Health and Well-Being Board
Tuesday, 25 September 2018, 2.00 pm, Council Chamber, County Hall

Supplement Agenda

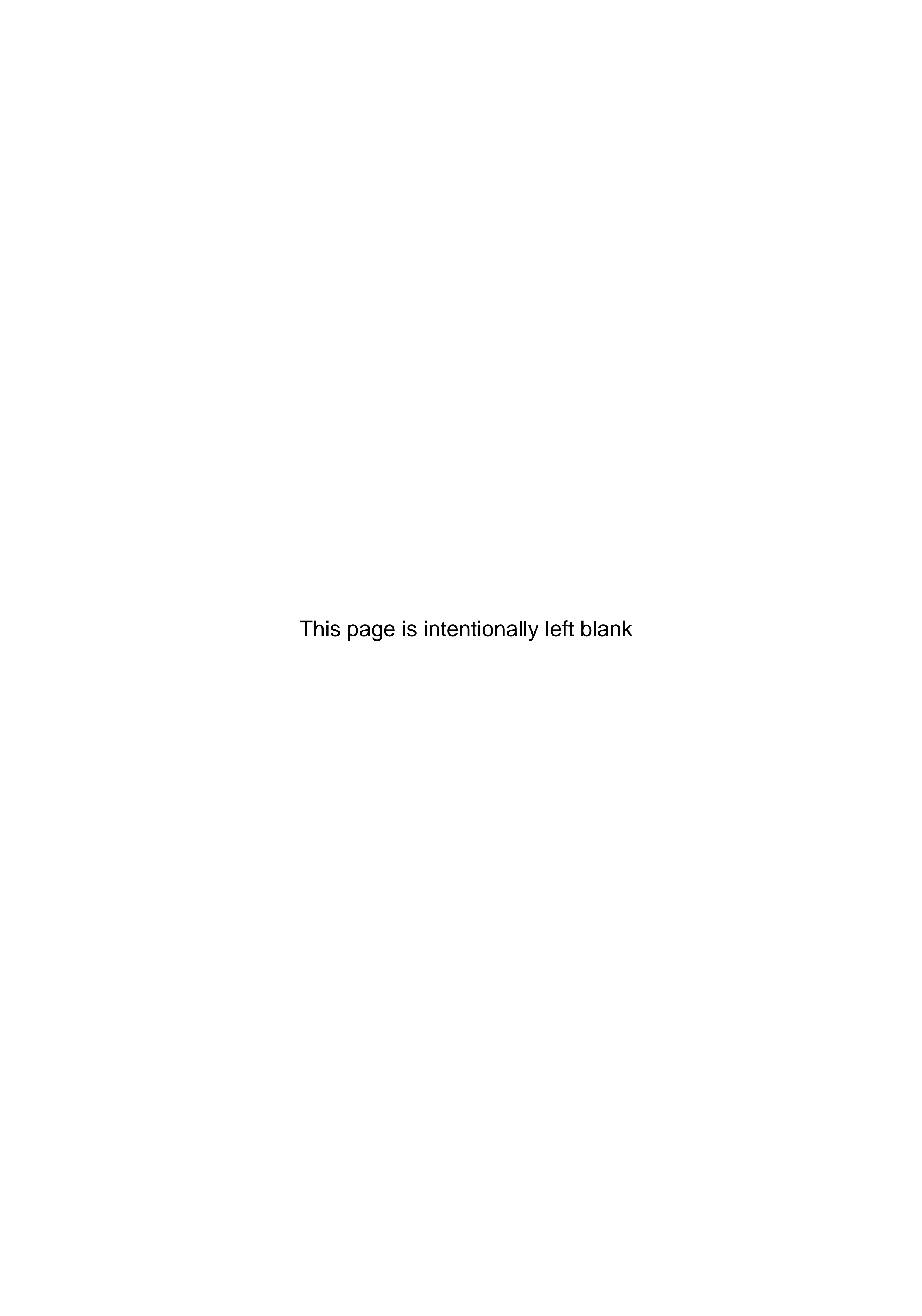
Item No	Subject	Presenter	Page No
5	**Worcestershire Safeguarding Children's Board** Plus the Child Death Overview Panel Report		1 - 58
6	**Worcestershire Safeguarding Adults Board**		59 - 84
7	**Director of Public Health Report and Joint Strategic Needs Assessment Update**		85 - 310
8	**Health Protection Group Annual Update**		311 - 318
9	**Better Care Fund**		319 - 348

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 at http://worcestershire.moderngov.co.uk/uucoverpage.aspx?bcr=1

Date of Issue: Monday, 17 September 2018


This page is intentionally left blank

Worcestershire Safeguarding Children Board

Annual Report 2017/18

Find out more online: www.worcestershire.gov.uk/safeguardingchildren

Contents

Foreword by Independent Chair 4

1. Introduction to the Worcestershire Safeguarding Children Board 6
   - 1.1 What is the Safeguarding Children Board? 6
   - 1.2 Purpose of the Annual Report 6
   - 1.3 Vision Statement 6
   - 1.4 Mission Statement 6
   - 1.5 WSCB Values 6
   - 1.6 WSCB Membership & Structure 7
   - 1.7 Business Plan 7
   - 1.8 Administration 7
   - 1.9 Funding 8
   - 1.10 New Local Safeguarding Children Arrangements 8

2. Context 9
   - 2.1 Context & Local Demographics 9
   - 2.2 Partnership Working 10

3. Key Priorities in 2017/18 12
   - 3.1 Children subject to Neglect 12
   - 3.2 Children affected by Domestic Abuse 12
   - 3.3 Children vulnerable to or experiencing Child Sexual Exploitation (CSE) 13
   - 3.4 Early Help 14
   - 3.5 Voice of the Child, Professional Curiosity and Escalation Policy 15
   - 3.6 Critical Friends (Service Improvement Plan) 15
   - 3.7 Thresholds 16

4. Effectiveness, Learning and Improvement 17
   - 4.1 Monitoring Effectiveness 17
   - 4.2 Quantitative Data 17
   - 4.3 Qualitative Data 18
   - 4.4 Learning and improvement 20
   - 4.5 Child Death Overview Panel (CDOP) 21
   - 4.6 Serious Case Reviews (SCRs) and Case Reviews 22
   - 4.7 Communications 22
   - 4.8 Engagement with Front Line Practitioners 23
   - 4.9 Engagement with Children, Young People and Families 23
   - 4.10 Policies & Procedures 23
   - 4.11 Evaluating the Effectiveness of Training 24

5. Formal Summary Statement 25

Appendix 1 - End of Year Financial Statement 27

Appendix 2 - Headlines from the Data 28

1. Contacts, Referrals & Assessments 28
2. Early Help 28
3. Children with a Child In Need Plan 28
4. Children with a Child Protection Plan 28
5. Looked After Children 29
6. Children who are Care Leavers 30
7. Children in Private Fostering 30
8. Unaccompanied Asylum Seeking Children (UASC) 30
9. Children with a Disability 30
10. Children Missing Education and Electively Home Educated Children 30
11. Children at Risk of Offending 31
12. Children and Mental Health 31
13. Missing Children 31
14. Concerns about Adults who are in Positions of Trust 31

Appendix 3 - Glossary 32

Foreword by Independent Chair

The Worcestershire Safeguarding Children Board's (WSCB) Annual Report for 2017/18 provides a summary and assessment of the effectiveness of child safeguarding and the promotion of the welfare of children in Worcestershire.

The purpose of a Local Safeguarding Children Board is to co-ordinate safeguarding arrangements across agencies and to ensure these are effective. In last year's report I stated that pending changes to legislation meant that effective local partnership working had never been more important as the removal of the statutory footing for safeguarding of children in each locality would require the partners to reaffirm their commitment to collaborative working arrangements. The publication of Working Together 2018 and its associated guidance places a significant responsibility on the local authority, the police and health partners to deliver new safeguarding arrangements from 2019.

I am assured that those three key safeguarding partners, along with other important sectors and agencies, are committed to delivering effective and inclusive safeguarding arrangements for the children and young people of Worcestershire.

The Annual Report covers the local and national context, governance and accountability arrangements, priorities, achievements and learning, and concludes with a formal summary statement about the sufficiency of arrangements to ensure children are safe in Worcestershire.

As in previous years the Report will be made publicly available on the Board's website, and will be formally submitted to the Chief Executive and Leader of the County Council. It will be presented to the County Council's Children and Families Overview and Scrutiny Panel, to the Health and Well-Being Board and to the Council's Cabinet. It will also be sent to the Police and Crime Commissioner and to key partnerships. Board members will ensure that their own agencies have access to the Report.

As was the case last year there has rightly been a focus on Children's Social Care with particular emphasis on developments around early help and the continuing delivery of wider service improvement. The exploitation of children and young people, be that Child Sexual Exploitation (CSE) or in other forms such as trafficking, will remain a priority across the partnership.

Worcestershire Safeguarding Children Board, its members and their colleagues, will continue its work to safeguard the children and young people of the county, and I would wish to express my appreciation to all of them for their efforts.

Derek Benson

Independent Chair: August 2018

Page 4

Assurance Statement

Worcestershire Safeguarding Children Board assurance statement for 2017/18:

Assurance provided	1. Robust monitoring arrangements are in place through Ofsted, the Children's Commissioner and Essex County Council (Improvement Partner) and progress is being made by Children's Social Care through delivery of its Service Improvement Plan
	2. There is increased engagement with schools at both strategic and operational levels in terms of welfare and safeguarding issues generally, and with decision making in respect of individual children and young people at risk of sexual exploitation
	3. There is good engagement across the partnership with the Child Sexual Exploitation (CSE) agenda and and Designated Safeguarding Leads in virtually all schools have received the Board's CSE training
	4. The Section 11 Audit demonstrates that there is good compliance reported by partner agencies with plans in place to address any required improvements in the delivery of safeguarding duties
	5. There is a robust approach to the co-ordination of services for children and families affected by domestic abuse by the Worcestershire Forum Against Domestic Abuse and Sexual Violence and there there is good linkage with WSCB

Assurance not yet provided	1. No up to date CSE problem profile for Worcestershire
	2. Low levels of awareness across the partnership of private fostering and the duty to notify the local authority
	3. Difficulties with accessing data from West Mercia Police to support trend analysis
	4. Children with disabilities receive a good service from specialist social workers, but assurance is not available about the larger cohort of other disabled children who do not meet the eligibility criteria for this service
	5. Need to consider the safeguarding needs of some groups of 'hidden children' identified by Ofsted in Special Educational Needs and Disabilities (SEND) Inspection
	6. Need to understand better why Worcestershire's data suggests a higher rate of Child Protection Plans due to Neglect than the England average or statistical neighbours
	7. Concern about the capacity of support services to meet the needs of children who are at risk of or have experienced sexual exploitation
	8. Awaiting evidence from the annual schools safeguarding audit (S175/157 Audit) of the extent to which schools have embedded the Whole School Approach to Healthy Relationships in support of the CSE prevention agenda
	9. We remain unsure about the effectiveness of early help delivered by the wider partnership

1. Introduction to the Worcestershire Safeguarding Children Board (WSCB)

1.1 What is the Safeguarding Children Board?

WSCB is the key statutory body which oversees 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.

1.2 Purpose of the Annual Report

It is a statutory requirement for the Independent Chair of the Safeguarding Board to publish an annual report on the effectiveness of child safeguarding arrangements in Worcestershire. This report relates to the preceding financial year. The report will be submitted to the Chief Executive and Leader of the Council, the Police and Crime Commissioner and the chair of the Health and Well-Being Board.

1.3 Vision Statement

All children and young people in Worcestershire are safe and thriving

1.4 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.

1.5 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

1.6 WSCB Membership & Structure

Membership of the Local Safeguarding Children Board is statutory for a number of partners as outlined in **Working Together (2015)**. A full list of member partner agencies can be found on the WSCB website at **www.worcestershire.gov.uk/safeguardingchildren**

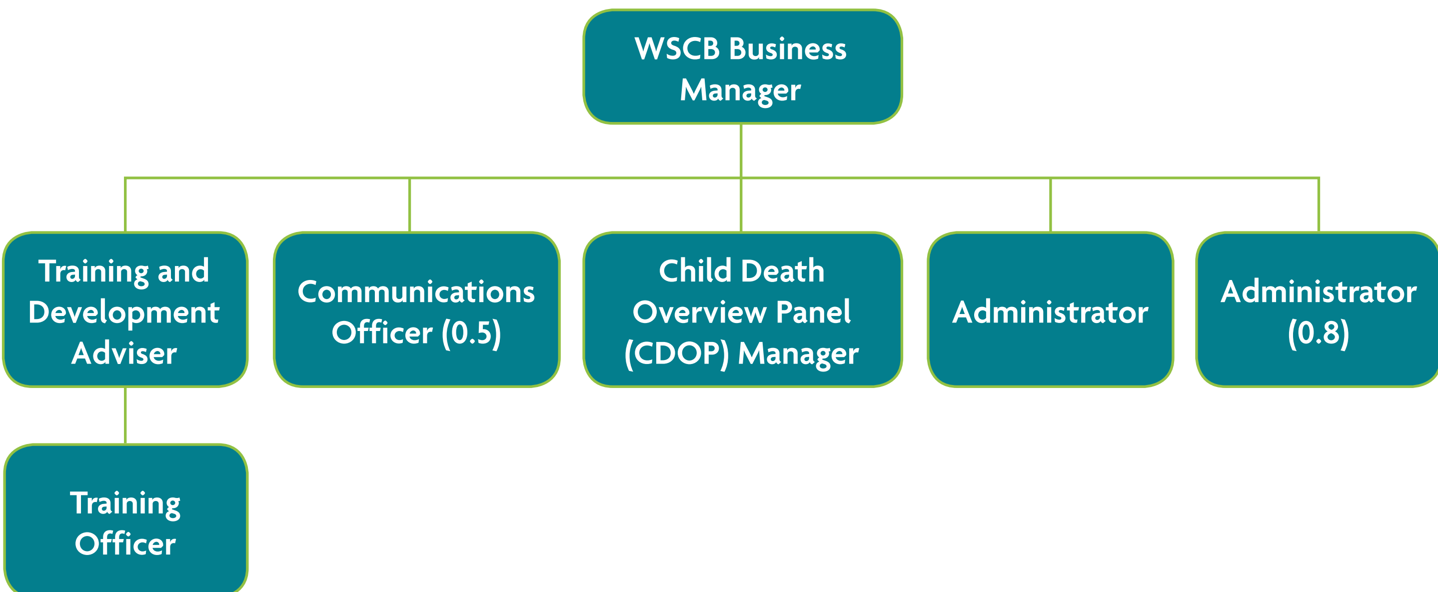
WSCB has a number of sub groups which co-ordinate the activity required for the Board to fulfil its statutory functions. The Board's structure chart is located at: **www.worcestershire.gov.uk/downloads/file/1998/structure_for_worcestershire_safeguarding_children_board_september_2013**

1.7 Business Plan

The WSCB Business Plan for 2017/18 is located on the Board's website at: **www.worcestershire.gov.uk/downloads/file/4732/wscb_business_plan_2016_to_2017**

1.8 Administration

The Board's Business Unit supports the Board's functions and is comprised of the following posts:



1.9 Funding

The WSCB is funded through a combination of annual contributions made by partner agencies and income generated through the training charging policy.

1.10 New Local Safeguarding Children Arrangements

The Children and Social Work Act 2017 replaces Local Safeguarding Children Boards (LSCBs) with new local safeguarding arrangements, led by the three safeguarding partners (Local Authority, Chief Officer of Police and the Clinical Commissioning Groups). LSCBs must continue to carry out all of their statutory functions, until the point at which safeguarding partnership arrangements begin to operate in a local area from 2019. Arrangements must be in place by September 2019.

2. Context

2.1 Context & Local Demographics

The largely rural county of Worcestershire is situated in the West Midlands. It has a population of 583,500 and 75% of residents live within the main towns and urban areas. According to figures released by Worcestershire County Council the county population is increasing by approximately 3,400 people per annum.

2.1.1 Age

Worcestershire has a resident population of approximately 116,100 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 5,100 (4.5%) with variations between age groups. The population of 10 to 15 year olds is projected to increase by 4.3% while the population of 16 to 17 year olds is projected to increase by 5.6%.

2.1.2 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 (8.2%). Polish, Urdu and Punjabi are the most commonly recorded spoken community languages in the area.

2.1.3 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. The average for the county is 17.7, ranked as 111 out of 152 Local Authority areas (1 being the most deprived).

2.1.4 Local Authority Provision

At the end of March 2017 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 2017	March 2018
Children 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).	795	695
Looked after Children (A child who is being looked after by the Local Authority is known as a child in care)	764	798
Child Protection Plans (Children require a Child Protection Plan if they are judged to be suffering, or likely to suffer significant harm).	526	415

2.2 Partnership Working

2.2.1 Linkages with other Strategic Boards

The Board is independent and not subordinate to, nor subsumed within, other local structures in order that it can properly provide effective scrutiny. 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).

During 2017/18 the following partnership activities and work streams were advanced:

- High level protocol between WSCB and Family Justice Board (as recommended by Ofsted) has been signed off
- Work has been undertaken to develop a protocol between WSCB, Corporate Parenting Board and the WCC Children & Families Overview & Scrutiny Panel
- Twice yearly meetings of the Chairs of HWB, SCB, Community Safety Partnerships (CSPs), WSAB & WSCB to consider cross-cutting issues and agree which partnership Board will lead on specific work streams
- In October 2017 Derek Benson became the Chair of the WSAB in addition to chairing the WSCB

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

The Board also works closely with the Worcestershire Safeguarding Adults Board and Worcestershire Forum Against Domestic Abuse and Sexual Violence, particularly on key issues such as substance misuse, domestic violence and parental mental health.

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. Key Priorities in 2017/18

3.1 Children subject to Neglect

A Task and Finish Group was established in October 2017 to look at neglect in Worcestershire.

Initial analysis of the data indicates that Worcestershire has a significantly higher rate of Child Protection Plans due to neglect (34.0 per 10,000 in 2017) than the rate for both statistical neighbours (21.6 per 10,000) and England (26.3 per 10,000). 63% of all current Child Protection Plans are for neglect which is significantly higher than the national average of 48%. Nearly three quarters of new Contacts or Referrals to Children's Social Care where neglect is a factor relate to children under 10 years and the other quarter to 11-15 year olds.

Two multi-agency case file audits (MACFAs) were undertaken in 2014 and 2017 on cases where children were experiencing neglect. The findings from these audits have been revisited and compared and, together with questions raised by the data, have guided the development of a Neglect Strategy.

The draft strategy will be presented to the Board in 2018 and will include a clear definition of neglect, a pathway and a toolkit to support the development of shared understanding and language. The WSCB Neglect Strategy will be implemented during 2018/19 with mechanisms in place for monitoring its impact on children and young people.

Impact: It is anticipated that as a result of the strategy thresholds will be applied consistently and risk assessments will be undertaken in a consistent way, with interventions informed by a good understanding of the lived experience of children and young people.

3.2 Children affected by Domestic Abuse

The Worcestershire Domestic Abuse Strategy was launched towards the end of 2017 by the Worcestershire Forum Against Domestic Abuse and Sexual Violence. In order to support this work a new multi-agency sub group was established during the year chaired by the Assistant Director (Safeguarding).

During the year WSCB undertook a MACFA on 12 children who had been exposed to domestic abuse five or more times. It found that in the main professionals were not aware when a Domestic Violence Protection Order (DVPO) had been put in place by the courts (5 out of 12 cases), providing a window of opportunity for work to be undertaken with victims and their children. Assurance has been provided by West Mercia Police that relevant partners will now be notified of the period of time available in which to offer support to victims and safeguard children. In support of this a series of leaflets have been produced for partners around the process and requirements for action. Worcestershire took out more DVPOs between September – December 2017 than other West Mercia force areas with 24 granted by the courts.

Approximately one third of all social work assessments have domestic abuse as a factor, and one third of all current Child in Need Plans, 45% of Child Protection Plans and 31% of Looked After Children have domestic abuse identified as a factor.

Audits were undertaken by Children's Social Care in July and December 2017 on the quality, timeliness and management of domestic abuse notifications received at the Family Front Door* and on children who were already subject of a social work plan. This was subject to further scrutiny during the Ofsted monitoring visit in January 2018. Multi-agency audit activity is being agreed as part of the Family Front Door Protocol looking at the quality of decision making and outcomes for the child, specifically identifying any repeat contacts/referrals or repeat assessments for particular scrutiny.

WSCB has been sighted on developments led by the Worcestershire Forum Against Domestic Abuse and Sexual Violence during the year.

Impact: All relevant partners are now being routinely notified of the window of opportunity to support victims and safeguard children when Domestic Violence Protection Orders are made by the court following incidents.

3.3 Children vulnerable to or experiencing Child Sexual Exploitation (CSE)

The Board's CSE Strategic Group, led by West Mercia Police, is responsible for co-ordinating the implementation of the CSE Strategy Action Plan 2017-19, and for providing assurance to the Board about the multi-agency response to children and young people at risk of or experiencing sexual exploitation.

An Ofsted recommendation made in 2016 was for there to be a review of the CSE Operational Group to ensure there was the right representation of partner agencies. Membership now includes representation from schools, a gap identified by Ofsted. Weekly Multi Agency Risk Reduction Strategy (MARRS) meetings have been established and replace the daily triage meetings at the Family Front Door. Schools are invited to contribute in person or via live link to these discussions.

During the year the following assurances/concerns have been noted by the Board:

- A multi-agency CSE dashboard is being developed
- An updated CSE Problem Profile is not yet available to replace the one produced by West Mercia Police in 2015 due to insufficient analytical capacity
- Feedback on their experiences of services has been provided by young people aged 16 years or older who were identified as having experienced or been at risk of to CSE in the last 12 months. This feedback will be particularly important to consider as the CSE Strategy Action Plan is refreshed to ensure that the views of young people are informing service developments going forward.
- Partners are signed-up and engaging with the CSE agenda.
- The West Mercia and Warwickshire Police 'Tell Someone' CSE communications campaign materials were widely circulated by the Board to partner agencies for them to utilise to promote CSE Awareness Day on 18 March 2018.
- The WSCB developed the Whole Schools Approach to Healthy Relationships toolkit for use in schools and set this as the standard for CSE prevention in education settings. The annual safeguarding audit to be completed by schools and colleges in 2018 will seek assurance about the extent to which the toolkit has been implemented in each school.
- Designated Safeguarding Leads (DSLs) in all secondary and middle schools have now received face to face training on CSE. Primary schools are currently being targeted where there are gaps. This training is delivered by the WSCB Business Unit with support from colleagues in the Police and Children's Social Care. Attendees are all required to complete a CSE e-learning module prior to attending face to face training.
- A CSE conference was held at Police headquarters in July 2017 which was attended by 68 practitioners from a range of agencies and was well-received.
- There is work in progress to review the CSE Pathway to ensure it reflects current processes and a new CSE Risk Assessment Tool is to be agreed.
- The Office of the Police and Crime Commissioner is now a standing member of the strategic group where concerns about the capacity of commissioned support services for victims of CSE to meet local need in Worcestershire has been raised, with assurance provided that this will be considered within the review of the Contract.

*The Family Front Door act as a point of referral and advice.

- The current CSE Action Plan requires us to consider the use of civil orders in the management of young people who are both facilitators of CSE (by introducing other young people to offenders) and also victims in their own right. Recent and current CSE investigations in Worcestershire will provide further insight and learning in respect of this particular challenge.

The WSCB has agreed that CSE will remain a strategic priority in 2018/19 and has agreed to extend the remit of its CSE sub group to include other forms of exploitation.

Referrals about CSE are being made by partner agencies and a number of investigations have been undertaken during the year involving multiple perpetrators who are known to each other.

Partner agencies are aware of the expectations on them in respect of sexual exploitation and there has been a high level of engagement with audits providing assurance that partner agencies are engaged with the CSE agenda.

It is hoped that by October 2018 Designated Safeguarding Leads in all primary and first schools will have completed the online and face to face training. WSCB holds a number of CSE training courses throughout the year to ensure those new in post can also access the training. The schools safeguarding audit (S175/157 Audit) will provide further assurance in 2018.

Impact: Decisions about risks to individual children and young people are now being made with the benefit of information from schools, awareness has increased across the partnership and CSE is being identified in Worcestershire.

3.4 Early Help

A Task and Finish Group was established in October 2017 to develop the action plan required to support implementation of the WSCB Early Help Strategy approved in September 2017.

Work completed or in progress:

- Seminar held on 9 November 2017 to consider the future model with Partners
- Development of short Early Help Assessment and Plan with associated guidance notes for practitioners
- Drafting of practice guidance on Consent
- Development of a Communications Strategy and website
- A Workforce Development Strategy is being produced
- Development of a WSCB framework for monitoring effectiveness of early help
- Partnership events – Designated Safeguarding Leads network and locality events
- Connecting Families Strategic Group agreed use of funds to support roll out of Signs of Safety to partner agencies

There are clear linkages between early help and the Children and Young People's Plan (CYPP) and in March 2018 it was agreed that responsibility for delivery of the Early Help Action Plan would transfer to the relevant sub-group of the Health and Well-Being Board.

Impact: Further Action 2018/19

- Clarify the future governance arrangements for the delivery of the Early Help Strategy action plan
- Work with partner agencies to raise awareness of their role in delivering early intervention and prevention
- Assurance to be provided to WSCB through its early help effectiveness framework to be overseen by the Monitoring Effectiveness Group (MEG) sub-group of the WSCB

Page 14

3.5 Voice of the Child, Professional Curiosity and Escalation Policy: Resolution of Professional Differences

MACFA and case review findings in previous years had indicated that practitioners did not always have an understanding of the lived experience of children and young people, or use this to inform decisions about them. Professional curiosity was often absent and indicators of risk not being identified, or explanations from parents and carers taken at face value sometimes leading to disguised compliance.

Learning and Improvement Briefings were developed on the Voice of the Child and Professional Curiosity. Drama students at a local high school produced a DVD which was used to support the Voice of the Child message from a young people's perspective. The DVD was played at Information and Guidance events held to promote the Learning and Improvement Briefings and disseminate the key messages.

The Briefings have also been promoted via the WSCB's newsletter and strategic leads across the partnership have been asked to ensure that links to Learning and Improvement Briefings have been disseminated to all relevant staff. A survey was circulated in May 2018 requesting feedback on action taken to provide assurance to the Board that its key messages have been widely communicated.

Policies and procedures are being reviewed to ensure that they provide appropriate guidance in respect of the Voice of the Child and this work will continue into 2018/19.

Key messages are included in the multi-agency training delivered by the WSCB.

Impact: All statutory partner agencies completed the survey in addition to a number of early years settings and schools. The WSCB can provide assurance that all partner agencies have actively disseminated to practitioners and relevant commissioned services the links to the two Learning and Improvement Briefings and to the Escalation Policy: Resolution of Professional Disagreements. Dissemination has been achieved using a variety of methods. The percentage of early years settings and schools to complete the survey is relatively small (26% and 18% respectively) but still valid. Further assurance will be obtained from the schools safeguarding audit (S175/157 Audit).

The total number of practitioners across the partnership who have received the links to the Learning and Improvement Briefings and the Escalation Policy is approximately 13,000. The impact on practice will continue to be evaluated through the WSCB's MACFA programme during 2018/19.

3.6 Critical Friends (Service Improvement Plan)

In March 2017 eight Board members were nominated to act as 'Critical Friends' to provide support and challenge to Children's Social Care as part of its improvement journey. The role of the Critical Friend was defined as:

A Critical Friend can be defined as a trusted person who asks provocative questions, provides data to be examined through another lens, and offers critiques of a person's work as a friend. A Critical Friend takes the time to fully understand the context of the work presented and the outcomes that the person or group is working toward. The friend is an advocate for the success of that work.

The nominated Critical Friend met with the relevant work stream lead and, where appropriate, the Assistant Director (Safeguarding), on a regular basis to review progress against the Service Improvement Plan, identify blockages and agree the actions to be completed to provide a solution.

Since the Service Improvement Plan was put in place there have been three monitoring Visits from Ofsted and Essex County Council has been engaged by the Council to act as its 'Improvement Partner'. As a result of the progress identified by Ofsted, Essex CC and the Critical Friends, the Service Improvement Plan is currently being refreshed.

The WSCB is to receive a presentation on the revised plan in June 2018 after which a decision will be made about the process for engaging with the Critical Friends going forward.

Impact: The Board has received assurance that these arrangements have proved beneficial to Children's Social Care and have contributed to the development of effective partnership working, as well as service improvement.

3.7 Thresholds

The final version of the Levels of Need (Thresholds) guidance was approved by the Board in September 2017. The guidance was referenced at the Board's Information and Guidance events held during Autumn 2017.

Letters were sent to strategic leads in April 2018 to formally request that the link to the Levels of Need guidance be disseminated again to all relevant staff and a survey was subsequently circulated to seek assurance that this had been achieved. All statutory partners completed the survey in addition to a number of early years settings and schools. Further assurance will be obtained from schools via the annual schools safeguarding audit (S175/157 Audit).

A decision was taken during the year that awareness of the thresholds guidance would be raised using a communications strategy rather than through face to face training. The appropriateness of referrals being made to Children's Social Care by partner agencies will be assessed by an audit taking place in July 2018.

Impact: The WSCB can provide assurance that all partner agencies have actively disseminated to practitioners and relevant commissioned services the link to the Levels of Need (Thresholds) guidance. In addition, all agencies confirmed that their staff know the name and contact details of the safeguarding lead to whom they should go to for advice about the action to be taken in respect of a specific child.

The total number of practitioners across the partnership who have received the link to the Levels of Need (Thresholds) guidance is approximately 13,000. The WSCB will continue to evaluate whether practitioners appropriately apply the thresholds for accessing services from Children's Social Care during 2018/19.

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:

Types of Evidence

Quantitative Data

(Multi-agency dataset of key key performance indicators)

Qualitative Evidence

Programme of multi-agency case file audits (MACFAs), case reviews, audits and safeguarding conversations

Voice of the Child

(Engagement with children, young people and parents on specific issues)

Voice of the Practitioner

(Engagement with front line practitioners and other staff)

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.

The Family Front Door receives all initial Contacts in order to evaluate whether a Referral should be made to Children's Social Care. A particular focus has been on the demand for Children's Social Care services and the need for targeting services at the right children and families. As partner agencies develop their understanding of the threshold for making a Referral it is anticipated that the number of Contacts which result in no further action should reduce.

Key headlines[1] from the 2017/18 data:

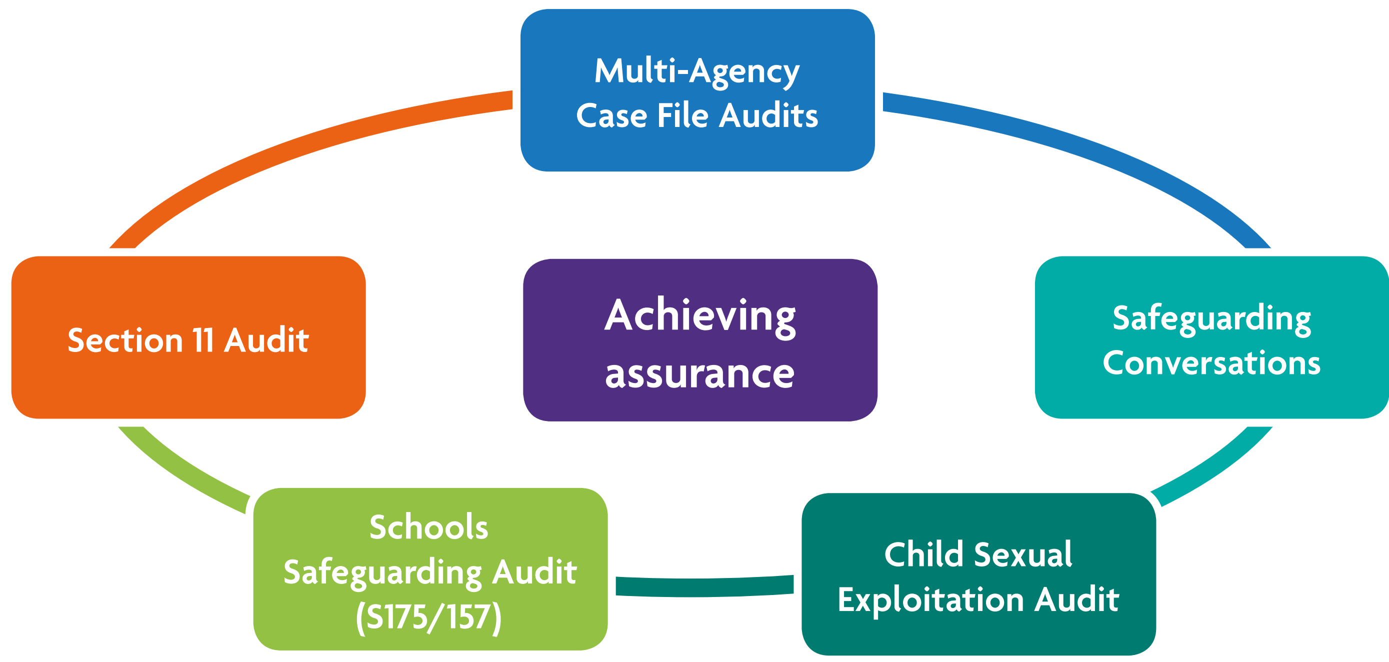
- ↑ 10,000 Contacts to the Family Front Door, an increase of 10% compared to last year
- ↑ Number of looked after children has increased from 764 last year to 798
- ↓ Number of open Section 17 assessments has reduced from 1035 to 386
- ↓ Number of Section 17 assessments completed has reduced from 5188 last year to 4953
- ↓ Number of open Section 47 (child protection) assessments has reduced from 195 last year to 90
- ↓ Number of open Child in Need Plans has reduced from 795 last year to 695
- ↓ Number of open Child Protection Plans has reduced from 526 last year to 415
- ↓ Percentage of Contacts that became Referrals has remained steady at 36% (37% last year)

Further detail and analysis is available in Appendix 2.

[1] Following acceptance of a referral by the local authority children's social care, a social worker should lead a multi-agency assessment under section 17 of the Children Act 1989. Local authorities have a duty to ascertain the child's wishes and feelings and take account of them when planning the provision of services.

4.3 Qualitative Data

In 2017/18 the following quality assurance audits were completed:



4.3.1 Section 11 Audit (statutory partners)

The Section 11 Audit is a self-assessment by partner agencies of the extent to which they are fulfilling their safeguarding responsibilities as defined in the Children Act 2004. 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 on a bi-annual basis. This year the Board utilised a new audit template devised by a working party from across the West Midlands.

The audit found that good compliance was reported by agencies, and that clear plans are in place to address any areas that require improvement. A challenge event is planned for the Autumn 2018, to be facilitated by the Independent Chair of the Board, where further assurance will be sought from partner agencies about the evidence provided to support their self-assessments.

4.3.2 Child Sexual Exploitation Audit

The CSE self-assessment tool and guidance was published on the WSCB website to enable all agencies to assess themselves against the standards established by the Board. Partner agencies have been asked to update the self-assessment submitted in 2016 to enable the WSCB to evaluate what progress has been made across the partnership in responding to children and young people at risk of sexual exploitation. A small number of schools and GP practices who determined that they required improvement in 2016 were asked to repeat the audit by outlining progress made against their action plan.

4.3.3 Section 175/157 Audit (safeguarding audit for schools and colleges)

Under the Education Act 2002 (Section 175/157) schools must “make arrangements to safeguard and promote the welfare of children”. This audit evidenced a high level of safeguarding activity across the education settings in Worcestershire. The return rate was 73% and from those schools who returned the audit:

96% report that staff are familiar with ‘Keeping Children Safe in Education’ and have been issued with the school’s safeguarding policy

94% confirmed that they are aware of and utilise the WSCB inter-agency guidance

This is a high level of compliance achieved across the settings, however the Board requires the return rate to be 100% and action will be put in place over the next year to support schools to achieve this.

4.3.4 Multi-Agency Case File Audits

Multi-Agency Case File Audits (MACFAs) are in-depth audits of a small sample of cases facilitated by an independent Auditor commissioned by the Board. This year MACFA themes have reflected the Board's strategic priority groups of children and all have been undertaken previously to provide opportunity to assess improvements in practice. This year the audits have reviewed a larger number of children than in previous years: 24 cases (12 boys, 12 girls). A Learning and Improvement Briefing has been published which summarises the key aspects of learning from the MACFAs. The Briefing can be found here: **www.worcestershire.gov.uk/landiresources**

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 training delivered by the Board.

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

This year four audits were undertaken on: Children with Disabilities, Neglect, Domestic Abuse and Child Sexual Exploitation.

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 four Board members, including the Director of Children, Families and Communities, were involved in the discussions.

The Safeguarding Conversations were based on Neglect and Domestic Abuse in line with WSCB priorities. Whilst this is a reflective learning process, action will be taken immediately if safeguarding issues are identified to ensure children are safeguarded and receive appropriate services.

4.3.6 Single Agency Inspections

Children's Social Care

Since the Single Inspection Framework (SIF) inspection of Children's Social Care by Ofsted in October 2016 the Board has received regular updates from the Director of Children, Families and Communities regarding progress against the Service Improvement Plan (SIP).

The Children's Commissioner, Trevor Doughty, has provided support and the local authority has appointed Essex County Council as its Improvement Partner. In addition, Ofsted have continued to monitor progress through quarterly monitoring visits. As a result of feedback received from Ofsted monitoring visits, Essex Diagnostics and the local authority's own Quality Assurance and Performance Information, the Service Improvement Plan has been updated to focus on a refreshed set of priorities.

At the same time, having been judged inadequate by Ofsted and placed under direction by the Department for Education, the business case for an Alternative Delivery Model has been developed. This was presented to Cabinet on 29 March 2018 and there was a unanimous decision to develop a wholly-owned Council company to deliver Children's Social Care services. The new Company will be implemented from October 2019.

The revised Service Improvement work streams are:

- Support and develop the workforce;
- Promote social care best practice;
- Build quality assurance processes;
- Listen to the Voice of the Child;
- Enhance multi-agency partnerships;
- Deliver effective Through Care.

A key part of the Service Improvement Plan has been the creation of a new Children's Social Care Operating Model and the implementation of the Signs of Safety approach to practice. The new structure was created in order to ensure that resources are being used most effectively, that there is sufficient management capacity to provide good oversight and supervision, and to ensure that caseloads for social workers are manageable. This enables them to build good relationships with children and young people and the journey for the child through services to be as coordinated and as seamless as possible.

The Children's Commissioner visited on 8-9 May 2017 and published his findings at: **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/645624/Worcestershire-Report_of_the_Commissioner_for_Childrens_Services.pdf**

Ofsted monitoring visits were undertaken on 22-24 May 2017, 12-13 September 2017 and 30-31 January 2018. Letters confirming their findings are published on the Ofsted website and can be found at: **https://reports.beta.ofsted.gov.uk/provider/44/80584**

Special Educational Needs and Disability (SEND) Services

Ofsted and the Care Quality Commission undertook a Joint Local Area SEND inspection in Worcestershire between 5-9 March 2018 to judge the effectiveness of the area in implementing the special educational needs and disability (SEND) reforms as set out in the Children and Families Act 2014.

The findings of the inspection are summarised in the published letter located at: **https://files.api.beta.ofsted.gov.uk/80584__1.PDF**

Worcestershire Acute Hospitals NHS Trust

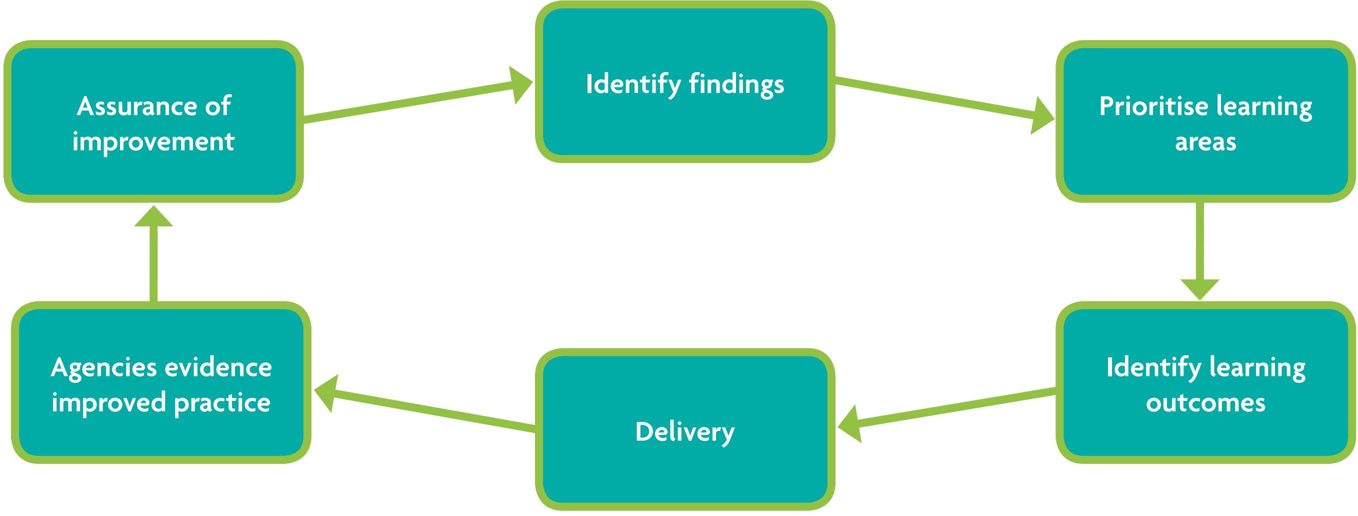
On 17 January 2018 the Care Quality Commission (CQC) published its report on the Worcestershire Acute Hospitals NHS Trust following their inspection in November 2017. The inspection assessed the core services of urgent and emergency care and medical care at the Alexandra and Worcestershire Royal Hospitals. The Trust has been in special measures since December 2015.

www.cqc.org.uk/provider/RWP

4.4 Learning and Improvement Framework

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)
- Safeguarding Conversations
- Domestic Homicide Reviews and Safeguarding Adults Reviews (where appropriate)



4.5 Child Death Overview Panel (CDOP)

The Child Death Overview Panel 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 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 Worcestershire CDOP received Notification of 25 Child Deaths; the lowest since CDOP processes began in 2008. Although this is very encouraging, we should not attach too much significance to a single year's figures.

CDOP and its sub-groups met on 9 occasions and undertook 25 Child Death Reviews. Modifiable Factors were present in 11 of the deaths and included lack of parental supervision, inaction following expression of suicidal ideation, maternal obesity, smoking and also possible incomplete evaluation of previous miscarriages.

Other issues coming to Panel included several incidents relating to hospital care, questions relating to teenage suicide along with the review and implementation of the West Mercia SUDIC (Sudden Unexpected Deaths in Infants and Children) Policy.

A thorough analysis of Child Death Reviews categorised as 'Suicide or Deliberate Self-Harm' was carried out by the Clinical Commissioning Group and it was reassuring to learn that Worcestershire data was not out of step with other parts of the country. It was also very helpful to receive and then to disseminate details of care support that one particular school had developed for pupils.

The Panel Chairman and Manager also participated extensively in consideration of plans for the implementation of the new child death arrangements (as detailed in Working Together 2018) and presented suggested modifications (particularly relevant to Worcestershire) to the December meetings of CDOP and then to WSCB.

Attention has been given to managing the backlog of Child Death Notifications received, especially those managed through the Rapid Response process, to ensure that Child Death Reviews are completed as promptly as post-death processes permit.

4.6 Serious Case Reviews (SCRs) and Case Reviews

The Serious Case Review Group considers cases which have been identified by partner agencies to decide whether the criteria for a SCR are met. During the year 3 cases were considered and all were found to meet the criteria, resulting in SCRs being formally commissioned by the Board. At the time of writing one Serious Case Review had been completed but not yet published awaiting the outcome of parallel processes (such as inquests, criminal proceedings or other formal review processes). As part of the SCR process learning events were held with practitioners to inform the process and the findings. Learning from all three SCRs will inform the Board's Learning and Improvement communications during 2017/18.

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. The learning from one completed case review initiated during 2016/17, 'Annabel', was presented at six Information and Guidance sessions for practitioners and included in a **Learning and Improvement Briefing**.

4.7 Communications

During the year WSCB has undertaken a wide range of communication activities to raise the profile of the Board, promote engagement and strengthen existing means of communication with members of the public, parents and carers, children and young people, and practitioners from all agencies.

Website

The WSCB website contains a broad spectrum of information and guidance on safeguarding subjects and links directly to the West Midlands Safeguarding Children Procedures. It also contains policies, links to statutory guidance, legislation and helpful websites. Data shows that there were 48,000 unique page views on the website during the year which demonstrates a high level of usage. During the year plans have been developed to commission a joint website with the Worcestershire Safeguarding Adults Board to provide a joint safeguarding resource, particularly important in respect of cross cutting issues such as Transition, Domestic Abuse, Mental Capacity Act and Exploitation, as well as supporting the 'Think Family' approach.

WSCB Newsletter

The newsletter, Safeguarding Matters, continues to be circulated quarterly. It contains news and information from WSCB as well as relevant updates from our partners. It provides a range of articles about local and national issues relevant to safeguarding children, as well as links to websites and documents. The newsletter is well received by practitioners.
www.worcestershire.gov.uk/info/20377/safeguarding_children/208/about_the_safeguarding_children_board/6

Events & Awareness Days

WSCB has issued communications for E-Safety Week and CSE Awareness Day. This has included a comprehensive communications plan, materials and ideas for how partners can contribute to publicity for the events. Collaboration between WSCB and West Mercia Police (WMP) took place for the CSE Awareness Day. WSCB promoted the 'Tell Someone' website and developed a PowerPoint presentation for partners use from the campaign materials by kind permission of WMP.

Learning and Improvement Briefings (LIBs)

The Board's Learning and Improvement briefings have been added to with briefings on: Voice of the Child; Professional Curiosity; and Learning from a Case Review. As well as being available on the WSCB website and cascaded via safeguarding leads the briefings were disseminated at information and guidance briefings involving over 300 local practitioners. The Learning and Improvement Briefings have been particularly well received as indicated by the following feedback from a Manager of an Integrated Safeguarding Team:

"Please keep producing these really useful mechanisms for feedback and learning to staff"

Further information and examples of WSCB communications can be located on the WSCB website at:
www.worcestershire.gov.uk/info/20380/safeguarding_children_information_for_professionals/482/learning_and_improvement/3.

Page 22

4.8 Engagement with Front Line Practitioners

Practitioner Network

Now in its thirteenth year 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 operating 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 relevant policies and Learning and Improvement Briefings, including Levels of Need (Thresholds) guidance, Voice of the Child, Professional Curiosity and the Domestic Abuse Training Pathway.

Specific presentations were made to the Practitioner Network on:

- SEND Information, Advice and Support Service
- Royal Mail Blues Programme[1]
- Domestic Abuse
- Adverse Childhood Experiences
- Signs of Safety
- Step Up/Step Down procedures

4.9 Engagement with Children, Young people and Families

WSCB has worked alongside other agencies this year and obtained feedback from domestic abuse victims, early help service users, and families as part of the case review and Serious Case Review processes.

The Board's Business Unit has recruited a social work student from the University of Worcester to support its work around engagement with young people and to bring a young person's perspective and challenge to discussions.

This year the Board commissioned a local school to produce a DVD about how young people perceive professionals. The DVD was shown to over 300 people at WSCB Information and Guidance Briefings and published on the WSCB **website**.

4.10 Policies & Procedures

On 1 April 2017 the **West Midlands Safeguarding Children Procedures** went live. These are online inter-agency procedures shared across nine of the fourteen Local Safeguarding Children Boards in the West Midlands. They were developed by an independent Provider, Phew Design Limited, who have been commissioned to host and maintain the procedures up to March 2020.

[1] The Blues programme, funded by Royal Mail, is a preventative course aimed for people aged 15-18 years-old who are suffering from, or who are at risk of developing a mental health disorder

4.11 Evaluating the Effectiveness of Training

WSCB delivered 58 multi-agency training events in 2017/18 to 1308 people. There is good attendance at multi-agency training by schools, Children's Services and the Worcestershire Health and Care NHS Trust. Some agencies use single agency training which research suggests is less effective at promoting multi-agency working. The WSCB Training Pathway can be found at:
www.worcestershire.gov.uk/downloads/file/4352/worcestershire_safeguarding_children_board_training_pathway_2014_to_2017

WSCB multi-agency training is rated extremely highly in terms of the content and style of delivery. The training content is regularly reviewed to ensure that current knowledge from MACFAs, case reviews and Serious Case Reviews is reflected. Learners report that their knowledge and confidence have improved after attending the training events. The Board seeks to demonstrate that this knowledge and confidence has impacted on practice by conducting post-training impact evaluations and audits, and partner agencies are asked to ensure that they follow the WSCB Framework for Evaluation (**www.worcestershire.gov.uk/downloads/file/4354/framework_for_evaluation**)

During the year impact evaluations were conducted three months after the training on a range of courses including CSE and core safeguarding training. The results highlight the increase in skills and knowledge from attending training and provide assurance that those who responded were able to demonstrate how learning had been transferred into the workplace and had impacted on children and their families.

1389 practitioners completed an e-learning course and 97% of these were satisfied or very satisfied that the course gave them all the information they needed. This represents a significant reduction in the number of licences used compared to previous years and in March 2018 the Board agreed that it will no longer broker e-learning after 2018/19. It will therefore be important to signpost partner agencies to alternative e-learning providers going forward..

Ofsted (2017) reported that: 'The board takes a robust approach to evaluating training. A comprehensive training evaluation… identifies that attendees rate WSCB multi-agency training highly, and that their knowledge and confidence improve as a result'.

The annual report prepared by the Board's Workforce Development Group is available at: **www.worcestershire.gov.uk/info/20380/safeguarding_children_information_for_professionals/897/safeguarding_children_training**

Page 24

5. Formal Summary Statement

Worcestershire Safeguarding Children Board has a responsibility to form an annual overall judgment on safeguarding arrangements and their effectiveness. Based on the learning from the Board's quality assurance activity and giving consideration to inspection findings during the year, it can make the following formal summary statement in respect of 2017/18:

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, although this year it has been necessary to escalate a number of slow responses to audits to ensure compliance. There have been changes to Board membership which have continued to challenge continuity and pace in some key aspects of the Board's work, most notably in respect of the development work around early help. Contributory partners have, despite competing financial demands, provided additional funding this year to support partnership initiatives following the Ofsted inspection. There remains evidence of a strong multi-agency commitment to learning and improvement across the WSCB partnership.

From September 2019 Local Safeguarding Children Boards will no longer exist in their current form and during the coming year the key safeguarding partners will be developing an alternative framework and governance for fulfilling the statutory functions set out in Working Together 2018 which is due to be published in June 2018.

A strategic objective for 2018/19 is to develop and publish details of the new safeguarding partnership arrangements to replace WSCB

Last year's annual report cited Ofsted's conclusions. From their 2016 inspection it was acknowledged by inspectors, and recognised by the WSCB, that the new Children's Social Care senior leadership team was starting to provide the 'focus and drive' required to drive through the necessary improvements.

As would be expected, much of the Board's attention has this year focused on Children's Social Care. The Service Improvement Board has been replaced by the Quarterly Performance Review Meetings which are chaired by Essex County Council. The Board's direct support and challenge role has come from the nominated Board members who have acted as Critical Friends in respect of the eight improvement areas in the Safeguarding Improvement Plan. This has worked better in some areas than others, but it has been particularly constructive in relation to the developments around early help. The Critical Friend role will continue into 2018/19 following a review. The Board has received regular updates from the Director of Children, Families and Communities and the Assistant Director (Safeguarding) has provided commentary and analysis regarding performance information at Board meetings. This, along with sight of the Ofsted findings summarised in their published letters, has formed the basis of the Board's scrutiny of developments in Children's Social Care during the year.

Page 25

In October 2017 Ofsted acknowledged that the local authority had taken steps to tackle its 'serious weaknesses' and was beginning to make progress to improve services for children and young people. By February 2018 Ofsted were acknowledging that 'whilst services for children in Worcestershire continue to require much work to be of a good standard, progress has been made since the last monitoring visit'.

WSCB will continue to seek assurance about practice and service improvements within Children's Social Care through the Critical Friend role and through receipt of updates from senior managers over the coming year.

A key part of the Service Improvement Plan has been the creation of a new operating model for Children's Social Care and the implementation of the Signs of Safety approach to practice. In addition, this year saw the development of a **business case** for an Alternative Delivery Model for Children's Social Care and a decision made by Cabinet on 29 March 2018 to develop a wholly-owned Council company for future delivery of Children's Social Care services to be implemented in October 2019. The Board will consider the implications of the new delivery model for children, young people and their families and any identified risks to safeguarding as the detail unfolds.

In other areas, the Board is assured that partner agencies are engaged with the CSE agenda and that virtually all schools have received CSE training delivered by the Board. It is encouraging that young people at risk of sexual exploitation are now being identified and during the year two significant CSE investigations have been initiated involving large numbers of potential child victims or witnesses. Whilst our understanding of CSE is developing, of concern is the lack of an updated CSE Problem Profile which reflects the emerging patterns of offending in Worcestershire. Work has been undertaken to ensure that support services for young people at risk of CSE are sufficiently flexible and resilient to meet need. Assurance will not be available about the embedding of the Whole School Approach to Healthy Relationships framework until next year's Section 175 audit is completed.

Work has been undertaken over the last few months to foster relationships with schools where there has been a gap previously. Schools are now more actively engaged in decision making about children at the Family Front Door which, in turn, leads to improved communication between partner agencies. Since the recruitment by the local authority of a new Education Safeguarding Adviser there is also much improved representation from education on the Board's sub groups and improved communication with schools about safeguarding issues.

The Board is particularly encouraged by the positive contribution made by partner agencies to multi-agency working, in particular the role of Police and Health in supporting the developing processes for early screening and decision making within the Family Front Door.

As of March 2018 WSCB concludes that progress has undoubtedly been made, however there is still some way to go to reach the necessary level of assurance that all children are receiving the right services at the right time.

Appendix 1 - End of Year Financial Statement

	WSCB Core Budget	Training Delivery	SCR (ringfenced)	Partnership Fund (ringfenced)	Total
Expenditure					
Salaries*	164,474				164,474
Independent Chair	16,503				16,503
Serious Case Reviews and Case Reviews			10,225		10,225
Performance Resources	21,933				21,933
Administration and business costs	21,131				21,131
Training Expenditure (excluding salaries)		23,195			23,195
E-Academy (E-learning)		17,086			17,086
Partnership Fund Expenditure				0	
Total Expenditure	224,041	40,281	10,225	0	274,547

Income					
Agency Contributions					
WCC - 50%	-122,647				-122,647
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		-56,275			-56,275
Income from E-Learning		-17,500			-17,500
Serious Case Review Income					
Partnership Fund Income				-39,200	-39,200
Total income	-245,318	-73,775		-39,200	-358,293
Net Expenditure	-21,277	-33,494	10,225	-39,200	-83,746
Holding account b/f as at 1st April 2017	-12,510	-37,780	-37,585		-87,875
Holding account as 31st March 2018	-33,787	-71,274	-27,360	-39,200	

* Savings of £40,000 have been made against long-term sickness absence by the WSCB Training Officer

Appendix 2 - Headlines from the Data[1]

1. Contacts, Referrals & Assessments

The Family Front Door receives all initial Contacts to answer questions about children or to receive reports or child protection concerns. Management decisions on Contacts are consistent with 98% now dealt with within 72 hours.

- There were just over 10,000 Contacts to the Family Front Door in the full year, an increase of 10% on last year[2] Percentages of Contacts by source are: Police 51%, Schools 14%, Health 12%, Individual 6%, Local Authority Services 5%, Others 12%.
- Percentages of Contacts by outcome are: Children's Social Care Referral 36%, Early Help 8%, No further action to Children's Social Care 55%.
- Repeat referrals within 12 months have increased slightly to 22% (last year was 20%).
- There were approximately 5,000 Social Work Assessments (including repeat assessments) completed with the following outcomes: 73% case closed to Children's Social Care (these include those that have stepped down to Early Help and Targeted Family Support), 14% went on to Child in Need Plans, 12% forwarded to a Section 47 Assessment, and 1% became a Looked After Child.
- Percentage of Social Work Assessments completed within time scale increased to 73% (last year was 68%), with February and March at 85% indicating an improving trend.

2. Early Help

Early help means providing support as soon as a problem emerges, at any point in a child's life, from the foundation years through to the teenage years. Early help can be provided to a child and family by a single agency or a group of agencies working together, particularly when a child or family has multiple and complex needs. All families can access universal services, whatever their level of need.

- Within the 2018 Service Improvement Plan is the need for an improved robust dataset that will provide consistent and accurate early help information. This is currently work in progress.

3. Children with a Child In Need Plan

A Child in Need (CIN) 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.

- The number of children with open CIN Plans has reduced to 695 (last year was 795) which reflects focused work undertaken to review cases that had been drifting without intervention. However in year 2018/19 the number of CIN Plans is increasing in line with the service approach to support families using non-oppressive practice where possible and to ensure that there is a consistent application of the Child Protection threshold for intervention

4. Children with a Child Protection Plan

Children require a Child Protection Plan if they are judged to be suffering, or likely to suffer significant harm. An Initial Child Protection Conference will be convened within 15 days of a Strategy Meeting[3] to plan how to safeguard the child. If the Child Protection Conference considers that the child is at continuing risk of significant harm they will be made subject to a Child Protection Plan.

[1] There were a number of changes made to the data collection methods in 2017/18 to ensure better monitoring of performance. This will have impacted on the data provided.

[2] This includes a number of Domestic Abuse incidents which were included in the data set for a short period of time in 2017/18

[3] A strategy meeting is held to share information and agree the conduct and timing of any investigation.

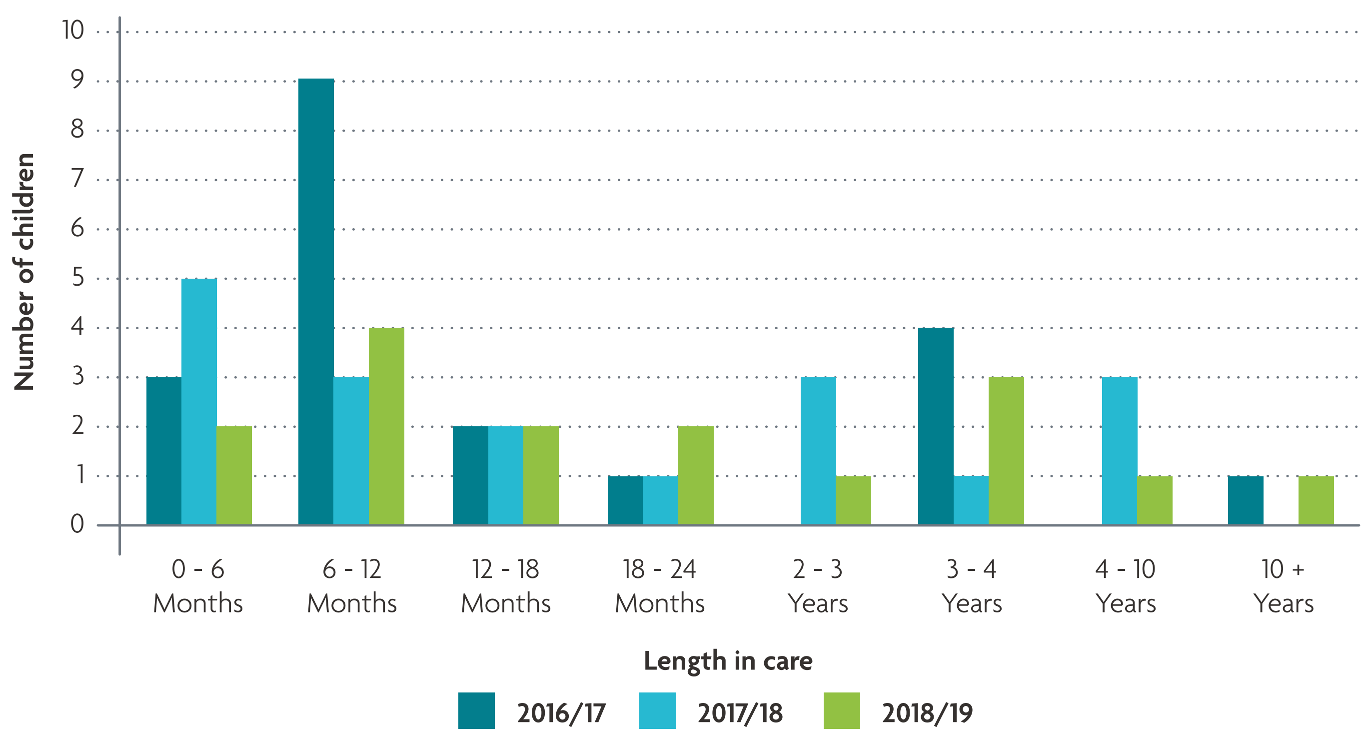
Children with a Child Protection Plan are considered to be in need of protection from either neglect, physical abuse, sexual abuse or emotional abuse, or a combination of these. The Plan details the main concerns for the child, what action will be taken to reduce those concerns and by whom, and how professionals and the family and child will know when progress is being made.

- Number of children with a Child Protection Plan has reduced to 415 (last year was 526). This reduction reflects the post Ofsted safeguarding work undertaken to improve assessments of risk and minimise drift and delay in case work.
- Number of children subject to a Child Protection Plan for longer than 18 months has reduced to 7 (last year was 19)
- The rate of Child Protection Plans per 10,000 has reduced to 36 (last year was 45, national rate was 43)
- Initial Child Protection Conference timeliness improved significantly to 75% (last year was 49%).
- Review Child Protection Conference timeliness improved to 95% (last year was 92%)

5. Looked After Children

A child who is being looked after by the Local Authority is known as a child in care.

- The number of looked after children has increased to 798 (last year was 764). This increase is linked to the fact that for 23% of children whose Child Protection Plan ended it had been necessary to place them in local authority Care due to outcomes not being achieved on the Plan. On average 23% of children ceasing to be on a Child Protection Plan have become Looked After and 70% because the threshold for significant harm is no longer met.
- A new Edge of Care panel process and offer was introduced in May 2017 and at the end of the year this offer has supported 76 children to stay out of care. Edge of Care development is in the Service Improvement Plan.
- The number of new entrants to the care system in 2017/18 is lower than 2016/17 although the overall entry rate is higher than statistical neighbours and the national average
- There have been significant numbers of children and young people who have been in care for many years without a Permanency Plan which would remove their status as a looked after child, e.g. adoption. Practice has improved in this area by the addressing of drift and delay in permanency planning. The data shows increasing numbers of children now achieving permanency within 12 months of being received into care and a rise in those moving out after 18 months - 3 years.



- The rate of looked after children per 10,000 has increased to 69 (last year was 66, national average was 62).

6. Children who are Care Leavers

As a care leaver, you can get Care Leaver Team service support from the age of 16 until 25 years

- There are currently 382 care leavers, of whom 88% are classed as 'in touch' with the service, 89% are known to be in suitable accommodation, for the majority of the others accommodation arrangements are not known.

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 parental 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 were 15 private fostering arrangements in place in 2017/18 (last year was 9). 66% of fostering visits were within timescale.

The Board has been informed that the number of privately fostered children is lower than expected, in line with the national picture, suggesting that there is a lack of awareness of private fostering situations or of the need to notify them to the local authority. Since the report was drafted lead practitioners with responsibility for privately fostered children have been identified within Children's Social Care and there are developments in place to continue to raise awareness of what constitutes private fostering and the duty on professionals to notify the local authority of these children.

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.

- 13 children were accepted as UASC during the year, all aged from 14-17 years. The total now placed in Worcestershire is 24, 17 of which are in foster care and 7 in semi-independent accommodation.

9. Children with a Disability

The Children with Disabilities Team offers 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 Children with Disabilities Team remained steady at 413, with 298 being subject to a Short Breaks Plan, 67 on a Child in Need Plan, 30 being looked after and 5 on a Child Protection Plan.

10. Children Missing Education & Electively Home Educated

A child missing education is a school-age child who is not on the roll of a school, not placed in alternative provision by the local authority, and who is not receiving a suitable education at home. Parents have the right to educate their children at home as long as they provide an education that is 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 electively home educated (EHE) and the guidance has extended this requirement to academies and independent schools.

- The number of children registered as missing education has remained steady at approximately 130, with 90 of these still under current enquiry
- The number of children being electively home educated has increased to 694 (last year was 507). Both of these are a key focus for the County Council and a CME & EHE strategy is under development

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 a decrease in both the number of children charged and detained by the police, as well as those held in police custody overnight for four hours or more.

12. Children and Mental 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 remained constant for the Child and Adolescent Mental Health Service in 2017/18 at 200 per month. The numbers on waiting lists for an initial appointment has remained steady at 293, whilst waiting times have increased slightly from 5.1 weeks in 2016/17 to 5.7 weeks this year.

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.

- Fewer children are going missing compared to last year. However, there has been an increase in missing children incidents, now averaging 100 per month (last year was 80). 36% of these were children missing from local authority Care, compared to 64% missing from home.
- Percentage of return interviews held within 72 hours of the child being located decreased to 34% from 49% last year, however since the recruitment in February 2018 of three missing children officers performance has started to improve and this trend is expected to continue into next year.

14. Concerns about Adults who are in Positions of Trust

The Local Authority Designated Officer (LADO) provides advice and manages the process for responding to concerns about adults who are in positions of trust because they work with children or young people. There is now a referral form in place which enables more transparency, accountability and ability to track cases. There is a need to implement a system which captures `low level advice' via telephone calls so that patterns and trends can be identified.

The Board has received assurance during the year about the effectiveness of the LADO arrangements and supported the initiative to improve the quality of intelligence to strengthen the service provided going forward.

- Number of meetings held was 177 (last year 247)
- There have been 43 cases where the outcome was substantiated (data not held last year)
- Percentage of cases closed within 3 months was 60%

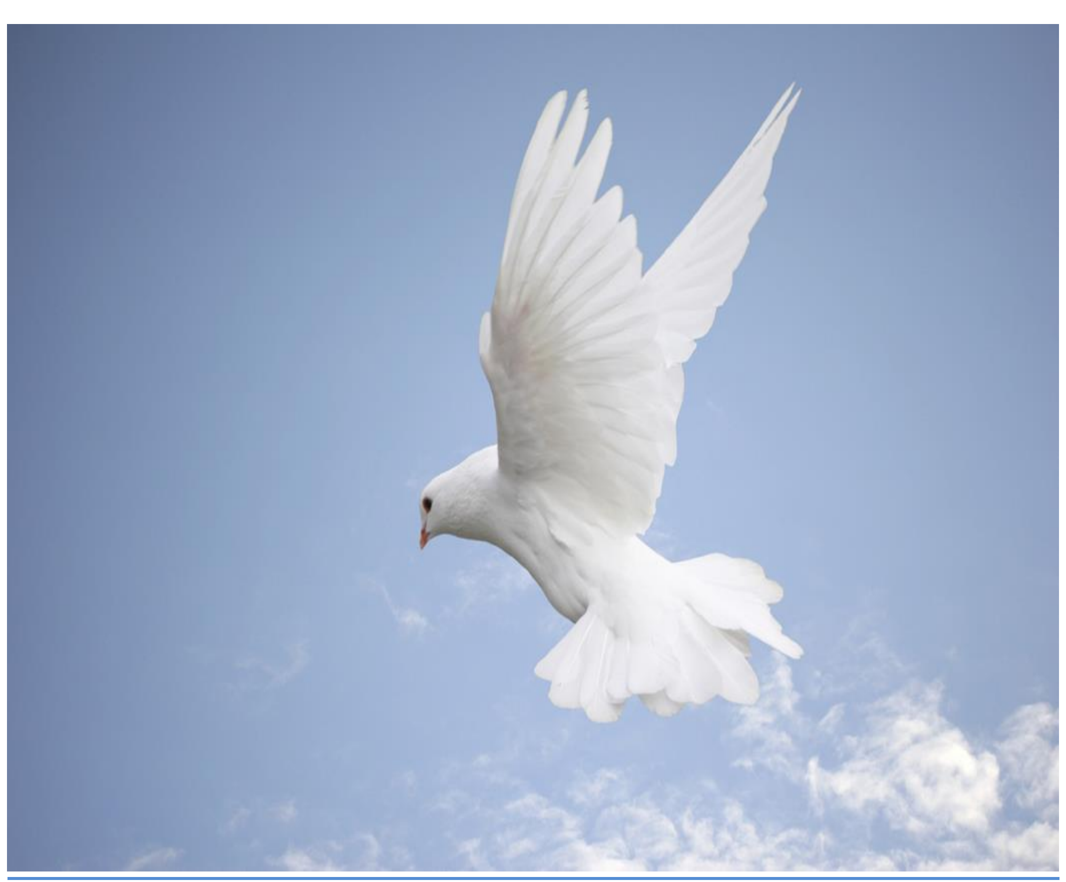
Appendix 3 - Glossary

CAFCASS	Children and Families Court Advisory and Support Service
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
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
EHE	Elective Home Education
FGM	Female Genital Mutilation
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
MACFA	Multi Agency Case File Audit
MASH	Multi Agency Safeguarding Hub
MEG	Monitoring Effectiveness Group
NPS	National Probation Service
QAG	Quality Assurance Group
SCR	Serious Case Review
SEND	Special Educational Needs & Disabilities
SUDIC	Sudden Unexpected Deaths in Infants and Children
WCC	Worcestershire County Council
WFADA & SV	Worcestershire Forum Against Domestic Abuse and Sexual Violence
WMP	West Mercia Police
WSAB	Worcestershire Safeguarding Adults Board
WSCB	Worcestershire Safeguarding Children Board
YJS	Youth Justice Service

The Child Death Review Process For Worcestershire

Tenth Annual Report

2017-2018



Contents

Item	Page
Contents	2
Foreword and Introduction	3
CDOP Data Summary 2017/18	4
Child Deaths Reviewed by Panel, 2017/18	5 - 6
Learning from Child Death Review	7 - 9
Developments and Initiatives	10 - 15
Future Activities	16 - 18
Appendix 1a Child Death Review Data	19
Appendix 1b Data Breakdown for Cases Reviewed by Panel 2017/18	20 - 22
Appendix 1c Cumulative Data 2008 to 2018	23 - 26

Foreword and Introduction

We present the Worcestershire Child Death Overview Panel's (WCDOP) 10th Annual 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 contributes directly to the work of Worcestershire Safeguarding Children Board, which is 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 ten 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 revisions in 2013, 2015, 2017 with a further revision expected in mid-2018

During 2017-18 WCDOP met **9** times reviewing a total of **25** deaths.

Previous annual reports of the Worcestershire Child Death Overview Panel have included information about the "raison d' être" for the child death review process, a summary of the statutory guidance and other information to assist those unfamiliar with the process. In the 2013/14 Annual Report we set a precedent to produce more concise reports and have continued that practice.

WCDOP Data Summary 2017/18

- Between 1st April 2017 and 31st March 2018, Panel received a total of **25** Death Notifications of Worcestershire resident children along with managing information about the deaths of 10 non-residents
- **76%** of notifications were **male** with **24% female**
- **60 %** of deaths recorded were of **children aged less than 1 year**
- **9** of the **25** deaths were unexpected and managed (in whole or in part) through the Rapid Response Process
- Of these **25** deaths reported to CDOP in 2017/18, **14** cases were reviewed at Panels in this year
- A further **11** of these cases await review
- Since 2008, the average number of annual notifications received is **36**

Child Deaths Reviewed by Panel, 2017 - 18

- From 2008-2018 Worcestershire CDOP has reviewed **342** child deaths; **95%** of all received **Notifications [360]**

- WCDOP is 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 2 years there have been many personnel changes in representing agency participants but Panel still has **4 experienced** members who have served for over **5 years**

- During the first 5 years, Panel, developed considerable expertise and consistency in the Child Death Review process with up to 15 established participants from a range of agencies.
  Both WCC Legal Services and WMAS support WCDOP, participating as and when their expertise is requested.
  Panel is keen to further expand participation and with WSCB support has recruited a participant from Education.

- Between 1st April 2017 and 31st March 2018 Panel and Perinatal Sub-Group met on **9** occasions to successfully review **25 cases:**
  NB
  Unusually, the number of deaths reviewed is equal to the number of deaths notified. However, child death reviews are not necessarily concluded in the financial year in which they occur and may also be involved with a range of explorative activities i.e. Coroner's Inquest, Police Investigations, and Litigation (ref Figure 1).

- Modifiable Factors were identified in **40%** of cases.

- There are **4 historic cases** undergoing further investigation processes.

- In 2015/16, there was a back log of Rapid Response (RR) child deaths pending review which, despite many fewer unexpected deaths, has now risen again. This is due, in part to delays in post-death processes such as Post Mortem and or Inquest.

Figure 1 Worcestershire CDOP Activity Since 2008

Data Breakdown for Child Deaths Reviewed by Panel in 2017/18 will be found in Appendix 1b

	Child Deaths Reviewed by WCDOP 2008-09	Child Deaths Reviewed by WCDOP 2009-10	Child Deaths Reviewed by WCDOP 2010-11	Child Deaths Reviewed by WCDOP 2011-12	Child Deaths Reviewed by WCDOP 2012-13	Child Deaths Reviewed by WCDOP 2013-14	Child Deaths Reviewed by WCDOP 2014-15	Child Deaths Reviewed by WCDOP 2015-16	Child Deaths Reviewed by WCDOP 2016-17	Child Deaths Reviewed by WCDOP 2017-18	Pending Child Death Reviews	Child Deaths Reviewed	Number of Child Death Notifications Received
2008-09	11	21									0	**32**	**32**
2009-10		23	18	3	1	1					0	**46**	**46**
2010-11			18	16	1		1+1*				0	**36+1**	**36**
2011-12				10	23						0	**33**	**33**
2012-13					15	23	2	1	1		1	**42**	**43**
2013-14						14	21	1		1	0	**37**	**37**
2014-15							23	19			1	**42**	**43**
2015-16								14	20	2	2	**36**	**38**
2016-17									15	8	4	**23**	**27**
2017-18										14	11	**14**	**25**
Totals	**11**	**44**	**36**	**29**	**40**	**38**	**47+1**	**35**	**36**	**25**	**19**	**341+1**	**360**

Learning from Child Death Review

Of the **25** Child Deaths reviewed by the CDOP in 2016/17, **10 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
- Substance Abuse in Pregnancy
- Obesity: BMI 30^+
- Sub-optimal Delivery Management
- Sub-optimal Post-delivery Management

Modifiable Factors Identified during the review of Child Deaths:

- Sub-optimal Medical Care Management
- Lack of Public awareness that the sharing of suicidal ideas must be taken seriously and acted upon as expert opinion advises; people who express suicidal thoughts go on to take their lives
- Peers with whom suicidal thoughts are vocalised need to be educated that it is not an act of betrayal to share this information with adults
- Mental health support recently self-terminated
- Smoking in Pregnancy
- Smoking in the Home Environment
- Access to and use of illicit or illegal drugs
- Failures in Multi-Agency Information Sharing
- Lack of Professional Curiosity
- Poor parenting capacity; poor supervision

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:

- An annual audit of the management of the Safer Sleeping Initiative following a reduction in the deaths classified as SUDICs. This has included further staff training for professionals to disseminate this message; see Developments and Initiatives

  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 & assessment of pregnancy difficult, particularly abdominal examination. 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 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 children.

- Commending the management of inter-agency collaboration following the presentation of young mothers in labour both those aware and unaware of being pregnant.

- 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 which 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 negative transfer to a Tertiary Centre. Many examples of excellent collaborative working between WCDOP Manager and local Acute Health Trust Midwifery, Obstetrics and Neonatology; managing information flow and ensuring copies of all 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 such as Coventry, Stoke-on-Trent, Bristol, Liverpool and Plymouth 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 would be most beneficial?

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

- Review of the WSCB Suicide Prevention Policy to include reference to the forwarding on of shared suicidal thoughts and that it is not an act of betrayal to share this information with adults.

- Health and Well Being Board is devising a Suicide Prevention Plan into which many of the issues arising and initiatives undertaken from review of deaths categorised as 'Suicide or Deliberate Self-inflicted -Harm' can be incorporated.

- Historically, Panel has tried to take the view that all Suicides should be preventable and therefore there should always be Modifiable Factors. However, regarding some deaths categorised as 'Suicide or Deliberate Self-inflicted -Harm', in some instances no Modifiable Factors can be identified.

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) has been reviewed in 2017/18 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.

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.

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?

Following interest from the West Midlands Parent Held Record Group in the Worcestershire Safer Sleeping Initiative, a safer sleeping pro-forma has been 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.

Rapid Response

There were significant personnel changes to the Rapid Response Team with appointments to the SUDIC Nurse and Administrator posts in 2016/17, which are now bedding-in.

During 2016/17 and 2017/18 for a variety of reasons, a back log of Rapid Response cases developed. These have been examined fully and specifically addressed to ensure that, going forwards, reviews are undertaken in a timely fashion. This has included discourse with the Coroner to ensure optimum information flow between agencies.

9 unexpected deaths were reported in 2017/2018; 36% fewer deaths than the 10 year average of 14. An audit of these deaths has been undertaken to ensure the protocol is being followed appropriately. Some key learning points identified include:

Continuing to ensure all children who have died are transported to Acute Hospital Emergency Department so that a full review and SUDIC samples can be obtained.

It is unfortunate that in 2 instances this was not undertaken. However, these deaths took place outside Worcestershire where the deceased children were taken to Tertiary Centres unaware of their local SUDIC Protocols; learning has been disseminated to the local CDOOPs involved.

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 in 2017/18, an additional member of staff has been recruited now providing 7 full time days [weekly] Bereavement Midwifery personnel. In 2018/19 there are plans to increase staffing to a Midwifery Bereavement Team of 3; providing 9 days full-time [weekly] 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 local management of post mortem examination of placentas.

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 die in the post-neonatal period having received neonatal care

- 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

- The contract for the PMRT programme will run for three years until 31st January 2020

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, Mortality Review, we have decided to convene PSG meetings post-PMRT to review a Draft Form C of all available collated information from agencies involved along with the locally or tertiary completed PMRT.

Often there are outcomes arising from the PSG CDR which are in addition to issues highlighted at PMRT review since information is provided by a wider data set, inclusive of CSC, Police and GP, to the exclusively medical nature of the PMRT. As before, learning and improvements are disseminated accordingly.

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 continue to be further improved to provide more effective tools to identify risk factors pertinent to the review of particular deaths.

By request, these proformae have been shared within the CDOP Network England.

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 are continuing to engage with the West Midlands Strategic Maternal and Children's Network and West Midlands CDOP Group to address this issue.

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 sleeping in a 'Poddle Pod'. These issues have subsequently been disseminated by WCDOP Manager to Worcestershire agencies.

- Further engagement with the Manchester University Study into Suicide and Young People.

- With reference to this Manchester Study, Panel requested an independent thematic review of historic Worcestershire CDRs categorised as 'Suicide or Deliberate Self-Inflicted Harm' and reviewed by Panel to 2008-2016; data was found to be broadly in-line with findings from Manchester Suicide Study.

- 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.
  An audit has demonstrated these leaflets have been provided for all parents of children experiencing an expected death 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 annually up-dated 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.

- Thematic Perinatal/Neonatal Reviews (including those requiring a RR) 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
  95% of PSG reviews are completed within 6 months of death so ensuring parents receive timely feedback and support with 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 pre CDOP processes (PM, Inquest etc.) are concluded, with the information available to inform the review, provide timely feedback to families and support the implementation of recommended actions. However, increasingly there are cases outstanding because parents are pursuing legal redress or there are delays in the coronial process

- 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 has again been positively commented on by Care & Quality Commission, CQC, praising this partnership of open and proactive review

- Panel has established effective communication to and from WSCB with WCDOP Manager attending the Improving Frontline Practice Group, IFPG, to which WCDOP provides quarterly reports.

- 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 CDOP and IFPG meetings.

- Continued support of the Review of Children's Services and WCDOP's Child Death Review processes, with requested documentation shared.

- 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
The Government's response to the publication of the Wood Report [December 2015] was shared in the form of a series of draft publications [Autumn2017] outlining proposed changes to the current Child Death Processes.

Feedback was sought via a series of 'Workshop' Events [attended by WCDOP Chair, Manager and WSCB Manager] along with written comments from interested parties including WSCB.

The outcomes of this consultation process were published early during 2018 and draft publications adjusted accordingly.

The transfer of National oversight of CDOPs from the Department of Education to the Department of Health is most welcome; WCDOP has long campaigned for this initiative.

WCDOP was also pleased to be advised that many practices undertaken as culture by our Panel are to be incorporated into the 'New Arrangement for CDR':

- Removal of term 'Preventability' focused move to '**Modifiable Factors'**
- Themed CDOP Review Meetings
- Introduction of Statutory 'Key worker' role for Bereaved Parents
- Revised Analysis Form [formerly Analysis Form C]

WCDOP Chair and Manager expect these documents to be the principal focus for changes to the WCDOP processes during 2018/2019 and look forward to working with our Safeguarding & CDR Partners to support the successful implementation of these 'New Arrangements'.
Please refer to:
Figure 2 ***Implementation Timeframe re 'New Arrangements for Statutory Child Death Review'***

Figure 2 Implementation Timeframe re 'New Arrangements for Statutory Child Death Review'

This information is correct as of 27 July, 2018

Phase	Completed	Task	Notes
Autumn 2017	30 December 2017	Consultation	WCDOP contributed via workshops & narrative submission
Early 2018	Mid-March 2018	Assess Consultation Responses & Necessary Amendments	Delayed
Spring 2018	04 July 2018	Working Together & Transition Documents Published	Delayed
29 June 2018 to 29 June 2019	Currently	Proposed 12 month period for Safeguarding & CDR Partners to Agree, & Publish 'New Arrangements'	Challenging owing to 3 month delay in publication of CDR Statutory Guidance
Summer 2018	Pending	Parliamentary Scrutiny & Debate completed Cross Government clearance of Guidance & Regulations	Publication of CDR Statutory Guidance expected mid-September 2018
29 June 2019 to 29 September 2019		Proposed 4 month period for CDR Partners to Implement 'New Arrangements'	
30 September 2019		'New Arrangements' for Child Death Review commence	
30 September 2019 to 29 January 2020		Period in which all outstanding Child Death Reviews [Notifications received before 30 September 2019] are completed by current CDOPs	

Other Activities Under Consideration Include:

- What could Public Health Worcestershire undertake to reduce smoking during pregnancy and smoking by parents with young families? Along with, the promotion of 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 co sleeping, which are discussed with parents as key risks for SIDS.

- Widening membership of WCDOP 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 the recently appointed WCC Safeguarding Advisor and is anticipated to be completed during 2018/19

NB

With reference to Figure 1 [Page 6]:

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

Appendix 1a DfE 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 ……

Since March 2018 WCDOP Manager has undertaken regular communication with both DfE and DH regarding the collection of data in England; at this juncture there has been no further correspondence received on this matter.

We feel it is best to produce the Annual Report for 2017/18 without this comparative data rather than delay publication further.

.

Appendix 1b Data Breakdown for Cases Reviewed by Panel 2017/18

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

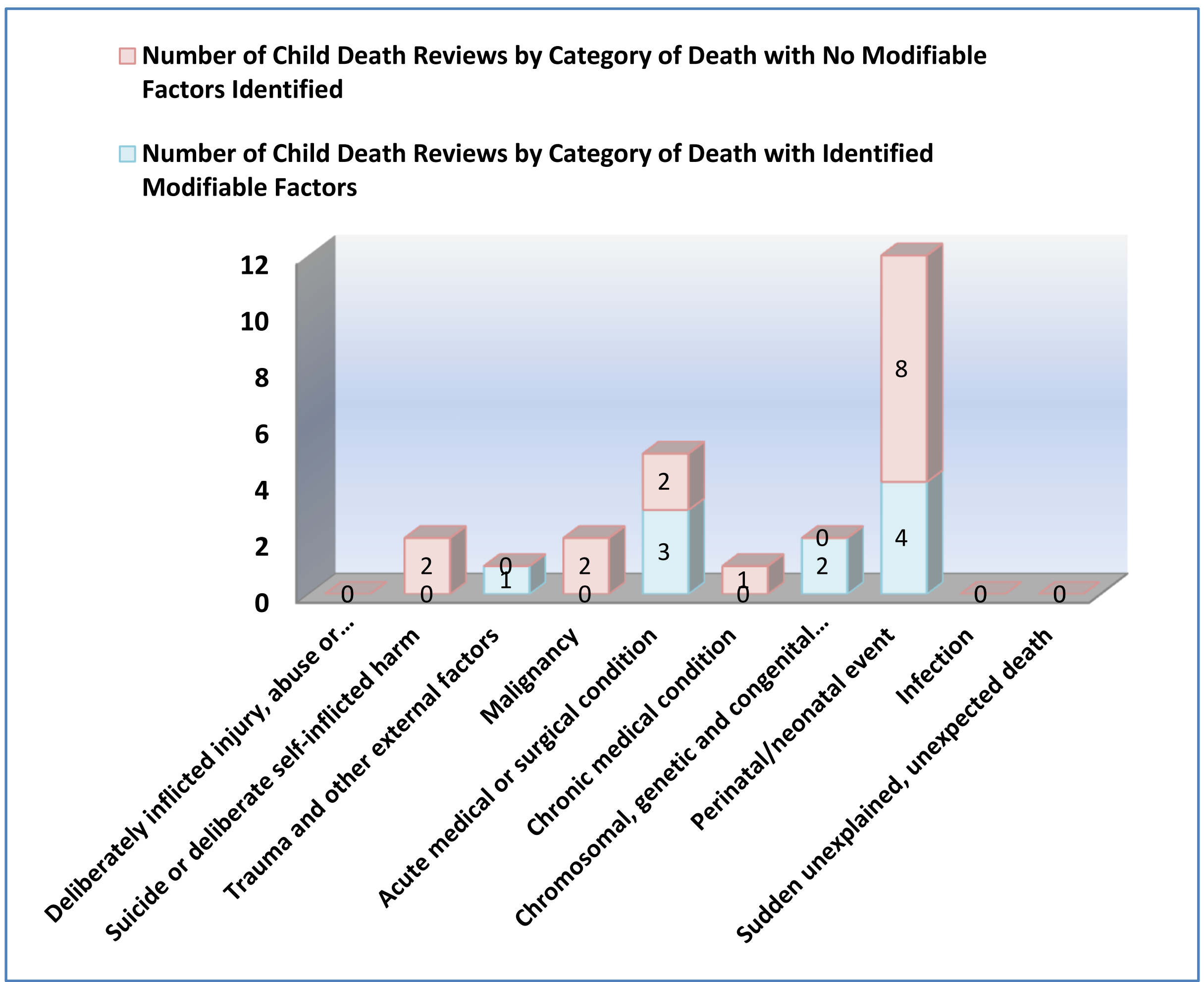


Figure 4: Breakdown of Child Death reviews completed in 2017/18 arranged by Location of the Child Death

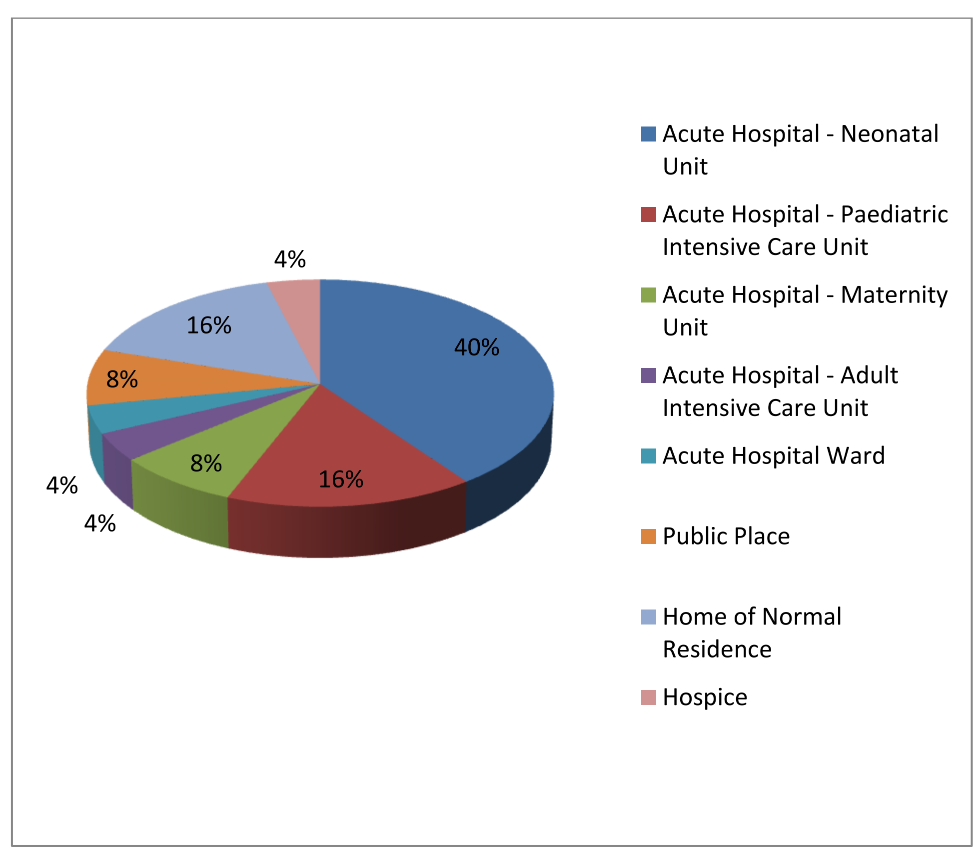
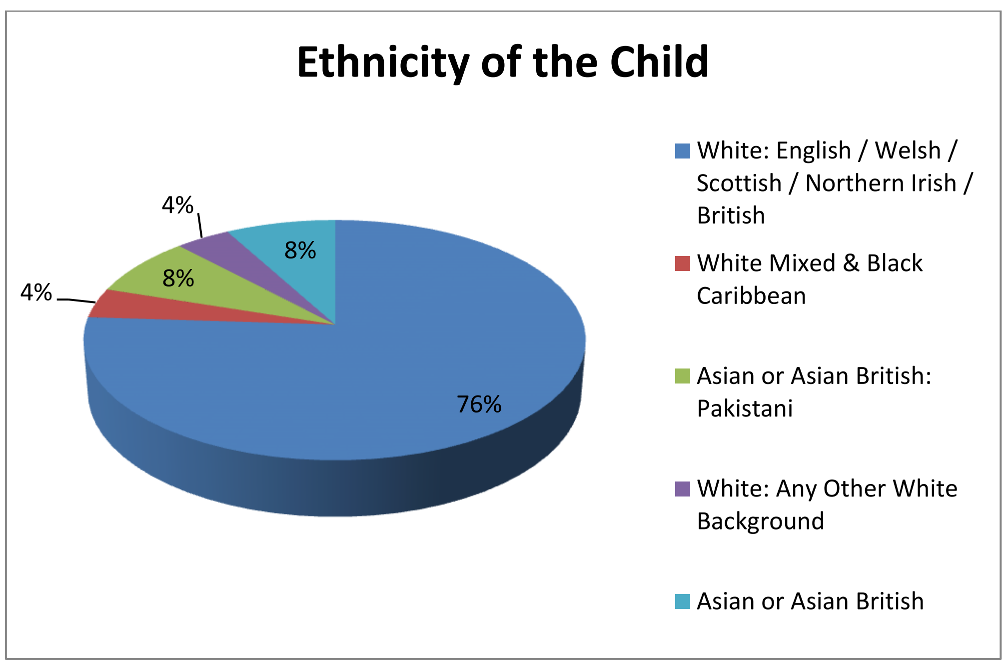
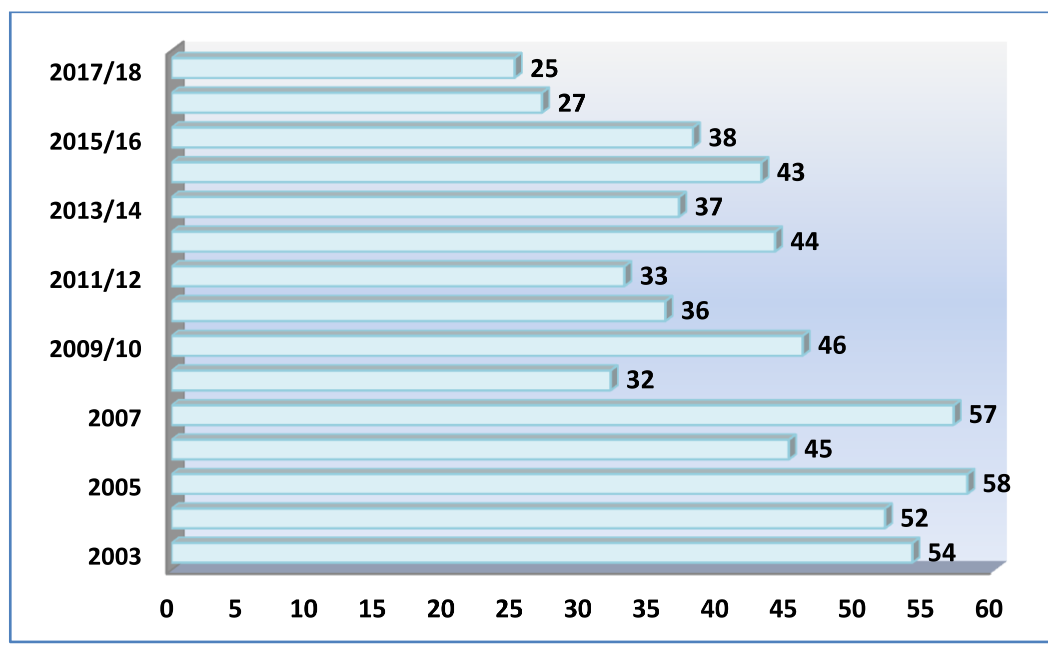


Figure 5: Breakdown of the 25 Child Death reviews completed by CDOP 2017/18 arranged by Ethnicity



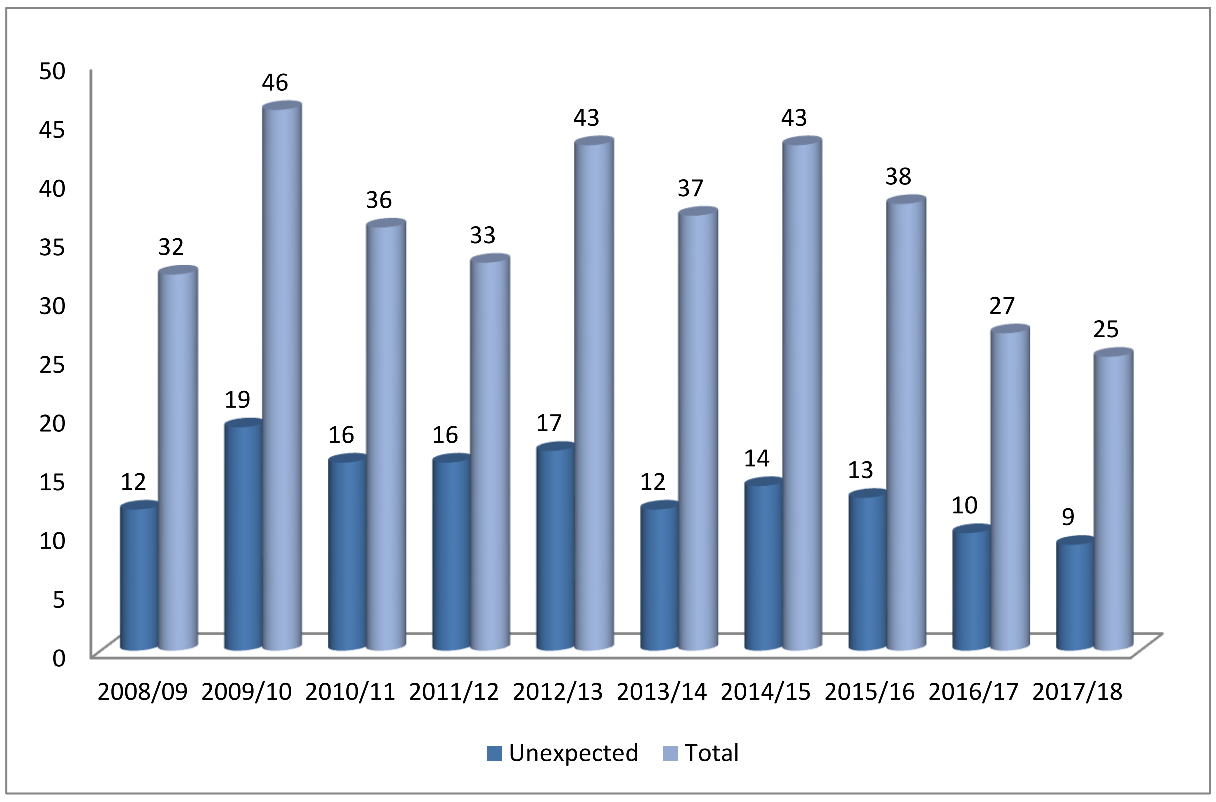
Appendix 1c Cumulative data 2008 – 2018

Figure 6: Number of Child Deaths in Worcestershire



Since 2008, the average number of annual notifications received is **36.**
NB data was collected by a different method prior to 2008/9

Figure 7: Breakdown of Notifications received 2008/09 to 2017/18 by Unexpected Death



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

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

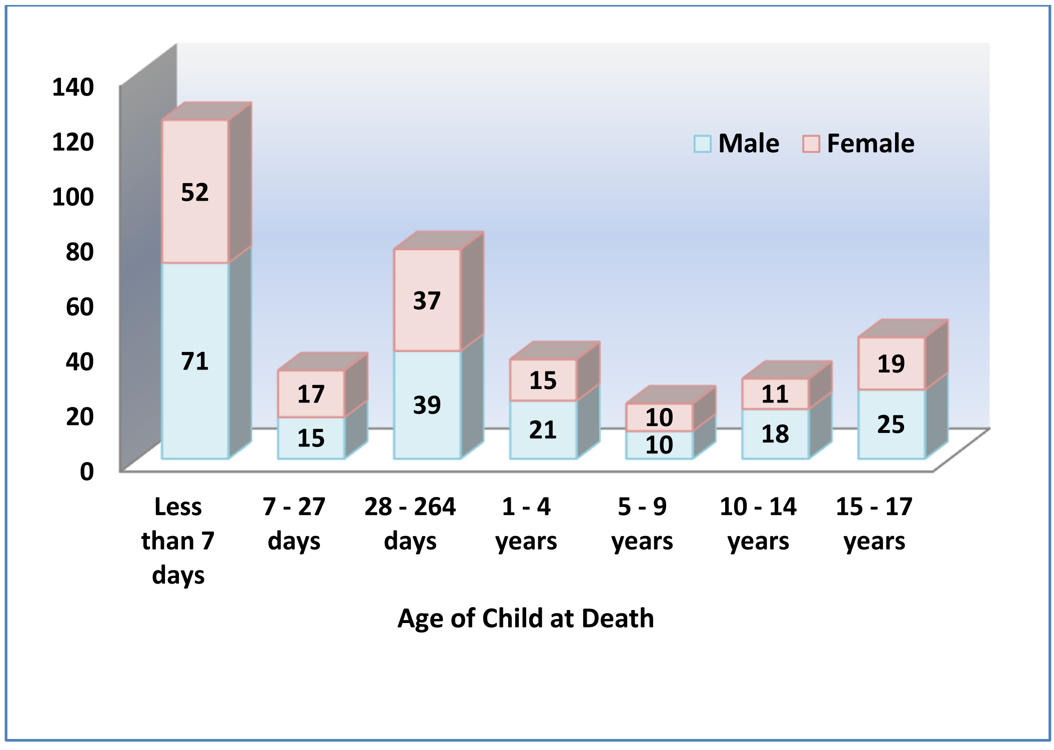
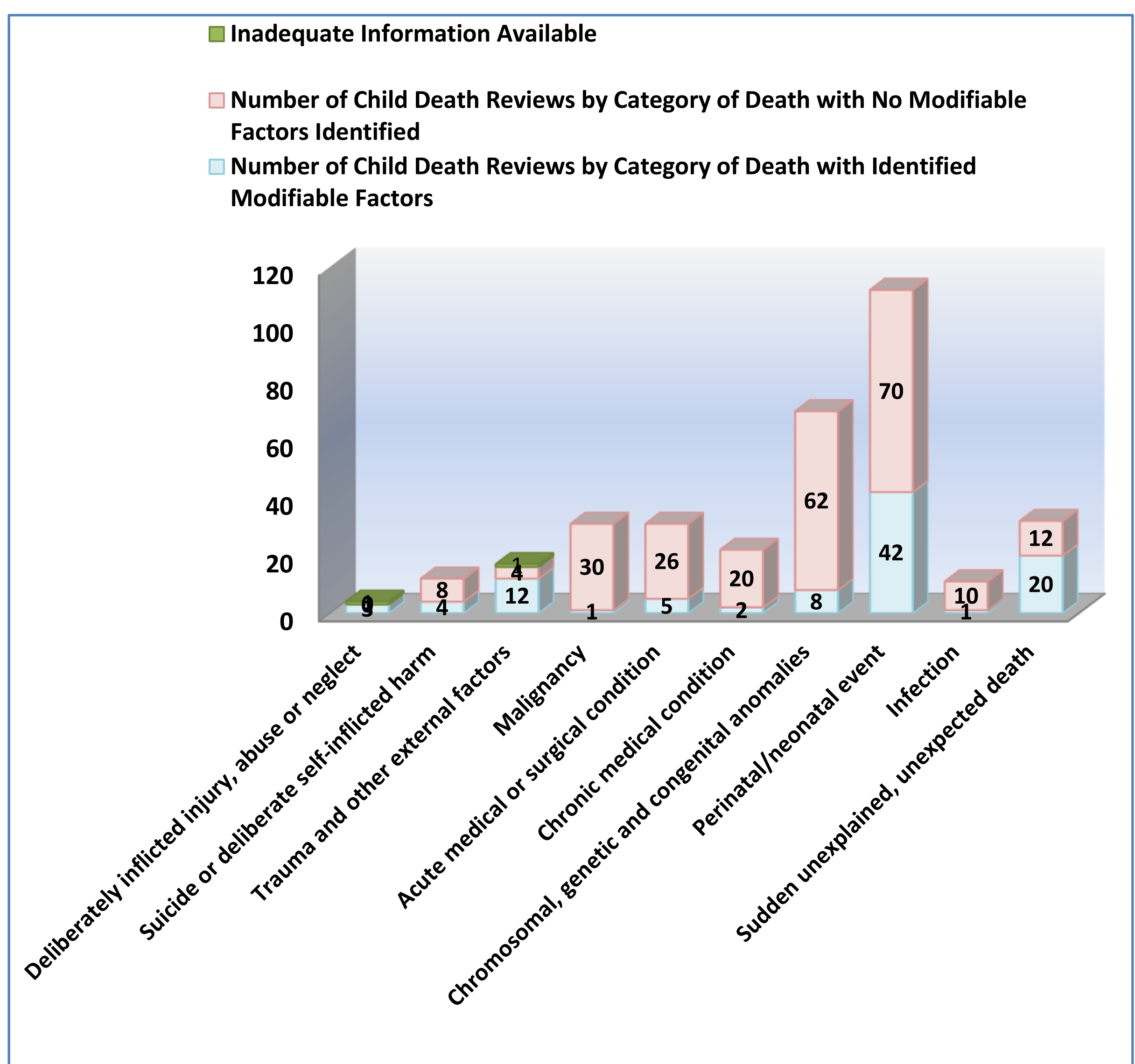


Figure 9: Child Deaths Reviewed Identified as Having Modifiable Factors, 2008 to 2018



Worcestershire Safeguarding Adults Board

Annual Report 2017/18

Worcestershire Safeguarding Adults Board

Document version: DRAFT 7

Document Control

- **Ratified by WSAB**
- **Date revision due** Not required

Revision History

Date	Version	Changes made	Author
16/05/18	V1	Draft version for Chairs Meeting	Bridget Brickley
12/06/18	V2	Incorporation of chairs feedback and updated statistics. To be presented to Board	Bridget Brickley
05/07/18	V3	Incorporation of Board Feedback for Chairs sign off.	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
Sue Lawrence	Worcestershire County Council
Suzanne Hardy	Worcestershire Health and Care NHS Trust
Ellen Footman	Clinical Commissioning Group
Deborah Narburgh	Worcester Acute Hospital NHS Trust
Amrik Klair	West Mercia Police
Mary Nettle	People With Experience Board Representative

Actions

Required Actions	Date
Upload to Website	September 2018
Raised with Community Awareness & Prevention for communication	
Produce Easy Read Version	

Contents

Document Control 2
Revision History 2
Contributors to the development of the document 2
Actions 2
Contents 3
Chairs Forward........ 4
1.0 Introduction 5
2.0 Background........ 5
2.1 Purpose of the Board 5
2.2 Board Membership 6
2.3 Annual Budget and Financial Contribution 7
2.4 Strategic Priorities 2015 to 2018........ 7
2.5 Delivery Model 8
2.6 .Business Objectives........ 8
3.0 Review of Activities 2016/17 10
3.1 Care Act Requirements 10
3.2 Work of the Board........ 11
3.3 Organisational Contributions 155
4.0 Safeguarding Activity and Performance 2017/18 17
4.1 Care Act (2014)........ 17
4.2 Number and Source of Concerns 17
4.3 Type of Abuse........ 19
4.4 Location of Risk 20
4.5 Source of Risk 20
4.6 Demographic Profiles........ 22
4.7 Making Safeguarding Personal........ 233
4.8 Deprivation of Liberty (DoLs) 24
5.0 Priorities for 2018/19 255
Key to Acronyms........26

Chairs Foreword

The Worcestershire Safeguarding Adults Board (WSAB) was established under the Care Act 2014 and this report provides an update on what has been achieved in 2017/18, whilst also outlining the scale of the challenge ahead.

Significant progress has been made since 2014 and an increasingly effective partnership has been developed in that time. Much of the credit for this rests with my predecessor, Kathy McAteer whose leadership, drive and ability to nurture an inclusive way of working between the partner agencies has built firm foundations for the oversight of adults safeguarding in Worcestershire. The contribution and continuing commitment of the partners, from the statutory and voluntary sectors should also be recognised.

I strongly believe that partnership working has never been more important, and that by working together, sharing information and promoting the importance of safeguarding, we can maintain an appropriate focus on those in our communities that are most in need of care and support. I recognise the financial and resourcing pressures faced by partners, and this underlines the necessity of working with a collaborative mindset.

Since taking on the role of Independent Chair in October 2017, I have sought to build on the work of the WSAB and deliver the objectives of the Business Plan. We will continue to seek closer engagement with the Worcestershire Safeguarding Children Board (WSCB), where I have been the Independent Chair since 2016, with the aim of identifying further efficiencies of process and procedure that improve the service provided to those who need it. We will also maintain close working relationships with the Health and Wellbeing Board and Community Safety Partnerships, focussing attention on cross-cutting issues that affect adults, children and families in the county.

It is an essential role of the Board to seek assurance as to safeguarding arrangement in Worcestershire, and this will remain a priority. Central to this will be oversight of issues around the Mental Capacity Act, Deprivation of Liberty and whether the ethos of 'Making Safeguarding Personal' is being embedded across the partnership.

Underpinning all of this is the determination to see the needs being met of the most vulnerable, and the WSAB will continue to give a voice to service users in the county.

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:

- Cleary 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 – Intentions to continue this

2.0 Background

2.1 Purpose of the Board

Safeguarding Adult Boards 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 at risk 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.

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 focused 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
- 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
- NHS England
- National Probation Service
- Regulatory Services
- Worcestershire Voices
- Representative from Worcestershire Housing Strategic Partnership
- Representative from Care Homes Association
- Representative from Carer reference group
- Lead Councillor for Adult Social Care

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 Agency

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	9.00

There was an under-spend for this financial year of £101,802.91. This included a cumulative under-spend from previous years, alongside the incompletion of some objectives, including the website, which have been carried over to the next business year.

The cost for SARs over the last year has been lower than predicted. These can vary in numbers each year as well as the time required by an author to complete a review due to levels of complexity. Given the unpredictability on the costs required for SARS a contingency budget is to be introduced to manage the variation across years. In addition, a number of areas of work have been identified for additional development, including building analytical capability, training and communication.

The Board therefore agreed that the cumulative underspend could be taken forward as committed expenditure for these projects and to meet outstanding objectives. However, the Board will also review future contributions against planned committed expenditure to ensure that this surplus is not replicated in future years.

2.4 Strategic Priorities 2015 to 2018

The Board agreed a three year Strategic Plan and the priorities for 2015 to 2018. There were 5 strategic objectives that the Board aimed to achieve over this three year period. These priorities were the key drivers for the work of the Board and helped to shape the annual objectives for each year. The three year priorities were:

1) To provide and seek assurance of effective leadership, partnership working and governance, holding partners and agencies to account.

2) To listen to people who have been subject to abuse or neglect, and seek assurance that people are able to be supported in the way that they want, are involved in decisions and can achieve the best outcomes.

3) To be assured that safeguarding is embedded in communities, raising, awareness, promoting well-being and preventing abuse and neglect from occurring.

4) To seek assurance that effective policies, procedures and practices are in place
that ensure the safety and well-being of anyone who has been subject to abuse or neglect, are proportionate and that action is taken against those responsible.

5) To learn lessons and make changes that prevents similar abuse or neglect happening to other people.

2.5 Delivery Model

Implementation of the Strategic Plan is achieved through the work of the Board and its five sub-groups (Fig 2.2). Each year annual business objectives are developed in line with the Strategic Objectives. The annual objectives are based on a review of priorities and progress made against the 3 year objectives.

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.

Table 2.2 WSAB Structure

<table>
<tr><td colspan="5">Worcestershire Safeguarding Adults Board</td></tr>
<tr><td colspan="5">Subgroup Chairs Subgroup</td></tr>
<tr><td>Case Review Subgroup</td><td>Communications Subgroup</td><td>Learning, Development & Practice Subgroup</td><td>Policy Subgroup</td><td>Performance & Quality Assurance Subgroup</td></tr>
<tr><td colspan="5">Virtual Network</td></tr>
</table>

2.6 Business Objectives

There were four key objectives identified in the 2017-18 business plan. Table 2.3 gives a summary of the annual objectives and details achievements and any barriers and challenges to progress.

Table 2.3 - Achievements and Challenges

WSAB Objective	Achievements and Challenges
1. Improving awareness across stakeholders of what 'safeguarding is as well as what it isn't.	**Achievements:** • The process for Safeguarding Adults Reviews (SARs) has been modified to ensure greater clarity of purpose and improve timescales; • An approved list of SAR chairs has been established; • A new Training Strategy is underway and due to be completed in the new business year; • Reviews of a number of policies have been undertaken during the year alongside the development of professional guidelines (see section 3.2.6) • The Annual Assurance Assessment was redesigned to focus more explicitly on identifying the processes organisations have in place to ensure that staffs understand the criteria and pathways for making safeguarding referrals as set out under Section 42 of the Care act. • The annual event to disseminate learning from SARs was oversubscribed and well received. The intention is to build on this in future years. **Challenges** • Whilst the County Council still hosts an interim website implementation of an independent website held jointly with the Children's Board continues to be a challenge, due to the logistics of joint procurement. However it continues to progress and this will be carried over into next year's business plan. The County Council will continue to host the website in the interim. • Whilst communication and awareness raising amongst staff has been undertaken at an organisational level, capacity to develop coordinated campaigns has been challenging.
2. Demonstrate listening to adults and gathering their views.	**Achievements** • An Advocacy Reference group has now been established, in line with the priorities set out in the Engagement Strategy; • A chair has now been identified to work with the Board in establishing a reference group for people with safeguarding experience;

WSAB Objective	Achievements and Challenges
	Challenges • Once the website is established this will enable this objective to develop further, alongside the development of a virtual network database. • A database has been developed but its full implementation has been problematic due to resource and data collection issues
3. Continue to seek assurance from partners in relation to Making Safeguarding Personal (MSP) and the Mental Capacity Act (MCA), Deprivation of Liberty safeguards (DoLs).	**Achievements** • The Annual Assurance Assessment was redesigned to focus more explicitly on identifying the processes organisations have in place to ensure that these key WSAB priorities are being embedded in practice. • A dashboard has now been established to measure the WSAB progress towards meeting its measurable objectives and is presented at the quarterly Board meetings; **Challenges** • The Board's robust assurance processes have identified that these areas continue to remain a priority and organisations' improvement plans will be reviewed over the coming year
4. Continue with cross cutting work with Worcestershire Safeguarding Children's Board (WSCB) in relation to professional curiosity and transition.	**Achievements** • The WSAB worked closely with the Children's Board 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. This year the focus was on policies and processes for addressing Child Sexual Exploitation (CSE) • A pathway has been established across children's and adults services which would include those young people where CSE has been identified;

3.0 Review of Activities 2017/18

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 work undertaken by the WSAB Sub Groups during the first year was to ensure partner agencies were all implementing the Care Act (2014) requirements. Activities over this second year built on these foundations. However, 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, Making Safeguarding Personal and Section 42 enquiries along with specific issues identified in SARs.

With Board processes now well established the Board sought to build on its engagement with people who have experience of health and social care services and their carers. Over the last year representation on the Board has been established with advocates and people who have experienced safeguarding services, alongside the already active engagement of the Worcestershire Association of Carers network. The work around engagement will continue to be developed and embedded over the next business year.

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.

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 and procedures;
- If these policies and procedures enabled the services required to be 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 2017/18 there were 9 referrals requesting consideration for a Safeguarding Adult Review (SAR) to be undertaken. Two of these referrals were made towards the end of the business year are still in scoping to determine whether the criteria to commission a SAR are met. Of the remaining referrals, none met the criteria for a full SAR to be commissioned. However, three of these referrals resulted in single agency actions being recommended and one referral is awaiting the outcome of a Learning Disabilities Mortality Review (LeDeR).

Work was completed on two SARs which were carried over from 2016/17 – 'Alan' and 'Karen'. Both have now been published and are accessible via the following link;

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

3.2.2 SAR Learning and Action

Action plans for each SAR are drawn up and progress of delivery of action plans is monitored. Key learning themes from the SARs published in 2017/8 include:

- Ensuring there is effective and timely record keeping;
- Embedding of the Mental Capacity Act in practice still remains a challenge;
- That body-maps are completed by a single agency prior to any hospital admission;
- Identifying the needs of carers and providing early offers of support;
- Ensuring that a Lead Professional/Key Co-ordinator role is embedded where there is multi agency involvement;
- Assurances are sought from partner agencies that there is adequate and appropriate support and information given to care and nursing facilities so they can provide emergency placements that are managed proportionately to the risk.

Some recommendations were also made in relation to the SAR process itself these included ensuring that there is clear communication with the family from the onset of a case being referred for a SAR so that families and carers understand the purpose, process, criteria and how decisions are made.

3.2.3 Learning Event

In January 2018 a multi-agency learning event was held and attended by over one hundred social care and health staff, alongside the voluntary and independent sector. At the event there was an in-depth presentation from a SARs Chair/Author on the findings the review into the death of RN.

Areas identified as needing further development through this review were:

- the role of the lead professional
- and issues around how self-neglect is defined and addressed.

Participants attended three workshops where they considered the findings of this review, within the context of the application of section 42, Mental Capacity Assessments and developing a person centred approach though MSP. They were encouraged to explore how they could overcome barriers and improve future practice.

Further information on the event can be accessed via the link below;

Learning Event link

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 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 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. These included:

- Auditing cases to better understand where the difficulties were so appropriate actions could be taken;
- Undertaking a staff survey to establish how well the safeguarding competencies were understood and embedded;
- Reviewing the provision of current services and pathways;
- Analysing data to target service areas where practice is not meeting the required standards and developing the appropriate actions;
- Targeting awareness of the processes and standards to those services where a weakness has been identified.

The outcome of the actions each organisation identified will be reviewed at the beginning of the new business year.

3.2.5 WSAB – Board Governance and Development

The WSAB continued to build on the robust governance processes which were already in place. Alongside the development of the Annual Assurance Framework notable work for 2017/18 includes:

- Ongoing development of Performance Management Framework to measure progress against Board objectives;
- Review and changes to Chairs and Sponsors to reflect the diversity of the Board membership;
- Formal representation from Worcestershire Housing Strategic Partnership;
- Representation from the County's Advocacy services on the Board;
- Appointment of a person with experience on the Board and to work with the WSAB in developing a reference group.

As part of the WSAB's commitment to improve engagement with people experience of safeguarding and service provision, an active approach has continued to evolve. 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 and identify any service issues which may need greater assurance.

3.2.6 WSAB Publications and Guidance

The following documents were reviewed or formally adopted and published by the WSAB during 2017/18m in order to promote evidenced based practice and support improvements in safeguarding practice across the partnership;

- Best interest decision meeting guidance;
- Mental Capacity Act Policy;
- Position of trust guidance;
- Safeguarding Judgments Guidance;
- Toolkit to support organisations in the self-assessment for benchmarking of Mental Capacity Act Policies.

The following documents were revised during the year:

- Assisted Suicide Policy;
- Self-Neglect Guidance;

- Toolkit to support organisations in the self-assessment of Safeguarding Adults Policies.

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 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: Improving awareness across stakeholders of what 'safeguarding is as well as what it isn't

- Regular meetings with Safeguarding Leads to disseminate key messages, with a focus on key topics and learning from SARs; (WHCT, WMP, CCG/GP Practices);
- Continual development of training to ensure that learning around safeguarding is embedded and understood; (WHCT, PH, WHAT, WCC, WMP, CCG);
- Bespoke training for key front line staff, including GP's and Nurses (CCG), drug and alcohol service providers (PH), and midwives (WAHT);
- Embedding the WSAB competency framework across the Adult Social Care directorate and undertaking a workforce review to test how well training has been embedded (WCC);
- Development of a reference chart to clarify what constitutes a safeguarding concern around tissue viability (WAHT and WCC);
- Linking Safeguarding Team members into locality teams (WCC);
- Quarterly and weekly safeguarding newsletters and briefings (WHCT, CCG);
- Providing information to patients and people who use services (CCG; WHCT, WAHT);
- Ensuring commissioned services include the expectation that there is mandatory safeguarding training for staff – (CCG);
- Strengthening assurance processes with a detailed safeguarding template which includes reporting requirements and training details for NHS providers. This includes providing evidence that learning from SARs has been implemented. (CCG);
- Ensuring that learning and actions from SARs are implemented across providers
    - through regular review of actions and strengthening the assurance process to reflect recommendations (CCG);

- Targeted awareness raising on domestic abuse with organisations who provide support to people with learning disabilities following a joint Domestic Homicide Review (DHR) and SAR (PH, CCG);
- Disseminating published SARs to internal and external tutors who deliver safeguarding courses (WCC);

Objective 2: Demonstrate listening to adults and gathering their views

- A number of partner organisations regularly present patient and service user stories to their Boards and utilise patient feedback to shape the work they do and services which are commissioned (WHCT, CCG);
- Work has been undertaken with service user and carer groups to ascertain their views around issues such as safeguarding;
- Working closely with an active learning disability group 'Speakeasy NOW' with one of the main areas of focus during the year being on staying safe, which includes safeguarding issues. (CCG, WCC and WSAB)
- Monthly analysis and reviews are undertaken on whether the outcomes that adults who go through safeguarding services are achieved (WCC)
- A local outcome survey is being developed to gather views of adults on their experience through the safeguarding process (WCC);
- Undertake customer satisfaction surveys, targeting vulnerable adults (WMP)

Objective 3: Continue to seek assurance from partners in relation to Making Safeguarding Personal (MSP) and the Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS).

- Quality assurance processes of commissioned services and NHS provider organisations regularly assess whether MCA and DoLS applications are being effectively undertaken and meet the needs of service users;
- MCA and DoLS training for staff is continually being developed and tested to ensure that it is embedded in practice;
- MCA and DoLS are viewed as key components of training which should be undertaken by services commissioned by the WSAB individual partners;
- An MCA crib card has been provided to all clinical staff. (WAHT):
- Following a report by the Coroner Court in relation to a DoLS /MCA case a number of actions have taken place, including the dissemination of wider learning within training for the Senior Nursing team to raise awareness (WAHT);
- A focus on supporting the development of GP's knowledge and awareness of safeguarding and in particular MCA and DoLS (CCG);

- Appointing Mental Health strategic and tactical leads (WMP)

Continue with cross cutting work with Worcestershire Safeguarding Children's Board (WSCB) in relation to professional curiosity and transition.

- Operating procedures for safeguarding alerts are being developed so that they are more standardised, and thus clearer, across both children's and adults services (WAHT);
- Ensuring the MARAC system which flags up domestic abuse works closely across both Adults and Children's services ;
- Safeguarding champions are integrated to ensure that support and advice can be clearly provided across both children's and adult services (WHCT);
- The Young Adults Team (YAT) has introduced a protocol of joint working arrangements with the Children's Disability Team (WCC);
- 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).
- Weekly CCG and GP Briefings includes safeguarding issues for information;
- Domestic abuse training is now delivered jointly across children's and adults services to ensure that it addresses the issue from a holistic perspective';
- Domestic abuse training is now mandatory for all staff (WHCT)
- 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.

4.0 Safeguarding Activity and Performance 2017/18

4.1 Care Act (2014)

When the Care Act (2014) was introduced in April 2015 there were some changes to the definition around the safeguarding criteria. These changes mean it is only possible to make direct comparisons for the last three business years.

4.2 Number and Source of Concerns

Over the last three years the number of concerns reported has decreased (Table 4.1). Ongoing analysis suggested that the high level of reports in the past was due to incorrect referrals. This has been addressed through a number of measures including raising awareness on what constitutes a safeguarding concern which will meet section 42 criteria, alongside reviewing the pathway for reporting care quality concerns. There has been a particular focus on services which consistently had high levels of inappropriate reporting.

The effectiveness of this effort can be demonstrated through the level of concerns reported which meet the section 42 criteria which, as outlined in the Care Act, are adults who;

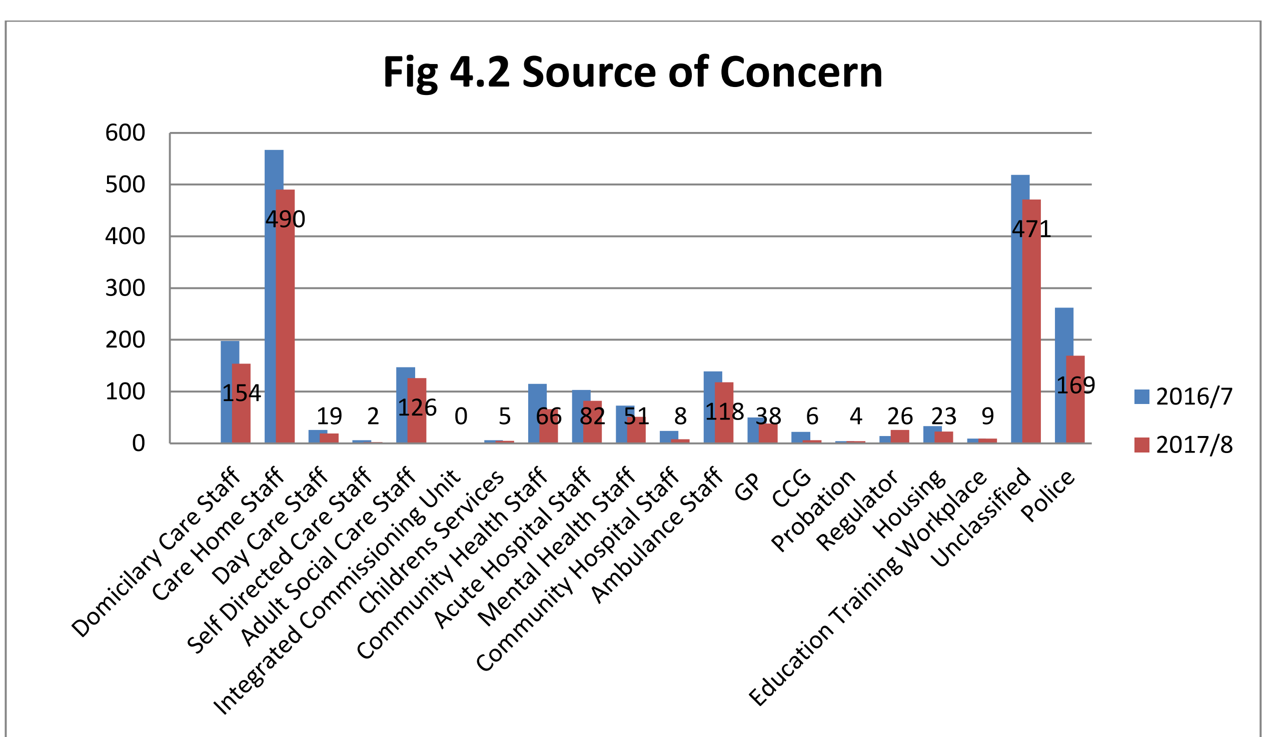
- *have needs for care and support (whether or not the local authority is meeting any of those needs) and;*
- *are experiencing, or at risk of, abuse or neglect; and*
- *as a result of those care and support needs are unable to protect themselves from either the risk of, or the experience of abuse or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

Numerically this has remained relatively constant over the three years meaning the percentage of appropriate reports has increased.

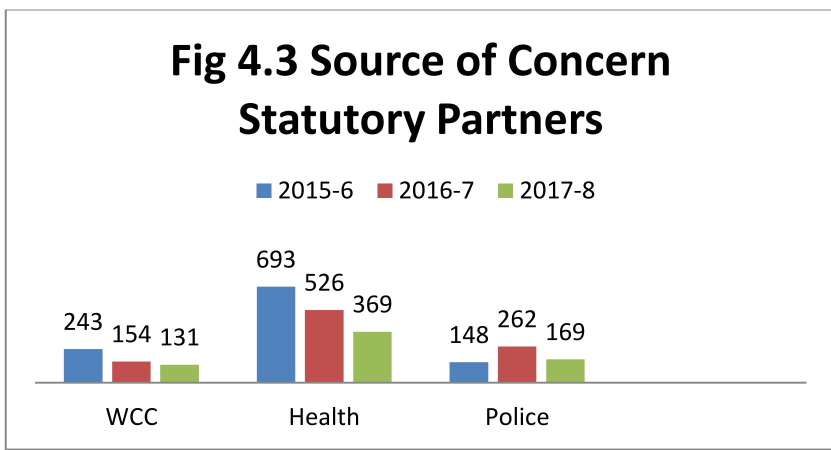
Table 4.1 – Concerns dealt with under safeguarding 2017/18 (compared to 2015/16 and 2016/17)

	2015-16	2016-17	**2017-18**
Concerns Reported	2653	2342	**1942**
Decisions Made	2492	2244	**1799**
High Risk	99	65	**79**
Section 42 applies (meets criteria)	343	328	**325**
Percentage of concerns reported where Section 42 Applies		15%	**18%**

As with the previous year the highest number of concerns were raised by Care homes, followed by the police, then domiciliary care providers (fig 4.2). Those recorded as unclassified include a broad spectrum of people and organisations, a large number of which are family and friends, currently not categorised for recording purposes. The categories are being reviewed and are likely to be extended.



In terms of the statutory partners (Health, County Council and Police), comparisons with the previous two years data shows a drop in the number of concerns being raised (Fig 4.3). Following the introduction of the care act there has been a concerted effort to target training and awareness raising across these sectors. This now needs to be built upon across the wider stakeholders.

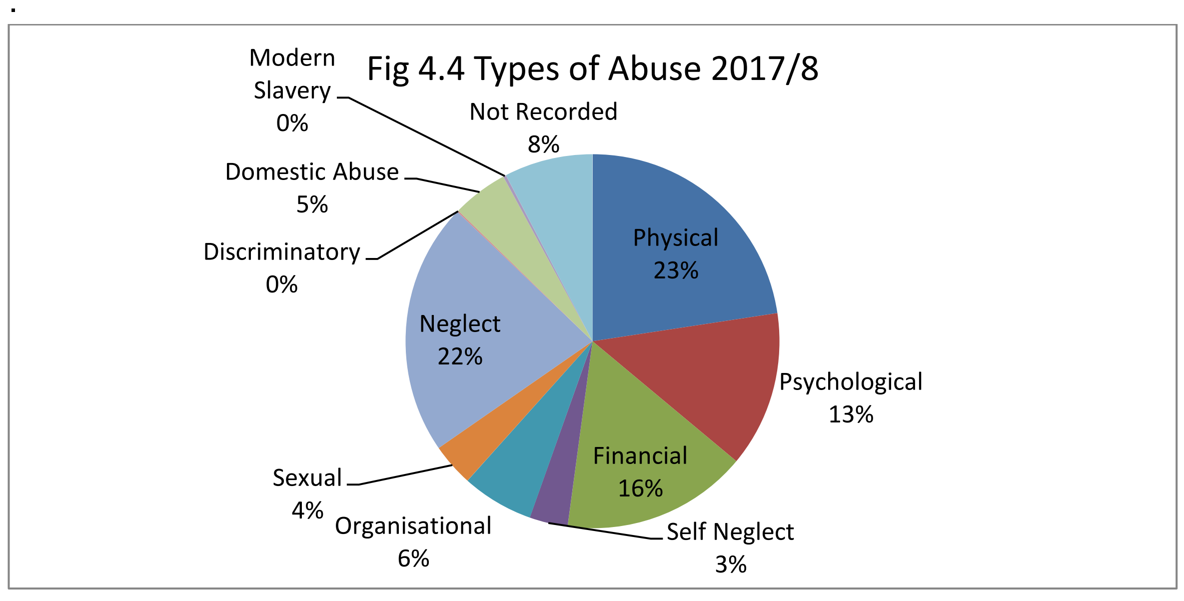


4.3 Type of Abuse

Reporting on the different types of abuse, as defined in the Care Act, is voluntary at a national level. Worcestershire County Council does not currently report Sexual Exploitation as it is considered to be a sub set of Sexual Abuse. However it has now been agreed that this will be introduced.

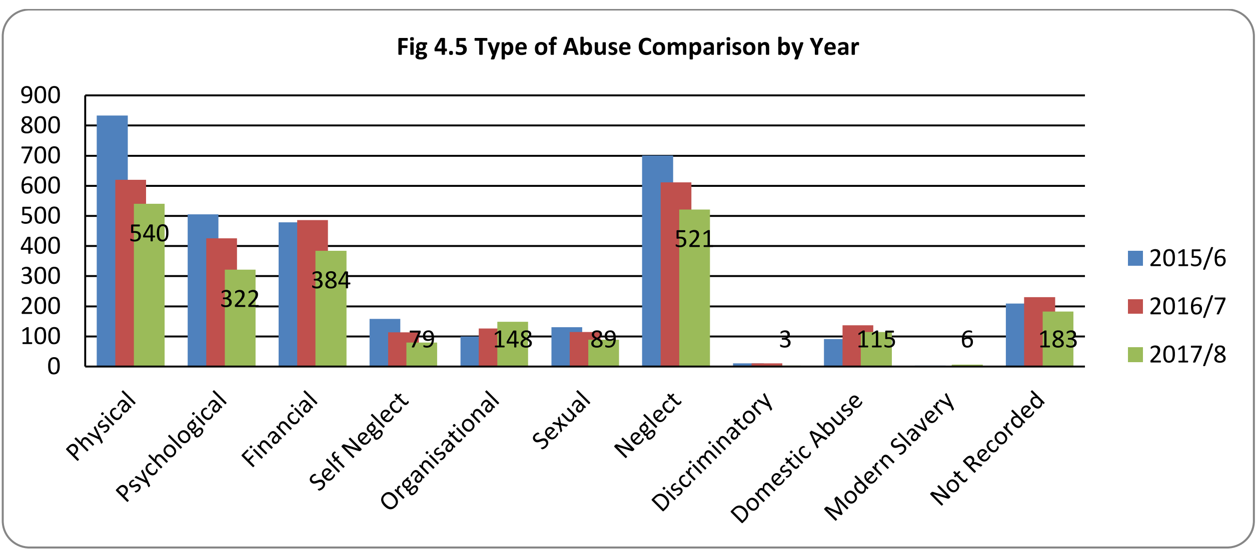
Physical abuse remains the highest type of abuse, fig (4.4), closely followed by neglect. The next highest levels are financial and psychological abuse

.



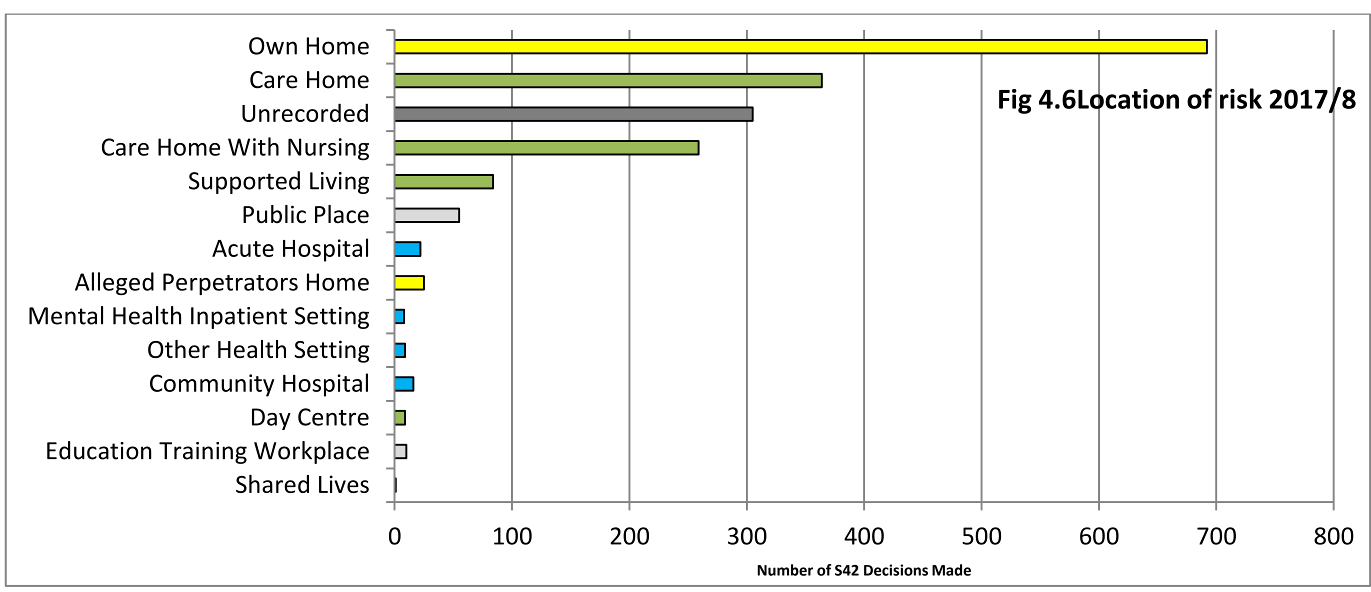
These mirror the highest types of reported abuse in the previous two years (Fig 4.5). A reduction is shown in all types of abuse this year, the exception being modern slavery,

although the numbers for this are relatively low. Types of abuse shown as 'not recorded' reflect the situation that in some cases when an incident is initially reported it is not possible to define the type of abuse.



4.4 Location of Risk

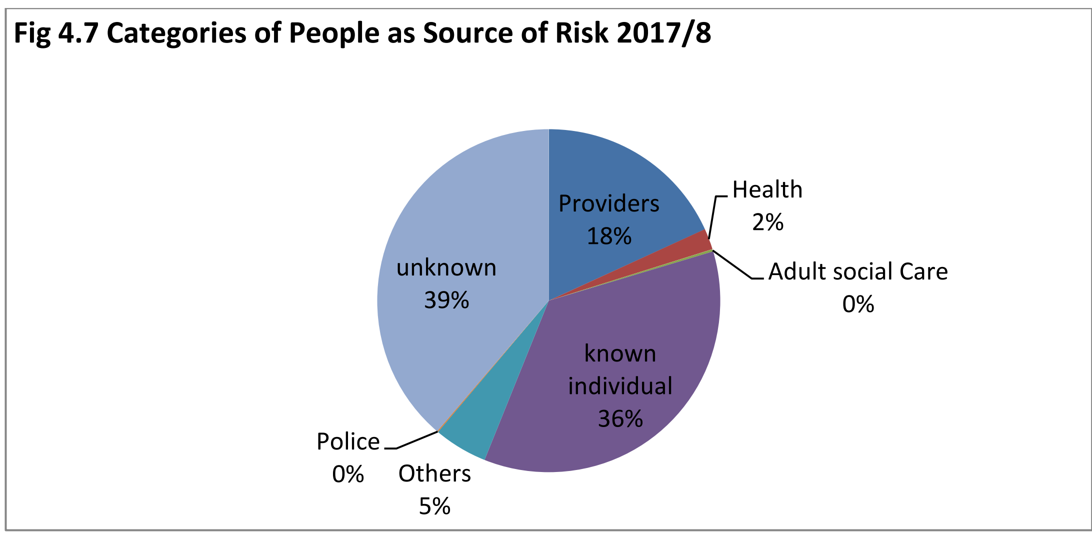
Data on the location again shows a similar pattern to previous years. The majority of safeguarding concerns, where a decision has been made that they meet the section 42 criteria, have taken place in the adult's own home. (Fig 4.6) As with the previous year, Care and Nursing homes continue to be the next highest locations.



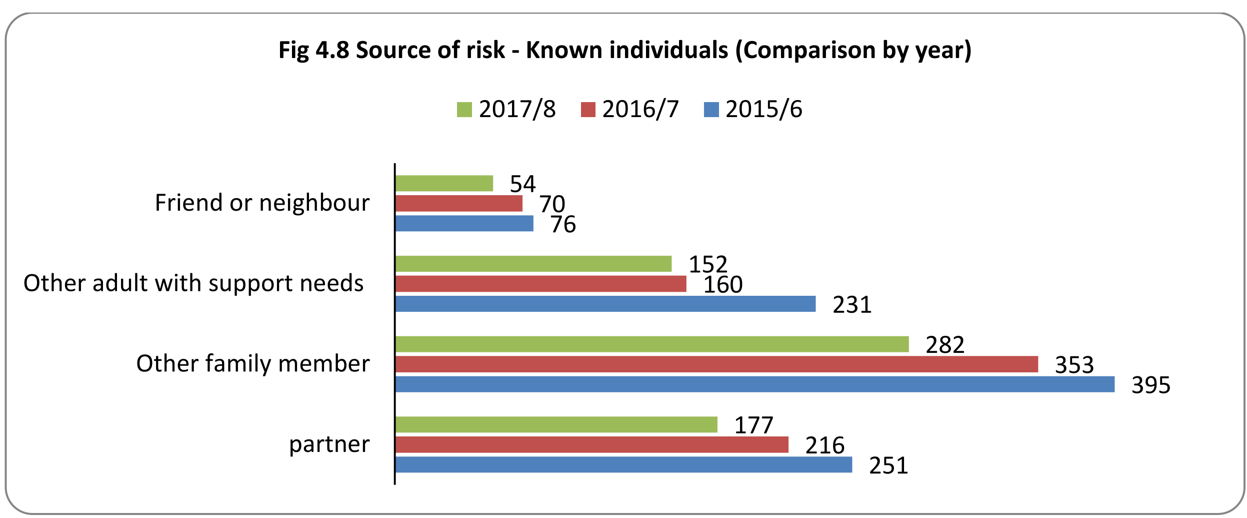
4.5 Source of Risk

One third of those people identified as the source of risk were known to the individual (Fig 4.7), (i.e. their partner, another family member, a friend or neighbour or, for those in a

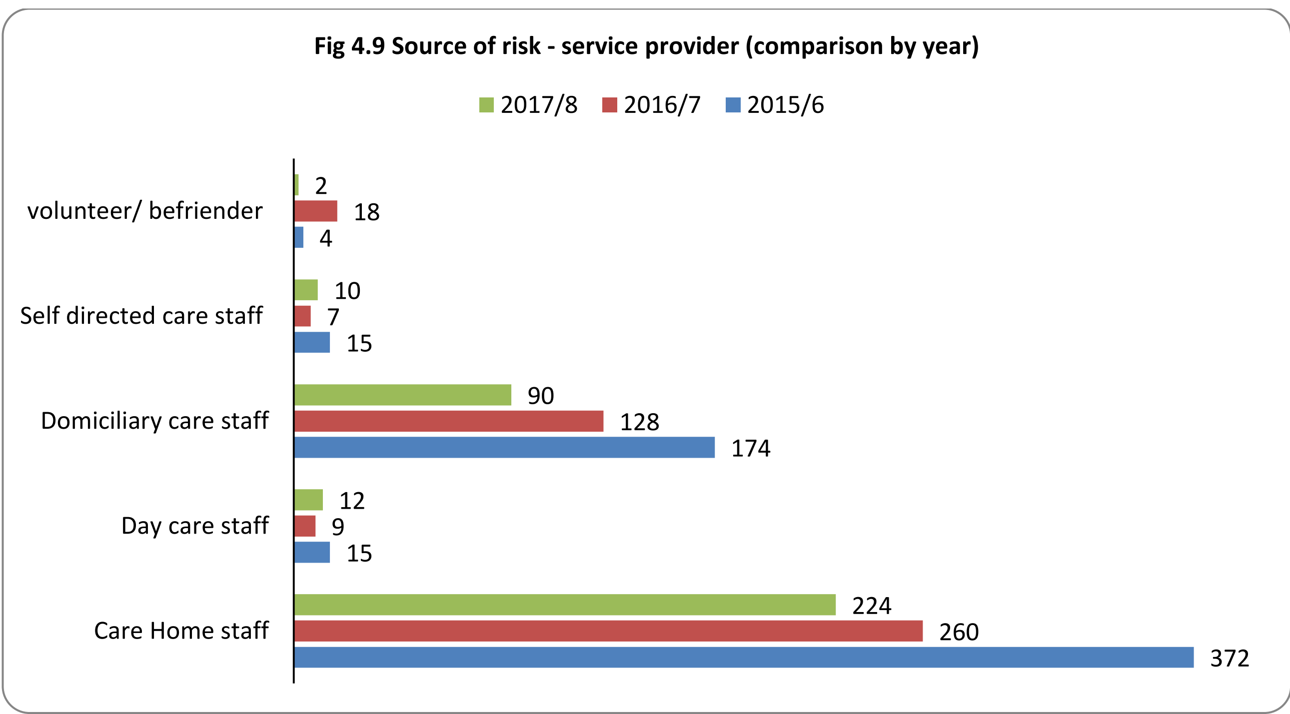
support setting, another adult with support needs). The next largest category was a service provider member of staff (i.e. Care homes and nursing homes). A large proportion were recorded as 'unknown'. This is because the data is extrapolated from the point the incident is first reported and some of these may be disclosed further down the investigation. It is also important to note that whilst Adult Social Care and the Police show up as 0% this is because the numbers are low. There were 4 incidents recorded where Adult Social Care staff were the source of risk and 6 where the Police were the sources of risk.



When looking more closely at the two greatest risk areas family members continue to be the largest group (fig 4.8) in the category of known individuals.



In the second highest category of 'Providers' (fig 4.9), Care Home Staff continue to be the highest source of risk. However this has shown a notable decline over the last three years, as has the number of Domiciliary care staff.

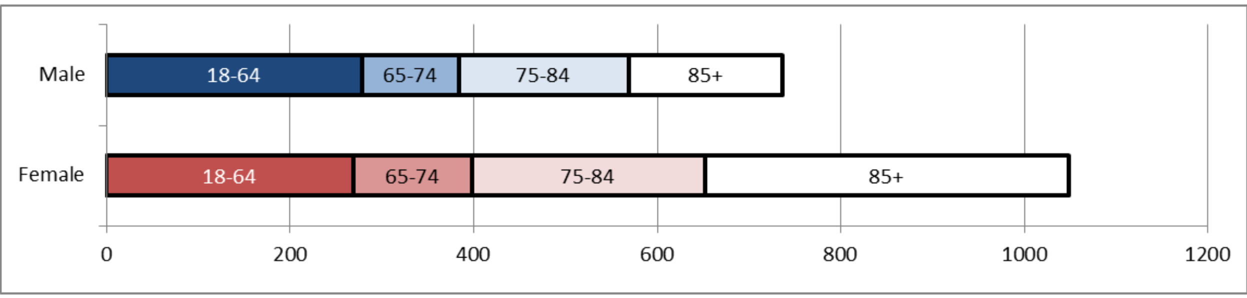


4.6 Demographic Profiles

Gender and Age

As with the previous year, the number of cases which meet the safeguarding section 42 criteria is higher for women than for men (Fig 4.10). This is particularly pertinent in age groups over 75 and is reflective of the gender demographic of the County.

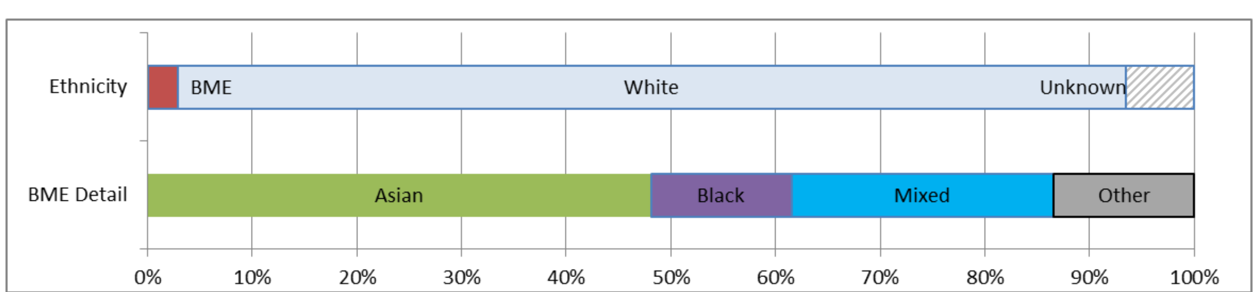
Fig 4.10 Gender/Age Profile of Concerns – Decisions Made (2017/18)



Ethnicity

In terms of ethnicity the level of cases again mirrors previous years, with the vast majority of those cases where the enquiry had been completed identified as being white (Fig 4.11).

Fig 4.11 Number of completed enquiries - Ethnicity



Within the BME groups Asian adults continue to represent the largest group, followed those adults identified as having a mixed ethnic background, then Black or Black British.

The percentage of safeguarding decisions made for all BME groups combined is 3 %, which is significantly lower than the 7.6% of BME groups living across the County. 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. 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 and over the last year it was a primary focus of the Board, being a central element of the Annual Assurance Process and the annual learning event.   .

Types of Outcomes

Of the 364 completed enquiries this year, 78% of the people being supported identified an outcome. Table 4.12 shows the type of outcomes which people wanted to achieve through the enquiry process and whether these were felt to be met. This year data shows that almost all outcomes were met. Whilst there has been a concerted effort to ensure outcomes are being achieved there has been a problem with the information management system which has led to some outcomes being added later as the enquiry progresses. This means that the outcome may not always have been identified by the person being supported at the beginning of the process. This could explain the exceptionally high success rate and is being addressed.

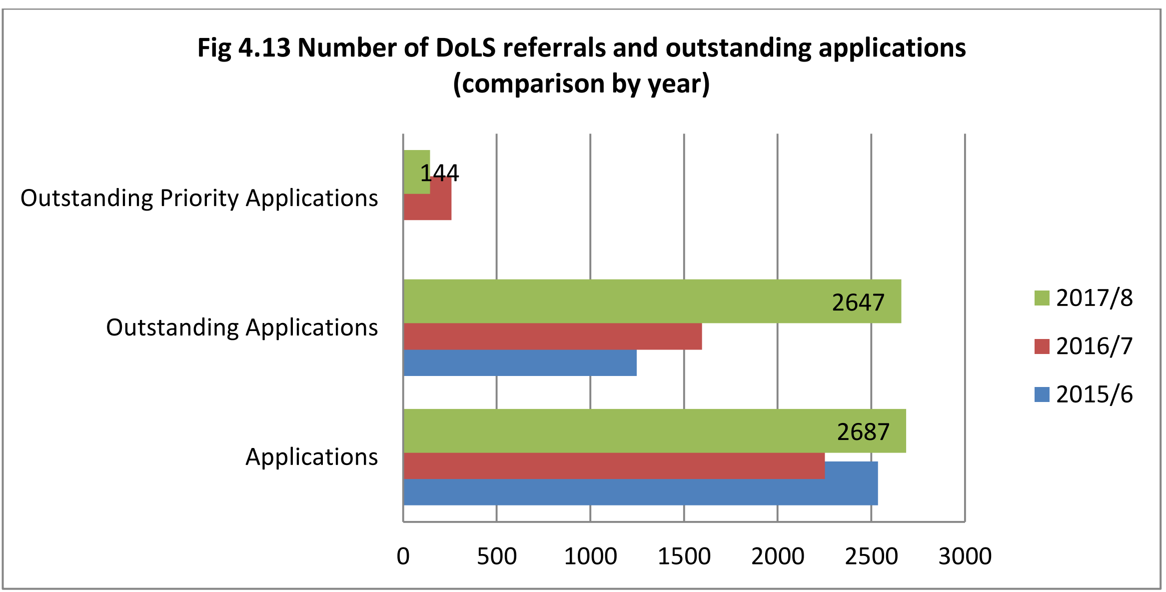
Table 4.12 Making Safeguarding Personal – Desired Outcomes –comparison by year			
Desired Outcome	**2017/18**	2016/17	2015/16
To Be And To Feel Safe	**100.0%**	100.00%	83%
To Know That Disciplinary Or Other Action Has Been Taken	**100.0%**	100.00%	100%
To Have Exercised Choice	**100.0%**	100.00%	100%
To Get New Friends	**100.0%**	100.00%	100%
To Maintain A Key Relationship	**100.0%**	100.00%	100%
To Maintain Control Over The Situation	**100.0%**	100.00%	90%
To Be Involved In Making Decisions	**100.0%**	98.20%	98%
To Know Where To Get Help	**100.0%**	92.10%	100%
To Know That This Won't Happen To Anyone Else	**98.0%**	93.10%	71%
To Have Help To Recover	**100.0%**	74.50%	100%
To Have Access To Justice Or An Apology	**100.0%**	85.40%	64%
Other Outcome	**100.0%**	71.40%	83%

4.8 Deprivation of Liberty Safeguards (DoLS)

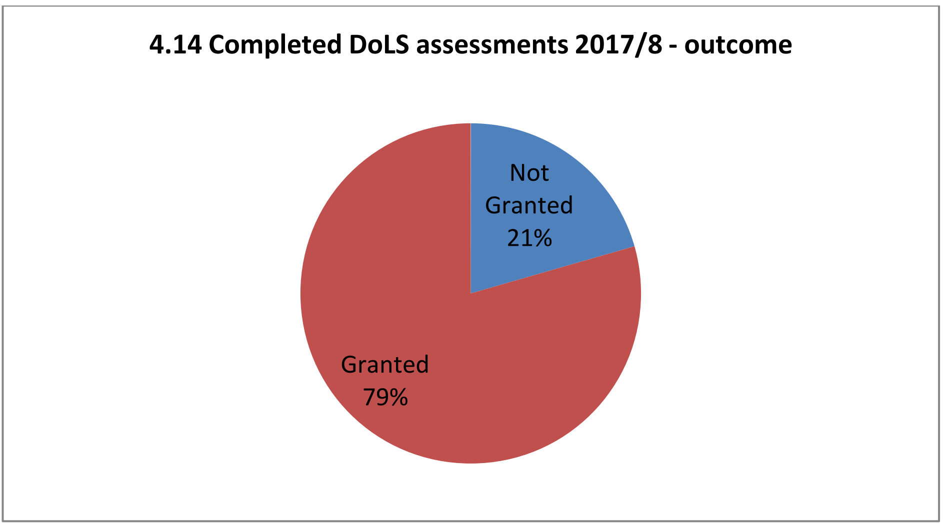
DoLS has continued to be a challenge, both locally and nationally, since the ruling in the Cheshire West case in 2014 which significantly increased the level of applications locally and nationally. As a consequence, alongside applications made during each financial year, there has also been a significant carry over of outstanding cases from the previous year. 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 2017/8 was 2687 (Fig 4.13). This is an increase of 19% compared to the previous year. Of these referrals 20% (524) were identified as a high priority.



During the year a total of 2660 assessments were completed during the year (Fig 4.14), of which 79% of the applications were granted (Fig 4.14):



The assessments completed during the DoLS process continue to be vital in order to ensure that the rights of vulnerable people are protected and that no one is deprived of their liberty unlawfully.

5.0 Priorities for 2017/18

In January 2018 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 events and consultations, were reviewed.

The Board agreed to move away from a three year strategy and focus on the Annual Business Plan in order to address emerging priorities identified through SARs and performance data. Priorities for the forthcoming year are:

- To improve awareness across all stakeholders of what safeguarding is. (Section 42 Criteria).
- Demonstrate that we are listening to service user and gathering their views.
- 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).
- 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.

These have been used to complete the Annual Business Plan for 2018/19 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
MCA	Mental Capacity Act
MSP	Making Safeguarding Personal
NHS	National Health Service
PH	Public Health
SAR	Safeguarding Adults Review
WCC	Worcestershire County Council
WHAT	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

Director of Public Health

Annual Report 2016 – 2018

Prevention is better than cure

Find out more online:
www.worcestershire.gov.uk

Annual Report
Prevention is better than cure
2016 – 2018

Welcome to the 2016 – 2018 Director of Public Health Annual Report. This report focuses on preventing poor health and describes the current picture and opportunities in Worcestershire during this period.

There is a strong evidence base that it is better and cheaper to prevent problems before they arise, in short, that prevention is better than cure. Focussing and investing in prevention will improve health outcomes; keep people independent; and improve peoples' well-being and quality of life. This will, in turn contribute to managing the demand for higher cost reactive services.

Our approach to prevention must be strong and systematic, protecting and improving population health, narrowing health inequalities and supporting our population to enjoy good health at every age. We are living through a period of great challenge, with a rising tide of avoidable disease; increasing numbers of frail older people; and reducing public sector budgets. Many of our public services are dealing with day to day crisis and emergency, and much of that is caused by avoidable demand. Our approach to prevention needs to change to achieve a shared view of action and priority.

The second section of the report is a compendium of local health indicators. This presents a core set of health indicators over time, for the whole population of Worcestershire. As in previous years, our population in Worcestershire is generally healthy when compared with national averages. However, we cannot be complacent.

Much of the data about children suggests that there are risks to their future health. For example, smoking in pregnancy; childhood obesity; breast-feeding rates; and school readiness among children whose families qualify for free school meals all show below average outcomes. Most of our middle-aged population are now following life-styles which may be in line with national averages, but which are unhealthy and will cause health problems now and in the future. For example, most of our population is now over-weight or obese, and too many are physically inactive, smoke, and drink too much We can predict that the diseases linked to these lifestyles (such as stroke, coronary heart disease and diabetes) will rise significantly in the years to come. Data about the older population shows that, although people live longer, they have extended the years of life lived in poor health, rather than the years spent in good health. It is clear that outcomes such as social isolation of carers, fuel poverty, sight loss, and falls must improve significantly if we are to enjoy a healthy old age. Health inequalities are still evident, with the difference between the most and least deprived being at its widest for the number of years spend in poor health.

Many aspects of ill health in the 21st century are avoidable. Investing in prevention is a key element of making health and social care systems affordable and sustainable. I hope that this annual report will influence our thinking and actions in Worcestershire. There are some clear signs now that a healthy future is under threat, unless we do all we can together to improve our delivery of at scale effective prevention.

Dr Frances Howie
Director of Public Health

The Case for Change

Political and public commitment to universal health care, free at the point of delivery, according to clinical need, remains as strong now as it was when the NHS was established in 1948. However, the costs of the NHS have risen dramatically. In 1948, the budget for the NHS was £437m, which would be about £15bn at today's prices. In fact, in 2016/17, expenditure was £120bn.[1]

Spend has gone up as a consequence of increases in:

- The extent of medical intervention possible due to advances in science in technology.
- Public expectation about the service.
- Life expectancy, which, for a child born in 2017 is 82 years compared with 68 years in 1948[2].
- Population size. In 1948, the UK population was 49.4 million[3] compared with 66.1 million in 2017.
- Changes in the pattern of disease. When the NHS was set up, the main burden of disease came from communicable disease from which, in general, the patient either died or recovered. Now, the main burden of disease comes from non-communicable diseases, such as coronary heart disease or cancer, which result in a longer life, but often with long term health conditions requiring long- term NHS support.

Successive governments have restated their commitment to the NHS, and have increased the spending. The % of GDP used to fund the NHS has changed from 3.5% in 1948[4] to 7.4% in 2016/17.[5]

Repeated policy changes have attempted to limit this growth in spending. However, costs have continued to rise as the system struggles to cope with the increased burden of ill-health and demographic change.
In 2014, NHS England produced the Five Year Forward View policy document and described the need to 'get serious about prevention', and to systematise a radical upgrade in prevention. This is still not evident, and the NHS and social system continues to try to resolve problems which could have been resolved at a far earlier stage.

Locally, the need for change is evident. The NHS has required local areas to produce a Sustainability and Development Plan (STP) which identifies gaps between where we are, and where we should be, in terms of health outcomes gap; service quality outcomes and finances. **The Plan shows health outcomes that show that Worcestershire has progress to be made to improve the health of its people**. For example

- Worcestershire ranks 55th out of 150 Authorities nationally (where 1st is best) for premature mortality rate per 100,000 population. In comparison with its statistical neighbours, Worcestershire ranks 12th out of 15, with a premature death rate of 320 per 100,000, compared with 256 for the 1st ranked (2012-14).
- The gap between life expectancy and healthy life expectancy at 65 years in Worcestershire is 7.2 years for males, and 8.9 years for females (2014-2016).

---

[1] HM Treasury, *Public Expenditure Statistical Analysis 2017*
[2] Average for males and females, the figure is for 2013-15, the closest year available.
[3] Source: OHE Guide to UK Health and Health Care Statistics, 2013
[4] Figure is for 1950/51, the first year available. Source: http://www.nhshistory.net/parlymoney.pdf
[5] Source: HM Treasury, Public Expenditure Statistical Analysis 2017, Table 4.4

- The gap in healthy life expectancy between the most and least deprived in Worcestershire is 11.8 years for males, and 11.5 years for females (2009-2013).

  - Only 46% of children receiving free school meals in Worcestershire reach a good level of development at the end of the reception school year. This is worse than the England average of 51% (2014/15)
  - The infant mortality rate in Worcestershire is 4.9 per 1,000 live births (2014-16) and is amongst the worst in comparison with its statistical neighbours.
  - 23% of reception class children are obese or overweight in Worcestershire (2015/16)
  - 2.7% of all live births at term in Worcestershire are of low birth weight, similar to the national average of 2.8% but higher than most comparator areas (2016).
  - Breast-feeding initiation rates are 66.7% in Worcestershire with a national figure of 74.5% (2016/17)

The data presented here show that lifestyles in the County are often not those which will produce the healthiest life. Continuing with these lifestyles will further widen the gap between where we are and where we should be. For example, an estimated 65,000 people smoke, 140,000 drink alcohol to excess, 98,000 are physically inactive, and 290,000 are overweight or obese. People do not make maximum use of preventive services such as influenza vaccination where 27.8% of over 65s were unvaccinated in 2016/17, and 6.8% of children at 5 years old had not received 2 doses of measles, mumps and rubella in 2015/16.

The particular pressures of a high proportion of older people; a majority of the middle-aged population following lifestyles with some health risk; and poor health outcomes among children, mean that there is a consistent pattern in Worcestershire as in the country as a whole of rising demand for high cost services and of people not being able to live life to the full. **The case for a shift towards prevention is strong**.

Worcestershire context

In 2013, local authorities were given a new statutory duty to improve population health and narrow health inequalities. This new function moved to the County Council, and a new Public Health Ring-fenced Grant (PHRFG) was given to the Council to execute its duties. Key functions for the council, under the leadership of the Public Health director and team, include commissioning prevention services; influencing the wider determinants of health through working with partners; and using intelligence and skills to maximise investment locally. The move to local authorities was hoped to strengthen place based approaches to healthy environments, and the NHS retained its duty to narrow health inequalities and improve health and well-being.

Local authorities were also required to set up Health and Well-being Boards and to produce a Health and Wellbeing Strategy. Our Strategy sets out our approach to prevention: preventing ill-health before it occurs; reducing the impact of problems which have occurred, (by detecting risk and problems as soon as possible and intervening early to limit their impact) and delaying the need for further help and avoiding crisis (by getting the right help quickly to those people who already have needs.)

Our Health and Well-being Strategy sets out a five point framework for local action on prevention:

- **Creating a health promoting environment** by developing and enforcing healthy public policy and taking health impact into account systematically in decision making.
- **Encouraging and enabling people to take responsibility for themselves, their families and their communities** by promoting resilience, peer support and the development of community assets.
- **Providing clear information and advice** across the age-range, so that people make choices that favour good health and independence.
- **Commissioning prevention services** for all ages based on evidence of effectiveness and within the funding available.
- **Gate-keeping services** in a professional, systematic and evidenced way, so that services are taken up by those who will most benefit and the service offer is available on the basis of need, regardless of differences between people in terms of where they live or characteristics such as deprivation.

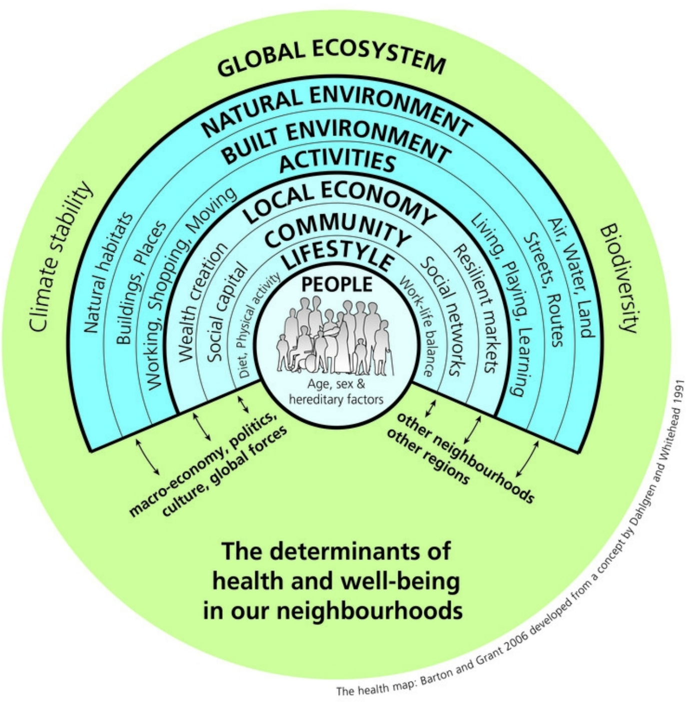
A range of initiatives are now in place across the County which aim to tackle prevention at every level. However, given the continued pattern of rising demand, we are still some way from the radical upgrade in prevention which is needed for the long-term sustainability of our services. It is timely to return now to revisit our ambition, and to consider whether or not we yet have an effective system approach to which deliver impact for our local population. **The data here suggest that the radical up-grade to prevention has yet to be realised**.

The following sections of this report describe three broad areas of prevention drawn from the framework above highlighting what works and considering current progress in Worcestershire.

Creating healthy places	Enabling people to help themselves, their families and their communities	Developing effective prevention services
Working in partnership to create healthy places which promote good health	Encouraging and empowering people to be active in their local community, health literate, and able to take responsibility for their own health	Primary, secondary and tertiary prevention services, universal and targeted, for all ages.
Healthy planning and homes	Engaging with communities to build community assets through people and places, including front line staff training in evidence based practice	Universal services from pre-birth for young people and parents – Midwifery – Health visiting - School nursing Targeted services for those who need them most – Perinatal mental health programmes – Parenting programmes – Child and adolescent mental health services
Healthy licensing policy	Citizen training in health and digital literacy including as champions for promotion of mental health and well-being and dementia awareness	Universal services for all adults – Front line staff training across the whole system in delivering motivational brief interventions
Access to green spaces	Clear information and advice usually digital	Targeted services for those who need them most: – Immunisation programmes for specified groups – Screening programmes for specified groups – NHS health checks programmes – Diabetes prevention programmes – Falls prevention programmes
Air quality	Supported information and advice for those who need it for example by social prescribing and community and health navigators	
Active and integrated travel		
Healthy work places, schools and colleges		
Focus on take-up and engagement with target populations, in particular those living with disadvantage.		

Creating Healthy Places

Good or bad health is not only a consequence of behavior, genetics, and health care. Social, economic and environmental factors are significant determinants of health and healthy places can promote good health, making sure that everyone has a good chance of good health and well-being.



In the next section, I highlight some areas for particular attention. It is important to remember that Worcestershire remains a relatively affluent county in terms of the wider determinants of health relating to education, employment, and income. However, our rising burden of avoidable ill-health should still be addressed through a wider determinants lens, and it is particularly important that we focus on lifestyle modification through place shaping. Much of this work takes place at community level, in our districts, towns, parishes, schools, colleges, and workplaces. Community leaders and local people right across the system can influence the place in which people live and work, and can be engaged in making each local area a healthy place to live for all its residents, whatever their age.

Healthy Planning and homes

The population of Worcestershire is projected to increase by 51,000 people by 2041, and much of this increase will be in people aged 75 years or over, largely driven by falling death rates and people living longer. However, with around 34,000 houses still planned to be built by 2030 across the County, planning has a key role in ensuring that the health needs of the current and future population of Worcestershire are met. The environment in which we live has a significant impact on health. The World Health Organization estimates that 23% of global deaths are due to modifiable environmental factors. Locally, there are opportunities for improving public health including in neighborhood design, improving the quality of housing, planning for an ageing population, improving access to quality food, improving and sustaining the environment, improving sustainable transport, infrastructure and road safety.

To support healthy planning, Health Impact Assessments (HIAs) are a tool for assessing and maximising the potential positive health impacts of a planning proposal, and mitigating

any negative impacts of proposed developments. The South Worcestershire Planning for Health Supplementary Planning Document (SPD), provides a good basis to ensure the systematic application and embedding of prevention into the planning process in Malvern Hills, Wychavon and Worcester City, **but more needs to be done to ensure a consistent approach to healthy planning across all Districts in Worcestershire, and elected members and planning officers at County and District level have an important part to play**.

Homes promote good health and healthy lives in many ways, including by the careful planning of the built environment and the provision of high quality housing which will enable people to be safe and warm. However, maximising good housing throughout life should be more focused and flexible too: good-quality supported housing for people with mental and physical health challenges; homes that can adapt to the needs of people as they age; and healthy care homes when they are needed are all needed to prevent ill-health, and to reduce some of the existing pressures on health and social care systems. Here it is important for health, social care, and voluntary sector partners to work together and with planners to make sure that the basic right to safe, affordable and appropriate housing is met.

Care homes have a unique role in creating a health promoting environment for the most frail older people. NICE guidelines,[6] focus on the opportunities in care homes to promote good mental and physical health, including through meaningful activities, good diet and hydration, and prevention of falls. Enhanced health in care homes can be achieved by close co-ordination between care homes and the range of health services required to meet the needs of older people living in the care homes, as well as with our local communities. Much has been done in Worcestershire to link care homes to named GPs, and there are well-being schemes in some of our care homes. **However, much more could be done to make the most of the care home setting in promoting good health and preventing further escalation of health problems.**

Healthy licensing policy

Excessive drinking is damaging to health in the short and long term. Short term effects include accidents and violent behaviour whilst longer term effects of persistent alcohol misuse include stroke, liver disease and liver cancer. Nationally, victims of violent crime believed the perpetrator to be under the influence of alcohol in 40% of violent incidents[7]. In Worcestershire, rates of violent crime linked to alcohol range from 2.36 per 1,000 (Malvern Hills) to 5.15 per 1,000 (Redditch and Worcester City).[8]

In Worcestershire, the rate of hospital admissions for alcohol related conditions was 634 per 100,000 (2016/17) which is similar to England average, and the rate of under 75 mortality from alcoholic liver disease was 16.6 per 100,000 (2014-16) equating to 278 deaths, also similar to England average, but rising whereas the rate is reducing elsewhere Although the burden of chronic drinking is in the home, it is important to create a healthy place where licensed premises are well-managed, in terms of quantity and quality. Worcester City has the greatest density of premises licensed to sell alcohol per square kilometre in the West Midlands (13 licensed premises per 1km^2), and has therefore agreed a 'Cumulative Impact Zone' (CIZ) which enables a restrictive planning environment. It is important to maintain

[6]NICE. Older people in care homes. Local government briefing. Published 18 February 2015. http://nice.org.uk/guidance/lgb25 Accessed 23/03/2018

[7] Crime Survey for England and Wales. Year ending March 2017.

[8] Public Health England. Local Alcohol Profiles for England. Alcohol Related Violent Crime 2012/13.

this, and to consider other areas for similar management approaches. Licensed premises should also be encouraged to make sure that non-alcoholic drinks and water are available and affordable, and to train staff so that excessive drinking is not permitted. Locally, licensees report increases in customers arriving from 'pre-drinking' at home, which can make it harder for them to realise that a customer has drunk enough. Councils have a key role in training for license holders, and in promoting a responsible drinking culture through their licensing powers.

Partner organisations such as the police and voluntary/community sector are actively working to reduce excessive drinking in public places, and this work could widen beyond the current, town centre, hotspots. This includes making formal representations alongside partners at licensing committees to curtail the proliferation of new establishments, as well as promoting safer drinking habits.

Access to green spaces

Proximity to, and use of green space and the natural environment is associated with better physical and mental health. Benefits include improving physical activity, and reducing excess weight and obesity leading to reduced risk of long term conditions. This in turn can lead to lower rates of mental health conditions such as anxiety and depression, and generally improved health, wellbeing, social interaction and social cohesion.

Providing children with good access to the physical environment is an important aspect of development, which also helps improve childhood wellbeing such as reduced mental illness and increased proportions of children being the recommended weight. People under the age of 25 are more likely to be obese if they do not have access to green space.[9]

Residents in Worcestershire are able to access high quality green spaces such as open countryside, woodlands, nature reserves, parks and waterways. According to Natural England there are over 11,750 hectares of strategic natural green spaces in Worcestershire that can be used by the general public,[10] which is above the national average. However, the latest information available suggests that only around 14.2% people (83,500 people) in Worcestershire use outdoor space for exercise/health reasons,[11] compared to 17.9% nationally.

Local initiatives are available across Worcestershire to promote exercise and use of green spaces – examples include the Park runs, Sports Partnership activity finder,[12] health walks [13] and a range of local activities, many of which are available through District Councils who have a statutory duty in this area. Local communities have an important role to play, local Parks Groups, Park runs, and health walks all rely on volunteers to enable people to be active lives in local green spaces. In 2017/18 there were 31,528 walks undertaken in Worcestershire as part of the Health Walks programme[14] and there are approximately 280 volunteer walk leaders without whom these would not be possible.[15] However, these programmes have yet to operate at scale, and a vision for every public place to be a starting place for a volunteer leader led health walk is far from being realised. **Further work with partners and communities could make a significant improvement here,**

---

[9] 7 Benefits of Green Infrastructure: Report by Forest Research (October 2010).

[10] Natural England, 2011. Nature Nearby; Accessible Natural Greenspace Guidance.

[11] Respondents are asked to indicate how many visits they have taken to the natural environment in the last 7 days.

[12] https://www.sportspartnershiphw.co.uk/activities

[13] http://www.worcestershire.gov.uk/info/20239/walks_and_rides/1013/health_walks/1

[14] Data does not refer to individuals rather number of walkers at all walks.

[15] Walk leaders active in Q1 2018.

with GP surgeries, schools, and parks being well-placed to support increased activity.

Air quality

Air pollution is a serious public health issue, contributing to around 40,000 deaths each year in the UK. Defra also estimates that nitrogen dioxide (NO2) contributes to shortening lives by an average of around 5 months – ranging from healthy individuals experiencing negligible effects to susceptible individuals whose poor health seriously deteriorates due to NO2 pollution. Around 1/3 of people in Worcester City and Wychavon are currently living in areas with high levels of NO2. Modern day air pollution is largely invisible and is predominantly caused by emissions from road vehicles – figures for car use are given in the following section.

Air pollution is associated with a number of adverse health effects across the lifecourse, contributing towards respiratory infections and asthma in young children, worsening long term conditions such as respiratory diseases, and exacerbating conditions such as heart disease and diabetes. Although air pollution affects everybody, its effects disproportionately affect children, older adults, those with existing health conditions and the most disadvantaged people within Worcestershire.

Local authorities have a range of powers which can be used to improve air quality, including effective and active monitoring of air pollution at a local level, declaring air quality management zones, restricting transport, smoke control areas and placing restrictions on environmental permits and planning. In Worcester City, interventions to promote improvements in air quality are being made across the district and appraisals are currently being made around suitable interventions which will help to improve air quality, which will benefit the health and wellbeing of people living, working and visiting Worcester City.

Further work should be considered to improve poor air quality across Worcestershire and mitigate its effect on health. This could include the analysis of rates of admissions for respiratory and cardiovascular diseases alongside air quality monitoring data, as recommended by the Chief Medical Officer. This would enable fuller understanding of the local health impact of poor air quality and support new interventions for prevention.[16]

Active and integrated travel

Sedentary lifestyles are a significant risk factor for many physical and mental illnesses. Promoting sustainable and active travel has the potential to bring significant physical and mental health benefit for individuals as well as a wider societal benefit by improving social cohesion, and improving air quality.

Around 69% of people in employment drive to work in cars or vans in Worcestershire (more than 190,000 people), 10% walk to work, 5% use public transport, and 5% are a passenger in a car or van.[17] Car use is sometimes a necessity in rural parts of Worcestershire, but also provides many benefits in terms of providing convenient access to services, leisure opportunities and jobs, but often results in a decrease in active forms of travel such as walking and cycling, and contributes significantly to our increasingly sedentary lifestyles and physical inactivity.

A significant shift in travel choices requires decision makers to take action in a number of ways, including: Councils using health impact assessments in planning to maximise

---

[16] https://www.gov.uk/government/publications/chief-medical-officer-annual-report-2017-health-impacts-of-all-pollution-what-do-we-know

[17] ONS. NOMIS. QS701EW – Method of travel to work, 2011 Census.

opportunities for promoting active and sustainable travel, developing cycling and walking infrastructure across the county; investing in cycle training and subsidised cycle ownership schemes and employers and schools developing sustainable travel plans, including implementation of Cycle to Work Schemes.

Healthy schools and colleges

Childhood is key in determining adult health and well-being and we need a strong focus on making sure that our colleges, schools and nurseries are health promoting places. In Worcestershire, many of our children are overweight or obese, and concerns about their mental health continue. Robust evidence shows that interventions taking a "whole school approach" have a positive impact in relation to outcomes including: body mass index (BMI), physical activity, physical fitness, fruit and vegetable intake, tobacco use, and being bullied.

A whole school approach is one that goes beyond the learning and teaching in the classroom to pervade all aspects of the life of a school including:

- culture, ethos and environment: the health and wellbeing of students and staff is promoted through the 'hidden' or 'informal' curriculum, including leadership practice, the school's values and attitudes, together with the social and physical environment
- learning and teaching: using the curriculum to develop pupils' knowledge, attitudes and skills about health and wellbeing
- partnerships with families and the community: proactive engagement with families, outside agencies, and the wider community to promote consistent support for children and young people's health and wellbeing.

'Healthy schools', 'health promoting schools' or "mentally healthy schools" approaches are used by some schools to help translate the whole-school approach into practice and to enhance health and educational outcomes of their pupils, but these are not yet evident at scale across the County.

Schools and colleges are well-placed too to focus on emotional health and wellbeing and here Personal Social Health and economic (PHSE) teaching is of great significance. This is a non-statutory subject, but the great majority of schools choose to teach it because it makes a major contribution to their statutory responsibilities to promote children and young people's personal and economic well-being; offer sex and relationships education; prepare pupils for adult life and provide a broad and balanced curriculum. A strong PHSE delivery is a key part of the prevention agenda, and one which is often not given high enough profile outside or inside schools. Ofsted review of PSHE found that the quality of PSHE education is not yet good enough in a sizeable proportion of schools in England The evidence for the impact of

- well-delivered PSHE on pupil's life chances is strong;
- their first sexual activity occurs later and they are more likely to report abuse and exploitation; Experts see PSHE education as the best way to promote the safe use of technology and address online abuse;
- they reduce risk-taking behaviours such as drug or alcohol addiction and improves diet and exercise levels, increases positive outcomes relating to emotional health;
- reduces stigma and helps pupils learn where to go if they have mental health concerns;
- has a positive impact on academic performance and life chances; boosts the employability of school-leavers; improves social mobility.

Sex and relationship education (SRE) is an important part of PSHE education and currently being consulted on in terms of compulsion through legislation. Ofsted have and there is currently a public consultation on extending the compulsory elements through regulation. Effective SRE is an essential part of preventing problems around relationships and sexual behaviours, yet Ofsted found a lack of high-quality, age-appropriate sex and relationships education in more than a third of schools.

Schools can shape good health and well-being by becoming health promoting settings, but they also have a key role in the wider determinants of health through their impact on educational outcomes. Education is a key marker for wellbeing and is positively associated with a range of outcomes in adulthood, including high income, low morbidity, and low involvement in crime. We know inequalities exist right from the very start of school, and the percentage of children with free school meal status achieving a good level of development at the end of reception is only 49.3% here, which is the second lowest rate in the West Midlands.

The place where children and young people spend their learning time gives a key opportunity for health improvement, nurturing their physical and mental health, and enabling them to maximise the benefit of the education offer, which brings lifelong health benefit. **As a County, more can be done at scale to make sure that all our educational settings are places where good health and well-being is maximised , and that all staff who teach in the important area of PHRE have a strong community of practice to enhance their work.**

Healthy workplaces

Employment in terms of having a job is a primary determinant of good health, impacting directly and indirectly on the individual, their families and communities. However, workplaces themselves can be a key health setting, as a place for employees to develop and be supported in healthy ways of living and working. Healthier, active and engaged employees are more productive and have lower levels of sickness absence. which brings business benefit as well as benefit to individual health. Nationally, the main causes of sickness absence are mental health and musculoskeletal problems, and both of these are amenable to change in the workplace. NICE estimates that the net benefit to employers of implementing interventions to promote the mental well-being of employees ranges from £130 to £5,020 per participating employee through reductions in presenteeism and absenteeism. (PHE 2016, Local Menu of Preventative interventions p.26).

In Worcestershire, the 'Worcestershire Works Well' scheme, supports businesses through an accreditation programme to improve employee health. Although the scheme evaluates well with those who are accredited, only 86 businesses across Worcestershire are engaged compared with 27,000 local workplaces in the county. Business partners across the County could do more to create healthy workplaces, so that the time staff spend at work brings positive health benefit, and **I would recommend that further efforts are made to promote employee health schemes in particular, with a focus on smaller businesses who employ predominantly routine and manual workforces, where health outcomes are poorest.**

Enabling people to help themselves, their families and their communities

Enabling people to help themselves and their communities lies at the heart of a refreshed approach to prevention. Over time, people have become increasingly passive recipients of services and their capacity to solve their problems themselves has been diminished. Social change has meant families are often dispersed nationally and internationally, and are of a different structure than in the past. There is also evidence that services either fail to reach the people who need them most, or fail to target the service itself to meet the needs of those people. For example, Black and Minority Ethnic people in Worcestershire are more likely to make use of emergency services than are white people (47% of all hospital admissions to people with an Asian ethnic group were an emergency, compared with 35% of all hospital admissions to people with a white ethnic group, and 35% of all emergency hospital admissions were to BAME groups).

Prevention means making sure that ill-health is avoided and good health is maximised. It also means making sure that everyone knows about healthy lifestyles; how to use services well; how to recognise signs and symptoms of ill-health; when to access services; how to manage self-care in the longer term; and how to support others when they need it. However, this is harder for some people that others and it is now well-evidenced that an asset based approach can bring real improvement in this area. This approach relates to both individuals and to their communities, and is rooted in building on assets that already exist, rather than applying a 'deficit model' which will result in increasingly heavy use of services. In time, more resilient communities will be built up, which are better able to meet the challenges of 21st century lives.

Engaging with communities to build their health assets

In a recent Worcestershire 'Viewpoint' survey, 50% of respondents agreed that the community needs to share more responsibility for the health and well-being of people with health and social care needs, however the evidence is that many people do not participate in keeping healthy and most are making greater use of local health and care services than ever before. . Whilst there is some use of asset-based approaches across the county, more can be done by all partners to strengthen this approach.

Community health assets have four domains which focus on bringing people together with the support of all sectors, to build resilient communities with informed residents who can help themselves and each other in ways that will impact positively on health and well-being:

In Worcestershire only approximately half of adult social care users (49.7%) and two-fifths of adult carers (38.4%) said they had as much social contact as they would like[18]. There is much more to do to prevent and deal with loneliness, which is becoming one of the most significant avoidable health burdens here and across the Country. The quality and quantity of social relationships affects health behaviours, physical and mental health, and risk of mortality. Social isolation and loneliness affect people in every age group, social class and ethnic group. Loneliness is perhaps more common than expected, with up to 80% of those under 18 years, and 40% of adults over 65 years reporting being lonely at least sometimes. Loneliness gradually decreases through middle adult years, but then increases in older age.

However, certain people or groups may be more vulnerable to social isolation than others, depending on factors like physical and mental health, level of education, employment status, wealth, income, ethnicity, gender and age or life-stage.

Although many people do have friends and good neighbours, many do not, and the Reconnections service in Worcestershire, innovatively funded through a Social Impact Bond with joint funding from the CCG and the County Council, is showing promise in connecting isolated people with their local communities. It relies on a model of recruiting and training volunteers, who then maintain their own community links, preventing their own social isolation in due course.

Volunteer and peer roles are important in the context of community centred approaches. The right types of opportunities help to enhance the ability and capability of individuals to provide advice and information in their communities. This may also extend into supporting or organising activities around health and well-being. Through actively promoting volunteering through asset-based approaches, communities are benefited as well as the volunteers themselves. This is demonstrated through higher ratings on the measures of life

[18] Respondents to the 'Adult Social Care Survey' and 'Personal Social Services Survey of Adult Carers' (2016/17).

satisfaction, happiness, and feeling that the things they do in life are worthwhile compared with those who do not volunteer.

There are numerous opportunities across the county to increase volunteering and improve the way people are paired with opportunities and encouraged to participate. Front line services, particularly through social prescribing, are encouraged to consider the benefit of promoting volunteering to the people, patients and public that they interact with.

Public services and third sector organisations need to scale up the asset-based and participatory approach to building confident and connected communities, where all groups, but especially those at highest health risk, can access social support and social networks, have an input in shaping services and are able to participate in community life.

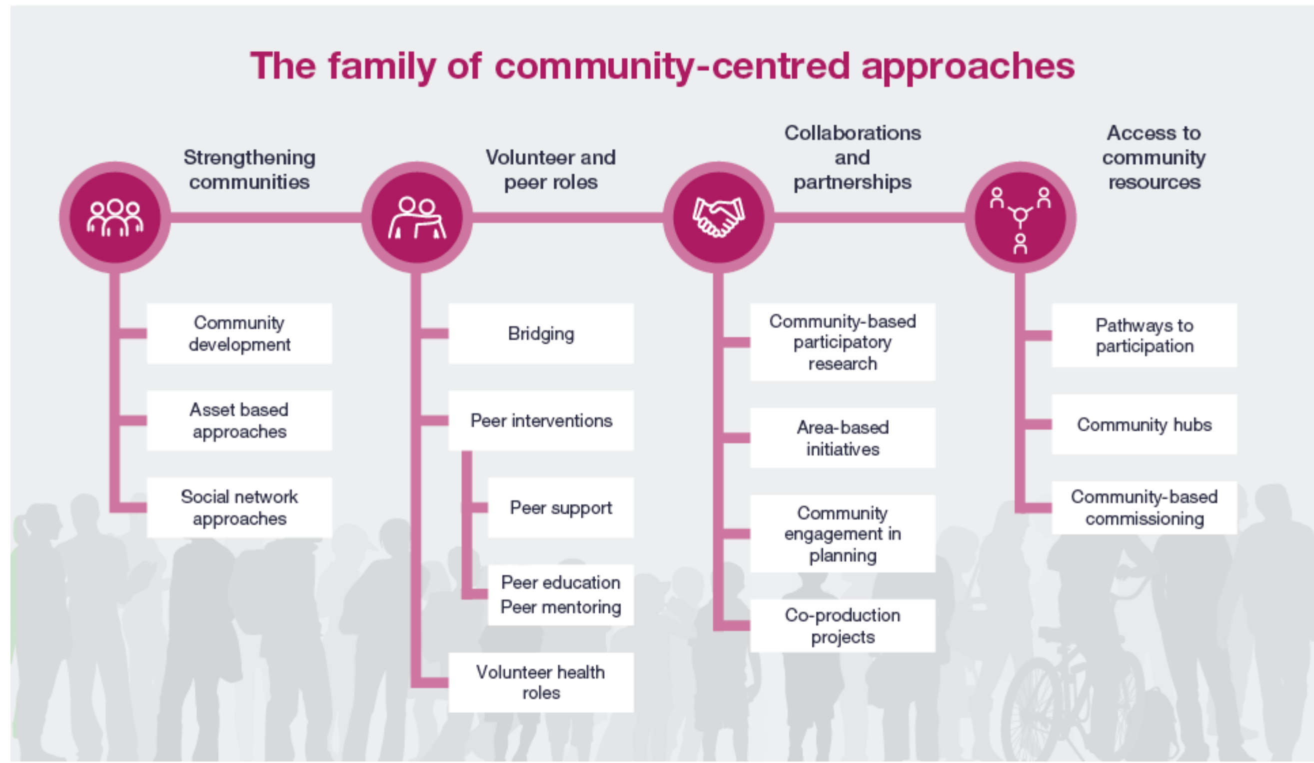
Front line staff training

Specific staff training is needed in community centred working, as patients are increasingly looked after as close to home as possible and it becomes even more important that health and care staff have new learning about community centred approaches, and are able to contribute to building resilience in a way that will prevent ill-health in the future. **Specific staff training is needed in community centred working.**

Public Health England guidance on community-centred approaches to improve health and well-being[19] makes the case for investing in community- centred ways of working and groups approaches into a framework of four families:

- Strengthening Communities – including: community development, asset based approaches, social action and social network approaches.
- Volunteer and Peer Roles – including bridging roles such as: health trainers, peer support and volunteer health roles.
- Collaborations and Partnerships – including: community-based participatory research, area-based initiatives such as healthy cities, community engagement in planning and co-production (a term used to describe engaging community members and service users as equal partners in service design and delivery).
- Access to Community Resources - including approaches that improve pathways to participation such as: social prescribing, community hubs and community-based commissioning.

[19] Public Health England (2018) Health matters: community-centred approaches for health and wellbeing. Available at: https://www.gov.uk/government/publications/health-matters-health-and-wellbeing-community-centred-approaches/health-matters-community-centred-approaches-for-health-and-wellbeing



Citizen training in health and digital literacy including as health champions

It is important that people are enabled to help themselves and others through specific face-to-face or group training, as well as through the wider community resilience work. Training in health can include specific topics such as CPR, living with dementia, suicide prevention, and well-being, and it can also mean joining self-help groups, often with the involvement of peer supporters.

Currently in Worcestershire, there are a number of opportunities for this kind of training, but these are not yet available systematically across the County and have very variable, and typically low, take-up. **This is an area for system action**. For example, adults newly diagnosed with diabetes need to acquire a large range of new skills and knowledge, such as how to manage their insulin therapy. In 2016/17 across all three Worcestershire Clinical Commissioning groups the percentage of people newly diagnosed with diabetes who attended a structured education programme was low. The percentage of people offered the programme ranged from 78.2 to 88.8% but the percentage of people who actually attended ranged from 0.9 to 5.6%. More recently, a Pre-Diabetes Prevention has been set up, as part of a national initiative, but again far less than half of the people who are invited to complete the course do so.

There are estimated to be around 8,000 people with dementia in Worcestershire and this number is projected to increase to nearly 14,000 by 2030. **'Dementia Friends'** training encourages people to change their perceptions of dementia and to act in small ways to help. Individuals and organisations are encouraged to sign up to become a 'Dementia Friend' or 'Champion' in order to improve the environment in which people with dementia can live. Numbers here are encouraging, but again more could be done to encourage greater take-up.

Time to Change Champions are people with lived experience of mental health problems who campaign to end mental health discrimination in their communities. Champions use their experience of mental health problems to change the way people think and act about mental health. As part of the recently established Worcestershire Time to Change hub, champions are being recruited across the county to run activities, share their stories, and initiate conversations about mental health in everyday interactions. So far, 51 individuals have signed up to the Champions database, and a variety of activities are being planned across Worcestershire.

Clear information and advice (usually digital)

In order to enable people to help themselves and their communities, they need access to reliable and easily accessible information. Again, there is a pattern of variation in availability across the County, and no systematic approach to the core offer. The best information is available on-line, through NHS sites such as NHS Choices which is the gateway to national and local information, and through Council sites such as Your Life Your Choice, which usually also have easy-read material. However, an estimated 50,000 people in Worcestershire are considered to be 'digitally excluded' – because they do not have the skills and confidence, or the equipment necessary, to access online resources. This creates an inequality which needs strong action as we move to digitalizing the NHS and other public sector services more generally. The NHS is changing quickly to maximize its use of on-line booking, virtual consultations, self-care on line resources, and tele-health and we must make sure that this can benefit the current population of digitally excluded people.

The Go On Worcestershire Partnership was established I 2014 to provide targeted local training and support to enable as many people as possible to have the opportunity to go confidently on line. Digital champions have been trained through the partnership, to support others in safe use of the internet, but there is considerable scope for more recruitment and for active identification of other places where training of volunteers and supported internet use are possible.

Hundreds more resources and websites exist in addition to those listed, which can seem fragmented and it can be difficult to find the right (and robust) information. **Providing a clear and joined up set of resources is important to help deliver improved health and wellbeing for the people of Worcestershire. It would be timely to give this area some early attention, including working with residents, so that a core set of reliable information sources is easily accessible.**

There are already local libraries, and they have the potential to be places where people meet, and find out more about their health and local community networks and activities. Libraries are sites of adult learning in digital training, and are places where there is free and supported access to the internet. As their role in accessing digital advice grows, some people will continue to want to read books which are valued by professionals. The local library based Books on Prescription scheme has collections on topics such as dementia, carers, child and adolescent health, mental health, and being a parent, and NHS staff are able to direct patients to the resource, using a 'prescription pad.' A total of 7,847 books were borrowed through the books on prescription scheme in 2017-18.

Again, a more systematic approach could be used to ensure that all libraries contain a core stock of relevant titles and more volunteers could be recruited to support people to navigate the health websites.

Supported information and advice for those who need it for example by social prescribing and community and health navigators, making full use of partner organisations.

Although, for many people, books and on-line resources are enough, there is evidence that relying on this method has tended to exclude people who need services the most. For these people, new ways to engage are needed. This again requires a shift in thinking, and the willingness to be innovative.

Early progress is being made in social prescribing, which is a priority for health services locally, and is embedded in the developing social work focus too on assets based practice. Social prescribing is based on GPs, nurses and other health professionals referring patients where appropriate to non-clinical services. This recognises that health is determined by a range of social, economic and environmental factors, and social prescribing links people with non-medical support to address their non-clinical needs. It also aims to support individuals to take greater control of their own health. Patients who are referred to a social prescriber will assess their needs, from money worries and relationship difficulties, to social groups to tackle isolation. The type of support varies widely, from employment and skills to health walks. An evidence review which looked at the impact of social prescribing on demand for healthcare found an average of 28% fewer GP consultations and 24% fewer A&E attendances where social prescribing 'connector' services are working well[20]. There are currently six pilots running across Worcestershire to test the effectiveness of social prescribing which includes 44 practices. As of May 2018, 152 people have been seen by a social prescriber and there are early signs of positive take-up by health professionals. **There is significant opportunity in Worcestershire to scale up social prescribing to reach more people who could benefit.**

Community navigators are typically local people who have been trained in understanding what services are available and who are able to give this information informally to others. I Worcestershire, small scale projects have taken place but have not been sustained, although people who received advice in this way found it helpful. Evaluations found that there were difficulties in linking navigators to the populations they were trained to inform, without an infrastructure of community organisation.

Health navigators are trained NHS staff, typically in public facing roles such as reception, who can assist patients to use existing health services well. They have a particularly useful role for those patients who tend to make use of emergency services rather than taking a more planned and appropriate approach. A pilot scheme is underway in part of the County but again there is not yet a County wide approach.

The Voluntary and Community Sector (VCS) has a particularly strong role in the provision of supported advice and information, and Worcestershire has a well-developed VCS with many local and national organisations being available for our residents. **However, as with the state sector, budgets are under pressure and there is a need to work together to ensure that communications between sectors are optimised so that referral pathways and priorities are shared. It is clear that investment priorities for prevention must include consideration of the sustainability of the VCS, and that a County-wide approach to investment is needed.**

Other partners too, in particular Fire and Rescue and the police, have a clear route into populations who can be hard to reach and there is scope for more joined up work with our partners on helping people to help themselves. There is already work in place with Fire and Rescue, building on their routine home safety check, which is being evaluated and, if effective, requires a County wide approach.

[20] Polley, M. et al (2017). A review of the evidence assessing impact of social prescribing on healthcare demand and cost implications. Available at: https://www.westminster.ac.uk/patient-outcomes-in-health-research-group/projects/social-prescribing-network

Developing effective prevention services

Prevention is better, and cheaper, than cure, but this does not mean that prevention services are not needed. We now have a clear knowledge base about what works, and this means that we can be hopeful of improving the health outcomes presented here and in the Joint Strategic Needs Assessment However, investment across the County has not yet been systematic or consistent, and the reach of services continues to vary according to where people live and their ability to access services. It is known that the hardest to reach populations can find it hardest to benefit from services, and this is a significant cause of health inequalities. There is an important role for co-production here, working with the people who will use the services to make sure that they are accessible and relevant, and will maximise impact. **Although there is a strategic commitment to co-production locally, many of these prevention services have not yet seen significant engagement of users in service planning and this is an opportunity for change.**

In the rest of this report, I summarise core prevention services which are known to work and, which, if delivered at scale and taken up by their target populations, would prevent much of the avoidable burden of ill-health. These are the services which it is the duty of the NHS and local government to provide, but which can still be improved in terms of reach, take-up and investment.

Front line staff training

Staff are currently working harder than ever before, with reducing budgets, more complex caseloads, and increased public expectation. The key front line training for staff to impact on prevention is Making Every Contact Count, a training package to enable staff to have an informed and motivational conversation with their patients and service users about healthy lifestyles. This training is readily available on line, but staff need to also receive face to face training, so that a change in their practice can be supported. It is known that staff face barriers to implementing the giving of lifestyle advice. They feel they have not been trained to do so; that they are acting outside their area of practice; and they are loath to give advice that they themselves may not follow. However, the changing population means that most patients will have unhealthy lifestyles and that advice can be given which will improve health, and so delivering the 'Making Every Contact Count' (MECC) messages become part of the core duty of the health and care professional in the 21st century.

Intervening at scale is important to achieve population-level behaviour change. Brief interventions by front line staff are an important component of prevention at scale, through helping people to change their behaviour and habits. The delivery of brief interventions and signposting by frontline staff has been shown to be both effective and cost-effective in supporting people to reduce their tobacco and alcohol use, and in improving their physical activity levels and diet.[21] MECC is the principle programme to help guide brief intervention conversations, with training available online for the NHS, University of Worcester clinical students and other organisations.

[21] NICE guidance 'Behaviour Change: individual approaches' PH49. Available at: https://www.nice.org.uk/guidance/ph49.

Universal services from pre-birth for young people (0-19 services)

The evidence base demonstrates that events occurring in early life affect health, well-being and outcomes in later life and children's life chances are most heavily predicated on their development in the first five years of life.[22] Positive early experience is vital to preventing problems in later life. Before and after the birth of their child, there is a key 'learning moment' when parents have contact with services and are especially receptive to advice. A number of services help to support during this critical period, including midwifery, school nursing, health visiting and immunisations and screening, all with a focus as universal prevention services:

Health visitors lead a key prevention service, identifying problems early and dealing with them rapidly when they do occur. The Healthy Child Programme includes 5 key checks of children, and although uptake is high, it is important that no one is missed out. In 2016/17, 5,653 (94.5%) received a face to face new birth visit by a heath visitor within 14 days, 5,779 (99.3%) received a 6-8 week check and 6,109 (96.4%) received a 12 month check in the correct timeframe. At the 2-2½ year check, an 'ages and stages questionnaire' should be used by health visitors to measure child development and in 16/17 91.6% children in Worcestershire received this as part of this check.

Immunisations and screening are available in pregnancy and after birth and form an important part of the universal prevention offer. Yet many children remain unvaccinated and at risk of serious preventable illness in Worcestershire. For example, 94.3% of children received vaccination against diphtheria, tetanus, pertussis, polio and haemophilus influenzae type b in 2016/17 leaving 5.7% at risk, and MMR vaccination was received by 94.5% of 2 year olds in 2016/17, leaving 5.5% unvaccinated and at risk.

Universal services for children support women to breastfeed. Breastfeeding is an important part of giving children the best start in life, preventing and reducing a number of health risks and associated with improved maternal outcomes such as reduced obesity. In Worcestershire the rates of breastfeeding initiation are below the national average (66.7% vs 74.5%) and this indicator shows a worsening trend. However, Worcestershire is better at supporting breastfeeding once it has been started. Data shows that at 6-8 weeks of age the percentage of infants being totally or partially breastfed is similar to the national rate (45.6% vs 44.4% nationally). **There is more to do in supporting women to start breastfeeding, and to finding new ways to reach the minority of children who do not receive universal services. Midwifery has an important role in both these areas, and we have more to do in linking the contributions from the different professional groups so that the contribution of midwifery to improved outcomes is maximised.**

Targeted services for those parents and children who need them most

The data shows persistent inequalities in health outcomes for children and young people. There is evidence that an approach based on progressive universalism will work best, providing services for all, and a targeted offer to reach those who need a different level of service.

[22] https://www.gov.uk/government/publications/health-matters-giving-every-child-the-best-start-in-life/health-matters-giving-every-child-the-best-start-in-life

Currently, key targeted services are in place in Worcestershire, but are not yet delivered to all who need them. Targeted services for parents and children include:

- Perinatal mental health programmes: During the perinatal period in 2015/16, between 575 and 860 women are estimated to have experienced mild-moderate depressive illness and anxiety, whilst 175 are estimated to have experienced severe illness.
- Parenting programmes: In Worcestershire between November 2016 and June 2018, there were a total of 1034 referrals for parenting support. At district level there is a variation of rates in referrals for parenting and young person support. Only approximately 50.6% (n.530) of referrals are from the 40% most deprived Super Output Areas (SOAs) across Worcestershire.
- Child and adolescent mental health services: In 2015, 8.8% of children between the ages of 5 and 16 in Worcestershire were estimated to have a mental health disorder (6,743 children in total).[23]
- Stop smoking in pregnancy service: In 2016/17, 626 women in Worcestershire were recorded at the time of delivery as smokers, representing 12% of maternities.[24]

Universal services for all adults

Screening and Immunisations

Screening is an upstream intervention that looks for signs of future disease. Screening programmes are set up as equitable programmes, being available to everyone in a given population. However, uptake of screening programmes is not the same across different groups of people – and generally people who are in higher socio-economic groups are more likely to receive screening than those in lower socio-economic groups. **People with special needs, such as learning disability, can find it particularly difficult to access screening services and more needs to be done to address this.**

This is seen nationally in breast screening, where 68.5% of women who live in the most deprived 10% of areas receive screening in comparison with 77.1% of women who live in the least deprived 10% of areas. In Worcestershire, rates of breast cancer screening are better than England average with 79.2% (56,869 women) receiving screening in 2017. However, there are differences in breast screening coverage between Worcestershire districts, for example, Redditch a relatively deprived area, has a lower screening coverage at 74.7% than Bromsgrove a relatively less deprived area at 82.6%[25].

There are a number of immunisation programmes too which are available as prevention measure against particular diseases. In Worcestershire, flu vaccination for at risk individuals under the age of 65 was significantly higher in Worcestershire than the national average in 2017/18 (38,000 people vaccinated - 52.9%), but remains below the national target value of 55%. However, there is evidence of low flu vaccination amongst people with learning difficulties (38.5% in Redditch and Bromsgrove, 41.1% in South Worcestershire, and 46.4% in Wyre Forest). This suggests significant unmet need and is likely to contribute to health inequalities. **Promoting uptake of flu vaccination for this group is therefore important, as is maximising uptake of the whole immunisation programme.**

[23] Public Health England. Children and Young People's Mental Health and Wellbeing Profile.

[24] Public Health England. Child and Maternal Health Profile. Calculated by PHE from the NHS Digital return on Smoking Status At Time of delivery (SATOD).

[25] Public Health England. Public Health Outcomes Framework. 2.20i - % of eligible women screened adequately within the previous 3 years on 31st March; 2017

NHS Health Checks

NHS Health Checks are one of the largest prevention programmes in the world. These checks, for those aged 40-74, are designed to spot the early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia. Eligible people are invited at five year intervals and checks consist of questions about family history and lifestyle, and measurement of height, weight, blood pressure and cholesterol. These, together with information on age, gender and ethnicity, are used to calculate a risk score which quantifies a person's risk of developing a heart or circulation problem over the next 10 years. If a person's risk score is in the higher range, they may be given lifestyle advice to help reduce their risk and/or prescribed medicines to lower cholesterol. They may also be asked to come back for more tests to check for high blood pressure, diabetes or kidney disease.

Since implementation of the Health Checks Programme, a good start has been made but too many people are still not taking up the offer of a Health Check – whilst 16,200 people received a Health Check in 2017/18, 60% of people did not take up their invite.

Uptake also varies between areas, genders and ages. Increasing uptake through targeting low uptake groups (especially in disadvantaged areas) would have an important impact on avoidable disease burden. This is pertinent to reducing health inequalities, as premature death rates from cardiovascular disease in the most deprived 10% of the population are nearly twice as high as rates in the least deprived 10%.

Providing advice and recommendations to patients is an important part of the NHS Health Check. Alcohol identification and brief advice (IBA) forms part of the NHS Health check, and can reduce weekly drinking by between 13% and 34%, resulting in 2.9 to 8.7 fewer drinks per week. This is an effective way of reaching people who may not yet have identified that they drink too much. **More should be done by commissioners and providers to increase uptake and impact of the NHS Health Checks programme.**

Diabetes Prevention Programme

In 2016/17 34,803 people over the age of 17 had a recorded diagnosis of diabetes in Worcestershire – this is 79.1% of people who are estimated to have diabetes in Worcestershire, therefore 20.9% remain undiagnosed.

There are a number of modifiable risk factors which can increase the risk of type 2 diabetes. One significant risk factor is excess weight and 62% of adults in Worcestershire are currently classified as overweight/obese. The Healthier You: NHS Diabetes Prevention Programme (NHS DPP) identifies those at high risk by confirming non-diabetic hyperglycaemia and refers them on to a tailored behaviour change programme using a health coaching approach as well as individual and group support.

This national programme has a strong evidence base for impact, and locally the data so far suggest that the system is able to identify those at highest risk of developing diabetes. **However, uptake of the programme remains variable and there is more to do to improve the engagement of those who have been assessed as needing the programme, but who are not yet ready to change. Both the Health Checks and the Diabetes Prevention Programmes need an onward referral for those who do find behaviour change hard to manage, and this should be a priority area for our county.**

Falls Prevention Service

Falls are a common and serious health issue for older people. Nationally, around 33% of all people aged 65 and over fall each year – this increases to about 50% of those aged 80 and over. In Worcestershire, there are approximately 2,200 injuries due to falls each year in people over 65, and as a result there are approximately 700 hip fractures throughout the county which cost the health and social care system over £9 million per annum.

The risk of falls increases with age and an ageing population in Worcestershire will lead to greater numbers of people having a fall in the future unless effective interventions are put in place.

Most falls (and associated fractures) are preventable. It is known that group and home-based exercise programmes, usually containing some balance and strength training exercises, effectively reduced falls, as did Tai Chi and that overall, exercise programmes aimed at reducing falls appear to reduce fractures[26]. A falls and fracture consensus statement by Public Health England and National Falls Prevention Coordination Group member organisations states that to be effective, programmes should comprise a minimum of 50 hours or more delivered for at least two hours per week. They should involve highly challenging balance training and progressive strength training. At the end of the programme, older people should be assessed and offered a range of follow-on classes. These should suit their needs and abilities, include strength and balance, and support their progression.

In Worcestershire a Postural Stability Instruction (PSI) programme has been implemented. In 2016/17, 748 people commenced on the PSI programme, of whom 82% attended 3 or more classes, 45% attended 14 sessions, and 23% attended 22 sessions. **Again there is a need to extend investment in the programme, and to increase the % of participants who engage fully with it.**

Evidenced-based weight management services

In 2016/17, it was estimated that 62% of adults in Worcestershire had excess weight. This was a similar rate to the national average of 61.3%. Higher levels of deprivation are associated with an increased likelihood of excess weight. For example, nationally in 2016/17, 67.3% of people who lived in the 10% most deprived areas were estimated to have excess weight compared to 56.7% of people who lived in the 10% least deprived areas. This was a difference of over 10%.

Public Health England advocate ensuring evidence-based weight management services are accessible to the local population and also that these services are integrated with mental health services, NHS Health Checks and the Diabetes Prevention Programme. In Worcestershire, as nationally, there is weak evidence for weight management services, in terms of maintaining significant weight loss. **However, this is an area where further work is needed, to find new approaches to support people to prevent the burden of obesity-associated ill-health. In some areas, a different approach, focussing on mental health and well-being, has been found to be useful, building levels of self-efficacy before specific weight loss can be achieved.**

---

[26] Gillespie LD, Robertson M, Gillespie WJ, Sherrington C, Gates S, Clemson LM, Lamb SE. Interventions for preventing falls in older people living in the community. Cochrane Systematic Review. September 2012.

Conclusions and Recommendations

It is clear that there is still considerable progress to be made in Worcestershire in terms of strengthening our approach to prevention, but this is essential if we are to control the rising burden of preventable ill-health. It is also essential if we are to narrow the health inequalities gap which continues to be evident throughout life, limiting the life chances of some young people, and restricting the quality of life of older ones.

There is strong and clear evidence about the impact of universal and targeted prevention services and these should be further developed, with investment and a focus on increasing uptake and reach. A move to a community assets approach has less clear evidence, but should be further developed and tested locally, and could change the scale and pace of change, bringing a transformational shift towards upstream prevention , empowering people to help themselves and their communities.

The data and discussion here form the building blocks of a new approach. Although detailed recommendations are embedded in the narrative, and highlighted in bold, to achieve these there are four overall recommendations:

1. **To recognise that a refreshed, system approach to prevention will be an investment for a healthier future and a means of improving outcomes and reducing demand**
2. **To work differently with communities, so that people are helped to help themselves and each other through community asset building and a shared approach with our residents**
3. **To work better together across a fragmented and challenged system to sharpen the lens on prevention and take shared ownership of it**
4. **To set up a Worcestershire Prevention Board, to drive improvement in prevention services to oversee development of the community assets approach in our County.**

Compendium of Health Indicators

Introduction

This is the third time in Worcestershire we have produced a Compendium of this sort to accompany the Director of Public Health Annual Report. Once again we have taken a selection of indicators from the Public Health Outcomes Framework produced online by Public Health England. The selection reflects local priorities and important issues either where Worcestershire has rates or numbers that are higher than they should be or that are important to monitor on an ongoing basis.

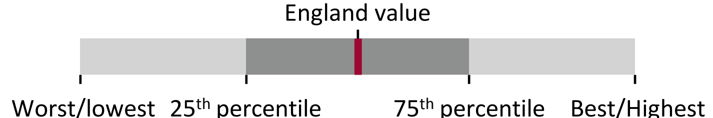
The compendium has been laid out with overarching indicators of life expectancy followed by a life-course division of the indicators. The indicators show the Worcestershire value compared to the national value, with each section a spine chart showing the indicators for that section and then a page for each indicator showing a table and chart of the time-series. The sections are:

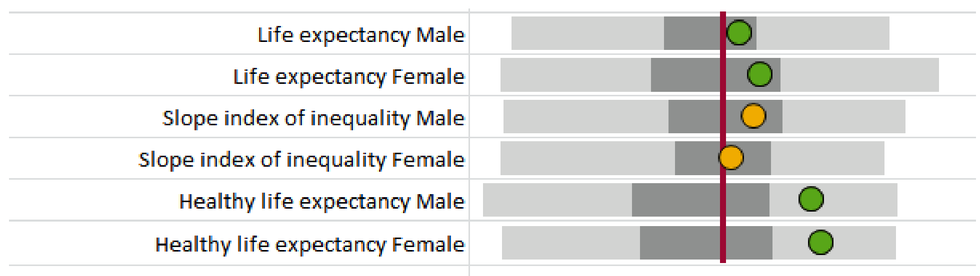
- Overarching indicators
- Conception & Early Years
- Adult Health
- Older People
- Mortality

Summary

- Overall Worcestershire has good health outcomes.
- However until recently there was a general pattern of decreasing gap to England for the life expectancy and premature mortality measures. The latest data seems to suggest that the gap has begun to widen again. Future data releases will help to confirm if this is a sustained positive change.
- Some measures of child health indicate poor outcomes in Worcestershire, especially for the most vulnerable, for example school readiness for those eligible for free school meals.
- In addition smoking in pregnancy and breastfeeding initiation rates are poor.
- In general screening and vaccination rates across the County are good compared to the national rates.
- Rates of domestic abuse and violent crime show increases in the latest year's data although this may be due to better recording rates.
- Most indicators for older people are relatively good, with the exception of fuel poverty.

Overarching Indicators





Significantly better than England   Not significantly different to England   Significantly worse than England

	Sex	Age	Period	Worcestershire Value	England Value	Worst	Best
Life expectancy	Male	All ages	2014 - 16	80.0	79.5	74.2	83.7
Life expectancy	Female	All ages	2014 - 16	83.8	83.1	79.4	86.8
Slope index of inequality	Male	All ages	2014 - 16	7.6	8.5*	14.9	3.2
Slope index of inequality	Female	All ages	2014 - 16	6.2	6.5*	13.9	1.1
Healthy life expectancy	Male	All ages	2014 - 16	66.7	63.3	54.3	69.9
Healthy life expectancy	Female	All ages	2014 – 16	68.0	63.9	54.6	71.1
HLE Slope Index	Male	All ages	2009 – 13	11.8	12.8	24.6	3.8
HLE Slope Index	Female	All ages	2009 – 13	11.5	12.6	22.1	2.8

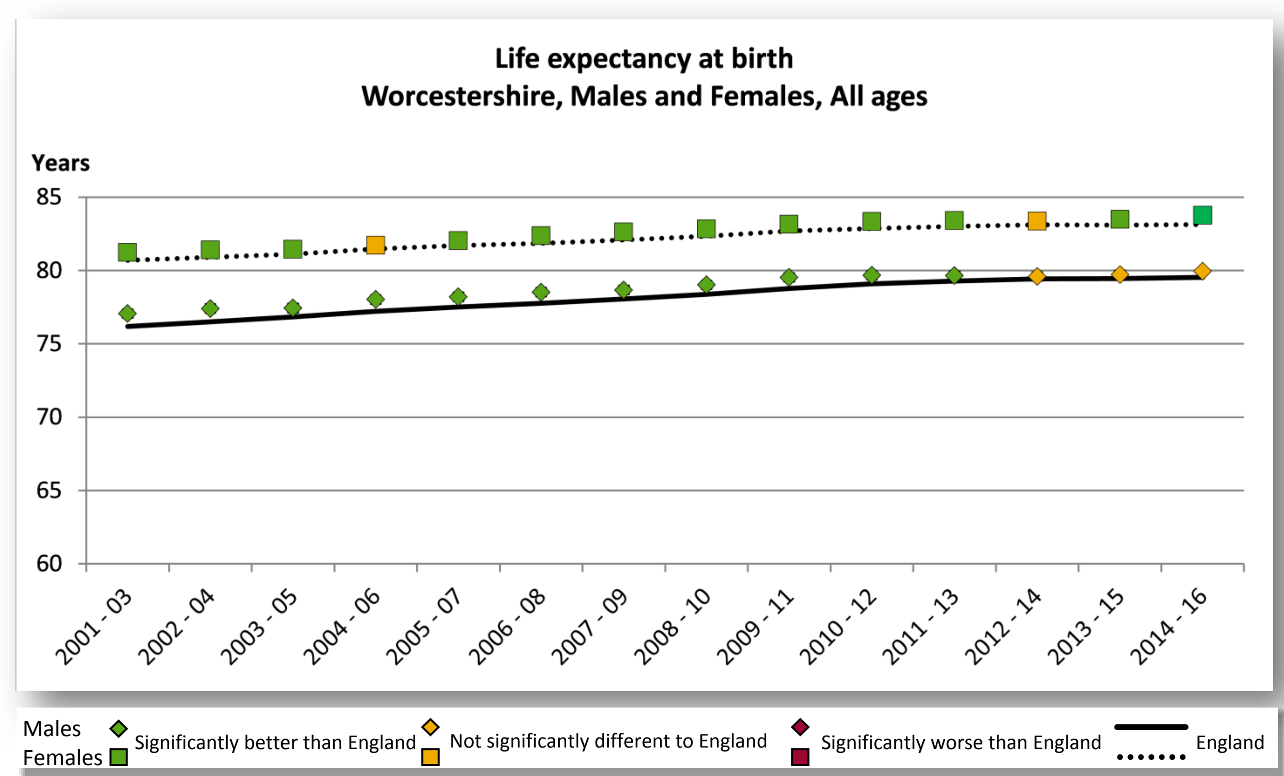
All values measured in years. *Average of all County/UA values

Life Expectancy

- Nationally we have seen steady increases in life expectancy for many decades, however, since 2011 these increases have been slowing down. The same trend has been seen in Worcestershire. However, it is too early to tell if this trend will continue.
- It has always been higher than England, but the gap has narrowed in the period up to 2013-15 and widened again slightly since.

Life expectancy at birth, Worcestershire, Males and Females, All ages (Years)

	Male				Female			
Period	Value	Lower CI	Upper CI	England	Value	Lower CI	Upper CI	England
2002 - 04	77.4	77.1	77.7	76.5	81.4	81.1	81.7	80.9
2003 - 05	77.4	77.1	77.7	76.8	81.4	81.2	81.7	81.1
2004 - 06	78.0	77.7	78.3	77.2	81.7	81.4	82.0	81.5
2005 - 07	78.2	77.9	78.5	77.5	82.0	81.8	82.3	81.7
2006 - 08	78.5	78.2	78.8	77.8	82.4	82.1	82.7	81.9
2007 - 09	78.7	78.4	79.0	78.1	82.6	82.3	82.9	82.1
2008 - 10	79.0	78.7	79.3	78.4	82.8	82.6	83.1	82.3
2009 - 11	79.5	79.2	79.8	78.8	83.2	82.9	83.4	82.7
2010 - 12	79.7	79.4	80.0	79.1	83.3	83.1	83.6	82.9
2011 - 13	79.7	79.4	79.9	79.3	83.4	83.2	83.7	83.0
2012 - 14	79.6	79.3	79.9	79.4	83.4	83.1	83.6	83.1
2013 - 15	79.7	79.4	80.0	79.5	83.5	83.2	83.8	83.1
2014 - 16	80.0	79.7	80.2	79.5	83.8	83.5	84.0	83.1



Data Source: Public Health England

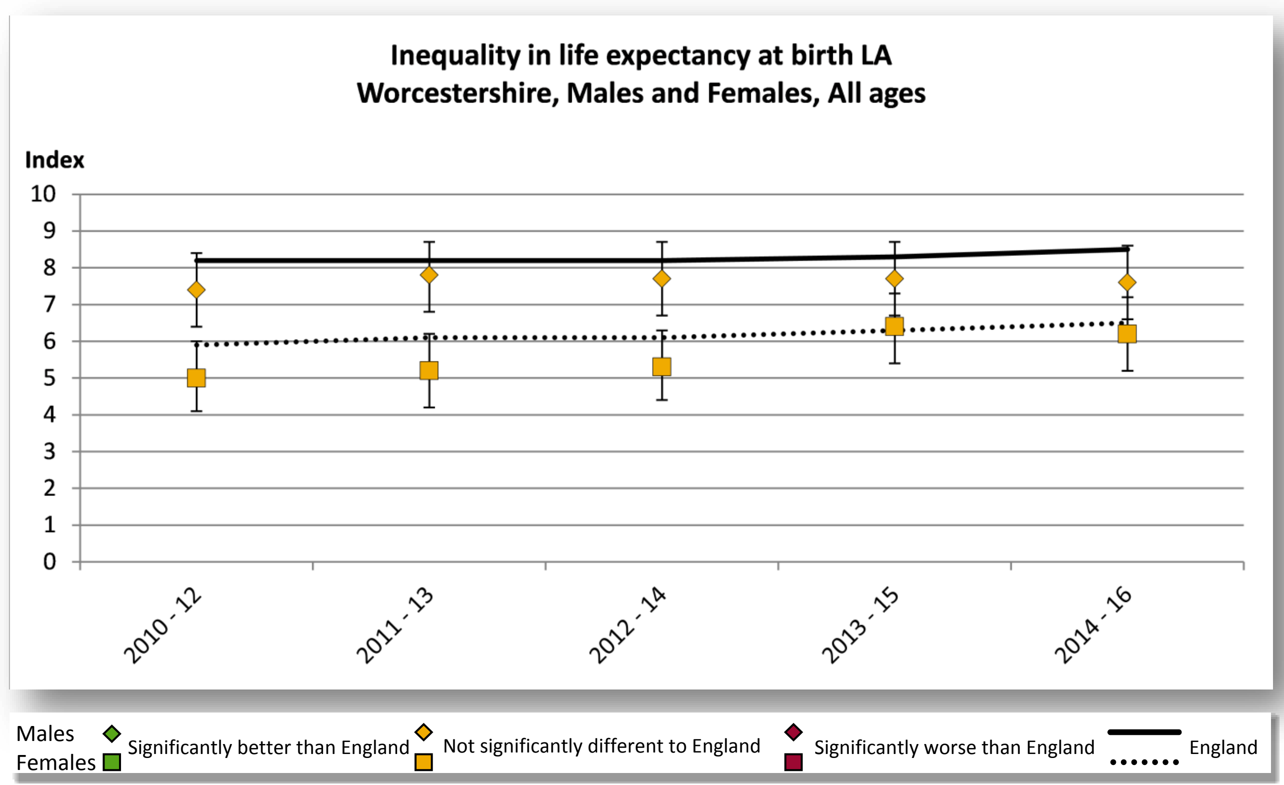
Inequalities in Life Expectancy

- In Worcestershire the slope index of inequality (SII) has increased slightly over time for women, but not changed significantly for men.
- It remains higher for men than for women, but the gap has narrowed slightly.

Slope index of inequality in life expectancy at birth, Worcestershire, Males and Females, All ages (Years)

	Male				Female			
Period	Value	Lower CI	Upper CI	England	Value	Lower CI	Upper CI	England
2010 - 12	7.4	6.4	8.4	8.2	5.0	4.1	6.0	5.9
2011 - 13	7.8	6.8	8.7	8.2	5.2	4.2	6.2	6.1
2012 - 14	7.7	6.7	8.7	8.2	5.3	4.4	6.3	6.1
2013 - 15	7.7	6.7	8.7	8.3	6.4	5.4	7.3	6.3
2014 - 16	7.6	6.6	8.6	8.5	6.2	5.2	7.2	6.5

N.B England value is the approximate UA/County average



Data Source: Public Health England

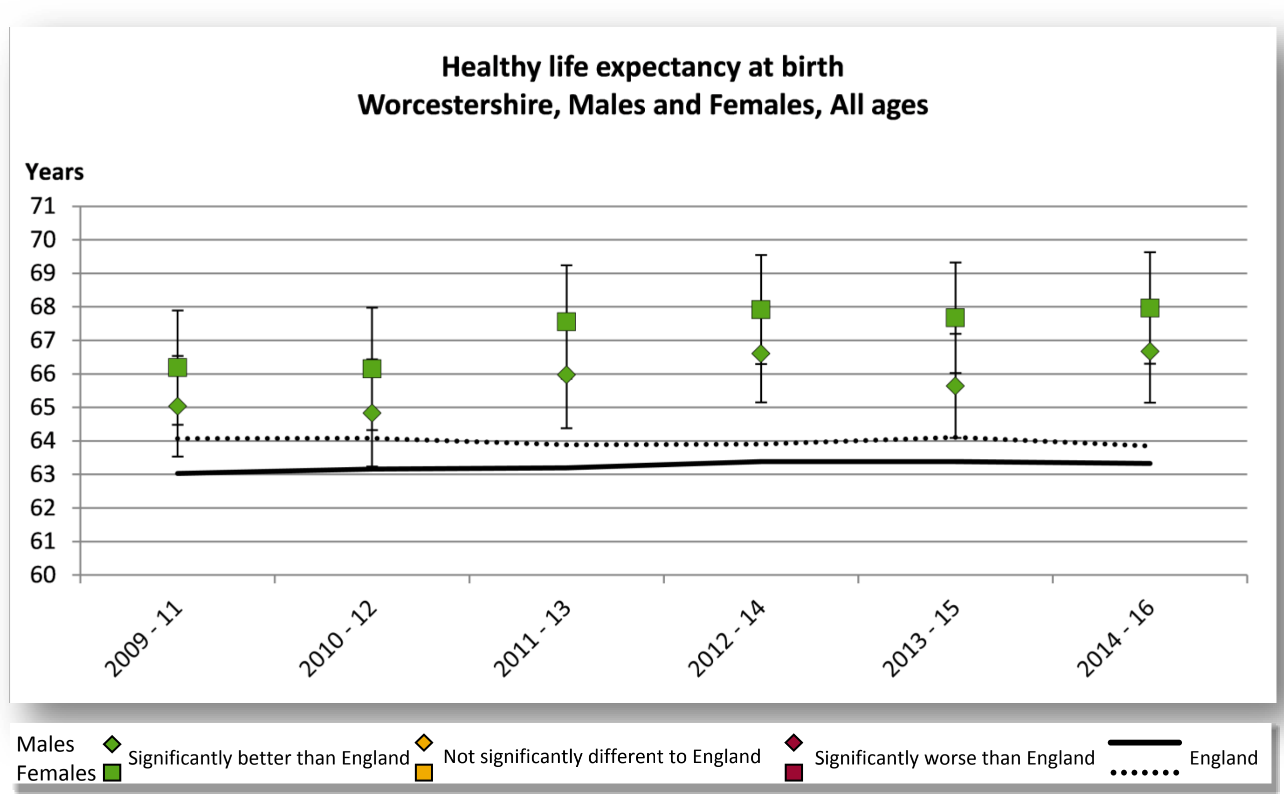
Slope Index of Inequality (SII)
This is calculated by grouping the population into equal groups according to the relative deprivation level of the area they live in and working out the average life expectancy in these groups (usually 10 groups or deciles). The gradient across these groups is the slope index of inequality or SII. The higher the number the greater the relative inequality and an SII of zero means there is no inequality across the groups.

Healthy Life Expectancy

- The gap in healthy life expectancy (HLE) between men and women is much smaller than that for life expectancy.
- Recent years have seen a slight improvement in HLE for females relative to the national average. Male HLE has remained flat both in Worcestershire and nationally.
- In Worcestershire in the period 2014-16 there was no significant change from the previous time period (2013-15).
- The measure of inequality in HLE is only available for one period and showed that Inequalities in healthy life expectancy are similar to nationally. In 2009-13 the slope index of inequality for HLE was 11.8 for males and 11.5 females in Worcestershire (12.8 and 12.6 respectively for England).

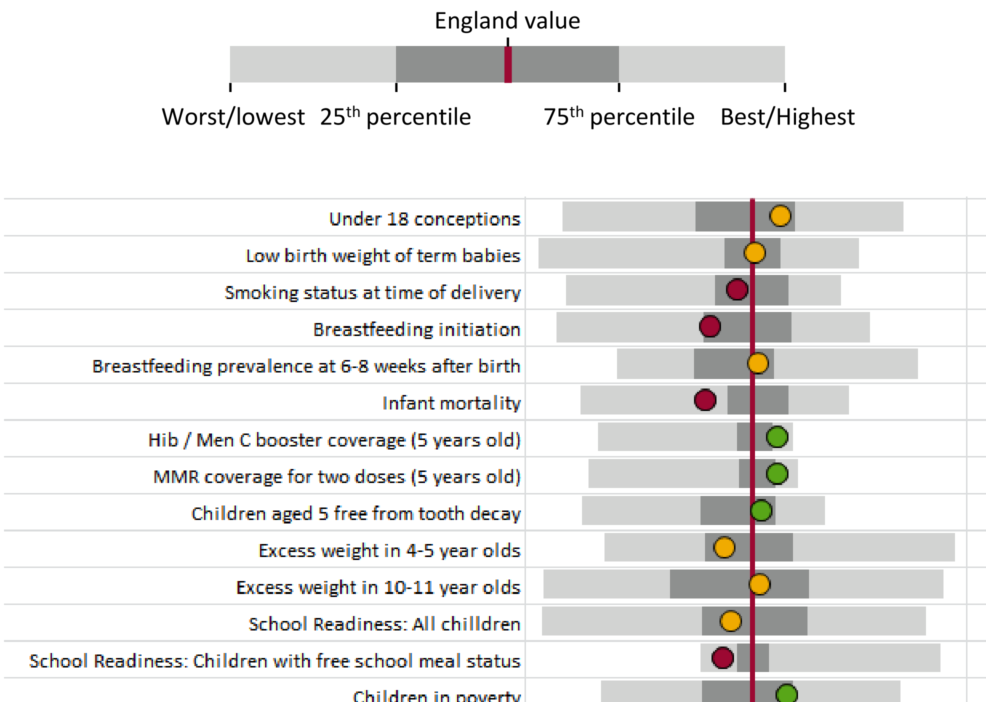
Healthy life expectancy at birth, Worcestershire, Males and Females, All ages (Years)

		Male					Female			
Period		Value	Lower CI	Upper CI	England		Value	Lower CI	Upper CI	England
2009 - 11	◆	65.0	63.5	66.5	63.0	■	66.2	64.5	67.9	64.1
2010 - 12	◆	64.8	63.2	66.4	63.2	■	66.1	64.3	68.0	64.1
2011 - 13	◆	66.0	64.4	67.6	63.2	■	67.6	65.9	69.2	63.9
2012 - 14	◆	66.6	65.2	68.1	63.4	■	67.9	66.3	69.5	63.9
2013 - 15	◆	65.6	64.1	67.2	63.4	■	67.7	66.0	69.3	64.1
2014 - 16	◆	66.7	65.1	68.2	63.3	■	68.0	66.3	69.6	63.9



Data Source: Public Health England

Conception & Early Years



Significantly better than England · Not significantly different to England · Significantly worse than England

	Sex	Age	Period	Worcestershire Count*	Worcestershire Value	England Value	England Worst	England Best
Under 18 conceptions per 1000	Female	<18 yrs	2016	151	16.1	18.8	36.5	4.6
Low birth weight %	Persons	>=37 wks	2016	148	2.7	2.8	5.8	1.3
Smoking status at time of delivery - current method %	Female	All ages	2016/17	626	12.0	10.7	28.1	2.3
Breastfeeding initiation %	Female	All ages	2016/17	3,928	66.7	74.5	37.9	96.7
Breastfeeding prevalence at 6-8 weeks after birth %	Persons	6-8 weeks	2016/17	2,636	45.6	44.4	19.3	75.6
Infant mortality	Persons	< 1 yr	2014 - 16	89	4.9	3.9	7.9	1.6
Hib / Men C booster coverage (5 years old) %	Persons	5 yrs	2016/17	6,080	96.2	92.6	71.1	98.4
MMR coverage for two doses (5 years old) %	Persons	5 yrs	2016/17	5,837	92.4	87.6	57.1	96.2
Children aged 5 free from tooth decay %	Persons	5 yrs	2016/17	2,764	78.2	76.7	52.9	87.1
Excess weight in reception (4-5 year olds) %	Persons	4-5 yrs	2016/17	1,512	23.6	22.6	28.2	15.0
Excess weight in year 6 (10-11 year olds) %	Persons	10-11 yrs	2016/17	1,899	33.8	34.2	43.9	25.3
School Readiness: All children %	Persons	5 yrs	2016/17	4,638	69.7	70.7	60.9	78.9
School Readiness: Children with free school meal status %	Persons	5 yrs	2016/17	385	49.3	56.0	43.9	100.0
Children in poverty %	Persons	0-19 yrs	2015	15,370	13.2	16.6	30.6	2.8

*Definition of count for each indicator is shown in the following sections.

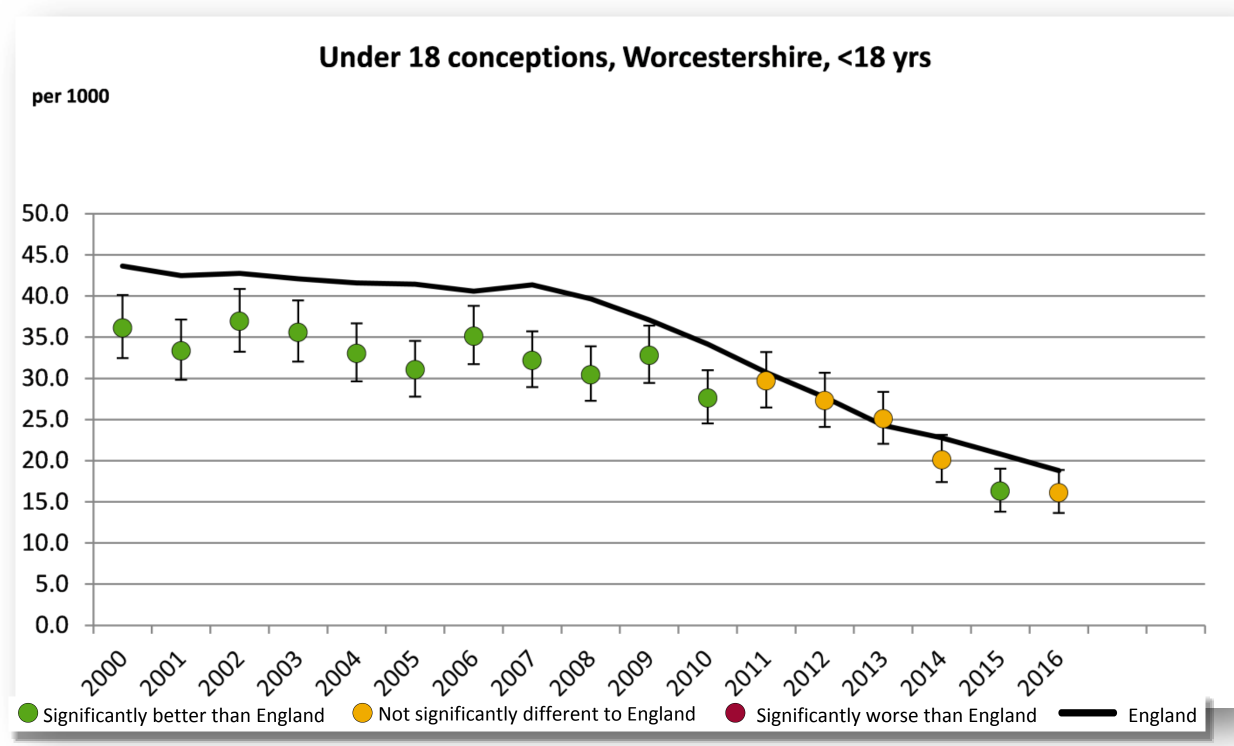
Under 18 Conceptions

- The number of conceptions for under 18s per 1000 female population aged 15-17.
- After a decade in which rates did not change significantly the rates in Worcestershire have decreased over the latest 4 years.
- This follows a national pattern but nationally the decrease began in 2007
- In 2015 Worcestershire was significantly below the national average following a three year period in which it was not significantly different.

Under 18 conceptions, Worcestershire, <18 yrs, Crude rate per 1,000

Period		Count*	Value	Lower CI	Upper CI	England
2000	●	351	36.1	32.5	40.1	43.6
2001	●	330	33.3	29.8	37.1	42.5
2002	●	370	36.9	33.2	40.9	42.8
2003	●	363	35.6	32.0	39.5	42.1
2004	●	346	33.0	29.6	36.7	41.6
2005	●	333	31.0	27.8	34.6	41.4
2006	●	387	35.1	31.7	38.8	40.6
2007	●	355	32.2	28.9	35.7	41.4
2008	●	332	30.4	27.3	33.9	39.7
2009	●	351	32.8	29.4	36.4	37.1
2010	●	289	27.6	24.5	31.0	34.2
2011	●	306	29.7	26.5	33.2	30.7
2012	●	274	27.3	24.1	30.7	27.7
2013	●	250	25.1	22.1	28.4	24.3
2014	●	197	20.1	17.4	23.1	22.8
2015	●	157	16.3	13.8	19.0	20.8
2016	●	151	16.1	13.6	18.9	18.8

* Number of pregnancies that occur in women aged under 18 and result in one or more live or still births or a legal abortion



Data Source: Public Health England

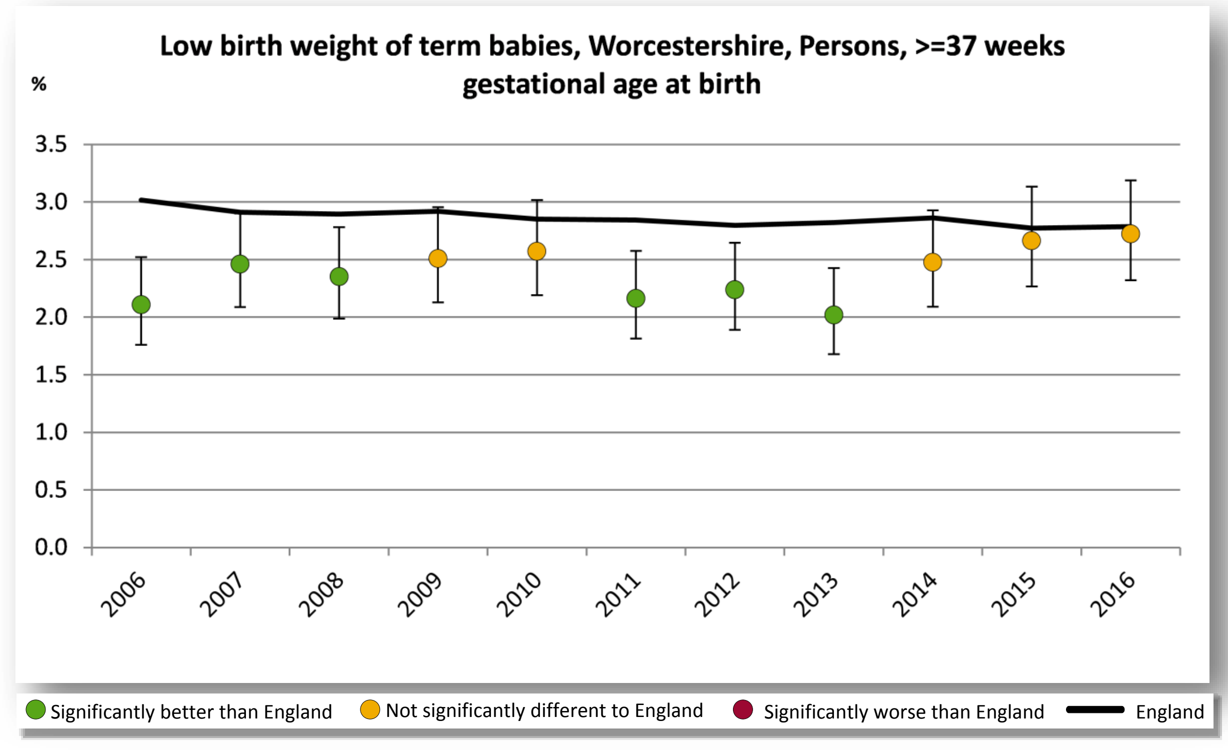
Low Birth Weight

- Low birth weight is an important measure both of a healthy pregnancy and of future health of the baby.
- Worcestershire has tended to have significantly low rates of low birth weight babies compared to the Country as a whole.
- The proportion has not changed significantly for over a decade.

Low birth weight of term babies, Worcestershire, Persons, >=37 weeks gestational age at birth (%)

Period		Count*	Value	Lower CI	Upper CI	England
2005	●	146	2.6	2.2	3.1	3.1
2006	●	116	2.1	1.8	2.5	3.0
2007	●	139	2.5	2.1	2.9	2.9
2008	●	132	2.4	2.0	2.8	2.9
2009	●	139	2.5	2.1	3.0	2.9
2010	●	146	2.6	2.2	3.0	2.9
2011	●	122	2.2	1.8	2.6	2.8
2012	●	133	2.2	1.9	2.6	2.8
2013	●	111	2.0	1.7	2.4	2.8
2014	●	132	2.5	2.1	2.9	2.9
2015	●	142	2.7	2.3	3.1	2.8
2016	●	148	2.7	2.3	3.2	2.8

*Number of live births at term (>= 37 gestation weeks) with low birth weight (<2500g)



Data Source: Public Health England

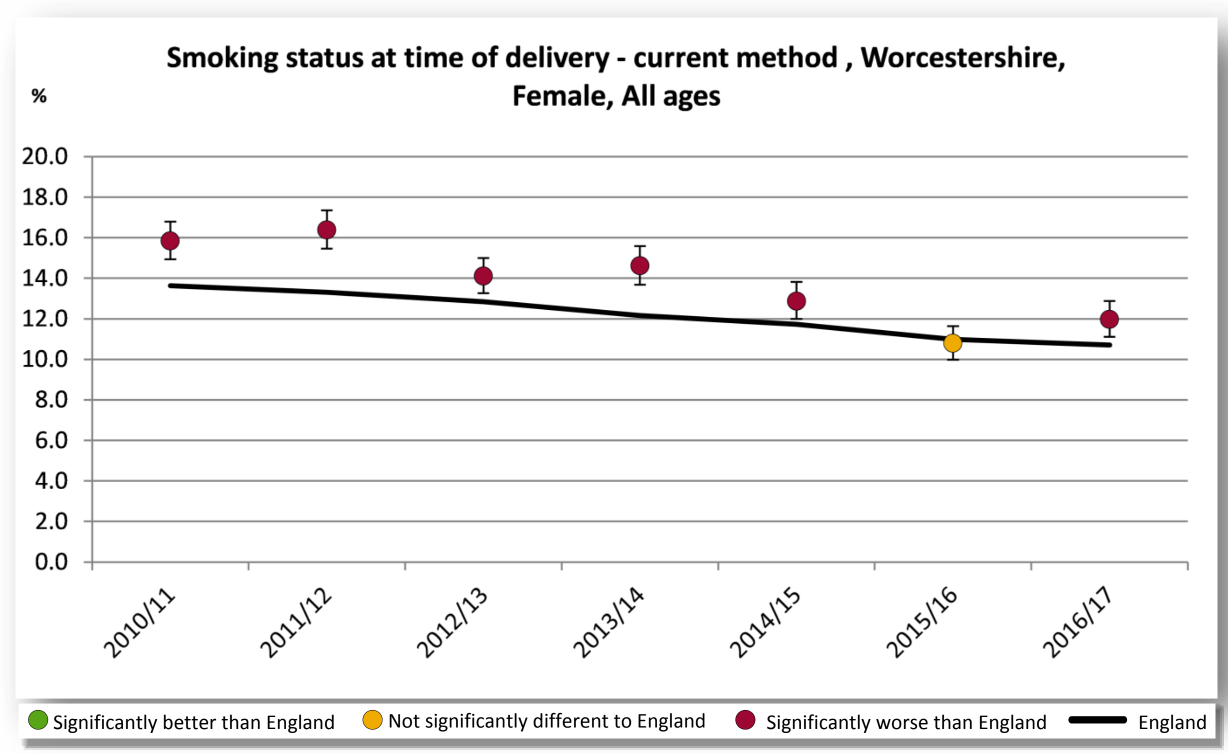
Smoking Status at Time of Delivery

- The proportion of women giving birth in Worcestershire who are smokers at the time of delivery has fallen by nearly a quarter over the last 6 years.
- The proportion in 2016/17 was significantly higher than the national average, following a year in which it was similar to the national average.
- About one in eight pregnant women are smokers at the time of delivery.

Smoking status at time of delivery, Worcestershire, Female, All ages (%)

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

*The number of mothers known to be smokers at the time of delivery



Data Source: Public Health England

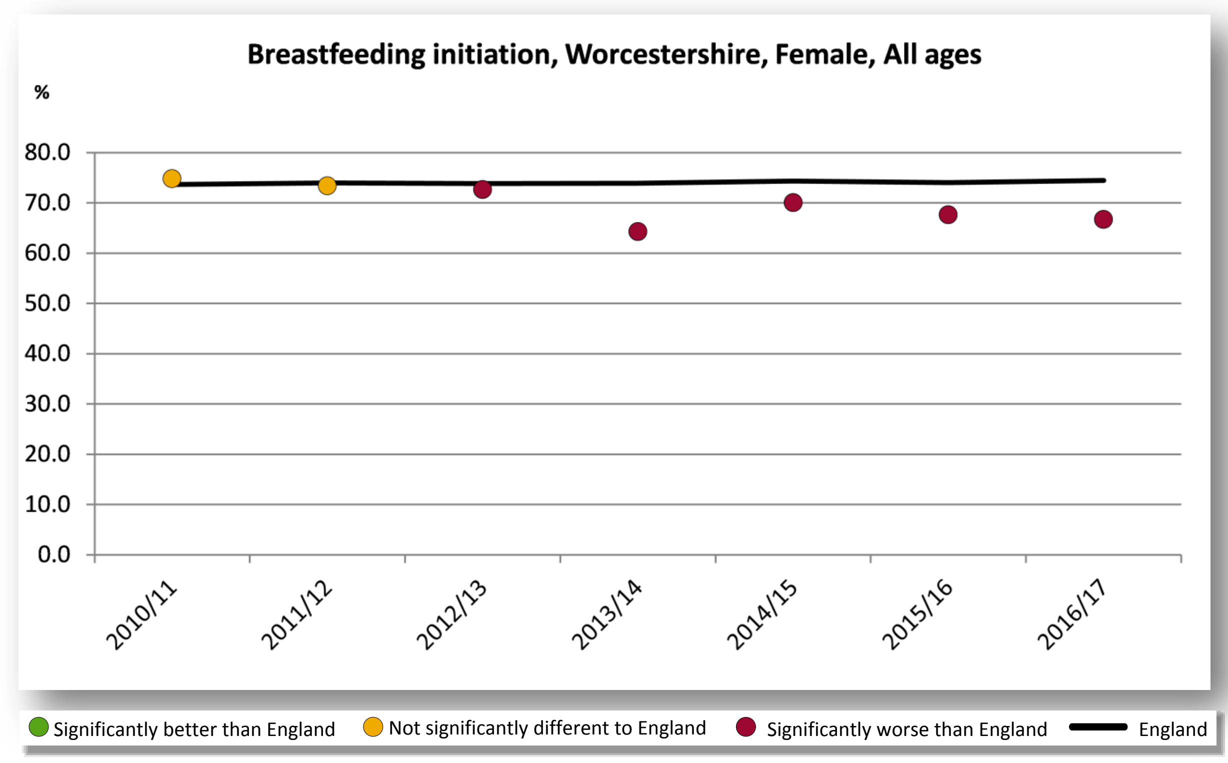
Breast Feeding Initiation

- The proportion of women who initiate breastfeeding has declined in Worcestershire
- The rate is now significantly below the national average which has remained relatively constant at around 74%

Breastfeeding initiation, Worcestershire, Female, All ages (%)

Period		Count*	Value	Lower CI	Upper CI	England
2010/11	●	4,525	74.8	73.7	75.9	73.7
2011/12	●	4,466	73.4	72.3	74.5	74.0
2012/13	●	4,521	72.7	71.6	73.8	73.9
2013/14	●	3,774	64.3	63.0	65.5	74.0
2014/15	●	3,999	70.1	68.9	71.2	74.3
2015/16	●	4,038	67.6	66.4	68.8	74.0
2016/17	●	3,928	66.7	65.5	67.9	74.5

*number of mothers initiating breast feeding in the first 48 hours after delivery



Data Source: Public Health England

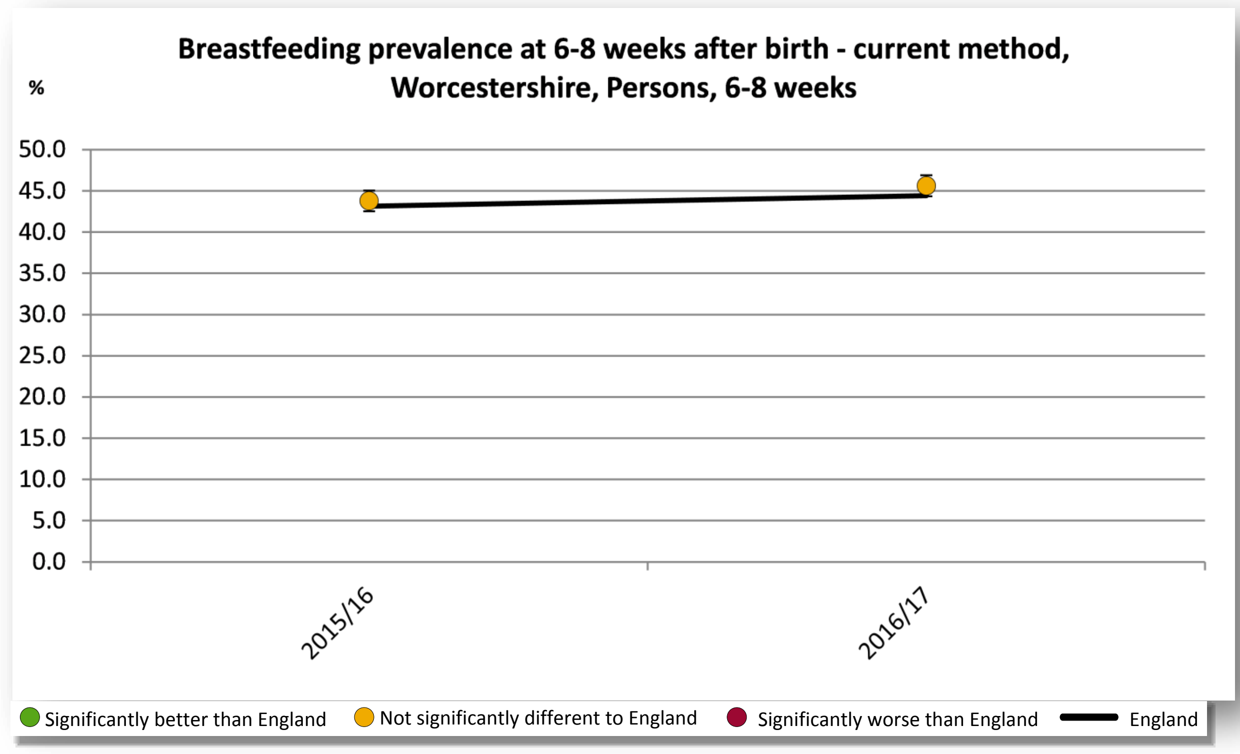
Breast Feeding Prevalence at 6-8 Weeks

- The proportion of babies being breastfed at 6-8 weeks has risen slightly in the latest year in Worcestershire.
- The method for calculating this indicator changed in 2015/16. The data for 2016/17 shows Worcestershire's rate as 45.6%, not significantly different to the national value of 44.4%. These figures cannot be compared with the historical data for 2014/15 and earlier.

Breastfeeding prevalence at 6-8 weeks after birth, Worcestershire, 6-8 weeks (%)

Period		Count*	Value	Lower CI	Upper CI	England
2010/11	●	2,617	41.5	40.3	42.8	46.1
2011/12	●	2,618	42.3	41.1	43.6	47.2
2012/13	●	2,762	43.1	41.9	44.3	47.2
2013/14	●	-	-	-	-	45.8
2014/15	●	2,640	45.5	44.3	46.8	43.8
2015/16 (new method)	●	2,542	43.8	42.5	45.1	43.2
2016/17 (new method)	●	2,636	45.6	44.3	46.9	44.4

*Number of infants at the 6-8 week check who are totally or partially breastfeeding



Data Source: Public Health England

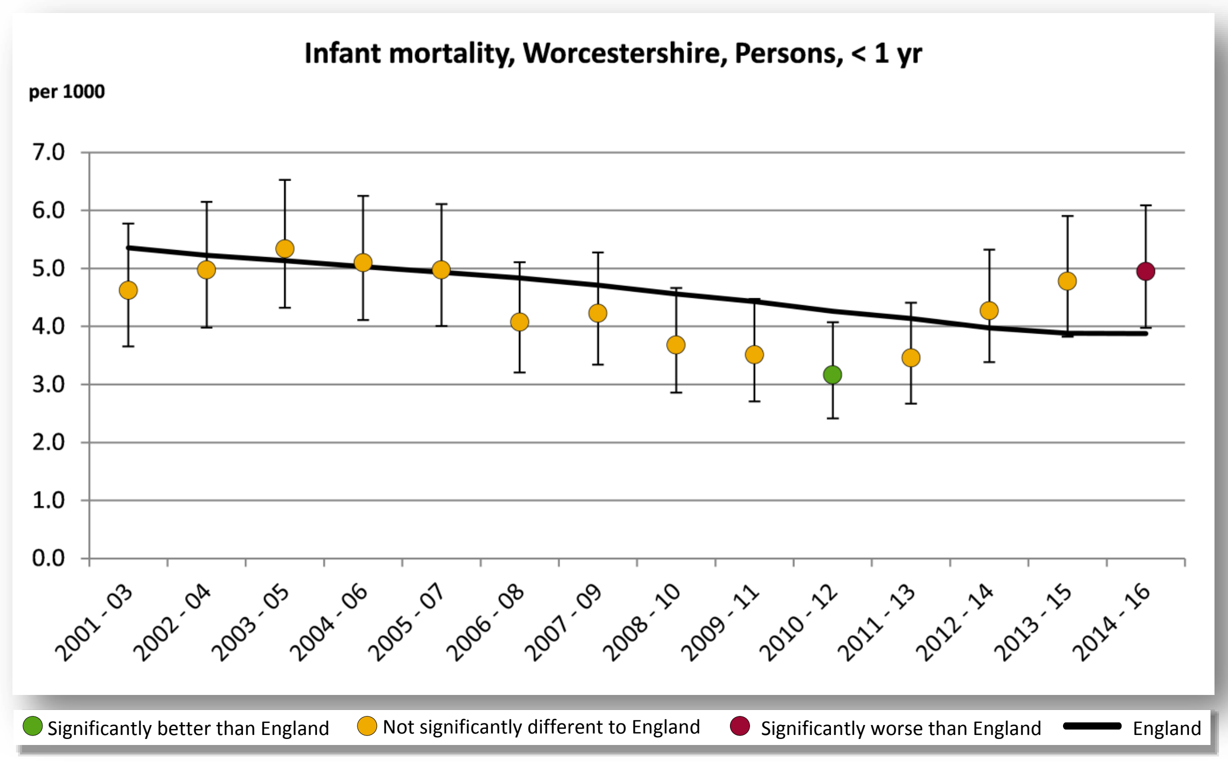
Infant Mortality

- Infant mortality rates in Worcestershire have been increasing from a low point in 2010-12 and are now statistically significantly higher than nationally.
- The counts in the table relate to the number of deaths in each three year period.

Infant mortality, Worcestershire, Persons, < 1 yr
Crude rate per 1,000 live births

Period		Count*	Value	Lower CI	Upper CI	England
2001 - 03	●	78	4.6	3.7	5.8	5.4
2002 - 04	●	86	5.0	4.0	6.1	5.2
2003 - 05	●	95	5.3	4.3	6.5	5.1
2004 - 06	●	92	5.1	4.1	6.3	5.0
2005 - 07	●	91	5.0	4.0	6.1	4.9
2006 - 08	●	75	4.1	3.2	5.1	4.8
2007 - 09	●	78	4.2	3.3	5.3	4.7
2008 - 10	●	68	3.7	2.9	4.7	4.6
2009 - 11	●	65	3.5	2.7	4.5	4.4
2010 - 12	●	60	3.2	2.4	4.1	4.3
2011 - 13	●	65	3.5	2.7	4.4	4.1
2012 - 14	●	79	4.3	3.4	5.3	4.0
2013 - 15	●	86	4.8	3.8	5.9	3.9
2014 - 16	●	89	4.9	4.0	6.1	3.9

*The number of infant deaths aged under 1 year that were registered in the three year period.



Data Source: Public Health England

School Readiness

- School readiness (good level of development) for all children has shown a year-on-year increase nationally and locally.
- The increase for all children in Worcestershire has been greater than nationally, meaning that following 2 years of being significantly worse than average, Worcestershire is now very close to the national average.
- For those eligible for free school meals Worcestershire has shown some improvement but is still significantly below the national average.

Children achieving a good level of development at the end of reception Worcestershire, Persons, 5 yrs (%)

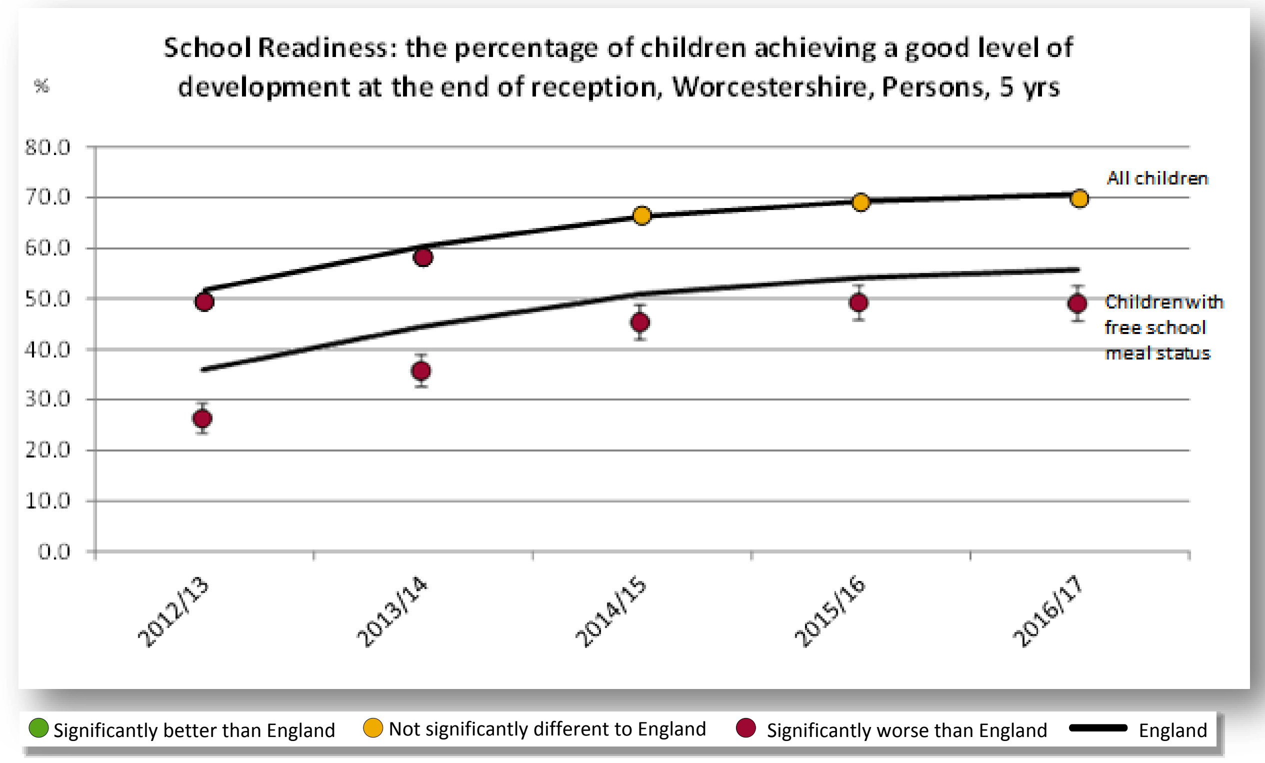
Period		Count*	Value	Lower CI	Upper CI	England
2012/13	●	3,030	49.4	48.1	50.6	51.7
2013/14	●	3,598	58.1	56.9	59.4	60.4
2014/15	●	4,246	66.4	65.2	67.6	66.3
2015/16	●	4,450	69.0	67.9	70.1	69.3
2016/17	●	4,638	69.7	68.6	70.8	70.7

* Number of children defined as having reached a good level of development at the end of the EYFS

Children with free school meal status achieving a good level of development at the end of reception Worcestershire, Persons, 5 yrs (%)

Period		Count*	Value	Lower CI	Upper CI	England
2012/13	●	228	26.6	23.8	29.7	36.2
2013/14	●	319	36.0	32.9	39.2	44.8
2014/15	●	350	45.6	42.1	49.1	51.2
2015/16	●	400	49.5	46.1	52.9	54.4
2016/17	●	385	49.3	45.8	52.8	56.0

* Number of children with free school meal status defined as having reached a good level of development at the end of the EYFS



Data Source: Public Health England

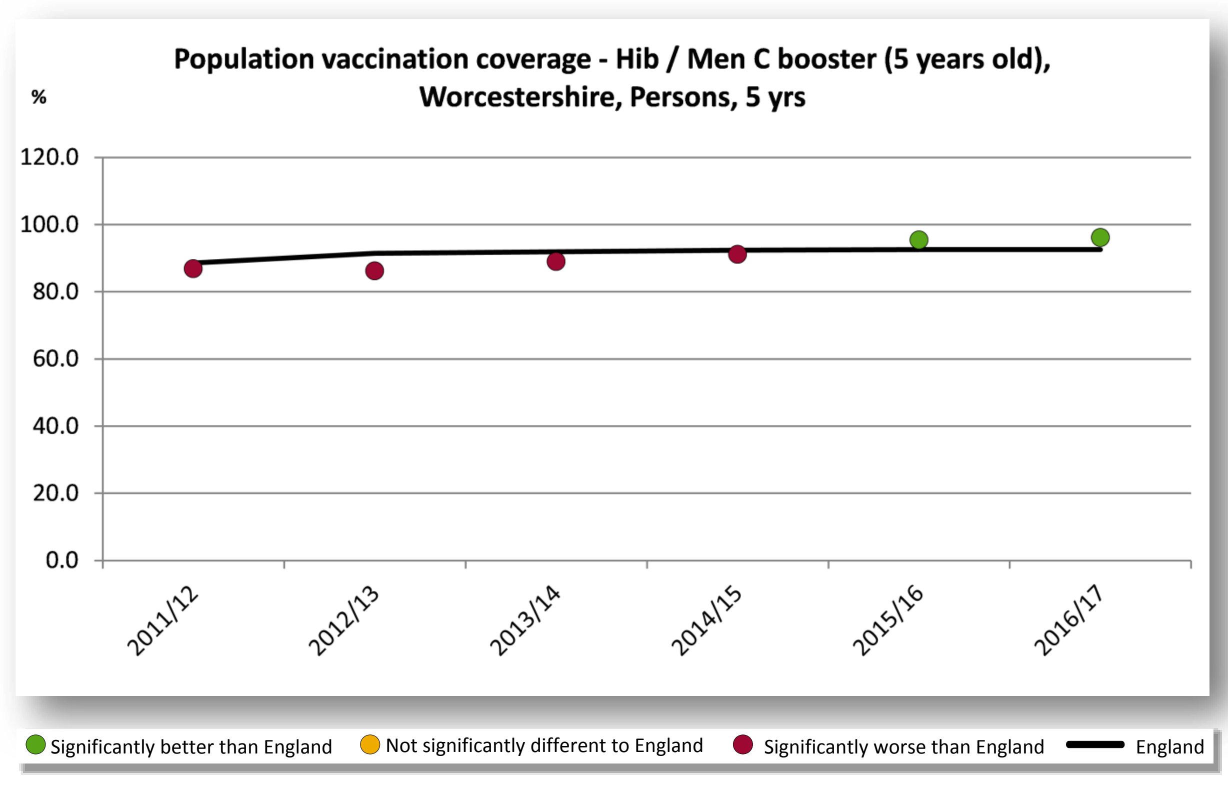
Population vaccination coverage – Hib / Men C booster (5 years old)

- Worcestershire has shown an increase in the proportion of 5 year-olds receiving the Hepatitis B and Meningococcal type C booster.
- In 2015/16 the rate increased to a value which is significantly better than the national average, having been worse historically.

Population vaccination coverage - Hib / Men C booster (5 years old), Worcestershire, Both Sexes, 5 yrs (%)

Period		Count*	Value	Lower CI	Upper CI	England
2011/12	●	5,570	86.9	86.0	87.7	88.6
2012/13	●	5,585	86.2	85.4	87.1	91.5
2013/14	●	5,671	89.0	88.2	89.7	91.9
2014/15	●	5,713	91.2	90.4	91.9	92.4
2015/16	●	6,335	95.4	94.9	95.9	92.6
2016/17	●	6,080	96.2	95.8	96.7	92.6

* Total number of children whose fifth birthday falls within the time period who received a booster dose of Hib/MenC at any time before their fifth birthday



Data Source: Public Health England

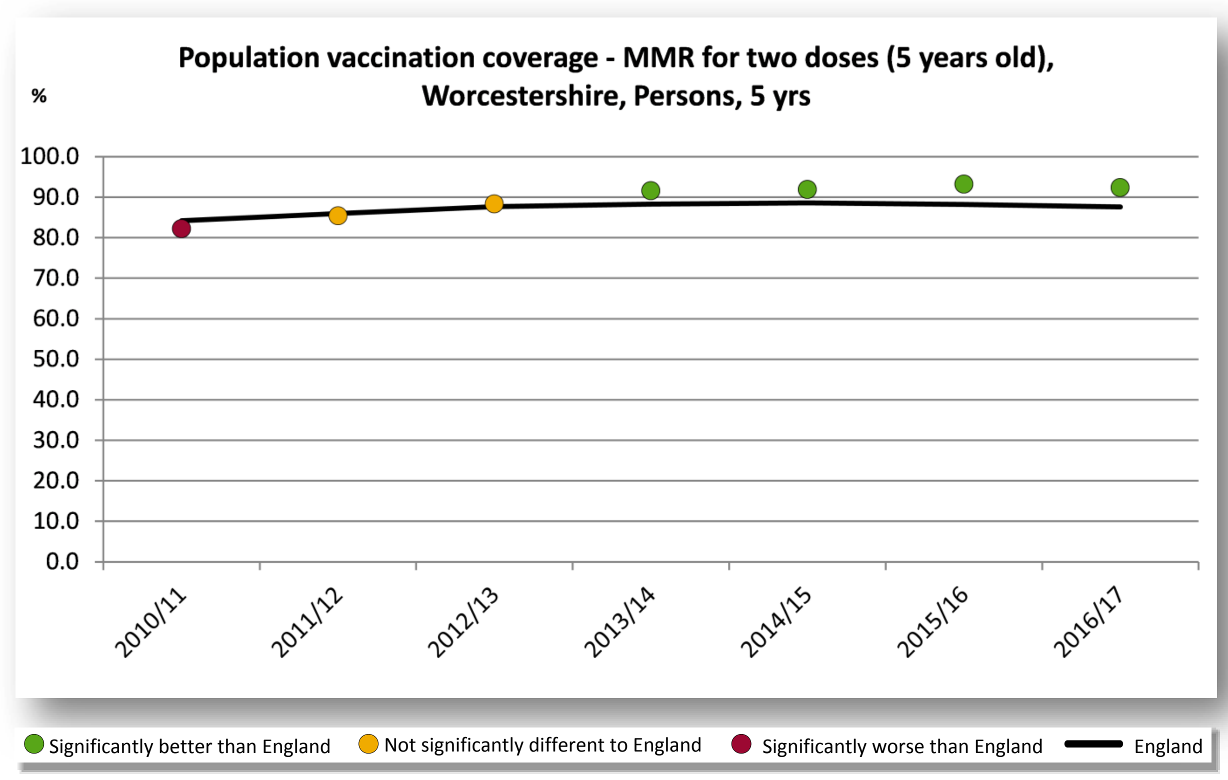
Population vaccination coverage - MMR for two doses (5 years old)

- The proportion of 5 year-olds who have had 2 doses of the measles, mumps and rubella triple vaccine has risen in Worcestershire over the last 5 years by about 7%.
- The rate is now both above the target of 90% and statistically significantly above the national average.

Population vaccination coverage - MMR for two doses (5 years old), Worcestershire, Both Sexes, 5 yrs (%)

Period		Count*	Value	Lower CI	Upper CI	England
2010/11	●	5,118	82.2	81.2	83.1	84.2
2011/12	●	5,473	85.4	84.5	86.2	86.0
2012/13	●	5,721	88.3	87.5	89.1	87.7
2013/14	●	5,838	91.6	90.9	92.3	88.3
2014/15	●	5,760	91.9	91.2	92.6	88.6
2015/16	●	6,188	93.2	92.6	93.8	88.2
2016/17	●	5,837	92.4	91.7	93.0	87.6

* Total number of children whose fifth birthday falls within the time period who received two doses of MMR on or after their first birthday and at any time before their fifth birthday.



Data Source: Public Health England

Children age 5 free from tooth decay

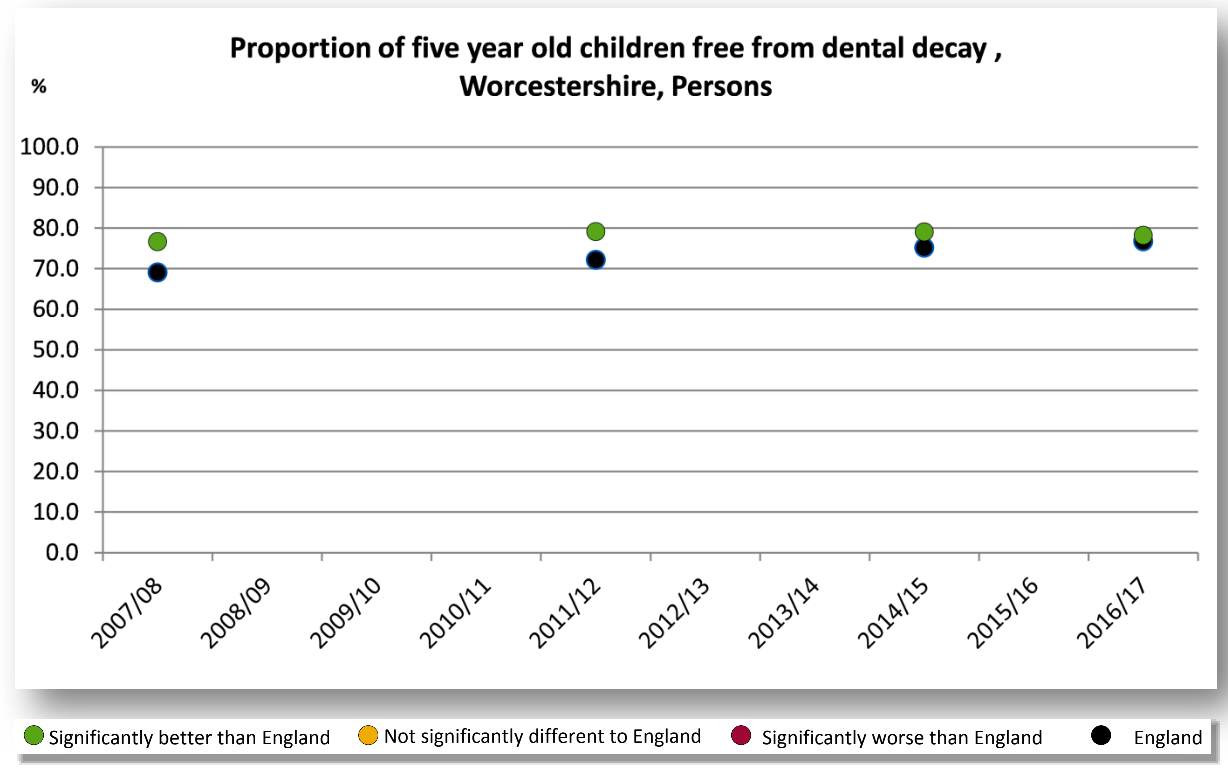
- The proportion of five year old children free from tooth decay is measured using a national survey every 2-4 years.
- Worcestershire data has remained significantly better than England for the last four survey years, though the gap has closed somewhat.

.

Children age 5 free from tooth decay %

Period		Count*	Value	Lower CI	Upper CI	England
2007/08	●	2,840	76.6	75.3	78.0	69.0
2011/12	●	2,824	79.2	77.8	80.5	72.2
2014/15	●	2,760	79.0	77.7	80.4	75.2
2016/17	●	2,764	78.2	76.8	79.6	76.7

* Total number of 5 year olds who are free from obvious dental decay examined under the Dental Public Health Epidemiology Programme for England



Data Source: Public Health England

Excess weight in Reception and Year 6

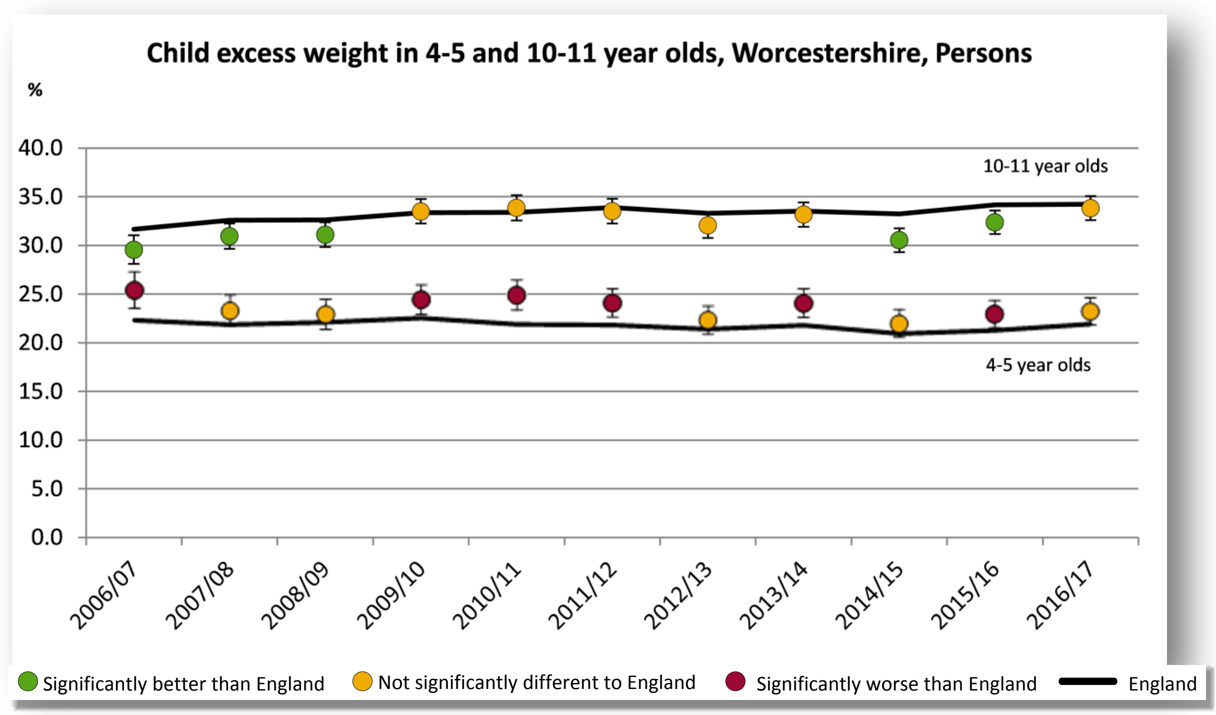
- The proportion of year 6 pupils (10-11 year-olds) with excess weight in Worcestershire has been close to or below the national average. For reception pupils (4-5 year-olds) the rate in Worcestershire has been at or above the national average.
- The counts in the tables below are the number of pupils with excess weight (overweight or obese) measured in the National Child Measurement Programme.

Excess weight in reception (4-5 year olds), Worcestershire, Both Sexes (%)

Period	Count	Value	Lower CI	Upper CI	England
2009/10	1,343	24.5	23.4	25.7	23.1
2010/11	1,338	24.8	23.7	26.0	22.6
2011/12	1,421	24.3	23.2	25.4	22.6
2012/13	1,326	22.9	21.9	24.0	22.2
2013/14	1,421	24.2	23.1	25.3	22.5
2014/15	1,336	22.7	21.6	23.7	21.9
2015/16	1,441	23.4	22.4	24.5	22.1
2016/17	1,512	23.6	22.6	24.7	22.6

Excess weight in Year 6 (10-11 year olds), Worcestershire, Both Sexes (%)

Period	Count	Value	Lower CI	Upper CI	England
2009/10	1,815	33.5	32.2	34.8	33.4
2010/11	1,728	33.8	32.6	35.2	33.4
2011/12	1,772	33.5	32.2	34.8	33.9
2012/13	1,633	32.0	30.8	33.3	33.3
2013/14	1,785	33.2	31.9	34.4	33.5
2014/15	1,668	30.5	29.3	31.8	33.2
2015/16	1,841	32.4	31.2	33.6	34.2
2016/17	1,899	33.8	32.6	35.1	34.2



Data Source: Public Health England

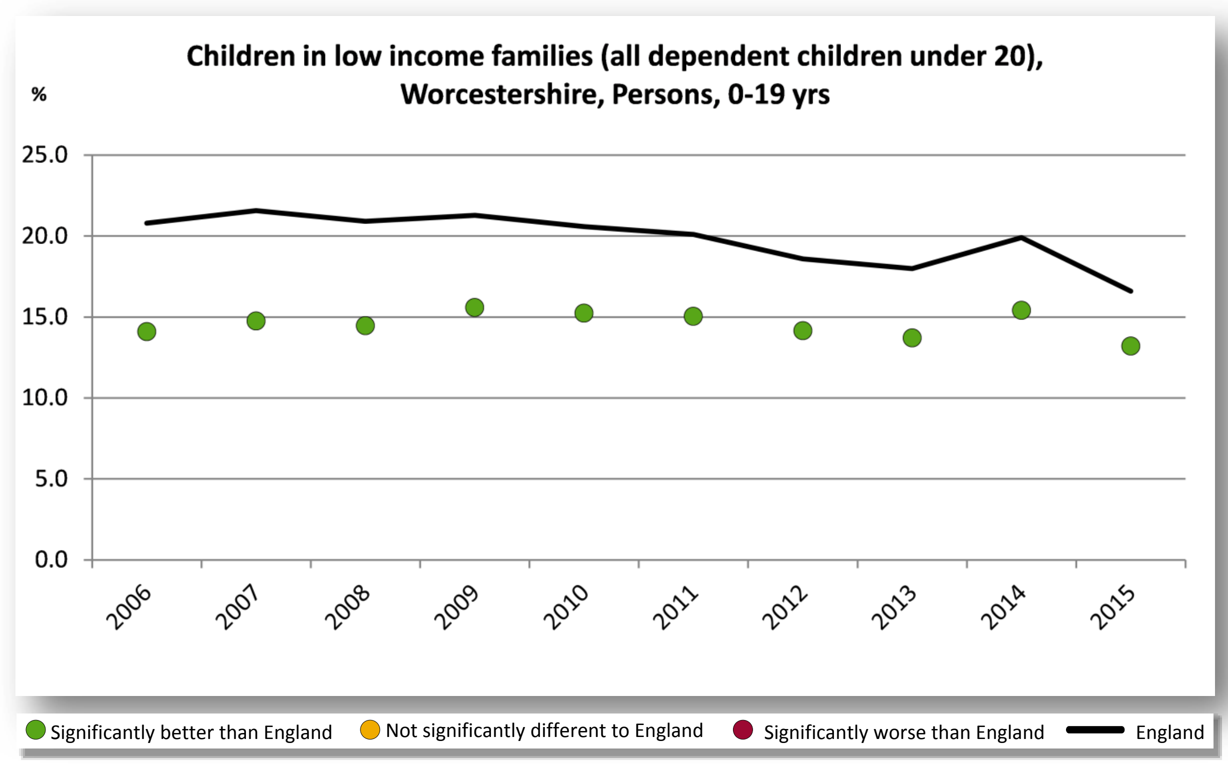
Children in low income families

- The proportion of children (all 0-19 years old) in low income families in Worcestershire is well below the national average, as it has been since 2006.
- However the rate in Worcestershire has not changed significantly in that time whist nationally there has been a decrease, meaning the gap is less than it was.

Children in low income families (all dependent children under 20), Worcestershire, Persons, 0-19 yrs (%)

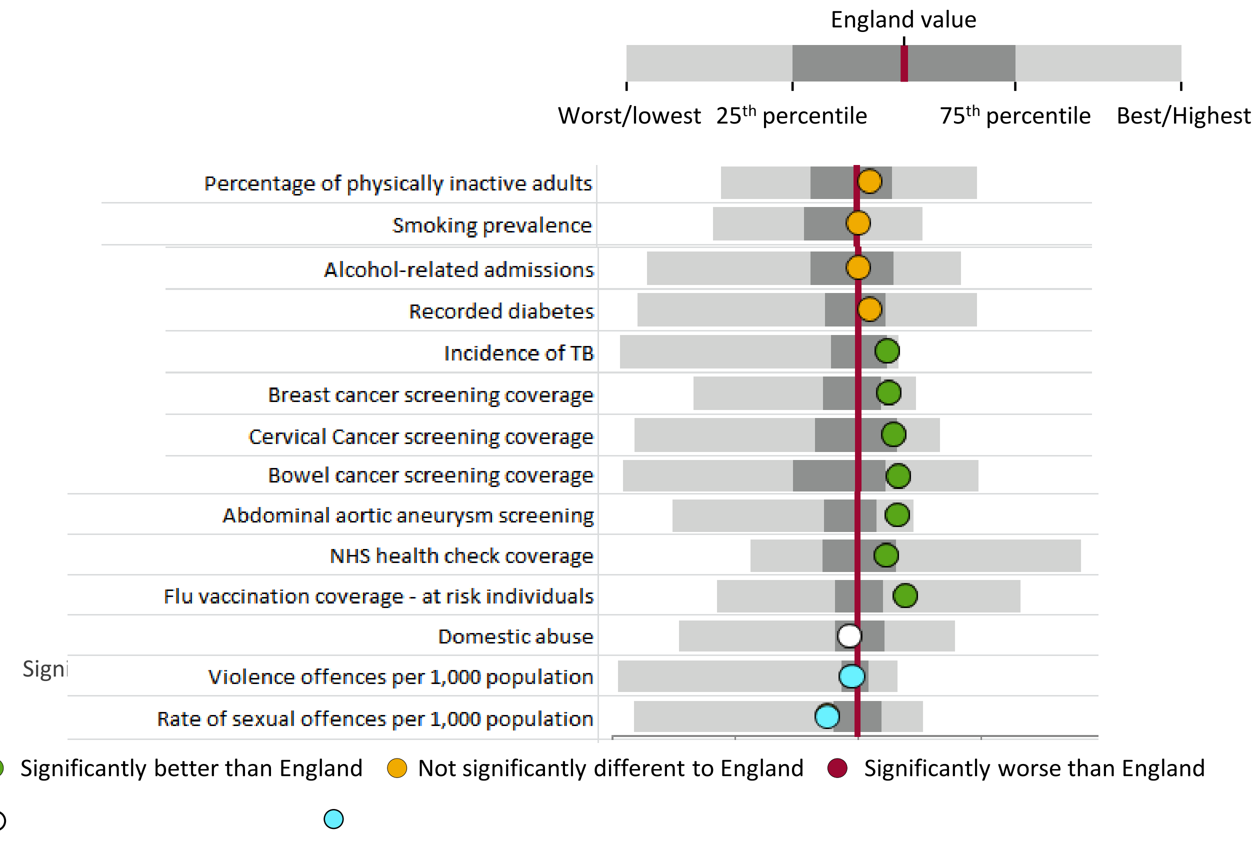
Period		Count*	Value	Lower CI	Upper CI	England
2006	●	16,590	14.1	13.9	14.3	20.8
2007	●	17,455	14.8	14.6	15.0	21.6
2008	●	17,060	14.5	14.3	14.7	20.9
2009	●	18,515	15.6	15.4	15.8	21.3
2010	●	18,055	15.2	15.0	15.4	20.6
2011	●	17,735	15.0	14.8	15.2	20.1
2012	●	16,675	14.2	14.0	14.4	18.6
2013	●	16,160	13.7	13.5	13.9	18.0
2014	●	18,065	15.4	15.2	15.6	19.9
2015	●	15,370	13.2	13.0	13.4	16.6

*Number of all dependent children under the age of 20 living in families in receipt of Child Tax Credits (CTC) whose reported income is less than 60 per cent of the median income or in receipt of Income Support (IS) or (Income-Based) Job Seekers Allowance (JSA)



Data Source: Public Health England

Adult Health



	Sex	Age	Period	Worcestershire Count*	Worcestershire Value	England Value	England Worst	England Best
Physically inactive adults (%)	Persons	19+ yrs	2016/17	N/A	21.1	22.2	33.3	12.4
Smoking prevalence	Persons	18+ yrs	2017	68,574	14.7	14.9	26.6	9.6
Alcohol-related admissions	Persons	All ages	2016/17	3,801	634.1	636.4	1,151.1	388.2
Diabetes diagnosis rate	Persons	17+ yrs	2017	N/A	79.1	77.1	41.3	46.3
Incidence of TB	Persons	All ages	2014 - 16	63	3.6	10.9	69.0	1.3
Breast cancer screening coverage	Female	53-70yrs	2017	56,869	79.2	75.4	55.3	82.3
Cervical Cancer screening	Female	25-64yrs	2017	109,349	74.9	72.0	53.8	78.7
Bowel cancer screening coverage	Persons	60-74yrs	2017	62,865	62.1	58.8	39.7	68.6
Abdominal aortic aneurysm screening	Male	65 yrs	2016/17	3,140	85.8	80.9	58.2	87.8
NHS health check coverage	Persons	40-74 yrs	2017/18	16,209	38.9	47.9	-	-
Flu vaccination coverage - at risk individuals	Persons	6 mths-64 yrs	2017/18	38,500	52.9	48.9	37.4	62.2
Domestic abuse per 1,000 population	Persons	16+ yrs	2016/17	-	23.5	22.5	44.4	10.7
Violence offences per 1,000 population	Persons	All ages	2016/17	12,688	21.9	20.0	98.0	7.0
Rate of Sexual Offences per 1,000 population	Persons	All ages	2016/17	1,394	2.4	1.9	5.6	0.8

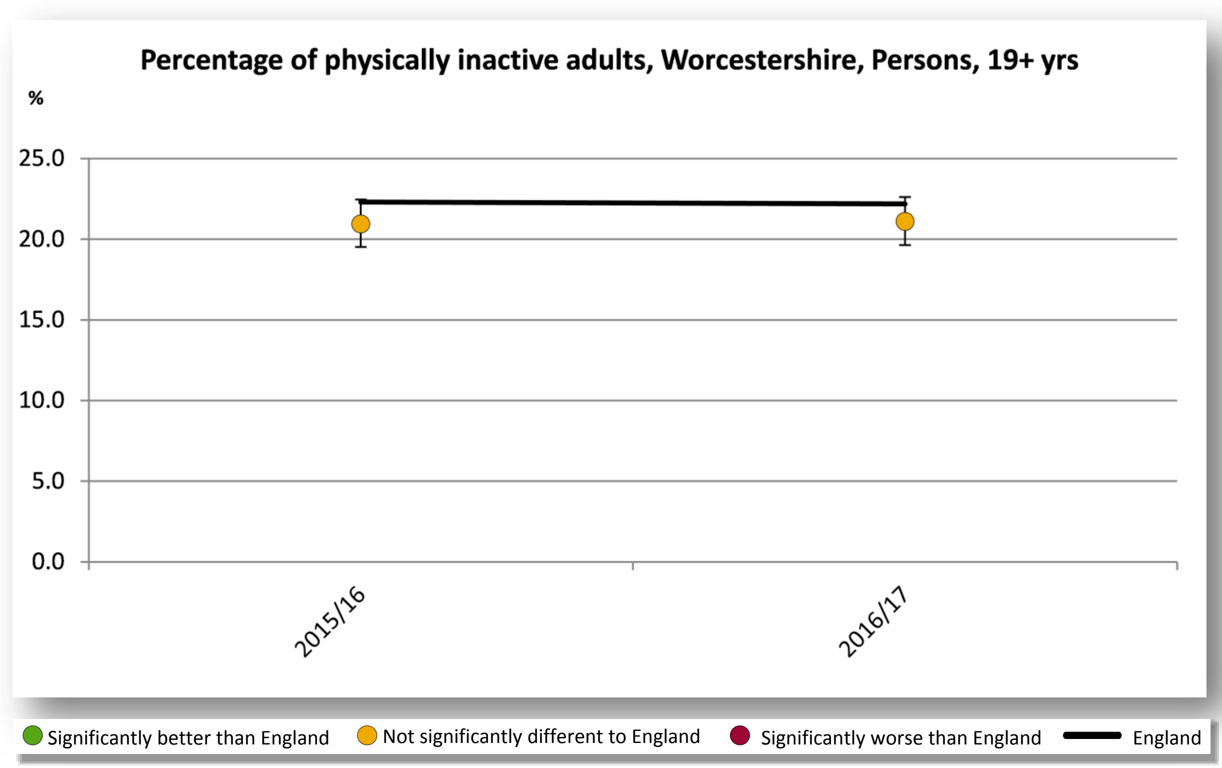
*Definition of count for each indicator is shown in the following sections.

Inactive adults

- Physically inactive adults are those aged 19 and over doing less than 30 moderate intensity minutes physical activity per week in bouts of 10 minutes or more in the previous 28 days.
- Around one in five of all adults in Worcestershire are physically inactive.
- The rate is statistically similar to the national average.

Percentage of physically inactive adults, Worcestershire, Persons, 16+ yrs

Period		Count	Value	Lower CI	Upper CI	England
2015/16	●	-	20.9	19.5	22.5	22.3
2016/17	●	-	21.1	19.6	22.6	22.2



Data Source: Public Health England

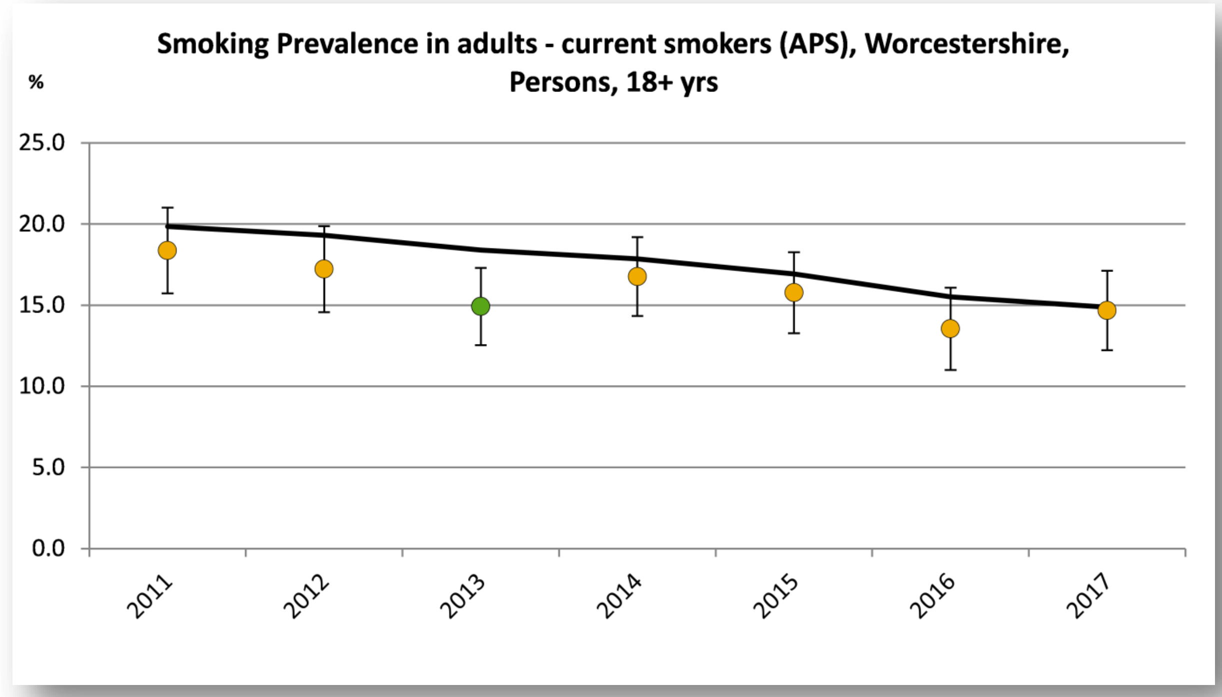
Smoking prevalence

- The proportion of adults who smoke in Worcestershire has decreased gradually in line with the national average.

Smoking prevalence, Worcestershire, Persons, 18+ yrs (%)

Period		Count*	Value	Lower CI	Upper CI	England
2012	●	78,307	17.2	15.1	19.3	19.3
2013	●	68,250	14.9	12.9	17.0	18.4
2014	●	77,309	16.8	14.7	18.8	17.8
2015	●	73,134	15.8	13.8	17.8	16.9
2016	●	63,303	13.5	11.6	15.5	15.5
2017	●	68,574	14.7	12.2	17.1	14.9

*Estimated number of smokers in the population, based on responses to the Annual Population Survey



Data Source: Public Health England

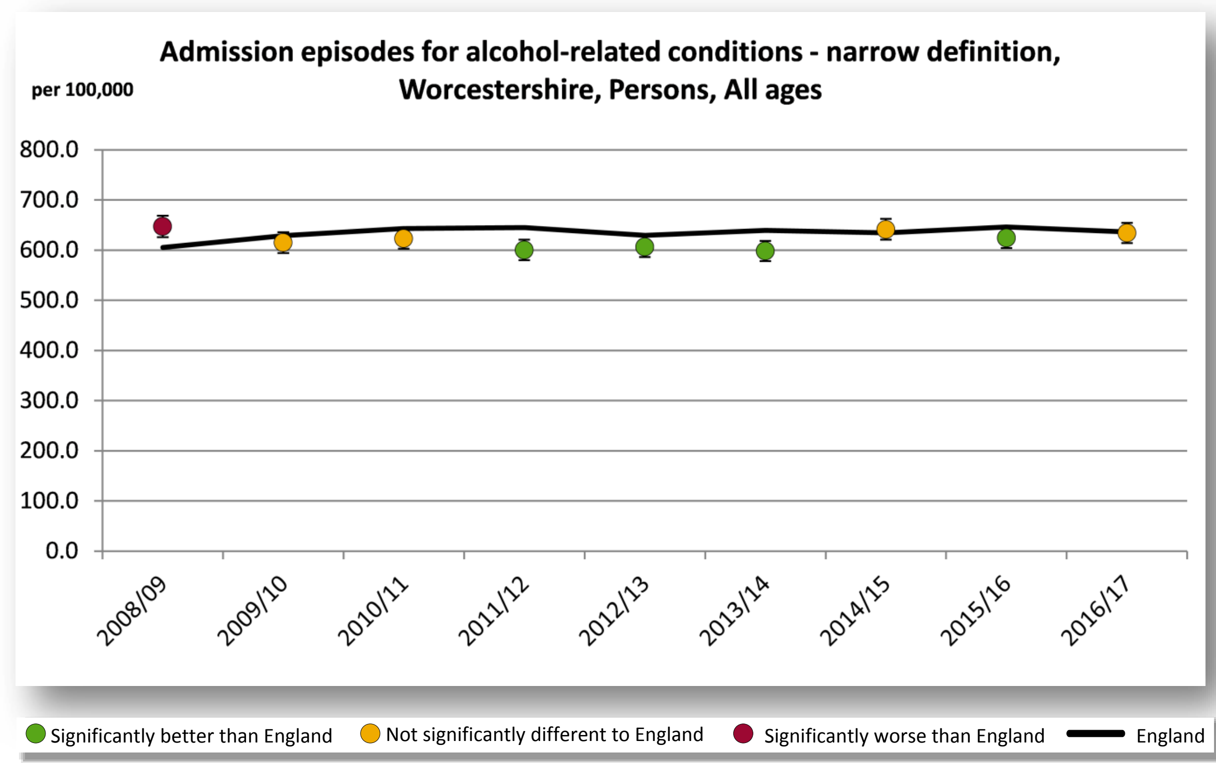
Admission episodes for alcohol-related conditions

- The latest year, 2016/17 is statistically similar to the national average.
- The rate has changed little in 8 years.

Admission episodes for alcohol-related conditions - narrow definition, Worcestershire, Persons, All ages
Directly standardised rate per 100,000

Period		Count*	Value	Lower CI	Upper CI	England
2008/09	●	3,582	647.3	626.1	668.9	605.8
2009/10	●	3,445	615.1	594.6	636.1	628.9
2010/11	●	3,508	623.3	602.8	644.4	643.3
2011/12	●	3,412	600.1	580.0	620.7	645.3
2012/13	●	3,465	606.2	586.1	626.9	629.8
2013/14	●	3,456	598.1	578.2	618.5	639.6
2014/15	●	3,465	641.2	620.7	662.3	634.7
2015/16	●	3,456	624.2	604.3	645.0	646.6
2016/17	●	3,801	634.1	613.9	654.7	636.4

*Admissions to hospital where the primary diagnosis is an alcohol-related condition or a secondary diagnosis is an alcohol-related external cause.



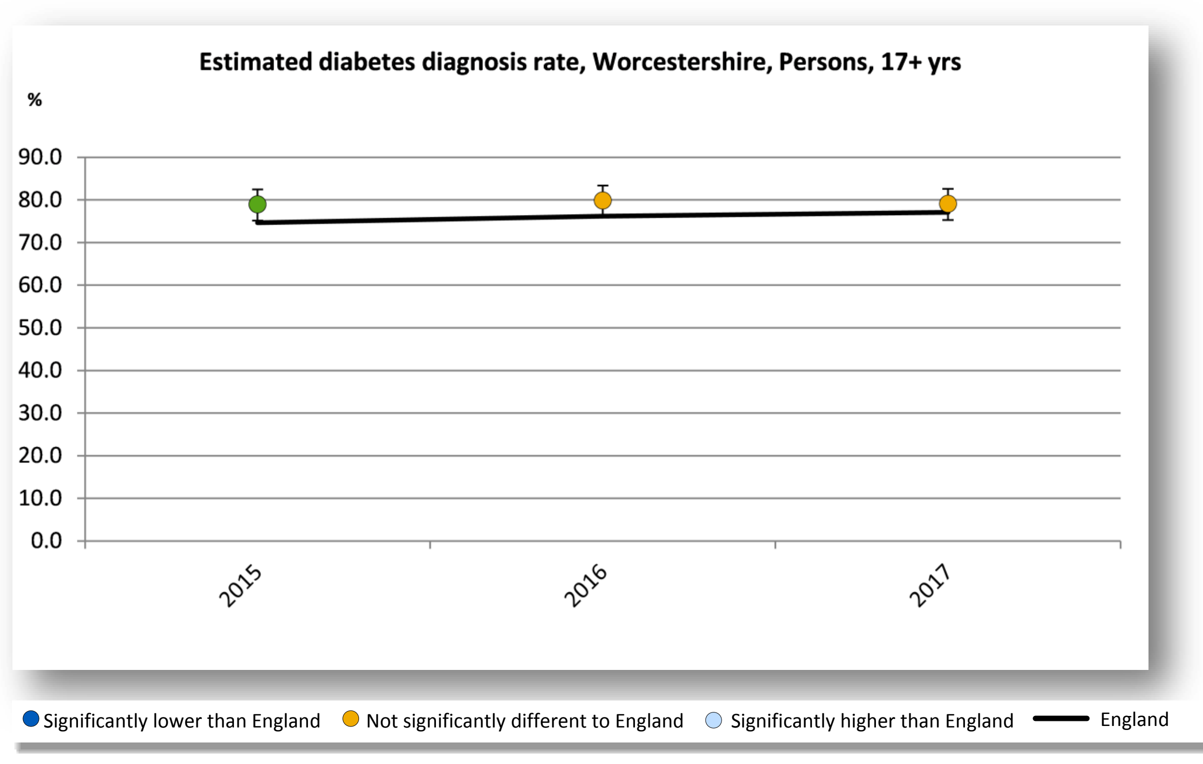
Data Source: Public Health England

Estimated Diabetes diagnosis rate

- This indicator measures the observed number of people with a formal diagnosis of diabetes as a proportion of the estimated number with diabetes. Earlier detection of Type 2 diabetes followed by effective treatment reduces the risk of developing diabetic complications.
- The diabetes diagnosis rate in Worcestershire is slightly above the national average.

Estimated Diabetes diagnosis rate, Worcestershire, Persons, 17+ yrs (%)

Period		Count	Value	Lower CI	Upper CI	England
2015	●	-	79.0	75.2	82.5	74.6
2016	●	-	79.9	76.0	83.4	76.2
2017	●	-	79.1	75.3	82.6	77.1



Data Source: Public Health England

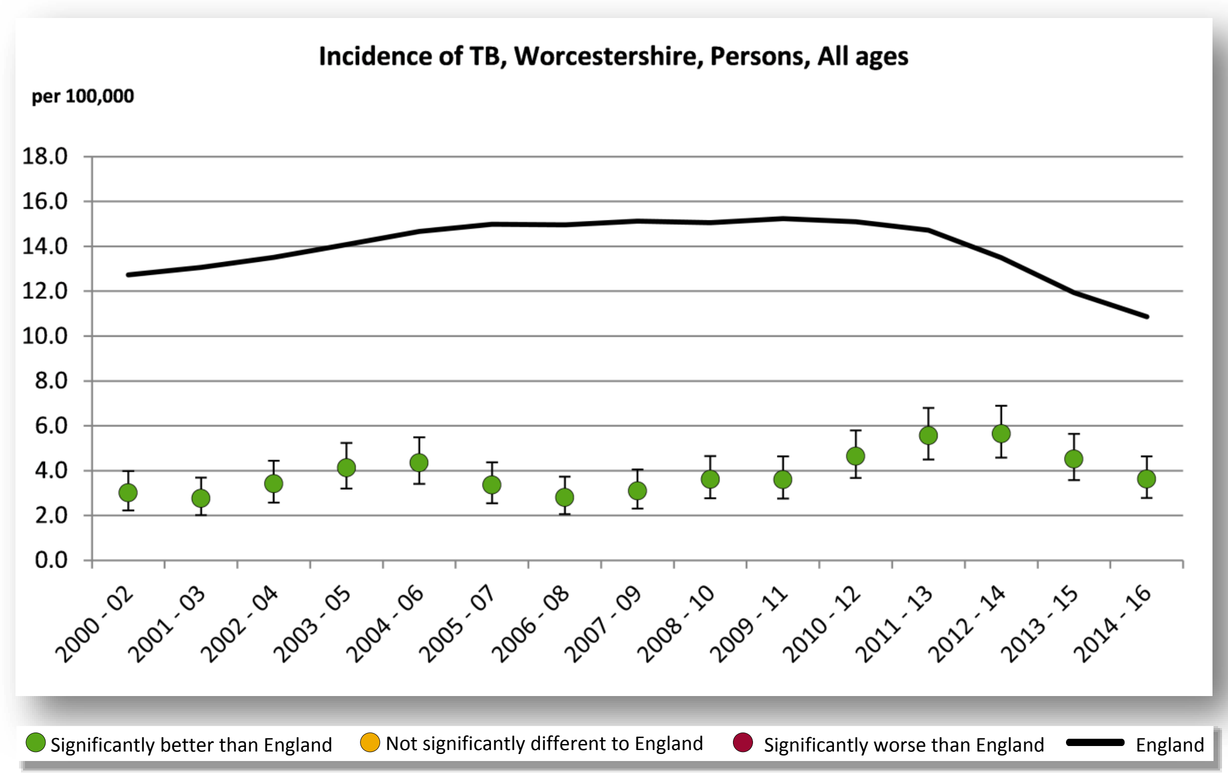
Incidence of tuberculosis (TB)

- The incidence of TB in Worcestershire has been well below the national average historically.
- The last few years have shown a gradual increase in Worcestershire and whilst rates remain low the gap is narrower from the national average than previously.
- The counts in the table below are a total for each three year period.

Incidence of TB, Worcestershire, Persons, All ages
Crude rate per 100,000

Period		Count*	Value	Lower CI	Upper CI	England
2000 - 02	●	49	3.0	2.2	4.0	12.7
2001 - 03	●	45	2.8	2.0	3.7	13.1
2002 - 04	●	56	3.4	2.6	4.4	13.5
2003 - 05	●	68	4.1	3.2	5.2	14.1
2004 - 06	●	72	4.4	3.4	5.5	14.7
2005 - 07	●	56	3.4	2.5	4.4	15.0
2006 - 08	●	47	2.8	2.1	3.7	15.0
2007 - 09	●	52	3.1	2.3	4.1	15.1
2008 - 10	●	61	3.6	2.8	4.6	15.1
2009 - 11	●	61	3.6	2.8	4.6	15.2
2010 - 12	●	79	4.6	3.7	5.8	15.1
2011 - 13	●	94	5.5	4.4	6.7	14.7
2012 - 14	●	98	5.7	4.6	7.0	13.5
2013 - 15	●	77	4.5	3.5	5.6	12.0
2014 - 16	●	63	3.6	2.8	4.6	10.9

*Sum of the number of new TB cases notified to the Enhanced Tuberculosis Surveillance system (ETS) over a three year time period



Data Source: Public Health England

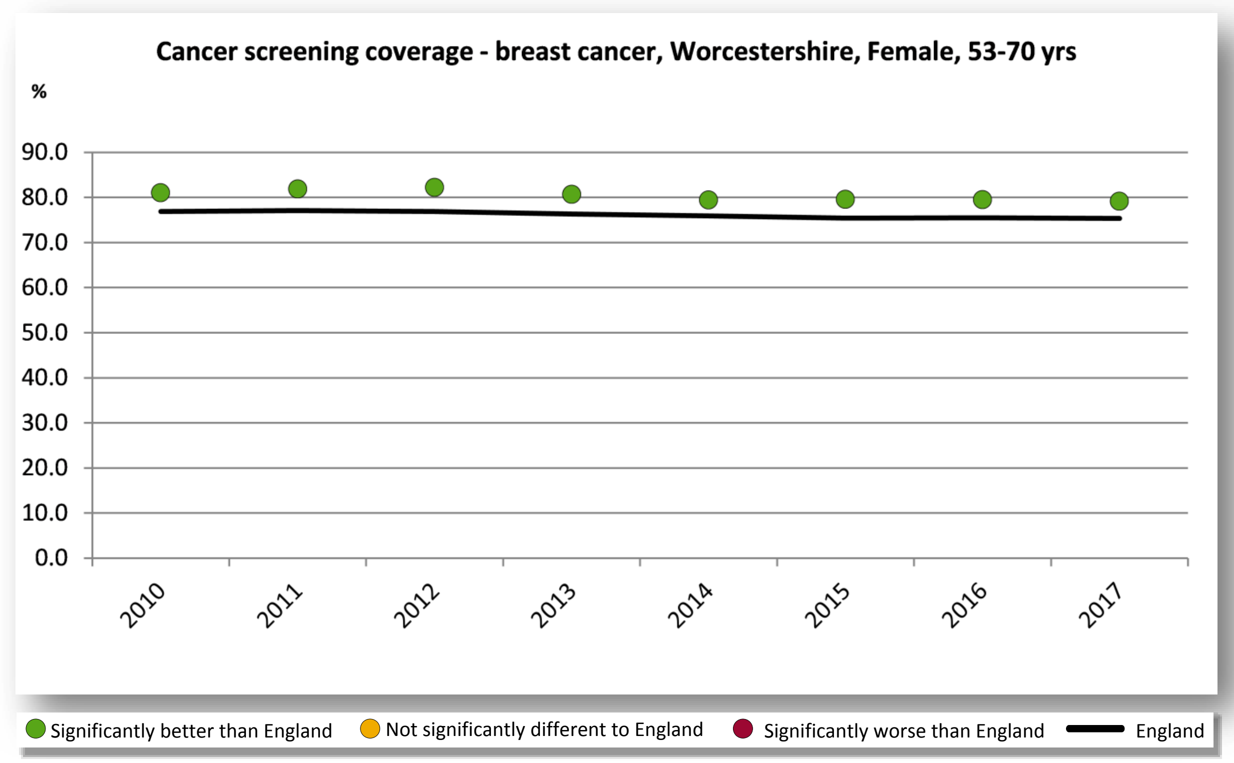
Cancer screening coverage - breast cancer

- Screening rates for breast cancer in women (the proportion of eligible women who are screened) in Worcestershire has been and remains significantly higher than the national average.
- However, rates have fallen slightly in the last 4 years to just below 80%.

Cancer screening coverage - breast cancer, Worcestershire, Female, 53-70 yrs (%)

Period		Count*	Value	Lower CI	Upper CI	England
2010	●	53,440	81.0	80.7	81.3	76.9
2011	●	54,771	81.8	81.6	82.1	77.1
2012	●	55,878	82.2	82.0	82.5	76.9
2013	●	55,654	80.7	80.4	81.0	76.3
2014	●	55,335	79.4	79.1	79.7	75.9
2015	●	55,885	79.6	79.3	79.9	75.4
2016	●	56,326	79.5	79.2	79.8	75.5
2017	●	56,869	79.2	78.9	79.5	75.4

*Number of women aged 53–70 resident in the area with a screening test result recorded in the previous three years



Data Source: Public Health England

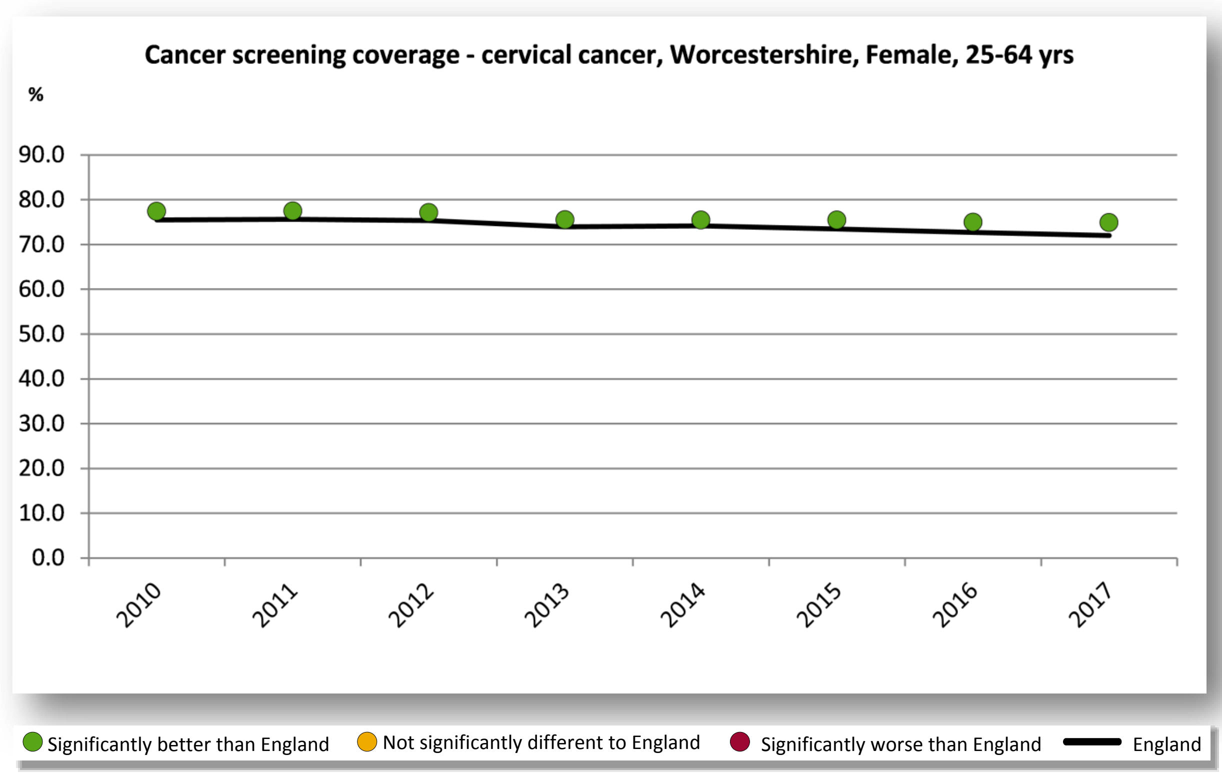
Cancer screening coverage - cervical cancer

- Cervical cancer screening coverage (the proportion of eligible women who are screened) shows a similar pattern to breast cancer.
- Rates are significantly higher in Worcestershire than nationally, but have fallen slightly over the last 5 years.

Cancer screening coverage - cervical cancer, Worcestershire, Female, 25-64 yrs (%)

Period		Count	Value	Lower CI	Upper CI	England
2010	●	107,432	77.4	77.2	77.6	75.5
2011	●	107,825	77.5	77.3	77.7	75.7
2012	●	107,618	77.1	76.9	77.4	75.4
2013	●	105,622	75.5	75.3	75.7	73.9
2014	●	105,896	75.5	75.3	75.7	74.2
2015	●	106,772	75.5	75.2	75.7	73.5
2016	●	107,784	75.0	74.8	75.2	72.7
2017	●	109,349	74.9	74.7	75.2	72.0

*Number of women aged 53–70 resident in the area with a screening test result recorded in the previous three years



Data Source: Public Health England

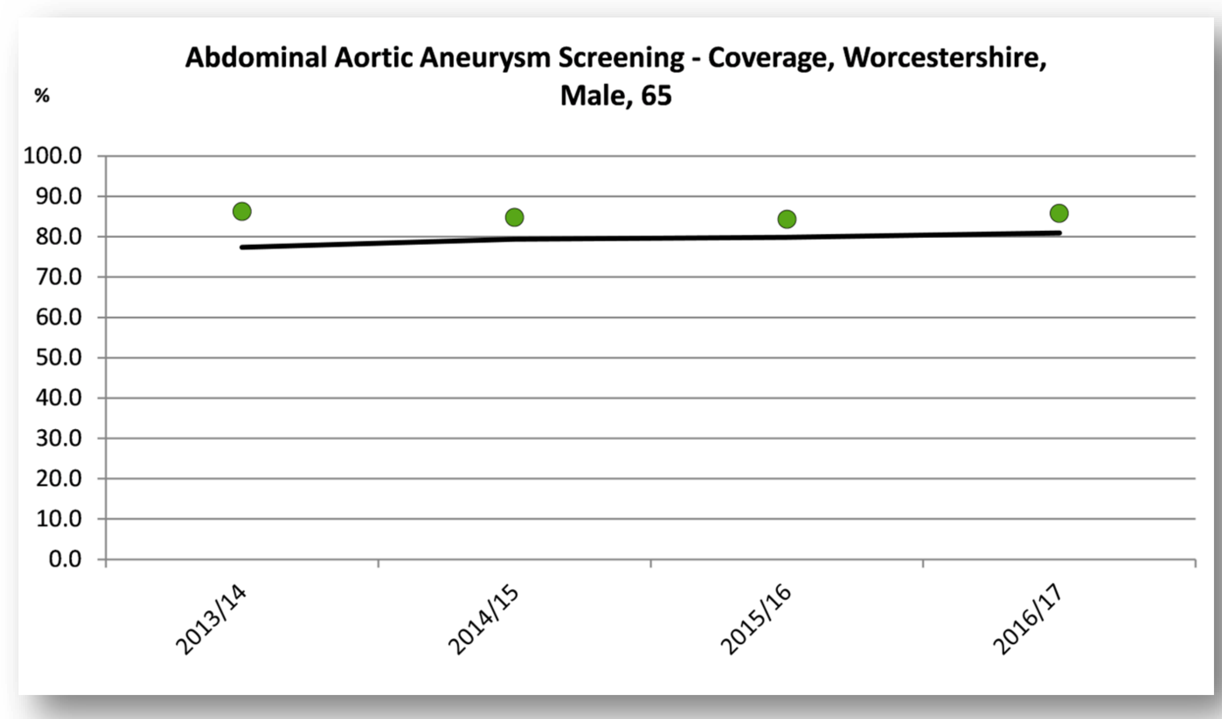
Abdominal aortic aneurysm screening

- Screening for aortic aneurysm (a swelling of the aorta, the main blood vessel leading from the heart) was introduced in England in 2009.
- Performance thresholds. Acceptable level: ≥ 75.0%. Achievable level ≥ 85.0%.

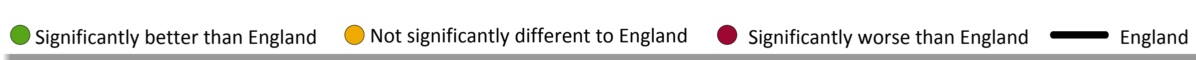
Abdominal aortic aneurysm screening, Worcestershire, Male, 65

Period		Count*	Value	Lower CI	Upper CI	England
2013/14	●	3,565	86.3	85.2	87.3	77.4
2014/15	●	3,245	84.8	83.6	85.9	79.4
2015/16	●	3,065	84.3	83.1	85.5	79.9
2016/17	●	3,140	85.8	84.6	86.9	80.9

*Number of men eligible for the initial screen who have had a conclusive scan result



Data Source: Public Health England



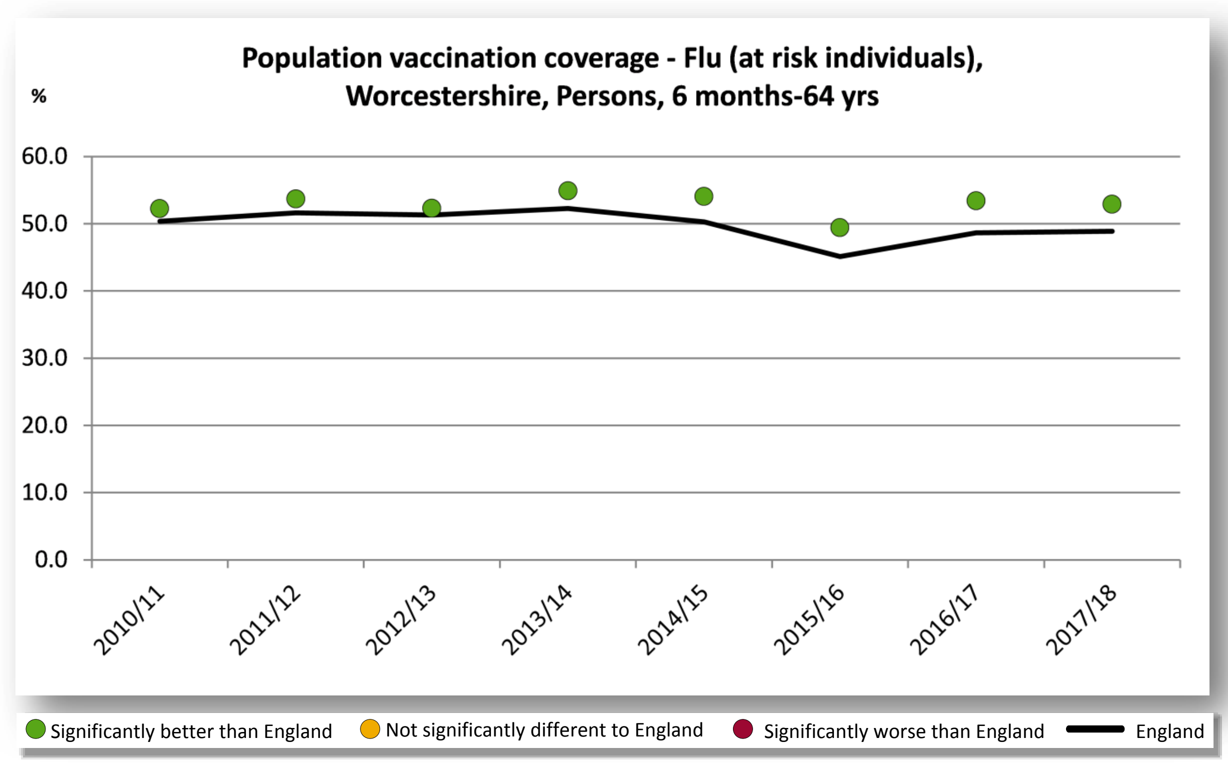
Population vaccination coverage - Flu (at risk individuals)

- Flu vaccination for at risk individuals under the age of 65 is significantly higher in Worcestershire than the national average. However it remains below the national target value of 55%.
- At risk individuals include those with certain medical conditions, pregnant women and carers.
- Rates have been similar for 5 years at just over half of those eligible.

Population vaccination coverage - Flu (at risk individuals), Worcestershire, Persons, 6 months-64 yrs

Period		Count*	Value	Lower CI	Upper CI	England
2010/11	●	28,619	52.2	51.8	52.7	50.4
2011/12	●	29,722	53.7	53.3	54.1	51.6
2012/13	●	29,761	52.3	51.9	52.7	51.3
2013/14	●	31,111	54.9	54.5	55.3	52.3
2014/15	●	33,405	54.1	53.7	54.5	50.3
2015/16	●	34,158	49.4	49.0	49.8	45.1
2016/17	●	34,538	53.4	53.0	53.8	48.6
2017/18	●	38,500	52.9	52.6	53.3	48.9

*number of vaccinations to at risk individuals administered during the influenza season between 1st September to 31st January for each period



Significantly better than England ● Not significantly different to England ● Significantly worse than England — England

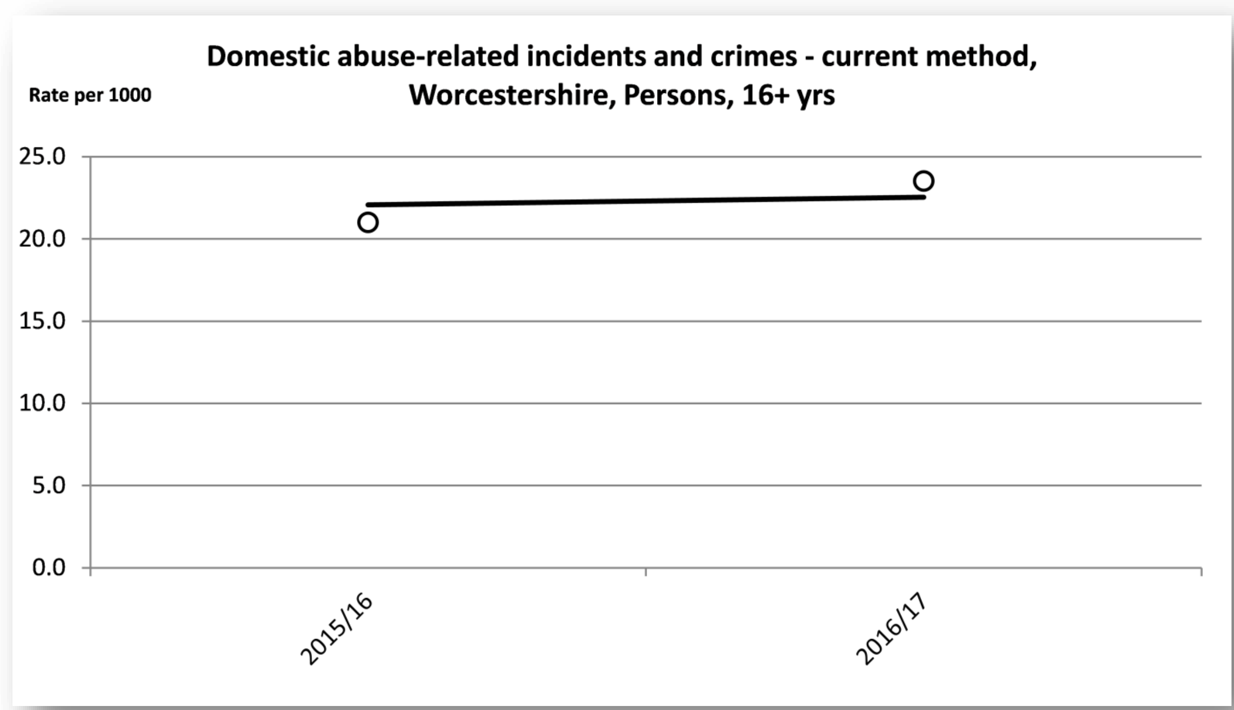
Data Source: Public Health England

Domestic abuse

- The method for calculating the rate of domestic abuse-related incidents and crimes recorded by the police changed in 2015/16. The data for 2016/17 shows Worcestershire's rate as 23.5, higher than the national value of 22.5. These figures cannot be compared with the historical data for 2014/15 and earlier.
- The increase in the rate may be due to better reporting rather than more incidents.
- Statistical significance is not reported for this indicator.

Domestic abuse, Worcestershire, Persons, 16+ yrs
Crude rate per 1000

Period	Count	Value	Lower CI	Upper CI	England
2010/11	-	16.7	16.4	17.0	18.4
2011/12	-	16.7	16.4	16.9	18.0
2012/13	-	15.4	15.2	15.7	18.1
2013/14	-	15.5	15.2	15.7	19.4
2014/15	-	17.8	17.5	18.0	20.4
2015/16 (new method)	-	21.0			22.1
2016/17 (new method)		23.5			22.5



Data Source: Public Health England

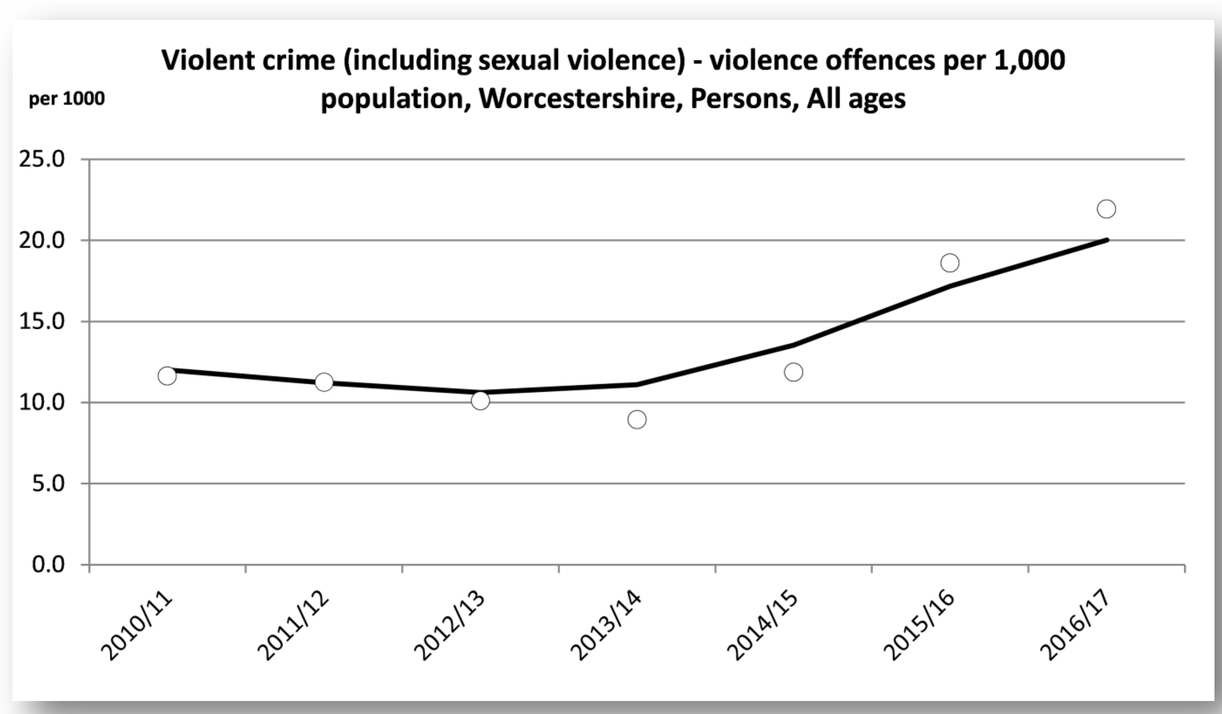
Violence offences per 1,000 population

- The rate in Worcestershire is significantly higher than the national average.
- Increases may be due to better reporting rather than more incidents, therefore we cannot determine whether a high level is better or worse.

Violence offences per 1,000 population, Worcestershire, Persons, All ages
Crude rate per 1000

Period	Count*	Value	Lower CI	Upper CI	England
2010/11	6,544	11.6	11.4	11.9	12.0
2011/12	6,352	11.3	11.0	11.5	11.2
2012/13	5,729	10.1	9.9	10.4	10.6
2013/14	5,091	8.9	8.7	9.2	11.1
2014/15	6,788	11.9	11.6	12.1	13.5
2015/16	10,701	18.6	18.2	19.0	17.2
2016/17	12,688	21.9	21.5	22.3	20.0

*Count of violence against the person offences, based on police recorded crime data



Data Source: Public Health England

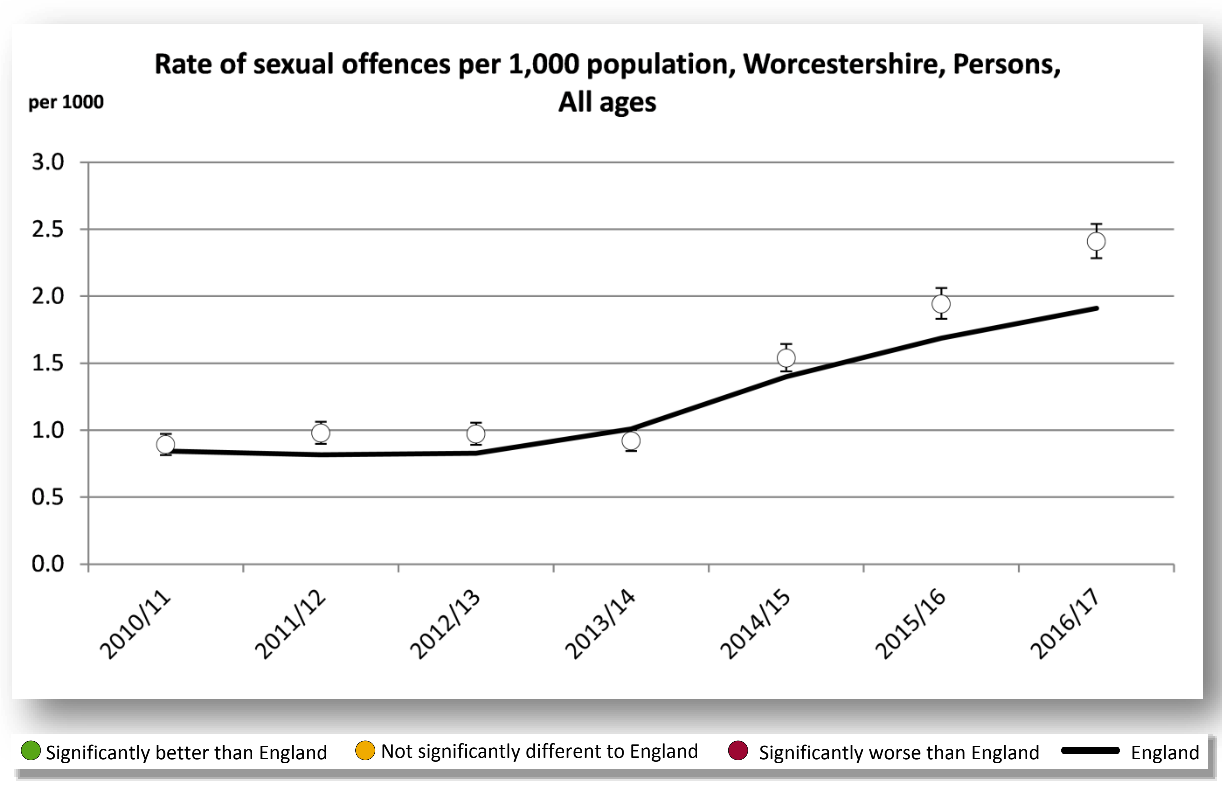
Rate of sexual offences per 1,000 population

- The national pattern for the rate of sexual offences shows an increase over the last two years.
- This increase is reflected in Worcestershire in the latest year.
- The rate in Worcestershire is significantly higher than the national average.
- Increases may be due to better reporting rather than more incidents, therefore we cannot determine whether a high level is better or worse.

Rate of sexual offences per 1,000 population, Worcestershire, Persons, All ages
Crude rate per 1000

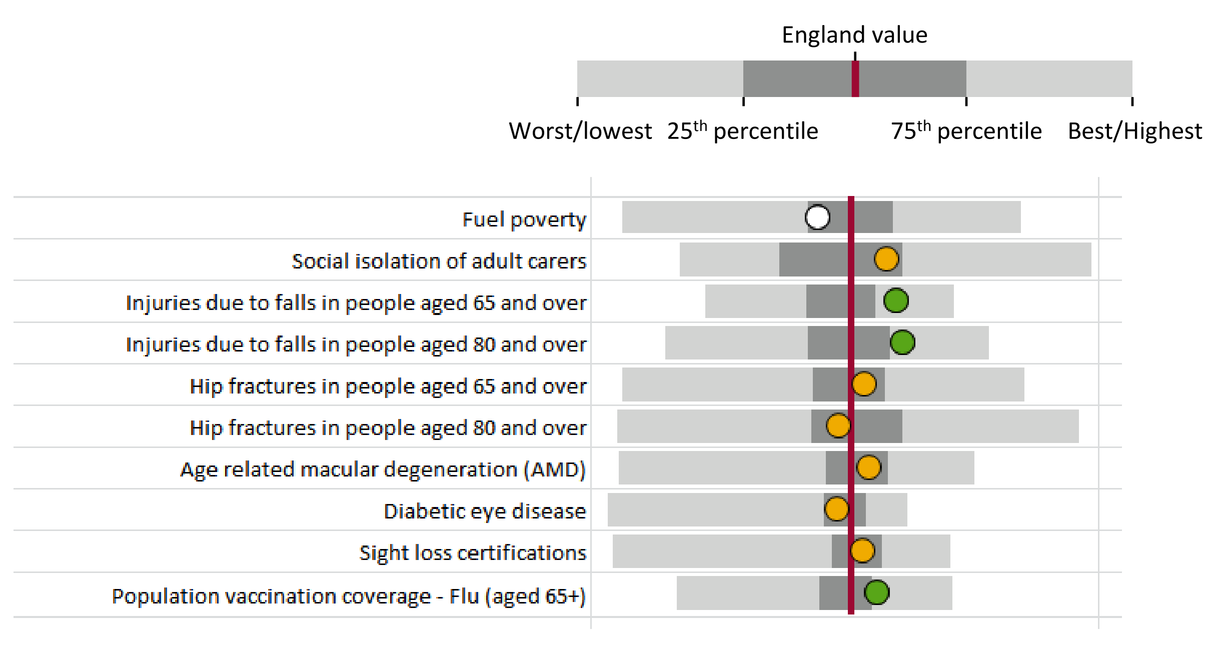
Period	Count*	Value	Lower CI	Upper CI	England
2010/11	501	0.9	0.8	1.0	0.8
2011/12	552	1.0	0.9	1.1	0.8
2012/13	550	1.0	0.9	1.1	0.8
2013/14	524	0.9	0.8	1.0	1.0
2014/15	880	1.5	1.4	1.6	1.4
2015/16	1,118	1.9	1.8	2.1	1.7
2016/17	1,394	2.4	2.3	2.5	1.9

*Count of sexual offences, based on police recorded crime data



Data Source: Public Health England

Older People



				Worcestershire		England		
	Sex	Age	Period	Count*	Value	Value	Worst	Best
Fuel poverty	Persons	All ages	2015	30,001	12.3	11.0	19.4	4.8
Social isolation of adult carers	Persons	All ages	2016/17	24,200	38.4	35.5	21.5	55.0
Injuries due to falls in people aged 65 and over	Persons	65+ yrs	2016/17	2,245	1,746.8	2,113.8	3,305.8	1,284.2
Injuries due to falls in people aged 80 and over	Persons	80+ yrs	2016/17	1,531	4,537.5	5,363.2	8,390.3	3,146.4
Hip fractures in people aged 65 and over	Persons	65+ yrs	2016/17	721	558.5	575.0	854.2	364.7
Hip fractures in people aged 80 and over	Persons	80+ yrs	2016/17	532	1,580.9	1,544.5	2,209.6	898.4
Age related macular degeneration (AMD)	Persons	65+ yrs	2016/17	124	96.9	111.3	299.9	11.7
Diabetic eye disease	Persons	12+ yrs	2016/17	18	3.6	3.1	12.0	1.0
Sight loss certifications	Persons	All ages	2016/17	224	38.4	42.4	130.0	6.3
Population vaccination coverage - Flu (aged 65+)	Persons	65+ yrs	2017/18	97,979	74.7	72.6	58.4	80.8

*Definition of count for each indicator is shown in the following sections.

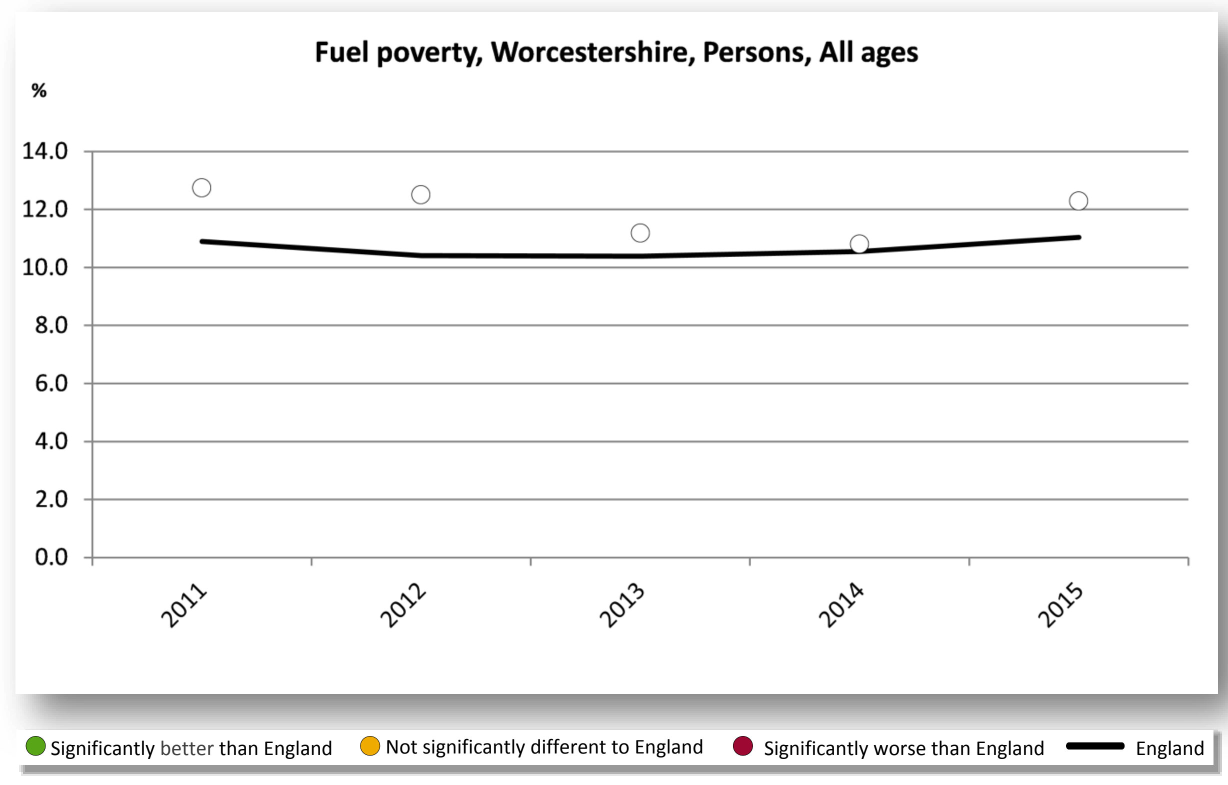
Fuel poverty

- Fuel poverty is estimated using a model developed by the Department for Business, Energy and Industrial strategy.
- The numbers and rate of households in fuel poverty in Worcestershire increased in 2015 and is higher than the national average,
- Approximately 30,000 households remain in fuel poverty.

Fuel poverty, Worcestershire, Persons, All ages (%)

Period	Count*	Value	Lower CI	Upper CI	England
2011	30,613	12.8	-----	-----	10.9
2012	29,302	12.5	-----	-----	10.4
2013	26,915	11.2	-----	-----	10.4
2014	26,159	10.8	-----	-----	10.6
2015	30,001	12.3	-----	-----	11.0

*The number of households in the corresponding geographical area that were in fuel poverty (modelled). See *https://www.gov.uk/government/statistics/fuel-poverty-sub-regional-methodology-and-documentation* for further information.



Significantly better than England · Not significantly different to England · Significantly worse than England · England

Significance not measured

Data Source: Public Health England

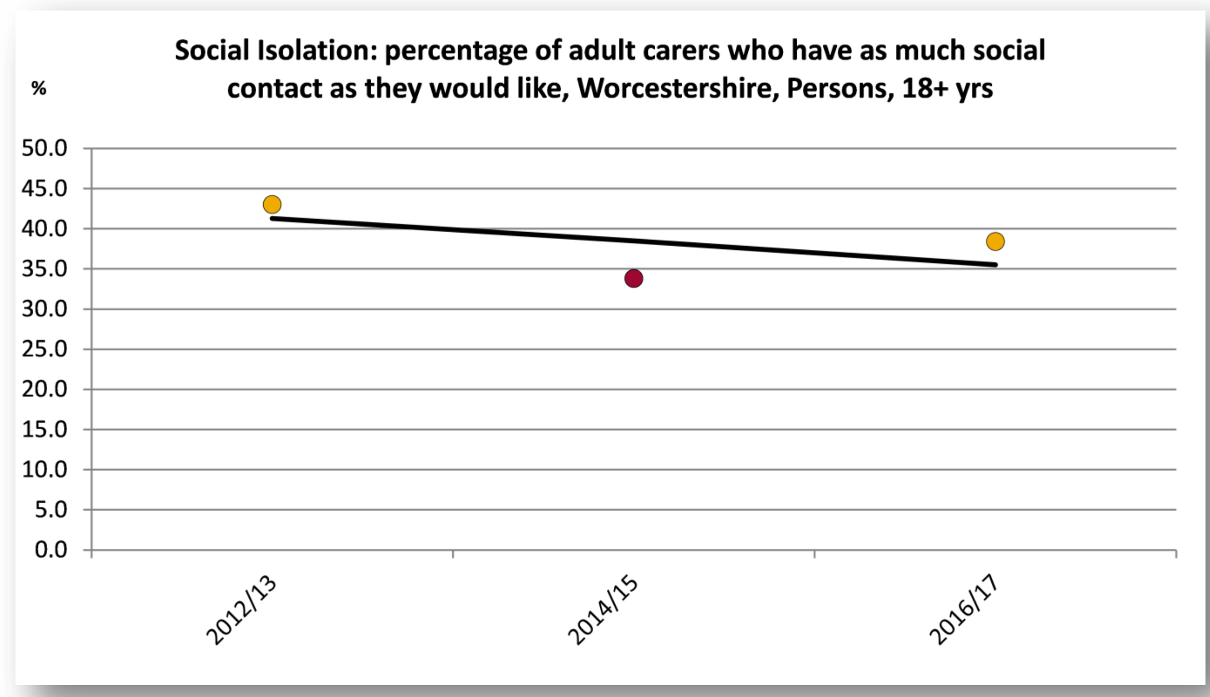
Social Isolation of adult carers

- The proportion of adult carers who have as much social contact as they would like has fluctuated since 2012/13 and is now slightly above the national level (though not significantly).
- The fluctuation may partly reflect the fact that this indicator is measured using a survey with a sample size in Worcestershire of 450.

Adult carers who have as much social contact as they would like, Worcestershire, Persons, 18+ yrs (%)

Period		Count*	Value	Lower CI	Upper CI	England
2012/13	Higher	-	43.0	38.5	47.5	41.3
2014/15	Lower	-	33.8	29.6	38.0	38.5
2016/17	Higher	24,200	38.4	34.0	43.0	35.5

*estimated number of carers in Worcestershire who have as much social contact as they would like using the Personal Social Services Survey of Adult Carers in England and Census of Population 2011



Data Source: Public Health England

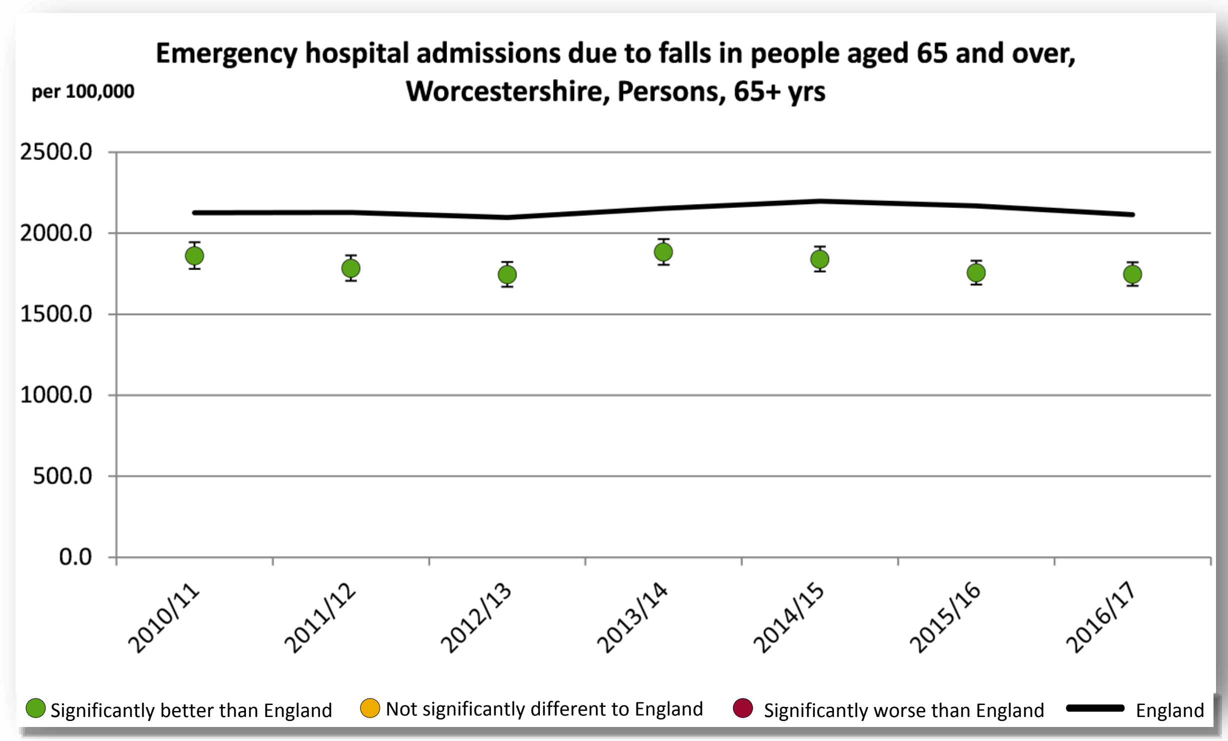
Emergency hospital admissions due to falls in people aged 65 and over

- Emergency hospital admissions due to falls in those aged 65+ are significantly lower in Worcestershire than nationally.
- The rate has not changed significantly over the last 5 years, although numbers have risen slightly in line with the ageing population.

Emergency hospital admissions due to falls, Worcestershire, Persons, 65+ yrs
Directly standardised rate per 100,000

Period		Count*	Value	Lower CI	Upper CI	England
2010/11	●	2,027	1860.5	1779.8	1943.8	2125.8
2011/12	●	1,998	1783.1	1705.4	1863.5	2128.5
2012/13	●	2,017	1744.7	1669.0	1822.9	2096.8
2013/14	●	2,236	1882.9	1805.4	1962.9	2154.0
2014/15	●	2,248	1839.2	1763.7	1917.1	2198.8
2015/16	●	2,188	1755.3	1682.3	1830.6	2169.4
2016/17	●	2,245	1746.8	1675.1	1820.7	2113.8

* Number of emergency admissions for falls injuries



Data Source: Public Health England

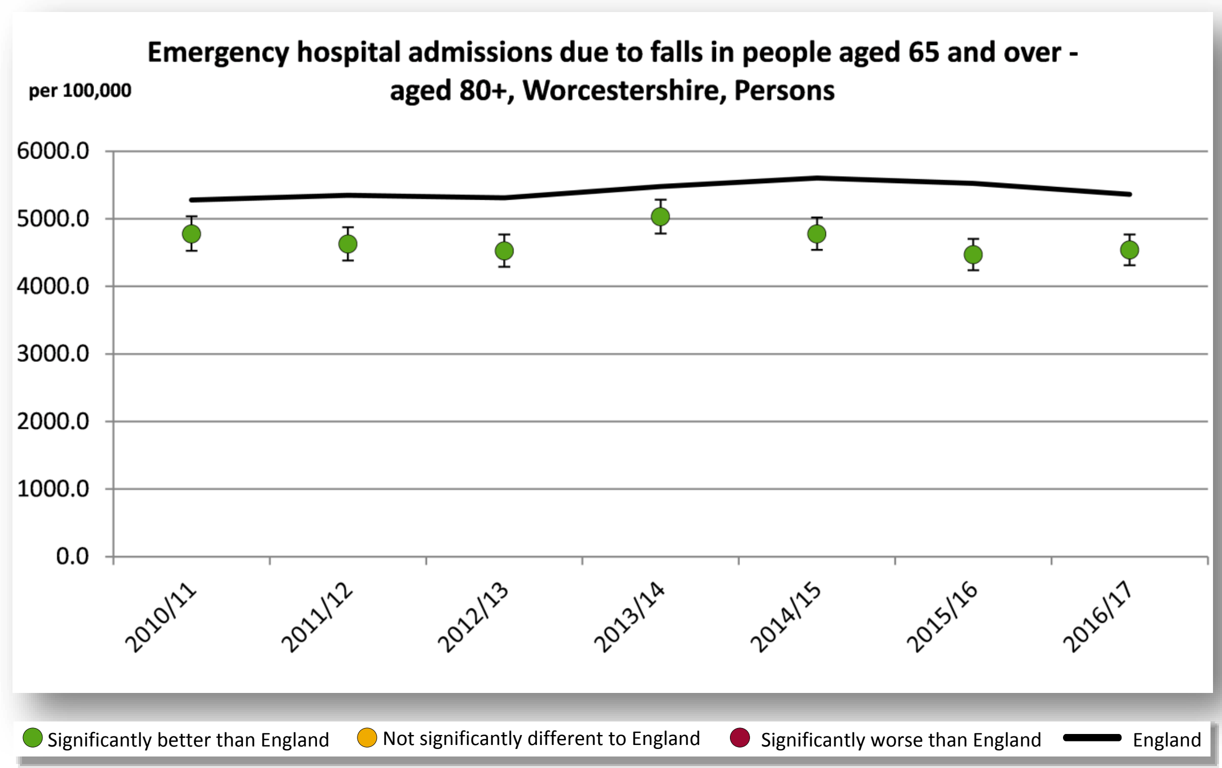
Emergency hospital admissions due to falls in people aged 80 and over

- In the oldest age group, those aged 80+, the rate of falls injuries has tended to fluctuate.
- The rate remains significantly below the national average.

Emergency hospital admissions due to falls, Worcestershire, Persons, 80+ yrs
Directly standardised rate per 100,000

Period		Count*	Value	Lower CI	Upper CI	England
2010/11	●	1,379	4275.9	4525.2	5036.7	5281.7
2011/12	●	1,381	4624.9	4383.0	4876.5	5351.5
2012/13	●	1,387	4524.3	4288.8	4767.4	5310.2
2013/14	●	1,576	5029.1	4783.5	5284.1	5479.1
2014/15	●	1,542	4776.2	4540.5	5020.9	5604.3
2015/16	●	1,464	4467.0	4240.8	4702.1	5525.6
2016/17	●	1,531	4537.5	4312.8	4770.8	5363.2

* Number of emergency admissions for falls injuries



Data Source: Public Health England

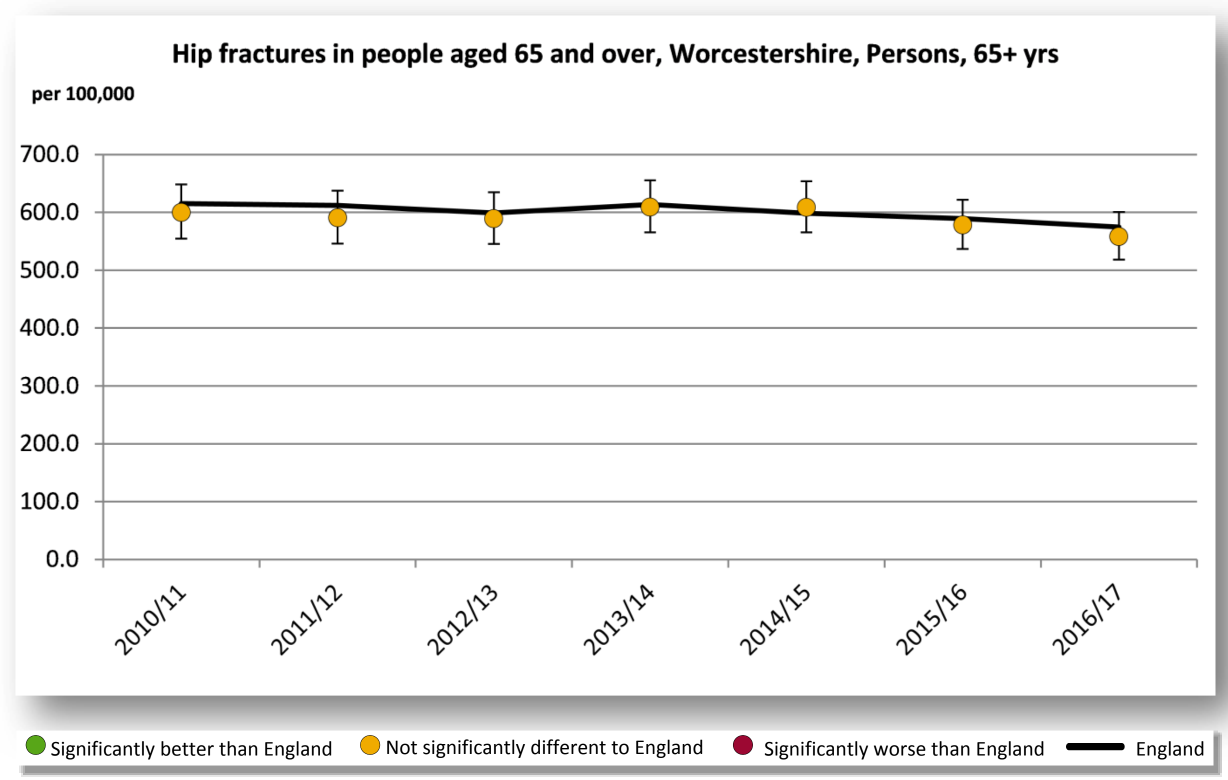
Hip fractures in people aged 65 and over

- The rate of hip fractures in Worcestershire shows a similar pattern to that of falls injuries as a whole.
- However the rate is not much below the national average suggesting that a higher proportion of falls injuries are hip fractures as these are mostly caused by falls.

Hip fractures, Worcestershire, Persons, 65+ yrs
Directly standardised rate per 100,000

Period		Count*	Value	Lower CI	Upper CI	England
2010/11	●	654	600.2	554.8	648.3	615.3
2011/12	●	665	590.5	546.2	637.4	612.1
2012/13	●	681	588.9	545.3	635.1	599.3
2013/14	●	724	609.2	565.5	655.4	614.0
2014/15	●	742	608.5	565.4	654.0	598.6
2015/16	●	721	578.1	536.6	622.0	589.5
2016/17	●	721	558.5	518.4	600.9	575.0

*Number of emergency hospital admission for hip fractures (fractured neck of femur) in persons aged 65 and over



Data Source: Public Health England

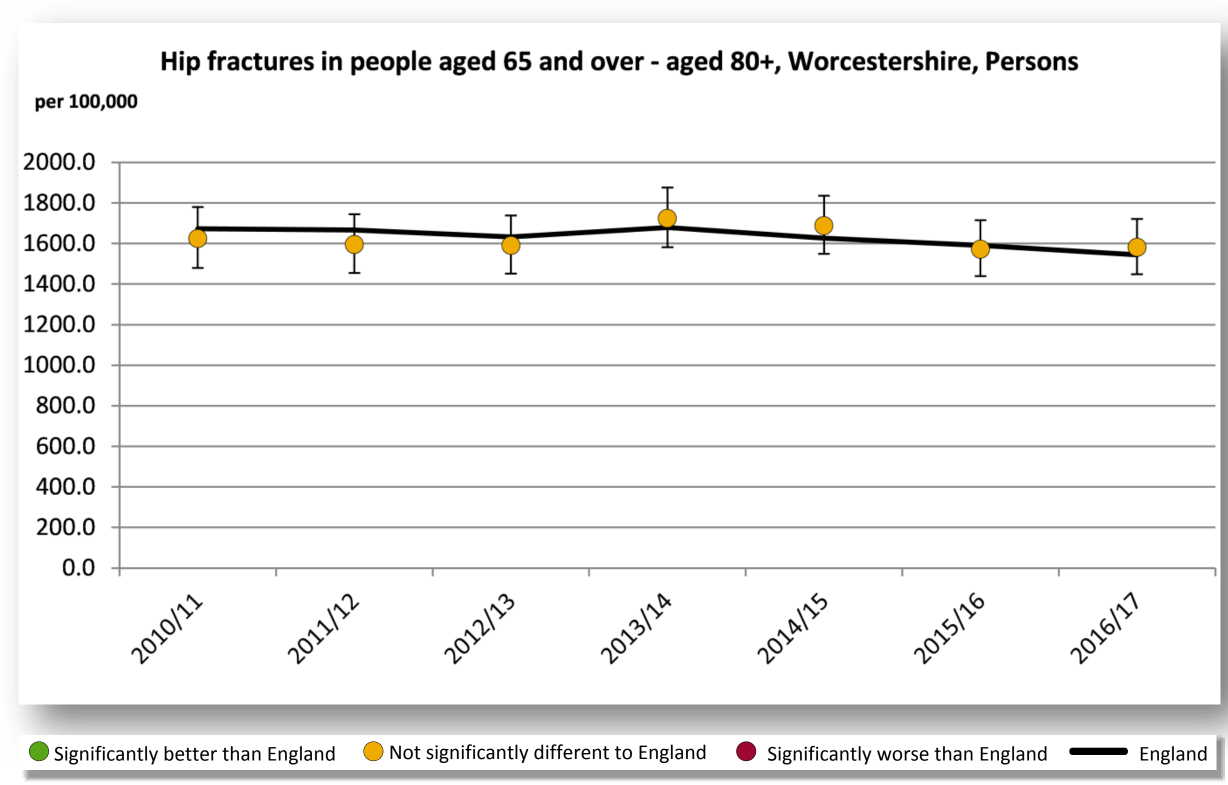
Hip fractures in people aged 80 and over

- As for the total 65+ age group, hip fractures in people aged 80 and over are not significantly different to the national average.

Hip fractures, Worcestershire, Persons, 80+ yrs
Directly standardised rate per 100,000

Period		Count*	Value	Lower CI	Upper CI	England
2010/11	●	468	1625.1	1480.1	1780.4	1672.6
2011/12	●	478	1594.4	1454.1	1744.6	1667.4
2012/13	●	488	1589.9	1451.6	1737.7	1633.5
2013/14	●	541	1723.7	1581.3	1875.5	1679.9
2014/15	●	544	1687.8	1548.8	1835.9	1627.4
2015/16	●	516	1572.4	1439.5	1714.3	1590.7
2016/17	●	532	1580.9	1449.3	1721.2	1544.5

*Number of emergency hospital admission for hip fractures (fractured neck of femur) in persons aged 65 and over



Data Source: Public Health England

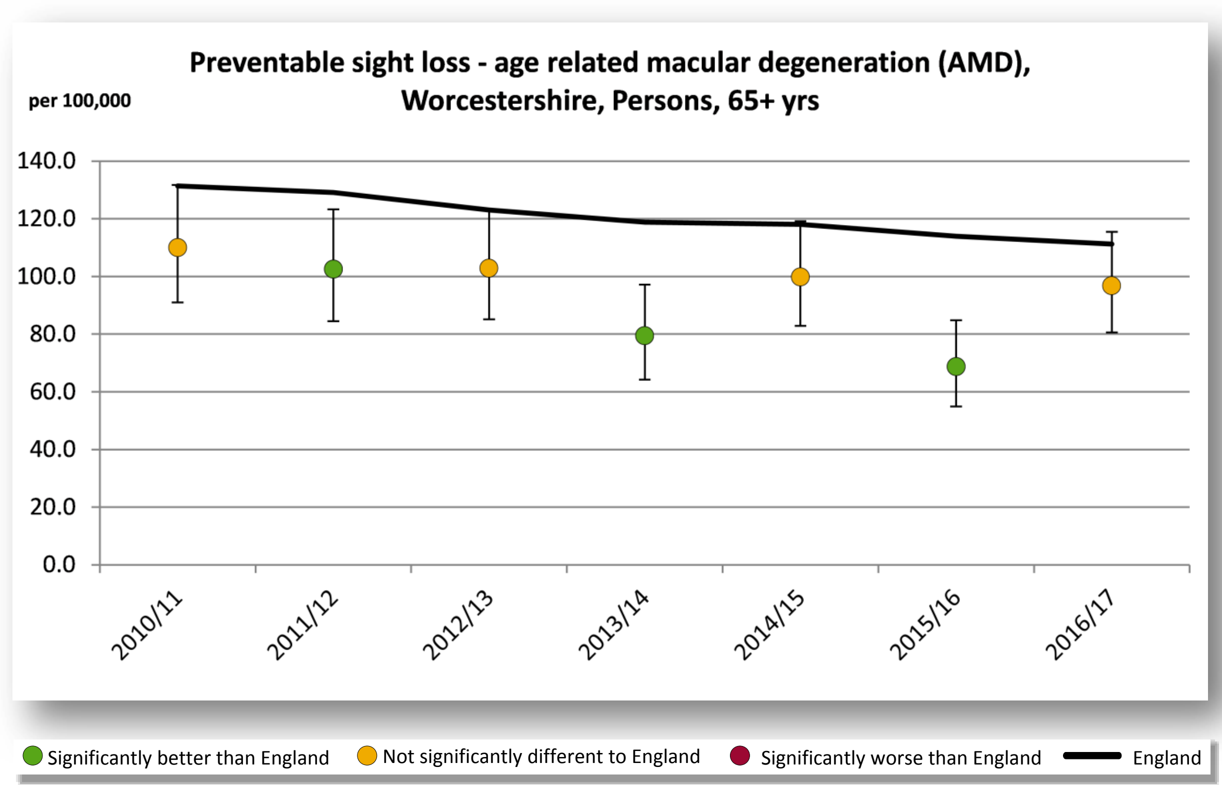
Preventable sight loss - age related macular degeneration (AMD)

- The rate of age-related macular degeneration in Worcestershire has tended to be significantly below the national average, despite a high elderly population.

Preventable sight loss – age related macular degeneration (AMD), Worcestershire, Persons, 65+ yrs
Crude rate per 100,000

Period		Count*	Value	Lower CI	Upper CI	England
2010/11	●	118	110.0	91.0	131.7	131.5
2011/12	●	113	102.6	84.5	123.3	129.1
2012/13	●	118	102.9	85.2	123.2	123.1
2013/14	●	94	79.4	64.2	97.2	118.8
2014/15	●	122	99.8	82.9	119.2	118.1
2015/16	●	86	68.7	54.9	84.8	114.0
2016/17	●	124	96.9	80.6	115.5	111.3

* Number of certifications with a main cause of sight loss of AMD or where no main cause is attributed but where AMD is a contributory cause.



Data Source: Public Health England

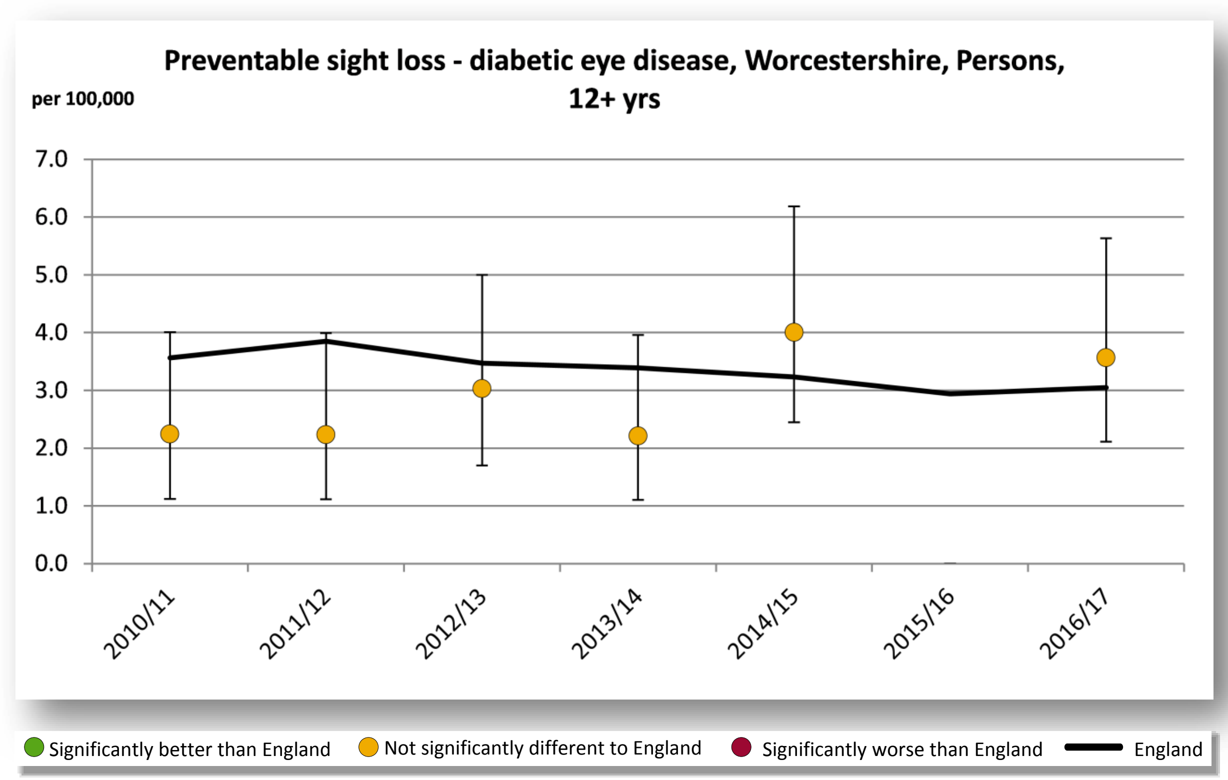
Preventable sight loss – diabetic eye disease

- Sight loss due to diabetic eye disease is relatively low in Worcestershire, however due to there being very small numbers this is not significant.
- The rate has not changed significantly in the 6 years for which we have data.

Preventable sight loss - diabetic eye disease, Worcestershire, Persons, 12+ yrs
Crude rate per 100,000

Period		Count*	Value	Lower CI	Upper CI	England
2010/11	●	11	2.2	1.1	4.0	3.6
2011/12	●	11	2.2	1.1	4.0	3.8
2012/13	●	15	3.0	1.7	5.0	3.5
2013/14	●	11	2.2	1.1	4.0	3.4
2014/15	●	20	4.0	2.4	6.2	3.2
2015/16		-	-	-	-	-
2016/17	●	18	3.6	2.1	5.6	3.1

* Number of certifications with a main cause of sight loss of AMD or where no main cause is attributed but where AMD is a contributory cause.



Data Source: Public Health England

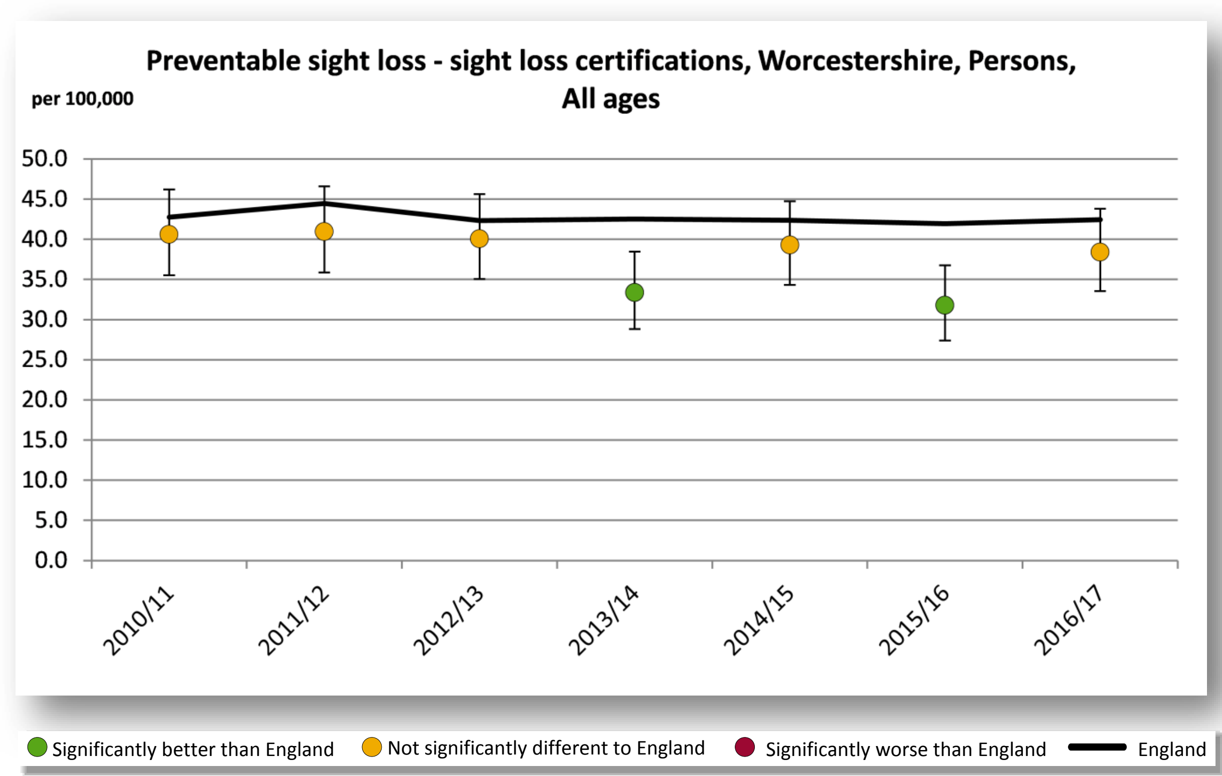
Preventable sight loss - sight loss certifications

- Total sight loss certifications in Worcestershire are close to the national average.

Preventable sight loss - sight loss certifications, Worcestershire, Persons, All ages
Crude rate per 100,000

Period		Count	Value	Lower CI	Upper CI	England
2010/11	●	229	40.6	35.5	46.2	42.7
2011/12	●	232	40.9	35.8	46.6	44.5
2012/13	●	228	40.1	35.0	45.6	42.3
2013/14	●	191	33.4	28.8	38.5	42.5
2014/15	●	226	39.3	34.3	44.7	42.4
2015/16	●	184	31.8	27.4	36.7	41.9
2016/17	●	224	38.4	33.6	43.8	42.4

*Number of certifications for sight loss



Significantly better than England | Not significantly different to England | Significantly worse than England | England

Data Source: Public Health England

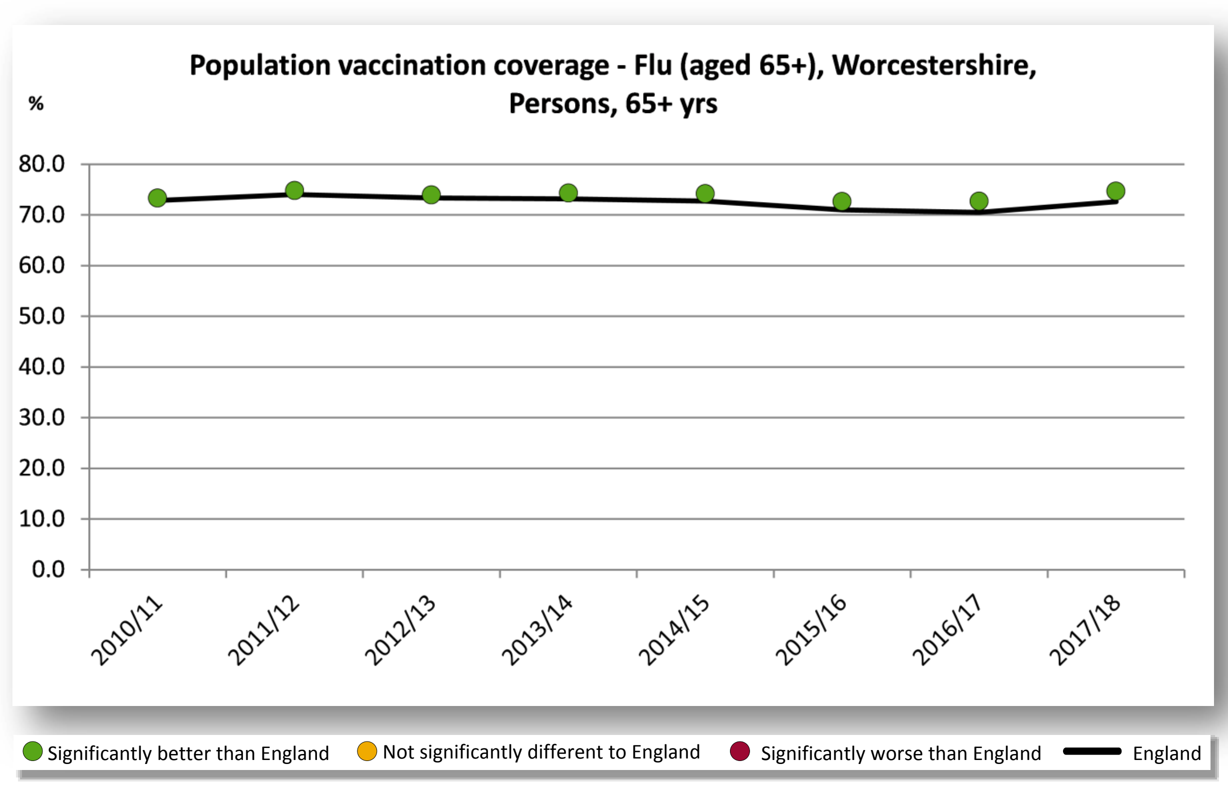
Population vaccination coverage - Flu (aged 65+)

- The vaccination rate for flu in those aged 65 and over in Worcestershire is significantly higher than nationally.
- However it remains slightly below the World Health Organisation target rate of 75%.

Population vaccination coverage - Flu (aged 65+), Worcestershire, Persons, 65+ yrs (%)

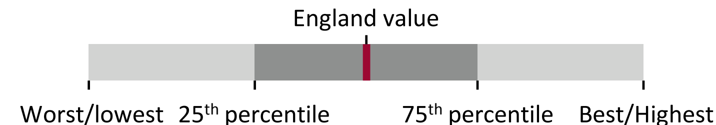
Period		Count	Value	Lower CI	Upper CI	England
2010/11	●	79,355	73.3	73.1	73.6	72.8
2011/12	●	84,717	74.8	74.6	75.1	74.0
2012/13	●	86,642	74.0	73.7	74.2	73.4
2013/14	●	89,583	74.3	74.0	74.5	73.2
2014/15	●	91,997	74.2	74.0	74.5	72.7
2015/16	●	92,325	72.6	72.4	72.9	71.0
2016/17	●	93,497	72.7	72.5	73.0	70.5
2017/18	●	97,979	74.7	74.5	75.0	72.6

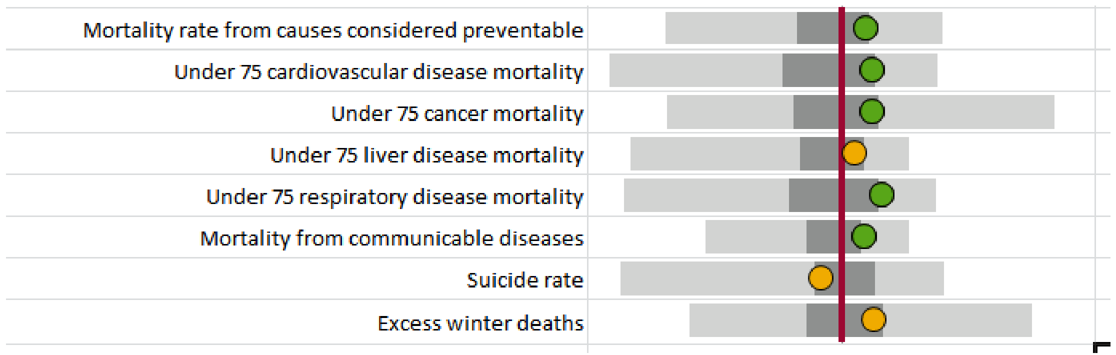
*number of vaccinations administered during the influenza season between 1st September to 31st January for each period



Data Source: Public Health England

Mortality





Significantly better than England   Not significantly different to England   Significantly worse than England

				Worcestershire		England		
	Sex	Age	Period	Count	Value	Value	Worst	Best
Mortality rate from causes considered preventable per 100,000 population	Persons	All ages	2014 - 16	3,021	162.8	182.8	330.0	98.8
Under 75 cardiovascular disease mortality per 100,000 population	Persons	<75 yrs	2014 - 16	1,092	64.6	73.5	141.3	45.6
Under 75 cancer mortality per 100,000 population	Persons	<75 yrs	2014 - 16	2,160	126.4	136.8	195.3	65.8
Under 75 liver disease mortality per 100,000 population	Persons	<75 yrs	2014 - 16	278	16.6	18.3	44.7	9.8
Under 75 respiratory disease mortality per 100,000 population	Persons	<75 yrs	2014 - 16	469	27.0	33.8	70.2	18.1
Mortality from communicable diseases per 100,000 population	Persons	All ages	2014 - 16	167	8.8	10.7	22.0	5.1
Suicide rate per 100,000 population	Persons	10+ yrs	2014 - 16	162	10.7	9.9	18.3	6.1
Excess winter deaths	Persons	All ages	Aug 2015 - Jul 2016	232	12.4	15.1	27.9	-0.7

*Definition of count for each indicator is shown in the following sections.

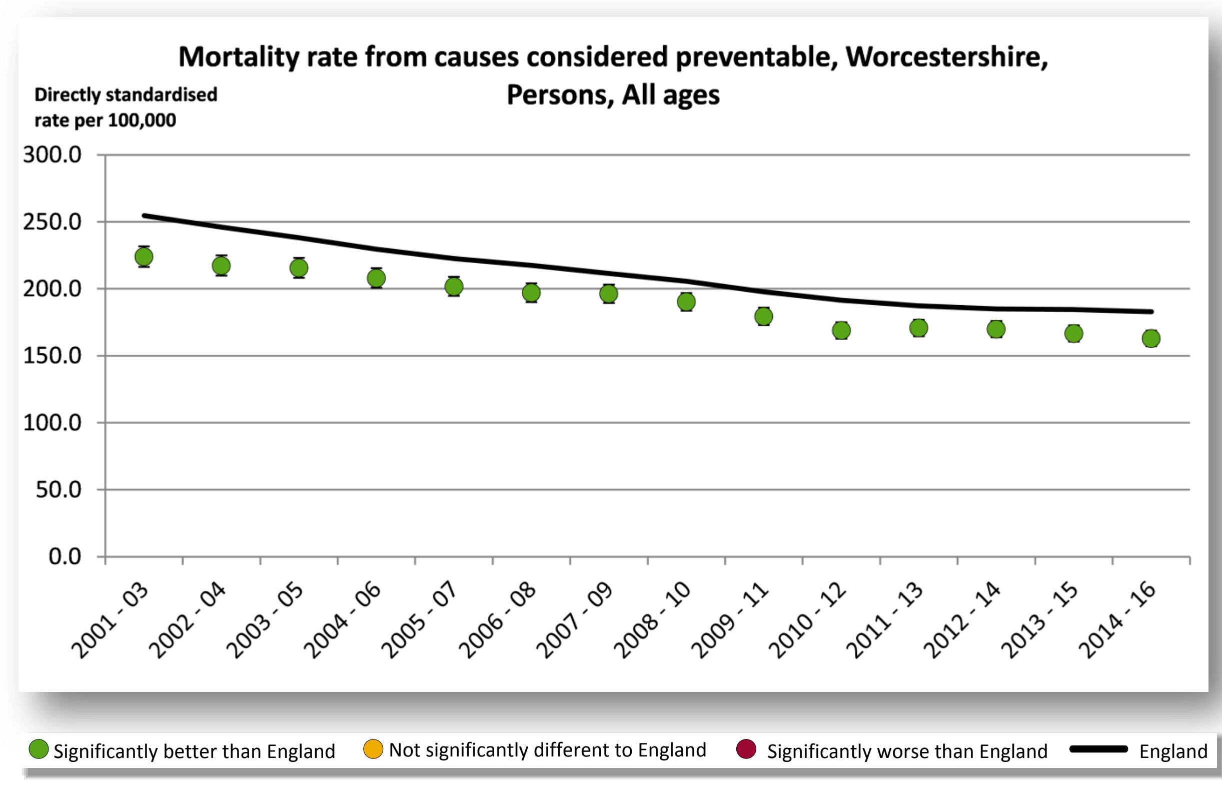
Mortality rate from causes considered preventable

- Worcestershire has significantly lower mortality from preventable causes than nationally.
- The trend is downward although the last few years have been flat.
- There are still nearly 1,000 people dying from preventable causes each year.
- The counts in the table below relate to the total number of deaths in each three year period.

Mortality rate from causes considered preventable, Worcestershire, Persons, All ages
Directly standardised rate per 100,000 population

Period		Count*	Value	Lower CI	Upper CI	England
2001 - 03	●	3,232	224.0	216.3	231.8	254.7
2002 - 04	●	3,197	217.2	209.8	224.9	246.0
2003 - 05	●	3,227	215.6	208.2	223.2	238.2
2004 - 06	●	3,179	208.0	200.8	215.3	229.5
2005 - 07	●	3,134	201.7	194.7	208.9	222.7
2006 - 08	●	3,117	197.0	190.1	204.0	217.6
2007 - 09	●	3,149	196.2	189.5	203.2	211.5
2008 - 10	●	3,109	190.1	183.5	196.9	205.8
2009 - 11	●	2,998	179.3	173.0	185.9	197.7
2010 - 12	●	2,877	168.8	162.7	175.0	191.4
2011 - 13	●	2,956	170.7	164.6	176.9	187.4
2012 - 14	●	2,987	169.9	163.8	176.1	185.1
2013 - 15	●	3,030	166.6	160.7	172.7	184.5
2014 - 16	●	3,021	162.8	157.0	168.8	182.8

*Number of deaths in each 3 year period from causes that are considered preventable (using underlying cause of death)



Data Source: Public Health England

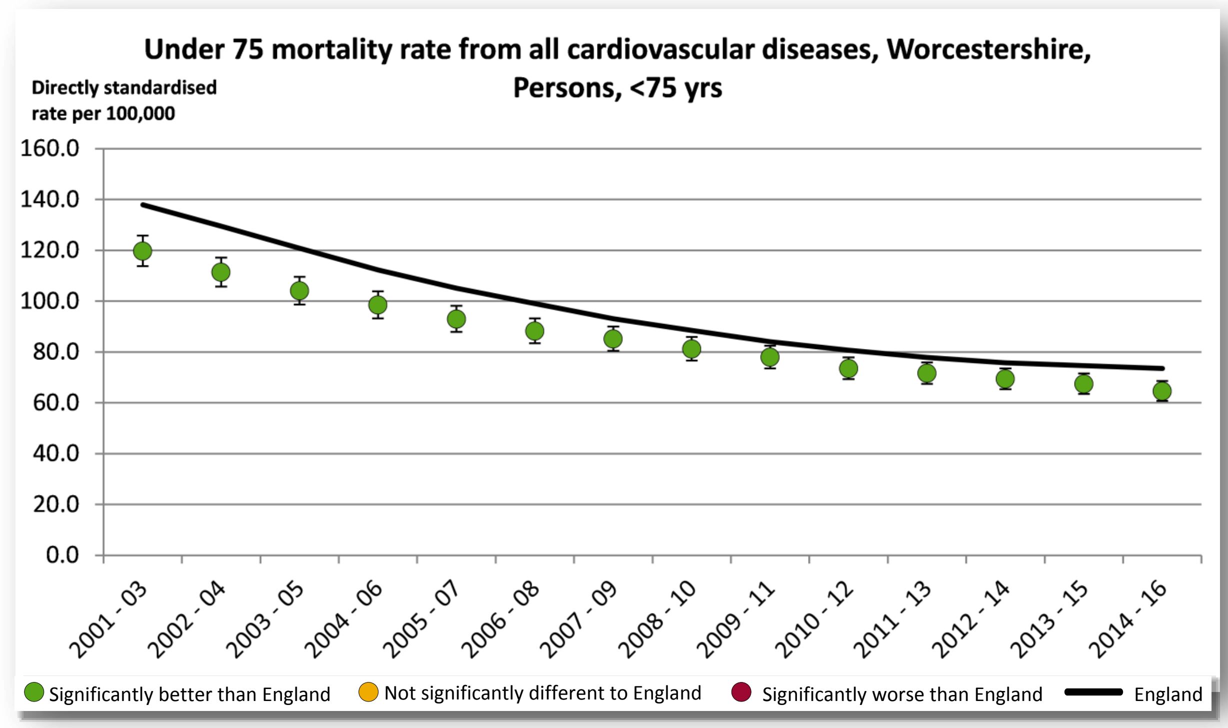
Under 75 mortality rate from all cardiovascular diseases

- The mortality rate from cardiovascular diseases in the under 75s in Worcestershire has decreased by a quarter in the last decade.
- The gap between the England average and Worcestershire narrowed over time until 2013-15. More recent data suggests that the gap between Worcestershire and England may have begun to widen again. Future data releases will help to confirm if this is a sustained positive change.
- The counts in the table relate to the total number of deaths in each three year period.

Under 75 mortality rate from all cardiovascular diseases, Worcestershire, Persons, <75 yrs
Directly standardised rate per 100,000

Period		Count*	Value	Lower CI	Upper CI	England
2001 - 03	●	1,576	119.7	113.8	125.8	138.0
2002 - 04	●	1,492	111.3	105.7	117.1	129.5
2003 - 05	●	1,423	104.0	98.7	109.6	120.9
2004 - 06	●	1,367	98.4	93.3	103.8	112.3
2005 - 07	●	1,312	92.9	87.9	98.1	105.1
2006 - 08	●	1,265	88.3	83.4	93.3	99.0
2007 - 09	●	1,250	85.1	80.4	90.0	93.1
2008 - 10	●	1,224	81.2	76.7	85.9	88.6
2009 - 11	●	1,199	77.9	73.6	82.5	84.0
2010 - 12	●	1,149	73.5	69.3	77.9	80.8
2011 - 13	●	1,140	71.6	67.5	75.9	77.8
2012 - 14	●	1,127	69.4	65.4	73.6	75.7
2013 - 15	●	1,118	67.4	63.5	71.5	74.6
2014 - 16	●	1,092	64.6	60.8	68.5	73.5

*Number of deaths in each 3 year period from cardiovascular disease (using underlying cause of death)



Data Source: Public Health England

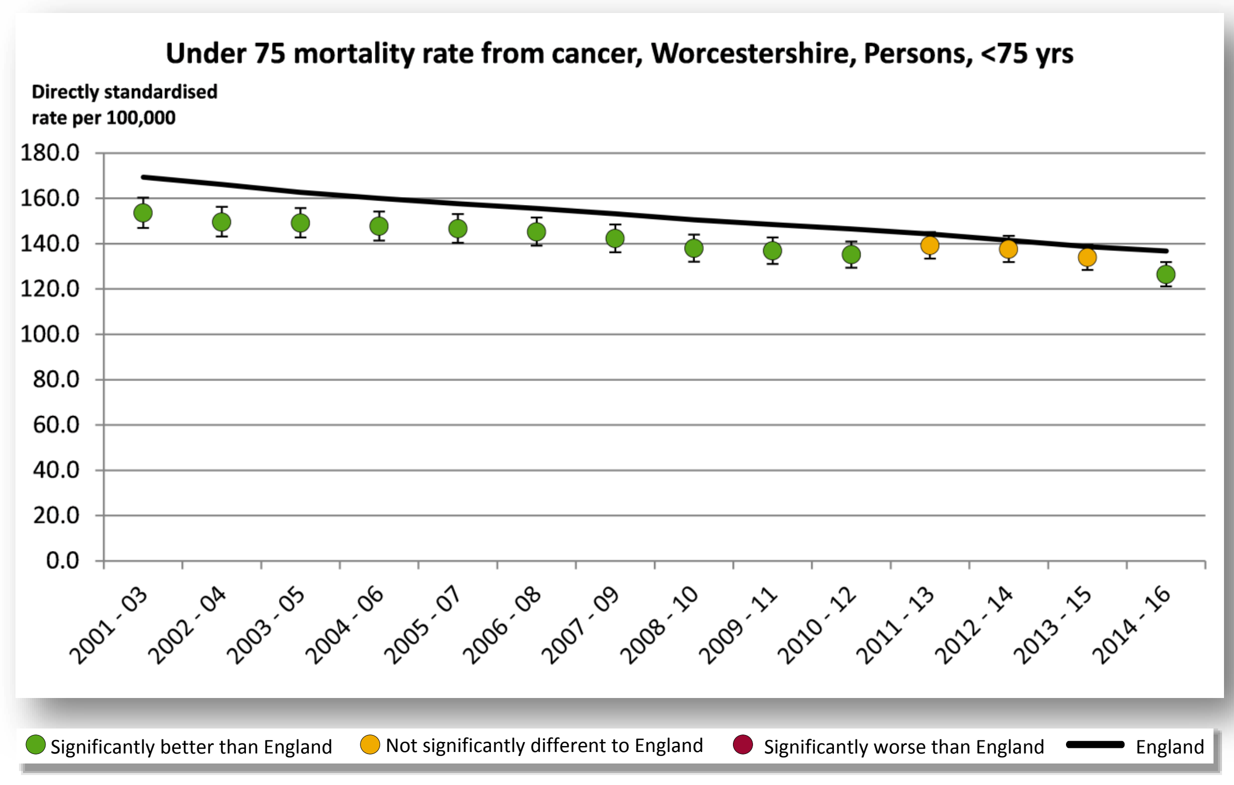
Under 75 mortality rate from cancer

- The gap between the England average and Worcestershire narrowed over time until 2013-15. More recent data suggests that the gap between Worcestershire and England may have begun to widen again. Future data releases will help to confirm if this is a sustained positive change.
- The rate is significantly below the national average.
- The counts in the table relate to the total number of deaths in each three year period.

Under 75 mortality rate from cancer, Worcestershire, Persons, <75 yrs
Directly standardised rate per 100,000

Period		Count	Value	Lower CI	Upper CI	England
2001 - 03	●	2,073	153.5	147.0	160.3	169.4
2002 - 04	●	2,064	149.6	143.2	156.2	166.2
2003 - 05	●	2,088	149.1	142.7	155.7	162.7
2004 - 06	●	2,099	147.7	141.4	154.2	160.0
2005 - 07	●	2,120	146.6	140.4	153.1	157.8
2006 - 08	●	2,132	145.3	139.1	151.6	155.7
2007 - 09	●	2,124	142.2	136.2	148.5	153.2
2008 - 10	●	2,099	138.0	132.1	144.1	150.6
2009 - 11	●	2,125	136.8	131.0	142.8	148.5
2010 - 12	●	2,133	135.1	129.4	141.0	146.5
2011 - 13	●	2,232	139.2	133.5	145.2	144.4
2012 - 14	●	2,249	137.6	131.9	143.4	141.5
2013 - 15	●	2,237	133.9	128.4	139.6	138.8
2014 - 16	●	2,160	126.4	121.1	131.9	136.8

*Number of deaths in each 3 year period from cancer (using underlying cause of death)



Data Source: Public Health England

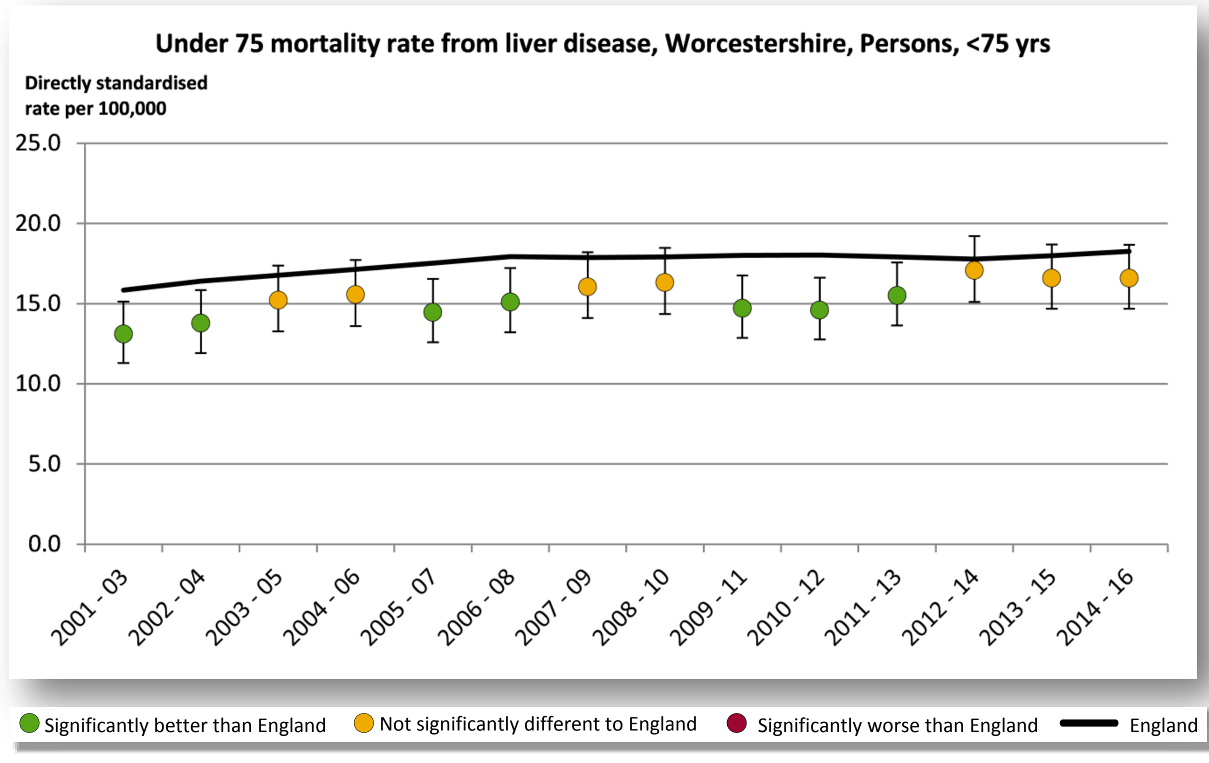
Under 75 mortality rate from liver disease

- Mortality from liver disease in the under 75s has been fairly level in Worcestershire
- The rate has tended to be below the national average.
- The counts in the table relate to the total number of deaths in each three year period.

Under 75 mortality rate from liver disease, Worcestershire, Persons, <75 yrs
Directly standardised rate per 100,000

Period		Count	Value	Lower CI	Upper CI	England
2001 - 03	●	189	13.1	11.3	15.1	15.8
2002 - 04	●	200	13.8	11.9	15.8	16.4
2003 - 05	●	221	15.2	13.3	17.4	16.8
2004 - 06	●	228	15.6	13.6	17.7	17.1
2005 - 07	●	216	14.5	12.6	16.5	17.5
2006 - 08	●	229	15.1	13.2	17.2	17.9
2007 - 09	●	246	16.1	14.1	18.2	17.9
2008 - 10	●	251	16.3	14.4	18.5	17.9
2009 - 11	●	230	14.7	12.9	16.8	18.0
2010 - 12	●	232	14.6	12.8	16.6	18.0
2011 - 13	●	250	15.5	13.6	17.6	17.9
2012 - 14	●	278	17.1	15.1	19.2	17.8
2013 - 15	●	274	16.6	14.7	18.7	18.0
2014 - 16	●	278	16.6	14.7	18.7	18.3

*Number of deaths in each 3 year period from liver disease (using underlying cause of death)



Data Source: Public Health England

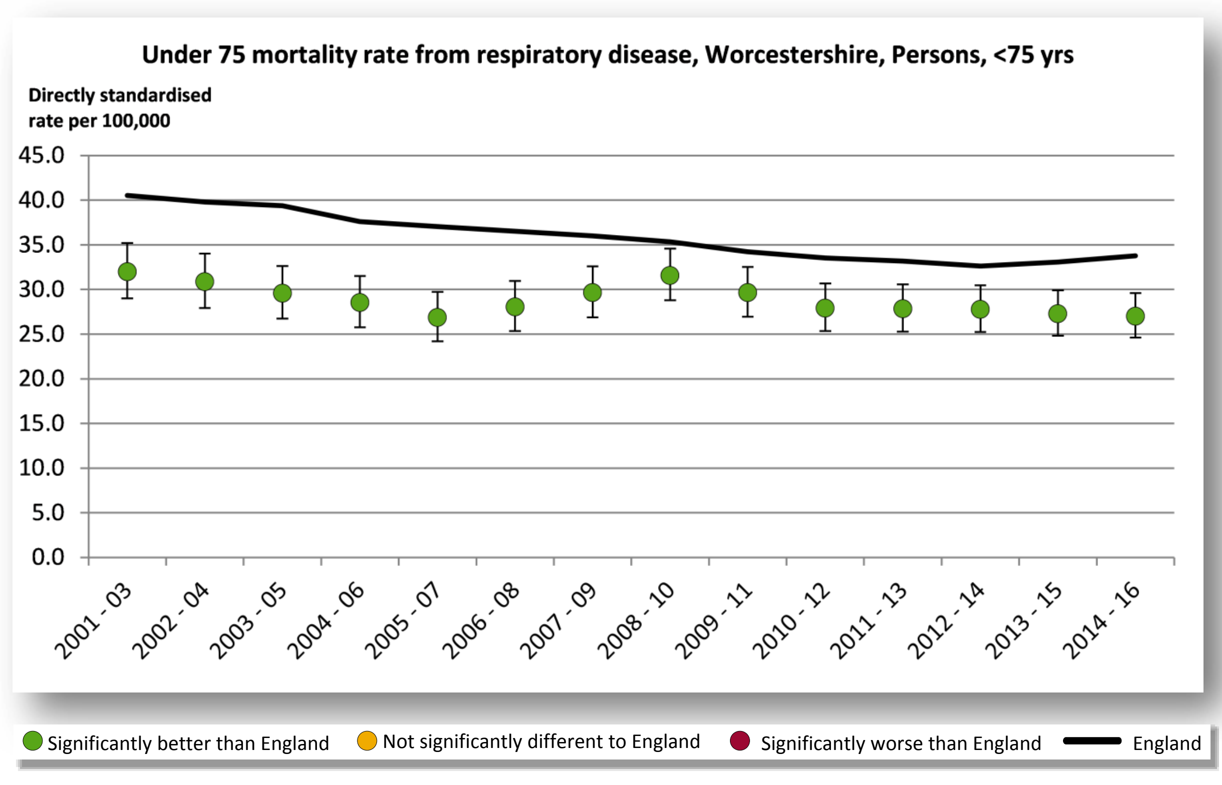
Under 75 mortality rate from respiratory disease

- Under 75 mortality from respiratory diseases is relatively low in Worcestershire.
- However rates have not decreased significantly in 10 years.
- The gap from the national average has narrowed.
- The counts in the table relate to the total number of deaths in each three year period.

Under 75 mortality rate from respiratory disease, Worcestershire, Persons, <75 yrs
Directly standardised rate per 100,000

Period		Count	Value	Lower CI	Upper CI	England
2001 - 03	●	420	32.0	29.0	35.2	40.5
2002 - 04	●	410	30.9	27.9	34.0	39.8
2003 - 05	●	400	29.6	26.7	32.6	39.4
2004 – 06	●	391	28.5	25.8	31.5	37.6
2005 – 07	●	376	26.9	24.2	29.7	37.1
2006 – 08	●	401	28.1	25.4	31.0	36.5
2007 – 09	●	433	29.6	26.9	32.6	36.0
2008 – 10	●	472	31.6	28.8	34.6	35.3
2009 – 11	●	451	29.6	27.0	32.5	34.2
2010 – 12	●	434	27.9	25.3	30.7	33.5
2011 – 13	●	438	27.8	25.3	30.6	33.2
2012 – 14	●	451	27.8	25.3	30.5	32.6
2013 – 15	●	458	27.3	24.8	29.9	33.1
2014 – 16	●	469	27.0	24.6	29.6	33.8

*Number of deaths in each 3 year period from respiratory disease (using underlying cause of death)



Data Source: Public Health England

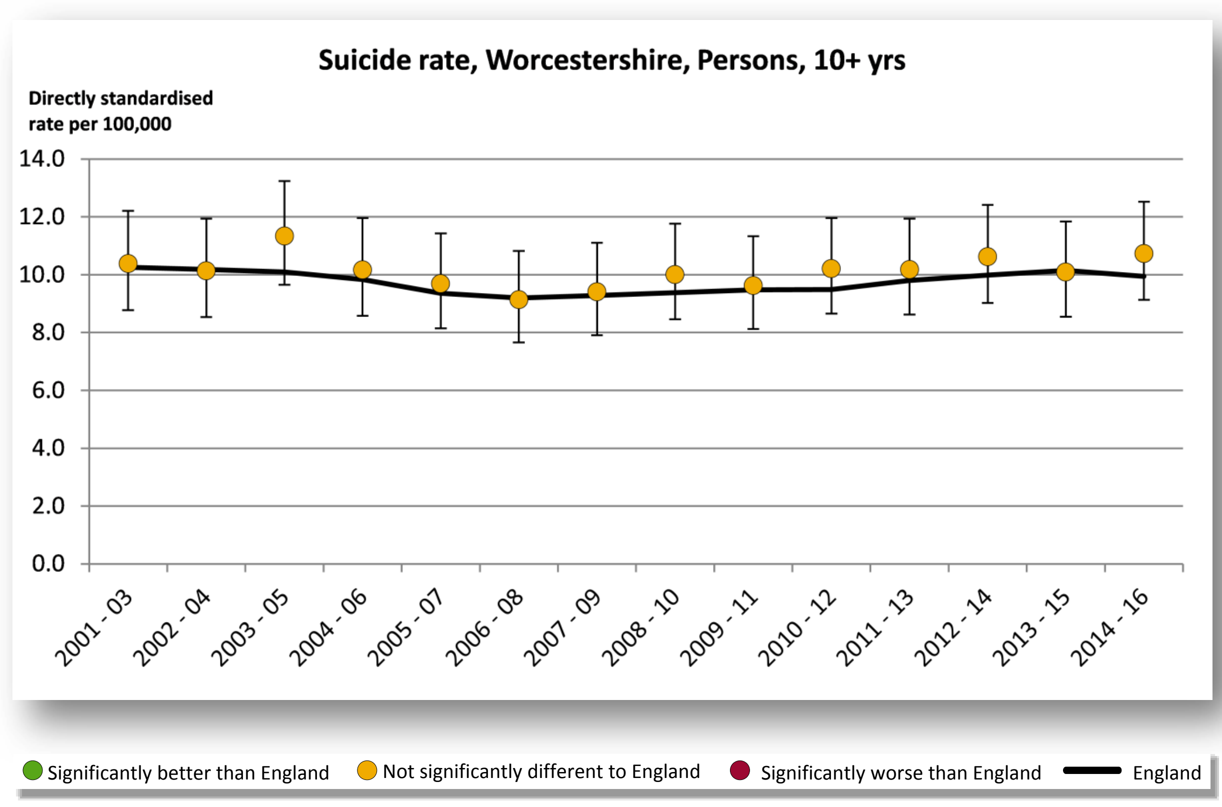
Suicide rate

- There are around 50 suicides a year in Worcestershire.
- The rate has not changed significantly in over a decade.
- The Worcestershire figures have been very close to the national average during this period.
- The counts in the table relate to the total number of deaths in each three year period.

Suicide rate, Worcestershire, Persons, All ages
Directly standardised rate per 100,000

Period		Count	Value	Lower CI	Upper CI	England
2001 - 03	●	149	10.4	8.8	12.2	10.3
2002 - 04	●	145	10.1	8.5	11.9	10.2
2003 - 05	●	162	11.3	9.7	13.2	10.1
2004 - 06	●	147	10.2	8.6	12.0	9.8
2005 - 07	●	142	9.7	8.2	11.4	9.4
2006 - 08	●	136	9.1	7.7	10.8	9.2
2007 - 09	●	140	9.4	7.9	11.1	9.3
2008 - 10	●	149	10.0	8.5	11.8	9.4
2009 - 11	●	146	9.6	8.1	11.3	9.5
2010 - 12	●	154	10.2	8.7	12.0	9.5
2011 - 13	●	153	10.2	8.6	11.9	9.8
2012 - 14	●	159	10.6	9.0	12.4	10.0
2013 - 15	●	152	10.1	8.5	11.8	10.1
2014 - 16	●	162	10.7	9.1	12.5	9.9

*Number of deaths in each three year period from suicide and injury of undetermined intent



Data Source: Public Health England

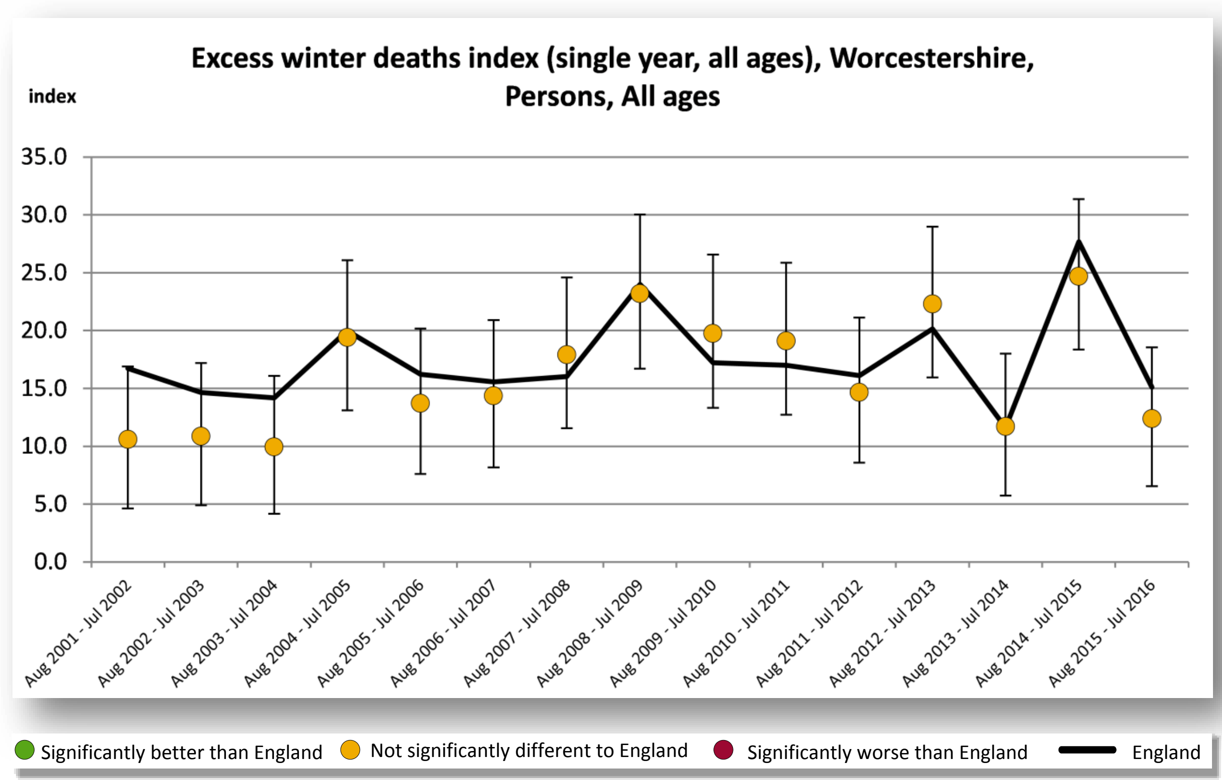
Excess Winter Deaths

- The Excess Winter Deaths Index is calculated as the number of excess winter deaths divided by the average non-winter deaths expressed as a percentage.
- The pattern for Worcestershire follows that for England as a whole.
- Variation in year-on-year tends to reflect weather patterns with harsh winters having higher rates.

Excess winter deaths index (single year, all ages), Worcestershire, Persons, All ages

Period		Count*	Value	Lower CI	Upper CI	England
Aug 2001 - Jul 2002	●	186	10.6	4.6	16.9	16.7
Aug 2002 - Jul 2003	●	191	10.9	4.9	17.2	14.7
Aug 2003 - Jul 2004	●	183	10.0	4.1	16.1	14.2
Aug 2004 - Jul 2005	●	338	19.4	13.1	26.1	20.0
Aug 2005 - Jul 2006	●	238	13.7	7.6	20.2	16.2
Aug 2006 - Jul 2007	●	245	14.4	8.2	20.9	15.6
Aug 2007 - Jul 2008	●	304	17.9	11.6	24.6	16.0
Aug 2008 - Jul 2009	●	400	23.2	16.7	30.0	24.0
Aug 2009 - Jul 2010	●	333	19.8	13.3	26.6	17.2
Aug 2010 - Jul 2011	●	323	19.1	12.7	25.9	17.0
Aug 2011 - Jul 2012	●	259	14.7	8.6	21.1	16.1
Aug 2012 - Jul 2013	●	399	22.3	16.0	29.0	20.1
Aug 2013 - Jul 2014	●	208	11.7	5.7	18.0	11.6
Aug 2014 - Jul 2015	●	455	24.7	18.4	31.4	27.7
Aug 2015 - Jul 2016	●	232	12.4	6.5	18.6	15.1

* Number of extra deaths from all causes that occur in the winter months compared with the expected number of deaths (average of the number of non-winter deaths)



Data Source: Public Health England

Worcestershire Health and Well-being Board

Joint Strategic Needs Assessment

Annual Summary

September 2018

www.worcestershire.gov.uk/jsna

Prepared by Worcestershire Directorate of Public Health

Date: 25/09/2018

Version: 0.6

Review Date: October 2019

South Worcestershire
Clinical Commissioning Group

Redditch and Bromsgrove
Clinical Commissioning Group

Executive Summary

This report is intended to provide a summary of the latest public health data and information for Worcestershire including an update on the three Health and Well-being Board priorities, a review of issues highlighted in the 2017 report, and a summary of emerging issues for 2018.

For a long period, Worcestershire has generally had good health outcomes and has consistently performed better on many mortality measures than England. However, the gap between England and Worcestershire for premature mortality caused by cardiovascular diseases and cancers, the two biggest causes of mortality for under 75s, had narrowed over time and for cancers had closed entirely. For this reason the narrowing gap between Worcestershire and England was highlighted in the 2017 JSNA Annual Summary. Encouragingly, more recent data suggests that this trend may be changing in a positive direction and that the gap between Worcestershire and England may have begun to widen. Future data releases will help to confirm if this is a sustained positive change.

Local data highlights that health inequalities continue to exist in Worcestershire. The gap in life expectancy between the most and least deprived areas is 7.6 years for males and 6.2 years for females[1] and there has been no significant change since the last period[2].

The gap between Healthy Life Expectancy and Total Life Expectancy is smaller in Worcestershire than for England as a whole. In Worcestershire females have a larger gap between healthy life expectancy and total life expectancy than males meaning they are living longer but in poorer health.

On some specific measures, Worcestershire is not performing as well as England as a whole. These include, the percentage of children with free school meal status achieving a good level of development at the end of reception, smoking status at the time of delivery, and eligible homeless people not in priority need. These topics are discussed further in this report.

The County Council, Districts, Health Services and other partners are encouraged to use findings from this report to inform plans, strategies and commissioning to help address existing and emerging issues, whilst keeping a focus on reducing health inequalities.

[1] 2014-16 data
[2] 2013-15 data

Health and Well-being Board Priorities Update

To help track data relating to the current Health and Well-being Board priorities (2016-2021), a live online dashboard has been created which is openly accessible, and can be accessed via the Health and Well-being Board[3] and the JSNA websites[4]. A review of each Health and Well-being Board priority area follows:

Keeping active at every age[1]

- Premature mortality from cardiovascular disease is significantly lower in Worcestershire in comparison to both West Midlands and national rates.
- There are geographical variations in the prevalence of excess weight.
- Prevalence of excess weight in children in Reception (4-5yr olds) across Worcestershire is similar to both West Midlands and the national rate.
- Prevalence of overweight and obese children in Year 6 (10-11yr olds) is similar to the England rate and significantly lower than the West Midlands rate.
- Worcestershire has levels of physical inactivity similar to the England rate at 21.1% vs 22.2% respectively. Rates are significantly lower than the West Midlands.
- Worcestershire had a similar proportion of respondents reporting they were 'fairly active' in comparison to the West Midlands and England.
- Worcestershire has a proportion of people reporting that they were 'Active' and undertaking 150 minutes exercise or more per week of 67.2%. This is similar to the England rate and significantly higher than the West Midlands rate.
- The proportion of individuals who reported taking part in sport and physical activity at least twice in the last 28 days in Worcestershire is higher than England and is significantly higher than the West Midlands.

Preventing alcohol harm at all ages[2]

- The rate of alcohol-specific hospital admissions for under 18's has fallen considerably from 97.0 per 100,000 in 2006/7–2008/9 to 29.7 per 100,000 in 2014/15-16/17. Rates are similar to the national average. Worcestershire has one of the lowest rates amongst the CIPFA nearest statistical neighbours.

---

3 http://www.worcestershire.gov.uk/info/20565/health_and_well-being_board

4 http://www.worcestershire.gov.uk/info/20122/joint_strategic_needs_assessment

[1] Unless otherwise stated this report refers to 'older people' as those aged 65+

[2] Unless otherwise stated data is for 2015-16.

- Hospital admission episodes for alcohol-related conditions (broad) are now lower than the national average.
- The latest rate of females admitted to hospital for alcohol-related conditions (narrow) in Worcestershire is similar to the national average, and has decreased compared to the previous year.
- The latest rate of males admitted to hospital for alcohol-related conditions (narrow) is significantly better than the national average. However, rates still remain higher than they were in 2011/12.
- Hospital admissions for alcohol-related conditions in females aged over 65 are significantly higher than the England rate and have increased over the last three years.
- The latest rate of alcohol-specific mortality in Worcestershire is similar to the national average, this has remained relatively stable since 2011-13.
- The latest rate of alcohol-related mortality in Worcestershire is similar to the national average but remains higher than 2013 rates.
- Pooled data from 2014-16 shows the premature mortality rate from liver disease was similar to the national average at 16.6 per 100,000 vs 20.9 per 100,000 respectively.
- The rate of hospital admission episodes for alcoholic liver disease has reduced significantly from 125.5 per 100,000 population in 2013/14 (when rates were highest) to 110.2 per 100,000 population in 2016-17.
- In 2016-17, the proportion of individuals waiting longer than three weeks to receive treatment for alcohol was significantly higher than both England and West Midlands rates at 13.7%. However, this is a significant improvement from 2015-16 where the rate was 23.9% and the highest in the West Midlands region.
- In 2016, the rate of successful completion of treatment for alcohol clients in Worcestershire was similar to the national average at 38.9%. This indicator showed a steady decline from 2012 and was significantly lower in 2013, 2014 and 2015, in comparison to nationally, where rates steadily increased.

Good mental health and well-being at all ages

- Prevalence of dementia in Worcestershire is similar to the national average and is increasing.
- There is a higher prevalence of common mental disorders such as depression and anxiety in Worcestershire. Prevalence of depression[5] is significantly higher in Worcestershire than England, at 10.5% and has increased from the previous year (10.0%).
- Emergency admissions to hospital for self-harm are similar to the national average and have been falling steadily since 2014-15.

[5] Public Health Outcomes Framework, http://www.phoutcomes.info/, July 2018

- Male mortality from suicide is similar in Worcestershire to the national average at 18.0 per 100,000 (vs 15.9 per 100,000). Female mortality from suicide is similar to the national average at 3.8 per 100,000 (vs 4.8 per 100,000).
- The proportion of the population using outdoor space for exercise and/or health reasons is statistically lower than the national and West Midlands average. It is also one of the lowest across all CIPFA nearest neighbour areas. There has been a year on year downward trend since data collection began in 2011-12.
- The proportion of individuals reporting a long-term health problem or disability is significantly higher in Worcestershire in comparison to the West Midlands and England.
- The proportion of children who receive school meals achieving a good level of development at the end of reception has increased year on year. However, the gap between Worcestershire and national rates has widened slightly in 2016-17, and remains significantly lower than England overall and lower than the proportion of all children who achieve a good level of development.

Emerging and Persistent Issues (2018)

A number of issues are emerging from routine analysis as being challenges for Worcestershire. A brief summary of these issues follows:

- **Antibiotic prescribing:** Worcestershire has seen a declining trend in antibiotic prescribing in primary care. However, the decline has not kept pace with national trends and all three Clinical Commissioning Groups have higher rates of antibiotic prescribing in primary care than England as a whole.
- **Air pollution:** is rising similarly to the England average. However, around 0.3% of the population in Worcestershire live in an air quality management area (AQMA) compared with 0.2% nationally. The impact of particulate matter (PM) and NO2 on District populations has been modelled. The model shows the estimated benefit of reducing exposure to these pollutants in terms of associated costs and morbidity.
- **School readiness:** the percentage of children with free school meal status achieving a good level of development at the end of reception is significantly lower in Worcestershire (49.3%) than England (56.0%).
- **Educational outcomes:** KS2 level outcomes are worse in Worcestershire than England and considerably worse for disadvantaged children.
- **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 assessed as children in need (CIN), children looked after (CLA) and those subject to child protection plans (CP) continue to increase.
- **Oral health**: the percentage of 5 year olds with any dental decay varies by district, and the two worst areas, Worcester and Wyre Forest, have seen an increase between 2014/15 – 2016/17 (from 27.3% to 29.9%, and 23.6% to 29.3% respectively).

Update on Emerging Issues Highlighted in the 2017 JSNA Annual Summary

The last JSNA Annual Summary highlighted a number of emerging issues for Worcestershire. This section provides a brief update on these.

- **Mortality**: Overall Worcestershire has good health outcomes and was consistently better on some mortality measures than England for a long period. However, for cardiovascular diseases and cancers, the two biggest causes of mortality for under 75s, the gap between the England average and Worcestershire had narrowed over time and for cancers had closed entirely. For this reason the narrowing gap between Worcestershire and England was highlighted in the JSNA Annual Summary 2017. More recent data suggests that this trend may be changing in a positive direction and that the gap between Worcestershire and England may have begun to widen.
- **Autistic spectrum disorder**: There are no estimates of the overall numbers of people with ASD in Worcestershire. However, schools do submit data on the number of children recorded as having ASD as a primary Special Educational Need (SEN) to the Department of Education. In January 2018, 868 children in Worcestershire were recorded as having ASD as a primary SEN (253 primary school pupils, 439 secondary school pupils and 176 children in special schools), which is a slight increase on 2017.
- **Infant mortality**: Infant mortality in Worcestershire historically was similar to the England average. However, the latest figures have risen and are now significantly above the England average. In 2014-16, of the six Worcestershire Districts, only Worcester had a statistically significantly higher rate of infant mortality than the national average at 7.1 deaths per 1,000.
- **Drug misuse deaths**: Nationally, the rate of deaths from drug misuse is rising and this trend is mirrored in Worcestershire. For the latest period (2014-2016), the rate was 4.3 deaths per 100,000 population in Worcestershire compared with 4.2 nationally. This represents 70 deaths over the three year period.
- **Excess weight and type 2 diabetes**: Excess weight is a contributory factor for type 2 diabetes. In 2016/17 the majority of adults in Worcestershire were estimated to be overweight or obese (62%) which is statistically similar to England (61.3%)[6].
- **Homelessness**: Homelessness is a significant issue in Worcestershire, with many indicators being 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. In recognition of the health issues faced by homeless people, the Worcestershire Health and Wellbeing Board have signed up to a 'Charter for Homeless Health'. As part of this commitment a JSNA profile which explores homelessness and the health of homeless people in Worcestershire has been produced.

[6] Public Health England, Public Health Profiles

Wyre Forest Clinical Commissioning Group

South Worcestershire Clinical Commissioning Group

Redditch and Bromsgrove Clinical Commissioning Group

- **Violent crime**: The rate of violent crime recorded in Worcestershire continues to increase and this reflects what is happening nationally. The latest figures available are for 2016-17 and show there were 12,688 violent offences recorded in Worcestershire or a rate of 21.9 violent offences per 1,000 population. It is difficult to determine whether high or low levels of violence offences are due high or low prevalence, or high or low levels of recording.

District Level Information

Bromsgrove: is one of the 20% least deprived districts in England and relative to England it has an older population.

However, health inequalities are evident as life expectancy is 8.8 years lower for men and 5.5 years lower for women in the most deprived areas of Bromsgrove compared to the least deprived areas.

Areas of potential concern for Bromsgrove include: breastfeeding initiation, influenza vaccination and the chlamydia detection rate.

Malvern Hills: has the highest proportion of people aged 65 and over (27.6%) in comparison to other Worcestershire districts. There are a lower proportion of people living in most deprived areas in the country when compared to the England average.

The gap in life expectancy for men is 4.0 years and for women is 5.3 years between the most deprived and least deprived areas in Malvern Hills.

Areas of potential concern for Malvern Hills include: breastfeeding initiation, diabetes diagnosis and chlamydia detection rate (15-24 year olds).

Redditch: has a higher proportion of people living in most deprived areas compared to the England average. It has a higher proportion of children and young people aged 0-19 (24.4%) in comparison to Worcestershire.

There are considerable health inequalities: Life expectancy is 9.3 years lower for men and 9.0 years lower for women in the most deprived areas of Redditch, compared to the least deprived.

Areas of potential concern for Redditch include: breastfeeding initiation, hospital admissions caused by unintentional and deliberate injuries (and for young people), average number of vegetables consumed daily, admission episodes for alcohol related conditions, smoking prevalence (in the general population and in routine and manual occupations), cervical cancer screening coverage, hip fractures, and influenza vaccination.

Worcester: overall is less deprived than England but has significant pockets of deprivation in the central area and towards the north east of the city.

Health inequalities are evident as life expectancy is 9.0 years lower for men and 4.1 years lower for women in the most deprived areas of Worcester, in comparison to the least deprived.

Areas of potential concern for Worcester include: statutory homelessness, breastfeeding initiation, cervical screening coverage, chlamydia detection rate, adjusted antibiotic prescribing in primary care by the NHS, infant mortality and estimated dementia diagnosis rate (aged 65+).

Wychavon: has a higher proportion of people aged 65 and over (24.5%) in comparison to Worcestershire overall. It has lower levels of deprivation than England.

Life expectancy is 7.5 years lower for men and 6.7 years lower for women in the most deprived areas of Wychavon, in comparison to the least deprived.

Areas of potential concern for Wychavon include: breastfeeding initiation, gap in the employment rate between those with a long-term health condition and the overall employment rate, killed and seriously injured (KSI) casualties on England's roads, child excess weight (4-5 year olds) and estimated dementia diagnosis rate (aged 65+).

Wyre Forest: has a higher proportion of people living in most deprived areas in the country compared to the England average. It has a higher proportion of people aged 65 and over (24.4%) in comparison to Worcestershire overall.

Life expectancy is 9.4 years lower for men and 8.5 years lower for women in the most deprived areas, in comparison to the least deprived.

Areas of potential concern for Wyre Forest include: the gap in the employment rate between those with a long-term health condition and the overall employment rate, breastfeeding initiation, smoking status at the time of delivery, child excess weight (4-5 year olds), child excess weight (10-11 year olds), proportion of the population meeting the recommended '5-a-day' on a usual day and under 75 mortality rate from liver disease.

Contents

Executive Summary ...2

Health and Well-being Board Priorities Update ...3

Emerging and Persistent Issues (2018) ...5

Update on Emerging Issues Highlighted in the 2017 JSNA Annual Summary ...6

District Level Information ...7

Contents ...9

Introduction ...11

Characteristics of the Worcestershire Population ...11

Current Population ...11

Ethnicity ...13

Future Population ...13

Deprivation ...15

Life Expectancy and Healthy Life Expectancy ...16

The Window of Need in Worcestershire ...18

Inequality in Life Expectancy - Deprivation ...19

Inequality in Life Expectancy - Worcestershire Districts ...20

Segmenting Life Expectancy Gaps by Cause of Death ...22

Update on Emerging Issues Identified in the 2017 JSNA Annual Summary ...24

Update on Premature Mortality ...24

Update Autism Spectrum Disorder (ASD) ...26

Update on Infant Mortality ...28

Update on Drug Misuse Deaths ...33

Update on Excess Weight and Diabetes ...35

Update on Homelessness ...35

Update on Violent Crime ...36

Wyre Forest
Clinical Commissioning Group

South Worcestershire
Clinical Commissioning Group

Redditch and Bromsgrove
Clinical Commissioning Group

Emerging Issues (2018) 38

Antibiotic Prescribing in Primary Care 38

Air Quality 43

Children and Young People 51

Dementia 61

Oral Health in Children Aged 5 Years 67

Substance Misuse and Alcohol: Successful Completion of Treatment 70

Update on Health and Wellbeing Board priorities 73

Good Mental Health and Well-being at All Ages 73

Keeping Active at Every Age 81

Preventing Alcohol Harm at All Ages 88

Appendix 1: District Level Information 97

Bromsgrove 97

Malvern Hills 101

Redditch 108

Worcester 119

Wychavon 127

Wyre Forest 133

Appendix 2: Summary of Reports on the Worcestershire Joint Strategic Needs Assessment (JSNA) Website 142

Glossary 148

Associated Documents and Information 152

Further Information and Feedback 152

Introduction

The Joint Strategic Needs Assessment (JSNA) is a continuous process of strategic assessment, the aim of which is to develop local evidence-based priorities for commissioning to improve the public's health and reduce inequalities. Outputs, in the form of evidence and the analysis of needs, should be used to help determine what actions local authorities, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and well-being.

This report is intended to provide a summary of the latest public health data and information for Worcestershire including an update on the three Health and Well-being Board priorities, a review of issues highlighted in the 2017 report, and a summary of emerging issues for 2018.

Characteristics of the Worcestershire Population

Current Population

The current population in Worcestershire is estimated to be around 588,370. A breakdown by district is shown in Table 1. Wychavon district has the largest proportion of the total population in the county and Malvern Hills the smallest.

Between 2016 and 2017, Worcestershire is estimated to have had an increase in population of 4,879 people and the percentage change is estimated to have been higher than England (Table 1). The largest component of this is migration from other areas of the UK (internal migration) which was estimated to be 3,658 people.

Of the six Worcestershire districts, Wychavon is estimated to have had the highest percentage population change with internal migration accounting for the largest component. Bromsgrove, Malvern Hills and Wyre Forest also have a population change rate that is higher than England.

Worcester City and Redditch are the only districts with a positive net population rise between births and deaths. Redditch has the lowest population percentage change overall.

TABLE 1 2017 MID-YEAR POPULATION ESTIMATES

Area	Estimated Population mid-2016	Estimated Population mid-2017	Change	% change
England	55,268,067	55,619,430	351,363	+0.64
West Midlands	5,810,773	5,860,706	49,933	+0.86
Worcestershire	**583,491**	**588,370**	**4,879**	**+0.84**
Bromsgrove	96,770	97,594	824	+0.85
Malvern Hills	76,555	77,165	610	+0.80
Redditch	85,088	85,204	116	+0.14
Worcester	101,927	102,314	387	+0.38
Wychavon	123,144	125,378	2,234	+1.81
Wyre Forest	100,007	100,715	708	+0.71

Source: Office for National Statistics.

TABLE 2 ESTIMATES OF POPULATION CHANGE 2016 - 2017

Area	Births minus Deaths	Internal Migration Net	International Migration Net	Other
England	156,763	-18,424	210,570	2,454
West Midlands	15,360	5,688	28,224	661
Worcestershire	**-110**	**3,658**	**1,360**	**-29**
Bromsgrove	-188	978	62	-28
Malvern Hills	-436	865	191	-10
Redditch	318	-517	324	-9
Worcester	293	-161	241	14
Wychavon	-35	1,843	437	-11

Wyre Forest Clinical Commissioning Group

South Worcestershire Clinical Commissioning Group

Redditch and Bromsgrove Clinical Commissioning Group

Wyre Forest	-62	650	105	15

Source: Office for National Statistics.

Ethnicity

Worcestershire has a higher proportion of individuals who identify as being White 95.7% compared to the West Midlands 82.7% and England 85.4%. In Worcestershire, there are a lower proportion of individuals who are in Black, Asian and Minority Ethnic Groups (BAME) 4.3% (24,345 people) compared to the West Midlands 17.4% and England 14.5%.

TABLE 3 ETHNICITY OF THE WORCESTERSHIRE POPULATION

	England (%)	West Midlands (%)	Worcestershire (%)	Worcestershire (No.)
White	85.4	82.7	**95.7**	**541,824**
Mixed / Multiple Ethnic	2.3	2.4	**1.2**	**6,794**
Asian: Indian, Pakistan, Bangladeshi, Chinese, Other	7.7	10.8	**2.4**	**13,588**
Black / African / Caribbean / Black British	3.5	3.3	**0.4**	**2,265**
Other Ethnic Group	1	0.9	**0.3**	**1,699**
Total				**566,169**

Source: Office for National Statistics

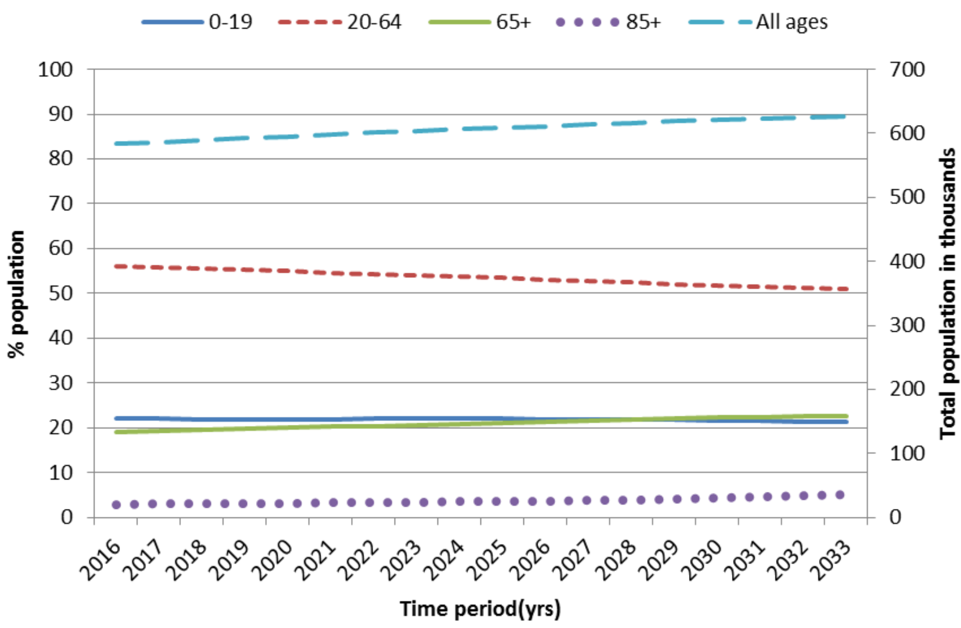
Future Population

The overall population of Worcestershire is projected to increase steadily over the next 15 years following a similar trend to England. The Worcestershire population is projected to increase by 7.4% compared to 9.0% for England by 2033.

Over the same period the population in the older age categories (65+ and 85+ years) is projected to increase steeply with the largest percentage change projected in the very oldest group (85+ years). The projected percentage increase in this group is 73.1% and 90.6% for England and Worcestershire respectively.

In contrast the number of people in the 20-64 age group is projected to decrease by 2.1%.

FIGURE 1 POPULATION PROJECTIONS FOR WORCESTERSHIRE 2016-2033



Source: Office for National Statistics. 2016 based population projections

TABLE 4 POPULATION PROJECTIONS TO 2033: RATE OF CHANGE BY AGE GROUP (IN THOUSANDS)

Age Category	England		% Change	Worcestershire		% change
	2016	2033		2016	2033	
All ages	55268.1	60251.5	**9.0**	583.5	626.8	**7.4**
0-19	13107	13698.2	**4.5**	129	132.9	**3.0**
20-64	32278.4	32882.7	**1.9**	326.5	319.6	**-2.1**
65+	8554.8	11372	**32.9**	111	141.5	**27.5**
85+	1328	2298.6	**73.1**	17.1	32.6	**90.6**

Source: Office for National Statistics. 2016 based population projections.

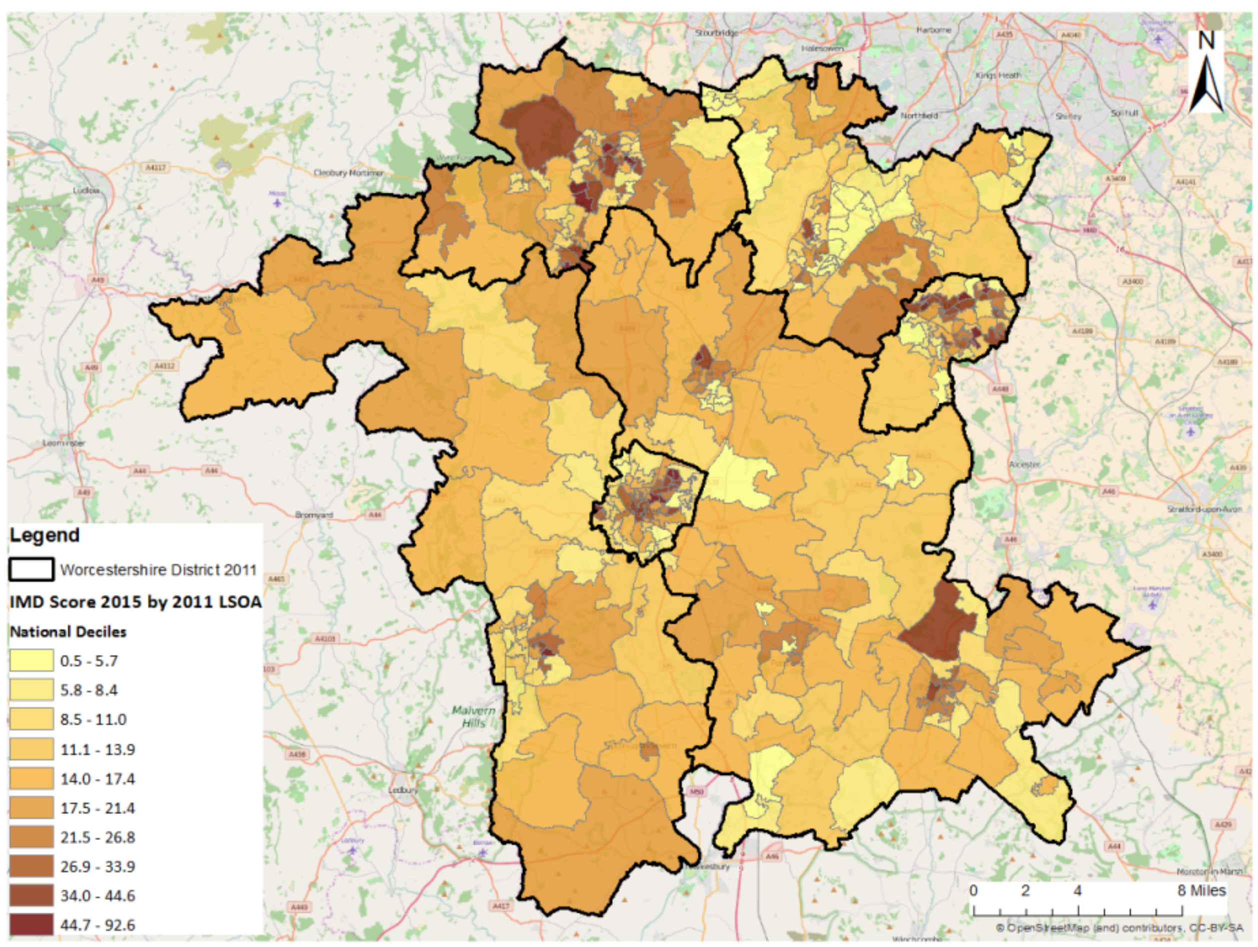
South Worcestershire
Clinical Commissioning Group

Redditch and Bromsgrove
Clinical Commissioning Group

Deprivation

Worcestershire as a whole is relatively less deprived than the national average (based on the IMD score 2015) as depicted by lighter shading on the map. However, there are pockets of relative deprivation in the urban areas of Worcester, Kidderminster (Wyre Forest) and Redditch. In addition, there are some deprived rural areas, most notably in the north of Wyre Forest and in Wychavon district, to the north of Evesham. The next set of data is expected in summer 2019.

FIGURE 2 WORCESTERSHIRE MAP - DEPRIVATION (IMD SCORE 2015)



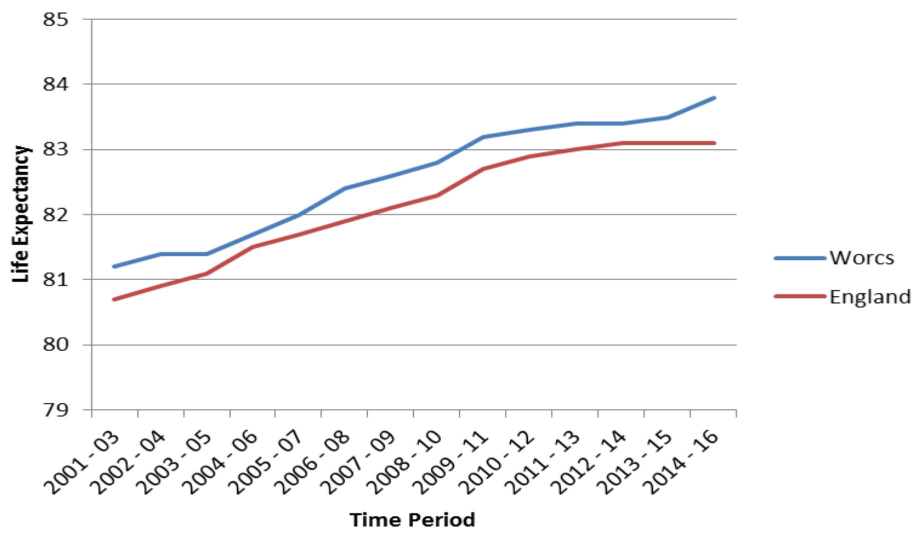
Source: Indices of Multiple Deprivation 2015

Life Expectancy and Healthy Life Expectancy

In Worcestershire both Life Expectancy and Healthy Life Expectancy, the average number of years someone would be expected to live in good health, are better than the England average. The current figures are 83.8 and 68.0 for women and 80.0 and 66.7 for men respectively (based on 2014-16 mortality rates). Healthy Life Expectancy in particular has been consistently better than the England average for a long period for both females and males. In Worcestershire in the period 2014-16 there was no significant change from the previous time period (2013-15) for both Life Expectancy and Healthy Life Expectancy for either gender.

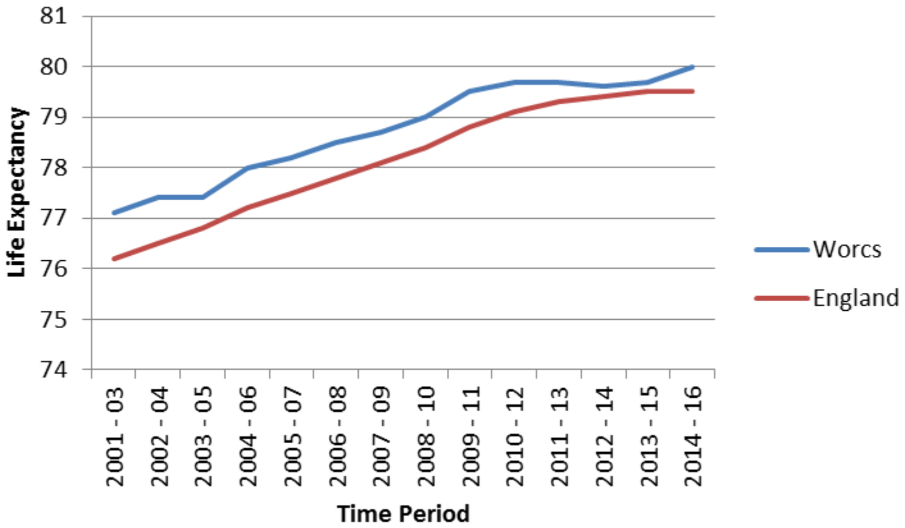
Nationally as people have been living longer we have seen steady increases in life expectancy for many decades, however, since 2011 these increases have been slowing down. The same trend has been seen in Worcestershire. However, it is too early to tell if this trend will continue.

FIGURE 3 FEMALE LIFE EXPECTANCY



Source: Public Health England, Public Health Outcomes Framework

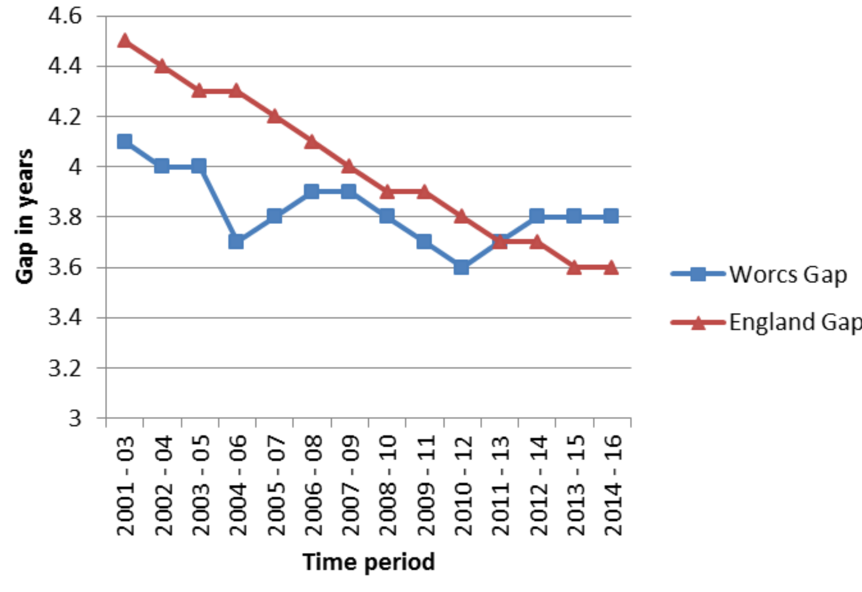
FIGURE 4 MALE LIFE EXPECTANCY



Source: Public Health England, Public Health Outcomes Framework

Nationally the gap between the female and male life expectancy at birth has been closing with time. Historically in Worcestershire this gap has been smaller but the latest time points suggest that this gap is now slightly wider suggesting the national gap may be closing at a faster rate.

FIGURE 5 GAP BETWEEN MALE AND FEMALE LIFE EXPECTANCY

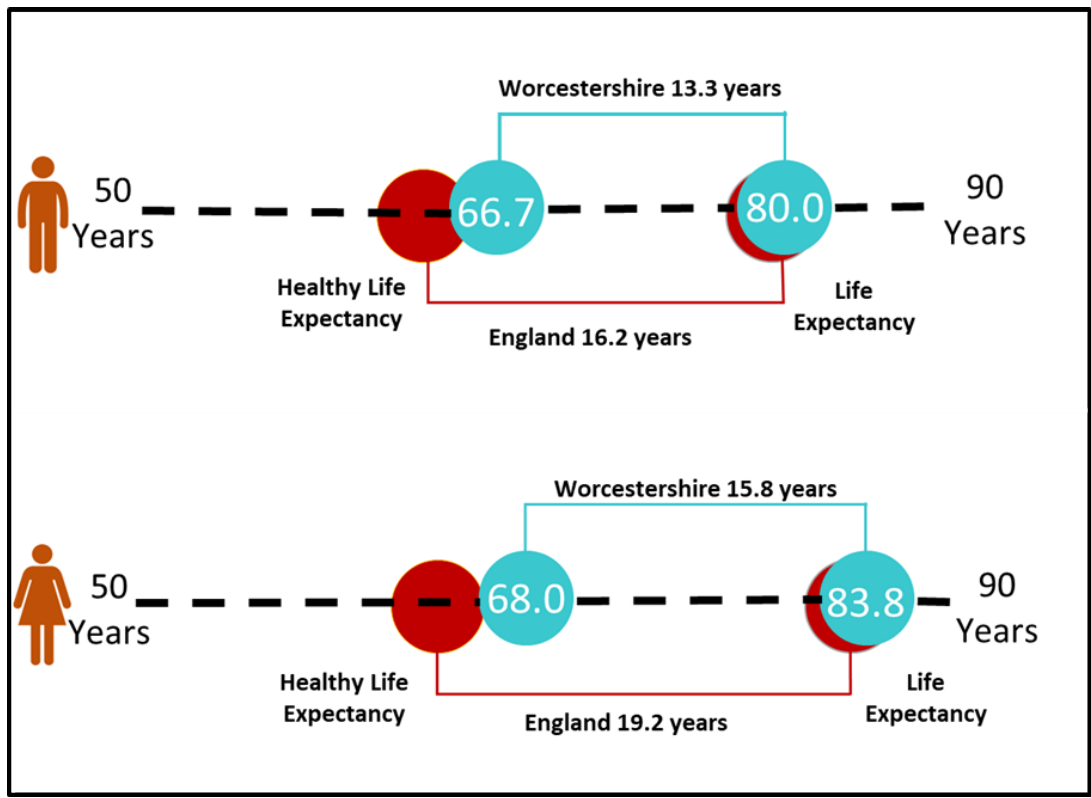


The Window of Need in Worcestershire

The gap between Healthy Life Expectancy and Total Life Expectancy has been referred to as the 'Window of Need'. The Window of Need is smaller in Worcestershire than for England as a whole.

In Worcestershire (and nationally) there is a larger gap between Life Expectancy and Healthy Life Expectancy for women. This means women are living longer but in poorer health.

FIGURE 6 HEALTHY LIFE EXPECTANCY/LIFE EXPECTANCY



Source: Public Health Outcomes Framework (PHOF), PHE (2018)

FIGURE 7 HEALTHY LIFE EXPECTANCY WORCESTERSHIRE MALE AND FEMALE 2009-2016

Source: Public Health Outcomes Framework

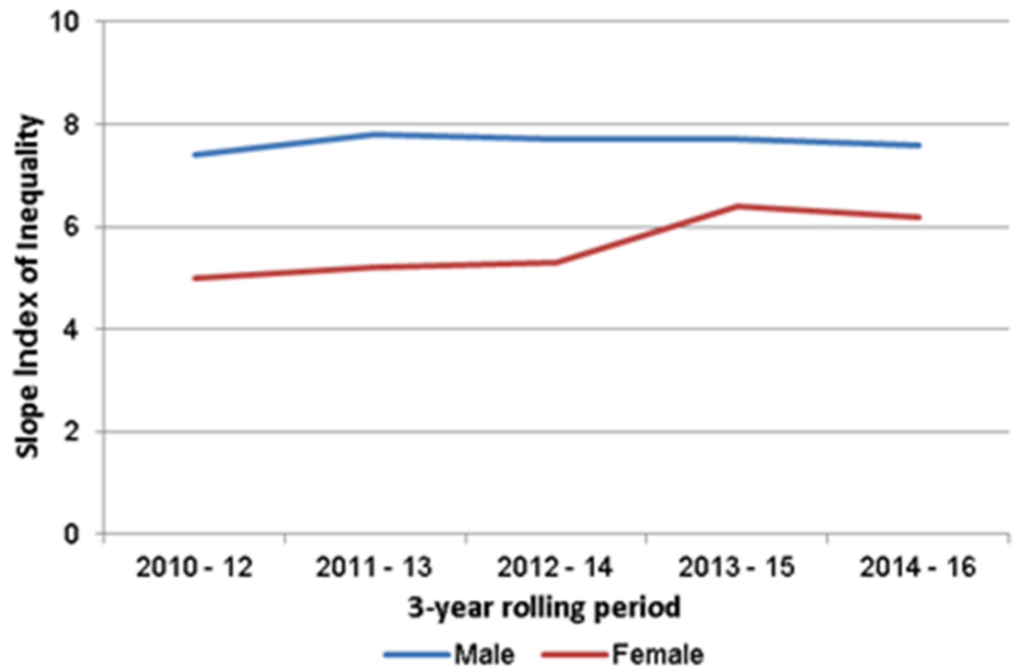
Over the 2009 to 2016 time period the Healthy Life Expectancy for both women and men has risen. Healthy Life Expectancy has been consistently better for females than males over this period.

Inequality in Life Expectancy - Deprivation

The slope index of inequality, measured in years, is an indicator of the difference in life expectancy between the most and least deprived areas of Worcestershire. For the period 2014-16 the index for males was 7.6 years and for females 6.2 years. There has been no significant change since the last period (2013-15).

For males the trend has been relatively static but there has been a slight increase in inequalities for women over the 2010 to 2016 time period but no change between 2013-15 and 2014-16. Further data should confirm if the trend has stabilised for females.

FIGURE 8 SLOPE INDEX OF INEQUALITY, LIFE EXPECTANCY, WORCESTERSHIRE, 2010-12 TO 2014-16

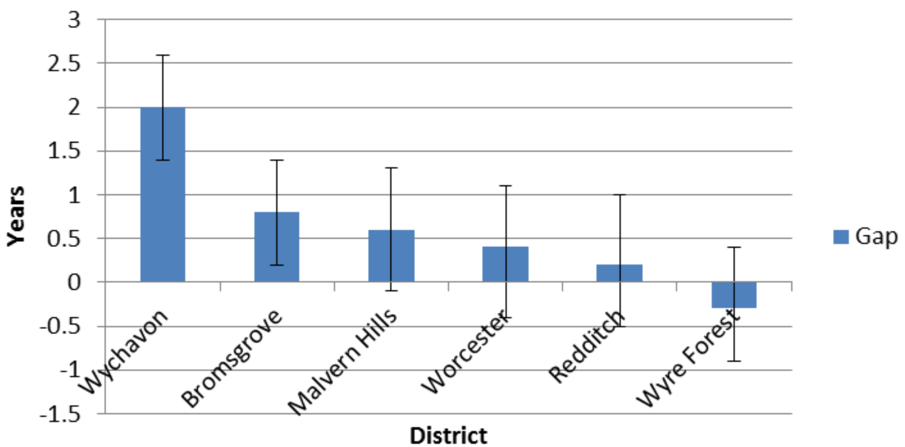


Source: Public Health Outcomes Framework

Inequality in Life Expectancy - Worcestershire Districts

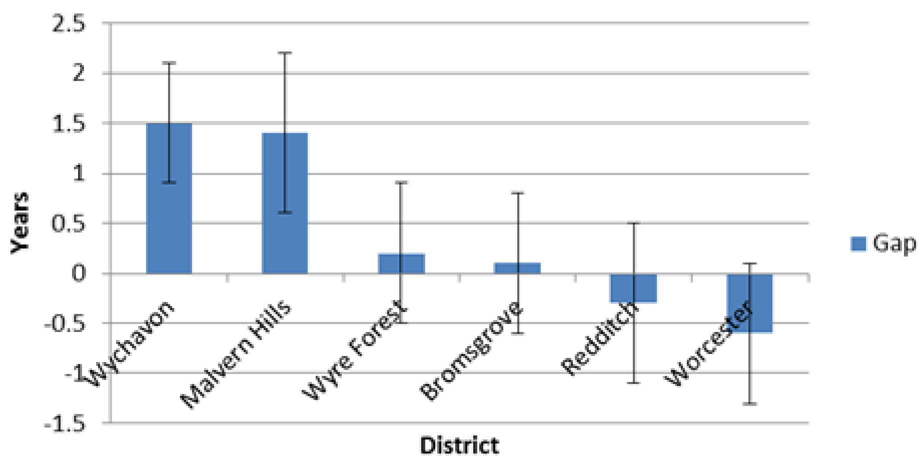
Compared to England, for both males and females, all Worcestershire districts have a similar or better Life Expectancy. For females, districts that have a better life expectancy than England are Wychavon and Bromsgrove. For males Wychavon and Malvern Hills have a better life expectancy.

FIGURE 9 GAP BETWEEN DISTRICT AND ENGLAND IN LIFE EXPECTANCY, FEMALE



Source: Public Health England, Public Health Outcomes Framework

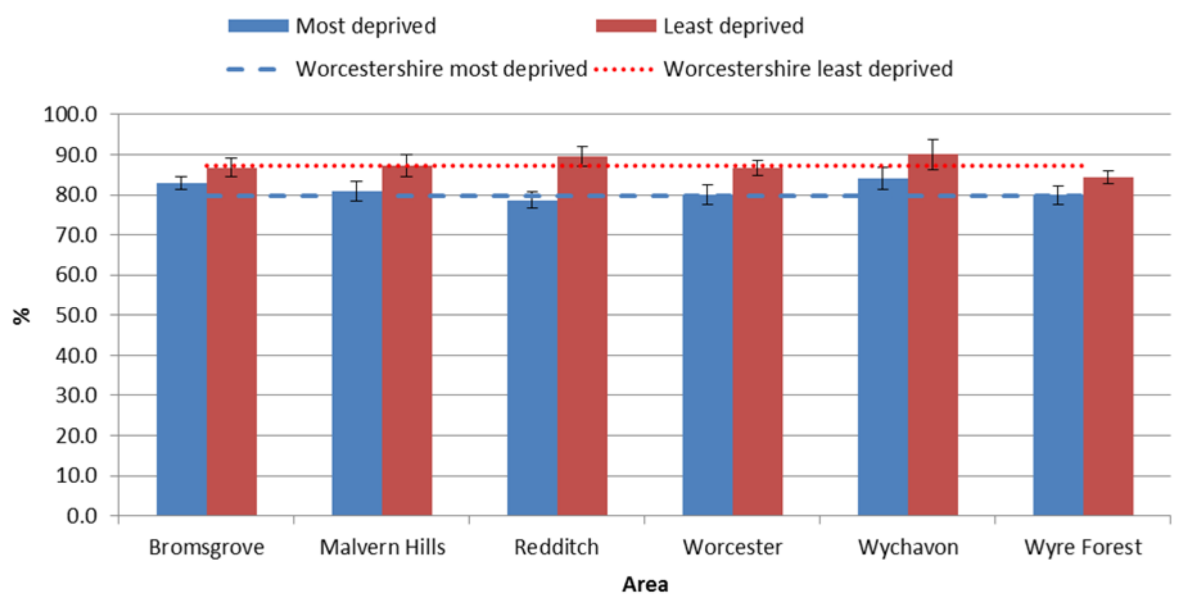
FIGURE 10 GAP BETWEEN DISTRICT AND ENGLAND IN LIFE EXPECTANCY, MALE



Source: Public Health England, Public Health Outcomes Framework

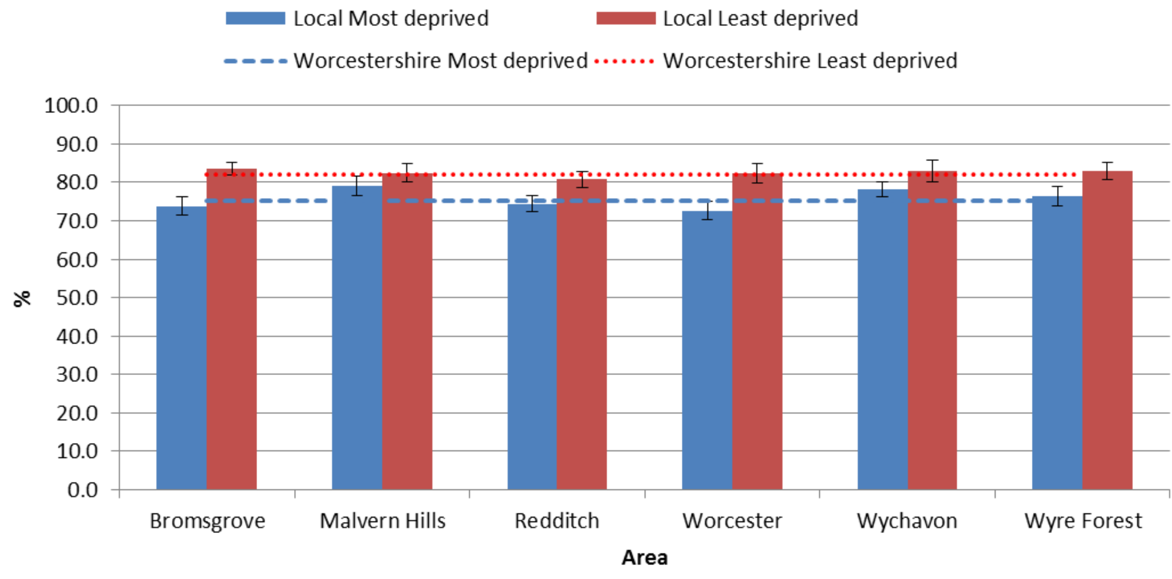
The gap in Life Expectancy between the least deprived and most deprived is wider in Redditch and Worcester indicating higher health inequalities.

FIGURE 11 INEQUALITIES IN LIFE EXPECTANCY - WORCESTERSHIRE DISTRICTS



Source: Public Health England, Public Health Outcomes Framework

FIGURE 12 INEQUALITIES IN HEALTHY LIFE EXPECTANCY - WORCESTERSHIRE DISTRICTS



Source: Public Health England, Public Health Outcomes Framework

Segmenting Life Expectancy Gaps by Cause of Death

The chart below shows, for each broad cause of death, the percentage contribution that it makes to the overall life expectancy gap for Worcestershire. It compares the most deprived

South Worcestershire
Clinical Commissioning Group

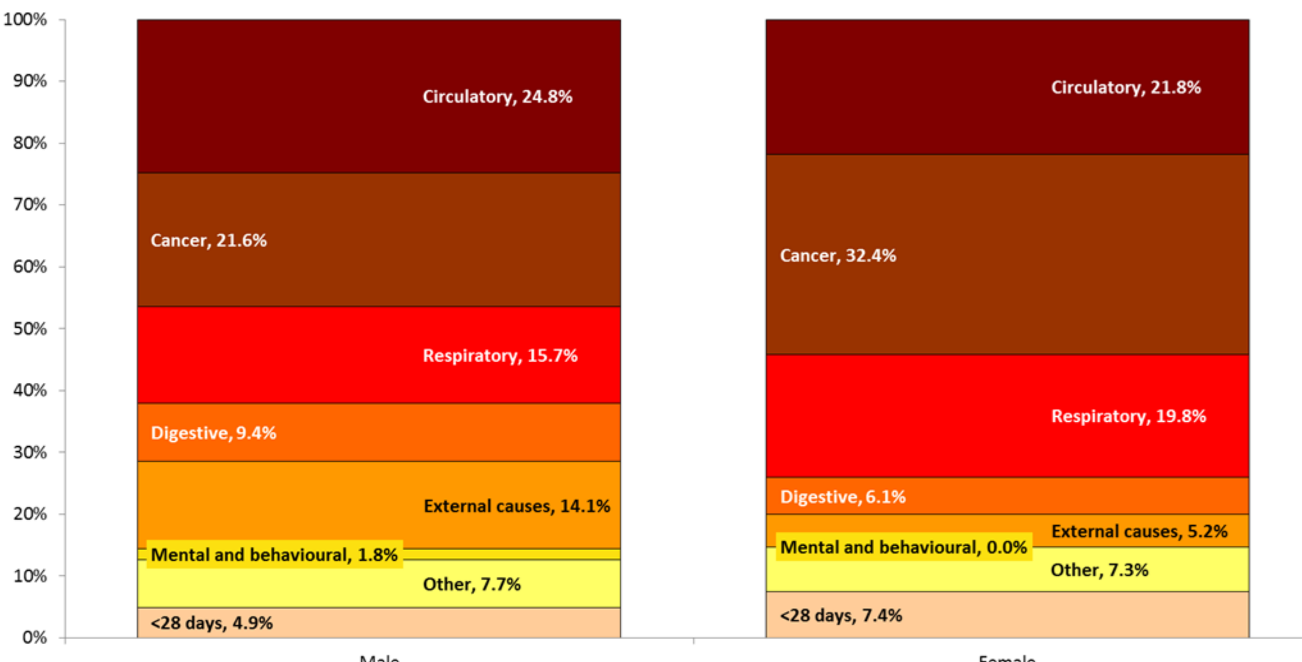
Redditch and Bromsgrove
Clinical Commissioning Group

quintile of the local authority and the least deprived quintile of the local authority. The comparisons cannot be made for Worcestershire against England as the life expectancy for Worcestershire is better than the national average. If a cause shows a contribution of 0, this means that the cause of death does not make any contribution to the life expectancy gap.

In Worcestershire, the largest contributors to the gap in life expectancy are circulatory disease, cancer and respiratory disease. The relative contribution each makes to the life expectancy gap differs by gender, for example, for females cancer makes up the largest contributory factor whereas for males this is circulatory disease.

It is interesting to note that the contribution of 'external causes' for male (14.1% male) is more than double that of female (5.2% female). 'External causes' include deaths from injury, poisoning and suicide. 'Mental and behavioural' includes dementia and Alzheimer's disease.

FIGURE 13 CHART SHOWING THE DISTRIBUTION OF THE LIFE EXPECTANCY GAP BETWEEN WORCESTERSHIRE'S MOST AND LEAST DEPRIVED QUINTILE, BY BROAD CAUSE OF DEATH, 2012-2014



Source: PHE (2016), The Segment Tool[7]: The Segment Tool: segmenting life expectancy gaps by cause of death

[7] PHE (2016) Segment Tool: https://fingertips.phe.org.uk/profile/segment

Update on Emerging Issues Identified in the 2017 JSNA Annual Summary

This section is intended to provide a concise update on the emerging issues which were highlighted in the JSNA Annual Summary 2017.

Update on Premature Mortality

Overall Worcestershire has good health outcomes and was consistently better on some mortality measures than England for a long period. However, for cardiovascular diseases and cancers, the two biggest causes of mortality for under 75s, the gap between the England average and Worcestershire had narrowed over time and for cancers had closed entirely. For this reason the narrowing gap between Worcestershire and England was highlighted in the JSNA Annual Summary 2017.

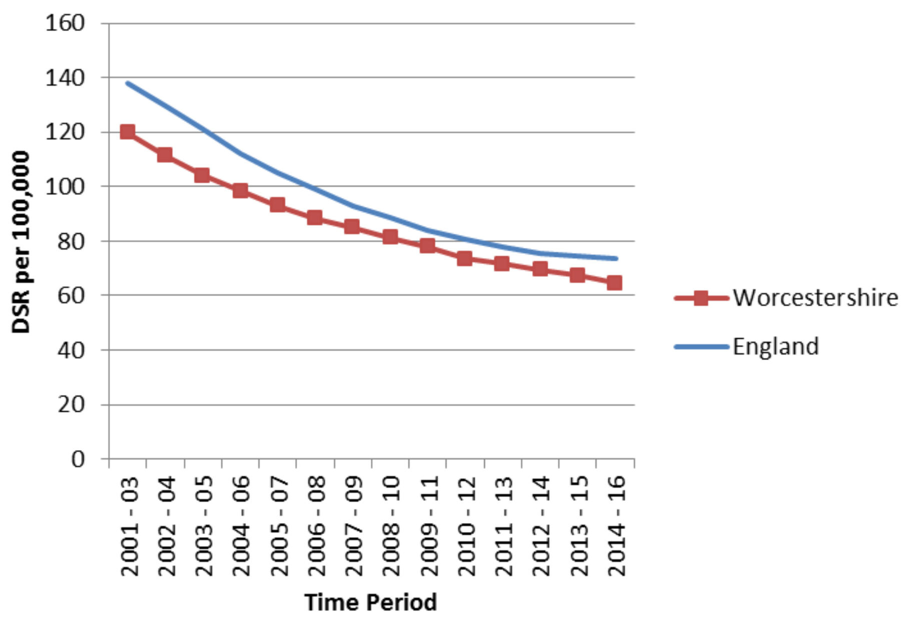
More recent data suggests that this trend may be changing in a positive direction and that the gap between Worcestershire and England may have begun to widen (as seen in

Figure 14, Figure 15,

Figure 16 and Figure 17. Future data releases will help to confirm if this is a sustained positive change.

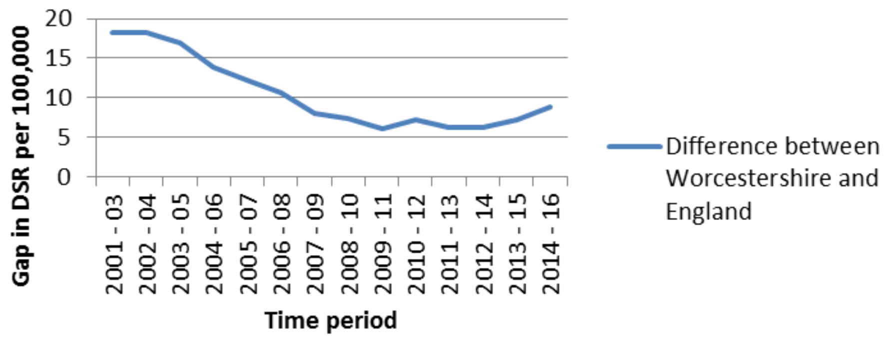
Out of 15 local authorities with similar socioeconomic characteristics, Worcestershire is worse than average for deaths from colorectal cancer, stroke and liver disease. It ranks particularly poorly at 14th for premature mortality due to stroke.

FIGURE 14 4.04I - AGE-STANDARDISED RATE OF MORTALITY FROM ALL CARDIOVASCULAR DISEASES (INCLUDING HEART DISEASE AND STROKE) IN PERSONS LESS THAN 75 YEARS OF AGE PER 100,000 POPULATION



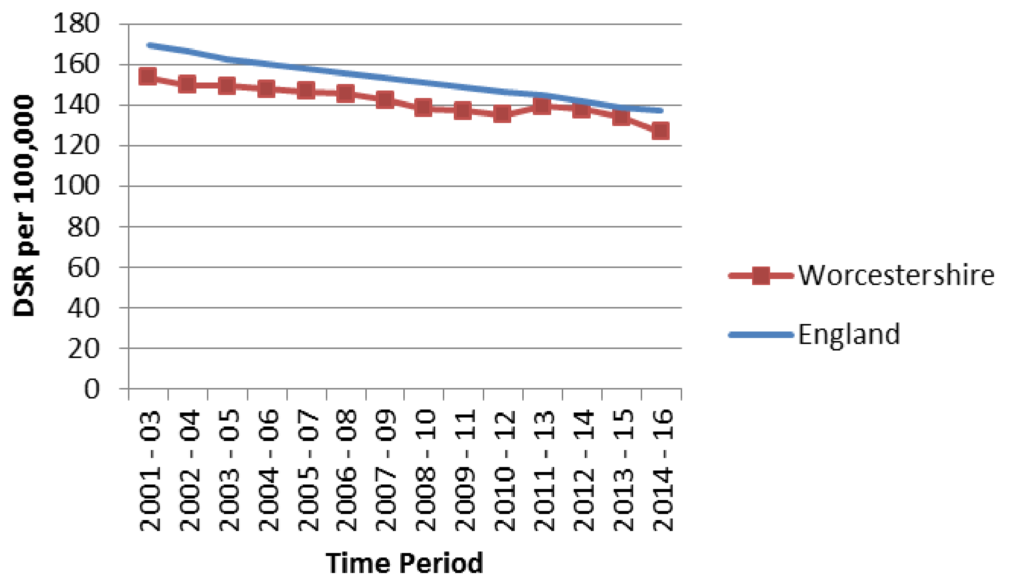
Public Health England, Public Health Outcomes Framework, 4.04i

FIGURE 15 4.04I – GAP IN AGE-STANDARDISED RATE OF MORTALITY FROM ALL CARDIOVASCULAR DISEASES (INCLUDING HEART DISEASE AND STROKE) IN PERSONS LESS THAN 75 YEARS OF AGE PER 100,000 POPULATION



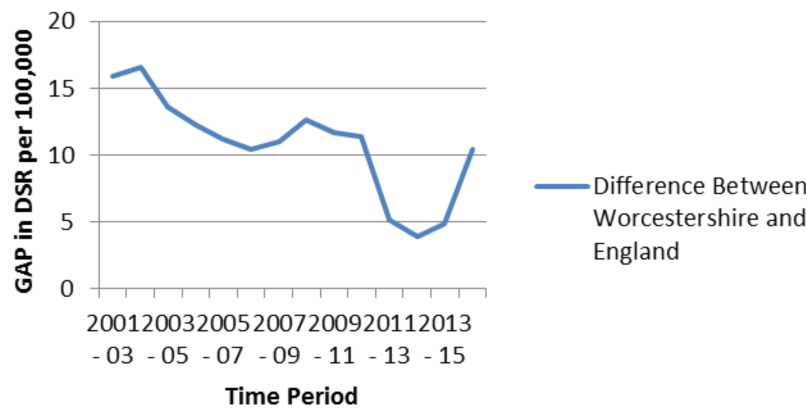
Source: Public Health England, Public Health Outcomes Framework, 4.04i Difference in DSR calculated by Worcestershire Public Health Team

FIGURE 16 4.05I - AGE-STANDARDISED RATE OF MORTALITY FROM ALL CANCERS IN PERSONS LESS THAN 75 YEARS OF AGE PER 100,000 POPULATION



Source: Public Health England, Public Health Outcomes Framework, 4.05i

FIGURE 17 GAP IN AGE-STANDARDISED RATE OF MORTALITY FROM ALL CANCERS IN PERSONS LESS THAN 75 YEARS OF AGE PER 100,000 POPULATION



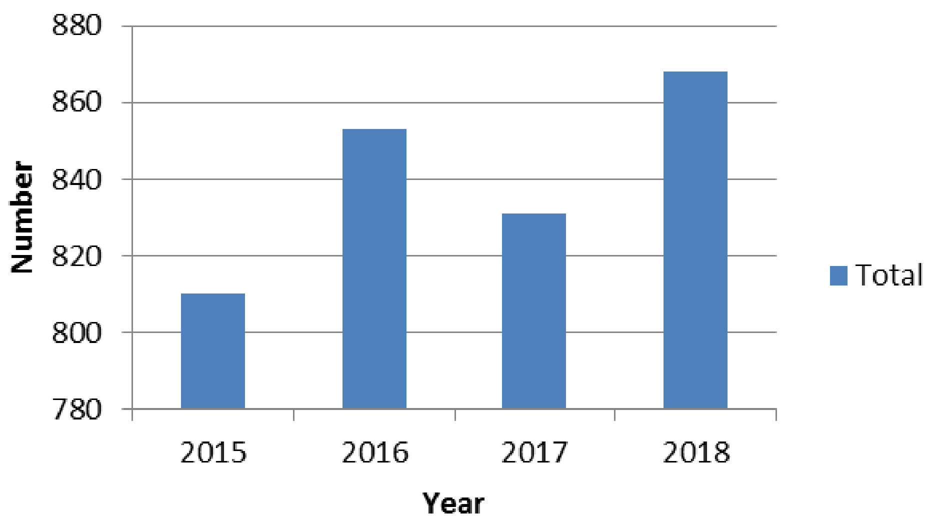
Update Autism Spectrum Disorder (ASD)

Autism Spectrum Disorder (ASD) is a lifelong, 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 (Brugha et al, 2012) indicate that 1.1% of the population may have autism - approximately 726,447 people in the UK[8].

There are no estimates of the overall numbers of people with ASD in Worcestershire. However, schools do submit data on the number of children recorded as having ASD as a primary special educational need (SEN) to the Department of Education. In January 2018, 868 children in Worcestershire were recorded as having an ASD (253 primary school pupils, 439 secondary school pupils and 176 children in special schools)[9].

FIGURE 18 NUMBER OF CHILDREN IN WORCESTERSHIRE WITH ASD RECORDED AS THEIR PRIMARY SEN



Source: Department of Education

The above data refers only to children with ASD as a primary type of need so is likely to under-represent actual numbers. It does not include independent schools.

Examination of data by local authority shows that variation is being caused by factors other than prevalence such as diagnosis and recording. Worcestershire data for 2017 shows that the proportion of children with ASD as a primary need in primary, secondary and special schools was 6.3% (CI: 5.9-6.7%) which is significantly lower than the figure for England 8.7% (CI: 8.7-8.8%). The picture becomes slightly more complicated when a comparison is made to our nearest statistical neighbours. Both Warwickshire (9.0%, CI: 8.5-9.5%) and Suffolk (9.8%, CI: 9.3%-10.3%) have significantly higher proportion of children with ASD as a primary need than Worcestershire but Gloucestershire has a significantly lower proportion (4.1%, CI: 3.8%-4.5%).

[8] An estimate derived from the 1.1% prevalence rate applied to the 2017 mid-year population estimate.

[9] Department for Education. Special educational needs in England: 2018. Local Authority Tables. Available at: https://www.gov.uk/government/statistics/special-educational-needs-in-england-january-2018

NHS
South Worcestershire
Clinical Commissioning Group

Redditch and Bromsgrove
Clinical Commissioning Group

There could be a number of reasons for this which may warrant further investigation including under-diagnosis of ASD in Worcestershire or issues relating to service access.

In March 2018 Healthwatch Worcestershire published a report on Autism Spectrum Conditions[10]. This report makes a number of recommendations about diagnosis, information and support, understanding and awareness of autism spectrum conditions, and access to health services.

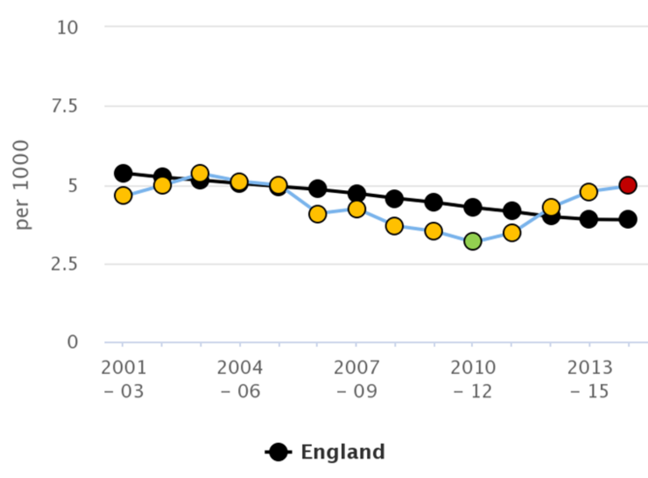
Update on Infant Mortality

Infant mortality measures the rate of deaths in babies aged under one year of age per 1,000 live births. Since 2010-12 the infant mortality rate in Worcestershire has increased despite a national decrease during the same period. For the latest time period available, 2014 - 16, the rate was 4.9 deaths per 1,000 - representing 89 deaths over a three year period.

Infant mortality rate is given in Figure 19 which shows that historically the rate of infant mortality in Worcestershire had been similar to the England average, but for 2010-12, it was significantly better at 3.2 deaths per 1,000 live births (representing 60 deaths over the three year period).

The latest figures have risen and are now significantly above the England average.

FIGURE 19 INFANT MORTALITY RATE IN WORCESTERSHIRE COMPARED TO ENGLAND



Source: Public Health England, Public Health Outcomes Framework

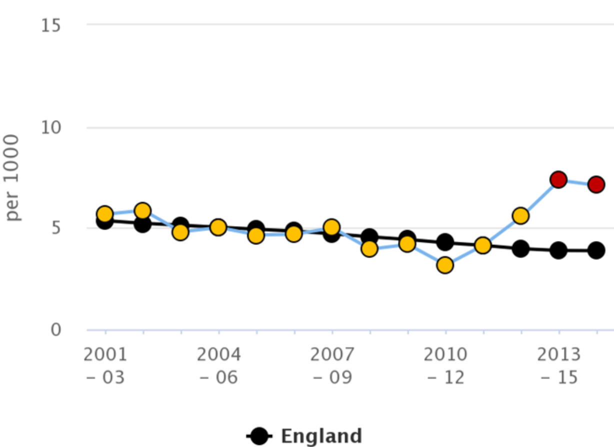
In 2014-16, of the six Worcestershire Districts, only Worcester had a statistically significantly higher rate of infant mortality than the national average at 7.1 deaths per 1,000. This represents

[10] Healthwatch Worcestershire (2018). Autism Spectrum Conditions. Available at: http://www.healthwatchworcestershire.co.uk/wp-content/uploads/2018/03/HWW-Autism-Spectrum-Conditions-Report-March-2018-v-1.0.pdf

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

26 deaths over a three year period (Figure 20). The figure of 7.1 deaths per 1,000 live births is more than double the rate for 2010-12 which was 3.2 deaths per 1,000.

FIGURE 20 INFANT MORTALITY RATE IN WORCESTER DISTRICT COMPARED TO ENGLAND



Source: Public Health England, Public Health Outcomes Framework

Other measures add to our understanding of infant mortality. These include the rate of neonatal mortality and post-neonatal mortality. These mortality measures are explored further in the following section.

Neonatal mortality

THE NEONATAL MORTALITY RATE MEASURES THE DEATHS OF INFANTS AGED LESS THAN 28 DAYS PER 1,000 LIVE BIRTHS.

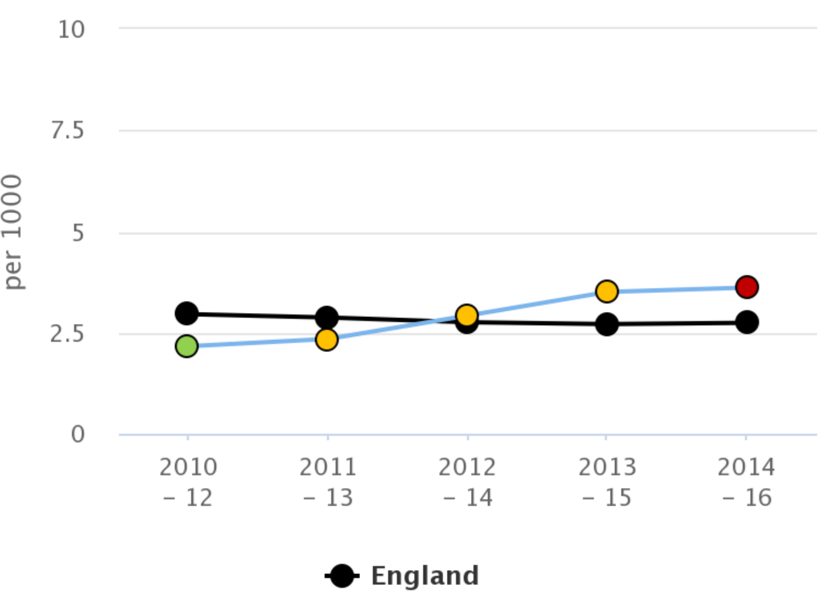
Figure 21 shows that in Worcestershire, since the period 2010-12, there has been a rising trend in the Neonatal mortality rate. For the latest time period available the Worcestershire rate was higher than the England average at 3.61 per 1,000 live births (vs 2.74 nationally). This represents 65 deaths over a three year period.

Wyre Forest Clinical Commissioning Group

South Worcestershire Clinical Commissioning Group

Redditch and Bromsgrove Clinical Commissioning Group

FIGURE 21 NEONATAL MORTALITY RATE IN WORCESTERSHIRE COMPARED TO ENGLAND

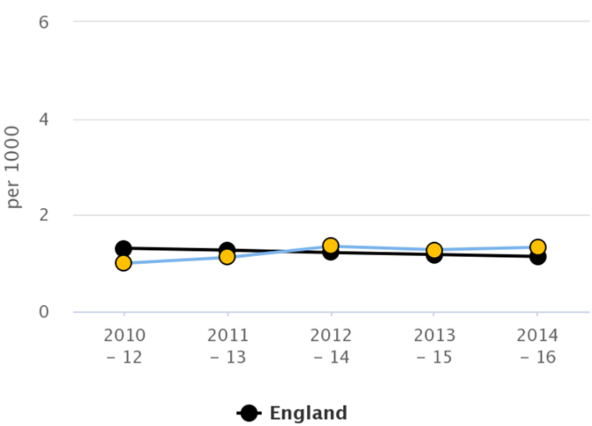


Source: Public Health England, Fingertips, Child and Maternal Health, Mortality

Post-neonatal mortality

Figure 22 shows the rate of deaths in infants aged between 28 days and one year per 1,000 live births. In 2014-16 the Worcestershire rate was 1.33 per 1,000 live births which was similar to the England rate of 1.14 per 1,000 live births. This represents 24 deaths over a three year period.

FIGURE 22 POST NEONATAL MORTALITY IN WORCESTERSHIRE



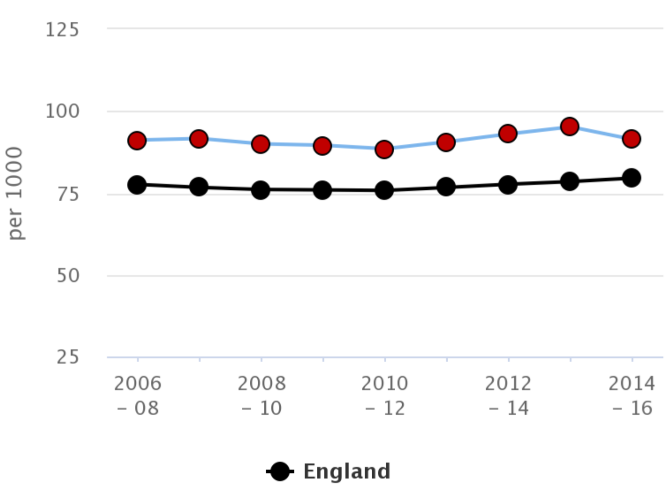
The data suggests that Worcestershire's higher than average infant mortality rate is being driven by the deaths of infants in the first 28 days of life.

Factors that contribute to infant mortality

It is well established that various factors increase risk of infant mortality, some of which are modifiable and some which are not modifiable. Such factors include prematurity, smoking during (and after) pregnancy, low birth weight, not breast feeding, maternal obesity, ethnicity and the age of mother. The most common causes of infant mortality differ according to the age of the infant.

Figure 23 shows that in Worcestershire the rate of premature births has been consistently higher than the national average since 2006-08. Figure 24 shows that amongst its nearest statistical neighbours Worcestershire has the highest rate of premature births. The most recent rate of 91.4 per 1000 births was statistically higher than the national average (79.5 per 1000 births).

FIGURE 23 PREMATURE BIRTHS (LESS THAN 37 WEEKS GESTATION), WORCESTERSHIRE



Source: Public Health England, Fingertips, Local Tobacco Profiles

FIGURE 24 PREMATURE BIRTHS (LESS THAN 37 WEEKS GESTATION), WORCESTERSHIRE'S STATISTICAL NEIGHBOURS

Premature births (less than 37 weeks gestation) 2014 - 16 — Crude rate - per 1000

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	158,657	79.5	79.1	79.9
Worcestershire	–	-	1,649	91.4	87.0	95.9
Staffordshire	–	4	2,185	84.3	80.8	87.9
Northamptonshire	–	14	2,222	82.2	78.8	85.7
Cumbria	–	13	1,170	81.6	77.0	86.5
West Sussex	–	10	2,134	80.6	77.3	84.1
Derbyshire	–	8	1,896	80.2	76.7	83.9
Norfolk	–	6	2,189	80.2	76.9	83.6
Warwickshire	–	1	1,418	79.0	74.9	83.2
Nottinghamshire	–	7	2,047	78.1	74.7	81.5
Gloucestershire	–	2	1,550	77.1	73.3	81.0
Somerset	–	5	1,269	75.9	71.8	80.2
Suffolk	–	3	1,813	75.9	72.5	79.5
Essex	–	9	3,689	74.7	72.3	77.1
North Yorkshire	–	11	1,261	74.1	70.0	78.3
Devon	–	15	1,565	73.6	70.0	77.4
Lincolnshire	–	12	1,680	72.9	69.4	76.4

Source: Office for National Statistics adhoc table request

Source: Public Health England, Fingertips, Local Tobacco Profiles

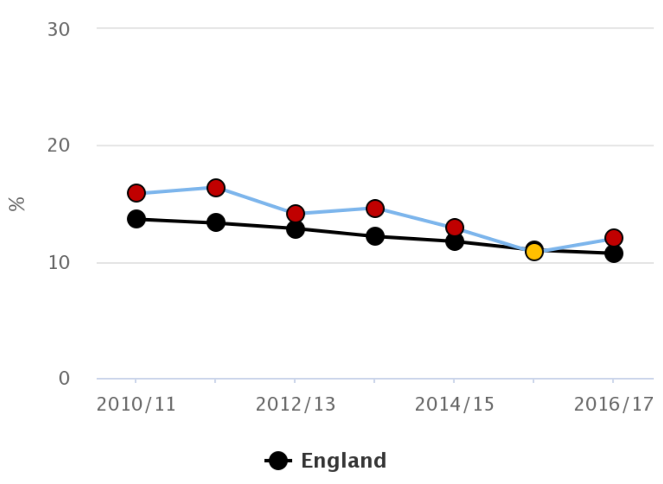
When the premature birth rate is examined at district level four out of the six districts had a higher rate than nationally for the period 2014-16. These were Malvern Hills, Redditch, Worcester and Wyre Forest. Malvern Hills is the only one of 16 nearest statistical neighbours to have a statistically higher than national rate.

Smoking is still the single biggest identifiable risk factor for poor birth outcomes. Figure 25 shows the proportion of mothers smoking at the time of delivery. There has been a downwards

Redditch and Bromsgrove
Clinical Commissioning Group

trend since 2010/11 (for both Worcestershire and England). In 2015-16 the rate was similar to the national average but for the latest available year 2016-17 it is statistically significantly higher than England at 12% (626 women). This overall rate hides local variation. When split by district only Wyre Forest has a rate that is higher than the national average at 14.3% (154 women).

FIGURE 25 SMOKING STATUS AT TIME OF DELIVERY, WORCESTERSHIRE



Source: Public Health England, Fingertips, Local Tobacco Profiles

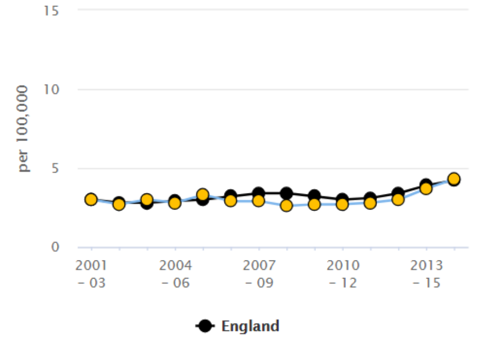
Other indicators linked to infant mortality where Worcestershire performed worse than England in 2016-17 were breastfeeding initiation (66.7% vs 74.5% nationally) and low birth weight of all babies (2016; 8% vs 7.3% nationally). The recent trend for breastfeeding initiation has been downwards.

Update on Drug Misuse Deaths

Nationally, the rate of deaths from drug misuse is rising and this trend is mirrored in Worcestershire. For the latest period (2014-2016), the rate was 4.3 deaths per 100,000 population in Worcestershire compared with 4.2 nationally. This represents 70 deaths over the three year period.

There are two factors that have been identified as contributing to this trend nationally. These are a) an increase in the availability and purity of heroin and b) an ageing cohort who started using heroin in the 1980s and 1990s are now experiencing cumulative physical and mental health conditions and are at higher risk of death. Each drug misuse death is reviewed locally by a multi-agency audit group to analyse the background to each death and implement any changes as a result of discussions/findings.

FIGURE 26 DEATHS FROM DRUG MISUSE, DSR PER 100,000



Recent trend: –

Period	Count	Value	Lower CI	Upper CI	West Midlands	England
2001 - 03	47	3.0	2.2	4.0	2.5	3.0
2002 - 04	41	2.7	1.9	3.6	2.5	2.8
2003 - 05	47	3.0	2.2	4.0	2.6	2.8
2004 - 06	45	2.8	2.1	3.8	2.6	2.9
2005 - 07	53	3.3	2.5	4.3	2.8	3.0
2006 - 08	47	2.9	2.1	3.9	2.9	3.2
2007 - 09	47	2.9	2.1	3.9	2.9	3.4
2008 - 10	42	2.6	1.9	3.5	2.9	3.4
2009 - 11	44	2.7	2.0	3.7	2.7	3.2
2010 - 12	44	2.7	2.0	3.7	2.7	3.0
2011 - 13	45	2.8	2.0	3.7	2.8	3.1
2012 - 14	49	3.0	2.2	4.0	3.5	3.4
2013 - 15	59	3.7	2.8	4.8	4.0	3.9
2014 - 16	70	4.3	3.3	5.4	4.3	4.2

Source: Office for National Statistics (ONS)

Source: Public Health England, Public Health Outcomes Framework

The majority of drug misuse deaths in England occur among people who are not in treatment, and evidence shows that being in treatment is protective against the risk of mortality. In addition to protecting the individual, drug treatment benefits wider society. Drug treatment also reduces drug related offending and therefore delivers substantial crime reduction benefits. Public Health England state the following are ways of preventing drug misuse deaths:

- Identifying drug users in the community
- Making treatment services easily accessible and attractive
- Delivering drug treatment services in line with the well-established body of evidence based guidelines
- Developing pathways that facilitate people who use drugs being screened for health conditions such as lung conditions or mental health problems

The drug strategy 2017 sets out how the government and its partners, at local, national and international levels, will take new action to tackle drug misuse and the harms it causes: https://www.gov.uk/government/publications/drug-strategy-2017

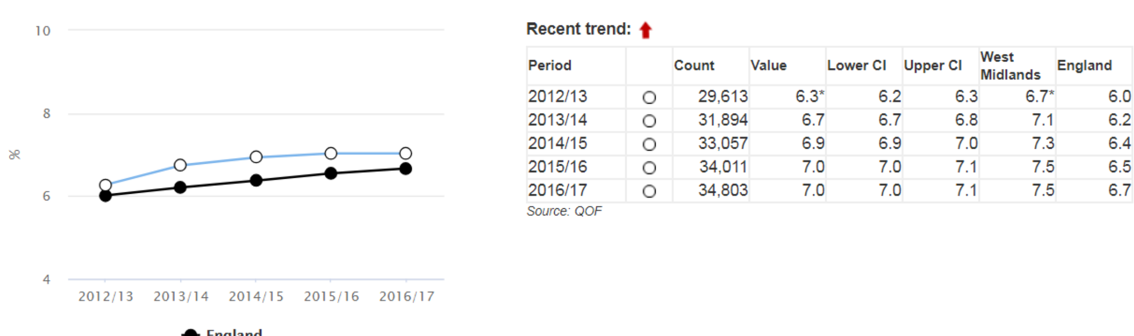
In response to concerns about deaths from heroin adulterated with fentanyls (potent synthetic opioids) in 2016 to 2017, Public Health England has an extensive programme of work to prevent future deaths, including supporting an increase in the provision of naloxone, the heroin overdose antidote. Two resources for local authorities are now available: guidance on preparing to respond to future threats from potent opioids, and modelling of recommended levels of local authority naloxone provision. These are available from the following link:

https://www.gov.uk/government/publications/fentanyl-preparing-for-a-future-threat

Update on Excess Weight and Diabetes

Figure 27 shows that recorded diabetes in Worcestershire has been increasing as it has been nationally. In 2016-17 there were 34,803 people over 17 who had a diagnosis of diabetes. This represents 7% of the registered population.

FIGURE 27 QOF PREVALENCE OF RECORDED DIABETES, WORCESTERSHIRE



Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2012/13	○	29,613	6.3*	6.2	6.3	6.7*	6.0
2013/14	○	31,894	6.7	6.7	6.8	7.1	6.2
2014/15	○	33,057	6.9	6.9	7.0	7.3	6.4
2015/16	○	34,011	7.0	7.0	7.1	7.5	6.5
2016/17	○	34,803	7.0	7.0	7.1	7.5	6.7

Source: QOF

Source: Public Health England, Public Health Profiles

Type 2 diabetes represents approximately 90% of these cases and is partially preventable. Diabetic complications (including cardiovascular, kidney, foot and eye diseases) result in considerable morbidity and have a detrimental impact on quality of life. Type 2 diabetes can be prevented or delayed by lifestyle changes.

Excess weight is a contributory factor for type 2 diabetes. In 2016/17 the majority of adults in Worcestershire were estimated to be overweight or obese (62%) which is statistically similar to England (61.3%)[11].

Update on Homelessness

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 is an issue.

Homelessness is a significant issue in Worcestershire, with many indicators being 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. Physical health problems include circulatory and respiratory conditions, joint aches and pains and poor oral health. Poor mental health is also

[11] Public Health England, Public Health Profiles

particularly prevalent. There is evidence that many homeless people have two or more long-term conditions (LTCs), a situation known as 'multimorbidity'.

There is a high prevalence usage of illegal and prescribed drugs, and of tobacco and alcohol amongst homeless people.

The majority (87%) of the sample in the Worcestershire Homeless Health Audit 2017 were smokers. This is a similar proportion to national studies of similar homeless groups and much higher than the general population prevalence of 17%. Amongst those who were drinking, the average units consumed per day were 11 – much higher than the officially recommended amounts (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 in the Worcestershire Homeless Health Audit 2017, diabetes was only reported by 1 person from the sample of 76 (1.3%). This rate is well below the reported prevalence in the overall population (6.7% for England), possibly suggesting significant under-diagnosis of this condition amongst this homeless population.

The Homelessness Reduction Act 2017 increased the duties of local authorities towards homeless people. Proposed changes to legislation and benefits are likely to have an impact on homeless numbers.

Locally, a Worcestershire-wide Homeless Health Group has been in operation since 2016. This forum brings together local authorities, NHS partners and voluntary sector organisations.

In recognition of the health issues faced by homeless people, the Worcestershire Health and Wellbeing Board have signed up to a 'Charter for Homeless Health'. As part of this commitment a JSNA profile which explores homelessness and the health of homeless people in Worcestershire in more depth has been produced.

Update on Violent Crime

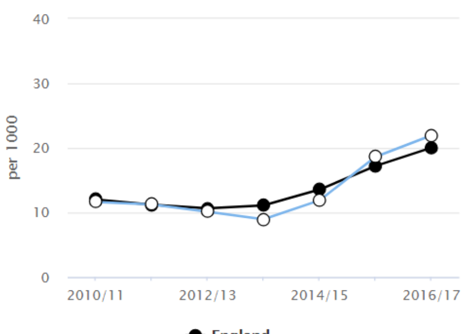
The rate of violent crime recorded in Worcestershire continues to increase (Figure 28) and this reflects what is happening nationally. The latest figures available are for 2016-17 and show there were 12,688 violent offences recorded in Worcestershire or a rate of 21.9 violent offences per 1,000 population.

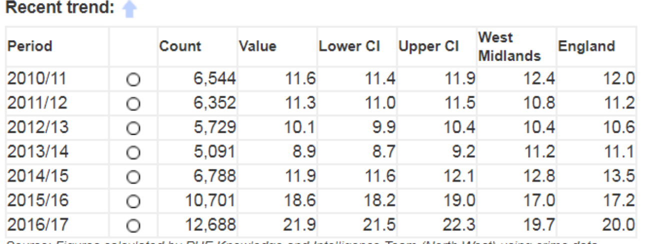
However, these statistics should be interpreted with caution because action taken by police forces to improve their compliance with the National Crime Recording Standard (NCRS) is likely to have resulted in an increase in the number of offences recorded. It is difficult to determine whether high or low levels of violence offences are due high or low prevalence, or high or low levels of recording.

Figure 29 illustrates this complexity as it shows the rate of hospital admissions due to violent crime continues to fall in Worcestershire again mirroring the national trend. The most recently available figures are for the period 2014-15 to 2016-17 and are 23.8 admissions per 100,000 population. This represents 386 admissions over a three year period.

Nationally it is thought the Crime Survey for England and Wales provides a better indication of more common but less harmful violent offences and police recorded crime provides a better measure of violent offences that are more harmful but less common[12]. Nationally, the Crime Survey for England and Wales shows long-term reductions in violent crime but little change in recent years.

FIGURE 28 RATE OF VIOLENT OFFENCES, WORCESTERSHIRE





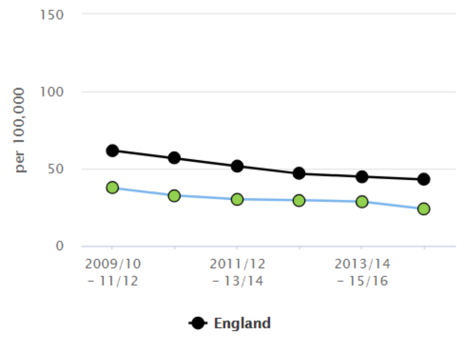
Recent trend:

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2010/11	○	6,544	11.6	11.4	11.9	12.4	12.0
2011/12	○	6,352	11.3	11.0	11.5	10.8	11.2
2012/13	○	5,729	10.1	9.9	10.4	10.4	10.6
2013/14	○	5,091	8.9	8.7	9.2	11.2	11.1
2014/15	○	6,788	11.9	11.6	12.1	12.8	13.5
2015/16	○	10,701	18.6	18.2	19.0	17.0	17.2
2016/17	○	12,688	21.9	21.5	22.3	19.7	20.0

Source: Figures calculated by PHE Knowledge and Intelligence Team (North West) using crime data supplied by the Home Office and population data supplied by Office for National Statistics (ONS).

Source: Public Health England, Public Health Outcomes Framework

FIGURE 29 RATE OF HOSPITAL ADMISSIONS DUE TO VIOLENT CRIME, WORCESTERSHIRE



Recent trend: –

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2009/10 - 11/12	●	609	37.5	34.5	40.6	57.0	61.7
2010/11 - 12/13	●	526	32.6	29.8	35.5	52.6	56.7
2011/12 - 13/14	●	486	30.1	27.5	32.9	48.5	51.5
2012/13 - 14/15	●	479	29.6	27.0	32.3	45.3	46.7
2013/14 - 15/16	●	464	28.7	26.1	31.4	44.2	44.8
2014/15 - 16/17	●	386	23.8	21.5	26.3	41.4	42.9

Source: Hospital Episode Statistics (HES), Health and Social Care Information Centre for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2017, Re-used with the permission of The Health and Social Care Information Centre. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England

Source: Public Health England, Public Health Outcomes Framework

---

[12] Office for National Statistics. Statistical Bulletin. Crime in England and Wales: year ending March 2018. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/crimeinenglandandwales/yearendingmarch2018

Emerging Issues (2018)

Antibiotic Prescribing in Primary Care

Summary

- Due to antimicrobial resistance society is rapidly getting close to a point where we are unable to prevent or treat everyday infections.
- Overuse and incorrect use of antibiotics is a major driver of resistance.
- Some groups are at increased risk of bacterial infection, including: older people, babies, people with heart failure, people who take insulin to control their diabetes, people with a weakened immune system.
- Nationally there has been a declining trend in antibiotic prescribing in primary care.
- Worcestershire has also seen a declining trend in antibiotic prescribing in primary care. However, the decline has not kept pace with national trends and all three Clinical Commissioning groups have higher rates of antibiotic prescribing in primary care than England as a whole.
- Of the three Clinical Commissioning Groups, South Worcestershire CCG has the highest rate of antibiotic prescribing in primary care.
- Antibiotic Guardian is a Public Health England led behaviour-change campaign to encourage improved behaviours and engagement on the prudent use and prescription of antibiotics. By making role-specific pledges stakeholders agree to change their behaviour around this issue.

Background

Bacteria, viruses and fungi are naturally adapting and becoming resistant to medicines used to treat infections that they cause. Coupled to this, the development pipeline for new antibiotics is at an all-time low. Together this means society is rapidly getting close to a point where we may not be able to prevent or treat everyday infections or diseases.

Antibiotic prescribing and antibiotic resistance are inextricably linked, as overuse and incorrect use of antibiotics are major drivers of resistance (PHE, 2018).

In 2013 the Department of Health published a five year antimicrobial resistance strategy (Department of Health, 2013).

The strategy identifies seven key areas for action:

- improving infection prevention and control practices

Wyre Forest Clinical Commissioning Group

South Worcestershire Clinical Commissioning Group

Redditch and Bromsgrove Clinical Commissioning Group

- optimising prescribing practice
- improving professional education, training and public engagement
- developing new drugs, treatments and diagnostics
- better access to and use of surveillance data
- better identification and prioritisation of AMR research needs
- strengthened international collaboration

Groups at risk of bacterial infections

Some groups of people are more vulnerable to the harmful effects of infection. These include:

- people aged over 75 years
- babies less than 72 hours old with a confirmed bacterial infection, or a higher than average risk of developing one
- people with heart failure
- people who have to take insulin to control their diabetes
- people with a weakened immune system – either because of an underlying health condition such as HIV infection or as a side effect of certain treatments, such as chemotherapy.

NHS Choices (2018)

This section of the JSNA Annual Summary focuses on local data that relates to optimising prescribing practice and improving professional education, training and public engagement in primary care.

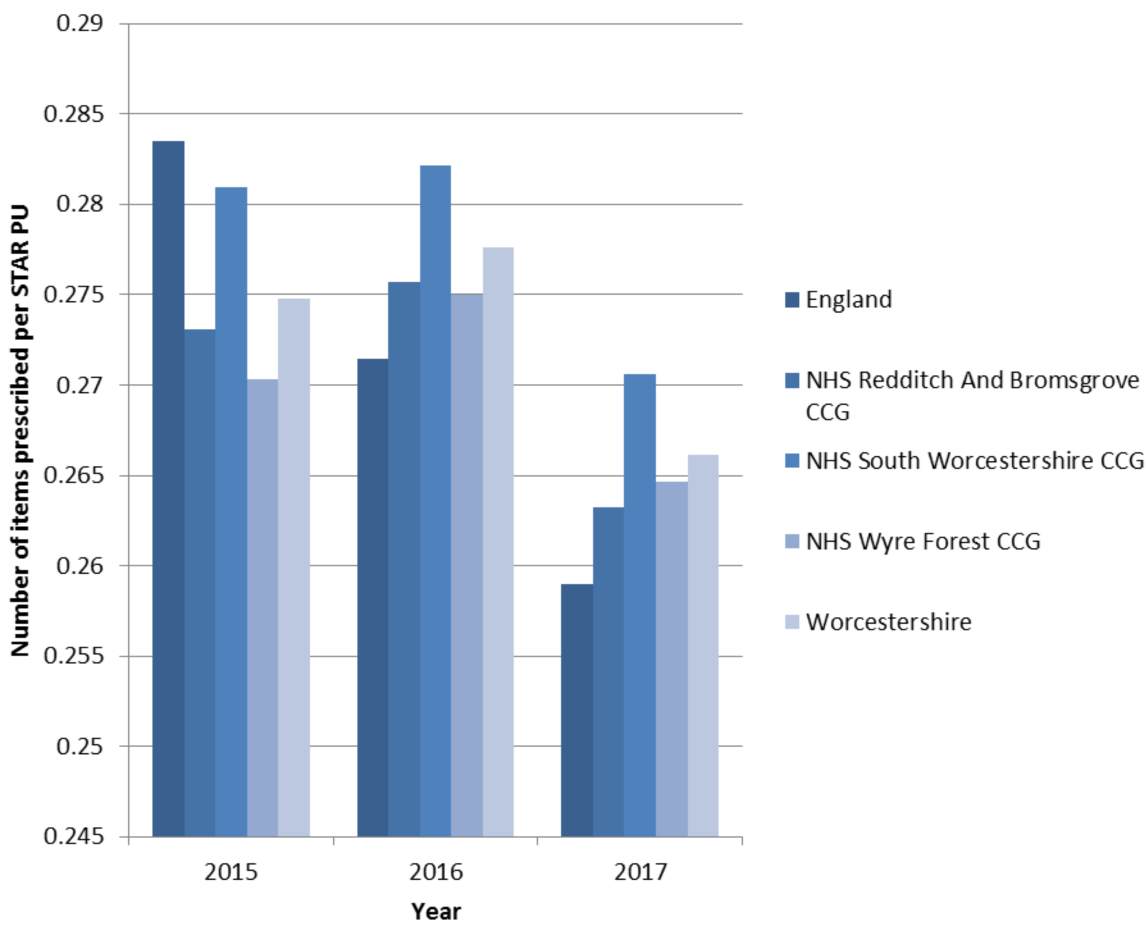
Antibiotic prescribing in Primary Care

The total number of prescribed antibiotic items per 1,000 registered patients is published by NHS Digital on quarterly basis. In order to make more accurate comparisons the data has been adjusted to take into account the demographic characteristics of the population thus producing a number of items prescribed per STAR-PU (see the data notes section for further information).

Figure 30 shows that nationally, over the period 2015-17, there has been a declining trend in antibiotic prescribing in primary care. Although there has also been a decline in antibiotic prescribing in Worcestershire over the same period this has not been as great as that seen nationally. So despite having a better prescribing rate at the beginning of the period Worcestershire now prescribes more antibiotics per STAR-PU in primary care than the national average (0.266 vs 0.259).

In 2017 compared to 2015, all Worcestershire Clinical Commissioning Groups (CCGs) have a reduced rate of antibiotic prescribing. However, for all CCGs this was higher than the national average. Of the three CCGs, South Worcestershire CCG had the highest prescribing rate for antibiotics in primary care. Redditch and Bromsgrove CCG has the lowest.

FIGURE 30 AVERAGE QUARTERLY PRESCRIBING OF ANTIBIOTIC ITEMS PER STARPU



Source: Public Health England, Fingertips, National General Practice Profile, AMR Local Indicators. A local calculation to produce an average quarterly figure has been performed.

Antibiotic Guardians

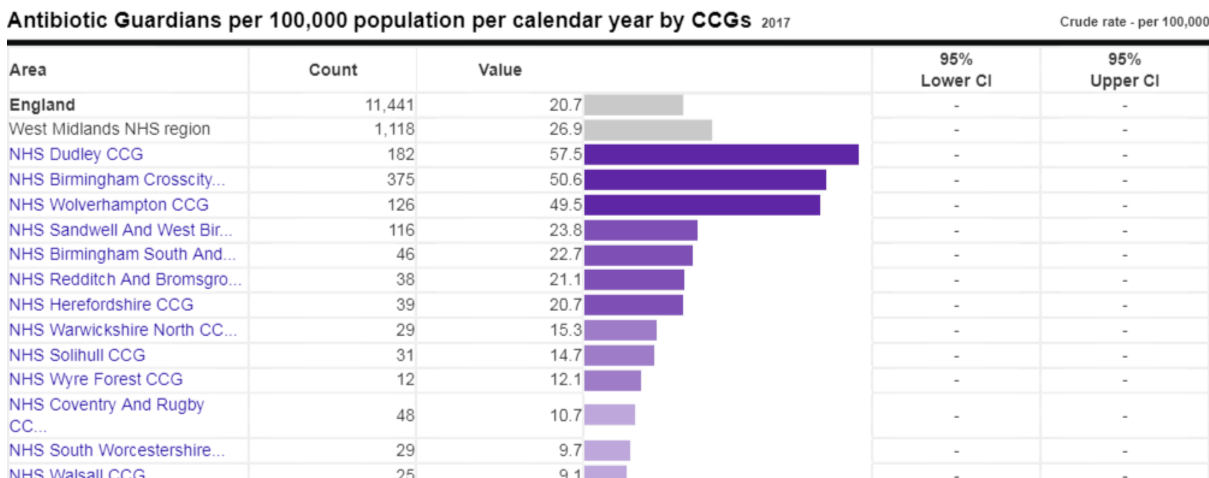
Antibiotic Guardians is a Public Health England led behaviour-change campaign to encourage improved behaviours and engagement on the prudent use and prescription of antibiotics. The campaign encourages health and social care professionals, members of the public, students, educators and scientists to pledge to do specific things tailored to their role (Antibiotic Guardian, 2018).

Figure 31 shows the rates of Antibiotic Guardians per 100,000 population per year by Clinical Commissioning Group as a measure of engagement within the area on antibiotic resistance. For this indicator, a higher rate is indicative of increased engagement.

It can be seen that Redditch and Bromsgrove CCG has a higher rate of Antibiotic Guardians than the national average (21.1 vs 20.7) and Wyre Forest and South Worcestershire CCGs have a lower rate (12.1 and 9.7 respectively).

Improvements in this indicator could be made if more stakeholders make pledges via the Antibiotic Guardian website: http://antibioticguardian.com/

FIGURE 31 ANTIBIOTIC GUARDIANS PER CALENDER YEAR BY CLINICAL COMMISSIONING GROUP, 2017



Antibiotic Guardians per 100,000 population per calendar year by CCGs 2017

Crude rate - per 100,000

Area	Count	Value	95% Lower CI	95% Upper CI
England	11,441	20.7	-	-
West Midlands NHS region	1,118	26.9	-	-
NHS Dudley CCG	182	57.5	-	-
NHS Birmingham Crosscity...	375	50.6	-	-
NHS Wolverhampton CCG	126	49.5	-	-
NHS Sandwell And West Bir...	116	23.8	-	-
NHS Birmingham South And...	46	22.7	-	-
NHS Redditch And Bromsgro...	38	21.1	-	-
NHS Herefordshire CCG	39	20.7	-	-
NHS Warwickshire North CC...	29	15.3	-	-
NHS Solihull CCG	31	14.7	-	-
NHS Wyre Forest CCG	12	12.1	-	-
NHS Coventry And Rugby CC...	48	10.7	-	-
NHS South Worcestershire...	29	9.7	-	-
NHS Walsall CCG	25	9.1	-	-
NHS South Warwickshire CC...	22	8.4	-	-

Source: Antibiotic Guardian counts and postcodes are extracted from www.antibioticguardian.com and include all healthcare professional, public and education sector pledges. Population estimates are based on ONS mid-year estimates.

Source: *Public Health England, Fingertips, AMR Local Indicators*

Associated documents and best practice

In 2017 Public Health England updated the 'Antimicrobial Resistance Resource Handbook'. This is a collation of national antimicrobial resistance, (AMR), antimicrobial stewardship (AMS) and infection prevention and control (IPC) resources which are relevant for various care settings. The handbook is available at:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/605967/PHE_AMR_resource_handbook.pdf

Key areas of work and local assets

The Medicines Commissioning team in Worcestershire continue to monitor antimicrobial prescribing and report data and concerns to individual Practices and host Providers. South Worcestershire CCG were asked to perform a comprehensive audit during quarter 1 of 18/19 as part of the promoting clinical excellence (PCE) contract. The Medicines Commissioning Team

have asked them to interrogate prescribing of co-amoxiclav, cephalosporins and quinolones with respect to local guidance. Practices are expected to then produce and submit individual action plans to address non-compliance with guidance.

Data notes/caveats

In order to fully appreciate antimicrobial prescribing, it is necessary to take into consideration demographic characteristics of the population as it may influence levels of prescribing. For that reason STAR-PU data is adjusted for both age and sex. STAR-PU is an indirectly standardised ratio that removes confounding effects of age and sex in the comparison of prescribing between different areas. This method allows for more accurate comparison of prescribing. In this specific indicator, a higher value is associated with increased prescribing (PHE, 2018). Yearly figures have been calculated by taking the average of quarterly values. If required, data can be broken down further by individual GP Practices.

Antibiotic Guardian counts and postcodes are extracted from www.antibioticguardian.com and include all healthcare professional, public and education sector pledges.

References

Antibiotic Guardian (2018). Available online at: http://antibioticguardian.com/

Department of Health (DH, 2013). UK Five Year Antimicrobial Resistance Strategy 2013 to 2018. September 2013. Available online at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/244058/20130902_UK_5_year_AMR_strategy.pdf

NHS Choices (2018). Antibiotics. Available online at: https://www.nhs.uk/conditions/antibiotics/uses/#people-at-risk-of-bacterial-infections

Public Health England (2018). AMR local indicators. Available online at: https://fingertips.phe.org.uk/profile/amr-local-indicators

Public Health England (2017). The Antimicrobial Resistance Resource Handbook. Available online at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/605967/PHE_AMR_resource_handbook.pdf

Air Quality

Background

Poor air quality affects everyone. However older people, children, those living in deprived areas and those with a pre-existing medical condition are more vulnerable to the adverse effects of poor air quality. Poor air quality has been recognised by World Health Organisation as a "public health emergency" (WHO)[1] and is regarded as a major environmental risk to the public's health in the UK. The health impacts of poor air quality are significant and well recognised such as increases in hospital admissions and deaths from cardiovascular diseases, respiratory diseases and lung cancer. A growing body of evidence also suggests that there are links between poor air quality, diabetes and neurological diseases.

The major air pollutants in the UK are Particulate matter and Nitrogen dioxide (NO_2)

Particulate matter (PM) is generally categorised on the basis of the size of the particles, the smallest being $PM_{2.5}$ which has a diameter less than 2.5 microns. Particulate matter has the highest epidemiological link to health outcomes. PM consists of finely divided solids or liquids such as dust, fly ash, soot, smoke, aerosols, fumes, mists, and condensing vapours that can be suspended in the air. In the UK, the most significant human-made sources of $PM_{2.5}$ are stationary fuel combustion (burning wood, coal and other solid fuels) and road transport.

NO_2 is a traffic-related gaseous pollutant. The largest source of NO2 emissions are diesel light duty vehicles (cars and vans).

National picture

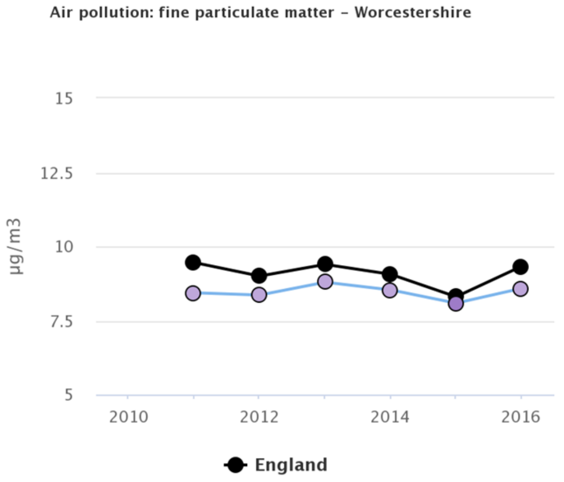
In 2010 the Department of Health's (DH) Committee on the Medical Effects of Air Pollutants (COMEAP) estimated the burden of particulate air pollution (measured in ug/m3) in 2008 to be equivalent to nearly 29,000 deaths and an associated loss of population life of 340,000 years. More recently, it is estimated that outdoor air pollution contributes to 40,000 early deaths each year. Reducing pollution by 10µg/m3 would extend lifespan in the UK by five times more than eliminating causalities on the road or three times more than eliminating passive smoking.

The total NHS and social care cost due to $PM_{2.5}$ and NO_2 combined[1] in 2017 was estimated at £42.88 million (based on data where there is more robust evidence for an association between the disease and air pollution), increasing to £157 million when diseases are included with less robust or emerging evidence for an association. Between 2017 and 2025, the total cost to the NHS and social care of air pollution with robust evidence for an association, is estimated to be £1.60 billion for $PM_{2.5}$ and NO_2 combined increasing to £5.56 billion if other diseases are included for which there is currently less robust evidence for an association.

Local picture

Air pollution in Worcestershire is rising similarly to the England average. Figure 32 shows the trend in air pollution based on concentration of particulate matter from 2011 to 2016.

FIGURE 32 AIR POLLUTION: FINE PARTICULATE MATTER - WORCESTERSHIRE



Source: Public Health Outcomes Framework

Postcodes in England were divided in tertiles based on exposure to $PM_{2.5}$ and NO_2 levels. Adult population in these postcodes were then allocated to categories of high, medium and low exposures to $PM_{2.5}$ and NO_2.

TABLE 5 AVERAGE PERCENTAGE OF ADULT POPULATION LIVING IN AREAS OF LOW, MEDIUM AND HIGH EXPOSURE PM 2.5 IN 2015 ACROSS ALL 6 WORCESTERSHIRE DISTRICTS

Key:

Low exposure = $PM_{2.5}$ < 12.3 micrograms/m^3

Medium exposure = $PM_{2.5}$ from 12.3 to 13.5 micrograms/m^3High exposure = $PM_{2.5}$ >= 13.5 micrograms/m^3

District	Low	Medium	High
Worcester (Males)	26.3	34.6	39.1
Worcester (females)	26.1	34.8	39.1
Wyre Forest(Males)	61.7	37	1.3
Wyre Forest (females)	62	37	1
Wychavon (males)	26.3	34.7	39
Wychavon (females)	26.2	34.7	39.1
Malvern (males)	42.8	51.5	5.7
Malvern (females)	42	52	6
Redditch (Males)	25	67.5	7.5
Redditch (Females)	25.4	67.1	7.6
Bromsgrove (males)	46.5	52.0	1.5
Bromsgrove (females)	44.8	53.6	1.6

Source:PHE Air pollution tool

As is seen from

Table 5, 39% of males and females in Worcester have a high annual exposure to $PM_{2.5}$ followed by Wychavon with 16.5% of males and 17% of females having high annual exposures to $PM_{2.5}$.

The average proportion of adult population with low, medium and high annual exposure to NO2 is shown in Table 6.

TABLE 6 AVERAGE ADULT PERCENTAGE OF POPULATION LIVING IN AREAS OF LOW, MEDIUM AND HIGH POLLUTION OF NO2 IN 2015 ACROSS ALL 6 WORCESTERSHIRE DISTRICTS

Key

Low exposure = NO_2 < 20.5 micrograms/m^3

Medium exposure = NO_2 values from 20.5 to 28.5 micrograms/m^3

High exposure = >= 28.5 micrograms/m^3

District	Low exposure prevalence(%)	Medium pollution prevalence(%)	High pollution prevalence(%)

Worcester (males)	33.5	33	33.5
Worcester (females)	33.5	33.2	33.3
Wyre Forest(Males)	27	56.5	16.5
Wyre Forest (females)	27	57	16
Wychavon(males)	33	33.4	33.6
Wychavon(females)	33.5	33.2	33.3
Malvern hills (Males)	85.5	14.4	>0.1
Malvern hills(female)	85.6	14.4	0
Redditch(Males)	17.4	74.6	8
Redditch(females)	17.3	75.1	7.6
Bromsgrove(Males)	8.9	62.3	28.7
Bromsgrove (Females)	8.6	62.0	29.5

As is seen from Table 6, 33% of males and females living in Worcester have a high exposure to NO_2 followed by 28.7% of males and 29.5% of females living in Bromsgrove.

Air quality management areas (AQMA) are declared where review and assessment have found National Air Quality Objectives and European directive limit and target values for the protection of human health are not being met. In 2017, it was estimated that 0.3% of the Worcestershire population was living in an AQMA which is higher than the England average of 0.2%.

Public Health England has recently developed a tool to help test the long term health impacts and cost implications of high concentrations of $PM_{2.5}$ and NO^2 on selected health conditions. Using this tool, an analysis of the long term health impacts of high $PM_{2.5}$ and NO_2 concentrations on people living in 6 districts across the county is presented below.

Worcester City

It is estimated that by 2037, if 100% of the population in Worcester city presently experiencing high exposure for NO2 move to an area with low annual exposure:

- 118 cases of asthma per 100,000 population are expected to be avoided by 2037.
- 357 cases of diabetes per 100,000 population are expected to be avoided by 2037.
- 3 cases of lung cancer per 100,000 population are expected to be avoided by 2037.

- This could avoid a cumulative cost of £1.3 million per 100,000 population in primary care, £1.8 million per 100,000 population in secondary care, £1.03 million per 100,000 population in medication costs and £2.06 million per 100,000 population in social care costs.

Similarly, if 100% of the pollution in Worcester city currently being exposed to high annual exposure of $PM_{2.5}$ move to an area with low air pollution then:

- 487 cases of coronary heart disease (CHD) per 100,000 population are expected to be avoided by 2037.
- 223 cases of chronic obstructive pulmonary disease (COPD) per 100,000 are expected to be avoided by 2037.
- 125 cases of stroke per 100,000 population are expected to be avoided by 2037.
- This could avoid a cumulative cost of £3.05 million per 100,000 population in primary care, £11.1 million per 100,000 population in secondary care, £5.78 million per 100,000 population in medication costs and £2.04 million per 100,000 population in social care costs.

Wychavon

It is estimated that by 2037, if 100% of the population in Wychavon presently experiencing high exposure for NO2 move to an area with low annual exposure then:

- 58 cases of asthma per 100,000 are expected to be avoided by 2037.
- 290 cases of diabetes per 100,000 population are expected to be avoided by 2037.
- 4 cases of lung cancer per 100,000 of population are expected to be avoided by 2037.
- This could avoid a cumulative cost of £1.5 million per 100,000 population in primary care, £2.1 million per 100,000 population in secondary care, £1.16 million per 100,000 population in medication costs and £2.36 million per 100,000 population in social care costs.

Similarly, if 100% of the pollution in Wychavon currently being exposed to high annual exposure of $PM_{2.5}$ move to an area with low air pollution then:

- 682 cases of CHD per 100,000 population are expected to be avoided by 2037.
- 239 cases of COPD per 100,000 are expected to be avoided by 2037.
- 179 cases of stroke per 100,000 population are expected to be avoided by 2037.
- This could avoid a cumulative cost of £3.78 million per 100,000 population in primary care, £17.5 million per 100,000 population in secondary care, £9.3 million per 100,000 population in medication costs and £4.7 million per 100,000 population in social care costs.

Wyre Forest

It is estimated that by 2037, if 100% of the population in Wyre Forest presently experiencing high exposure for NO^2 move to an area with low annual exposure then:

- 291 cases of diabetes per 100,000 population are expected to be avoided by 2037
- 3 cases of lung cancer per 100,000 of population are expected to be avoided by 2037

This could avoid a cumulative cost of £5.27 million per 100,000 of population in primary care, secondary care medication costs and social care costs.

Similarly, if 100% of the pollution in Wyre Forest currently being exposed to high annual exposure of $PM_{2.5}$ move to an area with low air pollution then:

- 200 cases of CHD per 100,000 population are expected to be avoided by 2037.
- 78 cases of COPD per 100,000 are expected to be avoided by 2037.
- 49 cases of stroke per 100,000 population are expected to be avoided by 2037.

This could avoid a cumulative cost of £9.5 million per 100,000 population across primary care, secondary care medication costs and social care costs.

Bromsgrove

Currently 28.5% of males and 29.5% of females in Bromsgrove live in areas with high annual exposure to NO2. If by 2037, 100% of this population experienced low exposure to NO2 then:

- 144 cases of asthma per 100,000 are expected to be avoided by 2037.
- 432 cases of diabetes per 100,000 population are expected to be avoided by 2037.
- 5 cases of lung cancer per 100,000 of population are expected to be avoided by 2037.

This could avoid a cumulative cost of £7.9 million per 100,000 population across primary care, secondary care, medication and social care costs.

Wyre Forest
Clinical Commissioning Group

South Worcestershire
Clinical Commissioning Group

Redditch and Bromsgrove
Clinical Commissioning Group

Reducing exposure to $PM_{2.5}$ amongst the high exposure groups in Bromsgrove could reduce cases of Coronary Heart disease by 248 per 100,000, COPD by 110 per 100,000 and stroke by 68 per 100,000.

Malvern

Malvern has less than 1% of its population residing in areas with high exposure to NO_2 and hence the impact of interventions to reduce NO_2 is small in terms of reducing cases of avoidable disease and associated cost savings.

Interventions to reduce the impact of high exposure to $PM_{2.5}$ in Malvern (e.g. burning wood for domestic fuel) could help to avoid 331 cases of CHD per 100,000, 130 cases of COPD per 100,000 and 91 cases of stroke per 100,000 by 2037.

Redditch

Currently between 7-8% of the adult population in Redditch live in areas with high annual exposure to NO_2 and $PM_{2.5}$. If by 2037,100% of the population moved to experiencing low exposure to NO_2 and $PM_{2.5}$ then 134 cases of asthma per 100,000 population, 267 cases of diabetes per 100,000, 343 cases of CHD per 100,000, 141 cases of COPD per 100,000 and 94 cases of stroke per 100,000 population could be avoided. The cumulative cost savings due to exposure of $PM_{2.5}$ are estimated at £16.5 million per 100,000.

Mortality

The fraction of all-cause adult mortality attributable to anthropogenic (human-made) air pollution has increased slightly in Worcestershire since 2014 as shown in Figure 33.

FIGURE 33 FRACTION OF MORTALITY ATTRIBUTABLE TO PARTICULATE AIR POLLUTION - WORCESTERSHIRE

3.01 – Fraction of mortality attributable to particulate air pollution – Worcestershire

7
6
% 5
4
3
2010 2012 2014 2016

England

National guidance

The National Institute for Health and Care Excellence (NICE) recommends taking a number of actions in combination to improve air quality as cumulative effects from multiple interventions can be more effective in producing significant improvements in air quality. NICE provides the following recommendations to improve the improve air quality and prevent a range of health conditions and death:

- Planning: Include air pollution in 'plan making' by all tiers of local government
- Development management: Consider ways to mitigate road-traffic-related air pollution eg: use of zero or low emission vehicles, managing street trees and vegetation.
- Clean air zones: Consider introducing a clean air zone
- Reducing emissions from public sector transport services and vehicle fleets
- Smooth driving and speed reduction
- Walking and cycling
- Awareness raising

For more information https://www.nice.org.uk/guidance/ng70

Children and Young People

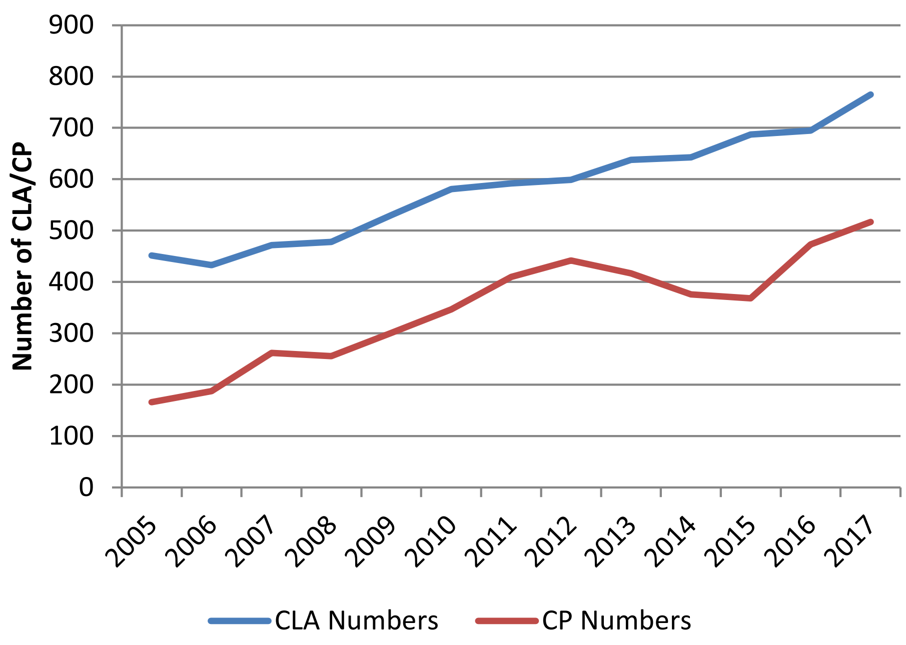
Summary

- The numbers of children who receive additional help or protection from Children's Social Care is continuing to rise. Numbers of children assessed as children in need (CIN), children looked after (CLA) and those subject to child protection plans (CP) continue to increase.
- Abuse or neglect is the most common primary need at assessment for children in need. Worcestershire has a higher percentage of children than England whose primary need was abuse or neglect and this has been rising.
- School readiness, defined as having reached a good level of development at the end of the Early Years Foundation Stage (EYFS), in Worcestershire is similar to England. However school readiness of our disadvantaged children remains worse.
- Whilst educational outcomes both at KS1 level and KS4 for Worcestershire are better than England, results are worse for disadvantaged children in Worcestershire than England.
- Educational outcomes at KS2 level are worse in Worcestershire than England and considerably worse for disadvantaged children.
- The rate of first time entrants to youth justice has increased over the last two years and was higher than the national average.
- The rate of decayed, missing or filled teeth in children aged 5 years in Worcester City is statistically significantly higher than England and has increased since the last survey.
- The homelessness rate of young people aged 16-24 remains higher than the national average.

Children in need and child protection

The data in the following figures are based on a snapshot of numbers at the 31st March each year.

FIGURE 34 TOTAL NUMBER OF CHILDREN LOOKED AFTER (CLA) AND CHILDREN WITH A CHILD PROTECTION PLAN (CP) IN WORCESTERSHIRE



Source: Department for Education, Children looked after in England including adoption SFR50/2017 and Characteristics of children in need SFR 61/2017

Figure 35 shows that the number of CLA has increased steadily and the numbers of CP increased up until 2012, declined for three years but has increased again over the last couple of years. The CLA rate in Worcestershire has increased at a faster rate than the national average. The Worcestershire rate has increased over the past decade to reach and now overtake the England rate (Figure 35).

FIGURE 35 CHILDREN LOOKED AFTER (CLA) RATE PER 10,000 PERSONS AGED <18, 2005-2017

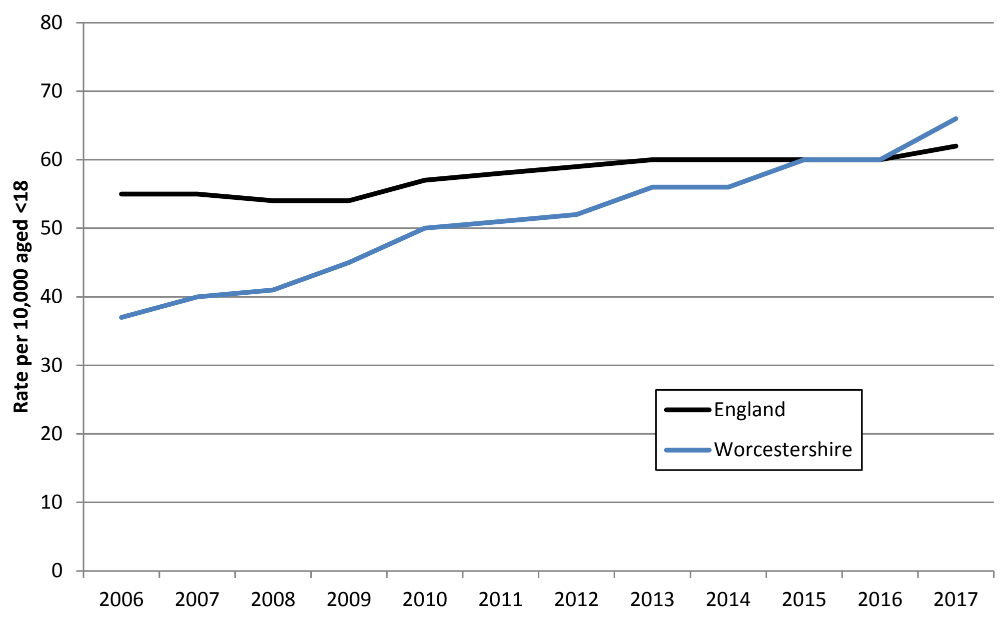
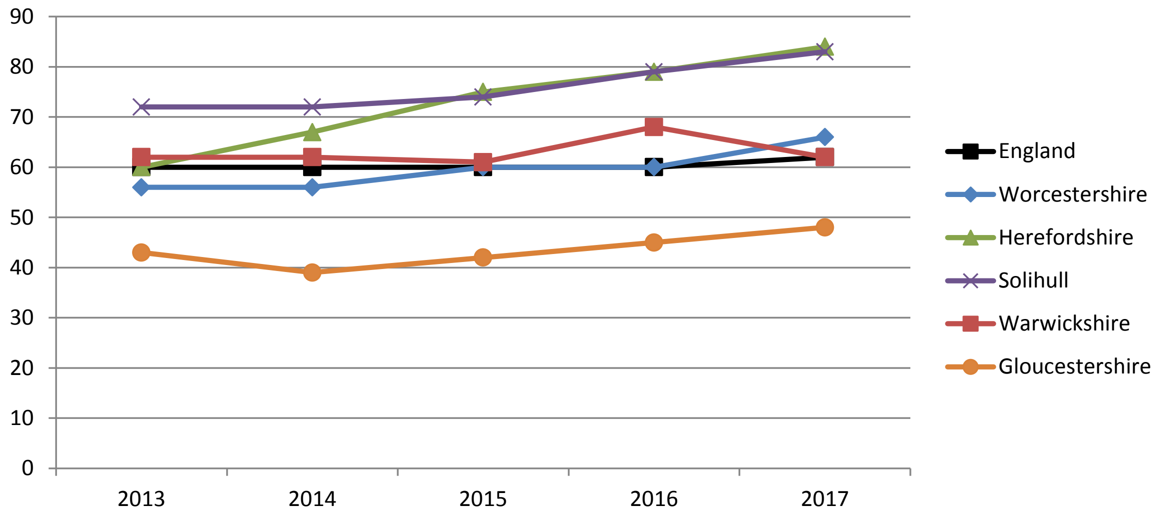
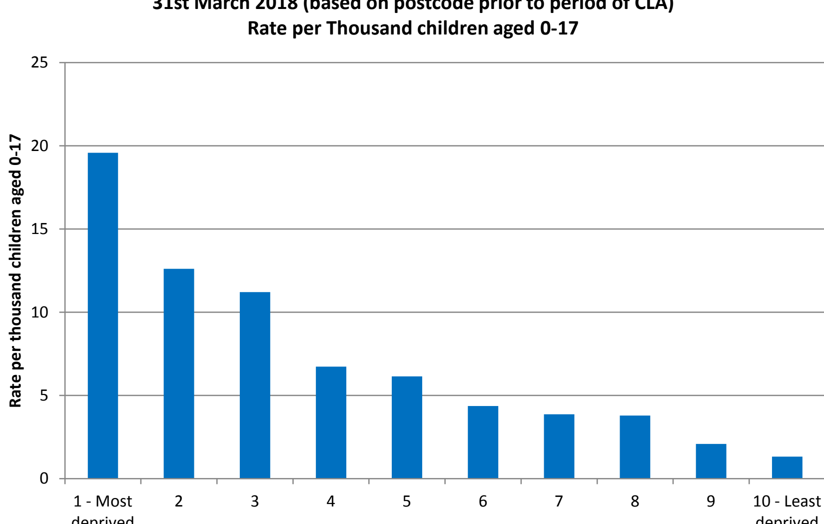


FIGURE 36 CHILDREN LOOKED AFTER AS AT 31ST MARCH – RATE PER 10,000 CHILDREN AGED <18, WORCESTERSHIRE COMPARED WITH STATISTICAL NEIGHBOURS



Although in 2017 Worcestershire had a higher rate than the England average, when compared to statistical neighbours, Worcestershire had the median value of the 5 areas with Herefordshire and Solihull having much higher rates.

FIGURE 37 CHILDREN LOOKED AFTER BY DEPRIVATION DECILE IN WORCESTERSHIRE AS AT 31ST MARCH 2018



Source: Worcestershire County Council, FWi data extract (local analysis)

Figure 37 shows the rate of CLA by their deprivation decile (based on the postcode prior to the period of CLA). This highlights that CLA are disproportionately from deprived areas of Worcestershire.

NUMBERS OF CHILDREN IN NEED (CIN) IN WORCESTERSHIRE HAVE ALSO CONSISTENTLY RISEN ALONGSIDE CLA AND CP NUMBERS AS CAN BE SEEN BY FIGURE 38. BY FAR THE LARGEST MAJORITY OF CIN ARE DUE TO CONCERNS THAT THE CHILD IS SUBJECT TO ABUSE OR NEGLECT AND THIS MAJORITY IS RISING YEAR ON YEAR (

Figure 39).

FIGURE 38 NUMBERS OF CIN, CLA AND CP IN WORCESTERSHIRE AS AT 31ST MARCH

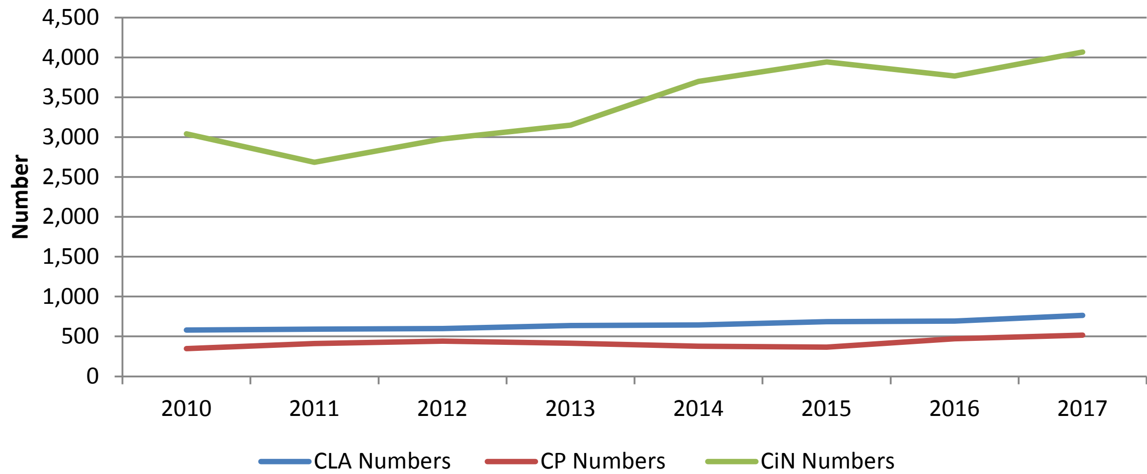
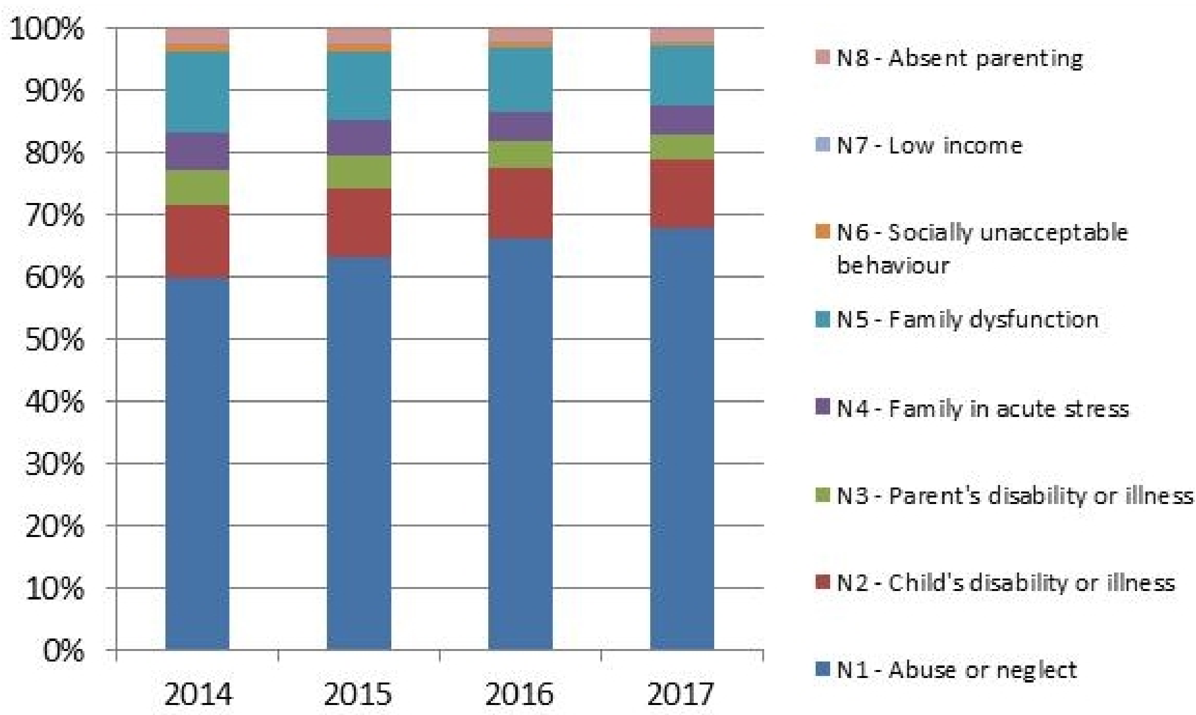


FIGURE 39 PRIMARY REASON FOR CIN REFERRAL

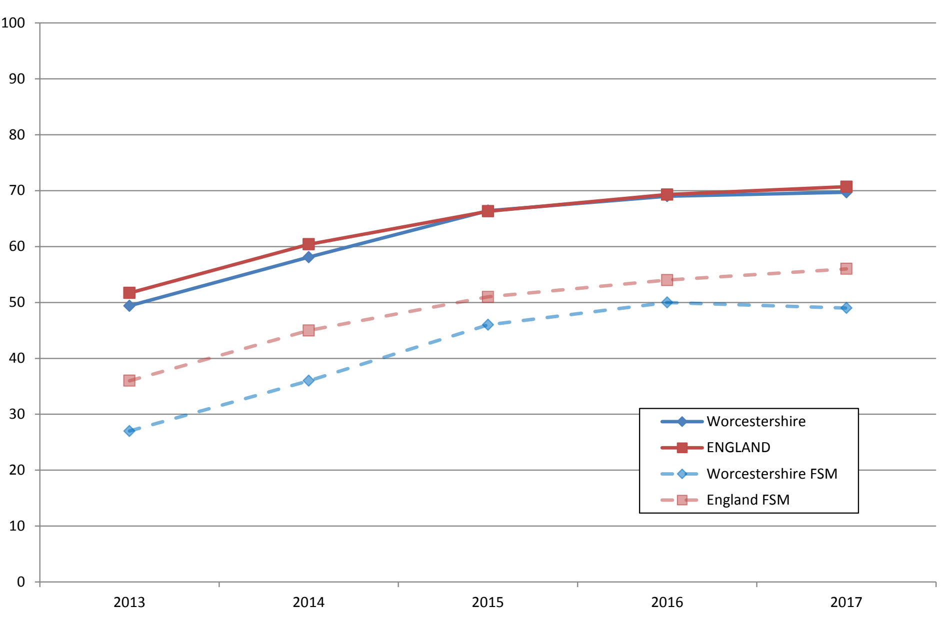


Worcestershire has a higher percentage of children than England whose primary need was abuse or neglect (68% compared to 52%). This accounts for over 2,750 of the 4,000 children flagged as CiN. The next largest category is Child's disability or illness with 450 children flagged in Worcestershire.

School Readiness (national data)

Whilst the overall percentage of children achieving a good level of development at the end of Reception is similar to England there are considerable differences between children who are eligible for free school meals in Worcestershire compared to these children nationally.

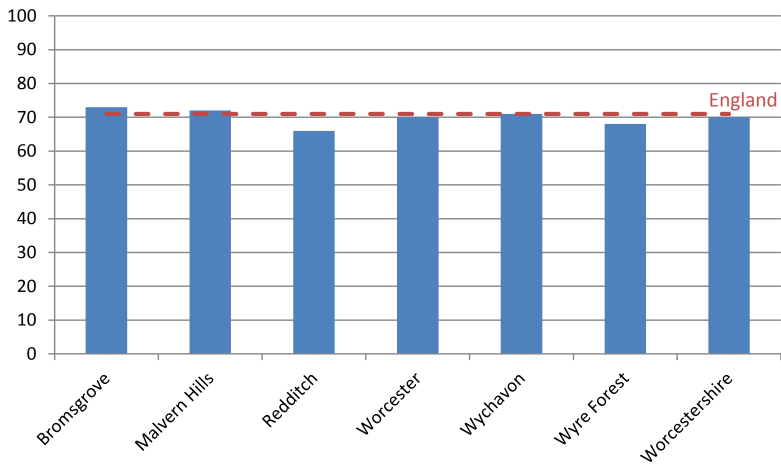
FIGURE 40 SCHOOL READINESS – PERCENTAGE OF CHILDREN ACHIEVING A GOOD LEVEL OF DEVELOPMENT AT THE END OF RECEPTION – ALL PUPILS COMPARED WITH THOSE ELIGIBLE FOR FREE SCHOOL MEALS (FSM)



Source: Department for Education, Early Years Foundation Stage Profile Statistics, SFR60/2017 tables

At sub-County level, Bromsgrove and Malvern council district children had a higher percentage of children with a good level of development than the England average in 2017, with Redditch having the lowest percentage. However, this percentage has improved over the last few years.

FIGURE 41 SCHOOL READINESS, 2017 – PERCENTAGE OF CHILDREN ACHIEVING A GOOD LEVEL OF DEVELOPMENT AT THE END OF RECEPTION BY COUNCIL DISTRICT AREA IN WORCESTERSHIRE



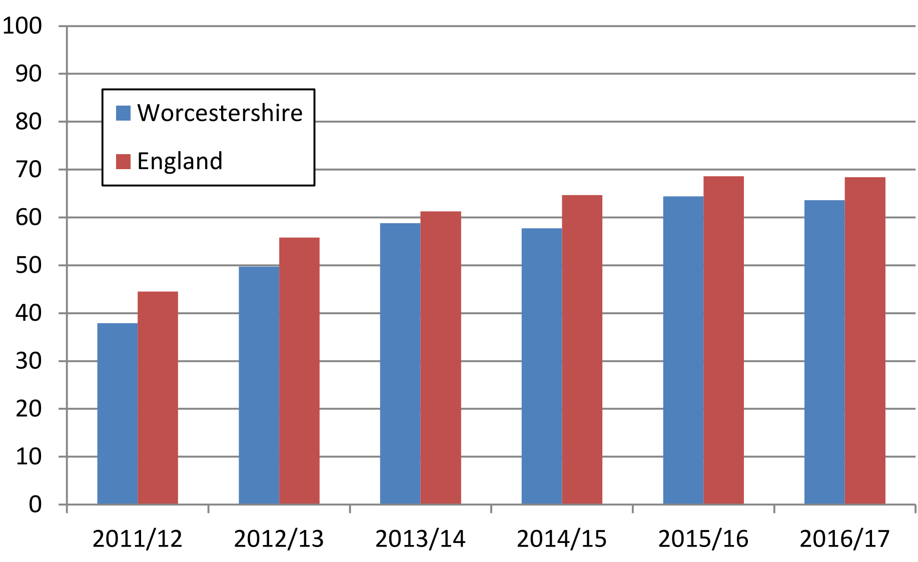
Source: Department for Education, Early Years Foundation Stage Profile Statistics, SFR60/2017 Additional tables

South Worcestershire
Clinical Commissioning Group

Redditch and Bromsgrove
Clinical Commissioning Group

The inequalities gap is highlighted again in the phonics element of the school readiness indicator where children eligible for free school meals in Worcestershire have consistently had lower results when compared with England.

FIGURE 42 SCHOOL READINESS: THE PERCENTAGE OF YEAR 1 PUPILS WITH FREE SCHOOL MEAL STATUS ACHIEVING THE EXPECTED LEVEL IN THE PHONICS SCREENING CHECK



Educational outcomes

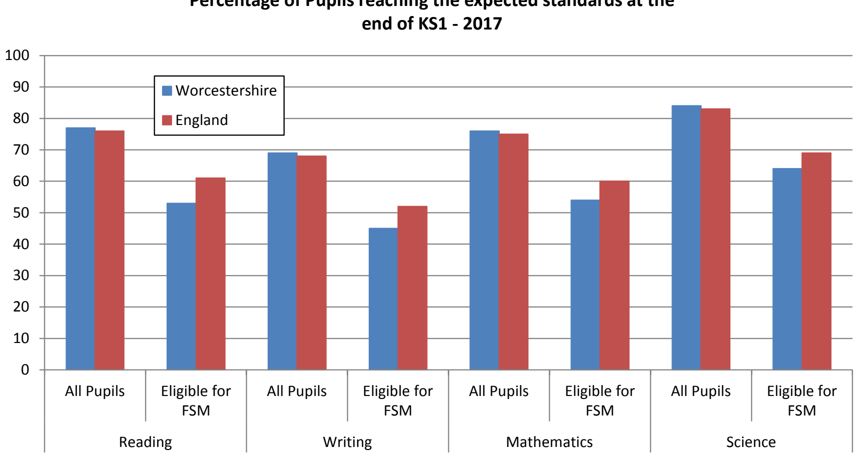
- KS1 results

  Worcestershire has a higher percentage of pupils reaching the expected standards for all 4 areas tested at KS1 level. However, 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.

South Worcestershire
Clinical Commissioning Group

Redditch and Bromsgrove
Clinical Commissioning Group

FIGURE 43 PERCENTAGE OF PUPILS REACHING THE EXPECTED STANDARDS AT THE END OF KS1 - 2017

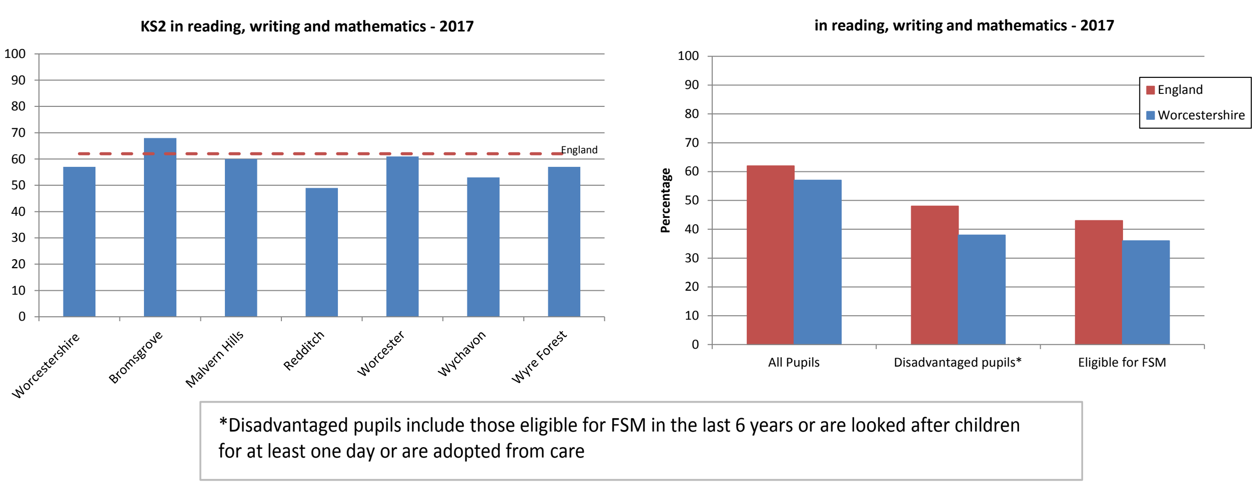


Source: Department for Education, National curriculum assessments at Key Stage 1, SFR49/2017

- KS2 results

  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 2017 (see Figure 44). These percentages were even lower for children who are classed as disadvantaged or eligible for free school meals.

FIGURE 44 PERCENTAGE OF PUPILS REACHING THE EXPECTED STANDARDS AT THE END OF KS2 IN READING, WRITING AND MATHEMATICS – 2017

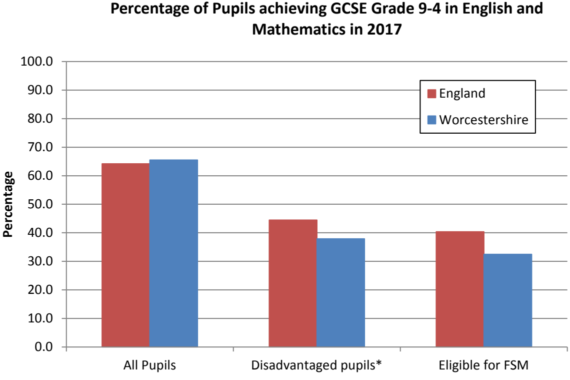


Source: Department for Education, National curriculum assessments at Key Stage 2, SFR69/2017

- 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.

FIGURE 45 PERCENTAGE OF PUPILS ACHIEVING GCSE GRADE 9-4 IN ENGLISH AND MATHEMATICS IN 2017

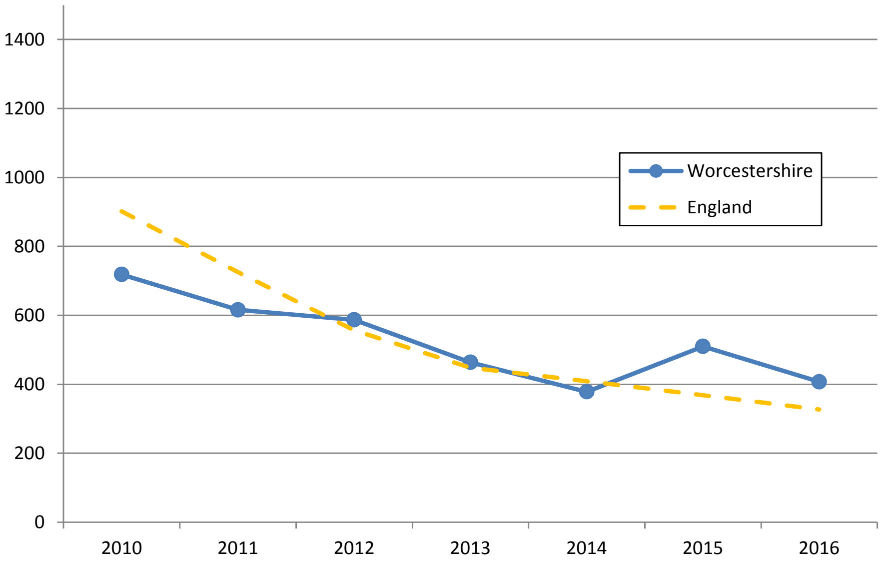


Source: Department for Education, National curriculum assessments at Key Stage 1, SFR01/2018

First Time Entrants in Youth Justice

Over the last 2 years, the rate in Worcestershire of first time entrants to youth justice has been statistically significantly higher than the national average. The data is calculated as the rate of 10-17 year olds receiving their first reprimand, warning or conviction per 100,000 population.

FIGURE 46 FIRST TIME ENTRANTS TO YOUTH JUSTICE SYSTEM PER 100,000 POPULATION AGED 10-17



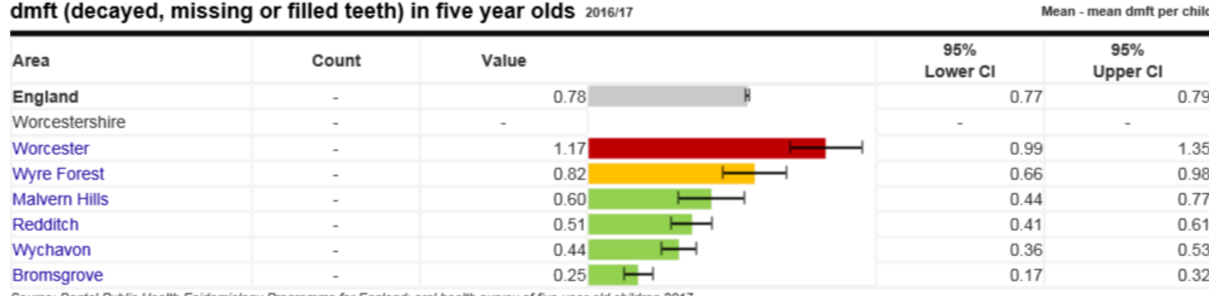
Source: Public Health England, Public Health Outcomes Framework

Oral health in Worcester City

As highlighted in the Oral Health emerging issue section, the rate of decayed missing filled teeth in children is of concern, particularly in Worcester City.

The figure below (Figure 47) shows the DMFT for all Districts within Worcestershire compared to England. In the previous Oral Health Survey, carried out in 2014/15, Worcester City had a child average of 0.9 decayed missing filled teeth per child aged 5 years. This has now deteriorated to an average of 1.17 per child aged 5 years old in 2016/17.

FIGURE 47 DECAYED, MISSING OR FILLED TEETH IN FIVE YEAR OLDS, 2016/17



dmft (decayed, missing or filled teeth) in five year olds 2016/17 — Mean - mean dmft per child

Area	Count	Value	95% Lower CI	95% Upper CI
England	-	0.78	0.77	0.79
Worcestershire	-	-	-	-
Worcester	-	1.17	0.99	1.35
Wyre Forest	-	0.82	0.66	0.98
Malvern Hills	-	0.60	0.44	0.77
Redditch	-	0.51	0.41	0.61
Wychavon	-	0.44	0.36	0.53
Bromsgrove	-	0.25	0.17	0.32

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

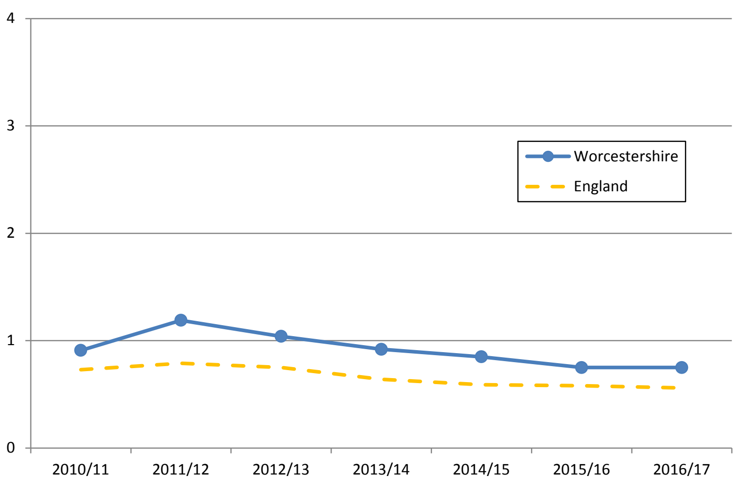
Source: Dental Public Health Epidemiology Programme: Oral Health Survey of 5 year olds

This issue is looked at in more detail in the Oral Health Needs Assessment which is available on the JSNA website.

Homeless young people

Worcestershire has consistently had a higher rate of homeless households headed by a young person as a rate per thousand households. A homelessness profile is currently being produced which will look at this issue in more detail.

FIGURE 48 HOMELESS HOUSEHOLDS HEADED BY A YOUNG PERSON AGED 16-24 YEARS AS A RATE PER THOUSAND HOUSEHOLDS



Source: Public Health England, Child at Maternal Health Profile

Dementia

Summary

- The number of people in Worcestershire who have a diagnosis of dementia is increasing. In 2016/17 it was around 5,000 people.
- However, this figure is likely to represent only a proportion of the people who actually have dementia.
- There are currently estimated to be around 8,000 people with dementia in Worcestershire and this number is projected to increase to nearly 14,000 by 2030.
- The diagnostic rate for dementia in Worcestershire is significantly lower than the national average at 61.0% (vs 67.7% nationally) and is also significantly lower than the national target of 66.7%.
- Diagnostic rates vary by Clinical Commissioning Group and South Worcestershire CCG in particular has a rate which is lower than the national target (57.7% vs the target rate of 66.7%).

Background

- The term dementia describes a collection of symptoms including memory loss, problems with reasoning and communication, and a reduction in a person's ability to carry out daily activities such as washing, dressing and cooking.
- Nationally it is calculated that dementia cost around £32,000 per person annually and 40% of the cost comes from informal care.
- Dementia prevalence increases with age, and age is an independent predictor of dementia[13].
- The most common types of dementia are: Alzheimer's disease, vascular dementia, mixed dementia and dementia with Lewy bodies[14].
- Dementia is a progressive condition that varies from person to person and each will experience dementia in a different way – people may often have some of the same general symptoms, but the degree to which these affect each person will vary[15].
- Diagnosing Well is one of the 5 strands within the Government's 'Well Pathway for Dementia' framework. The others are Preventing Well, Supporting Well, Living Well and Dying Well[16].
- A timely diagnosis of dementia enables people living with dementia, their carers and healthcare staff to plan accordingly and work together to improve health and care outcomes.
- Risk factors for dementia include high blood pressure, obesity, depression and cardiovascular related diseases.
- A variety of organisations including the NHS, voluntary and charity sector groups, contribute towards dementia services in the county. This can present challenges with access to local data.

Key indicators

Three key indicators for dementia are:

---

[13] Adelman, S., Blanchard, M., Rait, G., Leavey, G. and Livingston, G. 2011. Prevalence of dementia in African-Caribbean compared with UK-born White older people: two-stage cross-sectional study. British Journal of Psychiatry, 199, 119-25.
[14] NICE (2015): https://www.nice.org.uk/guidance/ng16

[15] Social Care Institute for Excellence: https://www.scie.org.uk/dementia/

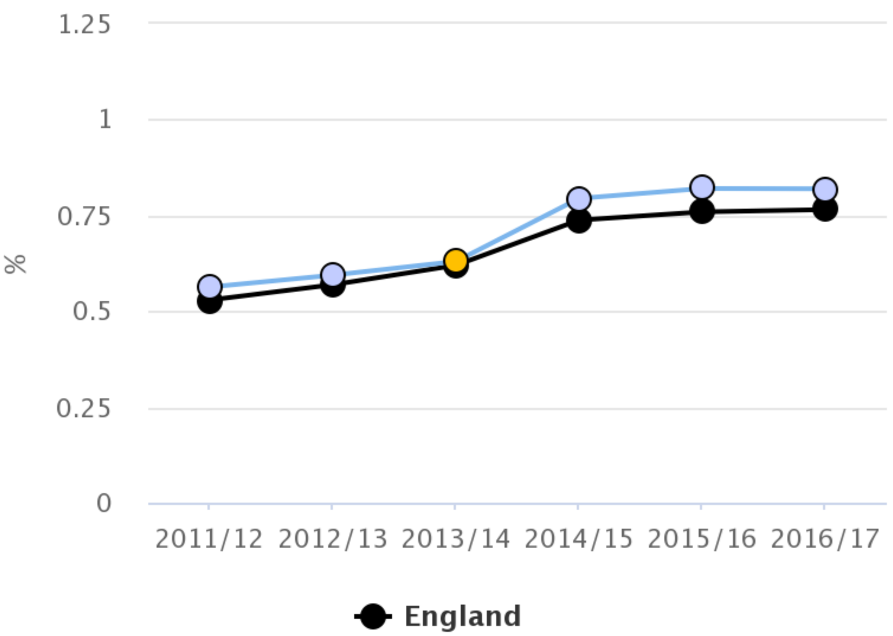
[16] NHS England (2018) https://www.england.nhs.uk/mental-health/dementia/

- Diagnostic rates
- Prevalence of risk factors
- People receiving an NHS Health Check

The number of people in Worcestershire who have a diagnosis of dementia is increasing. In 2016/17 it was around 5,000 people[17].

The recorded prevalence in the GP registered population is higher than the national average at 0.82% vs 0.76% respectively.

FIGURE 49 DEMENTIA: QOF PREVALENCE (ALL AGES) - WORCESTERSHIRE



Source: Public Health England Profiles, Dementia Profile

The recorded prevalence of dementia represents only a proportion of the true prevalence. Nationally a goal of diagnosing 66.7% of people with dementia has been set. Figure 50 shows how Worcestershire compares to similar local authorities on this goal (CIPFA neighbours). It can

be seen that Worcestershire is currently performing below the goal with only 61.0% of people aged 65 or over estimated to have dementia[18] having a diagnosis of dementia. Worcestershire

[17] Public Health England, Dementia Profile, Available at: https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia/data#page/4/gid/1938132811/pat/6/par/E12000005/ati/102/are/E10000034/iid/247/age/1/sex/4

[18] An expected value has been calculated given the characteristics of the population and the age and sex specific prevalence rates of the Cognitive Function and Ageing Study.

is also ranking relatively poorly with similar local authority areas. This suggests there is some room for improvement in diagnosing dementia.

FIGURE 50 DEMENTIA DIAGNOSIS RATES; WORCESTERSHIRE AND CIPFA NEAREST NEIGHBOURS

Estimated dementia diagnosis rate (aged 65+) 2017 — Proportion - %

Area	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	-	432,152	67.9	61.2	73.7
Nottinghamshire	7	7,472	75.2	67.5	81.7
Derbyshire	8	7,481	73.1	65.5	79.5
Northamptonshire	14	5,376	68.7	61.5	74.8
Staffordshire	4	7,187	68.3	61.3	74.3
Gloucestershire	2	5,823	68.2	61.2	74.2
Cumbria	13	4,924	67.4	60.4	73.3
North Yorkshire	11	5,746	65.8	59.1	71.6
West Sussex	10	8,528	64.5	58.0	70.0
Lincolnshire	12	6,822	63.4	56.9	68.9
Suffolk	3	7,134	63.3	56.9	68.8
Norfolk	6	8,414	62.8	56.5	68.2
Somerset	5	5,304	62.1*	55.8	67.5
Worcestershire	-	4,867	61.0	54.7	66.4
Warwickshire	1	4,440	60.9	54.6	66.4
Devon	15	7,622	60.6	54.5	65.9
Essex	9	11,463	60.5	54.4	65.7

Source: NHS Digital

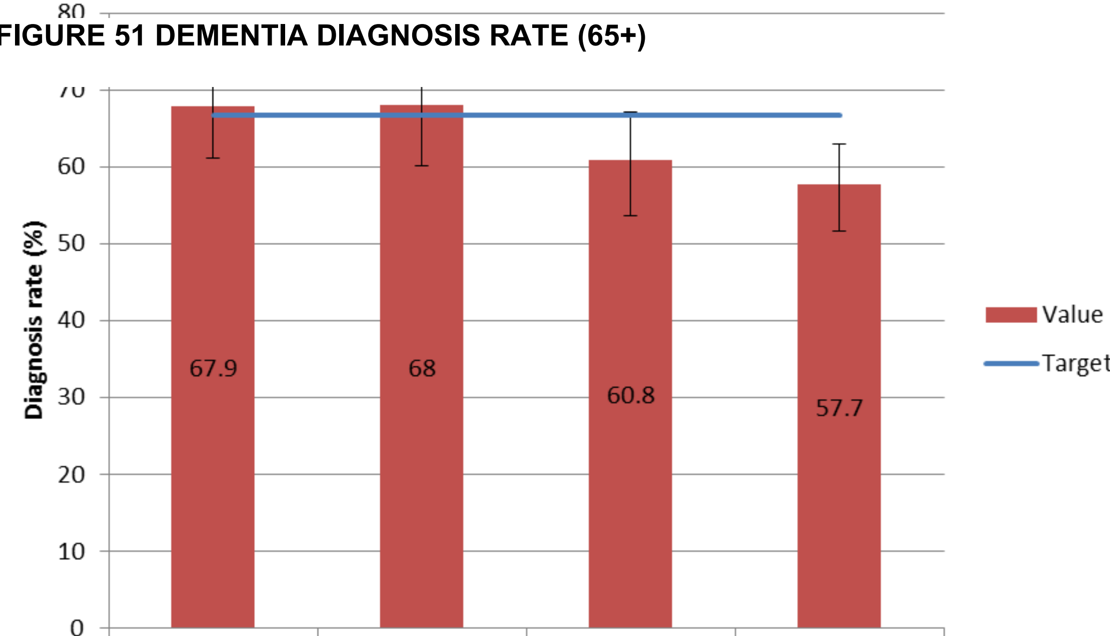
Source: Public Health England Profiles, Dementia Profile

Dementia diagnosis rates can also be broken down by Clinical Commissioning Group.

Error! Reference source not found. Figure 51 shows that Redditch and Bromsgrove CCG and Wyre Forest CCG have a diagnosis rate which is similar to the national goal of 66.7%. However, South Worcestershire has a rate that is significantly lower (57.7%).

Significance is determined by the non-overlapping of confidence intervals with the 66.7% benchmark.

FIGURE 51 DEMENTIA DIAGNOSIS RATE (65+)



Source: Public Health England Profiles, Dementia Profile

It has not been possible to determine the trend in diagnosis rates because no time series is available.

Risk factors

In 2016/17 Worcestershire had a higher recorded prevalence than England for the following dementia risk factors (Worcestershire vs England respectively):

- High blood pressure (15.7% vs 13.8%)
- Stroke (2.1% vs 1.7%)
- Diabetes (7.0% vs 6.7%)
- Coronary Heart Disease (3.4% vs 3.2%)
- Depression (10.8% vs 9.1%)

Source: Public Health England Profiles, Dementia Profile

NHS Health Checks

The NHS Health Check programme has the potential to promote opportunities in mid-life to reduce the behavioural risk factors for dementia and this is one area where Worcestershire

compares well to England. In 2016/17 the percentage of eligible people receiving an NHS Health Check in Worcestershire was 10.1% vs 8.5% nationally[19].

Associated documents and best practice

In January 2018 Public Health England published 'Dementia: Applying All our Health'. This guidance includes a list of interventions and examples of best practice in the area of dementia. It is available at https://www.gov.uk/government/publications/dementia-applying-all-our-health/dementia-applying-all-our-health

NHS England have collated a number of resources on dementia which can be accessed from their website: https://www.england.nhs.uk/mental-health/resources/dementia/. These resources include 'The Well Pathway for Dementia'.

The National Institute for Health and Care Excellence (NICE) have produced, amongst other guidance, the following guidelines that relate to this topic:

- Older people: independence and mental wellbeing. NG32. December 2015. Available at: https://www.nice.org.uk/guidance/ng32
- Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset. NG16 October 2015. Available at: https://www.nice.org.uk/guidance/ng16

A 2016 briefing on Mental Health is available from the Worcestershire Joint Strategic Needs Assessment website: http://www.worcestershire.gov.uk/info/20122/joint_strategic_needs_assessment/1473/jsna_publications_by_category/6

Key areas of work and local assets

Key services

- Early intervention dementia service (WHCT) - Worcestershire Early Intervention Dementia Service (EIDS) have developed a referral pathway, which includes pre-assessment counselling, consent, family engagement, assessment by a competent specialist and sensitive disclosure: https://dementiapartnerships.com/project/worcestershire-early-intervention-dementia-service/

[19] Public Health England, Dementia Profile. Available at: https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia/data#page/4/gid/1938132859/pat/6/par/E12000005/ati/102/are/E10000034/iid/91734/age/219/sex/4

- Dementia Advisory Service (Age UK Herefordshire and Worcestershire) - The service offers information and advice to people who are living with memory loss or dementia, as well as their family and friends: https://www.ageuk.org.uk/herefordshireandworcestershire/our-services/dementia-advice-service/
- Dementia Café (Alzheimer's Society); Connection Point (Alzheimer's Society – for early onset dementia) offer a place to socialise, learn more about dementia and local services, and enjoy something new each session. The Alzheimer's Society offers activities such as Singing for the Brain, Rare Dementia support group and Side-by-Side: https://www.alzheimers.org.uk/get-support/your-support-services/dementia-cafes
- Onside advocacy services - Onside provides a range of support and services for adults who may be vulnerable, disadvantaged, discriminated against or excluded. This includes mental and physical ill health, sensory impairment, learning disability, drug and alcohol misuse, older people, and carers: http://www.onside-advocacy.org.uk/
- Admiral Nursing - These are registered mental health nurses who specialise in dementia, giving much-needed practical and emotional support to family carers, as well as the person with dementia: https://www.hacw.nhs.uk/our-services/mental-health/oamhservices/dementia/caring-for-someone-with-dementia/

Data notes/caveats section

There is a lack of readily available local data to fully understand how dementia varies between groups with shared characteristics including socio-economic position, race or ethnic group, religion, gender, sexual orientation and disability.

References

Adelman, S., Blanchard, M., Rait, G., Leavey, G. and Livingston, G. 2011. Prevalence of dementia in African-Caribbean compared with UK-born White older people: two-stage cross-sectional study. British Journal of Psychiatry, 199, 119-25.
https://www.gov.uk/government/publications/dementia-prevalence-in-groups-by-protected-characteristics

Oral Health in Children Aged 5 Years

Tooth decay, also called dental cavities or dental caries, is the destruction of the outer surface (enamel) of a tooth. Decay results from the action of bacteria that live in plaque, a sticky, whitish film formed by a protein in saliva (mucin) and sugary substances in the mouth. Plaque bacteria stick to tooth enamel and use sugar and starch from food particles in the mouth to produce acid. Tooth decay is largely preventable.

There are two key indicators of child oral health:

- percentage of 5 year olds with any decay

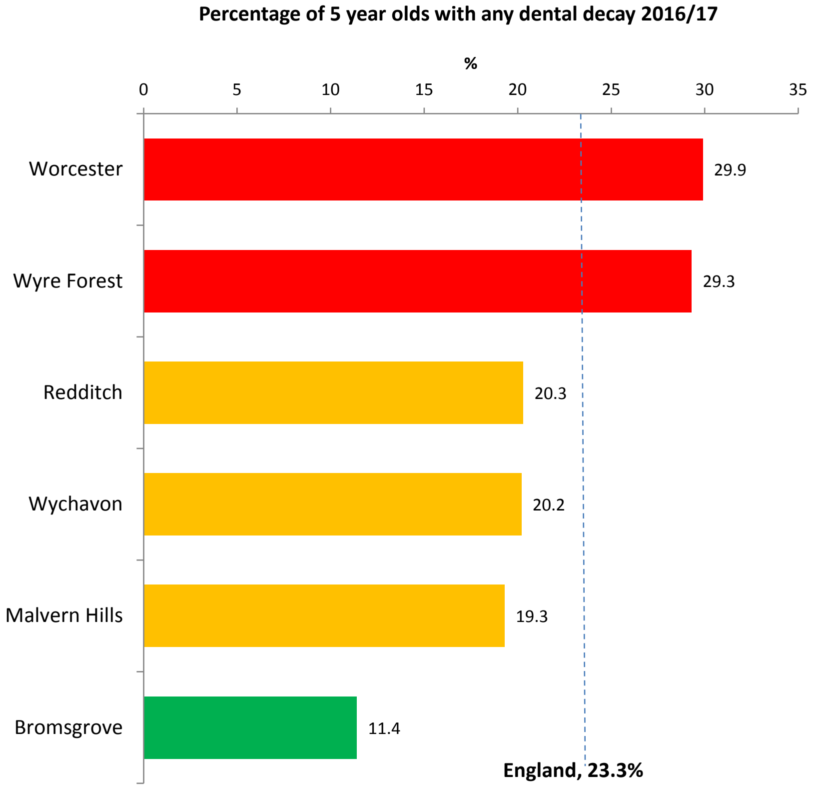
- average number of DMFT (decayed missing or filled teeth) for 5 year olds

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 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.

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 52: PERCENTAGE OF 5 YEAR OLDS WITH ANY DENTAL DECAY, 2016/17



Source: Dental Public Health Epidemiology Programme: Oral Health Survey of 5 year olds

There is considerable variation and widening inequality by district council in average numbers of decayed, missing or filled teeth (DMFT) in 5 year olds. The figure below shows that Worcester

DMFT deteriorated from 0.9 in 2014/15 to 1.17 in 2016/17, while Bromsgrove DMFT improved from 0.3 to 0.25 over the same period.

FIGURE 53: DECAYED, MISSING OR FILLED TEETH IN FIVE YEAR OLDS, 2016/17

dmft (decayed, missing or filled teeth) in five year olds 2016/17 — Mean - mean dmft per child

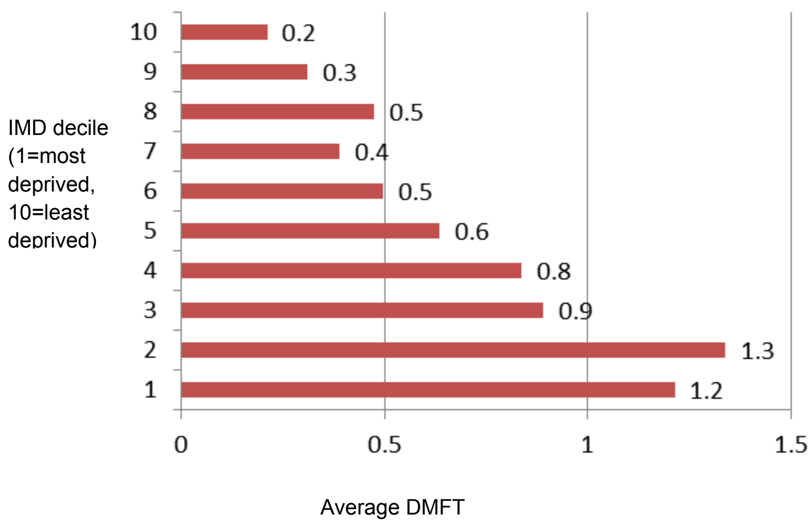
Area	Count	Value	95% Lower CI	95% Upper CI
England	-	0.78	0.77	0.79
Worcestershire	-	-	-	-
Worcester	-	1.17	0.99	1.35
Wyre Forest	-	0.82	0.66	0.98
Malvern Hills	-	0.60	0.44	0.77
Redditch	-	0.51	0.41	0.61
Wychavon	-	0.44	0.36	0.53
Bromsgrove	-	0.25	0.17	0.32

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

Source: Dental Public Health Epidemiology Programme: Oral Health Survey of 5 year olds

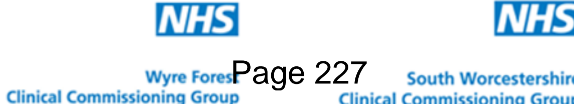
Part of the variation observed between districts is due to differences in deprivation levels. There is a clear relationship between child oral health and deprivation (Figure 54).

FIGURE 54: AVERAGE DMFT BY IMD DECILE, WORCESTERSHIRE, 2014/15



Source: Dental Public Health Epidemiology Programme: Oral Health Survey of 5 year olds

A further issue influencing variation in oral health outcomes is fluoridation of water supply: Bromsgrove, Redditch and most of Wychavon have fluoridated water supplies, while most of Wyre Forest, Malvern Hills and Worcester do not.



Redditch and Bromsgrove
Clinical Commissioning Group

Substance Misuse and Alcohol: Successful Completion of Treatment

Rather than an emerging issue of concern, this section is reporting on an emerging success story in Worcestershire.

According to Public Health England[20], individuals achieving successful completion of substance misuse and alcohol treatment demonstrate a significant improvement in health and well-being in terms of increased longevity, reduced blood-borne virus transmission, improved parenting skills and improved physical and psychological health.

There has been significant improvement in the last two years in all three successful completion indicators, from a significantly worse than national level in 2015 to being above the national level in 2017:

- Opiate treatment successful completions rose from 5.1% in 2015 to 8% in 2017;
- Non-opiate treatment successful completions rose from 23.8% in 2015 to 42.8% in 2017;
- Alcohol successful completions rose from 29% in 2015 to 46.5% in 2017.[21]

Performance against each of the substance misuse indicators has improved considerably following the commissioning of Swanswell, now part of the Cranstoun Group, who have been providing an integrated substance misuse service in Worcestershire since 2015.

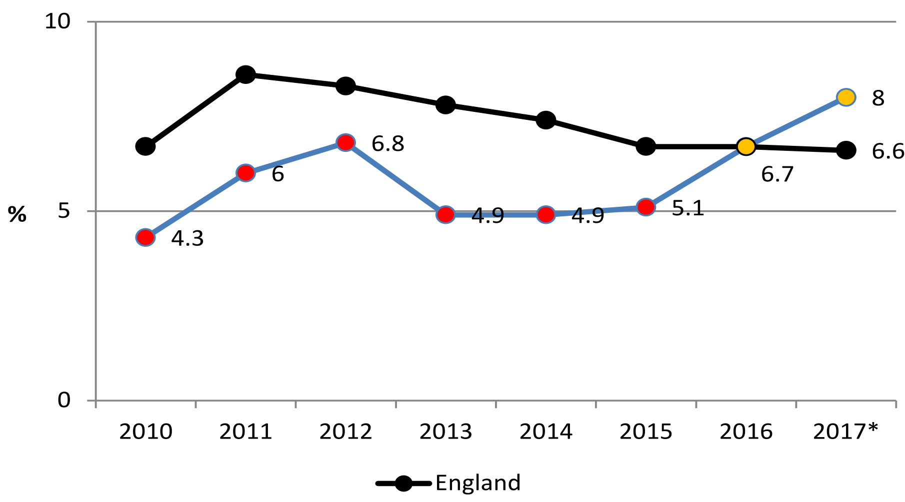
Key to their success has been the development of an effective GP Shared care model (i.e. where the Substance Misuse Worker and GP work together to share the care of a person with drug and/or alcohol problems) enabling increased access to early intervention and prescribing treatments across more than 30 GP practices in Worcestershire and 100 pharmacies. This is in addition to a specialist prescribing service for people with more complex needs. Swanswell also provide a young person and family service.

The service model also provides opportunities for people to access support groups staffed by peer mentors and volunteers to help sustain their recovery when they have become abstinent from drugs and alcohol.

[20] Indicator Definitions and Supporting Information: Available from: www.phoutcomes.info

[21] Note on data: the Public Health Outcomes Framework (PHOF) is updated on an annual basis using data from the National Drug Treatment Monitoring System (NDTMS). The latest information on the PHOF currently available is for 2016. The NDTMS reports the PHOF indicator on a monthly basis, the latest data, which is used here, is for December 2016-November 2017.

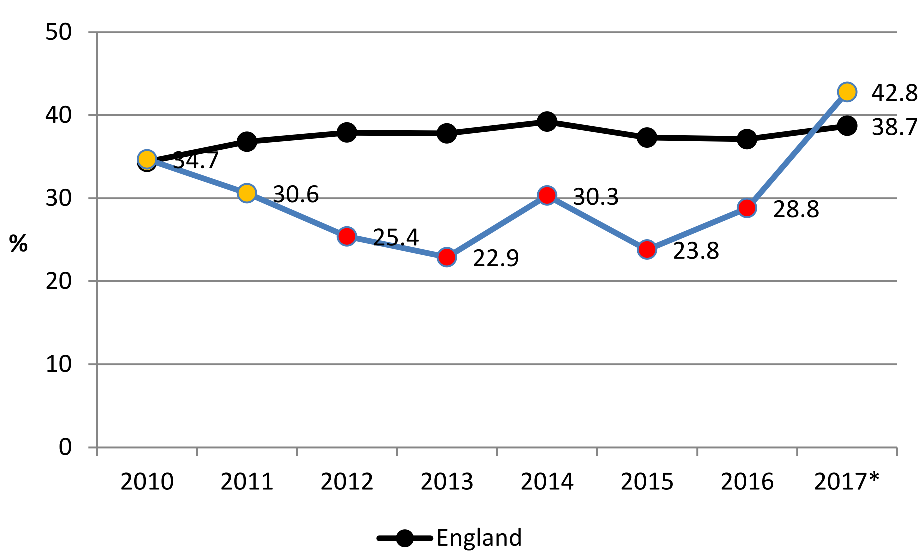
FIGURE 55: PHOF 2.15I - SUCCESSFUL COMPLETION OF DRUG TREATMENT - OPIATE USERS, WORCESTERSHIRE



Source: Public Health Outcomes Framework (2010-2016)/NDTMS (2017): Number of users of opiates that left drug treatment successfully who do not then re-present to treatment again within 6 months as a percentage of the total number of opiate users in treatment

**2017 data for the period December 2016 to November 2017*

FIGURE 56 PHOF 2.15II - SUCCESSFUL COMPLETION OF DRUG TREATMENT - NON-OPIATE USERS, WORCESTERSHIRE



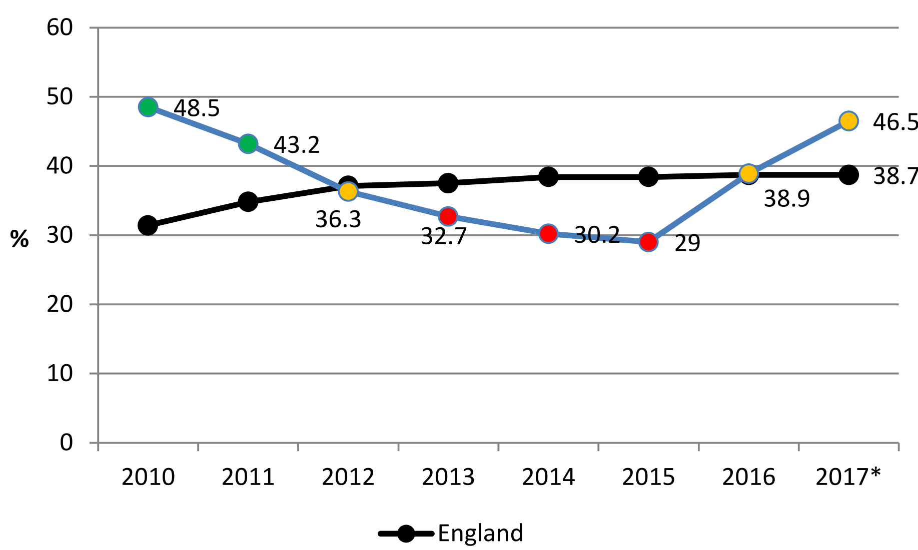
Source: PHOF (2010-2016), NDTMS (2017): Number of users on non-opiates that left drug treatment successfully who do not then re-present to treatment again within 6 months as a percentage of the total number of non-opiate users in treatment

**2017 data for the period December 2016 to November 2017*

South Worcestershire Clinical Commissioning Group

Redditch and Bromsgrove Clinical Commissioning Group

FIGURE 57: PHOF 2.15III - SUCCESSFUL COMPLETION OF ALCOHOL TREATMENT, WORCESTERSHIRE



Source: PHOF (2010-2016)/NDTMS (2017): Number of alcohol users that left structured treatment successfully (free of alcohol dependence) who do not then re-present to treatment within 6 months as a percentage of the total number of alcohol users in structured treatment.

**2017 data for the period December 2016 to November 2017*

Update on Health and Wellbeing Board priorities

Good Mental Health and Well-being at All Ages

Summary

- Nationally around one in four adults experiences at least one diagnosable mental health problem in any given year[22].
- Compared to England as a whole there is a higher recorded prevalence of common mental disorders such as depression and anxiety in Worcestershire. Recorded prevalence of depression[23] is significantly higher in Worcestershire than England, at 10.5% and has increased from the previous year (10.0%).
- Emergency admissions to hospital for self-harm are similar to the national average and have been falling steadily since 2014-15.
- Both locally and nationally males are more likely to commit suicide than females. Male mortality from suicide is similar in Worcestershire to the national average at 18.0 per 100,000 (vs 15.9 per 100,000). Female mortality from suicide is also similar to the national average at 3.8 per 100,000 (vs 4.8 per 100,000).
- The proportion of the population using outdoor space for exercise/health reasons is statistically lower than the national and West Midlands average. It is also one of the lowest across all CIPFA areas. There has been a year on year downward trend since data collection began in 2011-12.
- The proportion of individuals reporting a long-term health problem or disability is significantly higher in Worcestershire in comparison to West Midlands and England.
- The proportion of children who receive school meals achieving a good level of development at the end of reception has increased year on year and the gap has widened slightly in 2016-17 between national rates and rates within Worcestershire, and remain significantly lower than England overall and lower than the proportion of all children who achieve a good level of development.
- The recorded prevalence of dementia[24] in Worcestershire is lower than the national average but is increasing.

---

[22] NHS England (2016) The Five Year Forward View for Mental Health, [Online], Available from: https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf Accessed: 16/07/2018
[23] Public Health Outcomes Framework, http://www.phoutcomes.info/, July 2018
[24] Proportion of patients with dementia within a GP registered population.

Wyre Forest Clinical Commissioning Group

South Worcestershire Clinical Commissioning Group

Redditch and Bromsgrove Clinical Commissioning Group

Background

Good mental health and well-being is a key part of Worcestershire's Joint Health and Well-being Strategy. Nationally, NHS England has published a five year forward view with a focus on preventing poor mental health alongside services to treat mental health problems[22].

Mental health and well-being covers an extensive area and can be quite complex to navigate and understand. Work-streams around improving mental health and Well-being broadly fall under the following three categories: children and young people, working age adults and older people (aged 65 and over).

There are a number of significant risk factors for poor mental health including deprivation, poverty, housing, lack of education and life-long learning, lack of employment, crime and violence. There are particular groups in society who experience poorer mental health than the overall population, including individuals of Black, Asian or Minority Ethnicities (BAME), those with a physical or learning disability or sensory impairment, looked after children, prisoners and offenders, people who identify as Lesbian, Gay, Bisexual and transgender (LGBT), carers, individuals with long-term physical illness or disability, people who are homeless, and refugees and asylum seekers[25].

People living in more deprived areas are likely to have higher levels of mental health conditions and higher need for services. There is strong evidence to suggest that work is generally good for physical and mental health and well-being, taking into account the nature and quality of work and its social context, and that worklessness is associated with poorer physical and mental health. Homelessness is associated with severe poverty and is a social determinant of mental health. Child poverty is a key determinant of child and adolescent mental health problems. Young people in care are over-represented in mental health statistics. Being in care when young is also a determinant of adult mental health, such as levels of antisocial behaviour, emotional instability and psychosis complications[26].

Many cases of common mental disorders such as depression and anxiety go undiagnosed as many people do not seek treatment; either due to difficulty in recognising anxiety disorder or due to the stigma attached to mental illness. Primary mental health care services include effective treatment of common mental health disorders, have a clear focus on prevention and early identification and promote self-management by patients, including use of personalised care plans. Awareness of the essential elements of well-being is increasing; a majority of people understand what steps they can take to improve it, such as taking a walk, or spending time with family and friends (PHE, 2016).

---

[25] Public Health England (2017) Better Mental Health: JSNA Toolkit, [Online], Available from: https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit Accessed: 16/07/2018

[26] Worcestershire County Council (2015) Mental Health Needs Assessment, [Online], Available from: http://www.worcestershire.gov.uk/info/20122/joint_strategic_needs_assessment/1514/jsna_health_needs_assessments Accessed: 16/07/2018

An estimated 45% of looked after children have a mental health disorder, rising to almost three quarters of those in residential care. The government mental health strategy identifies 'looked after children' (LAC) as one of the particularly vulnerable groups and a priority for local authorities and the NHS (DoH, 2011).

Local picture

In Worcestershire, there are lower levels of deprivation, long-term unemployment and young people who are not in education, training or employment, in addition to this GCSE attainment is higher than England average.

In contrast, there are significantly higher levels of people with long-term health problems; a higher proportion of people aged 65+ who live alone, high levels of unpaid carers and higher levels of young people aged 16-24 years old who are homeless.

Recently there has been a significant increase in the gap in employment rate between those with long-term health conditions and the overall employment rate (in Worcestershire, in 2016/17 36.0% of people with a long-term health condition were employed compared to 29.4% in England).

TABLE 7 MENTAL HEALTH AND WELL-BEING INDICATORS FOR WORCESTERSHIRE, WEST MIDLANDS AND NATIONAL COMPARATORS

Indicator	Period	Units	England	West Midlands	Worcs	Trend
QOF: Dementia recorded prevalence (aged 65+): % of patients on GP practice register recorded as having dementia LCI - UCI	Q2 2017-18	%	4.3 4.31 - 4.34	4.2 4.17 - 4.24	3.8% 3.73 - 3.94	↔
Estimated dementia diagnosis rate (aged 65+) LCI - UCI	2017	%	67.9% 61.2% - 73.7%	65.6% 59.0% - 71.1%	61.0% 54.7% - 66.4%	-
QOF: Depression recorded prevalence (aged 18+) LCI - UCI	2016-17	%	9.1 9.1-9.1	9.3 9.3-9.4	10.8 10.7-10.9	↑
PHOF 4.10 Mortality rate suicide/injury of undetermined intent LCI - UCI	2014-16	DSR per 100,000	9.9 9.8-10.1	10.0 9.5-10.6	10.7 9.1 - 12.5	↑
HSCIC: Hospital admissions as a result of Self-Harm (10-24yrs) LCI - UCI	2016-17	DSR per 100,000	404.6 400.7-408.6	413.9 401.9 - 426.2	364.6 327.3 - 404.9	↓
PHOF 1.16: Use of outdoor space for exercise/health LCI - UCI	2015-16	%	17.9 17.4 - 18.4	17.7 16.4 - 19.0	14.2 10.8 - 17.7	↓
HSCIC: Percentage of adult carers who have as much social contact at they would like LCI - UCI	2016-17	%	45.4 45.0 - 45.8	46.1 44.7 - 47.5	49.7 44.6 - 54.8	↑
Census 2011: Long-term health problem or disability: % of population LCI - UCI	2011	%	17.6 17.6 - 17.7	19.0 18.9 - 19.0	17.9 17.8 - 18.0	-
ASCOF: Gap in Employment rate - Proportion of adults in contact with secondary mental health services in paid employment LCI - UCI	2016-17	%	67.4 67.2 - 67.6	63.4 62.5 - 64.3	66.9 63.4 - 70.4	↑
PHOF 2.23i: Self reported well-being - People with low satisfaction score LCI - UCI	2016-17	%	4.5 4.4 - 4.7	4.9 4.4 - 5.4	Not available -	n/a
PHOF 1.02i: School Readiness: % of children with free school meal status achieving a good level of development at the end of reception LCI - UCI	2016-17	%	56.0 55.7 - 56.3	55.7 54.9 - 56.6	49.3 45.8 - 52.8	↓

SOURCE: PUBLIC HEALTH OUTCOMES FRAMEWORK HTTP://WWW.PHOUTCOMES.INFO/ , PUBLIC HEALTH PROFILES, HSCIC

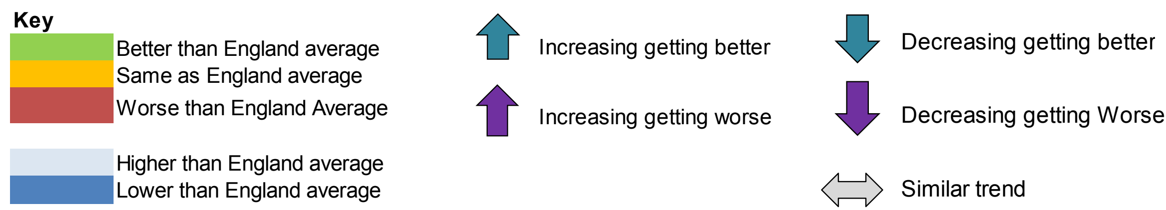
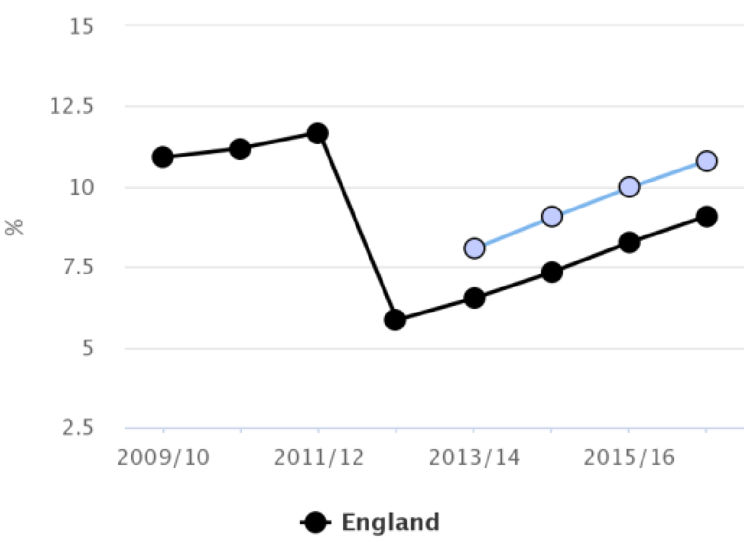


FIGURE 58 RECORDED PREVALENCE OF DEPRESSION, WORCESTERSHIRE



Source: Public Health Outcomes Framework, http://www.phoutcomes.info/, July 2018.

The highest prevalence for GP recorded depression is within NHS Wyre Forest CCG at 14.2% of registered patients aged 18+. This is significantly higher than the national rate and has been increasing year-on-year.

According to the GP Patient Survey it is estimated that the prevalence of depression and anxiety is:

- 13.7% in Redditch and Bromsgrove CCG which is the same as the England average.
- 13.4% in South Worcestershire CCG which is similar to the England average
- 15.1% in Wyre Forest CCG which is similar to the England average

Estimated dementia diagnosis rate (aged 65 and over)

A rapid increase in dementia, due to the ageing demographic, is a significant issue for Worcestershire, which has a higher proportion of people, aged 65+ than the national average. Estimated diagnosis rate of dementia in the over 65's is a new measure that has been developed to improve the rate of diagnosis of dementia across the country and ultimately aimed at improving care of people living with dementia. People living with dementia have better

outcomes with earlier formal diagnosis and in addition to this the correct levels of support can be put in place for families and carers[27].

The indicator itself is a complex one and uses age and sex specific dementia prevalence rates, which are subsequently, applied to the local patient population aged 65+ by age group and gender, which provides the number of expected cases of dementia within the local population. This is then divided by the actual number of cases diagnosed and provides an estimated diagnosis rate.

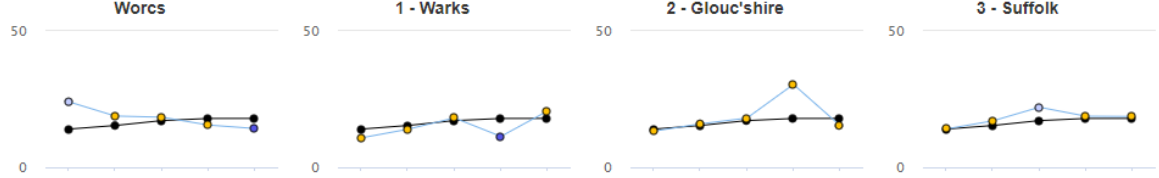
Worcestershire is one of only 19 counties and unitary authorities across England where the diagnosis rate is significantly lower than the national threshold of 66.7%, in comparison to similar CIPFA area. Worcestershire has a lower rate compared to both Gloucestershire (68.2%) and Suffolk (63.3%) but a similar rate to Warwickshire (60.9%), which also has a significantly lower rate compared to the national threshold. Diagnosis of dementia is explored further in the 'Emerging Issues' section of this report.

Utilisation of outdoor space

There is strong evidence to suggest that green spaces have a beneficial impact on physical and mental Well-being and cognitive function through both physical access and usage (Marmot, 2010 and Maas et al, 2009).

The proportion of the population using outdoor space for exercise/health reasons is statistically lower than the national and West Midlands average. It is also one of the lowest across all CIPFA areas. There has been a year on year downward trend since data collection began in 2011-12 (Figure 59).

FIGURE 59 UTILISATION OF OUTDOOR SPACE FOR EXERCISE/HEALTH REASONS



School Readiness

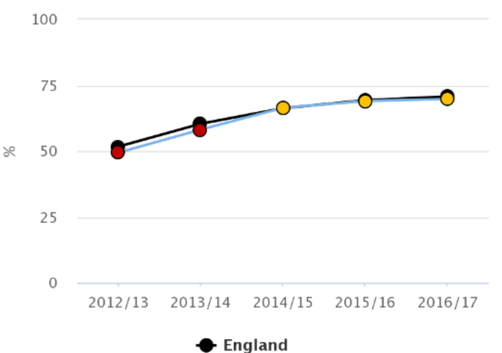
In Worcestershire the proportion of all children achieving a good level of development at the end of reception has been increasing over time and this reflects the national trend. Starting from a

[27] Indicator Definitions and Supporting Information: Dementia: 65+ Estimated Diagnosis Rate. Available from: www.phoutcomes.info

worse proportion, the gap between Worcestershire and England has closed. In 2016/17 the percentage of all children achieving a good level of development at the end of reception was similar to the England average at 69.7% (vs 70.7% for England).

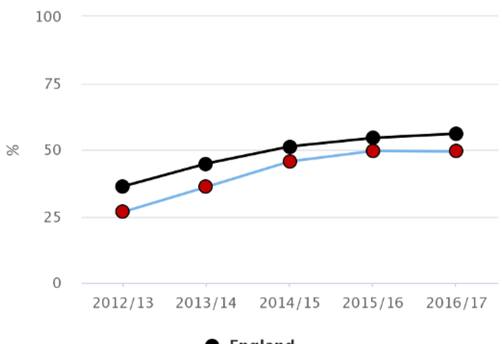
Although the proportion of children with free school meal status achieving a good level of development at the end of reception has also been increasing over time there is still a gap between how Worcestershire and England perform on this indicator (Figure 61). In 2016/17 the percentage of children with free school meal status achieving a good level of development at the end of reception was lower than the proportion of all children and significantly lower than England at 49.3% (vs 56.0% for England).

FIGURE 60 GOOD LEVEL OF DEVELOPMENT AT THE END OF RECEPTION - ALL CHILDREN



Source: Public Health England, Public Health Outcomes Framework

FIGURE 61 GOOD LEVEL OF DEVELOPMENT AT THE END OF RECEPTION - FREE SCHOOL MEAL STATUS



Source: Public Health England, Public Health Outcomes Framework

Community views

- In January 2017, a Healthwatch report highlighted that carers have an important role to play in supporting people who are experiencing a mental health crisis[28]. Healthwatch recommended that carers are identified as early as possible and professionals listen to and involve them in care planning for the person they care for, health and social care professionals adopt a consistent approach to providing appropriate and relevant information to all carers to support someone during a mental health crisis, and all carers are provided with information about what support is available to them and how to access it.

- In March 2017, Healthwatch Worcestershire published Children and Young People: Emotional Well-being Information, Advice and Support Report[29]. This set out recommendations about the need for promotion of new services for emotional well-being, as part of the implementation of Worcestershire's Transformation Plan for Children and Young People's Mental Health and Emotional Well-being. Feedback received from students shows that dealing with problems and emotional well-being is an important issue and they may be more likely to seek help from peers than a parent or teacher.

Associated documents and best practice

Worcestershire Joint Strategic Needs Assessment publications:

2017 Worcestershire JSNA Briefing on Suicide
2017 Worcestershire JSNA Briefing on Learning Disabilities
2016 Worcestershire JSNA Briefing on Mental Health
2016 Worcestershire JSNA Briefing on Older People
2015 Worcestershire JSNA Briefing on Homelessness
2015 Worcestershire JSNA Briefing on Early Help
2015 Worcestershire JSNA Mental Health Needs Assessment
2014 Worcestershire JSNA Briefing on Substance Misuse

Public Health England publications:

Prevention concordat for better mental health. August 2017. Available online at: https://www.gov.uk/government/collections/prevention-concordat-for-better-mental-health

---

[28] Healthwatch Worcestershire (2017) Support for Mental Health and Wellbeing – A Carers Perspective, [Online], Available from: http://www.healthwatchworcestershire.co.uk/wp-content/uploads/2017/03/Spotlight-On-Final-V-1.0.pdf

[29] Healthwatch Worcestershire (2018) Focus on Children and Young People's Emotional Wellbeing, [Online], Available from: http://www.healthwatchworcestershire.co.uk/wp-content/uploads/2018/05/HWW-Focus-on-CYP-Emotional-Wellbeing-V1.pdf
Accessed: 16/07/2018

National Institute for Health and Care Excellence (NICE) Guidelines:

PH40 Social and emotional Well-being : early years

PH22 Mental Well-being at work

PH20 Social and emotional Well-being in secondary education

PH16 Mental Well-being in over 65s: occupational therapy and physical activity interventions

PH12 Social and emotional Well-being in primary education

CG192 Antenatal and postnatal mental health: clinical management and service guidance

NG69 Eating disorders: recognition and treatment

NG66 Mental health of adults in contact with the criminal justice system

NG53 Transition between inpatient mental health settings and community or care home settings

NG32 Older people: independence and mental Well-being

NG26 Children's attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care

NG13 Workplace health: management practices

Keeping Active at Every Age

In 2016, the Health and Well-being Board identified 'Keeping Active at Every Age' as one of three priorities for 2016-2021. It was prioritised because physical activity is an important component in health and well-being across all ages and being inactive is a major cause of ill health throughout life. Being physically active has well evidenced and wide reaching health benefits to an individual including energy balance and expenditure, and is therefore a key determinant of weight control. Actions taken to tackle physical inactivity as part of the Health and Well-being strategy are likely to impact upon overall health and well-being in the County.

Summary

- Being inactive is a major cause of ill health throughout life - including heart disease, diabetes and some cancers.
- The negative health impact of being inactive is both avoidable and in some cases reversible.

Wyre Forest Clinical Commissioning Group

South Worcestershire Clinical Commissioning Group

Redditch and Bromsgrove Clinical Commissioning Group

- In Worcestershire at least a third of people do not meet the recommended guideline for being physical active.
- Premature mortality from cardiovascular disease is significantly lower in Worcestershire in comparison to both regional and national rates.
- The prevalence of overweight and obese children in Reception (4-5yr olds) and Year 6 (10-11yr olds) is similar to both West Midlands and England rates. There is no significant change based on the 2016-17 data.
- Worcestershire has levels of physical inactivity similar to the England rate at 25.1% and 25.6% respectively. Rates are significantly lower than the West Midlands rate of 29.5%
- Worcestershire has a significantly higher proportion of people aged 16 and over reporting that they have taken part in sport and physical activity at least twice in the last 28 days. This is significantly higher than both England and West Midlands.
- The physical activity levels of Worcestershire population remain the same with no significant change in 2016-17 compared to 2015-16.

The Active Lives Survey

The way of measuring sport and physical activity levels has recently changed as the 'Active People Survey' has been replaced by the 'Active Lives Survey'. The Active Lives Survey measures wider range of indicators and enables the measurement of some of the Key Performance Indicators (KPI) identified for the sector in the Government's strategy 'Sporting Future' to provide a much more nuanced understanding of behaviour. Two full years of data are now available but the change in the methodology means it is too early to draw meaningful conclusions about trends.

The indicators identified cover a wide range of measures of physical activity and participation in sport over a twelve month period. The survey in last year's report highlighted significant differences between socio-economic groups in relation to sport and physical activity levels based on occupation, gender and age[30].

Figure 62 below is a summary of how Worcestershire compares against England on the key indicators.

[30] NS SEC National Statistics Socio-economic Classification

FIGURE 62 KEEPING ACTIVE INDICATORS FOR WORCESTERSHIRE

	Period	Units	England	West Midlands	Worcs	CIPFA Rank *	Trend
Age-standardised rate of mortality from all cardiovascular diseases (including heart disease and stroke) <75yrs LCI - UCI	2014-16	DSR per 100,000	73.5 73. - 73.9	78.0 76.6 - 79.5	64.6 60.8 - 68.5	3	↓
Prevalence of overweight (including obese) among children in Reception (4-5yr olds) LCI - UCI	2016-17	%	22.6 22.5-22.7	24.2 23.9-24.5	23.6 22.6-24.7	4	↔
Prevalence of overweight (including obese) among children in Year 6 (10-11yr old) LCI - UCI	2016-17	%	34.2 34.1 - 34.4	37.1 36.7-37.5	33.8 32.6-35.1	3	↔
Percentage physically active for at least one hour per day seven days a week	2014-15	%	13.9 13.7 - 14.1	13.8 13.2 - 14.5	15.7 13.6 - 17.8	3	↔
Sport and Physical Activity Levels: Inactive LCI - UCI	2016-17	%	25.6% 25.3-25.9	29.5% 28.6-30.4	25.1% 23.2-27-2	3	↔
Sport and Physical Activity Levels: Fairly Active LCI - UCI	2016-17	%	12.4% 12.1-12.6	13.0% 12.3-13.6	12.3% 10.9-13.9	4	↔
Sport and Physical Activity Levels: Active LCI - UCI	2016-17	%	62.1% 61.8-62.4	58.7% 57.6-59.7	62.6% 60.3-64.8	2	↔
Adults (aged 16+) who have taken part in sport and physical activity at least twice in the last 28 days LCI - UCI	2016-17	%	77.2% 76.9 - 77.4	73.0% 73.1-73.9%	78.0% 76.05-79.8	2	↔
Adults (aged 16+) who have attended at least 2 live sports events in the last 12 months LCI - UCI	2016-17	%	23.5% 23.3 - 23.8	22.1% 21.2-22.9	27.9% 25.6 - 30.3	1	↔

* 1 = Highest Ranking and 4 = Lowest Ranking

Source: Public Health Outcomes Framework (PHOF), PHE (2018)

All keeping active indicators as identified in the Strategy 2016-2021 have remained similar or better than regional and national averages.

FIGURE 63 PUBLIC HEALTH ENGLAND PROFILE FOR KEY PHYSICAL ACTIVITY INDICATORS, WORCESTERSHIRE

Compared with benchmark: Better, Similar, Worse | Lower, Similar, Higher, Not Compared | Low … High

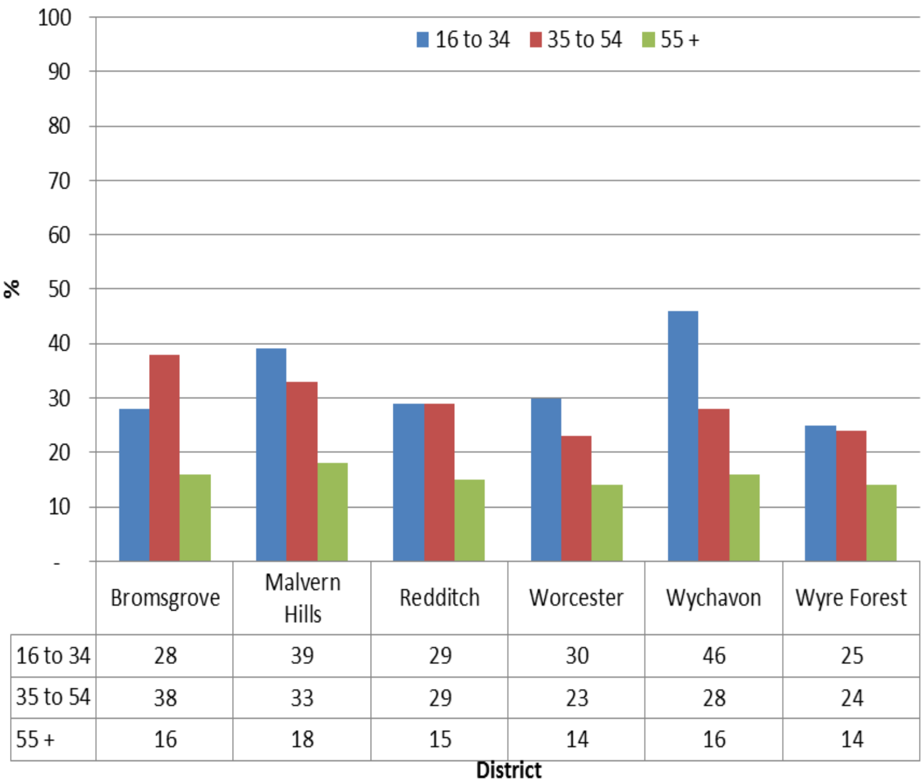
Benchmark Value — Worst/Lowest, 25th Percentile, 75th Percentile, Best/Highest

Indicator	Period	Worcs		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Percentage of physically active adults - current method	2016/17	-	67.2%	62.6%	66.0%	53.3%		78.0%
Percentage of physically inactive adults - current method	2016/17	-	21.1%	25.0%	22.2%	33.3%		12.4%
Percentage of physically active adults - historical method	2015	-	58.3%	55.1%	57.0%	44.8%		69.8%
Percentage of physically inactive adults - historical method	2015	-	26.4%	30.9%	28.7%	43.7%		17.5%
Percentage of adults doing 30-149 minutes physical activity per week - historical method	2015	-	15.4%	14.0%	14.3%	9.4%		19.5%
Percentage of 15 year olds physically active for at least one hour per day seven days a week	2014/15	-	15.7%	13.8%	13.9%	8.3%		18.8%
Percentage of 15 year olds with a mean daily sedentary time in the last week over 7 hours per day	2014/15	-	71.3%	70.9%	70.1%	81.0%		58.7%
Percentage of adults who do any walking, at least five times per week	2014/15	-	49.5%	48.0%	50.6%	39.9%		68.1%
Percentage of adults who do any walking, at least once per week	2014/15	-	80.4	78.2	80.6	70.4		91.3
Percentage of adults who do any cycling, at least three times per week.	2014/15	-	4.6%	3.3%	4.4%	0.7%		15.0%
Percentage of adults who do any cycling, at least once per month	2014/15	-	14.7%	12.6%	14.7%	5.6%		34.2%
Utilisation of outdoor space for exercise/health reasons	Mar 2015 - Feb 2016	-	14.2%	17.7%	17.9%	5.1%		36.9%
Access to woodland	2015	84,937	14.7%	-	16.8%	0.1%		61.9%

Source: Public Health Outcomes Framework, http://www.phoutcomes.info/

Worcestershire has similar or better rates of physically active adults and inactive adults compared to England average in almost all indicators. Despite the evidence of safe high-quality green spaces in the county, the utilisation of outdoor space for exercise/health reasons is the only indicator Worcestershire compares worse than the national average. This is not consistent with the rest of the indicators suggesting that whilst more could be required to encourage people to spend more time outdoors, there is however questions raised towards the robustness of the data used in terms of the sample size and survey questions. Utilisation of outdoor space for exercise/health reasons is defined as: the weighted estimate of the proportion of residents in each area taking a visit to the natural environment for health or exercise purposes. Natural environment include open spaces in and around towns and cities, including parks, canals and nature areas; the coast and beaches; and the countryside including farmland, woodland, hills and rivers but does not include time spent in own garden or routine shopping.

FIGURE 64 ADULT PARTICIPATION IN SPORT AND ACTIVE RECREATION OCTOBER 2014 TO SEPTEMBER 2016 BY AGE GROUP FOR WORCESTERSHIRE DISTRICT AREAS



	Bromsgrove	Malvern Hills	Redditch	Worcester	Wychavon	Wyre Forest
16 to 34	28	39	29	30	46	25
35 to 54	38	33	29	23	28	24
55 +	16	18	15	14	16	14

Source: Sport England, http://www.sportengland.org/research/who-plays-sport/active-people-interactive/ June 2017.

- Wychavon has by far the highest proportion of 16 to 34 year olds participating in 30 minutes of sport or activity at least 3 days a week at 45.7%, with Wyre Forest showing the lowest at 21.3%.
- Worcester has the lowest proportion of 35 to 54 year olds participating in sport or activity at 23.5% with Bromsgrove reporting the highest at 37.7%.
- Bromsgrove is the only district recording a higher percentage of middle aged people taking up sport than the younger age group of 16 to 34 year olds
- For those aged 55 and above the range between the lowest and highest rates across all six districts is only 2% ranging between 14% and 16%.
- The percentage of the population aged 55 and above taking up sport is low across all districts.

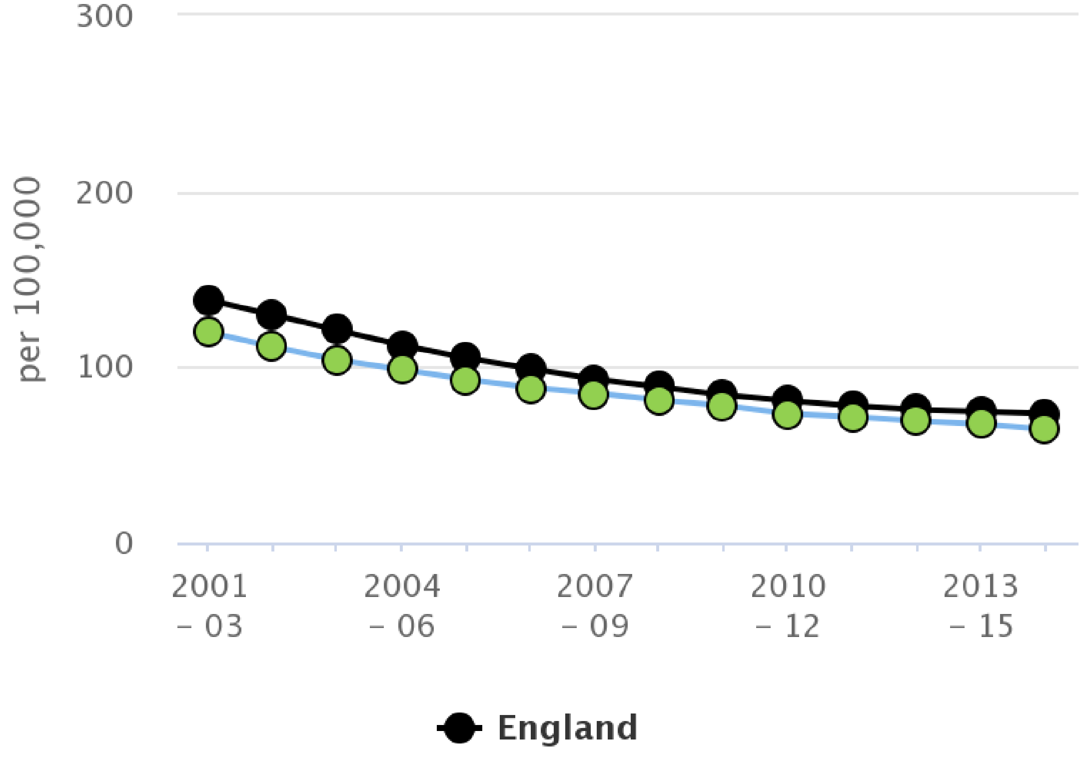
- The estimated direct cost of physical inactivity to Worcestershire is estimated to be over £10 million per year[31].

Cardiovascular disease

For the period 2014-16 Worcestershire had a premature mortality rate of 64.6 per 100,000 population. This represents 1,092 people dying prematurely over a three year period or an average of 364 people per year (almost one every day).

It can be seen from Figure 65 that the Worcestershire premature mortality rate from cardiovascular disease has been consistently better than England for a long period. The previous JSNA Annual Summary highlighted a narrowing gap between Worcestershire and England for this indicator. More recent data suggests that this trend may be changing in a positive direction and that the gap between Worcestershire and England may have begun to widen. Trends are examined more fully in the 'Update on Emerging Issues' section of this report. Future data releases will help to confirm if this is a sustained positive change.

FIGURE 65 WORCESTERSHIRE PREMATURE MORTALITY FROM CARDIOVASCULAR DISEASE 2001-16 (DIRECTLY STANDARDISED RATE - PER 100,000)



Source: Public Health Outcomes Framework (PHOF), PHE (2018)

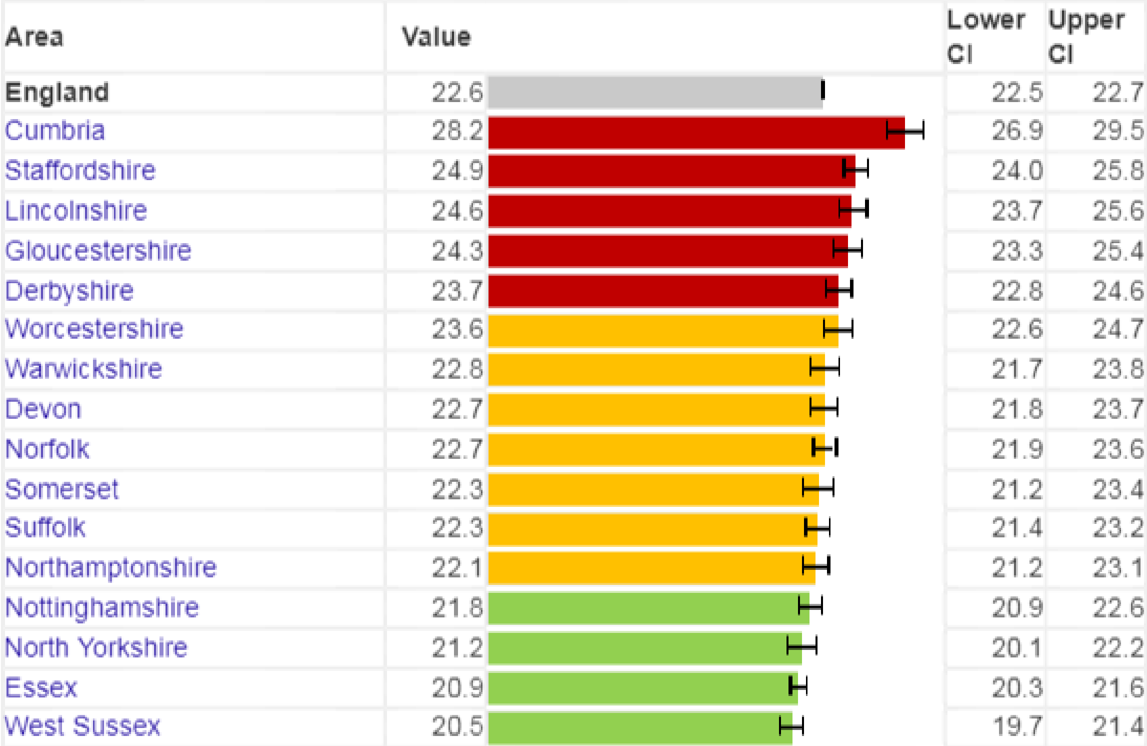
[31] Sport England, Local Sport Profile Tool 2017, http://localsportprofile.sportengland.org/

Overweight and obese children

Figure 66 shows the prevalence of overweight (including obese) children in Reception (4-5 yrs old) across Worcestershire is similar to the national rate (23.6% vs 22.6%).

Figure 67 shows the prevalence of overweight (including obese) children in year 6 (10-11 yr olds) is similar to the national average (33.8% vs 34.2%). For both indicators there has been no significant change in the recent trend.

FIGURE 66 PREVALENCE OF OVERWEIGHT AND OBESE CHILDREN IN RECEPTION (4-5 YRS OLD), 2016/17

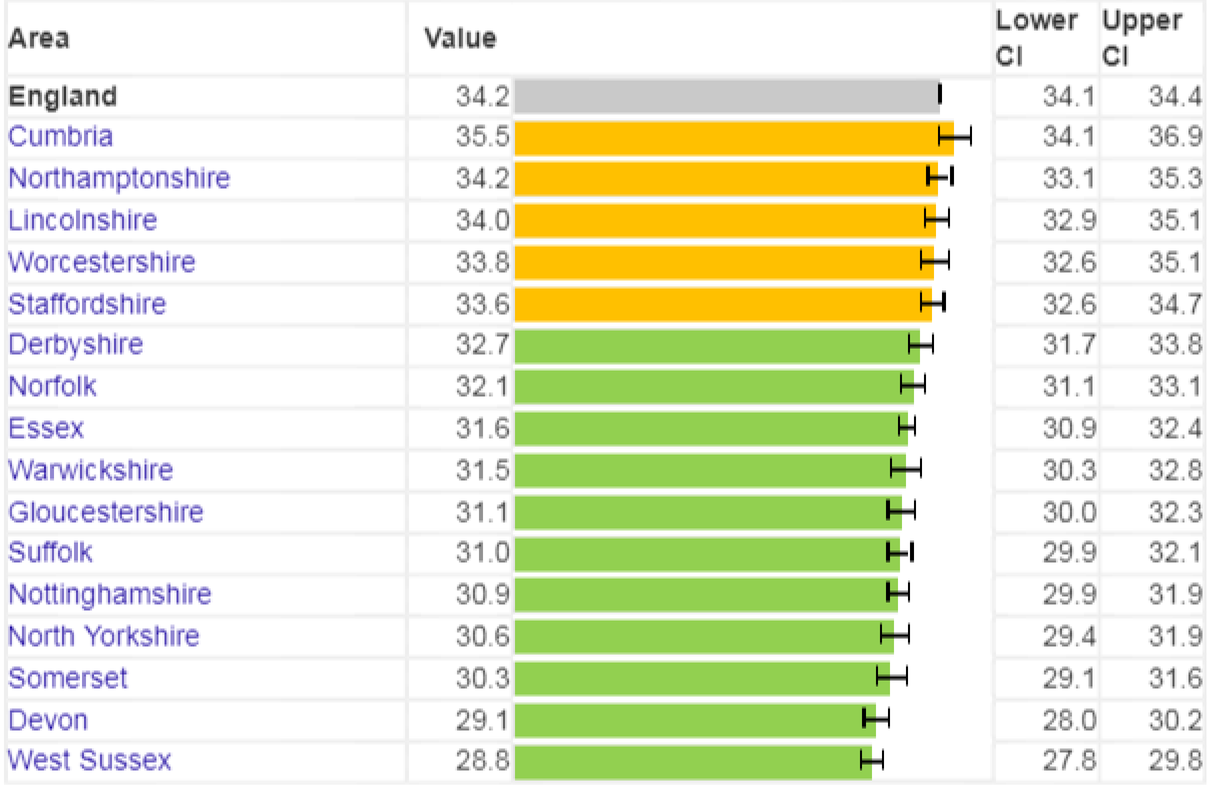


Area	Value	Lower CI	Upper CI
England	22.6	22.5	22.7
Cumbria	28.2	26.9	29.5
Staffordshire	24.9	24.0	25.8
Lincolnshire	24.6	23.7	25.6
Gloucestershire	24.3	23.3	25.4
Derbyshire	23.7	22.8	24.6
Worcestershire	23.6	22.6	24.7
Warwickshire	22.8	21.7	23.8
Devon	22.7	21.8	23.7
Norfolk	22.7	21.9	23.6
Somerset	22.3	21.2	23.4
Suffolk	22.3	21.4	23.2
Northamptonshire	22.1	21.2	23.1
Nottinghamshire	21.8	20.9	22.6
North Yorkshire	21.2	20.1	22.2
Essex	20.9	20.3	21.6
West Sussex	20.5	19.7	21.4

Source: NHS Digital, National Child Measurement Programme

Source: NHS Digital, National Child Measurement Programme

FIGURE 67 PREVALENCE OF OVERWEIGHT (INCLUDING OBESE) CHILDREN IN YEAR 6 (10-11 YRS OLD), 2016/17



Area	Value	Lower CI	Upper CI
England	34.2	34.1	34.4
Cumbria	35.5	34.1	36.9
Northamptonshire	34.2	33.1	35.3
Lincolnshire	34.0	32.9	35.1
Worcestershire	33.8	32.6	35.1
Staffordshire	33.6	32.6	34.7
Derbyshire	32.7	31.7	33.8
Norfolk	32.1	31.1	33.1
Essex	31.6	30.9	32.4
Warwickshire	31.5	30.3	32.8
Gloucestershire	31.1	30.0	32.3
Suffolk	31.0	29.9	32.1
Nottinghamshire	30.9	29.9	31.9
North Yorkshire	30.6	29.4	31.9
Somerset	30.3	29.1	31.6
Devon	29.1	28.0	30.2
West Sussex	28.8	27.8	29.8

Source: NHS Digital, National Child Measurement Programme

Source: NHS Digital, National Child Measurement Programme

Prevalence of overweight or obese children in Year 6 is significantly lower than the national rate. This is important because recent trend nationally indicate an increase in the prevalence rate of obese children of this particular age group.

Preventing Alcohol Harm at All Ages

Summary

- In Worcestershire, around one in three adults drink at a level that is harmful to their health: 30.2% drinking over 14 units of alcohol a week[32].
- Nationally, the estimated cost to society is around £21 billion annually which is broken down into £11 billion for alcohol-related crime, £7 billion through lost productivity by unemployment and sickness, and around £3.5 billion cost to the NHS.

[32] Public Health England (2018) Public Health Outcomes Framework, www.fingertips.phe.org.uk

Wyre Forest Clinical Commissioning Group

South Worcestershire Clinical Commissioning Group

Redditch and Bromsgrove Clinical Commissioning Group

- The rate of alcohol-specific hospital admissions for under 18's has fallen considerably from 97.0 per 100,000 people in 2006/7–2008/9 to 29.7 in 2014/15-16/17. Rates are similar to the national average. Worcestershire has one of the lowest rates amongst the CIPFA nearest statistical neighbours.
- In Worcestershire the latest rate of females admitted to hospital for alcohol-related conditions is significantly higher than the national average, this is similar to the rate in 2014-15.
- Admission episodes for alcohol-related conditions (narrow) in the over 65's has been significantly higher than the England average for the last three years and is the case for both males and females. In the district areas, rates have been significantly higher in Wychavon and Wyre Forest than the England average for the last two years.
- The latest rate of alcohol-specific and alchol-related mortality in Worcestershire is similar to the national average. This has remained relatively stable over the last ten year period.
- Pooled data from 2014-16 shows the premature mortality rate from liver disease was similar to the national average at 16.6 per 100,000 vs 20.9 per 100,000 respectively.
- The rate of hospital admission episodes for alcoholic liver disease has reduced significantly from 125.5 per 100,000 population in 2013/14 where rates were highest to 110.2 per 100,000 population in 2016-17.
- In 2016-17 the proportion of individuals waiting longer than three weeks to receive treatment for alcohol was significantly higher than both England and West Midlands rates at 13.7%. However, this is a significant improvement from 2015-16 where the rate was 23.9% and the highest in the West Midlands region.
- In 2016 the rate of successful completion of treatment for alcohol clients in Worcestershire was similar to the national average at 38.9%. This indicator showed a steady decline from 2012 and was significantly lower in 2013, 2014 and 2015, in comparison to nationally where rates steadily increased.

Background

Alcohol related harm is a significant public health issue and is one of seven key areas that Public Health England (PHE) has outlined as a priority for the next five years[33]. It is also a local priority for the Worcestershire Health and Well-being Board.

The Global Burden of Disease Study 2013 revealed that, in England, alcohol use disorder is the biggest risk factor for early death, ill health and disability for those aged 15 to 49 years.

Alcohol related harm has a significant impact upon an individual both physically and psychologically. Drinking above the recommended levels increases the risk of certain types of

[33] Public Health England (2014), From evidence into action: opportunities to protect and improve the nation's health, [Online], Available from: https://www.gov.uk/government/publications/from-evidence-into-action-opportunities-to-protect-and-improve-the-nations-health, Accessed: 26/01/2018

cancers including liver, breast and oral cancers. It is a determinant for liver disease, heart disease, depression, suicide, unsafe sex and injuries. Harmful drinking also has wider reaching effects including impacts upon children and families, domestic and partner violence, employment, housing, crime, violence and road traffic accidents.

Some populations experience multiple severe disadvantages in relation to alcohol use disorder including, people who misuse drugs and alcohol together, individuals who are homeless, those with poor mental health and individuals with offending behaviours[34].

National Picture

- Between 2005-2016, consumption rates of alcohol have fallen in the 16-24 year old age group significantly 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[35].
- Males are more likely to drink alcohol in comparison to females. Interestingly, there is a difference between males and females in relation to alcohol consumption by income. The more males earn, the more likely they are to drink. For women, the opposite is true[35].
- In England, there has been an increase in the number of hospital admissions directly related to alcohol consumption. This has increased by 3% from 2014-15 and is up by 22% from 2005-6[36].
- Alcohol is often a significant contributory factor for different types of crimes and is responsible for around 40% of all violent crimes, with variation by type of offence. Alcohol was a factor in 57.8% of Domestic violence with injury offences, 55.0% of non-domestic violence with injury offences and around 33.6% of violent offences without injury[37].

---

[34] Public Health England (2016), Health matters: harmful drinking and alcohol dependence, [Online], Available from: https://www.gov.uk/government/publications/health-matters-harmful-drinking-and-alcohol-dependence/health-matters-harmful-drinking-and-alcohol-dependence Accessed: 08/02/18

[35] Office for National Statistics (2017) Adult Drinking Habits in Great Britain; 2005 to 2016, [Online], Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/drugusealcoholandsmoking/bulletins/opinionsandlifestylesurveyadultdrinkinghabitsingreatbritain/2005to2016 , Accessed: 25/01/2018.

[36] NHS Digital (2017) Statistics on Alcohol in England, [Online], Available from: http://digital.nhs.uk/catalogue/PUB23940 Accessed: 25/01/2018

[37] Institute of Alcohol Studies (2017) Alcohol Related Crime in the UK, [Online], Available from: http://www.ias.org.uk/Alcohol-knowledge-centre/Crime-and-social-impacts/Factsheets/Alcohol-related-crime-in-the-UK-what-do-we-know.aspx, Accessed: 01/02/2018.

Wyre Forest
Clinical Commissioning Group

South Worcestershire
Clinical Commissioning Group

Redditch and Bromsgrove
Clinical Commissioning Group

Local Picture

Key indicators

Table 8 shows the key indicators in relation to alcohol related harm from the Public Health Outcomes Framework (PHOF) and Local Alcohol Profiles for England (LAPE) for Worcestershire, West Midlands and England in 2016-17.

TABLE 8 KEY INDICATORS FOR ALCOHOL

PHOF/LAPE Indicator	Period	Units	England	West Midlands	Worcs	Trend
2.18 - Hospital admissions for alcohol-related conditions (narrow definition) - Persons LCI - UCI	2016-17	DSR per 100,000	636.0 634 - 639	708.0 701 - 715	634.0 614 - 655	
2.18 - Hospital admissions for alcohol-related conditions (narrow definition) - Male LCI - UCI	2016-17	DSR per 100,000	818.0 815 - 822	889.0 877 - 900	780.0 748 - 813	
2.18 - Hospital admissions for alcohol-related conditions (narrow definition) - Female LCI - UCI	2016-17	DSR per 100,000	473.0 471 - 476	546.0 538 - 555	505.0 480.0 - 531.0	
2.01 - Alcohol-specific mortality - Persons LCI - UCI	2014-16	DSR per 100,000	10.4 10.3-10.6	12.9 12.4 - 13.5	10.8 9.3 - 12.4	
4.01 - Alcohol-related mortality - Persons LCI - UCI	2016	DSR per 100,000	46.0 45.5 - 46.6	50.1 48.2 - 52.0	45.4 40.2 - 51.1	
9.01 - Admission episodes for alcohol-related conditions (Broad) - Persons LCI - UCI	2016-17	DSR per 100,000	2185.0 2181 - 2189	2345.0 2332 - 2357	1982.0 1947 - 2018	
6.02 - Admission episodes for alcohol-specific conditions - Persons LCI - UCI	2016-17	DSR per 100,000	563.0 561 - 565	543.0 537 - 549	397.0 381 - 414	
5.02 - Admission episodes for alcohol-specific conditions - Under 18s - Persons LCI - UCI	2016-17	Crude rate per 100,000	34.2 33.6 - 34.8	28.5 26.8 - 30.2	29.7 24.3 - 36.1	
Treatment waiting time: % people waiting more than 3 weeks for alcohol treatment (NDTMS) LCI - UCI	2016	%	2.4 2.3 - 2.6	4.1 Not available	13.7 11.1 - 16.6	
15.01 - Successful completion of treatment for alcohol LCI - UCI	2016	%	38.7 38.4 - 39.0	38.2 37.2 - 39.1	38.9 35.9 - 42.1	

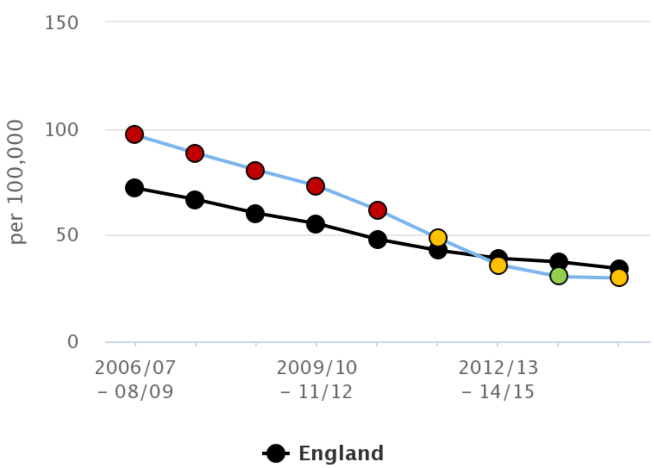
Source: Public Health England, Public Health Outcomes Framework

Alcohol specific hospital admissions for under 18's

Figure 68 shows that the rate of alcohol specific hospital admissions for under 18's has levelled off but continues to remain at some of the lowest levels seen since 2006-7, rates are similar to the national average and Worcestershire has one of the lowest rates amongst the CIPFA nearest statistical neighbours including Gloucestershire, Warwickshire, Suffolk, West Midlands

and England as comparator areas. At district level, all areas either have similar rates to national average or have rates significantly lower than the national average.

FIGURE 68 ALCOHOL-SPECIFIC HOSPITAL ADMISSIONS FOR UNDER-18 YEAR OLDS (2006/7-08/09 TO 2014/15-16/17)



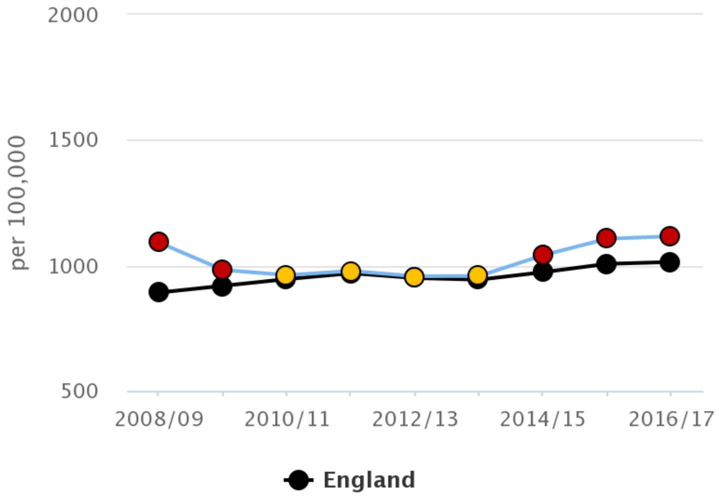
Source: Public Health England, Public Health Outcomes Framework

Admission episodes for alcohol-related conditions (narrow) in the over 65's

ALCOHOL MISUSE IN THE YOUNGER AGE GROUPS HAS BEEN DEMONISED OVER THE YEARS, PARTICULARLY IN THE MEDIA. IN CONTRAST TO THIS, ADMISSION EPISODES FOR ALCOHOL-RELATED CONDITIONS (NARROW) IN THE OVER 65'S HAS BEEN SIGNIFICANTLY HIGHER THAN THE ENGLAND AVERAGE FOR THE LAST THREE YEARS (

Figure 69). Rates are significantly higher in both males and females. In the district areas, rates have been significantly higher in Wychavon and Wyre Forest than the England average for the last two years.

FIGURE 69 10.08 - ADMISSION EPISODES FOR ALCOHOL-RELATED CONDITIONS (NARROW) - OVER 65S – PERSONS (2008-9 TO 2016-17)



Source: Public Health England, Public Health Outcomes Framework

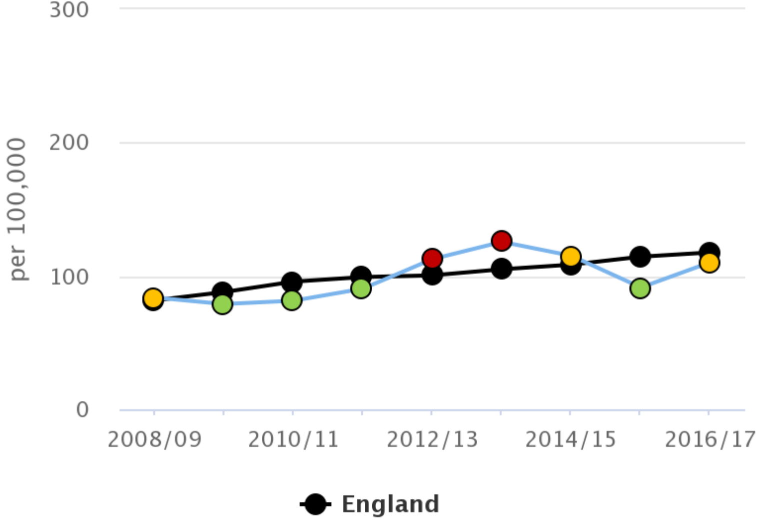
Hospital admission episodes for alcoholic liver disease condition

Figure 70 shows the rate of hospital admission episodes for alcoholic liver disease condition (broad condition) per 100,000 population for Worcestershire compared to England.

In 2016/17 the rate of hospital admission episodes for alcoholic liver disease was 110.2 per 100,000 population in 2016-17, which is similar to the national rate.

The rate of hospital admission episodes for alcoholic liver disease is the highest in comparison to our top three CIPFA neighbours. Rates are significantly higher than Gloucestershire, Warwickshire and Suffolk.

FIGURE 70 HOSPITAL ADMISSION EPISODES FOR ALCOHOLIC LIVER DISEASE CONDITION



Source: Public Health England, Public Health Outcomes Framework

Alcohol Related Hospital Admissions: Data Notes

Statistics relating to alcohol can be difficult to navigate and understand because of the complexity of language used. Alcohol Use Disorder contributes significantly to 48 health conditions, wholly or partially, due either to acute alcohol intoxication or to the toxic effect of alcohol use disorder over time. Conditions include cardiovascular conditions, cancers, depression and accidental injuries. Risk of ill health increases exponentially as regular consumption levels increase. Most of these harms are preventable[38].

Hospital admissions relating to alcohol are based upon attributable fractions being either wholly or partially attributable to alcohol.

Wholly attributable condition: A condition which by definition is 100% caused by alcohol consumption e.g. alcoholic cardiomyopathy[39].

Alcohol attributable fraction: Indicates the proportion of a disease or injury that could be prevented if exposure to alcohol was eliminated**Error! Bookmark not defined.**.

---

38 Public Health England (2016), Local Health and Care Planning: Menu of Preventative interventions, , Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/683016/Local_health_and_care_planning_menu_of_preventative_interventions_DM_NICE_amends_14.02.18__2_.pdf [Accessed: 7th March 2018]

39 Jones, L and Bellis, M (2013). Updating England-Specific Alcohol-Attributable Fractions. [online] Liverpool: Centre for Public Health, Liverpool John Moores University, p.4. Available at: http://www.cph.org.uk/wp-content/uploads/2014/03/24892-ALCOHOL-FRACTIONS-REPORT-A4-singles-24.3.14.pdf [Accessed 7 Mar. 2018].

Definitions for Alcohol Statistics

Alcohol Indicator	Definition
Alcohol Specific Hospital Admissions	Admissions where alcohol is **wholly attributable** to the hospital admission and where code is in Primary or Secondary diagnosis. E.g. Mental and behavioural disorders due to alcohol, Alcoholic gastritis, Ethanol poisoning, Toxic effect of alcohol.
Alcohol Related Hospital Admissions – Narrow	Admissions where alcohol is **wholly or partially attributable** to the hospital admission and where here is an alcohol attributable code in the primary diagnosis code and an alcohol attributable external cause code (e.g. Accidents, Falls)
Alcohol Related Hospital Admissions – Broad	Admissions where alcohol is **wholly or partially attributable** to the hospital admission and where there is an alcohol attributable code in the primary or secondary diagnosis code.

Associated Documents and Best Practice

Worcestershire Health and Well-being Board - Joint Health and Well-being Strategy 2016 to 2021: http://www.worcestershire.gov.uk/downloads/file/7051/joint_health_and_well-being_strategy_2016_to_2021

Worcestershire JSNA - Substance Misuse Needs Assessment: http://www.worcestershire.gov.uk/downloads/file/2916/2014_substance_misuse_needs_assessment

Public Health England - The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies An evidence review:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/583047/alcohol_public_health_burden_evidence_review.pdf

Public Health England - Alcohol and drug misuse prevention and treatment guidance: https://www.gov.uk/government/collections/alcohol-and-drug-misuse-prevention-and-treatment-guidance

National Institute of Health and Care Excellence (NICE) Guidance -

Wyre Forest Clinical Commissioning Group

South Worcestershire Clinical Commissioning Group

Redditch and Bromsgrove Clinical Commissioning Group

Alcohol-use disorders: prevention (PH24) is one of three pieces of NICE guidance addressing alcohol-related problems among people aged 10 years and older:
https://www.nice.org.uk/guidance/ph24

Alcohol-use disorders: diagnosis and management (QS11) covers the care of children (aged 10 to 15 years), young people (aged 16 to 17 years) and adults (aged 18 years and over) drinking in a harmful way and those with alcohol dependence in all NHS-funded settings:
https://www.nice.org.uk/guidance/qs11

Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (CG115) is evidence-based advice on the diagnosis, assessment and management of harmful drinking and alcohol dependence in adults and in young people aged 10 to 17 years:

https://www.nice.org.uk/guidance/cg115

Alcohol-use disorders: diagnosis and management of physical complications (CG100) covers the care of adults and young people (aged 10 years and older) who have any physical health problems that are completely or partly caused by alcohol use:
https://www.nice.org.uk/guidance/cg100

Appendix 1: District Level Information

Bromsgrove

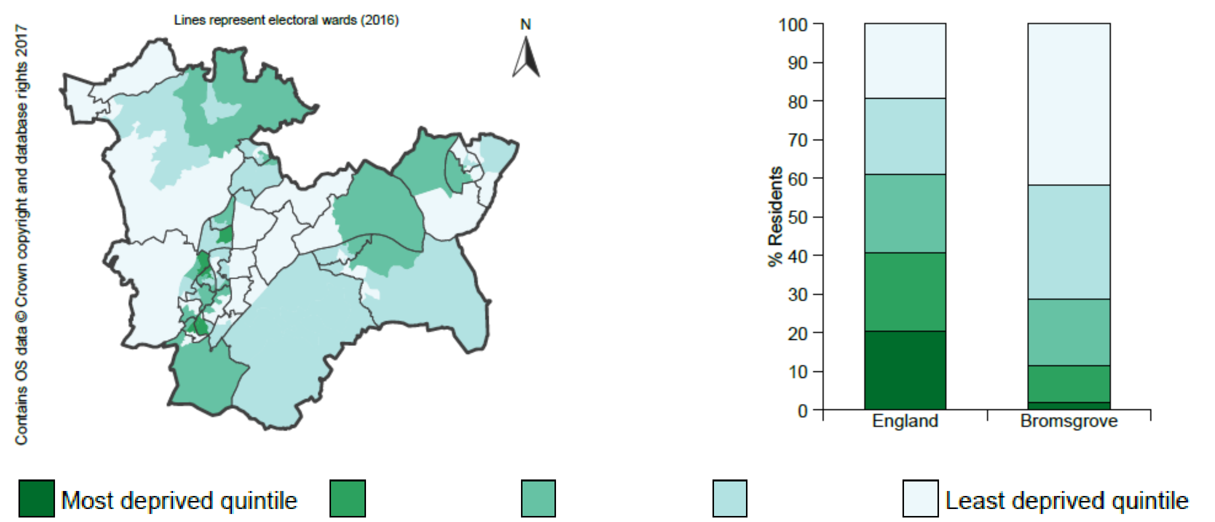
Population and demographics: key facts

- Population: 95,594[40].
- Bromsgrove has a lower proportion of younger people aged 20-39 and higher proportion of adults aged 40 plus compared to England.
- One of the 20% least deprived districts in England.
- 9.4% of children living in low income households in 2015 (1,475).
- 3.8% of people living in Bromsgrove are from an ethnic minority group, compared to 13.2% in England.
- Compared to England GCSE attainment (5 GCSEs A*-C incl. English and Maths) in 2015/16 is significantly higher in Bromsgrove at 65.0%.
- Life expectancy is 8.8 years lower for men and 5.5 years lower for women in the most deprived areas of Bromsgrove compared to the least deprived areas.
- 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.

FIGURE 71 INDEX OF MULTIPLE DEPRIVATION 2015 (QUINTILES) BY LSOA

% of population in Bromsgrove living in areas at each level of deprivation compared to England

[40] ONS mid-year population estimates 2017



Source: Public Health England – Health Profile 2017: Bromsgrove

The map shows differences in deprivation in this area based on national comparisons, using national quintiles (fifths) of the Index of Multiple Deprivation 2015 (IMD 2015), shown by lower super output area. The darker coloured the area the more deprived the neighbourhood[41].

Areas of concern and changing needs

Breastfeeding Initiation

Breastfeeding initiation is considered to be a valid and important measure of public health. Benefits of breastfeeding are significant for both mother and child. Babies who are breastfed have lower rates of respiratory and gastrointestinal infection. Breastfeeding also lowers the risk of both breast and ovarian cancers.

The rate of breastfeeding initiation in Bromsgrove was 68.1% in 2016/17, significantly lower than England (74.5%) and similar to the West Midlands rate of 68.9%.

Influenza Vaccination

Vaccination against flu is an important public health intervention. Flu can be a dangerous disease, particularly for the very young and the older population. There are also other at-risk groups such as pregnant women and immunocompromised individuals. Vaccination against flu can reduce pressures on health services by reducing hospital admissions and limit exacerbations of existing medical conditions in these particular groups. The national vaccine uptake ambition during 2017-18 was 75.0% for individuals aged 65 and over and 55.0% for individuals considered being at-risk aged 6 months to 65.

[41] Public Health England, Health Profile 2017 – Bromsgrove. Online. Available from: http://fingertipsreports.phe.org.uk/health-profiles/2017/e07000234.pdf

In 2017-18, Redditch and Bromsgrove CCG fell short of the target at 73.0% of individuals aged 65 and over vaccinated as did England as a whole (72.6%); this was the lowest across the three CCG groups in Worcestershire. 49.5% (48.9% England) of individuals in at-risk groups were vaccinated against a target of 55.0%[42].

Chlamydia Detection Rate 15-24yr Olds

The National Chlamydia Screening Programme (NCSP) recommends screening for all sexually active young people under 25 annually or on change of partner (whichever is more frequent). The chlamydia detection rate amongst under 25 year olds is a measure of chlamydia control activity, aimed at reducing the incidence of reproductive sequelae of chlamydia infection and interrupting transmission onto others.

Public Health England (PHE) recommends that local authorities should be working towards achieving a detection rate of at least 2,300 per 100,000 population aged 15-24. The recommendation was set as a level that would encourage high volume screening and diagnoses[43].

The chlamydia detection rate in Bromsgrove has worsened between 2016 and 2017 decreasing from 1,686 per 100,000 to 1,241 per 100,000 population aged 15-24 and is significantly lower than the England rate of 1,882 per 100,000 population aged 15-24.

[42] Seasonal Flu Vaccine Uptake (GP) 2017/18 - DATA ON GP REGISTERED PATIENTS. Provisional end of January 2018 cumulative uptake data for England on influenza vaccinations given from 1 September 2017 to 31 January 2018

[43] Indicator Definitions and Supporting Information: Chlamydia Detection rate 15-24yr olds. Available from: www.phoutcomes.info

Wyre Forest Clinical Commissioning Group

South Worcestershire Clinical Commissioning Group

Redditch and Bromsgrove Clinical Commissioning Group

Local strategy

The local strategy details outlined below are for the financial year 2017-18.

Priority Area	Projects
Improve mental wellbeing	• Raise awareness of Wellbeing Hub and Worcestershire Healthy Minds hub • Wider partner agency engagement for Secondary Care Mental Health Transformation • Support initatives and training including: Time to Change, Mental Health First Aid, Your life Your Choice, 5 Ways to wellbeing • Raise awareness and consider local impact of integrated 0-19 prevention service "Starting Well", Parenting and Family support providers. • Set up cross provider network to increase awareness of activities taking place with different providers.
Increase physical activity (including inactivity)	• Raise awareness of locally delivered services which increase physical activity including input on existing provision and barriers to delivery • Support initatives and training including: One You, Worcestershire Works Well, Health Chat training, Eating Well on a Budget, Worcestershire Welcomes Breastfeeding. • Set up Bromsgrove Children and Young people provider network to raise awareness of activities taking place across district. • Consider Childhood Obesity: A plan for action and identify and relevant local actions.
Reduce harm from alcohol	• Raise awareness of local service provision with consideration how agencies can support existing provision and support wider partners to address alcohol related issues highlighted in the Bromsgrove Health and Wellbeing Plan.
Ageing Well	• Improve dementia awareness • Tackle fuel poverty and reduce excess winter deaths • Falls Prevention • Address social isolation and loneliness and promote ageing well • Improve stroke awareness • Support carers
Local Priorities	• Stroke Awareness • Alcohol Awareness and Dry January • Ageing Well and Pensioners Day • Digital inclusion • Mental Health
Support and reduce NEETs	• Work closely with partners for continued reduction of NEETs, Partnership panels and raising awareness and consideration of the impact of WCC proposals to change provision of family support and individuals at risk of becoming NEET.

Wyre Forest Clinical Commissioning Group

South Worcestershire Clinical Commissioning Group

Redditch and Bromsgrove Clinical Commissioning Group

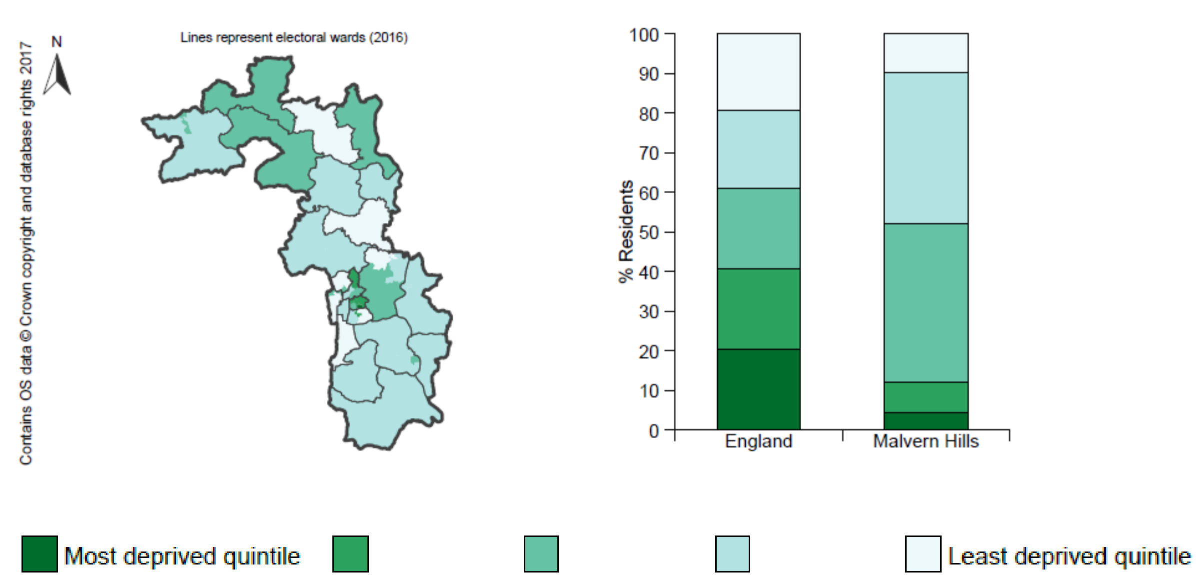
Malvern Hills

Population and demographics: key facts

- Population: 77,165[44].
- Malvern Hills has the highest proportion of people aged 65 and over (27.6%) in comparison to other Worcestershire districts.
- 13.0% of children living in low income households in 2015 (1,445).
- 3.9% of people living in Malvern Hills are from an ethnic minority group, compared to 13.2% in England.
- Compared to England as a whole GCSE attainment (5 GCSEs A*-C incl. English and Maths) in 2015/16 is significantly higher in Malvern Hills at 64.9%.
- Life expectancy is 4.0 years lower for men and 5.3 years lower for women in the most deprived areas of Malvern Hills compared to the least deprived areas.
- There are a lower proportion of people living in most deprived areas in the country when compared to England.

FIGURE 72 INDEX OF MULTIPLE DEPRIVATION 2015 (QUINTILES) BY LSOA

% of population in Malvern Hills living in areas at each level of deprivation compared to England



Source: Public Health England – Health Profile 2017: Malvern Hills

---

[44] ONS mid-year population estimates 2017

The map shows differences in deprivation in this area based on national comparisons, using national quintiles (fifths) of the Index of Multiple Deprivation 2015 (IMD 2015), shown by lower super output area. The darker the area is coloured the more deprived the neighbourhood[45].

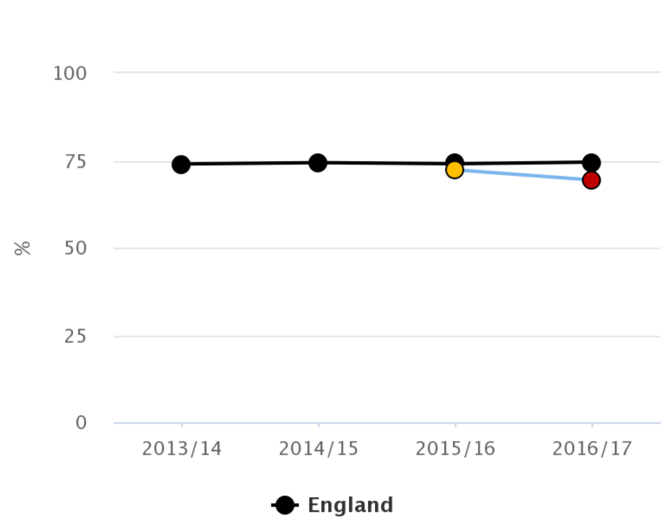
Areas of concern and changing needs

Breastfeeding Initiation

Breastfeeding initiation is considered to be a valid and important measure of public health. Benefits of breastfeeding are significant for both mother and child. Babies who are breastfed have lower rates of respiratory and gastrointestinal infection. Breastfeeding also lowers the risk of both breast and ovarian cancers.

The rate of breastfeeding initiation in Malvern Hills was 69.4% in 2016/17, significantly lower than England (74.5%) and similar to the West Midlands rate of 68.9%. This was a decline from the 2015/16 value (72.3%).

FIGURE 73 BREASTFEEDING INITIATION - MALVERN HILLS



Source: Public Health Outcomes Framework (PHOF)

Diabetes Diagnosis

[45] Public Health England, Health Profile 2017 – Malvern Hills. Online. Available from: http://fingertipsreports.phe.org.uk/health-profiles/2017/e07000235.pdf

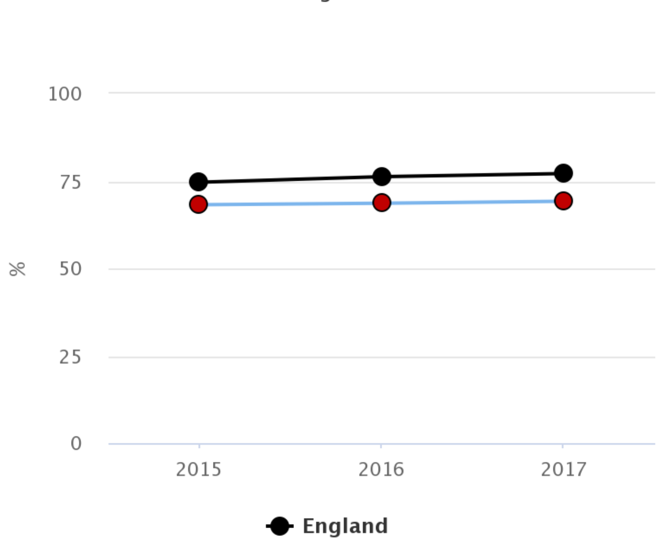
Diabetic complications (including cardiovascular, kidney, foot and eye diseases) result in considerable morbidity and have a detrimental impact on quality of life. Type 2 diabetes (approximately 90% of diagnosed cases) is partially preventable – it can be prevented or delayed by lifestyle changes (exercise, weight loss, health eating). Earlier detection of Type 2 diabetes followed by effective treatment reduces the risk of developing diabetic complications.

This indicator is used by clinical commissioning groups and local health and well-being boards, to:

- Understand the scope for prevention and make headway in tackling the rising numbers of people with or at risk of diabetes.
- Measure the progress that they are making towards closing the gap (i.e. meeting previously unmet need) between observed prevalence (number of cases of diabetes recorded) and actual prevalence in identifying people at high risk or with hitherto undiagnosed diabetes.

In 2017, the estimated diabetes diagnosis rate in Malvern Hills was 69.2%, which is significantly lower than the West Midlands (85.6%) and England (77.1%).

FIGURE 74 ESTIMATED DIABETES DIAGNOSIS RATE - MALVERN HILLS



Source: Public Health Outcomes Framework (PHOF)

Fuel Poverty

Living at low temperatures has a substantial negative effect on individual health and wellbeing, including being responsible for approximately 1 in 10 excess winter deaths[46], exacerbation of

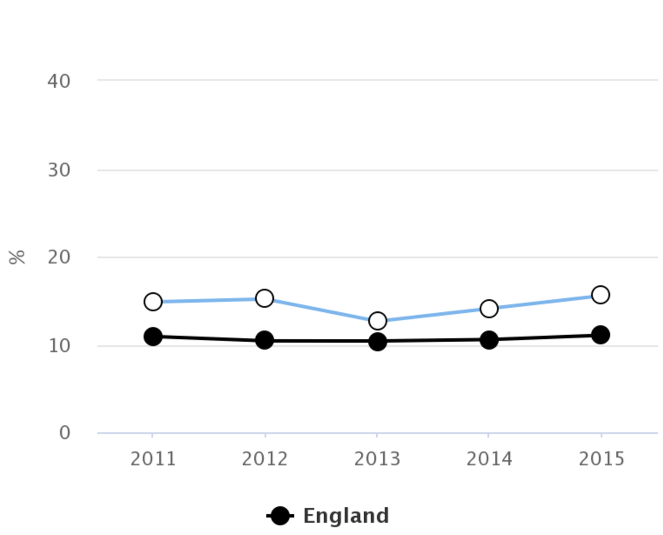
[46] Indicator Definitions and Supporting Information: Fuel Poverty. Available from: www.phoutcomes.info

medical conditions such as circulatory diseases, respiratory problems, mental health and other conditions such as colds and flu, rheumatisms and arthritis[47]. The most vulnerable groups in society, the very young and the elderly and those with long-term conditions are at highest risk from fuel poverty.

For some people living in Malvern Hills, fuel poverty is a significant issue. 15.6% of households experience Fuel Poverty in the district and this is the highest of the Worcestershire districts and fourth highest of thirty district and Unitary Authority areas within the West Midlands. In 2015 the rate was significantly higher than both the England and West Midlands average. The proportion of households living in fuel poverty has been higher than the England rate and has not changed much over a 4 year period from 2011. The lowest rate was in 2013 where 12.6% of households experienced fuel poverty.

National data shows that rural areas tend to have significantly higher levels of fuel poverty. Nationally there is a clear gradient in relation to deprivation where 12.5% of households in the most deprived decile (ie 10% most deprived population) experience fuel poverty compared to 7.6% in the least deprived decile.

FIGURE 75 FUEL POVERTY - MALVERN HILLS



Source: Public Health Outcomes Framework (PHOF)

47 Marmot Review Team (2011) The Health Impacts of Cold Homes and Fuel Poverty, pp. 23 -30. Available from: https://www.foe.co.uk/sites/default/files/downloads/cold_homes_health.pdf

FIGURE 76 FUEL POVERTY 2015

1.17 - Fuel poverty 2015

Area	Count	Value
England	2,502,217	11.0
Worcestershire	30,001	12.3
Bromsgrove	4,124	10.6
Malvern Hills	5,100	15.6
Redditch	3,696	10.5
Worcester	5,181	12.1
Wychavon	6,398	12.7
Wyre Forest	5,502	12.6

Source: Department for Business, Energy and Industrial strategy

Chlamydia Detection Rate 15-24yr Olds

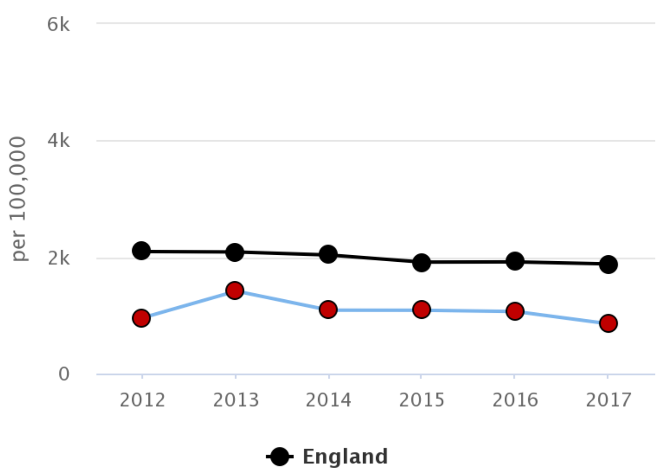
The National Chlamydia Screening Programme (NCSP) recommends screening for all sexually active young people under 25 annually or on change of partner (whichever is more frequent). The chlamydia detection rate amongst under 25 year olds is a measure of chlamydia control activity, aimed at reducing the incidence of reproductive sequelae of chlamydia infection and interrupting transmission onto others.

Public Health England (PHE) recommends that local authorities should be working towards achieving a detection rate of at least 2,300 per 100,000 population aged 15-24. The recommendation was set as a level that would encourage high volume screening and diagnoses[48].

The chlamydia detection rate in Malvern Hills has worsened between 2016 and 2017 decreasing from 1,065 per 100,000 to 855 per 100,000 population aged 15-24 and is significantly lower than the England rate of 1,882 per 100,000 population aged 15-24. It is possible that this is partly attributable to a low population prevalence in a predominantly rural area which has a relatively high proportion of older people.

[48] Indicator Definitions and Supporting Information: Chlamydia Detection rate 15-24yr olds. Available from: www.phoutcomes.info

FIGURE 77 CHLAMYDIA DETECTION RATE (15-24 YEAR OLDS) - MALVERN HILLS



Source: Public Health Outcomes Framework (PHOF)

Wyre Forest Clinical Commissioning Group

South Worcestershire Clinical Commissioning Group

Redditch and Bromsgrove Clinical Commissioning Group

Local strategy

The local Health and Wellbeing strategy (2017-18) for Malvern Hills is below:

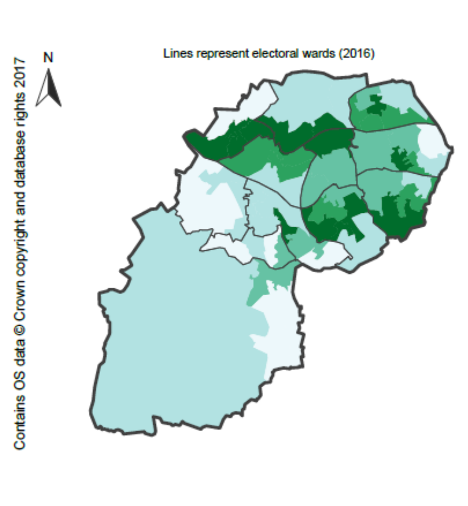
Priority Area	Projects
Mental health and well-being throughout life	• Promotion of mental health campaigns locally. • Delivery of health chats training sessions • Older peoples showcasing events • Delivering dementia friends sessions, support businesses and communities to become dementia friendly and aware. • Reduce social isolation & support individuals living with dementia, vulnerable individuals and wider communities. • Reconnections for people aged 50+ tackling social isolation and loneliness. • Support local volunteering schemes • Digital inclusion • Community first aid programmes • Mental Health Awareness support networks, mental health champions, family and community support programmes.
Being active at every age	• Supporting children aged 4+ to learn how to ride a bike • Community sports awards • Support local sports clubs and individuals • Strength and balance classes • Active holiday play schemes - YMCA/Freedom Leisure Holiday activity programme • Sportivate - Increase activity in 11-25yr olds • Free swimming for over 75's and Under 8's • Couch to 5k • Walking for health • Fortis living - community lifestyle programme for over 55's
Reducing harm from drinking too much alcohol	• Alcohol awareness and education • Peer mentor support • Worcestershire Works Well Scheme • Best Bar None Scheme

Redditch

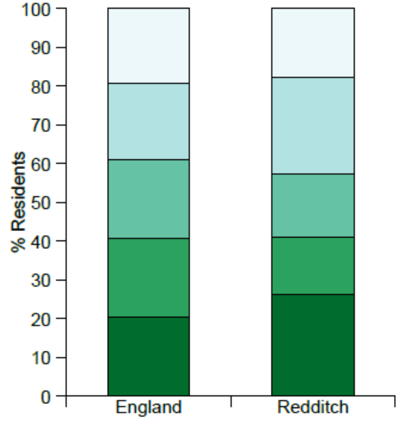
Population and demographics: key facts

- Population: 85,204[49].
- Redditch has the highest proportion of children and young people aged 0-19 (24.2%) in comparison to other Worcestershire districts.
- 15.5% of children were living in low income households in 2015 (2,585)
- 9.4% of people living in Redditch are from an ethnic minority group, compared to 13.2% in England.
- GCSE attainment (5 GCSEs A*-C incl. English and Maths) in 2015/16 is similar to the national average at 55.9%.
- There are a higher proportion of people living in most deprived areas in the country compared to England.
- Life expectancy is 9.3 years lower for men and 9.0 years lower for women in the most deprived areas of Redditch, compared to the least deprived.
- For premature deaths in males the gap between the richest and poorest areas in Redditch has widened since 2011-13.

FIGURE 78 INDEX OF MULTIPLE DEPRIVATION 2015 (QUINTILES) BY LSOA



% of population in Redditch living in areas at each level of deprivation compared to England



Most deprived quintile ... Least deprived quintile

Source: Public Health England – Health Profile 2017: Redditch

[49] ONS mid-year population estimates 2017

Wyre Forest Clinical Commissioning Group

South Worcestershire Clinical Commissioning Group

Redditch and Bromsgrove Clinical Commissioning Group

The map shows differences in deprivation in this area based on national comparisons, using national quintiles (fifths) of the Index of Multiple Deprivation 2015 (IMD 2015), shown by lower super output area. The darkest coloured areas are some of the most deprived neighbourhoods in England[50].

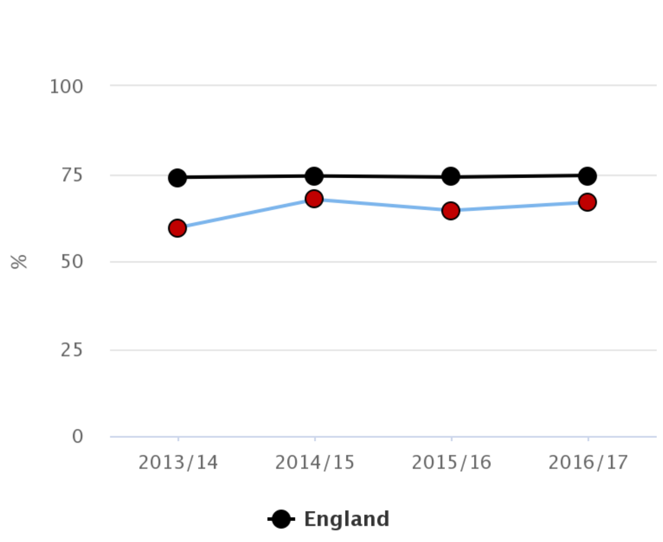
Areas of concern and changing needs

Breastfeeding Initiation

Breastfeeding initiation is considered to be a valid and important measure of public health. Benefits of breastfeeding are significant for both mother and child. Babies who are breastfed have lower rates of respiratory and gastrointestinal infection. Breastfeeding also lowers the risk of both breast and ovarian cancers.

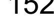
The rate of breastfeeding initiation in Redditch was 66.8% in 2016/17, significantly lower than England (74.5%) and lower than the West Midlands rate of 68.9%.

FIGURE 79 BREASTFEEDING INITIATION - REDDITCH



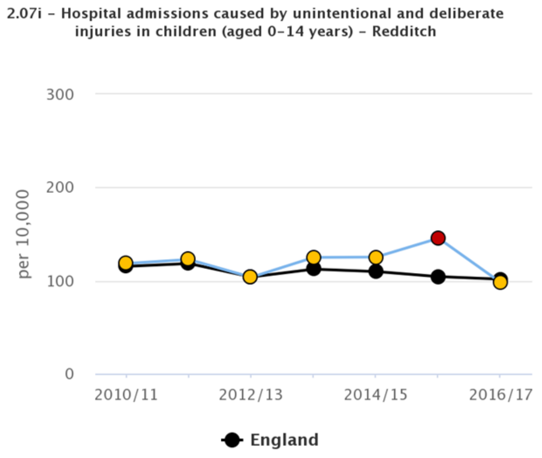
Source: Public Health Outcomes Framework (PHOF)

[50] Public Health England, Health Profile 2017 – Redditch. Online. Available from: http://fingertipsreports.phe.org.uk/health-profiles/2017/e07000236.pdf



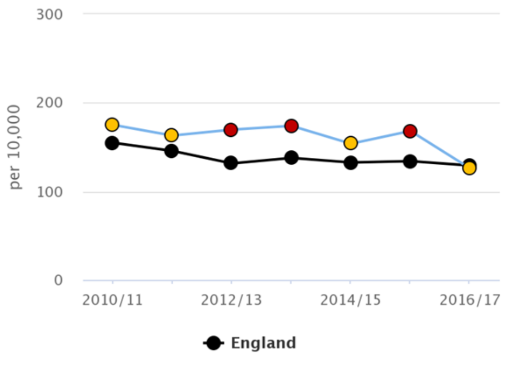
Injuries are a leading cause of premature mortality and hospitalisation for children. They are also a source of long-term health issues, including mental health related to experience(s). In Redditch, the rate of hospital admissions caused by unintentional and deliberate injuries in children and young people was significantly higher than both the West Midlands and England average across all age groups in 2015/16 (0-14 years and 15-24 years), but has shown an improvement for both age groups in 2016/17 to be similar to national levels. The rate has been persistently above the national average for seven years, and is still an area of potential concern.

FIGURE 80 HOSPITAL ADMISSIONS CAUSED BY UNINTENTIONAL AND DELIBERATE INJURIES IN CHILDREN (AGED 0-14 YEARS) REDDITCH



Source: Public Health Outcomes Framework

FIGURE 81 HOSPITAL ADMISSIONS CAUSED BY UNINTENTIONAL AND DELIBERATE INJURIES IN YOUNG PEOPLE (AGED 15-24) - REDDITCH

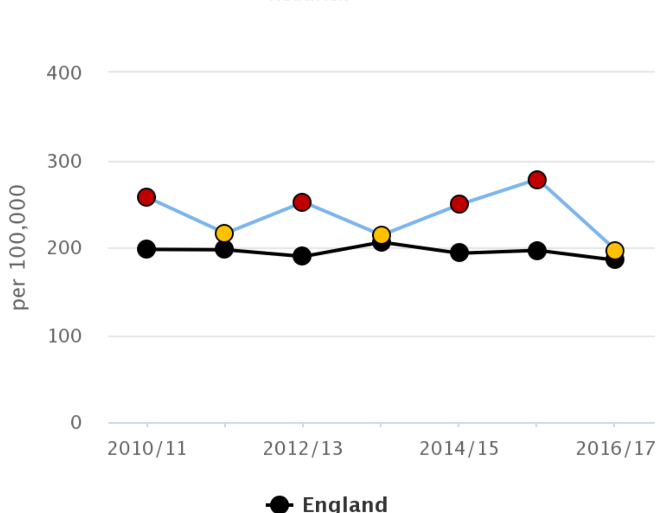


Source: Public Health Outcomes Framework (PHOF)

Self-harm is one of the top five causes of acute medical admission and those who self-harm have a 1 in 6 chance of repeat attendance at Accident and Emergency within the year. One study of people presenting at Accident and Emergency (AandE) showed a subsequent suicide rate of 0.7% in the first year – 66 times the suicide rate in the general population[51].

The rate of emergency hospital admissions for intentional self-harm in Redditch in 2016/17 is higher at 196.9 admissions per 100,000 compared to 189.0 admissions per 100,000 in the West Midlands and 185.3 admissions per 100,000 for England overall. While the 2016/17 rate is not significantly high (and has shown an improvement since 2015/16), Redditch has had values that have been higher than the national average for the last seven years, indicating a persistent issue with this indicator.

FIGURE 82 EMERGENCY HOSPITAL ADMISSIONS FOR INTENTIONAL SELF-HARM - REDDTCH



Source: Public Health Outcomes Framework (PHOF)

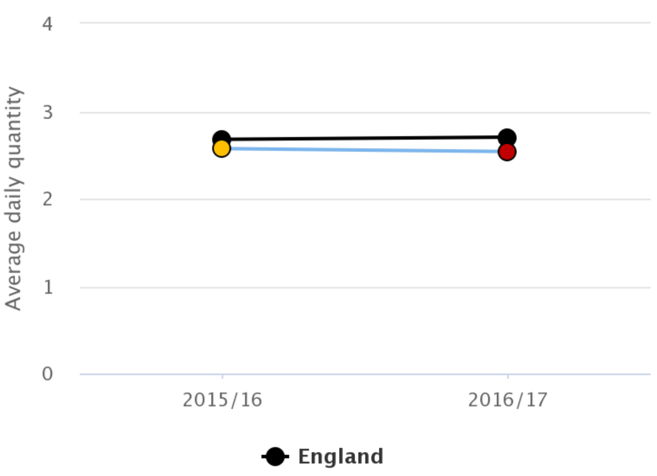
Average Number of Portions of Vegetables Consumed Daily

[51] Indicator Definitions and Supporting Information: Emergency Hospital Admissions for Intentional Self-Harm. Available from: www.phoutcomes.info

Poor diet and obesity are leading causes of premature death and mortality, and are associated with a wide range of diseases including cardiovascular disease and some cancers, which can have a significant impact on an individual's physical and mental health and wellbeing.

The average number of portions of vegetables consumed daily in 2016/17 in Redditch was 2.54 per adult, which is statistically significantly below the national value of 2.70.

FIGURE 83 AVERAGE NUMBER OF PORTIONS OF VEGETABLES CONSUMED DAILY (ADULTS) - REDDITCH



Source: Public Health Outcomes Framework (PHOF)

Admission Episodes for Alcohol-Related Conditions

The reduction of alcohol-related harm is one of the key indicators within Public Health England's national strategy. Alcohol is a significant contributory factor for a range of health conditions and is estimated to cost the NHS approximately £3.5 billion per year and society as a whole £21 billion annually[52].

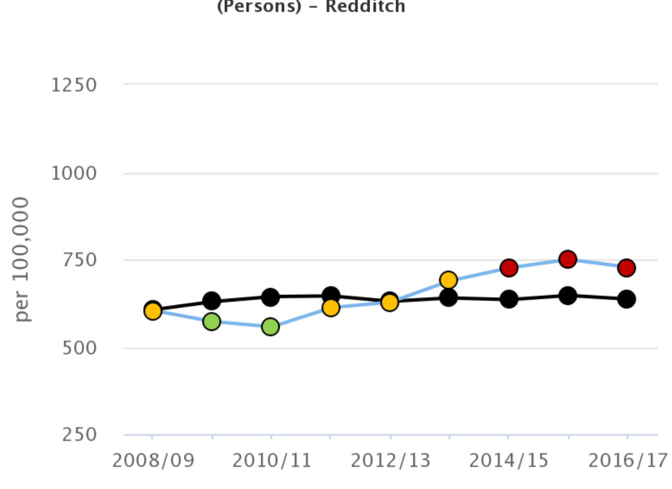
The rate of hospital admissions for alcohol related harm (narrow definition[53]) in Redditch has been increasing and has been significantly higher than England for the last three years. The

[52] Indicator Definitions and Supporting Information: Admission episodes for alcohol related harm – narrow definition Available from: www.phoutcomes.info

[53] PROVIDE DEFINITION OF NARROW CRITERIA

latest data (2016/17) shows that the rate is 728 admissions per 100,000 compared to the England rate of 636 admissions per 100,000.

FIGURE 84 ADMISSION EPISODES FOR ALCOHOL-RELATED CONDITIONS (NARROW) (PERSONS) - REDDITCH



Source: Public Health Outcomes Framework (PHOF)

Smoking Prevalence – adults

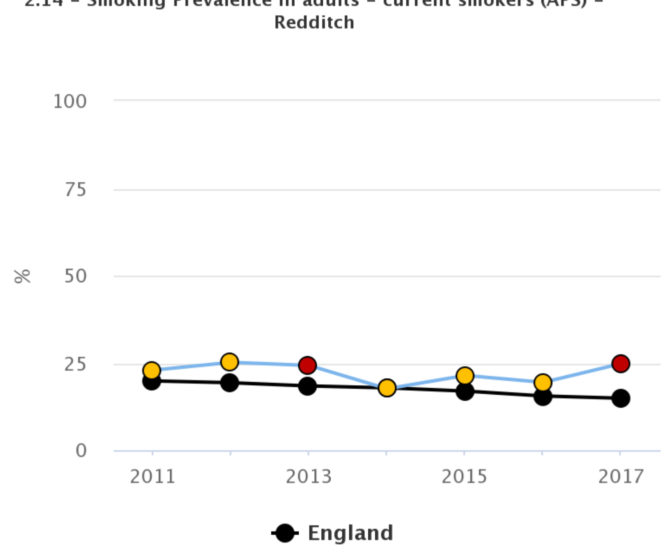
Smoking is the most important cause of preventable ill health and premature mortality in the UK. Smoking is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease. It is also associated with cancers in other organs, including lip, mouth,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

Smoking is a modifiable lifestyle risk factor; effective tobacco control measures can reduce the prevalence of smoking in the population.

In 2017 smoking prevalence in Redditch was estimated to be 24.8% of adults, an increase from the 2016 level of 19.4%. For routine and manual occupations prevalence was 39.5% in 2017, up from the 2016 level of 29.1%. Both values are now statistically significantly above national levels.

Whilst these figures appear concerning, it should be borne in mind that they are based on a sample of people and are subject to uncertainty. Also, there are two other national measures of smoking that are yet to report for 2017. However, the fact that both indicators have been above the national level for 6 years does confirm a persistent issue in Redditch.

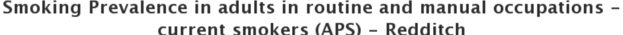
FIGURE 85 SMOKING PREVALENCE IN ADULTS - CURRENT SMOKERS (APS) - REDDITCH

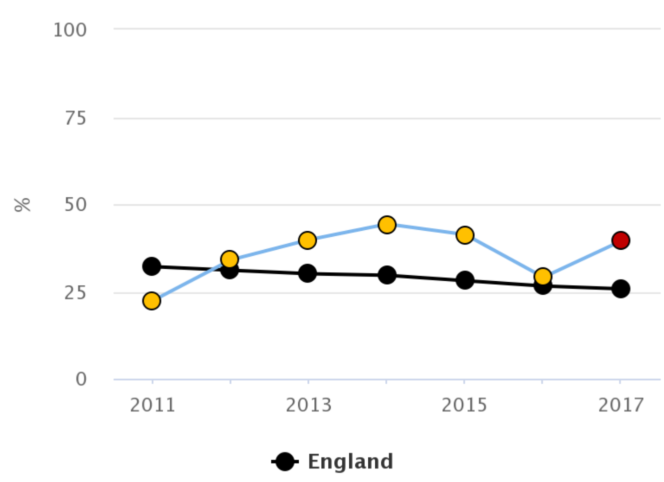


Source: Public Health Outcomes Framework (PHOF)

Smoking Prevalence – routine and manual occupations

FIGURE 86 SMOKING PREVALENCE IN ADULTS IN ROUTINE AND MANUAL OCCUPATIONS - CURRENT SMOKERS (APS) - REDDITCH





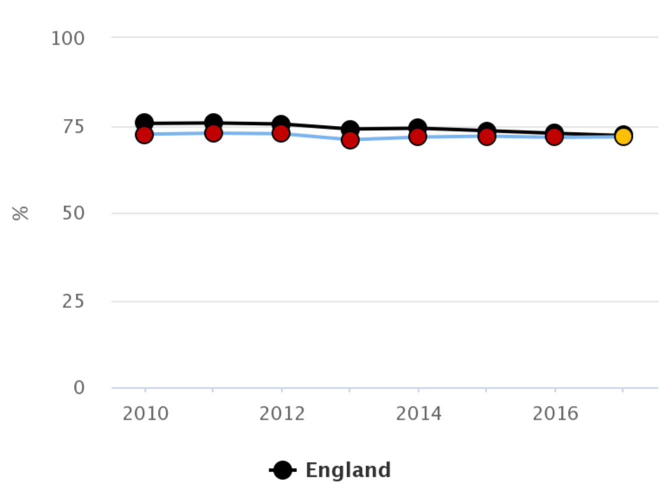
Source: Public Health Outcomes Framework (PHOF)

Cancer Screening Coverage - cervical cancer

Cervical cancer screening supports detection of symptoms that may become cancer and is estimated to save 4,500 lives in England each year. Improvements in coverage would mean more cervical cancer is prevented or detected at earlier, more treatable stages.

Cervical cancer screening coverage in Redditch was 71.7% in 2016/17, compared to the national level of 72.0%. This difference is not statistically significant, whilst in the previous seven years the screening rate in Redditch was significantly below England. It is worth monitoring this indicator in future to check that this improvement is maintained.

FIGURE 87 CANCER SCREENING COVERAGE - CERVICAL CANCER - REDDITCH



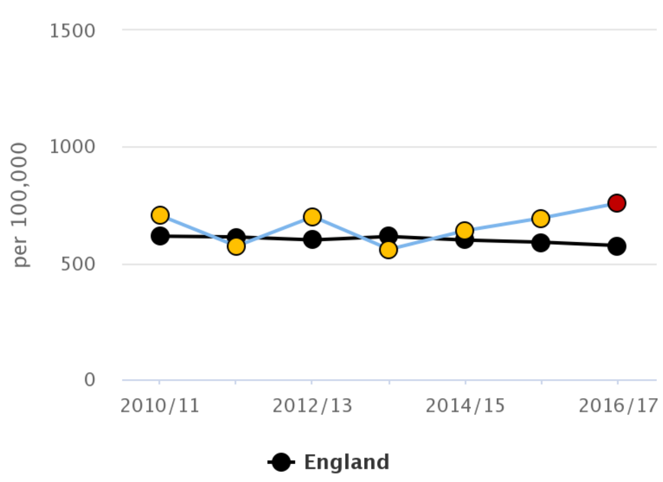
Source: Public Health Outcomes Framework (PHOF)

Hip Fractures

Hip fracture is a common serious injury that occurs mainly in older people. For many previously fit patients it means loss of prior full mobility; for some frailer patients the permanent loss of the ability to live at home. For the frailest of all it may bring pain, confusion and disruption to complicate an already distressing illness.

The rate of hip fractures for the over 65 population in Redditch in 2016/17 was 758, statistically significantly higher than the England rate of 575.

FIGURE 88 HIP FRACTURES IN PEOPLE AGED 65 AND OVER - REDDITCH



Source: Public Health Outcomes Framework (PHOF)

Influenza Vaccination

Vaccination against flu is an important public health intervention. Flu can be a dangerous disease, particularly for the very young and the older population. There are also other at-risk groups such as pregnant women and immunocompromised individuals. Vaccination against flu can reduce pressures on health services by reducing hospital admissions and limit exacerbations of existing medical conditions in these particular groups. The national vaccine uptake ambition during 2017-18 was 75.0% for individuals aged 65 and over and 55.0% for individuals considered being at-risk aged 6 months to under 65.

In 2017-18, Redditch and Bromsgrove CCG fell short of the target at 73.0% of individuals aged 65 and over vaccinated as did England as a whole (72.6%); this was the lowest across the three CCG groups in Worcestershire. 49.5% (48.9% England) of individuals in at-risk groups were vaccinated against a target of 55.0%. [54]

[54] Seasonal Flu Vaccine Uptake (GP) 2017/18 - DATA ON GP REGISTERED PATIENTS
Provisional end of January 2018 cumulative uptake data for England on influenza vaccinations given from 1 September 2017 to 31 January 2018

Local strategy

The local strategy for Redditch below is for 2016/17. The plan is currently under review and will be finalised later in the financial year.

Priority Area	Projects
Maternal and Early Years Health and	• Increase awareness and uptake of the Healthy Start (HS) programme/ vouchers • Increase positive lifestyles choices during pregnancy
Obesity	• Increase the development of healthy cooking on a budget within communities • Increase the amount of activity families and individuals are doing in the Borough • Improve health in the workplace • Ensure frontline staff across Redditch are able to deliver Healthy Lifestyle brief interventions in order to 'make every contact count' • Deliver an information campaign increasing awareness of diabetes and positive lifestyle behaviours to prevent and manage diabetes
Mental Health and Wellbeing throughout life	• Increase support for those with low level mental health conditions • Improve the mental wellbeing of staff in Redditch/Bromsgrove councils • Provide low level coaching and mentoring support for people stepping down from more intensive counselling and coaching • Provide additional opportunities for people in Redditch to access Counselling services • Increase the confidence of frontline staff in Redditch to support children and young people they are working with that may have mental health issues
Ageing Well	• Promote healthy lifestyle services and opportunities available for older people • Support Redditch to become Dementia friendly • Reduce social isolation amongst older people in Redditch • Improve older peoples health by raising awareness and informing them of healthy eating choices and options.
Reducing harm from drinking too much	• Increase awareness of support available for alcohol related issues • Promote safe drinking for residents of Redditch
Improving attainment and aspirations in young people	• To investigate what issues exist around school readiness and attainment at the Early Years Foundation Stage. • To understand how and where illegal exclusions are taking place and how extensive the use of part time timetables is for young people in the town. To understand the impact of this on children and young people.
Support and enhance youth activities for Young People in Redditch	• Ensure services for young people are joined up and also aligned with the commissioned Positive Activities. • Facilitate the development of the Redditch Youth Forum. • Look at the sustainability of the current PA activities and how these might be built on in the future.

Worcester

Population and demographics: key facts

- Population: 102,314[55].
- Higher proportion of people in 20-29 year old age group (15.9%) in comparison to the Worcestershire (11%) and England (13.2%).
- Less deprived on average than England but in Worcester city there are significant pockets of deprivation in the central area and towards the north east.
- 15.8% of children living in low income households (3,000).
- 2.8% of people living in Worcester are from an ethnic minority group, compared to 13.2% in England.
- GCSE attainment (5 GCSEs A*-C incl. English and Maths) in 2015/16 is similar to the England average in Worcester at 59.2%.
- Life expectancy is 9 years lower for men and 4.1 years lower for women in the most deprived areas of Worcester, in comparison to the least deprived.
- For premature deaths the gap between the richest and poorest areas in Worcester in males has widened since 2011-13.

Areas of concern and changing needs

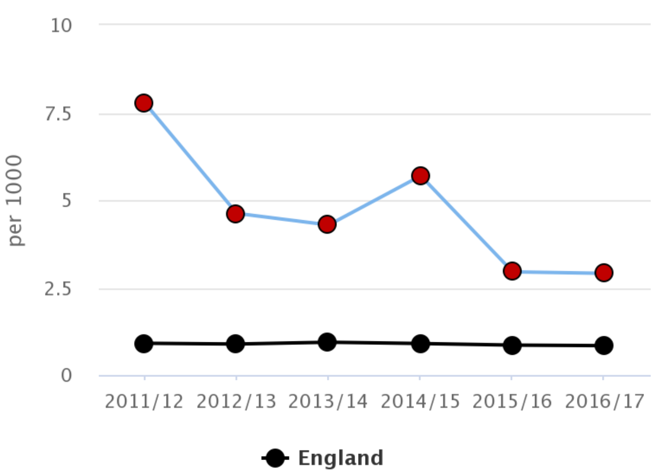
Statutory Homelessness - eligible homeless people not in priority need

This indicator demonstrates the number of households that have presented themselves to their local authority but under homelessness legislation have been deemed to be not in priority need. The majority of the people that fall under this cohort are single homeless people.

In 2016/17 the rate was 2.9 per 1000, which is statistically significantly higher than the England rate of 0.8. This suggests a relatively high number of single homeless people in Worcester.

[55] ONS mid-year population estimates 2017

FIGURE 89 STATUTORY HOMELESSNESS - ELIGIBLE HOMELESS PEOPLE NOT IN PRIORITY NEED - WORCESTER



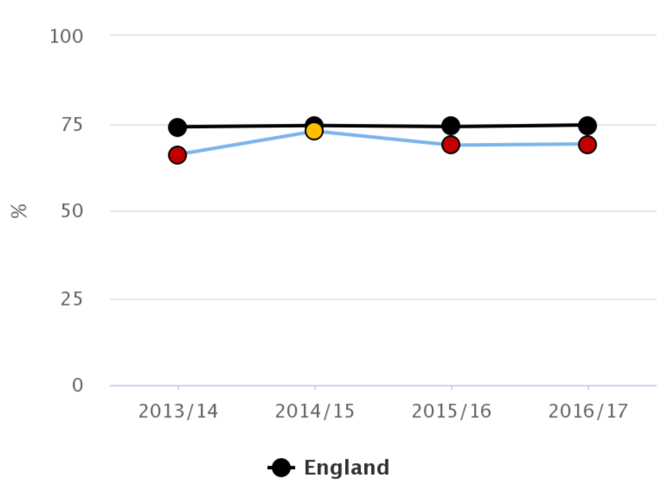
Source: Public Health Outcomes Framework (PHOF)

Breastfeeding Initiation

Breastfeeding initiation is considered to be a valid and important measure of public health. Benefits of breastfeeding are significant for both mother and child. Babies who are breastfed have lower rates of respiratory and gastrointestinal infection. Breastfeeding also lowers the risk of both breast and ovarian cancers.

The rate of breastfeeding initiation in Worcester was 69.0% in 2016/17, significantly lower than England (74.5%) and similar to the West Midlands rate of 68.9%.

FIGURE 90 BREASTFEEDING INITIATION - WORCESTER



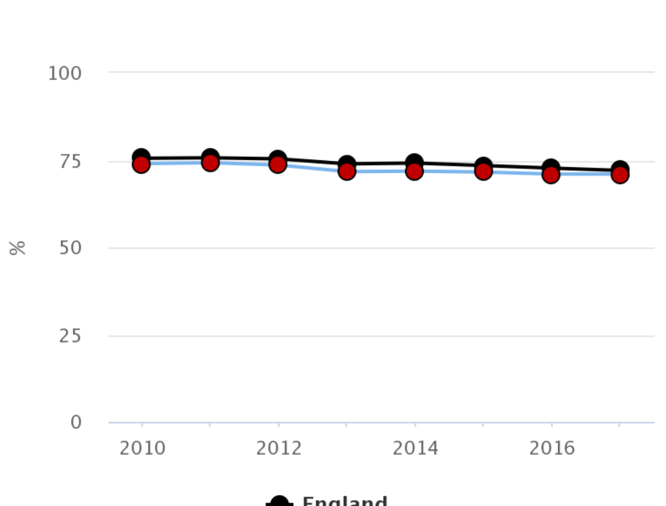
Source: Public Health Outcomes Framework (PHOF)

Cervical Cancer Screening Coverage

Cervical cancer screening supports detection of symptoms that may become cancer and is estimated to save 4,500 lives in England each year. Improvements in coverage would mean more cervical cancer is prevented or detected at earlier, more treatable stages.

Cervical cancer screening coverage in Worcester was 71.0% in 2016/17, compared to the national level of 72.0%. The screening rate in Worcester has been significantly worse than England for eight years.

FIGURE 91 CANCER SCREENIG COVERAGE - CERVICAL CANCER - WORCESTER



Source: Public Health Outcomes Framework (PHOF)

Chlamydia Detection Rate (15-24 year olds)

The National Chlamydia Screening Programme (NCSP) recommends screening for all sexually active young people under 25 annually or on change of partner (whichever is more frequent). The chlamydia detection rate amongst under 25 year olds is a measure of chlamydia control activity, aimed at reducing the incidence of reproductive sequelae of chlamydia infection and interrupting transmission onto others.

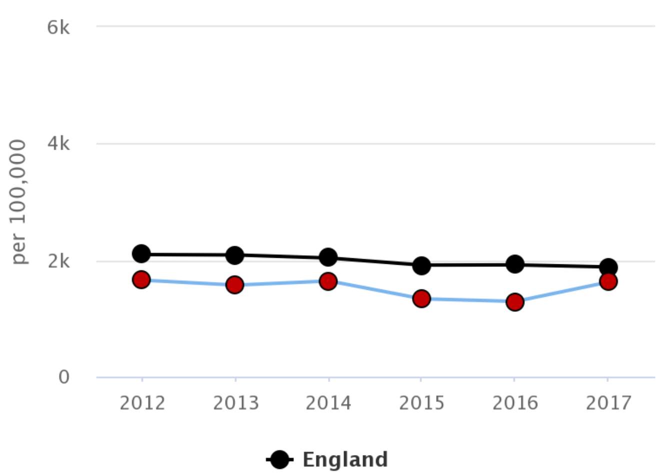
Public Health England (PHE) recommends that local authorities should be working towards achieving a detection rate of at least 2,300 per 100,000 population aged 15-24. The recommendation was set as a level that would encourage high volume screening and diagnoses[56].

The chlamydia detection rate in Worcester has improved between 2016 and 2017 increasing from 1,290 per 100,000 to 1,623 per 100,000 population aged 15-24 but remains significantly lower than the England rate of 1,882 per 100,000 population aged 15-24.

---

[56] Indicator Definitions and Supporting Information: Chlamydia Detection rate 15-24yr olds. Available from: www.phoutcomes.info

FIGURE 92 CHLAMYDIA DETECTION RATE (15-24 YEARS OLD) - WORECSTER



Source: Public Health Outcomes Framework (PHOF)

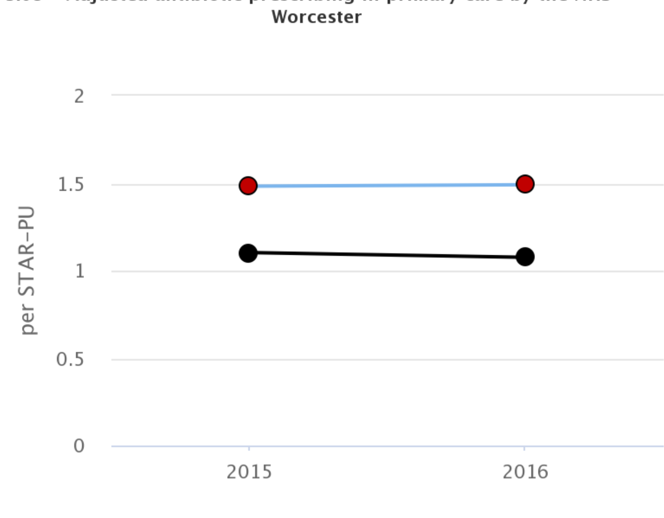
Adjusted Antibiotic Prescribing In Primary Care

Antibiotic resistance is one of the most significant threats to patients' safety and is driven by overusing antibiotics and prescribing them inappropriately. Infections with antibiotic-resistant bacteria increase levels of disease and death, as well as the length of time people stay in hospitals. As resistance in bacteria grows, it will become more difficult to treat infection, and this affects patient care.

The antibiotic prescribing rate can be used to monitor reductions in antibiotic consumption which in turn will reduce antibiotic resistance.

The adjusted antibiotic prescribing rate for Worcester in 2016 was 1.49, significantly above the national rate of 1.08.

FIGURE 93 ADJUSTED ANTIBIOTIC PRESCRIBING IN PRIMARY CARE BY THE NHS - WORCESTER



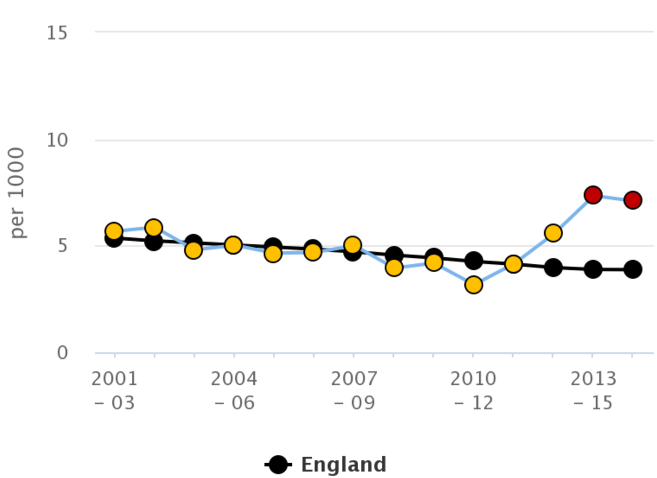
Source: Public Health Outcomes Framework (PHOF)

Infant Mortality

Infant mortality is an indicator of the overall health of the population. This is particularly in relation to the wider determinants of health including social, economic and environmental conditions. Reducing infant mortality is a key public health priority to reduce the levels of inequality between the richest and poorest in society.

The infant mortality rate in Worcester has increased significantly from 2008-10 where the rate was similar to the England average at 4.0 per 1,000 live births to 7.1 per 1,000 in 2014-16. The latest data shows that the infant mortality rate is significantly higher than the England average of 3.9 for the second time over a 15 year period (the data is for 2013-15 and 2014-16 so there is some overlap). The rate in Worcester is almost twice as high as the England rate and is a significant cause for concern. When compared to all local authorities across the country, Worcester has one of the highest rates of infant mortality and ranks 4th worst overall. However, we must consider the small numbers of deaths involved which can significantly affect rates. A public health review is currently ongoing to identify possible causes of the current trend.

FIGURE 94 INFANT MORTALITY - WORCESTER



Source: Public Health Outcomes Framework (PHOF)

Estimated Dementia Diagnosis Rate (aged 65+)

A timely diagnosis of dementia enables people living with dementia, their carers and healthcare staff to plan accordingly and work together to improve health and care outcomes.

In 2017 788 people aged 65 or over had a formal diagnosis dementia in Worcester, which was an estimated 58.3% of the expected number. This is statistically significantly lower than the national level of 67.9%.

Local strategy

The local strategy for Worcester (below) is for projects between 2016 and 2018.

Priority Area	Projects
Good mental health and wellbeing throughout life	Training - Health chats, parenting courses, Plan and deliver a mental health campaign locally Host an annual 'Wise and Well' event for people over the age of 50 years. Community gardening - building networks, allotments and healthy living, volunteering opportunity, community involvement. Dementia - Awareness sessions, action alliance Reconnections - reducing isolation and loneliness, Snack and Chat, community connectors Digital inclusion Parenting groups Home from Hospital Independent living - aids & adaptions, handyperson Homelessness health care centre Bereavement support Living with long term conditions Carers support - Macmillan
Increasing physical activity	Multi-skill sports community programme School sports programmes Fortis living - Healthy lifestyle roadshow Sportivate - motivating younger generation to be physically active Community clubs and programmes Living Well service Strength and Balance classes Loving later life - Over 55's reducing social isolation Walking for health & Walking programmes Disability Sport Worcester Healthier Food Choices scheme for Employers Promoting physical activity in over 50's
Reducing harm from Alcohol	Alcohol Awareness Campaign Worcestershire Works Well Alcohol Education Sessions Best Bar None - Responsible operation of premises serving alcohol
Local health Needs	Air Quality Improvements Health Outcomes for BAME Groups Smart Move - Helping individuals who are homeless or who are at risk of homelessness to secure accommodation. Smart Lets - Affordable private rented accommodation Money Management and Budgeting

Wychavon

Population and demographics: key facts

- Population: 125,378[57].
- Wychavon has a higher proportion of people aged 65 and over (24.5%) in comparison to Worcestershire overall (22.2%).
- An estimated 1.1% of people living in Wychavon are from an ethnic minority group, compared to 13.2% in England.
- There were 11.0% of children living in low income households in 2015 (2,175).
- GCSE attainment (5 GCSEs A*-C incl. English and Maths) in 2015/16 is significantly higher in Wychavon at 62.2% compared to the England average of 57.8%.
- Life expectancy is 7.5 years lower for men and 6.7 years lower for women in the most deprived areas of Wychavon, in comparison to the least deprived. For women, the gap in life expectancy is the largest compared to all other districts in Worcestershire.
- For premature deaths in males the gap between the richest and poorest areas in Wychavon has widened since 2011-13.

Areas of concern and changing needs

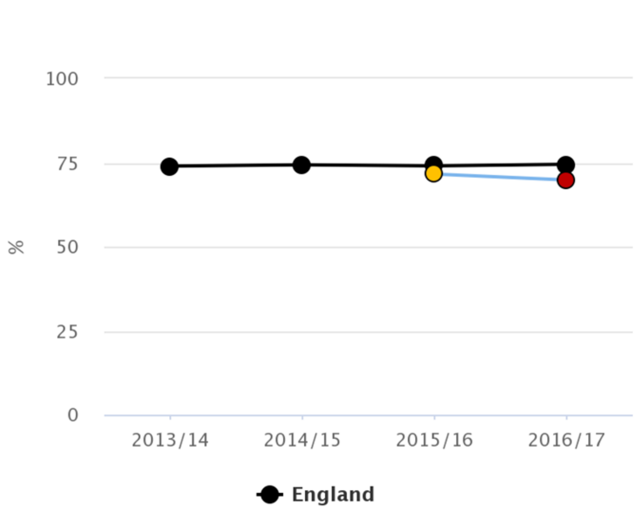
Breastfeeding Initiation

Breastfeeding initiation is considered to be a valid and important measure of public health. Benefits of breastfeeding are significant for both mother and child. Babies who are breastfed have lower rates of respiratory and gastrointestinal infection. Breastfeeding also lowers the risk of both breast and ovarian cancers.

The rate of breastfeeding initiation in Wychavon was 69.8% in 2016/17, significantly lower than England (74.5%) and similar to the West Midlands rate of 68.9%.

[57] ONS mid-year population estimates 2017

FIGURE 95 BREASTFEEDING INITIATION - WYCHAVON



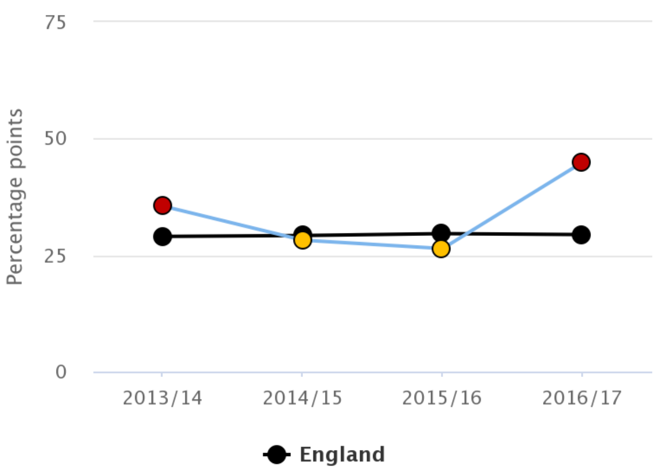
Source: Public Health Outcomes Framework (PHOF)

Gap in the Employment Rate Between Those With a Long-Term Health Condition and the Overall Employment Rate

This indicator provides a good indication of the impact limiting long-term illness has on employment among those in the "working well" life stage.

In 2016/17 the employment rate gap in Wychavon was 44.9 percentage points, statistically significantly higher than the England value of 29.4 percentage points.

FIGURE 96 GAP IN THE EMPLOYMENT RATE BETWEEN THOSE WITH A LONG-TERM HEALTH CONDITION AND THE OVERALL EMPLOYMENT RATE - WYCHAVON



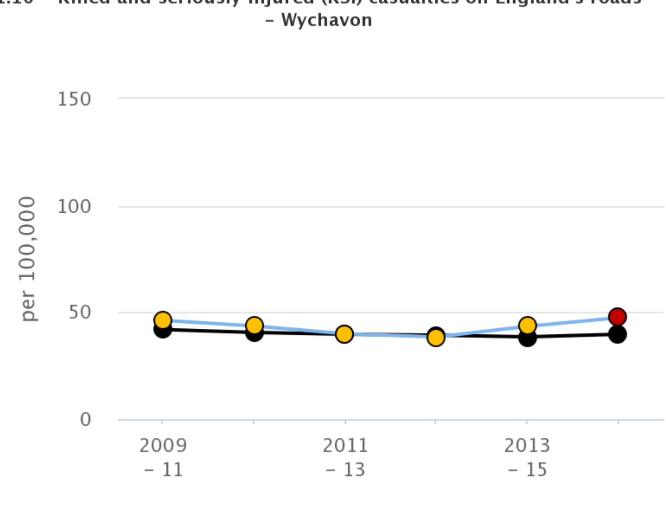
Source: Public Health Outcomes Framework (PHOF)

Killed and Seriously Injured (KSI) Casualties on England's Roads

Motor vehicle traffic accidents are a major cause of preventable deaths and morbidity, particularly in younger age groups. The vast majority of road traffic collisions are preventable and can be avoided through improved education, awareness, road infrastructure and vehicle safety.

In the three year period from 2014 to 2016 there were 173 KSI casualties on roads in Wychavon, a rate of 47.5 per 100,000. This is statistically significantly higher than the rate for England which was 39.7 per 100,000.

FIGURE 97 KILLED AND SERIOUSLY INJURED (KSI) CASUALTIES ON ENGLAND'S ROADS - WYCHAVON



Source: Public Health Outcomes Framework (PHOF)

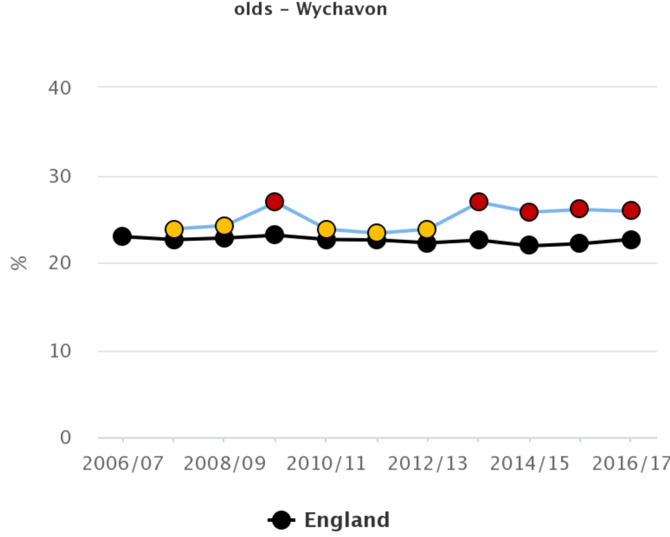
Child Excess Weight - 4-5 year olds

The health consequences of childhood obesity include: increased blood lipids, glucose intolerance, Type 2 diabetes, hypertension, increases in liver enzymes associated with fatty liver, exacerbation of conditions such as asthma and psychological problems such as social isolation, low self-esteem, teasing and bullying.

In 2016-17, Wychavon had a significantly higher proportion of children aged 4 to 5 in Reception who are either overweight or obese (25.8%) in comparison to the West Midlands (24.2%) and England (22.6%). The rate in Wychavon is the second highest of the six Worcestershire districts. The proportion of children who are classed as overweight or obese has remained significantly above the England level for the last four years.

Data for England shows a significant link between excess weight and levels of deprivation, with 26.8% of children in the most deprived areas classed as overweight or obese compared to 17.3% of children in the least deprived areas.

FIGURE 98 CHILD EXCESS WEIGHT IN 4-5 AND 10-11 YEAR OLDS - 4-5 YEAR OLDS - WYCHAVON



Source: Public Health Outcomes Framework (PHOF)

Estimated Dementia Diagnosis Rate (age 65+)

A timely diagnosis of dementia enables people living with dementia, their carers and healthcare staff to plan accordingly and work together to improve health and care outcomes.

In 2017, 869 people aged 65 or over had a formal diagnosis dementia in Wychavon, which was an estimated 51.0% of the expected number. This is statistically significantly lower than the national level of 67.9%.

Local strategy

The health and wellbeing strategy for Wychavon shown below is for the time period 2016 to 2020. The plan is currently being refreshed to reflect issues raised in current data.

Priority Area	Projects
Being active at every age	• Campaign promoting physical activity • Investment in sport and leisure facilities • At least 3 new play areas/open spaces in the towns • Improved public access to wildlife sites including encouragement of volunteering and community involvement
Mental health and wellbeing throughout life	• Visit older people in at least 14 rural areas support across a range of public health priority areas - loneliness, isolation, energy, fire safety, health and independent living. • Pilot offering services to families and younger people in one or more deprived urban areas in Wychavon. • Work with parish councils and community groups to identify and raise awareness of local needs. • Identify local housing needs and support the delivery of sites for affordable rural housing.
Local priorities	• Smoking in pregnancy - identify reasons for higher rates and strategies to reduce rates. • Homelessness - Identify reasons for homelessness, cross-partnership working to reduce homelessness • Undertake Health Impact Assessments for new developments and how these enourage physical activity and healthy living environments. • Rurality - Equality of access to services should be considered as part of commissioning decisions. • Older people - Support Droitwich to become a dementia friendly town. Implement befriending scheme for people living with dementia. Ensure new developments are dementia friendly. Ensure support is in place for older carers.

Wyre Forest

Population and demographics: key facts

- Population: 100,715[58].
- Wyre Forest has a higher proportion of people aged 65 and over (24.4%) in comparison to Worcestershire overall (22.2%).
- 17.2% of children living in low income households in 2015 (2,900).
- 1.7% of people living in Wyre Forest are from an ethnic minority group, compared to 13.2% in England.
- GCSE attainment (5 GCSEs A*-C incl. English and Maths) in 2015/16 is similar to the national average at 58.8%.
- Life expectancy is 8.2 years lower for men and 7.6 years lower for women in the most deprived areas of Wyre Forest, in comparison to the least deprived.
- For premature deaths in females the gap between the richest and poorest areas in Wyre Forest has widened since 2011-13.

Areas of concern and changing needs

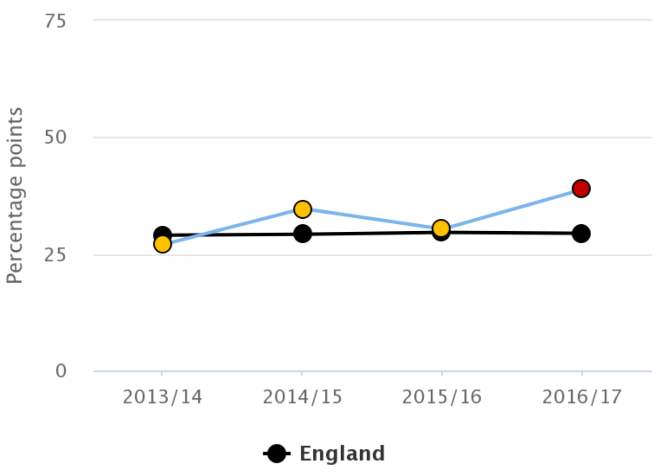
Gap in the Employment Rate Between Those With a Long-Term Health Condition and the Overall Employment Rate

This indicator provides a good indication of the impact limiting long-term illness has on employment among those in the "working well" life stage.

In 2016/17 the employment rate gap in Wyre Forest was 38.8 percentage points, statistically significantly higher than the England value of 29.4 percentage points.

[58] ONS mid-year population estimates 2017

FIGURE 99 GAP IN THE EMPLOYMENT RATE BETWEEN THOSE WITH A LONG-TERM HEALTH CONDITION AND THE OVERALL EMPLOYMENT RATE - WYRE FOREST



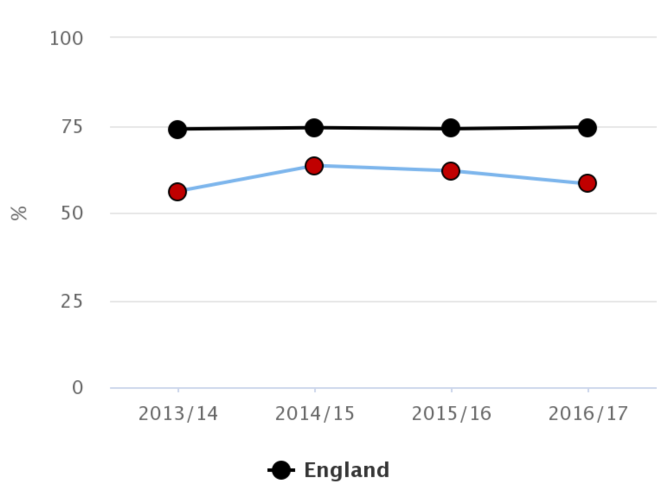
Source: Public Health Outcomes Framework (PHOF)

Breastfeeding - breastfeeding initiation

Breastfeeding initiation is considered to be a valid and important measure of public health. Benefits of breastfeeding are significant for both mother and child. Babies who are breastfed have lower rates of respiratory and gastrointestinal infection. Breastfeeding also lowers the risk of both breast and ovarian cancers.

The rate of breastfeeding initiation in Wyre Forest was 58.2% in 2016/17, significantly lower than both England (74.5%) and West Midlands (68.9%).

FIGURE 100 BREASTFEEDING INITIATION - WYRE FOREST



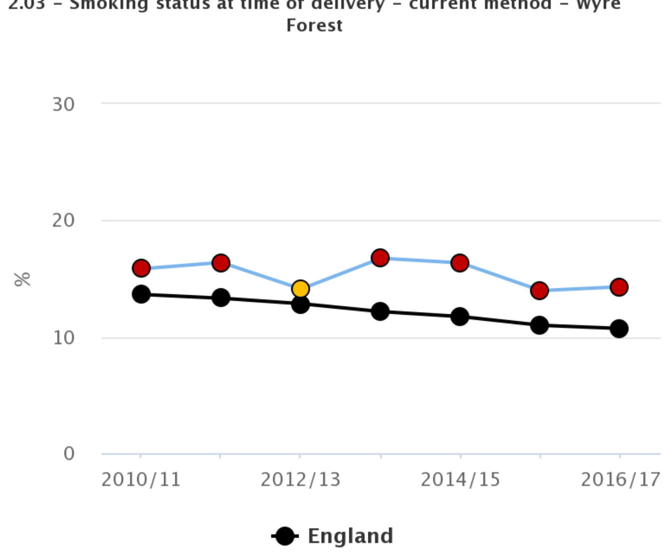
Source: Public Health Outcomes Framework (PHOF)

Smoking Status at Time of Delivery

Smoking during pregnancy can cause serious pregnancy-related health problems. These include complications during labour and an increased risk of miscarriage, premature birth, stillbirth, low birth-weight and sudden unexpected death in infancy.

In 2016/17 14.3% of women in Wyre Forest were smokers at the time of delivery which is significantly higher than the rate of 10.7% in England.

FIGURE 101 SMOKING STATUS AT TIME OF DELIVERY - CURRENT METHOD - WYRE FOREST



Source: Public Health Outcomes Framework (PHOF)

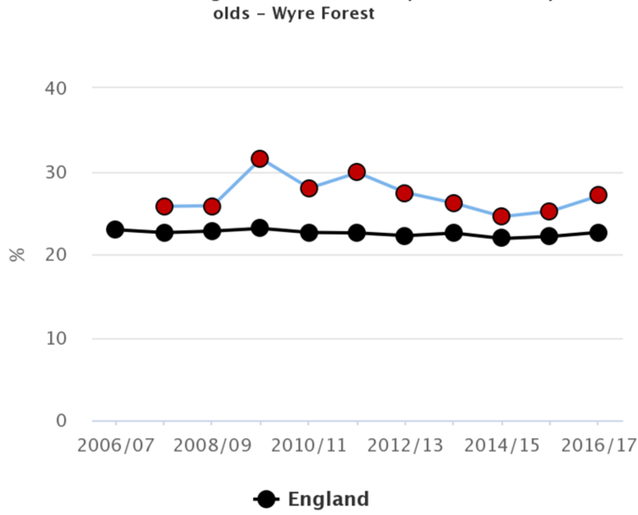
Child Excess Weight - 4-5 year olds

The health consequences of childhood obesity include: increased blood lipids, glucose intolerance, Type 2 diabetes, hypertension, increases in liver enzymes associated with fatty liver, exacerbation of conditions such as asthma and psychological problems such as social isolation, low self-esteem, teasing and bullying.

Wyre Forest has a significantly higher rate of children aged 4 to 5 who are overweight or obese in comparison to the England average. In 2016-17, Wyre Forest had a significantly higher proportion of children aged 4 to 5 in Reception who are either overweight or obese (27.0%) in comparison to the West Midlands (24.2%) and England (22.6%). The rate in Wyre Forest is the second highest of the six Worcestershire districts. The proportion of children in Reception who are overweight or obese has always remained significantly higher than the England average since the National Child Measurement Programme (NCMP) began in 2006/7.

Data for England shows a significant link between excess weight and levels of deprivation, with 26.8% of children aged 4 to 5 in the most deprived areas classed as overweight or obese compared to 17.3% of children in the least deprived areas.

FIGURE 102 CHILD EXCESS WEIGHT IN 4-5 AND 10-11 YEAR IKDS - 4-5 YEAR OLDS - WYRE FOREST



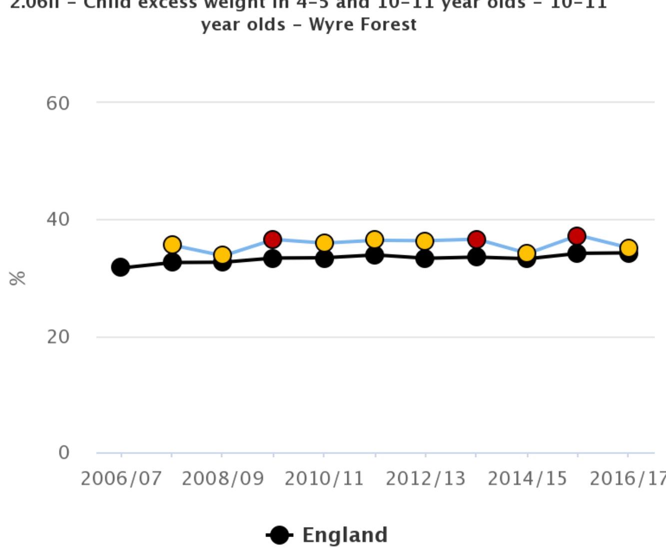
Source: Public Health Outcomes Framework (PHOF)

Child Excess Weight - 10-11 year olds

Wyre Forest has a significantly higher rate of children aged 10 to 11 who are overweight or obese in comparison to the England average. In 2016-17, Wyre Forest had a significantly higher proportion of children aged 10 to 11 in Reception who are either overweight or obese (35.1%) in comparison to England (34.2%). The proportion of children age 10 to 11 who are overweight or obese in Wyre Forest has remained higher (although not always significantly so) than the England average since the NCMP began in 2006/7.

Data for England shows a significant link between excess weight and levels of deprivation, with 40.9% of children aged 10 to 11 in the most deprived areas classed as overweight or obese compared to 24.2% of children in the least deprived areas.

FIGURE 103 CHILD EXCESS WEIGHT IN 4-5 AND 10-11 YEAR OLDS - 10-11 YEAR OLDS - WYRE FOREST



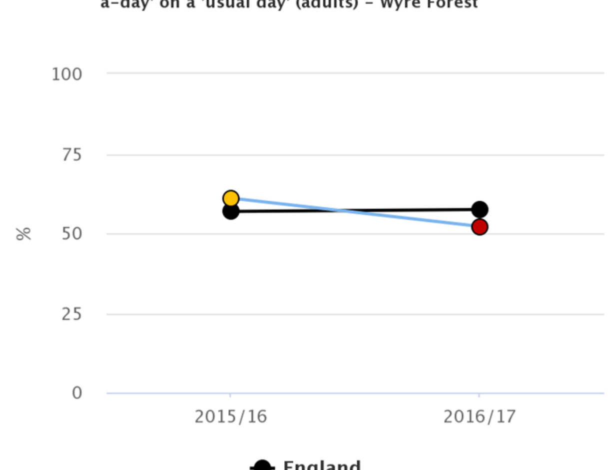
Source: Public Health Outcomes Framework (PHOF)

Proportion of the Population Meeting the Recommended '5-A-Day' on a 'Usual Day'

Poor diet and obesity are leading causes of premature death and mortality, and are associated with a wide range of diseases including cardiovascular disease and some cancers, which can have a significant impact on an individual's physical and mental health and wellbeing.

In 2016/17 the proportion of the population in Wyre Forest meeting the recommended '5-a-day' was 52.1%, which was significantly lower than the national figure of 57.4%.

FIGURE 104 PROPORTION OF THE POPULATION MEETING THE RECOMMENDED '5 A DAY' ON A 'USUAL DAY' (ADULTS) - WYRE FOREST



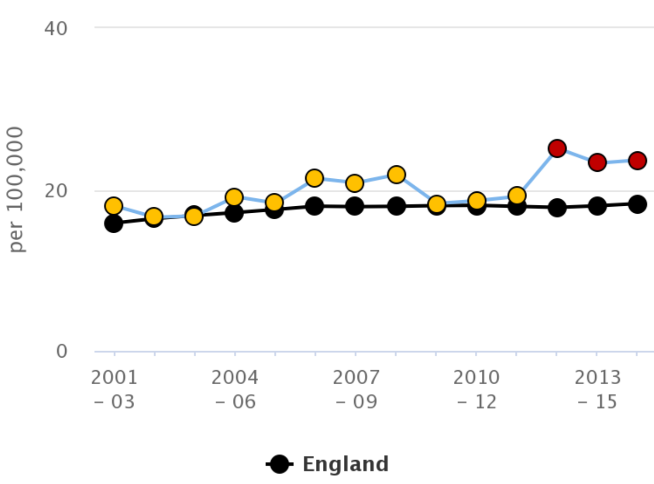
Source: Public Health Outcomes Framework (PHOF)

Under 75 Mortality Rate From Liver Disease

Liver disease is one of the top causes of death in England and people are dying from it at younger ages. Most liver disease is preventable and is influenced by alcohol consumption and obesity prevalence, which are both amenable to public health interventions.

The under 75 mortality rate from liver disease for Wyre Forest in 2014-16 was 23.7 per 100,000, significantly higher than the England level of 18.3.

FIGURE 105 UNDER 75 MORTALITY RATE FROM LIVER DISEASE - WYRE FOREST



Source: Public Health Outcomes Framework (PHOF)

Local strategy

The local strategy below relates to strategy for Wyre Forest for 2016-2021. A revision of this strategy is planned.

Priority Area	Projects
Good mental health and wellbeing throughout life	• Mental Health First Aid Training • Mental Health and Wellbeing in schools • Dementia Friendly Communities • Reduce Social Isolation and Loneliness • Digital Inclusion
Being active at every age	• Sports Development / Activities • Adult Cycle Training • Leisure Centre • Green Gyms and Parks
Reducing harm from	• Raising Alcohol Awareness

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

alcohol at all ages	• Training on Alcohol Awareness • Reducing the strength / accessibility to encourage responsible drinking

Local Priorities

- Raising rates of breastfeeding
- Reducing Statutory Homelessness
- Reducing Diabetes
- Tackling fuel poverty
- Reducing Smoking in pregnancy
- Reducing overweight and obese adults
- Brief Interventions – Eating well on a budget, Health Chats
- Campaigns – Stroke Campaign, Ageing well, implementation of social media to promote lifestyle messages.
- Worcestershire Works Well.

Appendix 2: Summary of Reports on the Worcestershire Joint Strategic Needs Assessment (JSNA) Website

Key:

NA=Needs Assessment, **B**=Briefing, **P**=Profiles, **S**=Summaries, **DB**=Dashboard (live data)

Topic/Title	**Category**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
Health and Well-being Board Strategy Indicators	**DB**							**O**
Public Health Annual Report	**R**			**O**	**O**	**O**		
JSNA Summary	**S**		**O**	**O**	**O**	**O**	**O**	**O**
Falls Needs Assessment	**NA**							**O**
Executive Summary on Carers Profile	**P**							**O**
Domestic Abuse and Violence Needs Assessment	**NA**					**O**		
Early Help Needs Assessment (Age 0-19 Years)	**NA**				**O**			
Speech and Language Therapy Needs Assessment	**NA**				**O**			
Sexual Health Needs Assessment	**NA**				**O**			
Mental Health Needs Assessment	**NA**			**O**	**O**			
Early Help Needs Assessment	**NA**				**O**			
Wellbeing in Older people				**O**				
Substance Misuse Needs Assessment	**NA**			**O**				

Briefing on Suicide	**B**						**O**	
Briefing on Learning Disabilities	**B**						**O**	
Briefing on Rural Health	**B**					**O**		
Briefing on Road Safety and Older People	**B**					**O**		
Briefing on Older People	**B**			**O**		**O**		
Briefing on Fuel Poverty	**B**					**O**		
Briefing on Homelessness	**B**				**O**			
Briefing on Excess Winter Deaths	**B**			**O**				
Briefing on Sensory Impairment – Visual	**B**		**O**					
Briefing on Smoking in Pregnancy	**B**					**O**		
Briefing on Teenage Pregnancy	**B**				**O**			

Topic/Title	Category	2012	2013	2014	2015	2016	2017	2018
Briefing on National Childhood Measurement Programme NCMP	B				O			
Briefing on Early Help	B				O			
Briefing on Breastfeeding	B		O					
Briefing on Cancers	B		O					
Briefing on Cardiovascular Disease	B		O					
Briefing on Chronic Obstructive Pulmonary Disease	B		O					
Briefing on Alcohol	B		O	O	O	O		
Briefing on Self Harm	B							
Briefing on Substance Misuse	B		O	O				
Briefing on Bromsgrove	B			O				
Briefing on Bromsgrove Older People Profile	B			O				
Briefing on Redditch	B		O					
Briefing on Worcester City	B		O					
Briefing on Wyre Forest	B			O				
Briefing on Mental Health	B		O	O	O	O		
Briefing on Physical Activity	B				O			O
Briefing on Obesity	B		O	O				O
Briefing on Sexual Health	B					O		
Briefing on Health of Black and Minority Ethnic Groups	B						O	
Briefing on Communicable Disease	B		O					
Pharmaceutical Needs Assessment	NA				O			O

Oral Health Needs Assessment								**O**
Redditch District Needs and Assets Profile	**P**							**O**
Bromsgrove Health and Wellbeing Profile Executive Summary	**S**					**O**		
Gender Differences in Health and Wellbeing Infographics Summary	**S**					**O**		
Gender Differences in Health and Wellbeing Infographics Summary	**S**					**O**		
Gender Differences Profile	**P**					**O**		

Wyre Forest Clinical Commissioning Group

South Worcestershire Clinical Commissioning Group

Redditch and Bromsgrove Clinical Commissioning Group

Topic/Title	Category	2012	2013	2014	2015	2016	2017	2018
Ophthalmology Profile	P			O				
Worcestershire Census Atlas	P			O				
Worcestershire End of Life Profile	P	O						
Bromsgrove Early Years	P					O		
Bromsgrove Health and Wellbeing	P					O		
Malvern Hills Early Years	P					O		
Malvern District Health and Wellbeing	P				O			
Redditch Early Years	P					O		
Worcester Health and Well-being	P				O			
Worcester Early Years	P					O		
Wychavon Early Years	P					O		
Wychavon Local Profile	P				O			
Wyre Forest Health and Well-being	P						O	
Wyre Forest Early Years	P					O		
Wyre Forest Dermatology	P			O				
Redditch and Bromsgrove Profile	P						O	
Redditch and Bromsgrove Profile	P					O		
Redditch and Bromsgrove Profile	P				O			
Redditch and Bromsgrove Profile	P			O				
Redditch and Bromsgrove Dermatology	P			O				
Redditch and Bromsgrove Profile	P		O					
South Worcestershire Profile	P						O	
2016 South Worcestershire Profile	P					O		

South Worcestershire Profile	**P**				**O**			
South Worcestershire Profile	**P**			**O**				
South Worcestershire Profile	**P**		**O**					
Wyre Forest Profile	**P**	**O**	**O**	**O**	**O**	**O**	**O**	

Glossary

Air Quality Management Area (AQMA) - Since December 1997 each local authority in the UK has been carrying out a review and assessment of air quality in their area. This involves measuring air pollution and trying to predict how it will change in the next few years. The aim of the review is to make sure that the national air quality objectives will be achieved throughout the UK by the relevant deadlines. These objectives have been put in place to protect people's health and the environment. If a local authority finds any places where the objectives are not likely to be achieved, it must declare an Air Quality Management Area there.

BAME – Black, Asian and Minority Ethnic

Children in Need (CIN) - Children in Need are defined in law by Section 17 of the Children Act 1989. This defines children in need as under 18 and -

(a) they are unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision of services by a local authority

(b) their health or development is likely to be significantly impaired, or further impaired, without the provision of such services; or

(c) they are disabled.

CIPFA - Chartered Institute of Public Finance and Accountancy

CIPFA Nearest Statistical Neighbours - A model developed by the Chartered Institute of Public Finance and Accountancy (CIPFA) to aid local authorities in comparative and benchmarking exercises. The model groups local authorities based on their similarity on a range of socio-economic indicators.

Confidence Interval – a measure of the preciseness of the estimate. The range of values within which it is highly likely the true value lies. Where confidence intervals overlap it is not possible to determine if there is a true difference between values. Commonly set at a 95% 'confidence' level (95% CI). See also (statistically) significantly lower or higher/better or worse.

CYP - Children and young people

Directly standardised rate (DSR) - A rate that has been adjusted to allow better comparison between areas. The technique mitigates the effect of different population demographics.

Early Years Foundation Stage (EYFS) - The early years foundation stage sets standards for the learning, development and care of your child from birth to 5 years old. All schools and Ofsted-registered early years providers must follow the EYFS, including childminders, preschools, nurseries and school reception classes.

Eligible Homeless People Not in Priority Need - demonstrates the number of households that have presented themselves to their local authority but under homelessness legislation have

been deemed to be not in priority need. The majority of the people that fall under this cohort are single homeless people.

Excess winter deaths (EWD) – additional deaths that occur during the winter period in comparison to the remainder of the year.

Excess Weight - Adults are defined as overweight (including obese) if their body mass index (BMI) is greater than or equal to 25kg/m2. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.

Fly Ash - ash produced in small dark flecks by the burning of powdered coal or other materials and carried into the air.

GP - General practitioner

Healthwatch Worcestershire - In April 2013 Healthwatch Worcestershire was established as the independent consumer champion – giving the public, patients and users of health and social care services in Worcestershire a voice. Healthwatch Worcestershire gathers views on what people think of health and social care services, makes sure people have a say in how health and social care services are run and helps people hold services to account.

Healthy Life Expectancy (at birth; HLE) - the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health.

Index of Multiple Deprivation (IMD) score 2015 - The English indices of deprivation measure relative deprivation in small areas in England called lower-layer super output areas (LSOAs). The index of multiple deprivation is the most widely used of these indices and combines information from the seven domains listed below to produce an overall relative measure of deprivation.

- Income Deprivation
- Employment Deprivation
- Education, Skills and Training Deprivation
- Health Deprivation and Disability
- Crime
- Barriers to Housing and Services
- Living Environment Deprivation

Each of these domains is based on a basket of indicators.

JSNA - Joint strategic needs assessment

KS1, KS2, KS3, KS4, KS5 - All schools must follow a National Curriculum which is divided into Key Stages:

	Key Stage	Year Groups	Age of Children
Primary	1	1, 2, 3	5 – 7
Primary	2	4, 5, 6	8 – 11
Secondary	3	7, 8, 9	12 -14
Secondary	4	10, 11	15 – 16
Secondary	5	12, 13	17 – 18

At the end of Key stage 1 and 2 all students take Standard Assessment Tests (SATS) in the core subjects of English, Mathematics and Science.

At the end of KS4 pupils sit GCSE (General Certificate of Secondary Education) examinations in a variety of subjects. There are also some vocational qualifications which can be gained at this stage.

At the end of Year 12 the students take AS (Advanced Subsidiary) level examinations followed by A (Advanced) level examinations at the end of Year 13. This is the most common form of entry into university and other further education courses.

Life Expectancy (at birth) - the average number of years a person would be expected to live given contemporary mortality rates.

NCMP - National Child Measurement Programme

NDTMS - National Drug Treatment Monitoring Service

NHS - National Health Service

NICE - National Institute for Health and Care Excellence

ONS - Office for National Statistics

PANSI - Projecting Adult Needs/Service Information System

PHE - Public Health England

PHOF - Public Health Outcomes Framework

POPPI - Projecting Older People Population Information System

Premature Mortality - Death under the age of 75 years

Prevalence - The most commonly used measure of disease frequency. Prevalence is an estimate of the number of cases of a given disease or risk factor in the population at a point in time (point prevalence) or over a given time period (period prevalence).

(Statistically) Significantly lower or higher/better or worse - A statistical term that means it is very likely there is a real difference i.e. the difference is unlikely to be due to chance variation alone. See also Confidence Interval.

Violent Crime - Violent crime covers a wide range of offences from minor assaults (such as pushing and shoving), harassment and abuse (that result in no physical harm), through to wounding and homicide.

Associated Documents and Information

All JSNA publications are available on the Worcestershire JSNA website at:
http://www.worcestershire.gov.uk/homepage/109/joint_strategic_needs_assessment

Further Information and Feedback

This profile has been prepared by Worcestershire Directorate of Public Health. We welcome your comments on our work - please do contact us if you have any:
Email: jfulton@worcestershire.gov.uk Tel: 01905 843359

This document can be provided in alternative formats such as Large Print, an audio recording or Braille; it can also be emailed as a Microsoft Word attachment. Please contact Public Health Admin on telephone number 01905 845637 or by emailing HWBadmin@worcestershire.gov.uk.

Appendix

Screening and Immunisation figures for Worcestershire

Source of data: NHS England 7a Assurance reports

Immunisations

Indicator	Lower threshold[1]	Standard[2]	Key			Geography	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
3.03xii - Population vaccination coverage - HPV (%)	80	90	<80	80-90	>=90	Worcestershire					92.4	84.8	87.4
						England					89.4	87.0	87.2
3.03xiii - Population vaccination coverage - PPV (%)	65	75	<65	65-75	>=75	Worcestershire	74.9	71.6	72.4	72.0	72.9	73.3	73.1
						England	70.5	68.3	69.1	68.9	69.8	70.1	69.8
3.03xiv - Population vaccination coverage - Flu (aged 65+) (%)	70	75	<70	70-75	>=75	Worcestershire	73.3	74.8	74.0	74.3	74.2	72.6	72.7
						England	72.8	74.0	73.4	73.2	72.7	71.0	70.5
3.03xv - Population vaccination coverage - Flu (at risk individuals) (%)	50	55	<50	50-55	>=55	Worcestershire	52.2	53.7	52.3	54.9	54.1	49.4	53.4
						England	50.4	51.6	51.3	52.3	50.3	45.1	48.6
3.03xviii - Population vaccination coverage - Flu (2-4 years old) (%)	30	40	<30	30-40	>=40	Worcestershire					38.0	39.1	40.2
						England					37.6	34.4	38.1
3.03xvii - Population vaccination coverage - Shingles vaccination coverage (70 years old) (%)	50	60	<50	50-60	>=60	Worcestershire					64.5	58.5	50.8
						England					59.0	54.9	48.3

Source: PHOF, PHE

[1] Lower threshold based on the 2017-18 Public Health Functions Agreement

[2] Standard is the clinical standard required to control disease and ensure patient safety.

Childhood immunisations

Cohort	Indicator	Lower threshold[1]	Standard[2]	Geography	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
12 months	3.03i - Population vaccination coverage - Hepatitis B (1 year old)			Worcestershire							
				England							
	3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old)	90	95	Worcestershire	94.6	96.3	95.6	96.4	96.1	96.8	94.2
				England	94.2	94.7	94.7	94.3	94.2	93.6	93.4
	3.03iv - Population vaccination coverage - MenC	90	95	Worcestershire	94.3	95.7	95.1			97.8	
				England	93.4	93.9	93.9				
	3.03v - Population vaccination coverage - PCV	90	95	Worcestershire	94.0	95.7	95.1	95.8	95.1	96.3	95.0
				England	93.6	94.2	94.4	94.1	93.9	93.5	93.5
24 months	3.03i - Population vaccination coverage - Hepatitis B (2 years old)			Worcestershire							
				England							
	3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old)	90	95	Worcestershire	96.7	97.2	97.6	97.5	97.9	97.5	96.1
				England	96.0	96.1	96.3	96.1	95.7	95.2	95.1
	3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old)	90	95	Worcestershire	93.5	94.2	95.1	95.1	95.5	95.3	94.3
				England	91.6	92.3	92.7	92.5	92.1	91.6	91.5
	3.03vii - Population vaccination coverage - PCV booster	90	95	Worcestershire	90.7	92.2	93.9	94.4	94.7	94.8	94.4
				England	89.3	91.5	92.5	92.4	92.2	91.5	91.5
	3.03viii - Population vaccination coverage - MMR for one dose (2 years old)	90	95	Worcestershire	89.9	93.1	94.6	95.1	95.3	95.2	94.5
				England	89.1	91.2	92.3	92.7	92.3	91.9	91.6
5 years	3.03ix - Population vaccination coverage - MMR for one dose (5 years old)	90	95	Worcestershire	92.1	92.9	94.6	95.6	96.5	97.6	97.5
				England	91.9	92.9	93.9	94.1	94.4	94.8	95.0
	3.03vi - Population vaccination coverage - Hib / Men C booster (5 years old)	90	95	Worcestershire		86.9	86.2	89.0	91.2	95.4	96.2
				England		88.6	91.5	91.9	92.4	92.6	92.6
	3.03x - Population vaccination coverage - MMR for two doses (5 years old)	90	95	Worcestershire	82.2	85.4	88.3	91.6	91.9	93.2	92.4
				England	84.2	86.0	87.7	88.3	88.6	88.2	87.6

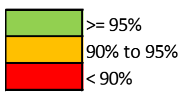
Source: PHOF, PHE

N.B. Indicators in 2013/14 to 2016/17are combined for Cornwall & Isles of Scilly and for Hackney and City of London.

All indicators in 2013/14 to 2016/17 are combined for Leicestershire and Rutland. MMR for one dose (2 years old) in 2015/16 to 2016/17 is also combined for Leicestershire and Rutland.

Population vaccination coverage - MenC in 2015/16 and 2016/17 is combined for Leicester and Rutland.

Key:


>= 95%
90% to 95%
< 90%

[1] Lower threshold based on the 2017-18 Public Health Functions Agreement

[2] Standard is the clinical standard required to control disease and ensure patient safety.

Screening Programmes

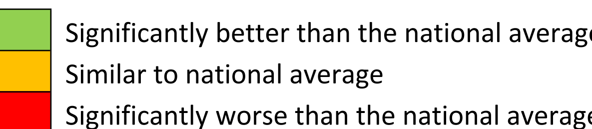
Cancer Screening Programmes

Breast, Cervical and Bowel programmes

Indicator	Lower threshold[1]	Standard[2]	Geography	2010	2011	2012	2013	2014	2015	2016	2017
2.20i - Cancer screening coverage - breast cancer (%)	70	80	Worcestershire	81.0	81.8	82.2	80.7	79.4	79.6	79.5	79.2
			England	76.9	77.1	76.9	76.3	75.9	75.4	75.5	75.4
2.20ii - Cancer screening coverage - cervical cancer (%)	75	80	Worcestershire	77.4	77.5	77.1	75.5	75.5	75.5	75.0	74.9
			England	75.5	75.7	75.4	73.9	74.2	73.5	72.7	72.0
2.20iii - Cancer screening coverage - bowel cancer (%)*	55	60	Worcestershire						62.4	62.1	62.1
			England						57.1	57.9	58.8

Source: PHOF, PHE

Key:



Significantly better than the national average

Similar to national average

Significantly worse than the national average

[1] Lower threshold based on the 2017-18 Public Health Functions Agreement

[2] Standard is the clinical standard required to control disease and ensure patient safety.

* This indicator was first introduced in December 2015

Non Cancer Screening programmes

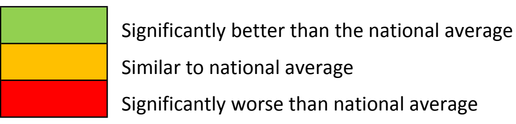
Ante-natal and New-born, Diabetic Eye and Abdominal Aortic Aneurysm

Indicator	Lower threshold[1]	Standard[2]	Geography	2013	2014	2015
2.20ix - Infectious Diseases in Pregnancy Screening – Hepatitis B Coverage (%)			Worcestershire			
			England	97.9	97.4	98.1
2.20viii - Infectious Diseases in Pregnancy Screening – Syphillis Coverage (%)			Worcestershire			
			England	98.0	97.4	98.2

Indicator	Lower threshold[1]	Standard[2]	Geography	2013/14	2014/15	2015/16	2016/17
2.20vii - Infectious Diseases in Pregnancy Screening – HIV Coverage (%)	≥ 95%	≥ 99%	Worcestershire				
			England	98.9	98.9	99.1	99.5
2.20x - Sickle Cell and Thalassaemia Screening – Coverage (%)	≥ 95.0%	≥ 99.0%	Worcestershire				
			England	98.9	98.9	99.1	99.3
2.20xi - Newborn Blood Spot Screening – Coverage (%)	≥ 95.0%	≥ 99.9%	Worcestershire	99.1		99.1	
			England	93.5	95.8	95.6	96.5
2.20xii Newborn Hearing Screening – Coverage (%)	≥ 97%	≥ 99.5%	Worcestershire	98.8	99.4	99.8	
			England	98.5	98.5	98.7	98.4
2.20xiii - Newborn and Infant Physical Examination Screening – Coverage (%)	≥ 95.0%	≥ 99.5%	Worcestershire				
			England		93.3	94.9	93.5
2.20v – Diabetic eye screening - uptake (%)	≥ 70.0%	≥ 80.0%	Worcestershire				
			England		82.9	83.0	82.2
2.20iv – Abdominal Aortic Aneurysm Screening – Coverage (%)	≥ 75%	≥ 85.0%	Worcestershire	86.3	84.8	84.3	85.8
			England	77.4	79.4	79.9	80.9

Source: PHOF, PHE

Key:



Significantly better than the national average

Similar to national average

Significantly worse than national average

[1] The lower threshold is the lowest level of performance which programmes are expected to attaint to ensure patient safety and programme effectiveness.
All programmes are expected to exceed the acceptable threshold and to agree service
improvement plans that develop performance towards an achievable level.
[2] The Standard represents the level at which the programme is likely to be running effectively; screening programmes should aspire towards attaining
and maintaining performance at this level.

This page is intentionally left blank

Worcestershire Health and Well-being Board

Health Protection Group

Terms of reference

Purpose

To provide assurance that adequate multi agency arrangements are in place to protect the public from major threats to health and well-being in Worcestershire.

Objectives

1. To ensure that Worcestershire County Council, District Councils, NHSE and PHE (as category 1 responders) and CCGs (as category 2 responders) deliver their responsibilities for Emergency Preparedness, Resilience and Response (EPRR) under the Civil Contingencies Act, and where relevant for health protection under the Health and Social Care Act.
2. To identify major threats to health and well-being and ensure that comprehensive, up to date and tested plans are in place, working with the West Mercia Local Health Resilience Partnership and West Mercia Local Resilience Forum.
3. To ensure that robust arrangements for leading and coordinating the response to specific incidents and emergencies are in place.
4. To ensure that adequate procedures are in place to manage and prevent health protection incidents from occurring.
5. To review the response to serious incidents and emergencies and make recommendations to inform improvements to planning and response to future events.
6. To raise concerns to the Health and Wellbeing Board where deficiencies in the preparation, resilience and/or response to threats to health and well-being are identified.
7. To develop an integrated partner approach to ensure that public health messages are received by residents, businesses and other stakeholders in a relevant and timely manner as part of a rolling programme.
8. To review immunization coverage, overall and in specific groups, and to oversee the development and implementation of plans for improvement where necessary.
9. To review the coverage and quality of national screening programmes, overall and in specific groups, and to oversee the development and implementation of plans for improvement where necessary.
10. To review the incidence of health and social care acquired infections, and oversee the development and implementation of plans to reduce these where necessary.

Accountability

The Group is accountable to the Health and Well-being Board.

Membership

- Director of Public Health (Chair)
- County Council lead Member(s)
- NHS England (HO EPRR & HO Public Health)
- Public Health England either Consultant or Senior Practitioner
- Member from District Councils – South
- Member from District Councils – North
- WAHT (Emergency Planning Officer)
- Head of Worcestershire Regulatory Services
- CCG Chief Operating Officers
- Chair Worcestershire Infection Prevention & Control Committee
- WCC Advanced Practitioner in Public Health
- Public Health England (Screening and Immunisations Lead)
- Consultant in Public Health (Health Protection)
- WHCT (Emergency Planning Manager)

Arrangements for deputies

Each member to nominate one deputy to attend in their absence.

Quoracy and decision making

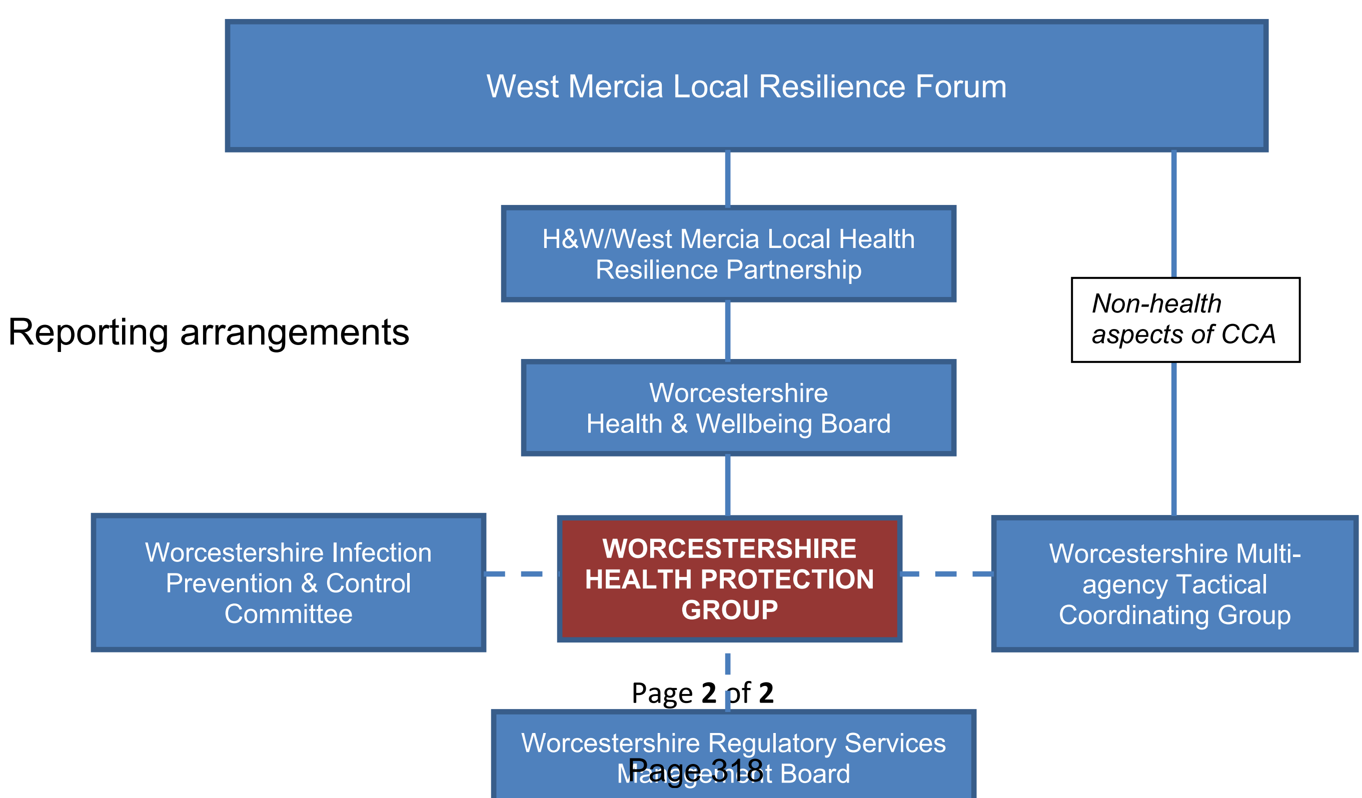
Meetings will be quorate if at least five members or substitutes are present including at least one elected Member from the County or District Council and one GPCC representative.

It is expected that any decisions of the HPC will generally be by consensus, otherwise by a majority of those members present.

Frequency of meetings

Quarterly. Agenda items to be added via DPH or Lead Public Health Consultant

Reporting arrangements



Worcestershire Better Care Fund Narrative Document

Summary

Local Authority	Worcestershire County Council
Clinical Commissioning Groups	South Worcestershire
	Wyre Forest
	Redditch and Bromsgrove
Boundary Differences	The CCG's together are coterminous with the Worcestershire County Council, subject to the usual differences between resident and registered population.
Date agreed at Health and Well-Being Board:	CCG and Local Authority representatives on HWB delegated to sign off for submission by 11th September 2017. (Agreed at July 2017 HWB). The submitted plan will be taken to full HWB on 10th October 2017.
Date submitted:	11th September 2017
2017/18 BCF from CCG Minimum Revenue Contributions	£34,512,837
2017/18 BCF from Local Authority Contributions (DFG)	£4,634,934
2017/18 iBCF Contribution	£10,144,557
Total agreed value of BCF and iBCF 2017/18 Plan	£49,292,329

NHS
Redditch and Bromsgrove
Clinical Commissioning Group

NHS
Wyre Forest
Clinical Commissioning Group

Sign off

Signed on behalf of the Clinical Commissioning Group	South Worcestershire CCG, Wyre Forest CCG and Redditch and Bromsgrove CCG
By	Simon Trickett
Position	Chief Accountable Officer
Date	11th September 2017

Signed on behalf of the Local Authority	Worcestershire County Council
By	Sander Kristel
Position	Director of Adult Services
Date	11th September 2017

	KLOE	Supporting Documents
Context for Worcestershire Worcestershire has focussed on delivering a “home first” principle for several years, commissioning services that support people to recover at home and avoid unnecessary hospital admissions. In addition, as part of our Pioneer status, we have been working with key providers across the county to integrate the delivery of key community based recovery services traditionally provided separately by health and social care, thereby reducing duplication, improving efficiency and increasing the capacity available to support people at home. Retaining the locality focus, three Alliance Boards are already in place across the county, all with a vision of an integrated model that wraps care around the person, integrating out of hospital services. Each Alliance Board has strong GP support and leadership with good collaborative relationships with other key partners. All three are working towards a more proactive, less hospital based system. Plans are in development for the creation of a single countywide Interim Accountable Care Board, with a parallel Financial Control Board to oversee and provide leadership for the effective development of Accountable Care across Worcestershire. The countywide Worcestershire Alliance Programme Board will continue support Alliance Boards to deliver the operational requirements, with a focus upon integration and improvement of health and adult social care in Worcestershire. Each of the Alliance Boards is focussed on the growing needs of our ageing population and the impact this has on services, including emergency admissions. As a result, developing services that support people living with frailty continues to be a high priority and the focus of many of the changes planned for 2017-2019. For the local authority, the 2017-2022 Corporate Plan 'Shaping Worcestershire's Future' lays out the organisational vision for Adult Social Care, identifying that "Our focus for Adult Social Care is to keep people with care and support needs and those that support them as independent as possible, and to enable them to have as much choice as possible about how they live their lives.". In addition to this, the Corporate Plan makes clear the ambition to work in a more integrated way with local		2.0 Hereford & Worcestershire STP 3.0 CCG Operational Plans 4.0 WCC Corporate Plan – 'Shaping Worcestershire's Future' -

NHS organisations. "We will work with health service leaders at both a strategic and operational level to support the NHS reform in developing new care models which will enable more people to receive treatment and support closer to home, recognising that some of the challenges being faced are just too vast to be tackled by single organisations in isolation, and instead would be better and more effectively solved in partnership. We recognise that people are better supported where NHS and social care staff work closely together and we will continue to develop health and care services on this basis, focusing on service delivery and partnerships to avoid historical constraints around organisational boundaries." The Better Care Fund in Worcestershire is used to fund schemes that contribute towards the achievement of these strategic objectives. The following document details how the use of the Better Care Fund in Worcestershire meets the BCF KLOEs. It is intended as a supplement to the BCF Planning Template Spreadsheet, and where appropriate, will refer to this planning template as well as other important documents.		
All parties are signed up to the Better Care Fund plan, as evidenced by the signatures of the Local Authority Chief Executive and the Clinical Commissioning Group Chief Accountable Officer on page 2 of this document. Emailed agreement dated 11th September 2017 has been attached as Appendices 18.0 and 18.1 in lieu of signatures being obtained and scanned.	1	18.0 CCG Sign-off email 18.1 LA Sign-off email
The STP Partnership Board membership includes Local Health Providers, VCS representation, Social Care, and CCGs. This ensures that providers are involved with the plan at the very highest level. The membership of the board and Terms of Reference are attached as Appendices 5.0 and 6.0. Local providers have been involved in the plan for the delivery of the STP objectives where appropriate. Worcestershire Alliance is led by a multi-agency Programme Board, including the GP Chairs of each Alliance Board, representation from the Local Medical Council, Worcestershire Acute Hospitals NHS Trust, Worcester Health and Care Trust, Worcestershire County Council and chaired by the CCG. Example notes of an Alliance Programme Board Meeting, showing membership of Acute (WAHT) and Community (WHACT) providers is attached as Appendix 7.0. There is a key focus upon supporting the local Alliances and jointly tackling key enablers – by utilising and bringing together existing infrastructure within Worcestershire such as IT, workforce development and governance.	2	5.0 STP Partnership Board Membership 6.0 STP Partnership Board Terms of Reference 7.0 Alliance Programme Board Minutes

<table>
<tr><td>Some of the plan schemes funded from the iBCF are around uplifts to providers, with the intent to stabilise and bolster the care market, reducing DTOCs. In such schemes, providers would be directly consulted on proposals. An example would be the 2-year uplift to Domiciliary Care fees for providers, which is part of Scheme 40 on the BCF Planning Template. The letter to providers detailing the outcome of the consultation process is attached as Appendix 8.0</td><td></td><td>8.0 Domiciliary Fee Review Letter</td></tr>
<tr><td>Disabled Facilities Grant.

The 2017/18 DFG has been passported to the districts in the full amounts, as shown in the table below.

<table>
<tr><th>District</th><th>2016/17 Allocation (£)</th><th>2017/18 Allocation (£)</th><th>Growth (£)</th></tr>
<tr><td>Bromsgrove</td><td>709,261.25</td><td>777,821</td><td>68,560</td></tr>
<tr><td>Malvern Hills</td><td>478,123.45</td><td>517,932</td><td>39,809</td></tr>
<tr><td>Redditch</td><td>649,144.55</td><td>713,501</td><td>64,356</td></tr>
<tr><td>Worcester</td><td>537,726.43</td><td>587,487</td><td>49,761</td></tr>
<tr><td>Wychavon</td><td>858,864.03</td><td>940,693</td><td>81,829</td></tr>
<tr><td>Wyre Forest</td><td>1,002,622.47</td><td>1,097,500</td><td>94,878</td></tr>
<tr><td>Total</td><td>4,235,741.18</td><td>4,634,934</td><td>399,193</td></tr>
</table></td><td>3</td><td></td></tr>
<tr><td>The Better Care Fund Plan 2017-2019 spreadsheet shows that the amount designated for Social Care from CCG minimum contributions has risen in line with CCG inflation.

The 2016/17 figure of £11,561,321 has risen to £11,768,269 in 2017/18. Although some of the scheme detail for 2018/19 is yet to be fully finalised, the amount designated as Social Care from CCG contributions</td><td>4, 5</td><td>1.0 BCF Planning Template</td></tr>
</table>

has been agreed at £11,991,866. This can be seen in the 'HWB Expenditure Plan' tab of the BCF Planning Template. The amount designated for Social Care does not exceed the minimum required. The increase is in line with the inflation to CCG minimum contributions. Therefore affordability is not considered an issue.		
The amount designated for Social Care from CCG minimum contributions has only risen in line with inflation to CCG minimum contributions. There are no 'big shifts' to Social Care for 2017/18 or 2018/19 and therefore it is not considered that this could destabilise the local health and social care system. Proposed schemes for the BCF are discussed first at Integrated Commissioning Executive Officer's Group (see KLOEs 18-20, and example Appendix 9.0 – Howbury Reinvestment Plan ICEOG paper) and this is an opportunity for the schemes and their impact to be discussed in a wider context.	6	9.0 Howbury Reinvestment Plan ICEOG paper
Column G of the 'HWB Expenditure Plan' portion of the BCF Planning Template denotes which schemes are considered to be Social Care. Columns D-F show that the Social Care schemes fall into a variety of scheme types, such as Reablement/Rehabilitation Services, Intensive short-term support to enable discharge home from hospital, Emergency Social Worker Interventions to reduce likelihood of Acute Admission, High Impact Change Model for Managing Transfer of Care, and Integrated care planning. This illustrates the health benefit of the Social Care schemes and how they support the overall aims of the STP.	7	1.0 BCF Planning Template
The BCF planning template shows that the amount of Better Care Fund committed to NHS-Commissioned Out of Hospital services is £19,095,900 for 2017/18. The minimum allocation required to complete the template is £9,807,570. .	8	1.0 BCF Planning Template
An additional target for non-elective admissions has not been set as part of the Worcestershire BCF plan.	9 & 10	
Self-assessment against the High Impact Change model undertaken in April 2017 sets out the key challenges and immediate priorities for the A&E Delivery Board to address. This self-assessment is attached as Appendix 10.0. The assessment was completed jointly by the Local Authority, The CCGs, the Acute provider, and the Community Provider for Worcestershire. For each change, the assessment includes a category, from a choice of 'Not Yet Established', 'Plans in Place', 'Established', 'Mature', and 'Exemplary'. Anything marked as 'Established' or higher **indicates that something has already been commissioned to support that change**. However, the assessment still	11,12, 13	10.0 Self-Assessment against HICM. 11.0 A&E Delivery Board plan

includes information on what is currently working well, and what else needs to happen as part of the work on that change. For instance Change 6 – Trusted Assessor – is marked as established:

High Impact Change Toolkit		2017/18								
Please refer to the illustrations from the High Impact Change model at the end of this document to help make your assessment. Once completed please return to jacky.edwards@abintramcl.co.uk by 24th April 2017.		Please indicate Y against the applicable category as assessed by you against the change model illustrations.					Brief description only please			
Change	Change Descriptor	Not yet established	Plans in place	Established	Mature	Exemplary	What are the key challenges?	What's working well?	What else needs to happen?	Is this an immediate priority Y/N?
6	**Trusted Assessor.** Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way			x			Changing cultures Quality of assessments developing trust	Acceptance to test trusted assessor working with a number of care homes	Learning from the test of trusted assessor to facilitate roll out of the model across the system. Explore widening the groups of staff acting as trusted assessor	Yes Linked to improving patient flow A&E LDB plan

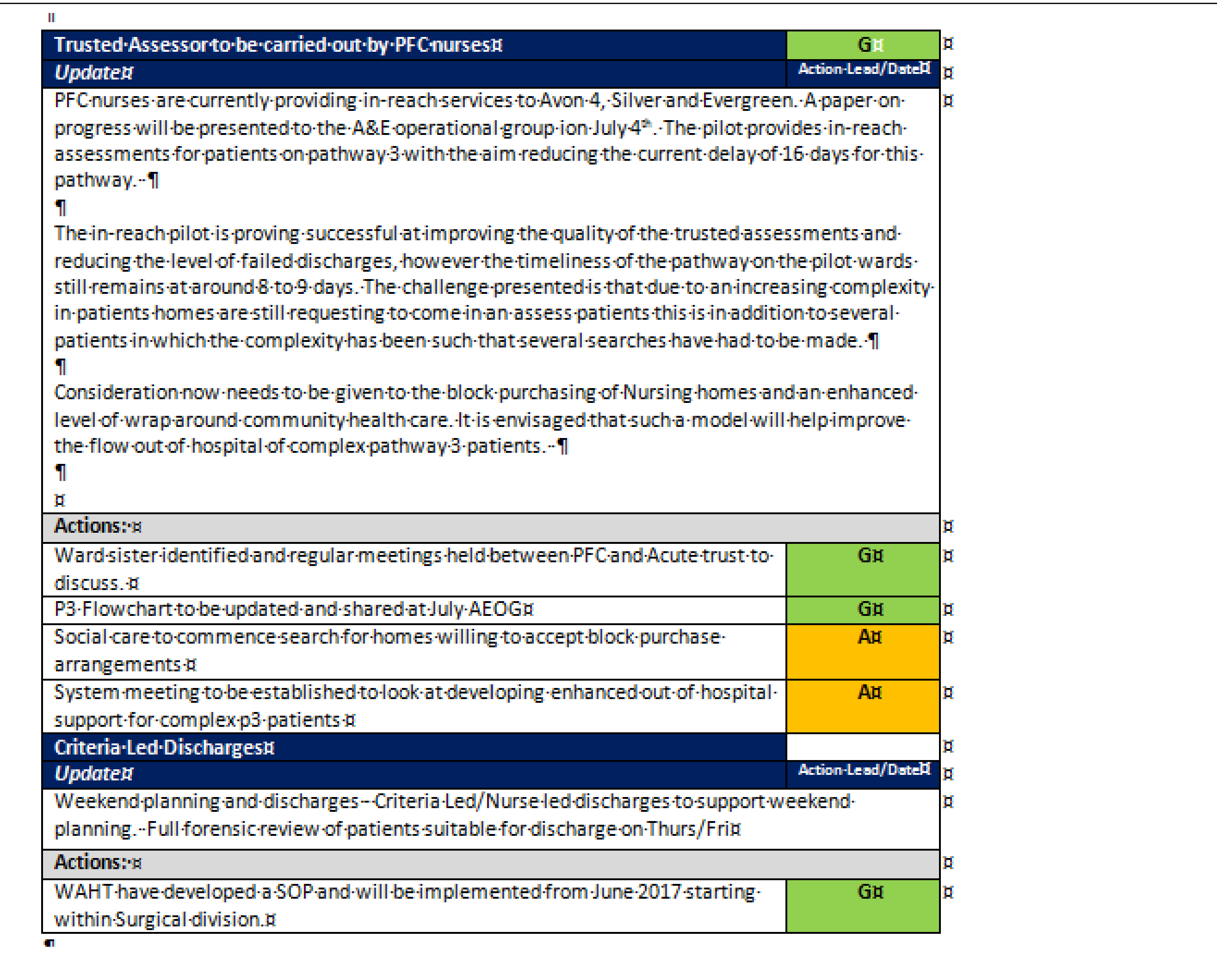
The assessment shows 'what needs to happen' in order to implement each of the 8 changes in Worcestershire, and states that the delivery will be through the work of the A&E Delivery Board Plan.

The Worcestershire A&E Delivery Board Urgent Care Programme plan (Appendix 11.0) sets out the system approach to implementing the high impact change model for managing transfers of care. The scope of the Delivery Board plan however, is wider than the HICM. **Thus the plan for delivering the HICM is within the A&E Delivery Board Urgent Care Programme Plan.**

Progress on HICM is monitored through the A&E Delivery Board, with specific monitoring on individual changes. A priority assurance example (Appendix 10.1) on the Trusted Assessor shows that progress is RAG rated and ongoing actions agreed.

1.0 BCF Planning Template

10.1 AEDB Priority Assurance



Trusted Assessor to be carried out by PFC nurses	G
Update	Action Lead/Date
PFC nurses are currently providing in-reach services to Avon 4, Silver and Evergreen. A paper on progress will be presented to the A&E operational group ion July 4th. The pilot provides in-reach assessments for patients on pathway 3 with the aim reducing the current delay of 16 days for this pathway. The in-reach pilot is proving successful at improving the quality of the trusted assessments and reducing the level of failed discharges, however the timeliness of the pathway on the pilot wards still remains at around 8 to 9 days. The challenge presented is that due to an increasing complexity in patients homes are still requesting to come in an assess patients this is in addition to several patients in which the complexity has been such that several searches have had to be made. Consideration now needs to be given to the block purchasing of Nursing homes and an enhanced level of wrap around community health care. It is envisaged that such a model will help improve the flow out of hospital of complex pathway 3 patients.	
Actions:	
Ward sister identified and regular meetings held between PFC and Acute trust to discuss.	G
P3 Flowchart to be updated and shared at July AEOG	G
Social care to commence search for homes willing to accept block purchase arrangements	A
System meeting to be established to look at developing enhanced out of hospital support for complex p3 patients	A
Criteria Led Discharges	
Update	Action Lead/Date
Weekend planning and discharges – Criteria Led/Nurse led discharges to support weekend planning. Full forensic review of patients suitable for discharge on Thurs/Fri	
Actions:	
WAHT have developed a SOP and will be implemented from June 2017 starting within Surgical division.	G

The BCF Planning Template shows (in the 'Scheme Type' column in the 'HWB Expenditure Plan' tab) that there are a number of schemes within the BCF plan that contribute specifically to the 8 changes. These are

across health and social care, and are funded by the iBCF. The budget allocated to the schemes specifically linked to the HICM is £4.2m in 2017/18:

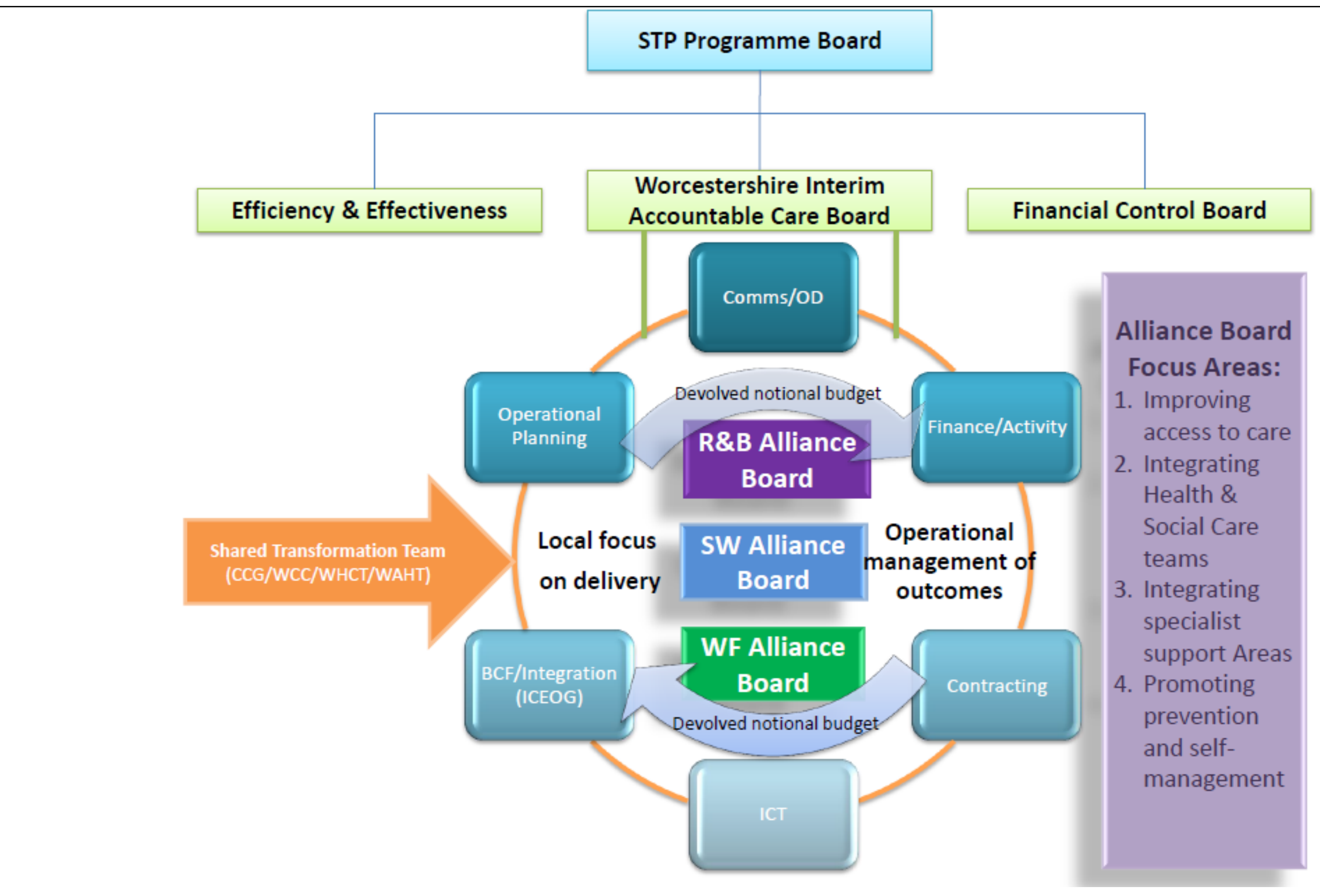
35	Reducing Pressures on the NHS - CHC/EOL Care	9. High Impact Change Model for Managing Transfer of Care	3. Multi-Disciplinary/Multi-Agency Discharge		Continuing Care		CCG			NHS Community Provider	Improved Better Care Fund	2017/18 Only	£800,000		New
36	Reducing Pressures on the NHS - Alliance Boards to include admission prevention and timely discharge	9. High Impact Change Model for Managing Transfer of Care	4. Home First/Discharge to Access		Community Health		CCG			NHS Community Provider	Improved Better Care Fund	2017/18 Only	£1,200,000		Existing
37	Reducing Pressures on the NHS - Social Workers in Acute Wards	9. High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning		Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£300,000	£300,000	New
38	Reducing Pressures on the NHS - Other Transformation Projects	9. High Impact Change Model for Managing Transfer of Care	7. Focus on Choice	Transformation Projects	Social Care		Local Authority			Private Sector	Improved Better Care Fund	Both 2017/18 and 2018/19	£1,300,000	£1,300,000	New
39	Stabilisation of the Care Market - Dementia Complex Care Provision	9. High Impact Change Model for Managing Transfer of Care	8. Enhancing Health in Care Homes		Social Care		Local Authority			Private Sector	Improved Better Care Fund	Both 2017/18 and 2018/19	£600,000	£600,000	New

In addition to this, the 'What's working well?' column of the Self-assessment document illustrates how BCF-funded schemes are already contributing to areas of the HICM, such as Discharge Planning and Systems to Monitor Patient Flow. This is to be expected when the strategic aims of the BCF in Worcestershire – such as Home First and Enabling Choice (see 'Context for Worcestershire' section above) – align so closely with the 8 High Impact Changes. Specific Better Care Fund schemes that contribute towards the maintaining flow / hospital discharge element of the high impact actions are considered to be:

Scheme	**2017/18 BCF budget (£)**
Urgent and Unplanned beds at Timberdine	218,000
Urgent and Unplanned beds spot purchased	208,000
Plaster of Paris placements	442,000
Patient Flow Centre	580,000
Discharge Pathway 1 and UPI	3,516,400
Discharge Placement Social Worker	38,000
Discharge Pathway 3	1,167,500
Band 6 Nurse in UPI	45,000
Total	**6,214,900**

Therefore support from the BCF towards the implementation of the HICM can be considered to be £6.215m

The local vision for integrating Health and Social Care Services by 2020/21 is clearly outlined in the STP document. This includes improving the patient and service user experience and reducing duplication across professional domains. The STP also clearly states that the BCF will be used to drive this strategic aim: **"Our vision by 2020/21**, ***"Local people will live well in a supportive community with joined up care underpinned by specialist expertise and delivered in the best place by the most appropriate people",*** is set out in the Herefordshire and Worcestershire Sustainability and Transformation Plan. **Our Strategic Aim** (STP Priority 3) for developing out of hospital care is to transform the way care is provided, proactively supporting people to live independently at home and providing responsive, compassionate and personalised care, delivered by an integrated health & social care workforce.	14 & 15	2.0 Hereford & Worcestershire STP 3.1 Updated Worcestershire Alliance Programme Diagram



In order to transform our services it is essential that we find more effective ways of organising services to respond to the increasingly complex and chronic health and social care needs of our population. This is to reduce duplication as well as to deliver improved outcomes for people and their carers. The evidence indicates that integration results in improved clinical outcomes and a better patient experience (Ref: Stepping up to the Place, NHS Confed and ADASS, 2016). This is supported by our engagement with local people who live with long term conditions and/or multiple needs, which highlights that people want more joined up care. In particular they tell us that the divide between health and social care often impacts on the effectiveness and the efficacy of the support they receive.

We are committed to continue developing services that work in a more integrated way; wrapping the necessary skills and competencies around people and their carers to enable them to live as independently at home for as long as possible. We

<table>
<tr>
<td>believe that redesigning services around the needs of individuals in a locality / place presents the best opportunity to improve health and well-being and reduce health inequalities whilst also helping to bring about financial sustainability.
We will use our integrated care plans (Better Care Fund) to drive this integrated front line service delivery, developing and sharing skills and competencies across organisations at locality level, and at larger levels where it makes sense to do so. This includes working with organisations outside the NHS, including public sector partners and the VCS, to meet the totality of people’s needs.
To deliver this we will:
Improve early and consistent provision of advice and information to individuals, their carers and families, to enable proactive decision making that supports and enables independence and self care
Offer more choice and control for individuals and their carers, including the wider adoption of Direct Payments/Integrated Personalised Budgets as appropriate
Embed personalised care planning, in partnership with individuals and their carers, as the central tenet to our ways of working. We will ask’ “what matters to you”, as well as “what's the matter with you.”
Ensure joined up working across disciplines through the MDT approach, supported by shared information
Develop a multi skilled workforce that can work across organisational and professional boundaries, whilst identifying tasks which can be shared across professional domains to reduce duplication and improve efficiency
Work with local communities and the voluntary/community sector, to understand where and how partnership working can support individuals and carers to manage their own health and care needs
Successful delivery will require us to nurture leadership across our workforces, to drive change in both culture and ways of working across personal and professional boundaries."</td>
<td></td>
<td></td>
</tr>
<tr>
<td><u>NC 3. Seven day services</u>

The CCG Operational Plan (Page 10) describes the ambition - and steps towards – realising 7-day services in Acute, Community, and Primary Care:</td>
<td>16</td>
<td>3.0 CCG Operational Plan

2.0 Hereford & Worcestershire STP

12.0 EPACCS Evaluation report</td>
</tr>
</table>

Ambitions for 7 day services

Acute care

- Standard 2: In Herefordshire, the Trust will undertake a major improvement programme in 2017 to address patient flow and improve performance from 48% to 80% (arrival to consultant review). Plans include the provision of a Surgical Assessment Unit which will improve performance further. In Worcestershire by November '17, all patients admitted through an emergency portal will be reviewed by a consultant within 6 hours, supported by AEC and OPAL services.
- Standard 5: In Herefordshire, The Trust plans to work closely with Worcestershire Acute Hospitals NHS Trust to improve access to cardiac interventions through a formally agreed networked arrangement and clear protocols. In Worcestershire by November '17, 95% of all patients requiring access to diagnostics will receive this within 12 hours.
- Standard 6: In Herefordshire, The Trust plans to work closely with Worcestershire Acute Hospitals NHS Trust to improve access to cardiac interventions through a formally agreed networked arrangement and clear protocols. In Worcestershire by March 17, utilise independent sector consultant telephone support for urgent care with agreed pathways to AEC, OPAL and direct diagnostics.
- Standard 8: In Herefordshire, the Trust has reviewed this and will work to maintain their performance in the top quartile. In Worcestershire by July 17, twice daily ward rounds will be undertaken on MAU, SCDU and ICU with 90% compliance 7 days per week.

Community Care

Community Services across Herefordshire and Worcestershire are working towards delivering 7-day services in line with national requirements. A summary is detailed below:

In Herefordshire we will seek public engagement to explore experiences of health care provision and build upon the insights generated to develop what a better home-based care model looks like. During 2017/18, we will transform community rehabilitation and intermediate care to improve clinical outcomes for people such as maximise independent living and recovery. We are developing our interagency frailty pathway, building upon risk stratification, falls prevention and virtual wards schemes. This is in recognition of Herefordshire demography and rising pressure on current services. Across health and social care organisations, we recognise that workforce development is fundamental to ensure that multi-disciplinary ways of working are embedded in our culture. This includes person-centred integrated care. Training, networks and closer working opportunities will be rolled out in 2017.

In Worcestershire our community hospitals are an integral partner in the local Urgent Care Pathway which supports the implementation of the priority standards. We have an established Patient Flow Centre to co-ordinate complex discharges and we are continuing to develop seven day services. For example, in our Community Hospitals we are developing a 7 day therapy service to prevent any delay in commencement of therapy. We are also reviewing and, where opportunities arise, implementing weekend medical cover so there is timely clerking of patients and enhanced 'in-house' medical support for deteriorating patients.

Primary Care (details set out in the GP Forward View submission)

- Working at scale, including the development of New Models of Care
- Improving access to general practice (examples only)
  - HCCG – review current 7 day services to ensure the location of hubs gives equitable access to extended primary care & to increase number of appointments available
  - RBCCG – During 16/17 establishment of a Redditch Access Hub which will support extended access in 17/18 across 6 of the 22 practices across the locality
  - SWCCG – November 2016 the CCG will be commissioning enhanced consultation capacity of 30 minutes per 1000 population from StayWell Healthcare
  - WFCCG - maximise opportunities in areas such as use of technology, remote consultations, data sharing and ICT central solutions to optimise delivery and value locally across practices

The Better Care Fund contributes towards this through a number of the schemes listed in the BCF Planning Template, including continued funding for the Patient Flow Centre, Additional Social Work Capacity in the Urgent Care Team, and Pathway 1, which picks up discharges to the community 7 days a week.

NC 4. Better data sharing

The sharing of information across organisations is one of the Sustainable General Practice priorities as shown on Page 12 of the STP:

A single page summary of the big priorities for this STP

Sustainable General Practice
- Prioritise investment to ensure delivery of the General Practice Forward View – developing primary care at scale "bottom-up" with practices , community pharmacy, third sector and health and care services.
- Redesign the primary care workforce, sharing resources across primary and secondary care to provide resilience and sustainability as well as capacity.
- Adopt an anticipatory model of provision – with proactive identification, case management and an MDT approach for those at risk of ill-health.
- Share information across practices and other providers to enable seamless care.
- Move to "big system management" – with real time data collection and analysis providing the intelligence to support continuous quality improvement and demand management.

Primary & Community Services
- During 2018/19, organise and provide services from locality based Multi-Speciality Community Providers (Worcestershire) and similarly formed alliance model (Herefordshire).
- Through the One Herefordshire Alliance and the Worcestershire Alliance Boards, develop population based integrated teams wrapped around general practice covering physical and mental health, wider primary and social care services and engage with the population to deliver services close to home.
- Support patients and carers to self-manage their own conditions, harnessing voluntary sector partners and communities to support independence and reduce loneliness.
- Develop plans which integrate specialist support, reducing the time taken to access specialist input and reducing the steps in the pathway. Initially focussed on supporting people living with frailty and end of life care, but adopting principles and learning quickly to a range of other priority pathways.

Prevention, self care and promoting independence
- Embed at scale delivery of evidence based prevention interventions across all providers of health and social care, achieving population behaviour change.
- Put long term life outcomes for children, young people and their families' needs at the heart of the STP agenda in order to prevent the need for more intensive and high cost services now and in the future.
- Support people to manage their own health, linking them with social support systems in their communities and identify when a non-clinical intervention will produce the best experience and outcomes for patients.

MH & LD
- Deliver the requirements of the national taskforce.
- Work with NHS specialised services to increase local child mental health services to reduce demand for complex out of county services and enable repatriation of complex cases back to their local areas.
- With local authorities, develop joint outcomes and shared care for people with learning disabilities.

Urgent Care
- Reduce the number of individual physical access points to urgent care services across the two counties by 2020/21.
- Retain 3 units with an A&E function across the two counties. Explore the need for the number of MIUs and the Walk in Centre as we move to 7 day primary care services, and the opportunity for standardised opening hours for MIUs in Worcestershire.
- Shift to home based care – explore whether we should reduce the number of community based beds across the system and shift resources to primary and community services.

Maternity
- Implement the clinical model for maternity inpatient, new born and children's services within Future of Acute Services in Worcestershire programme.
- Develop a Local Maternity system across Herefordshire and Worcestershire delivering the Better Births strategy.
- Establish a single service with specialist teams working under a common management structure, delivered locally within both counties.

Elective Care
- Develop 4 key prevention programmes to reduce demand for surgery delivered at scale and improve the likelihood of positive clinical outcomes following surgery.
- Across Worcestershire undertake a greater proportion routine elective activity on "cold" sites to reduce the risk of cancellations and to improve clinical outcomes.
- Develop strategic partnerships with external partners to secure organised access to elective surge capacity in a planned and managed way.
- Expand pan STP working on cancer services and deliver the requirements of the national taskforce.

Infrastructure
- Explore the benefits from integration in pathology, radiology and pharmacy services across the two counties.
- Develop robotic pharmacy functions and maximise the use of technology.
- Develop a single strategy and implementation plan for a joined up place based back office across all local government and NHS partners.
- Develop a place based estates strategy and a place based transport strategy.

There are various projects currently ongoing to address this priority. One example with which Worcestershire has had some early success is the **EPACCS (Electronic Palliative Care Co-ordination system)** initiative, a report on which is attached as Appendix 12.0. The evaluation explains the background for this specific system:

Background to the Project Worcestershire's bespoke EPaCCs was developed by Black Pear and Advanced and enables GPs to record patients' preferences as they near their end of life. The solution automatically generates an emailed form to WMAS and provides relevant information automatically and directly into Adastra for 111 and Out of Hours to view from within their own system. Other health care professionals involved in the care of the patient outside of the practice, will be able to access and amend the patient's EPaCCs record once work with NHS digital is complete. The GP Practice will be notified of any changes made to a record. There are not specific BCF-funded schemes in the Planning template that focus on information sharing. However, BCF support for areas that have previously been funded by base budget has freed up budget for investment in this area. <u>NC 5. Joint approach to assessments and care planning</u> Page 10 of the STP describes the vision for joined up care by 2020/21: …with joined up care… — Where individuals have a health or care need this will be delivered in an integrated way, with a single plan developed with and owned by the individual in true partnership and available wherever people access the system. Local integrated delivery teams will be in place which recognise the central role of the GP and reflect a broad range of skills and expertise from across the organisations. We will make care boundaries invisible to people using our services by removing operational boundaries between organisations and we will ensure that co-production is embedded in everything we do. This is also a key part of the Local Authority Corporate Plan (see 'Context for Worcestershire' section above). The BCF and iBCF fund various schemes that support this vision, and these can be seen in the BCF Planning Template. These include: a. Funding for Alliance Boards from iBCF b. BCF funding for the Integrated Community Equipment Service, which provides for both NHS and Social Care services c. BCF funding for Carers' Services, which includes Carer Support Advisors attached to each GP		

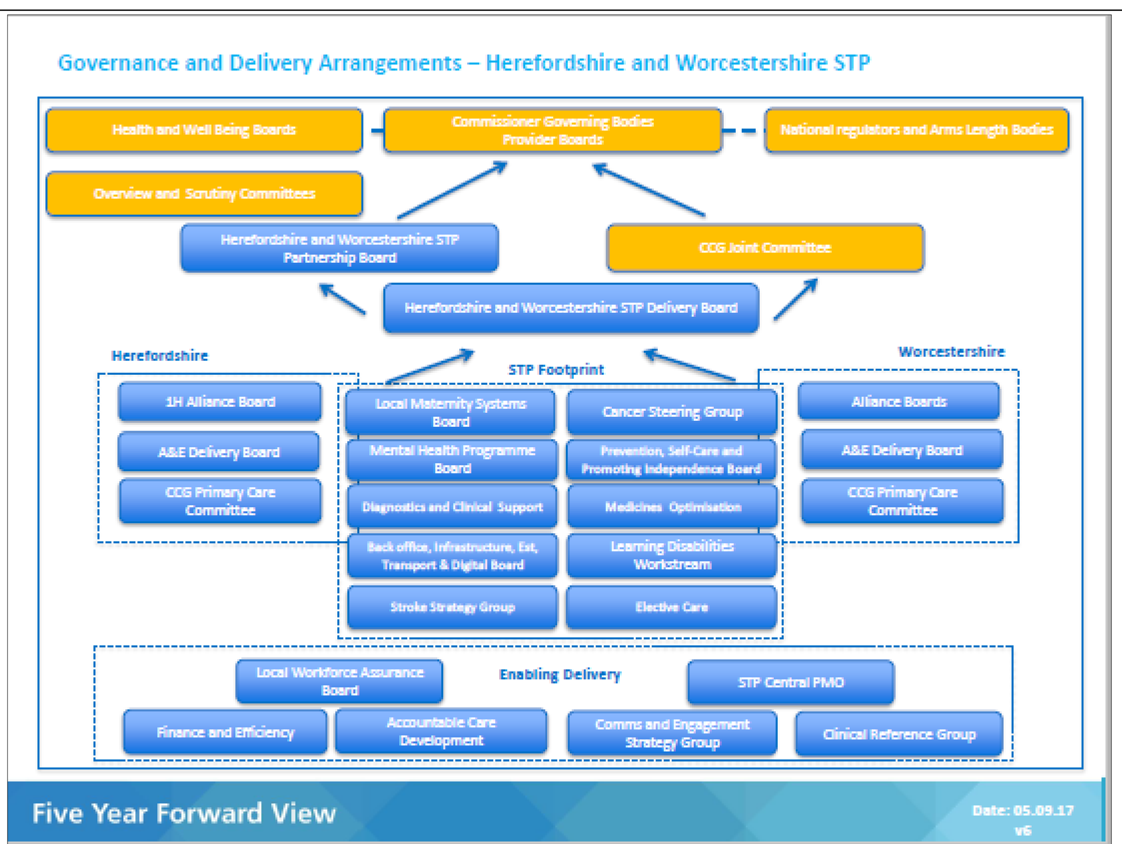
practice.		
The challenge of moving towards integration in Health and Social Care is addressed in the STP, as well as the biggest challenges (Pages 13-18). Page 25 of the STP document breaks the strategic priorities down into Delivery Programmes, and pages 34-76 of the STP document put more detail behind the plans to achieve the priorities, including details on what will be different by 2020/21. The CCG Operational Plans also include an assessment of the challenges in delivering the strategic aims of the STP – the issues that our strategic plans aim to resolve: **Our biggest challenges from the STP** **Health and Well Being** • Closing the gap between life expectancy and healthy life expectancy • Addressing premature mortality rates vary significantly between the 2 counties • Tackling premature mortality concerns for specific conditions • Reducing the gap in mortality rates between advantaged and disadvantaged communities • Improving outcomes for children and young people which are lower than expected for the population we serve • Improving mental health and well being • Tackling unhealthy lifestyles, such as poor diet, smoking, alcohol and physical inactivity **Care and Quality** • Addressing the lack of capacity and resilience in primary care and general practice • Improving social care provider capacity and quality • Supporting Worcestershire Acute to implement the CQC special measures improvement plan • Improve performance and outcome for urgent care • Improve performance against elective care referral to treatment times and access to mental health services • Improve performance of cancer waiting times • Increase dementia diagnosis rates • Improve outcomes from maternity services **Finance and Efficiency** • Address the total financial challenge for the system by the end of 2020/21 of £336m • Deliver a combined QIPP programme across the four CCGs of £45.7m in 17/18 • Achieve an appropriate balance between the need to live within individual control totals in the short term and the delivery of a balanced and sustainable system in the long term • Develop an implementation plan to address the significant disparity in the scale of the financial challenge across the STP footprint	17	2.0 Hereford & Worcestershire STP 3.0 CCG Operational Plan

The CCG Operational Plans state the desired impact ('Outcome') of each deliverable measure within the plan. Below is page 32 of the plan, which highlights the deliverables of Integrated Primary and Community services, which is just one of the areas being supported by the Better Care Fund (through schemes such as Night Sitters, Enhanced Care Teams, and Pathway 1 discharge)

Delivery Plan – Priority 3B: Integrated Primary and community services - Worcestershire

Deliverables	Milestones	16/17		17/18				18/19				Outcome	9 Must Do's
		3	4	1	2	3	4	1	2	3	4		
3B1 From 2018/19 onwards, organise and provide services from locality based Multi-Speciality Community Providers.	MCP development Governance structure established and fully constituted	✓										By April 2019 we anticipate having integrated primary and community services commissioned through an overarching Multi-specialty Community Provider (MCP) or similar alliance framework that supports the efficient functioning of locality based integrated teams. Care will be delivered by an integrated workforce, spanning primary, community, secondary and social care, organised around natural neighbourhoods.	1.1 2.2 2.3 3.1 3.2 3.3 3.4 3.5
	Alliance boards fully constituted, with agreed work programmes and associated shadow population based budget												
	Local community, general practice and other providers engaged in development of new clinical model, Alliance Boards												
	Population based budgets calculated at locality level, ready for shadow implementation 17/18 Q1												
	Multi agency shared Transformation team established to provide dedicated support to drive and manage the transformation												
	Shared local vision based on a new clinical model agreed and documented												
	Workforce plan completed												
	Agree commissioning process, contractual approach and timeline												
	Award contract												
3B2 Through the Worcs Alliance Boards, develop population based integrated teams wrapped around general practice covering physical and mental health, wider primary and social care services and engage with the population to deliver services close to home.	Agree relationship between delivering improved access to primary care and other community based urgent care services at neighbourhood level.											An integrated frailty pathway will be in place . Patients and their carers will be fully involved in the assessment of their needs. Patients will have one first point of contact in a crisis.	1.1 2.2 2.3 3.1 3.2 3.3 3.4 3.5
	Agree Commissioning /contractual implications of contract												
	Estates requirements determined and reflected in Estates plan completed												
	Testing pilot phase begins												

There are overarching governance arrangements for the STP, and there are specific governance arrangements for the Better Care Fund. The governance arrangements for the STP included as Appendix 2.1, and show how the different delivery groups and alliance boards feed into the STP Delivery Board, with governance over this from the Commissioner Governing Bodies and Health and Wellbeing Boards for Herefordshire and Worcestershire.	18 & 20	2.1 Updated Hereford & Worcestershire STP Governance Arrangements 13.0 Example



For the Better Care Fund in Worcestershire, overall governance is a more direct route to the Health and Wellbeing Board. ICEOG (Integrated Commissioning Executive Officers Group) comprises membership from CCGs and the Local Authority, including the Director of Adult Social Care, and the Chief Accountable Officer of the CCGs. ICEOG meets on a monthly basis and receives monthly reports on BCF finances, as well as regular reports on the effectiveness of BCF schemes, outcomes and benefits realisation, capturing learning, and addressing underperforming schemes. ICEOG is overseen by the Health and Wellbeing board, and quarterly reports on the BCF, as well as any interim reports that need HWB attention (such as plans for BCF investment) are taken to HWB after sign-off from ICEOG.		ICEOG BCF monitoring paper.

Example minutes of an ICEOG BCF monitoring report is attached as Appendix 13.0.		
The STP (Page 14) acknowledges health inequalities in Worcestershire, including the mortality variation between different social groups: **Our biggest challenges – health and well-being** There is a gap in mortality rates between advantaged and disadvantaged communities, particularly in Worcestershire – Our health and well-being strategies identify approaches to tackle this gap, and these are reflected throughout the STP. The range of years of life expectancy across the social gradient at birth is 7.8 years in Worcs and 4.9 in Herefordshire. In our rural areas, health inequalities can be masked by sparsity of population but we know differences exist which need to be tackled, including issues of access. Some outcomes for children and young people which are lower than expected: • **School readiness** - In Herefordshire only 40% of Children receiving free school meals reach a good level of development at the end of the reception school year. In Worcestershire the figure is 46%. Both are worse than the England average of 51% • **Neonatal mortality and stillbirth rates** – These are amongst the worst in the comparative groups for both counties. In Herefordshire it is 9.7 per 1,000 live births and Worcestershire 7.5 per 1,000 • **Obesity** – In Herefordshire 22% and in Worcestershire 23% of reception class children are obese or overweight • **Alcohol admissions under 18s** – In Herefordshire the figure of 56 per 100,000 population and in Worcestershire 46.5 per 100,000 are both significantly higher than the England average of 40. This equates to an additional 30 admissions in Herefordshire and 37 in Worcestershire per annum • **Breast-feeding initiation** rates are both below the national average (68% in Herefordshire and 70% in Worcestershire with a national figure of 74%). • **Occurrence of low birth weight** in both counties is amongst the worst of their comparator groups • **Teenage conceptions** - 24 per 1,000 in Herefordshire and 25 per 1,000 in Worcestershire are the highest rates amongst their comparator groups **Mortality variation between different social groups** Difference between less deprived and more deprived areas Herefordshire: 4.9 yrs Worcestershire: 7.8 yrs **Areas of concern regarding poor outcomes for children and young people across both counties** Younger ——— Older • Neonatal mortality and still births • Low birth weight • Breastfeeding rates • School readiness • School age obesity • Under 18 alcohol admissions • Teenage conception rate This is also picked up in the CCG Operational Plans (page 6), and the reduction of health inequalities is embedded in all areas of the CCG Delivery Plan, for example deliverable 4D11 addresses factors that prevent uptake of cancer screenings in some areas or social groups (Page 41):	19	2.0 Hereford & Worcestershire STP 3.0 CCG Operational Plan 17.0 Worcestershire Integrated Carers Hub Social Value Report

4D11 Far greater uptake of screening programmes across the population	H&W - Work with Breast and Bowel Screening service to review potential for integrated working with respective symptomatic services.										Earlier recognition and faster diagnosis of cancers, resulting in improved survival rates. Increased update of screening programmes.
	Work across health and social care to increase uptake to screening by addressing the factors that prevent uptake										

The Better Care Fund contributes to addressing inequalities in a number of schemes. A good example is the Integrated Carers Hub, which is one of the schemes funded from the £1.2m Carers budget in the BCF. Appendix 17.0 shows some example case studies in which the services at the hub have addressed the theme of 'Providing support for individuals or groups facing greater social or economic barriers'.		
Key risks to the delivery of the strategic plans in Worcestershire are included in the STP document (pages 30-31). With the level of transformational changes being implemented as part of the STP, it is key that risks are monitored closely and for the STP, as well as mitigating actions being agreed. This takes place at STP partnership board – an example of the Risk Register is attached as Appendix 14.0. Risks relating specifically to BCF scheme delivery are reported first to ICEOG, in accordance with the BCF governance arrangements detailed earlier in this document. Risks are discussed on a monthly basis and are rated for likelihood and potential impact, as well as mitigating actions being agreed. An example of the ICEOG risk register from July 2017 is included as Appendix 15.0. Note that the scope is wider than just BCF schemes, as the BCF is just one part of ICEOG remit. An example of BCF risk monitoring through ICEOG would be the Integrated Community Equipment Service risks below:	21	2.0 Hereford & Worcestershire STP 14.0 STP risk register 15.0 ICEOG Risk Register July 2017

Risk no/ category	Description (Causal factor)	Controls already in place / Activity undertaken in the last 3 months to reduce/mitigate the risk	Additional action planned	Date raised/ Risk level changed	Likelihood	Impact	Current Rank	Accountable Officer	Governance	ICEOG	CMB	CQR
Integrated Community Equipment Service (ICES)										Y	Y	Y
(F)	Potential for overspend on equipment within ICES with financial implications for both CCGs and WCC	Action plan in place with WHCT to reduce predicted overspend has been effective in bringing adults equipment budget in around budgeted level for 16/17. Ongoing discussions between adults and children's commissioners around integration and pooling of budgets	Adults and Children's continue to monitor budgets closely and more proactive forecasting is planned. Commissioning action plan for the future includes policy refresh, updated specification and comprehensive Needs Assessment. Revised specification and refresh of policies being progressed by Commissioning Manager - report presented to ICEOG July 2017 and subsequent plan being developed.	13/08/2014 (19 R) Risk level reduced: 26/1/15	High	Substantial	12	Fran Kelsey / Philippa Coleman	CCG Governing Bodies/ Cabinet	Y	Y	N
(H)	ICES service unable to respond effectively to increasing demand resulting in unsafe practice or failure to meet needs appropriately.	BCF funding agreed to support increased demand for equipment as a result of demographic pressures. New workstreams which will have a need for equipment must be identified by Lead Commissioners ASAP. Report to ICEOG Feb 2017 setting out new commissioning workplan.	To continue to monitor growth of service to pre-empt issues recurring. Potential implications of the Care Act and possible increase in assessments. Forecasting work taking place for proactive budget planning and monitoring 2017/18.	01/04/2013 (15 A) Risk level reduced: 11/2/14	Low	Critical	14	Fran Kelsey / Elaine Carolan	CCG Governing Bodies / Cabinet	Y	Y	Y
(SF)	Change in law has led to a reclassification of licence for ICES delivery vehicles. This has led to drivers needing an enhanced licence to drive vehicles and vans needing to be regularly weighed. Issues retaining and recruiting trained staff. Vans off road one day a month for weighing.	Further recruitment by WHCT ongoing. Opportunity to purchase or lease smaller vans with lower classification to replace currently hired vehicles. Service is managing situation and covering with agency staff where essential. Agreement to short-term (12 month) hire of three vehicles April 2017 to address immediate issues re driver recruitment and vehicle reliability etc.	Long-term leasing options being explored. Overall arrangements for vehicles will be discussed and agreed through the spec and contract exercise. Three new vans have been hired through Northgate via WCC fleet services and converted to meet ICES needs. Suitable drivers have now been recruited. David Griffiths (Procurement Manager) leading on discussions with transport re new transport plan. Proposals to come to ICEOG for discussion/sign-off	23/03/2015 (12A) Risk level reduced: 31/7/17	Medium	Substantial	11	Fran Kelsey / Elaine Carolan	CCG Governing Bodies / Cabinet	Y	Y	N

Historically, the BCF is considered to be 'ring-fenced' in Worcestershire. This means that ICEOG will aim to manage BCF variances within the fund as much as possible before requiring additional resource.

22 & 23

The regular budget monitoring reports to ICEOG will highlight any variances on individual schemes, and to the BCF as whole. The Local Authority and CCGs may consider the following options.

1. To take corrective action to reduce or eliminate the variance i.e. reduce the planned activity in a scheme.

2. For one organisation to support individual scheme variances, if this is considered preferable to corrective action. There are a number of BCF schemes which are considered to be high-risk as the spend is driven by demand –Pathway 1, Pathway 3 placements, Plaster of Paris placements, Enhanced Interim Packages of Care, and Urgent & Unplanned Placements, with budgets totalling £5.35m. For these and any other schemes, stakeholder organisations may wish to support

overspends, rather than limit or cease activity, due to the potential impact on the system. There is no theoretical limit to the amount of variance in individual schemes. This extra support to the BCF would be approved through the mechanisms of the responsible organisation in the first instance. 3. For the CCGs and Local Authority to jointly support the variance for the overall BCF, net of any individual variance support as per point 2. The ratio of support would be agreed by ICEOG on a case-by-case basis, but could typically be a 50% liability for the overall fund overspend for the Local Authority, and 50% for the CCGs. There is no theoretical limit to the overall variance in BCF spend. The overall variance and associated liability for the organisations forms part of the regular budget monitoring reports to the Health and Wellbeing board for final agreement. The support for both individual and overall BCF variances by both the CCGs and LA does not result in an amended BCF plan, as it is not considered to be a planned variance. .		
The BCF Planning Template shows that the minimum contributions have all been included ('HWB Funding Sources' tab): (see table below)	24,25, 26, & 27	1.0 BCF Planning Template

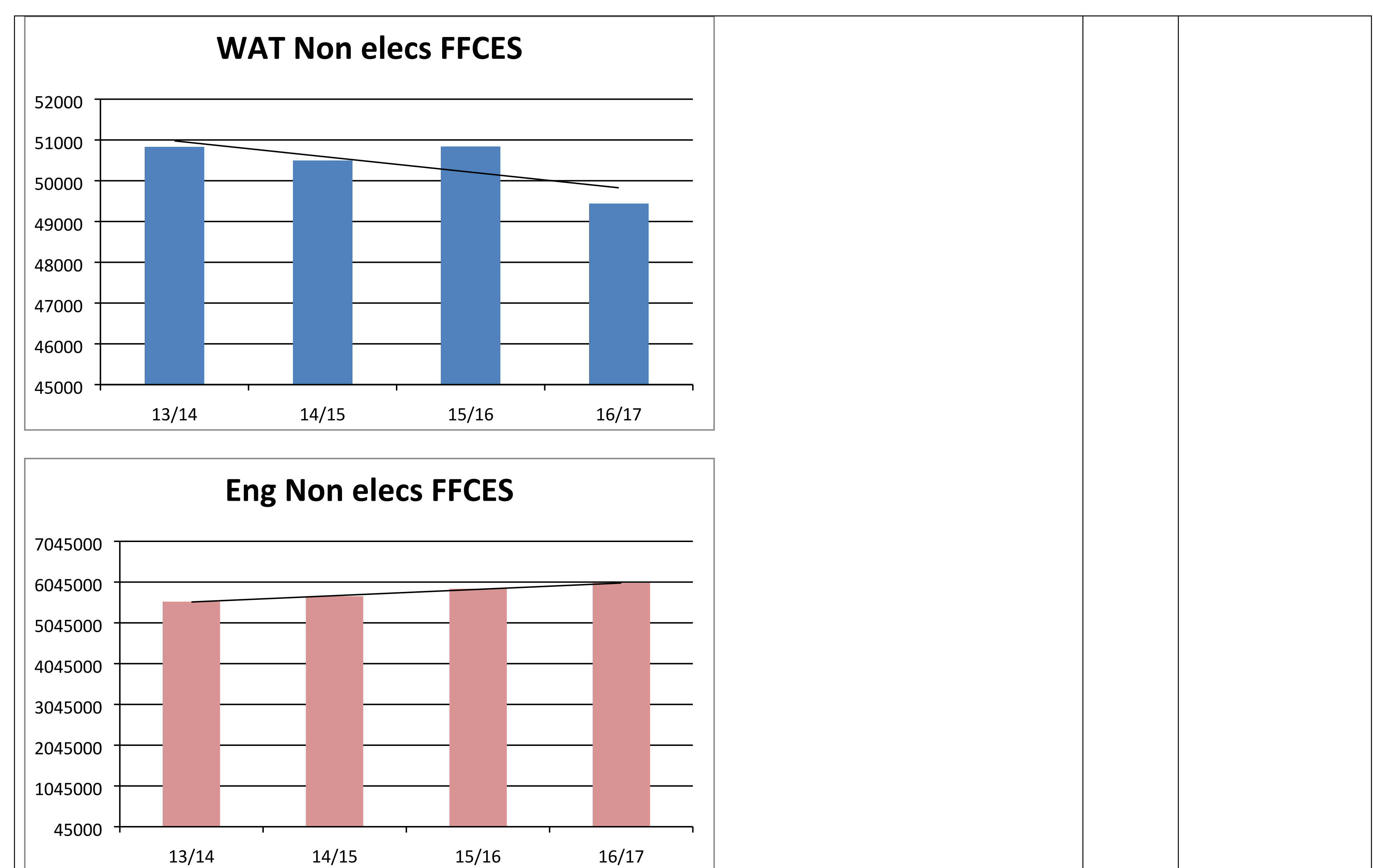
	2017/18	2018/19
Total BCF pooled budget	**£49,292,329**	**£53,586,286**

The BCF Planning Template ('HWB Expenditure Plan' tab) shows that the contributions have all been included in the list of scheme budgets. This is illustrated by the Running Balances table showing zero (£0) entries

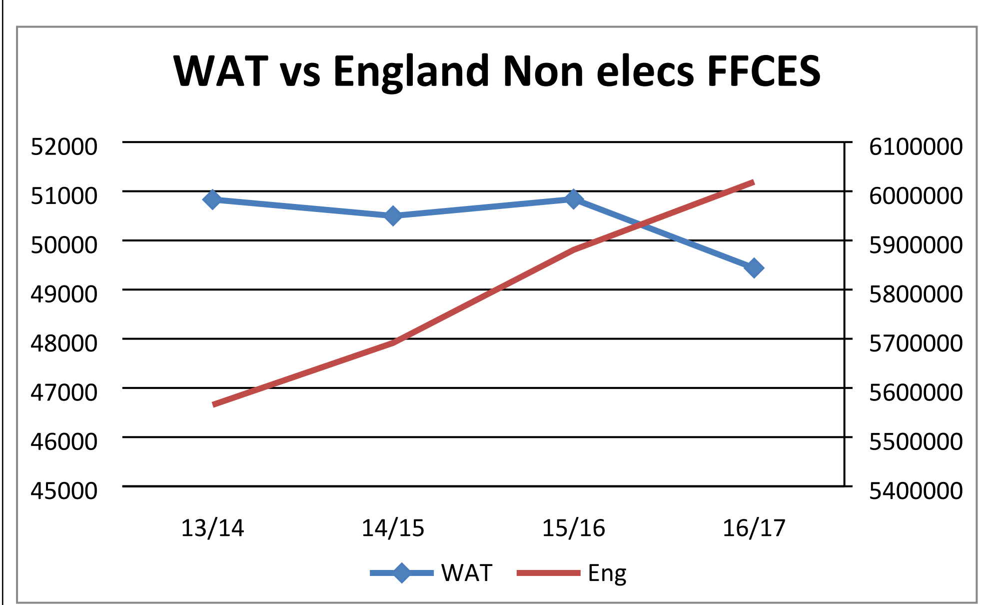
Link to Summary sheet

Running Balances	**2017/18**	**2018/19**
BCF Pooled Total balance	£0	£0
Local Authority Contribution balance exc iBCF	£0	£0
CCG Minimum Contribution balance	£0	£0
Additional CCG Contribution balance	£0	£0
iBCF	£0	£0

The amounts for Care Act Implementation, Carers' Services, Reablement and the Disabled Facilities Grant can be seen in the titles and categorisation of the BCF and iBCF schemes in the 'HWB Expenditure Plan tab. The breakdown of the iBCF schemes in the BCF Planning Template (Schemes 33-40) clearly shows the distribution across the three purposes of the grant – Meeting Adult Social Care Needs, Reducing Pressures on the NHS, and Stabilisation of the Care Market.		
<u>Emergency Admissions</u> The CCG operational plans compare the performance in Worcestershire to national performance for Emergency Admissions. The target figures entered into the BCF Planning Template ('HWB Metrics' tab) reflect the operational plans. Worcestershire CCG Emergency Admissions to Worcestershire Acute Hospitals NHS Trust have remained relatively flat in recent years, and bucked the trend nationally in 16/17. End of year figures are shown below and demonstrate that admissions in 2016/17 are the lowest in the last four years. Compared to national figures these demonstrate a good degree of demand mitigation that has occurred in the local health economy. *Source: MAR data*	28	1.0 BCF Planning Template. 3.0 CCG Operational Plan



WAT Non elecs FFCES
52000
51000
50000
49000
48000
47000
46000
45000
13/14
14/15
15/16
16/17
Eng Non elecs FFCES
7045000
6045000
5045000
4045000
3045000
2045000
1045000
45000
13/14
14/15
15/16
16/17



Our strategy for achieving the non-elective reductions

We have an established transformation programme that continues to target the reduction in avoidable emergency admissions. The information above suggests that this has been successful to date in mitigating demand on our main provider. The programme is built around two main facets relevant to BCF plans:

1) An out of hospital strategy built around Alliance Boards overseeing the development of integrated community teams and virtual wards closely aligned to GP practices. There are three operational Alliance Boards in the County and they are forming the foundations of our strategy to develop a single multispecialty health community provider model supporting locality delivery teams, aligned to Social Care locality teams. A core objective of this part of the programme is to provide proactive care to help avoid the need for people to use unplanned care services. In the main this area focuses on three key areas - frailty admissions, stroke, and falls.

Integrated Health & Social Care teams - these have been implemented in a phased approach across the county, which commenced in January 2017 providing services to a registered population based in natural neighbourhoods and delivering integrated community MDTs. Co-located with general practice, supported by information that is shared across providers and practices and implementation of a risk stratification approach which supports the identification of people living with frailty, the integrated care service will deliver proactive care, ensuring that personalised care plans are in place to support those people identified as most at risk of deterioration and admission to hospital. Proactive admission avoidance is a core component of the model, but the service will also provide a reactive rapid response service to avoid a hospital admission or to support the discharge of a patient from hospital as soon as their needs can be met in their usual place of residence. The teams will also focus specifically on a limited number of patients who attend ED frequently and provide maintenance to house-bound patients with long term conditions who have on-going clinical care requirements.

Support for people living in Care Homes – Building on services already commissioned and support provided to Care Home staff, a county wide programme of work has been established aimed at preventing unnecessary admissions from care homes to secondary care and supporting the early discharge of residents from hospital to their care home, thereby reducing their length of stay in an acute or community hospital setting. Linked to the development of neighbourhood based integrated health and care team, current practice is being benchmarked to national evidence and to the learning emerging from the Vanguards focussed on delivering enhanced care home services.

2) Development of Ambulatory Emergency Care Pathways that support the rapid diagnosis, treatment and turnaround for patients with specific ambulatory conditions that, whilst they require hospital treatment, they do not require admission. There are specific pathways being developed including UTI, COPD, Pneumonia, Abdominal Pain, Headache etc.

A number of BCF schemes directly support this measure, including Night Sitters, and Urgent and Unplanned beds. These are established schemes and so their impact was included in the calculation of existing targets.

A targeted further reduction in emergency admissions (i.e. a reduction larger than that in the operational plans) was not considered appropriate for the Better Care Fund plan.	29 & 30	
The BCF Planning Template 'HWB Metrics' tab shows that a metric has been set for Admissions to Residential Care. It should be noted that this target refers to Social Care-funded admissions for people aged 65 and over only. The figure is 635 which is a reduction of 1.2% on the figure observed in 2016/17 (643). This target for small improvement reflects the ambition for decreasing residential admissions in the local authority corporate plan, whilst recognising that there are significant demographic pressures in Worcestershire for this cohort of the population. The Local Authority Corporate Plan states the ambition to see people supported in their own communities, as an alternative to being placed in a residential care home: *"We are keen to see people supported in their own communities, and will seek to increase the number of people in supported living arrangements or extra care arrangements, which provide all the benefits of independent living in an owned or rented home but with flexible home care support available on site, if and when required. We will invest in supported living accommodation units and the provision of extra care housing for older people recognising the improved outcomes they deliver to those people with care and support needs, enabling them to maintain their independence and avoid the use of institutional care provision, as much as possible. We recognise that carers play a vital role in society and we will continue to support them by working closely with the Worcestershire Carers' Association. We will ensure that good quality, accessible information and advice is readily available through our website "Your Life Your Choice", which was visited by more than 25,000 visitors in 2015/16."* Page 11 of the plan also states that minimising the number of permanent residential and nursing admissions is one of the measures on which the success of the strategy will be judged.	31	1.0 BCF Planning Template. 4.0 WCC Corporate Plan – 'Shaping Worcestershire's Future'
The BCF Planning Template 'HWB Metrics' tab shows that a metric has been set for the number of people still at home 91 days after discharge from hospital to rehabilitation or reablement. The target figure in the planning template is 86.1%. The target was set with the aim to improve performance – out-turn for 2016-17 was 78.3% against the target for 2016-17 (which was also 86.1%).	32	1.0 BCF Planning Template

The decision was made to maintain the target for 2017-18 at the same level, reflecting the aim in the WCC Corporate Plan to ensure people remain independent for as long as possible. Performance for the Q1 2017-18 is improving – showing 83.9% for June 2017 A number of BCF schemes directly support this measure, including Pathway 1, UPI and Stroke Rehabilitation. These are established schemes and so their impact was included in the calculation of existing targets.		
The BCF Planning Template 'HWB Metrics' tab shows the system-wide DTOC targets for Worcestershire for each quarter in 2017/18 and 2018/19. The detailed DTOC template, which shows the attribution split between NHS, Social Care, and Joint DTOCS is attached as Appendix 16.0. All partners have agreed to the target in this template The starting point for the targets in the BCF Planning Template are the target figures issued by NHS England. The target given by NHS England is 1,782.5 Delays per month across the whole system, which has been assumed as a 30-day month at the 2017 population. The target per month has been derived by taking this figure and adjusting for the days per month and the increase to the population projection from Q4 17/18. Appendix 16.1 shows how the figures in the BCF Plan have been worked up from the NHS targets shown below, distributed by NHS England in August 2017:	33	1.0 BCF Planning Template 16.0 September Worcestershire DTOC Return 16.1 DTOC Reconciliation Document

LA Name	New Targets (rates per 100,000). Lowest figure from the Dboard or BCF returns				New Targets (total delays in month)			
	REVISED Total Delayed Days per day per 100,000 18+ population	**REVISED NHS** Delayed Days per day per 100,000 18+ population	**REVISED Social Care** Delayed Days per day per 100,000 18+ population	**REVISED Both** Delayed Days per day per 100,000 18+ population	**REVISED** Total Delays in month	**REVISED NHS Total** Delays in month	**REVISED Social Care** Total Delays in month	**REVISED Both Total** Delays in month
Worcestershire	12.7	5.5	2.6	4.6	1,785.2	770.6	364.3	650.4

Page 1

NHS DTOC targets are in line with the expected reductions issued by NHSE. Following advice from NHSE, 50 delayed days per month have been moved from the Jointly attributable target to the Social Care target. The total has therefore stayed in line with the figures issued by NHSE. as per the updated DTOC return, which is attached as Appendix 16.0, and a reconciliation between this return and the figures in the BCF Planning Template is included as Appendix 16.1. The figures are in line with the targets passed down by NHS England, on the basis that the figures for Social Care-attributable DTOCs are for Acute and Consultant-led beds only.	34	16.0 September Worcestershire DTOC Return 16.1 DTOC Reconciliation Document
Following advice from NHSE, 50 delayed days per month have been moved from the Jointly attributable target to the Social Care target. The total has therefore stayed in line with the figures issued by NHSE. as per the updated DTOC return, which is attached as Appendix 16.0, and a reconciliation between this return and the figures in the BCF Planning Template is included as Appendix 16.1. The figures are in line with the targets passed down by NHS England, on the basis that the figures for Social Care-attributable DTOCs are for Acute and Consultant-led beds only.	35	16.0 September Worcestershire DTOC Return 16.1 DTOC Reconciliation Document
The target takes into account the impact of BCF and iBCF schemes, on the basis that the figures for Social Care-attributable DTOCs are for Acute and Consultant-led beds only. Specific schemes have been introduced this year to ensure that the targets in the template can be met, including Social Workers on Acute Wards, and continuing funding for The Grange over the winter period.	36	16.0 September Worcestershire DTOC Return 16.1 DTOC

		Reconciliation Document
NHS and Social Care providers have been involved with the narrative, through discussions at the A&E delivery board.	37	
The Narrative Plan, BCF Planning Template and DTOC template have been locally checked, through circulation to ICEOG members before sign-off.	38	