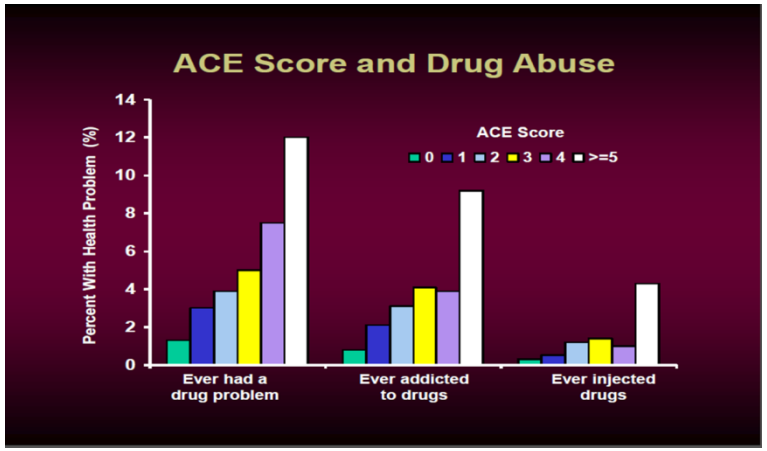


ACEs study USA









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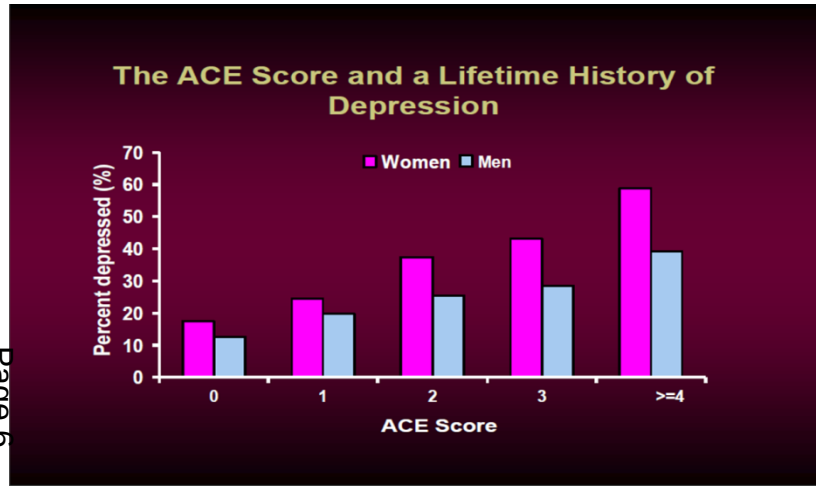
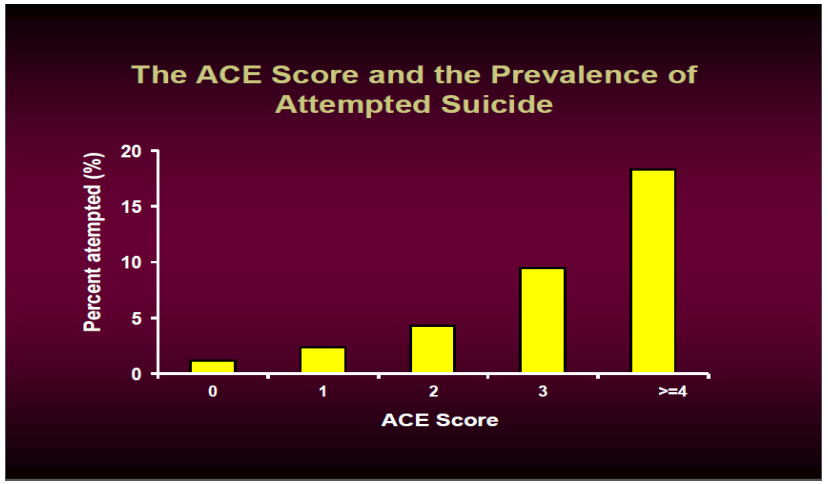
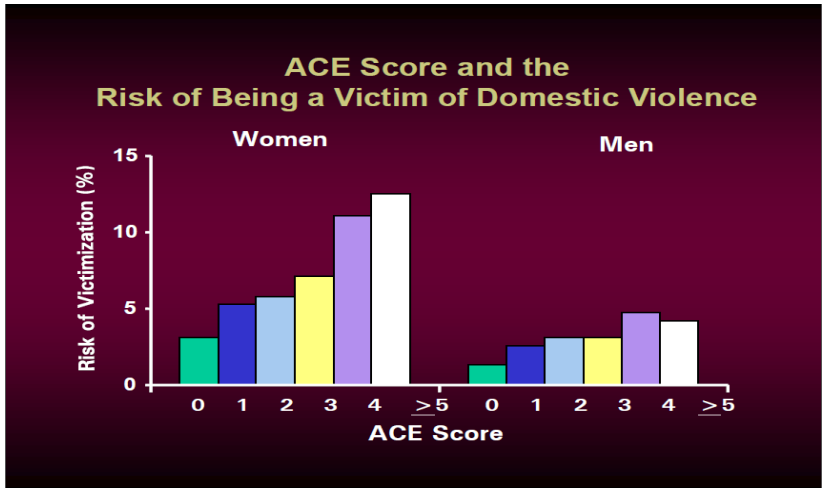
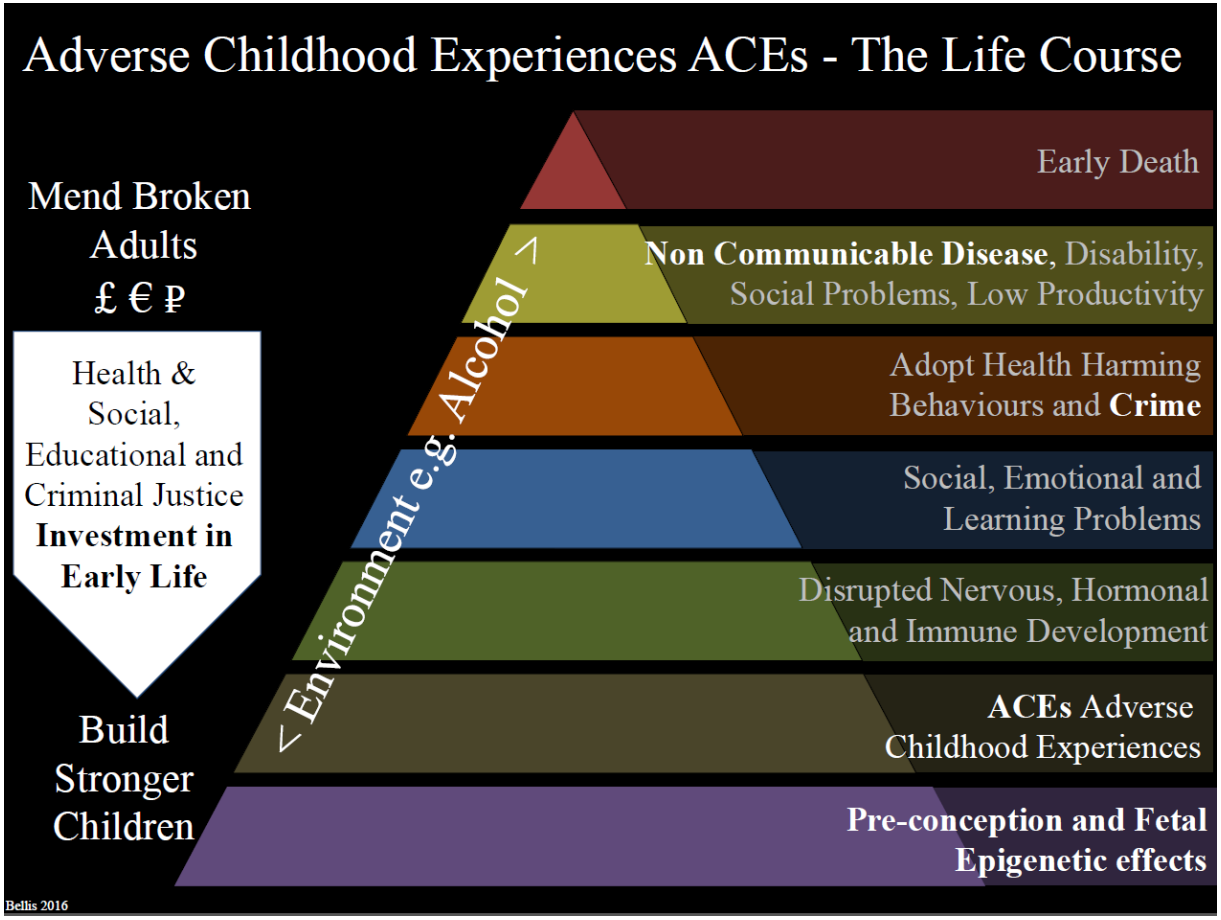






ACEs - the Life Course



ACEs Study - UK

Outcome	All		Adverse Childhood Experience %				χ^2trend	P
	%	n	0	1	2to3	4+		
Sexual Behavior								
Unintended teenage pregnancy (<18 years)	5.5	3836	2.9	5.6	8.3	17	106.097	<0.001
Early sexual initiation (<16 years)	16.8	3374	10	19.4	23	37.8	164.629	<0.001
Substance use								
Smoking (current)	22.7	3885	17.7	21.8	28.3	46.4	127.022	<0.001
Binge drinking (current)	11.3	3885	9.3	13.2	12.6	16.7	18.579	<0.001
Cannabis use (lifetime)	19.5	3878	12.2	21.5	27	47.7	241.57	<0.001
Heroin or crack cocaine use (lifetime)	2.2	3882	0.9	1.5	4	9	84.106	<0.001
Violence and criminal justice								
Violence victimization (past year)	5.3	3883	2.4	4.2	10.7	16.1	137.578	<0.001
Violence perpetration (past year)	4.4	3884	2	3.6	8.7	13.9	119.609	<0.001
Incarceration (lifetime)	7.1	3879	3.1	8.1	10.2	24.5	182.58	<0.001
Diet, weight and exercise								
Poor diet (current)	15.6	3879	13.3	15.9	18.3	25.1	31.679	<0.001
Low physical exercise (current)	43	3881	44.1	41.4	41.2	42.7	1.434	0.231

ACEs Study - UK

UK: Compared with no ACEs, those with 4+ ACEs were:

- 2x more likely to binge drink
- 3x more likely to be current smoker
- 5x more likely to have had sex under 16 years
- 7x more likely to be involved in recent violence
- 11x more likely to have used heroin or crack
- 11x more likely to have been incarcerated

INDEPENDENT OF POVERTY

If they had no ACEs problems could be reduced by:

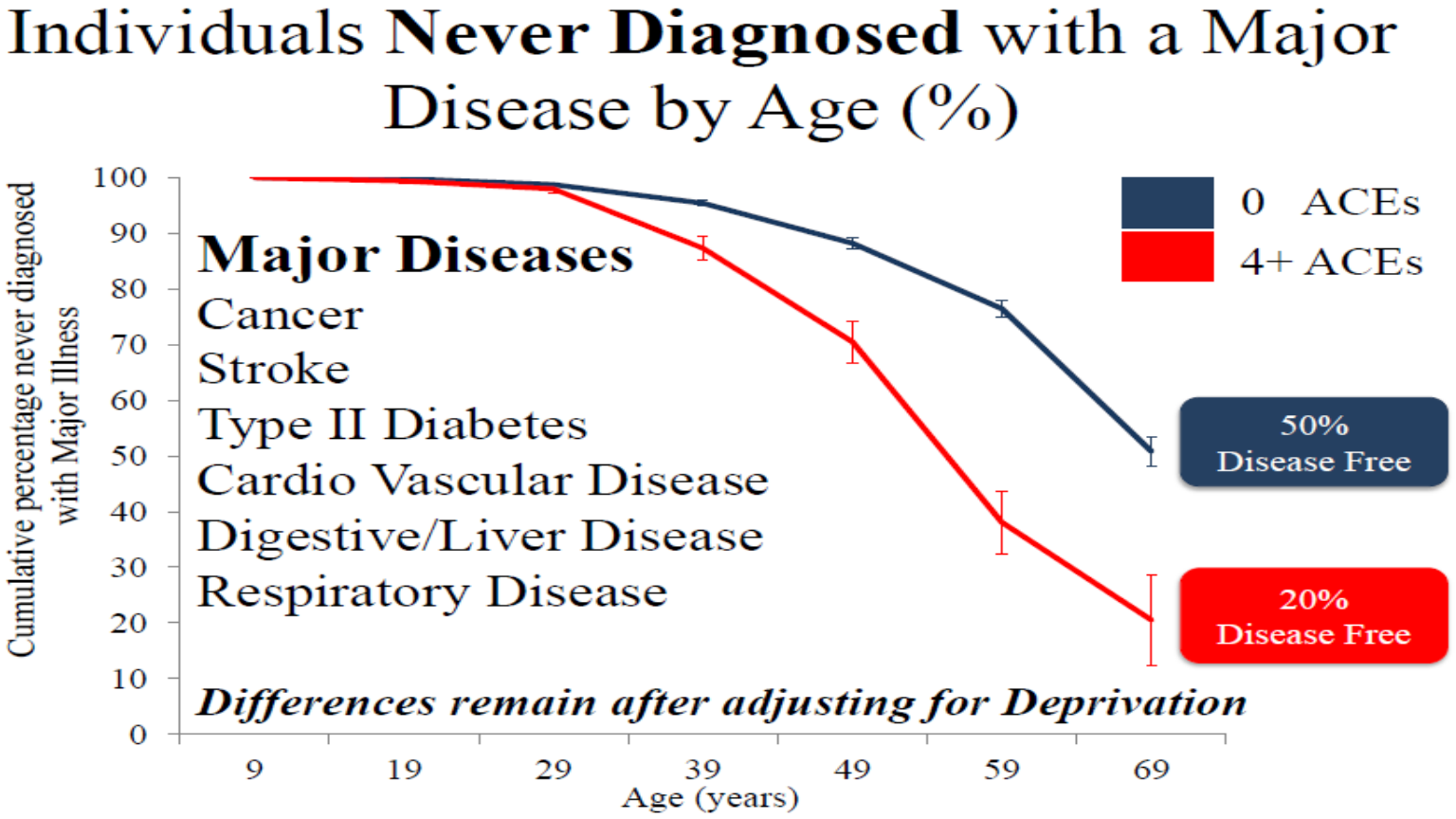
Smoking	Early Sex	Heroin/Crack	Binge Drinking	Violence
16%	33%	59%	15%	60%

Aged 18-70 years

Bellis 2016

Bellis et al. 2014, n=3885

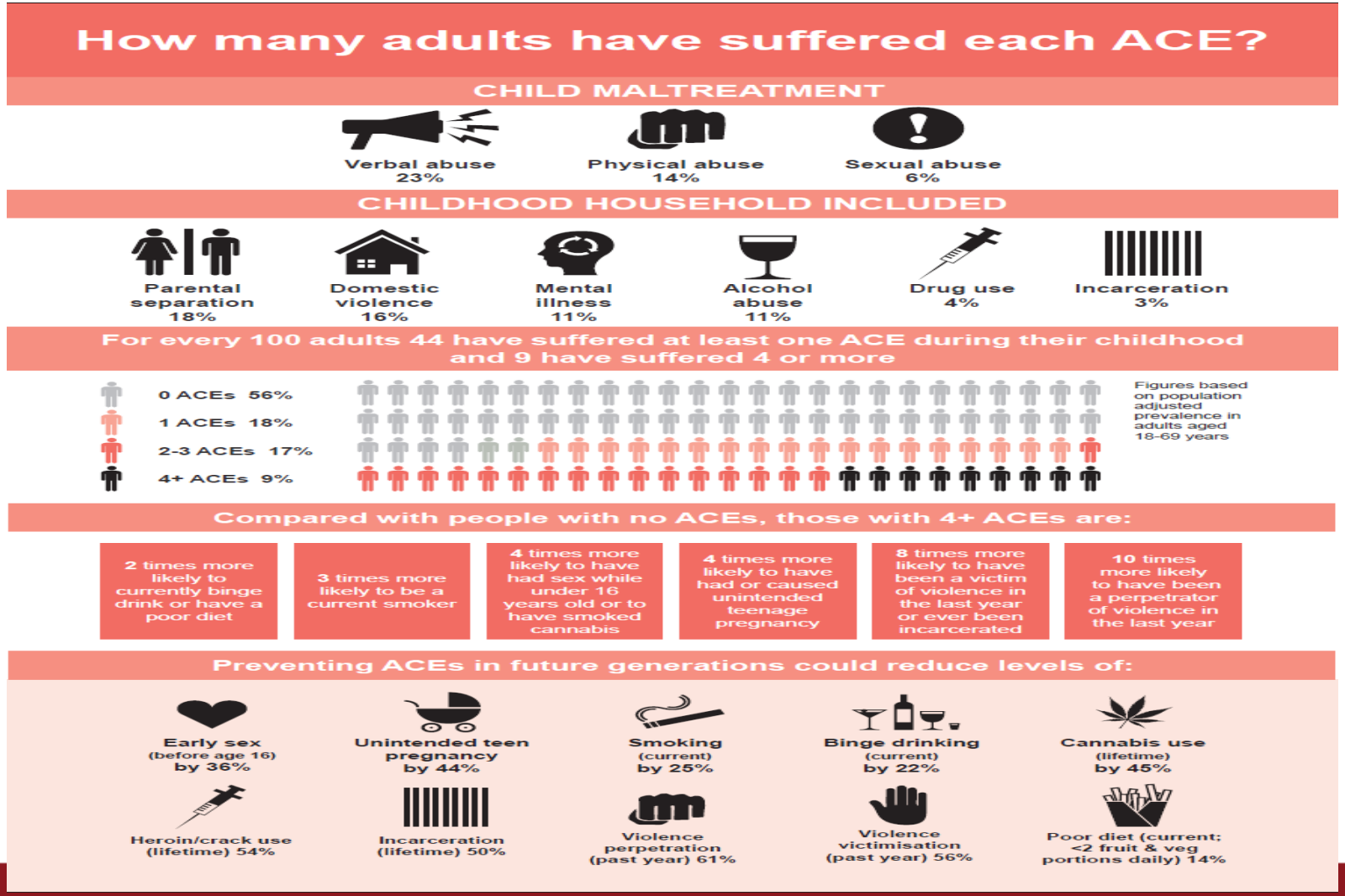
ACEs Study - UK



Aged 18 to 69 years; (n = 3,885) Bellis et al, Journal of Public Health, 2014

Bellis 2016

ACEs study -Hertfordshire, Luton & Northamptonshire



Adverse Childhood Experiences (ACEs) in Wales

ACEs are stressful experiences occurring during childhood that directly harm a child (e.g. sexual or physical abuse) or affect the environment in which they live (e.g. growing up in a house with domestic violence).

How many adults in Wales have been exposed to each ACE?

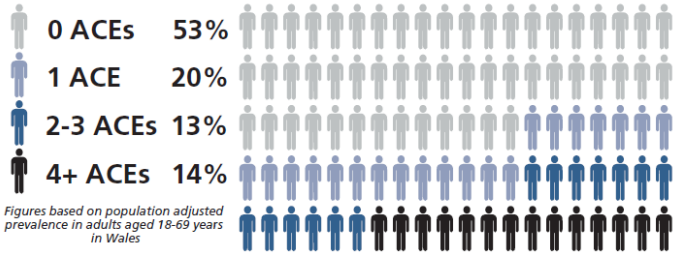
CHILD MALTREATMENT

- Verbal abuse 23%
- Physical abuse 17%
- Sexual abuse 10%

CHILDHOOD HOUSEHOLD INCLUDED

- Parental separation 20%
- Domestic violence 16%
- Mental illness 14%
- Alcohol abuse 14%
- Drug use 5%
- Incarceration 5%

For every 100 adults in Wales 47 have suffered at least one ACE during their childhood and 14 have suffered 4 or more.



Figures based on population adjusted prevalence in adults aged 18-69 years in Wales

ACEs increase individuals' risks of developing health-harming behaviours

Compared with people with no ACEs, those with 4+ ACEs are:

- **4** times more likely to be a high-risk drinker
- **6** times more likely to have had or caused unintended teenage pregnancy
- **6** times more likely to smoke e-cigarettes or tobacco
- **6** times more likely to have had sex under the age of 16 years
- **11** times more likely to have smoked cannabis
- **14** times more likely to have been a victim of violence over the last 12 months
- **15** times more likely to have committed violence against another person in the last 12 months
- **16** times more likely to have used crack cocaine or heroin
- **20** times more likely to have been incarcerated at any point in their lifetime

Preventing ACEs in future generations could reduce levels of:

- Heroin/crack cocaine use (lifetime) by 66%
- Incarceration (lifetime) by 65%
- Violence perpetration (past year) by 60%
- Violence victimisation (past year) by 57%
- Cannabis use (lifetime) by 42%
- Unintended teen pregnancy by 41%
- High-risk drinking (current) by 35%
- Early sex (before age 16) by 31%
- Smoking tobacco or e-cigarettes (current) by 24%
- Poor diet (current; <2 fruit & veg portions daily) by 16%

Systematic Review (2017)

- 4+ ACEs increased risk **all** health outcomes
- Weak association: inactivity, obesity & diabetes
- Moderate: smoking, alcohol, cancer, heart disease, respiratory disease
- Strong: sexual risk taking, mental health, problematic alcohol use
- Strongest: drug use & violence
- Outcomes for multiple ACEs represent ACE risks for next generation-
  - Violence, mental illness & substance use

What should we do?

What *can* Be Done About ACES?

These wide-ranging health and social consequences underscore the importance of preventing ACEs before they happen. **Safe, stable, and nurturing relationships and environments** (SSNREs) can have a positive impact on a broad range of health problems and on the development of skills that will help children reach their full potential. Strategies that address the needs of children and their families include:

Voluntary home visiting programs can help families by strengthening maternal parenting practices, the quality of the child's home environment, and children's development. Example: Nurse-Family Partnership

Home visiting to pregnant women and families with newborns

Parenting training programs

Intimate partner violence prevention

Social support for parents

Parent support programs for teens and teen pregnancy prevention programs

Mental illness and substance abuse treatment

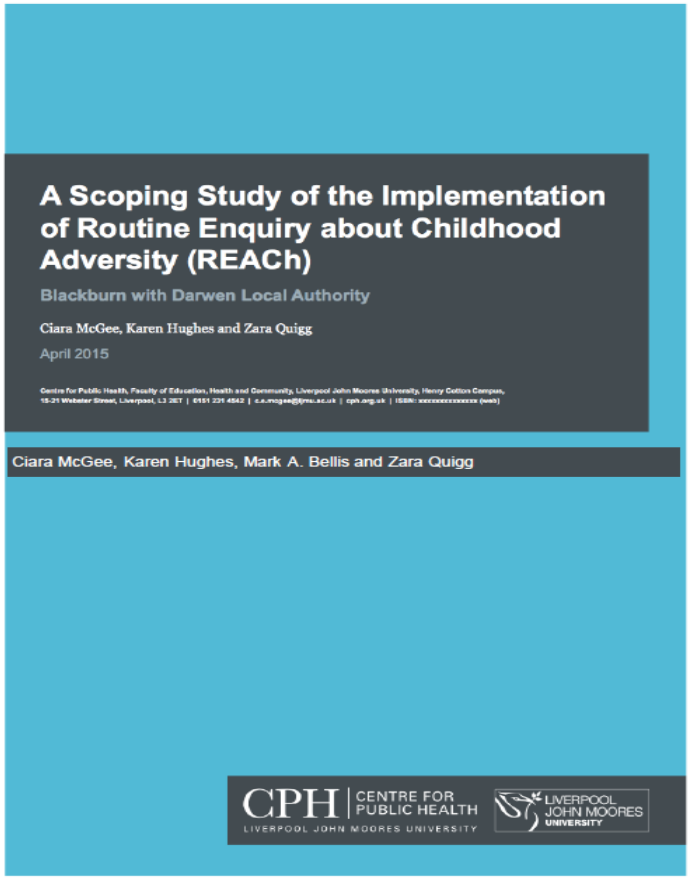
High quality child care

Sufficient Income support for lower income families

Routine Enquiry about Adversity in Childhood

- 10 years before individual discloses. May ask 1 or 2 ACEs
- Don't ask: risk repeating interventions that don't address issue
- Chronic Diseases & behaviours: determined decades earlier, in childhood

Public Health – Commissioned LCFT to train front line staff



How can we respond?

- Primary Prevention
  - **Prevent** ACEs occurring
  - Ensuring best start in life, supporting parents, building resilience
- Secondary Prevention
  - **Identify** adverse events as/when they occur to reduce impact (trauma informed approach)
- Tertiary Prevention
  - **Enquiry** to identify past ACEs in those with established physical or emotional problems/illness & provide support or therapeutic care to enable change

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