Worcestershire County Council

Agenda

Health and Well-Being Board

Tuesday, 1 November 2016, 2.00 pm
County Hall, Worcester

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Health and Well-Being Board
Tuesday, 1 November 2016, 2.00 pm, Council Chamber, County Hall

Membership

Full Members (Voting):

Mr J H Smith (Chairman)	Cabinet Member with Responsibility for Health and Well-being
Dr C Ellson (Vice Chairman)	South Worcestershire CCG
Ms J Alner	NHS England
Mr M L Bayliss	Cabinet Member with Responsibility for Children and Families
Mrs S L Blagg	Cabinet Member with Responsibility for Adult Social Care
Dr R Davies	Redditch and Bromsgrove CCG
Catherine Driscoll	Director of Children, Families and Communities
Mr S E Geraghty	Leader, Worcestershire County Council
Dr Frances Howie	Director of Public Health
Dr A Kelly	South Worcestershire CCG
Sander Kristel	Director of Adult Social Services
Clare Marchant	Chief Executive, Worcestershire County Council
Peter Pinfield	Healthwatch, Worcestershire
Dr Simon Rumley	Wyre Forest CCG
Simon Trickett	Redditch & Bromsgrove & wyre Forest Clinical Commissioning Group

Associate Members

Mrs C Cumino	Voluntary and Community Sector
Chief Supt. L. Davenport	West Mercia Police
Cllr. Karen May	North Worcestershire District Councils
Cllr. Gerry O'Donnell	South Worcestershire District Councils

Agenda

Item No	Subject	Presenter	Page No
1	**Apologies and Substitutes**		

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Date of Issue: Friday, 21 October 2016

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2	**Declarations of Interest**		
3	**Public Participation** *Members of the public wishing to take part should notify Legal and Democratic Services in writing or by e-mail indicating the nature and content of their proposed participation on items relevant to the agenda, no later than 9.00am on the day before the meeting (in this case 9.00am on Monday 31 October 2016). Enquiries can be made through the telephone number/e-mail address below.*		
4	**Confirmation of Minutes**		1 - 14
5	**Shaping Worcestershire's Future - Our Plan for Worcestershire 2017-2022**	Simon Geraghty 2.10-2.20pm	15 - 32
6	**Sustainability and Transformation Plans**	Sarah Dugan / David Mehaffey 2.20-3.05pm	
7	**Emotional Well-being and Mental Health Transformation Plan for Children and Young People**	Hannah Needham 3.05-3.15pm	33 - 86
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10	**Better Care Fund**	Anne-Clarke 3.35-40pm	133 - 138
11	**Future of Acute Hospital Services**	Simon Trickett 3.40-3.50pm	
12	**Future Meeting Dates** **Private Development meetings** (2pm, Lakeview Room) • 6 December 2016 **2017** **Public meetings** (All at 2pm, Council Chamber) • 14 February 2017 • 25 April 2017 • 11 July 2017 • 10 October 2017		

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Health and Well-Being Board
Tuesday, 13 September 2016 Council Chamber, County Hall - 2.00 pm

Minutes

Present:

Mr J H Smith (Chairman), Dr C Ellson (Vice Chairman), Ms J Alner, Mrs S L Blagg, Catherine Driscoll, Mr S E Geraghty, Dr Frances Howie, Sander Kristel, Clare Marchant, Peter Pinfield and Simon Trickett.

Also attended:

Sarah Dugan, Sue Harris and David Mehaffey and Sarah Dugan(for item 5); Elaine Carolan, Lucy Hancock, Sandra Hill Sandra Rohan Kickam and Pete Sugg (for item 9); Rachel Barrett, Richard Keble and Caroline Kirby (for item 10); and Derek Benson, Felix Borchardt and Sue Haddon (for item 11) and Anne Clarke (for item 12).

Available papers

The members had before them:

A. The Agenda papers (previously circulated);

B. The Minutes of the meeting held on 10 May 2016 and 14 June 2016 (previously circulated).

Copies of documents A and B will be attached to the signed Minutes.

379 Apologies and Substitutes

Apologies for absence had been received from Carole Cumino, Lee Davenport, Anthony Kelly, and Karen May the new North Worcestershire District Councils Representative.

Jonathan Sutton attended for Carole Cumino.

380 Declarations of Interest

None

381 Public Participation

None

382 Confirmation of Minutes

The minutes of the meetings held on 10 May 2016 and 14 June 2016 were agreed to be a correct record of the meeting and were signed by the Chairman.

383 Sustainability and Transformation Planning

Sarah Dugan summarised presented information regarding the Sustainability and Transformation Plan. Board members were familiar with the concept of addressing the triple aim gap of Health and Well-being, Care and Quality and Finance and Efficiency; but

following meetings with the national team the Programme Board was particularly focussing on what money would be available in 5 years' time – what future allocations would be given to CCGs rather than what would be done differently with the current spend.

Under the structured budget prioritisation work, 14 different work programmes had been identified, each one led by a Chief Executive Officer – but prevention and children and young people were themes which ran through all the different programmes. Analysis was taking place to find benchmarks which could be compared to other STP areas. The analysis would help to ensure that Herefordshire and Worcestershire were being as efficient as possible. Help was being received from the Commissioning Support Agency who had supported Board members in a programme budgeting exercise.

All areas of investment should show a decrease in costs elsewhere. For example investment in care at home should see a decrease in acute care costs. Back office and infrastructure efficiencies were also being sought across the public sector.

All local STPs had an allocation which could be invested in areas of national priority such as the digital agenda, 7 day services and parity for mental health services. The requirement for provider efficiencies was not yet included in the plans but once the plans had been worked up they would be brought back to the HWB and also to scrutiny.

Engagement with Healthwatch and the VCS was on-going and once draft plans had been completed engagement would occur with a wider group of stakeholders. Sue Harris had been working on an engagement strategy which would include public, patients and staff.

The next submission would be made on 21 October and as there would be a very tight turnaround it was proposed that proposals would be emailed to members of the HWB for comment. A full report would then be brought to the meeting on 1 November.

During the discussion, Board members queried how the consultation would be approached:

- The plan was the beginning of the process and then specific consultation would occur and inform some of the detail before various parts of the plan were implemented;
- The strategic plan being submitted on 21 October

would outline the series of changes that would need to happen and then consultation would occur on those proposals as appropriate. Cabinet Office guidelines suggested best practice should be for consultations to be for 12 weeks but it depended on the size of the changes;

- Board members felt that although consultation would happen prior to the implementation of certain proposals, they felt that general issues such as prevention, self- care and back office efficiencies should be communicated to the public straight away. Also the STP should be discussed at each HWB so that all members could take details back to their organisations. There was a need for the process to be as open and transparent as possible;
- National guidelines about engagement and what should be revealed publicly were expected to be announced, but there had been on-going communications regarding core issues such as self–care and healthy communities and there had been a consistent message about why things needed to change. However it was accepted that the public now needed to understand what the changes would look like and how it would affect them;
- It was pointed out that the changes were needed because of workforce challenges as well as financial ones;
- The programme Board, made up of all the statutory organisations with an independent Chairman, was overseeing the development of the STP although the Plan was bringing together existing work rather than working from scratch;
- Board members felt it was important that public expectations were managed given that some of the solutions may be quite radical;
- It was good that the Local Authority and other partners were involved in preparing the plan. However this was balanced against the fact that although the footprint was one of the smallest in the Country, proportionately Hereford and Worcestershire were the 3rd most challenged area out of 44 STP areas, with 2 acute providers who were in financial deficit and in CQC special measures;
- It was clarified that although the two counties were working together on the STP the resources within each county would stay within the individual county. Of the total, Worcestershire was responsible for around 75% and Herefordshire

around 25% of resources, although the greater proportion of financial challenge was in Herefordshire;

- NHS England clarified that the plans would be sent to Simon Stevens and Jeremy Hunt who would decide if the plans were robust enough to proceed to public consultation in local areas.
- In response to a question from the public gallery Sarah Dugan said the plan was a 5 year plan but timelines may vary in different areas and it was important that a robust job was done. Following an opportunity for HWB Members to comment on the draft submission, greater details would be available at the November HWB meeting.

RESOLVED that the Health and Well-being Board:

a) **Noted the progress on development of the Herefordshire and Worcestershire Sustainability and Transformation Plan (STP),**
b) **Noted the Programme Budgeting approach being taken to allocate spend in healthcare and the implication of this on service transformation through to 2020/21, and**
c) **Agreed that the draft plan would be emailed around HWB members for comment on 14 October prior to its submission to NHS England on the 21 October.**

384 Future of Acute Hospital Services in Worcestershire

The Future of Acute Hospital Services programme had been looking at the sustainability of acute services for 5 years and that work had contributed to the STP.

The programme needed to go through 2 tests. Firstly that it was clinically sound and the West Midlands Clinical Senate had provided independent clinical endorsement of the plan in early summer. The second test was the financial and business viability of the plan. The pre-consultation business plan would be signed off by the CCG Governing Bodies and then NHS England would be testing the plan on 19 October. Once the plan was agreed there would be a 12 week consultation period before the outcomes could be implemented and it was expected the process would be concluded by the end of the financial year.

The programme was needed due to concerns about sustainability. However, safety issues had emerged which had necessitated emergency changes to some maternity and paediatric services in recent months, which had been centralised at Worcester Acute.

In response to questions it was clarified that:

- Two aspects of the plan still needed to be implemented – Emergency surgery to be centralised to Worcester and A&E in Redditch to become Adult only but with an urgent care centre alongside,
- Communicating with the public was very important and although some of the changes had already been implemented on an emergency basis, the consultation period was important to engage with the public and explain why the changes were happening;
- The number of beds at the acute hospital assumed a level of efficiency which was not being delivered. Better discharge systems and prevention services were needed but uncertainty over the future of the services was part of the problem. Patient feedback was being sought and an A&E Delivery Board was being set up to help with issues such as waiting times in A&E.

RESOLVED that the Health and Well-being Board noted the update on the Future of Acute Hospital Services in Worcestershire.

385 Director of Public Health Annual Report

The Chairman congratulated Dr Frances Howie on becoming Director of Public Health. Dr Howie then presented her Annual Report.

The report was in two parts – Part one: Ageing in Worcestershire and Part Two: Compendium of Health Indicators. There were larger numbers of older people in Worcestershire than in many areas of the Country. There was a difference between life expectancy and healthy life expectancy, and system leaders had a part to play in encouraging healthy lifestyles.

The numbers of older people were increasing but there was a difference between the people living in disadvantaged circumstances who were more likely to have a lower life expectancy and a longer period of ill health, compared to those who were advantaged.

The report compared some outcomes around the Country and internationally and lessons should be learnt. It was realistic to have the ambition to close the gap between Worcestershire and the best performing areas.

There were five recommendations:

1. System leaders giving higher priority to reducing

the gap between life expectancy and healthy life expectancy. People should expect good health till the end of life,

2. Building for a healthy old age. Worcestershire planners and decision makers should give more focus to the health impact of the planned environment, increasing the chances of a healthy old age,
3. Enabling people to help themselves, scaling up training to create a public health army, building inclusive digital assets and systematising social prescribing,
4. Developing targeted and evidence based prevention services, such as falls prevention, vaccination and lifestyle change,
5. Shifting attitudes towards celebrating later life.

The compendium of Health Indicators summarised that overall Worcestershire had good health outcomes. Some areas of concern were around smoking in pregnancy, levels of breastfeeding, child obesity and children living in poverty where the figures were not improving.

In the discussion it was noted that:

- District Councils could do a lot to support these issues without additional funding, such as awareness raising and all District Councils should be aware of the health implications of their work;
- Screening programmes were nationally set but local effort was needed to make sure that they reached the relevant population, and not only the most advantaged,
- Volunteering was an asset for Worcestershire as well as for the people who took part, but it should be recognised that people could organise volunteering themselves in their community,
- Public health was an important part of the STP, with prevention being embedded in each of the 14 programmes;
- Board Members would appreciate partners reporting back on the actions they were taking. The Health Improvement Group would report back on various action plans and actions on health inequality would be highlighted;

RESOLVED that the Health and Well-being Board:

a) Noted and discussed the content of the Annual Report of the Director of Public health;

b) Discussed how the organisations represented on the Board might best respond to the recommendations of the report, and resolved

to take this discussion into different organisations; and

c) Agreed that Member bodies should use the Compendium of Health Indicators in service planning and commissioning.

386 Joint Health and Well-being Stakeholder Event Summary

A Joint Health and Well-being Stakeholder Event took place on 9 June and was attended by more than 100 people. The event looked at Developing Action Plans around the three priorities from the Joint Health and Well-being Strategy 2016-21, which were:

- Good mental health and well-being throughout life,
- Being active at every age, and
- Reducing harm from alcohol at all ages.

The various action plans would be reported to the Health Improvement Group and then back to the HWB.

RESOLVED that the Health and Well-being Board:

a) Noted the summary of the 'Developing Action Plans' stakeholder event held on 9 June 2016,

b) Noted the on-going and further development of the priority area action plans,

c) Would ensure that delivering the action plans was given priority in the Member organisations, bringing a refreshed and joined up approach to tackling the three priority areas.

387 Learning Disability Strategy Progress Report

Lucy Hancock, an expert by experience gave some details of her experience which included problems with being weighed and not receiving any physiotherapy in the last five years. She believed that the liaison nurses did a great job but it was important that people had some choices about where they lived and with whom, although people with learning disabilities may not be able to afford to move. Lucy left copies of a letter from her mother for Board Members which detailed the lack of physiotherapy for adults with disabilities.

Sandra Rohan Kickham who was a carer for her son with complex health needs then spoke about the resource centre her son attended in Bromsgrove. She felt that the new model was working well although some attendees had not received their annual user support plan reviews for 15 months. She queried what was going to happen when carers required a break and mentioned that it would be useful to have a transition plan for older carers. She felt that there was inconsistency in the service being offered to the LD community from GPs and social workers and felt that generally people with complex

needs received inferior healthcare. The Your Life Your Choice website had had a poor start but more recently carers had reported it contained useful information. It was felt that carers assessments were inconsistent with the advice they offered and finally that the range of housing options that was now available for people with Learning Disabilities was good.

Elaine Carolan explained that the agenda report gave an overview of the Learning Disability Strategy one year on. The LA was required to complete a Framework Assessment and had completed a self-assessment with 30-40 partners. Mainly improvements had been seen but there were concerns in a few areas such as transitions to adult services.

Up to March 2016, 1124 individuals with LD had received services. It was pointed out that there were significant health inequalities with regards to people with LD and their life expectancy was 10 – 12 years lower than average.

Updated copies of the Learning Disability Strategy were left for Board Members.

Board members made the following comments:

- They were pleased to hear of the improvements in services and that the Connect day centre was doing well,
- The County Council supported employment for people with disabilities and were ambitious to get other employers interested in employment for people with disabilities,
- The commissioning of LD services had a higher profile than it had in the previous 10 years which was good, however,
- The presentations had brought up some concerns that needed to be picked up by the Staying Healthy Group and health representatives were keen to address these.

RESOLVED that the Health and Well-being Board noted the progress made on the Learning Disability Strategy.

388 The Worcestershire Transforming Care Plan

The Transforming Care Plan was a nationally mandated programme concerning people with a learning disability, autism, mental illness and presenting with challenging behaviour. The plan had been submitted in June after being signed off by ICEOG and now needed to be ratified by the HWB.

The number of people in locked or secure hospitals needed to be decreased by 50% and Worcestershire started in a good position as it already had low numbers in secure hospitals.

NHS England would be providing match funding but that was only for one year so it was difficult to plan for services after that date. When people were discharged from hospitals the costs would fall to CCGs and Local Authorities and it was not yet certain that the funding would be transferred from NHS England to local areas.

Rachel Barrett, an expert by experience, explained that she had been involved with Speak Easy Now Healthcheckers team since 2010 since the Winterbourne View case had been highlighted. She had learnt about abuse and how to spot it and had been involved in making recommendations. Healthcheckers had been involved in care and treatment reviews. She was pleased that the person being reviewed was now central to the process and it was being recognised that moving people back to their community to be near family and friends was important.

Board members supported the Transforming Care Plan and supporting people to live in their communities where it was safe for them to do so, but they were concerned about the future funding burden and felt it was important for dowries to be transferred to local areas.

RESOLVED that the Health and Well-being Board:

a) **Agreed to ratify the Worcestershire Transforming Care Plan (TCP),**
b) **Noted that the Plan had already been submitted to NHS England with an accompanying letter stating that Worcestershire expects the cost of meeting TCP to be cost neutral;**
c) **Agreed that any financial pressure arising from the discharge of patients should be met by NHS England as set out in paragraphs 18 to 21, and**
d) **Supported writing to the Government to reiterate the importance of NHS England dowries being paid to local areas.**

389 Worcestershire Safeguarding Children Board

Derek Benson, appointed Chairman of the Worcestershire Safeguarding Children Board in April 2016 presented the findings from the Safeguarding Boards Annual Report 2015/16.

(WSCB) Annual Report 2015-16

At the September 2015 meeting the previous Chairman said she could not be assured about the safety of Children in Worcestershire. As of March 2016 the situation remained the same and the Chairman and Board could not be assured of the robustness of the child protection system.

This view had been established from a range of data and although there was commitment to safeguarding in the County, and arrangements were in place, they needed to be better and more co-ordinated. The pace of change was not sufficient and although strategies were in place, oversight was needed to ensure delivery. It was recognised that improvement was needed against a backdrop of reducing resources and increasing demand.

The focus of the Safeguarding Board in 2015/16 was:

a) Implementing the child sexual health strategy,
b) Early Help,
c) The Integrated Family Front Door,
d) Children's Social care 'Back to Basics' improvement programme.

There were no serious case reviews in 2015/16 and following audits, compliance was found to be good. The Board fulfilled all its statutory functions and commitment was strong. The Police had confirmed that funding for the Board would be sustained for next year.

When asked what had been achieved since April and what assurance was needed from partners, the Safeguarding Board Chairman replied that:

- He had attended the CSE Strategy Board but they had not yet got a full picture of the situation. With regard to missing children, there had been an improvement in the return interviews but the quality needed to be maintained,
- He supported the ethos of the Family Front Door but they now needed to see if their ambitions could be achieved,
- Back to basics needed to be scrutinised more as improvement was not at the necessary level, and
- He felt he still needed to understand what Partners commitment would be and they were looking to introduce a process so that Partners assessed how any changes to their processes would impact on safeguarding.

Felix Borchardt Chairman of the Child Death Review

Panel reported that there had been 38 notifications in the last year. 35 case reviews were conducted and modifiable factors had been found in 31% which was slightly higher than the national average, although it was noted that definitions of modifiable were locally determined and Worcestershire had a relatively broad definition.

Smoking and obesity remained as the main modifiable factors and the Panel were concerned about the proposed changes to health visitors who played a key part in the health of under-fives.

The Panel played a role in informing parents of the consequences of an unhealthy lifestyle such as with the safer sleeping initiative which had been delivered through health visiting, with significant Public Health input. They would also work closely with Public Health on pre-pregnancy planning. A safety book was being produced for parents and advice packs for schools. Good health was important from the beginning of life.

In the discussion it was explained that:

- There had been an increase in pace since Derek Benson had become Chairman of the Safeguarding Board and more was being achieved between meetings,
- The Monthly Improvement Board should keep meeting to ensure that improvements continued,
- The work of the Safeguarding Board and Panel were relevant to people with learning disabilities and poor health outcomes as well as to children. It also impacted on work to do with obesity and alcohol,
- There was a role for District Councils who were an important partner in raising concerns and understanding thresholds of when to refer to social care, and also around hotspots and looking at trends regarding missing children and CSE,
- In January 2016 young people had been asked to a meeting to give their views and rather than repeat that, in January 2017 young people would be asked to attend a Board development session so that they could hear what has been done in the last year – professionals would be held to account.

RESOLVED that the Health and Well-being Board:

a) **Noted the key headlines and conclusions from the 2015/16 Annual Report;**
b) **Considered any points which may inform**

future work of the HWB in respect of its strategic priorities; and

c) Identified cross cutting these where the HWB had a role to play in reducing risks to children.

390 Better Care Fund Update

Anne Clarke confirmed that the BCF had been approved through the NHS England assurance process after it had been submitted on 22 July. The quarter 1 report had then been submitted on 9 September as required.

In 2014/15 there had been a £141,000 underspend which had been transferred to 2015/16. It was expected that there would be a £50,000 underspend this year due to the lower use of client schemes concerning avoidable admissions and discharge plans. Last summer it had been expected that the client schemes would result in an overspend so the weekly panel which had been set up to assess the use of the schemes and the length of stay of people in the schemes would continue.

On 30 September Better Care Funding for Howbury would cease and there were presently no new admissions.

There would be increased funding for intermediate care support which was being developed with South Worcestershire CCG. This was based on the principle of 'home first' and used increased night support and medical support to allow people to stay at home while going through assessments.

Guidance for 2017/18 BCF was currently awaited.

It was clarified that spending on client schemes was falling due to the better use of community beds and resources.

RESOLVED that the Health and Well-being Board:

a) Noted the "Approved" status of the 2016/17 Better Care Fund plan

b) Noted the current plans for the use of the reserve created by the 2015/16 underspend;

c) Noted the financial position for 2016/17, as reported to the Integrated Commissioning Executive Officers Group on 5 September 2016;

d) Noted the ending of BCF Funding for Howbury from 30 September 2016; and

e) Noted the information on the planning process for 2017/18.

391 Future Meeting Dates

The Chairman announced that the next public meeting would be held on
1 November.

There were also private development meetings on **11 October** and **6 December**.

Meeting Dates 2017

Public meetings (All at 2pm)

- 14 February 2017
- 25 April 2017
- 11 July 2017
- 10 October 2017

Private Development meetings (All at 2pm)

- 25 January 2017
- 14 March 2017
- 13 June 2017
- 12 September 2017
- 7 November 2017
- 5 December 2017

The meeting ended at 4.50 pm

Chairman …….

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AGENDA ITEM 5

HEALTH AND WELL-BEING BOARD
1 NOVEMBER 2016

CORPORATE PLAN REFRESH – SHAPING WORCESTERSHIRE'S FUTURE (2017-2022)

Board Sponsors
Simon Geraghty – Leader of WCC
Clare Marchant – Chief Executive, WCC

Priorities	(Please click below then on down arrow)
Older people & long term conditions	Yes
Mental health & well-being	Yes
Obesity	Yes
Alcohol	Yes
Other (specify below)	

Groups of particular interest	
Children & young people	Yes
Communities & groups with poor health outcomes	Yes
People with learning disabilities	Yes

Safeguarding	
Impact on Safeguarding Children	Yes
If yes please give details	
Impact on Safeguarding Adults	Yes
If yes please give details	

Item for Decision, Consideration or Information
Consideration

Recommendation

1. The Health and Well-being Board is asked to note the Corporate Plan refresh – Shaping Worcestershire's Future, Our Plan for Worcesteshire 2017-2022; prior to it being considered at Council on 10 November.

Background

2. The Council's current Corporate Plan *Worcestershire: FutureFit (2013-17)* was adopted by Council in January 2013.

3. The current Corporate Plan period is set to expire in 2017 and acknowledging the changing national and local landscape in which the Council is operating, the plan

has been refreshed to ensure the content continues to be relevant over the next five years through to 2022.

4. The refreshed plan will help guide the work of the Council and its relationship with individuals, families communities and partners over the next 5 years. It moves the Council towards becoming financially self- sufficient and encourages individuals, families and communities to do more for themselves, allowing the Council and its partners to focus limited resources on those who need help the most.

5. The Four Priorities are
   - Open for Business
   - Children and Families
   - The Environment
   - Health and Well-being

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Supporting Information

- Appendix - Shaping Worcestershire's Future. Our Plan for Worcestershire 2017-2022.

Shaping Worcestershire's Future

Our plan for Worcestershire
2017 - 2022 (DRAFT)

worcestershire
county council

Foreword by the Leader of Worcestershire County Council: Simon Geraghty

Worcestershire is one of Britain's best kept secrets! Home to over half a million people, covering 672 square miles and a diverse mix of vibrant urban areas and idyllic rural communities with one of England's historic Cathedral Cities at its heart. Stretching from the edge of Birmingham in the north, to Gloucestershire in the south, Worcestershire really is a hidden gem in the Midlands.

Our **Environment** is one of the county's key features. 85% of the county is rural providing easy access to the countryside with stunning scenery, streams and rivers that complement the landscape and an array of natural fauna and flora. Our county parks, open spaces and woodlands provide great walking and cycling opportunities, helping to sustain good **Health and Well Being.**

Yet it is also one of the fastest growing local economies in the country – the county is truly **Open for Business** with many renowned and successful companies, great education – with 9 out of 10 schools rated good or outstanding - and improving transport links and digital connectivity – with 90% superfast broadband coverage – to regional, national and global markets. Record investment is being delivered into road, rail and digital infrastructure and economic "game changing" sites are on course to provide employment land where it is most needed. 16,000 apprenticeships have been delivered between 2012 - 2015 and the county has low unemployment and fewer young people not in education, employment or training. Worcestershire provides a great quality of life for **Children and Families**. So why do we need to change?

The County Council supports some of the most vulnerable people in society, has responsibility for visible public services like maintaining roads and pavements, street lighting, household waste sites, libraries and county parks to name but a few. We currently oversee around £900m of public expenditure per year – which includes funding for schools and capital investment – and receive around 70% of your overall Council Tax bill. Around 60% of our net revenue budget is spent on social care services for vulnerable children and adults. People are living longer but with more complex needs, and we have more children who need our care. We want to meet resident and business expectations around the quality of roads and pavements we provide as well as investing in priority projects. Therefore it's vital we have a forward looking plan for the place and the people we serve.

Our role is changing to improving Worcestershire as a place and helping people find the solutions they require to the problems they face.

Our refreshed Corporate Plan **"Shaping Worcestershire's Future"**, with our four key priorities, will help guide the work of the Council and our relationship with individuals, families, communities and partners over the next five years. We will work proactively with partners – both within the county and externally - to achieve the aims set out. We will increasingly work together – to act and speak as "One Worcestershire" – as an outward facing and self-confident county that plays an active role in the Midlands and beyond.

This plan moves the Council towards becoming financially self-sufficient – making the link between a strong and successful economy producing the

This plan moves the Council towards becoming financially self-sufficient.

We will seek to deliver excellent value for your money and be driven by those things that you say are most important to you.

income, through Council Tax and Business Rates, to sustain the services and investments we all want to see. Growing our income base and making the most of our assets is equally as important as continuing to find efficiencies as we rely less on central government funding and free up resources to support the priorities.

It encourages individuals, families and communities to do more for themselves - where possible - making informed choices and planning for the future leading to greater self-reliance rather than dependence. Our role as an "enabling authority" is to help and support this to flourish, share best practice and celebrate successes. This in turn allows the Council and our partners to focus our limited resources on those that need our help the most, sustain the services – like maintaining roads and pavements - that are most valued by the public and allows us to invest in projects that will grow the economy.

In everything we do we will seek to deliver excellent value for your money and be driven by those things that you say are most important to you. In order to achieve this we will focus on outcomes and source those best placed to deliver. We won't seek to do everything ourselves – our role will be to define what needs to be done and work with the people that can make that happen.

Our role is changing to improving Worcestershire as a place and helping people find the solutions they require to the problems they face. We will always be there for the most vulnerable in society that need us most. This refreshed five year Corporate Plan sets out the vision, and the changing relationship of the council with individuals, families and communities in order to achieve the outcomes that we all want to see.

I look forward to working with you to turn these aspirations into reality on the ground.

Simon Geraghty
Leader, Worcestershire County Council

We will always be there for the most vulnerable in society that need us most

Championing...

Open for Business

Priority: Open for Business

Vision and Objectives

Worcestershire has **one of the fastest growing local economies in the country.** Being 'Open for Business' remains the key priority for the Council. This is vital if both individuals and businesses are to achieve their full potential and if Worcestershire is going to continue to prosper.

A successful and growing local economy will **generate wealth for residents and businesses**, and this growth will increase Council income, enabling us to invest more in those areas that our residents and businesses tell us are most important to them.

Promote a World Class Worcestershire – support and play our part in delivering on the economic vision

We have worked closely as part of the Worcestershire Local Enterprise Partnership (WLEP) to develop a 10 year Strategic Economic Plan which sets out our ambitions through to 2025. We aim to **boost the economic value** (Gross Value Added – GVA) of the county by around a third (£2.9bn), **create 25,000 extra jobs and build 21,500 new homes by 2025.** We have spoken to more than 1,200 local businesses, which make up over 50% of the private sector workforce in Worcestershire, so we know what support and help is needed to achieve our ambition.

We will promote and support businesses in the county or those relocating to Worcestershire and strive towards becoming an **entrepreneurial county** that encourages businesses (both large and small) to innovate, push the boundaries and trial new concepts and ideas.

WORCESTERSHIRE'S ECONOMY PERFORMANCE:

1ST STRONGEST GROWTH IN HIGHER LEVEL WORKFORCE SKILLS
OF ALL LEP AREAS NATIONALLY BETWEEN 2010 - 2014

2ND HIGHEST GROWTH IN PRODUCTIVITY
OF ALL LEP AREAS NATIONALLY BETWEEN 2009 - 2014

3RD HIGHEST GROWTH IN PROSPERITY
OF ALL LEP AREAS NATIONALLY BETWEEN 2010 - 2014

We will seek to:

- Support the growth of existing businesses
- Provide direct support, particularly to start-ups, to help them survive and then grow
- Improve skill levels in the county and support the development of a skilled workforce
- Attract inward investment into the county
- Act in a business friendly way

Deliver a connected county - locally, nationally and globally

Our **continued investment in Worcestershire's transport and digital infrastructure** is essential to provide businesses with **improved access to markets** and to support economic growth.

Transport infrastructure **investment will be targeted** to unlock the potential of key employment and housing development sites across the county.

Reducing journey times across the county and beyond is a key ambition, with investment focusing on improving access to national and global markets and **enhancing connectivity** between key economic centres. Our priorities for investment include:

- **Worcestershire Parkway Rail Station**, to improve access and reduce journey times to Bristol, Birmingham and London and in due course provide links with HS2 at Birmingham
- Completing the dualling of the **Southern Link Road (A4440)** from the M5 across the River Severn to the Powick roundabout
- Increasing capacity and reducing congestion on the **A38 in Bromsgrove**

We will continue to **invest in Worcestershire's digital infrastructure**. We recognise the importance of 4G, mobile connectivity, superfast broadband and wireless connectivity in delivering economic growth and increasing productivity. We will explore opportunities for improving **access to real-time information** to deliver enhanced experiences, for example, using your mobile phone to access information to optimise bus, rail and car journeys.

As an excellent commissioning-based authority and one of the largest employers in the county, we will always encourage the use of the local supply chain and consider the impact of our decisions on the local economy.

Deliver 'Game Changer' employment sites and locations

The Worcestershire 'Game Changer Programme' is a flagship initiative. Working with key partners and the private sector we are developing schemes across the county that will **deliver employment sites** with a **significant economic impact.** Current game changer sites include:

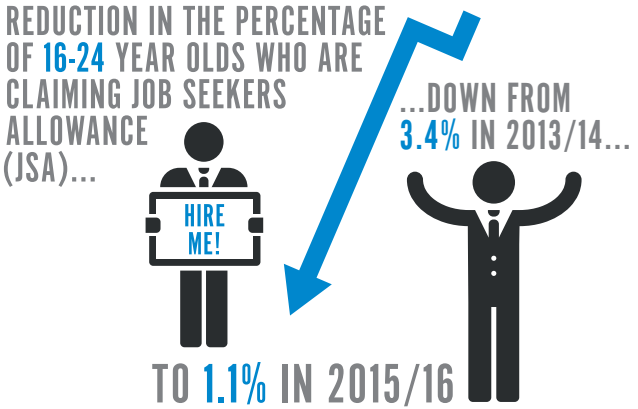
- Worcester Growth Corridor
- Malvern Hills Science Park
- South Kidderminster Enterprise Park
- Redditch Eastern Gateway

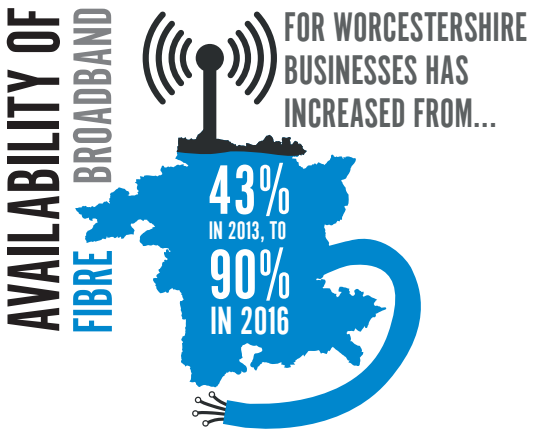
We will continue to support partners and the private sector with the identification and delivery of sites that provide major opportunities to **attract market-led investment**, and **create employment opportunities** in Worcestershire. For example, Blackmore Park in Malvern and the Food Enterprise Zone as part of the Evesham Vale Park development.

We will also seek to create and sustain **high quality city and town centre spaces** offering a wide range of opportunities for living, working and recreation. Our programme of town centre improvements in Kidderminster, Redditch, Droitwich, Worcester and Bromsgrove will be extended to include other locations, increasing the opportunities for further **private sector investment and employment growth.**

Create a World Class Workforce

Creating better paid jobs in Worcestershire is a key Council objective. We will achieve this by increasing the volume of higher-skilled employment opportunities and by **improving the skill levels** of the workforce. We want to see an increase in the average salary levels of Worcestershire-based jobs.





Our ambition is for all children and young people in Worcestershire to contribute to, and benefit from, **increased prosperity** in the county. We will champion work experience and apprenticeship schemes, supporting both young people and employers to increase the number of opportunities in our **key economic sectors.**

How will we judge progress?

- An increase in the number of jobs in our key economic sectors
- An increase in the average salary for Worcestershire-based jobs
- Improving coverage and take-up rates of fibre broadband for businesses
- Increased Gross Value Added (GVA) of Worcestershire's economy
- Reduced journey times to key economic centres
- Increased productivity of Worcestershire's economy

Priority: Children and Families

Vision and Objectives

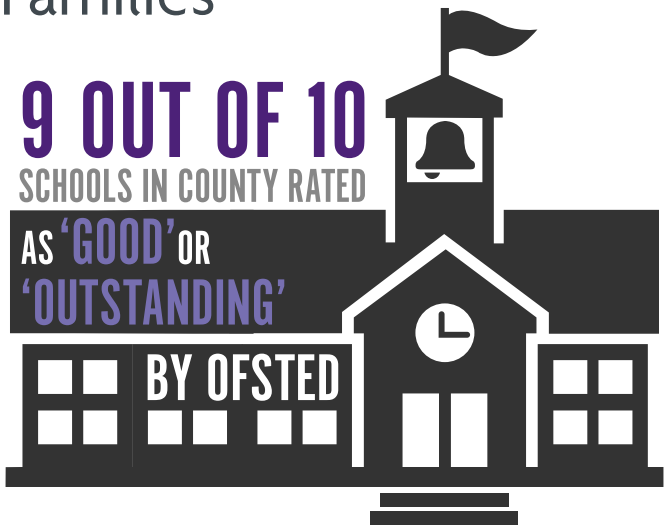
We are focused on **improving outcomes** for all children, young people and families in Worcestershire. Our ambition is to see more children and young people **achieving their full potential in education** and being fully prepared to live happy, healthy, independent and prosperous adult lives.

Keeping children and young people safe is a key priority for this Council and its partners. When the only safe option, for those vulnerable children and young people most at risk, is to come into our care, we will focus our efforts on providing a **positive care experience** in order for them to thrive and achieve their maximum potential.

Children and young people achieving their full potential in education

Our services are designed to give children and young people the best possible start in life.

Whilst the landscape of education provision continues to evolve at a national level, (e.g. the formation of academies), we are focused on ensuring it **delivers positive outcomes and attainment** for our children and young people.



We will continue to play an essential role in managing and coordinating the school system across the county and ensuring education provision across the county remains fit for purpose. We will:

- strive to ensure Worcestershire schools **provide high quality education** for all children and young people (Ofsted rated 'good' or 'outstanding')
- **provide adequate capacity** by creating the right number of school places to respond to parental preference
- **support successful schools to expand** in an appropriate form, to meet housing growth
- support our children and young people in **achieving good attainment** and **realising their potential**

We will focus our efforts on **improving outcomes for vulnerable learners** including care leavers and create a **culture of lifelong learning** by working closely with partners, communities and learners to sustain good access to learning resources and experiences.

More young people moving successfully into employment

We will actively encourage young people to prepare for their adult life by focusing on helping them to reach their full potential in education and to progress into employment. We will promote the importance of gaining suitable employmentand the impact this has on their future health and well-being.

In addition to schools, we will seek to **connect education and training providers, colleges and the university with local businesses** so they work together to prepare all young people for the world of work. Children and young people will have access to the right information, advice and guidance about the **career options** available to them.

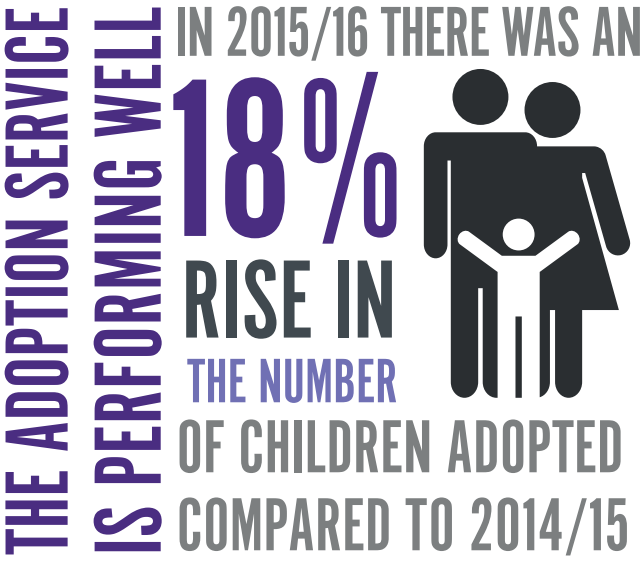
We are also committed to the development of a **University Technical College (UTC)** in Worcestershire, recognising the important role this can play in supporting our Open for Business ambitions to create a better skilled workforce in key value-added economic sectors; and promoting the importance of Science, Technology, Engineering and Mathematics (STEM) sector skills to improve young people's prospects of future employability.

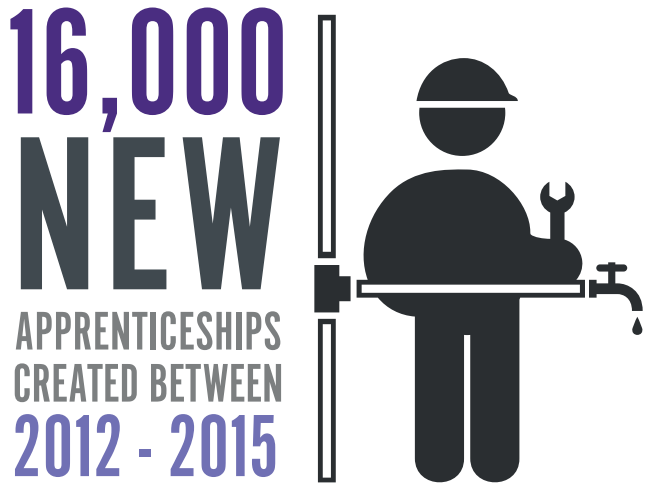
Safeguarding at the heart of everything we do

Keeping children and young people safe is a key priority for this Council and for our partners.

We are **fully committed to child protection** and will do everything we can to keep children safe and stable; and wherever possible promote these principles within their own family to **minimise the intervention needed.** When the only safe option for those vulnerable children and young people most at risk is to come into care, we will focus our efforts on providing a **positive care experience** for them, and improving their life chances.

We will focus our efforts on **ensuring they have the right placement** and will progress their **long term care plan** as soon as possible in order for them to thrive and **achieve their maximum potential.** We will shape, develop and support our workforce to ensure that we meet this challenge.





How will we judge progress?

- The number of schools rated by Ofsted as good or outstanding
- Reduce the amount of time that children spend in our care
- School place planning – increase first choice success rate and ensure adequate capacity to meet growth
- Improving the outcomes for vulnerable and disadvantaged learners including care leavers
- Improve educational attainment

Protecting...

The Environment

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Priority: The Environment

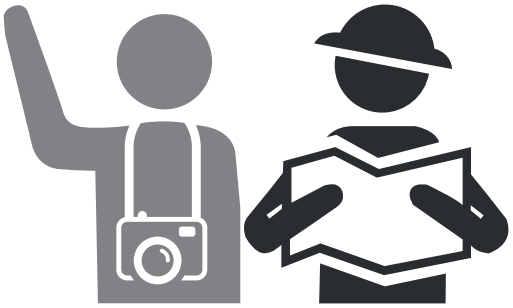
Vision and Objectives

Our environment is one of the county's key features, providing easy access to the countryside and a wealth of stunning scenery. Our country parks, open spaces and woodlands provide great walking and cycling opportunities which support our health and well-being vision.

Worcestershire is a **diverse county** with fantastic examples of a historic and natural environment, which contributes to the unique character of the county.

The quality of the environment, and the **recreational, cultural and heritage offer** which includes the distinction of being Elgar's county, is crucial to the **success of Worcestershire's tourism economy**, whilst also providing an **attractive place to invest** in a new business or to grow an existing one.

A **sustainable environment** is important for people's wellbeing, the economy and for the natural environment.



OVER £850M ANNUAL VALUE OF WORCESTERSHIRE'S TOURISM ECONOMY

Being a responsible custodian of the county's environment

We recognise **Worcestershire's natural and built environment as a key asset** and will continue to promote the county as a great place to live, work and visit.

We will seek to **maximise our environmental assets** to help to deliver sustainable economic growth whilst enhancing the quality of life in the county.

Our riverside locations provide **attractive leisure spaces**, whilst **also enhancing active lifestyles**. Over 5,600 hectares of public recreational space is available across the county, managed by the council and partners, which includes country parks, green spaces and picnic sites. There are approximately 64km of canals that are available for boating – alongside which there are towpaths available for walking, running and cycling. The Council also manages over 4,600km of public rights of way, made up of Footpaths, Bridleways and Byways.

As one of the largest employers in the county, we will encourage and monitor **responsible environmental performance** by our suppliers and contractors. We will continue to champion the use of appropriate renewable energies, with a focus on energy efficient schemes that make a positive contribution to the environment.

Commitment to improve our transport networks and deliver resilient infrastructure

We are committed to **improving our roads and pavements**, recognising that they are a high priority for our residents and businesses. We will **strive for top quartile performance** in the quality of our roads and pavements, understanding their importance in supporting our Open for Business and Health and Well-Being objectives. This will build on the good work done to date and further demonstrate our **commitment to being a responsive council.**

We also want to support **improved journey times** through greater use and access to technology, for example, focusing on smarter traffic signalling systems, **tackling key congestion pinch-points** across the county, and exploring opportunities for increasing access to real-time information to enable people to optimise their journey.

In addition to our investment in roads, we will seek opportunities to enhance travel choice including **enhancing walking and cycling routes**, particularly where this is not to the detriment of the motorist. Rail travel is a key part of our transport strategy. Improvements at Worcester Foregate and Malvern Link stations, the new Bromsgrove rail station, and our plans to deliver the Worcestershire Parkway station clearly demonstrate our **commitment to our railways.**

We recognise the importance of buses in **public transport choice**, with a focus on encouraging a market for more commercially operated services, with community transport solutions filling gaps where possible.

We know that flooding is a major issue for residents and businesses, particularly for those that live in the areas most affected. We will continue to **minimise the impact of flooding** on our transport network and reduce the frequency of closures related to flooding so that people are able to get out and about and continue with their daily lives. We will also seek to increase the number of homes and businesses protected by investment in **effective flood prevention and mitigation measures.**

Minimising waste

We are predicting an increase in the demand for waste disposal services over the next 5 years, in part due to the significant number of new homes planned across the county.

Our ability to manage this demand efficiently and cost-effectively is crucial to sustaining the quality of our environment. Our focus is to try and **minimise the amount of waste** being generated despite the economic and housing growth across the county.

We will encourage residents to reduce, re-use, recycle and compost more. We will also promote the concept of waste being a resource from which as much value as possible should be recovered.

We are **committed to sending less waste to landfill**, due to the detrimental impacts on the environment. A key part of our strategy to achieving this is through delivery of the county's Energy from Waste plant, in Hartlebury, which opens in 2017.

How will we judge progress?

- Minimising the amount of waste produced
- Reducing journey times and improving access to real-time journey information
- Maintaining access to quality recreational green-space across the county
- An increase in additional number of homes / businesses protected from flooding
- Improving the condition of our roads and pavements

Promoting...

Health and Well-being

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Priority: Health and Well-Being

Vision and Objectives

It is our priority, working with partners, to ensure Worcestershire residents are healthier, live longer, have a better quality of life and **remain independent** for as long as possible.

We will work together with partners and communities to enable Worcestershire residents to **make responsible choices** when planning their lives to achieve the best possible outcomes. We will enable individuals to become or remain independent, self-reliant and an integrated part of their local communities.

Promoting healthy and active lifestyles

Health and well-being is influenced by a range of factors over the course of people's lives. They are related to people's surroundings and communities as well as their own behaviours. Collectively, these factors have a much greater impact on health and well-being than health and social care services.

SINCE APRIL 2014,
308 ADDITIONAL
UNITS OF EXTRA CARE
ACCOMMODATION
HAVE BEEN CREATED
WORKING WITH PARTNERS,
WHICH HAS ENABLED MORE SERVICE USERS
TO LIVE INDEPENDENTLY FOR LONGER

OVER 10,000 DEMENTIA
FRIENDS TRAINED ACROSS THE COUNTY
TO RAISE AWARENESS AND HELP CREATE
DEMENTIA-FRIENDLY
COMMUNITIES

Adopting a healthy and active lifestyle is a **personal responsibility** which starts with individuals making responsible choices as part of their general **life planning**. As individuals (where we have the capacity to do so) we should be proactive about improving our own health rather than expecting others to decide and provide services on our behalf to fix the effects of unhealthy lifestyles.

Individuals and families have a responsibility for their own life planning, from ensuring the best possible start in life, through education and providing a safe and stable environment for children and young people to thrive, through to championing the benefits of prosperity and employment. This responsibility continues into planning for life after work and into retirement.

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.

Wherever possible we will **enable individuals and families to take responsibility and improve their own health and well-being** by improving access to

information, advice and guidance so that responsible choices are made, leading to **improved outcomes and healthier lives**.

Our natural environment, green spaces and areas of outstanding natural beauty - including riverside locations and canal networks with towpaths - offer numerous walking, cycling and recreational options across the county and will be championed as providing accessible opportunities for better health.

Enabling vulnerable people to live as independently and safely as possible with the support of their families, friends and communities

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.

As a council, this may mean we provide care services but it will also involve us **ensuring that there are good quality care providers locally**, recognising our market-shaping responsibilities for Worcestershire residents.

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 avoids the use of institutional care provision, as much as possible.

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.

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.

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.

Continue to work with partners to make sure all health and social care services are evidence based, effective, and good value for money

We are committed to working with partners in realising our ambition to **improve the health and social care system** in Worcestershire and to make it work more effectively and efficiently for residents.

We will ensure **social care and public health work closely with the health economy** and other local government services, as well as third sector organisations and local communities.

We will draw on the evidence of what works best when developing strategies and plans for action. We will ensure that services and resources are measured for effectiveness to **improve the quality and value for money** of health and social care and to make sure that prevention is embedded in care planning.

How will we judge progress?

- Increase in the number of active residents (30 mins exercise per day)
- Increase in healthy life expectancy
- Increase in the number of people aged 65 or more living independently for longer
- Minimising the number of people who need to go into permanent residential / nursing placements

What Does This Mean for You, Your Family, Communities, and the Council?

We have an **ambitious vision to improve the county as a place to live, work, visit and invest in.** We aim to help people achieve their full potential and live healthy, happy, prosperous and independent lives for as long as possible.

Through working with our communities and by helping people who can, to do more for themselves and for their communities, we will **unlock a greater level of community capacity.**

We recognise the important roles played by Parish, Town and District Councils and the Voluntary and Community Sector (VCS) in supporting local communities to come together and do things for themselves; taking control of improving the quality of life in the places where they live.

By working with our communities we will enable self-reliance, resilience and unlock a greater level of community capacity to sustain those things that we all wish to see continue, but which the public sector alone can't do.

However, it is important to stress that **we will always be there for the most vulnerable people in our society who need us most.**

For You, Your Family and Communities

In the same way the Council needs to embrace change, so do our individuals, families and communities.

The ability to grow community capacity and enable individuals, families and communities to do more for themselves is vital if we are to realise the aspirations for Worcestershire outlined in this plan.

There are already some great successes across the county which demonstrate the power of local communities working together to meet local needs. 'Act Local' in Worcestershire has seen local communities shaping and remodelling local services. We have acted as the enabler and have empowered communities to effect change and to make things happen in local areas. Examples are many and include the ownership of local youth service provision, support for local initiatives through the Councillor Divisional Fund, developing locally-led community libraries that reflect local need and the Parish Lengthsman Scheme.

We aim to **inspire communities and individuals to get involved** by sharing examples of the great work already happening across Worcestershire, and by signposting to sources of help, information and

advice. It is estimated that there are more than 120,000 hours of volunteering in Worcestershire every year. With a growing active older population and a willingness amongst many people of all ages to do something for their community, this presents further opportunities for us to **build on the success of the excellent voluntary and community work** already in place across the county.

Individuals and communities will be enabled to take more ownership and responsibility for their own needs, to be proactive and to access those services and resources readily available to them. They will be able to work with organisations and commissioners to co-produce services and resources as appropriate, supporting more vulnerable members of the community to maintain good health and develop strong social connections. By planning for the future, individuals and communities will only access limited, high cost services, when it is necessary for them to do so.

For the Council

As a Council we are constantly looking to improve the way we achieve better outcomes and **positively shape Worcestershire's future** whilst at the same time delivering **better value for your money.**

We will continue to shape our decisions around those areas that our residents and businesses tell us are most important to them.

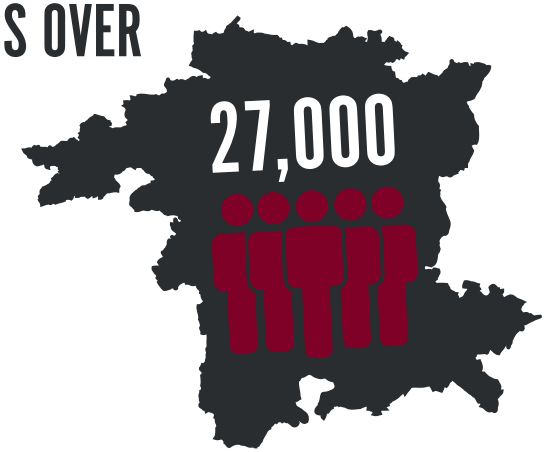
We will seek to innovate more and look for new and more efficient and effective ways of doing things. We are keen to create an environment within the Council and with partners, where we can push boundaries and try out new concepts, ideas and different ways of working. This will require a willingness to accept some things won't always work perfectly first time but we will use the learning gained to adjust and refine our approach.

We need to effectively manage change, innovate, and become more flexible and responsive in our approach to change. We need to be more agile in our decision-making and accelerate implementation. A key focus of the Council, in fact part of its DNA moving forward, will be to proactively **develop successful strategies to better manage demand for services.** We recognise that success will hinge on taking a holistic approach to avoid displacing demand across partners.

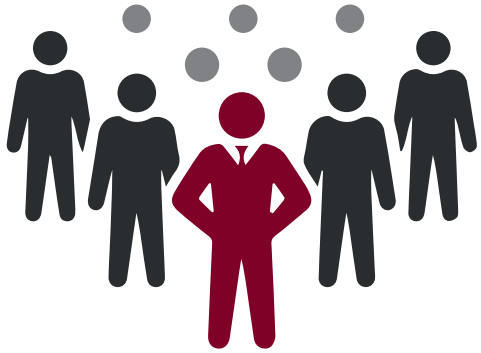
We will continue to forge partnerships within the private, public and voluntary sectors, with the aspiration of cultivating a '**One Worcestershire' approach**. When considered as a single workforce, 'One Worcestershire' (i.e. the public sector – WCC directly employed and commissioned services, schools and academies, District Councils, Police, NHS, and Fire and Rescue services) employs over 27,000 people. This presents significant opportunities to join up and deliver together on our priorities for the benefit of the county.

ONE WORCESTERSHIRE

SIZE OF PUBLIC SECTOR WORK-FORCE IN WORCESTERSHIRE IS OVER



INVESTING IN THE FUTURE



OUR COMMITMENT TO WORKFORCE DEVELOPMENT

Looking forward, we are seeking to lead public sector commissioning activities together with public sector partners to realise savings and maximise income generation opportunities. In doing so, we will always **encourage the use of the local economy.**

As we continue to change, commissioning skills will remain a key focus area. However, we will also develop our skills to effectively manage demand on our high cost services, including how we approach and measure the impact of prevention.

We have a great workforce, committed to achieving better outcomes for our residents and businesses. Our test in coming years will be the extent to which we can adapt and flex to an increasingly demanding and changing environment whilst still remaining **focused on the needs of our residents and businesses.**

At the start of 2017, the Council directly employed over 2,500 Full Time Equivalent (FTE) staff, excluding those staff who work in schools. Salaries account for about one third of all council revenue spend and so it is critical that not only do we have a highly skilled and agile workforce but we continue to reduce bureaucracy and management overheads.

SINCE 2010 WE HAVE SPOKEN TO AND SURVEYED MORE THAN 55,000 PEOPLE ABOUT OUR SERVICES

By 2022, we still expect to be one of the biggest employers in the county. However, by then we would anticipate that many more roles will be shared with other organisations, **making most use of the Worcestershire pound** and moving further to a 'One Worcestershire' approach to public services across the county. This will require major **investment in skills** as well as changes to the way roles are recruited and approaches to career planning. This work began during 2016 with our Investing in the Future workforce development programme.

Technology will continue to play a major part in everyone's lives, and for the Council, will continue to form a major part of how we work and **deliver services as a Digital Council.** The rollout of 4G, superfast broadband and other emerging technologies will offer the council great opportunities to develop services and intelligence about how residents use services. Intelligent use of data will form a major part of how the Council will improve the lives for the residents of Worcestershire.

By combining data from different sources we will create more opportunities for improving efficiency, effectiveness and the outcomes for our services in real time. This will play a major part in the council's strategy for prevention across the social care and health system through **better understanding and forecasting of demand.**

We aim to continue to invest in the Councillors' Divisional Fund, **enabling local community solutions** to meet local needs. Already, this scheme has been used to good effect by councillors.

Local Councillors will act as leaders for their communities and catalysts for change, supporting communities and individuals to become more self-sufficient, resilient and empowered. Councillors are local champions for their communities and by providing local knowledge and intelligence can influence and inform policy and decision-making. Our workforce will be geared up to work with and support councillors in this important role.

We have **developed a strong track record for consulting and engaging** with residents, businesses, partners and stakeholders, to identify our priorities.

We have spoken to and surveyed more than 55,000 people since 2010. Our Residents Viewpoint Panel consists of over 5,000 volunteers and in 2016 alone, councillors and senior officers have talked to more than 1,000 residents at public roadshows held across the county.

We engage with residents every day on social media platforms, including Facebook, Twitter, Instagram and LinkedIn. The Worcestershire County Council website is visited by around 130,000 users a month and we will drive other innovative ways to engage residents, businesses and service users.

FINANCIALLY SELF - SUFFICIENT COUNTY COUNCIL BY 2022

We now have more opportunities than ever before to communicate the outcomes we deliver, to better explain the services that Worcestershire County Council provides and to build effective relationships with residents, businesses, partners and staff.

Our Finances

We will move further away from reliance on Central Government funding and become more focused on how we generate our income locally, seeking to **control our own destiny.**

We have developed a strong track record of **robust financial management,** delivering over £100 million worth of budget reductions since 2010/11, whilst at the same time meeting demographic pressures and investing in new projects and priorities.

There is a financial imperative for us to continue to plan over the medium term, particularly as demand for our services in Adult Social Care, Children's Social Care and Waste Management increase. We have also been consistent in the requirement to achieve additional income, deliver efficiencies or make savings with a further £70 - 80 million required by 2022, based on current plans.

However, despite this challenge, we have committed approximately £430m investment of capital funding since 2015, to deliver a number of significant benefits for the residents and businesses of Worcestershire including, for example:

- County-wide rollout programme for superfast broadband
- Energy from Waste Plant
- Game Changer economic development sites

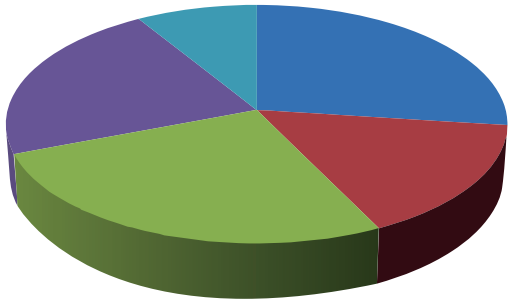
- Flood Alleviation projects across the county
- £12m Driving Home programme to improve local roads

To date, working with the Worcestershire Local Enterprise Partnership, we have also been successful in bidding for and winning in excess of £57m in central government capital funding through the Local Growth Deal, from 2015/16, to support and deliver initiatives such as:

- Worcester Six Business Park enabling works (highways and services infrastructure)
- HooBrook Link Road in Kidderminster
- Southern Link Road (A4440) dualling improvements
- Worcestershire Parkway Rail station

Resources we currently oversee

Worcestershire County Council -
Total Gross & Capital Expenditure (2016/17)

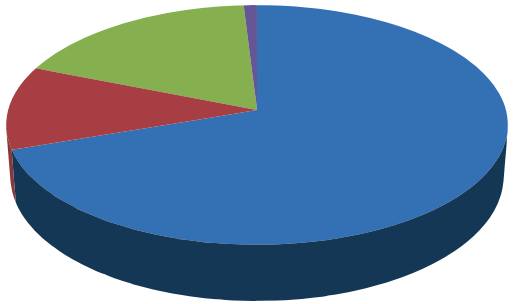


- Adult Social Care & Health £248m
- Supporting vulnerable children, Education place planning, libraries and museums £144m
- Schools funding £242m
- Highways and planning, transport and household waste £203m
- Support services, debt financing and pensions £80m

Total: £917m

Where we get our income from

Worcestershire County Council -
Net Revenue Funding (2016/17)



- Council Tax £225m
- Government Revenue Support Grant £36m
- Business Rates £58m
- Collection Fund Surplus £3m

Total: £322m

By 2022, the Council will be largely self-sufficient. We will move further away from reliance on Central Government funding and **become more focused on how we generate our income locally,** seeking to control our own destiny. Self-sufficiency will support our **focus on how we better use substantial assets of the Public Sector in Worcestershire** to shape the services and improve our county.

We will continue to deliver efficient and effective services from our better use of property across the Council and through our public and private sector partners. Our pioneering property estate joint venture, Place Partnership Ltd, will save money, integrate services and improve service user and customer experiences. This may also be pivotal in identifying the potential for future business growth.

These changes are amongst the most significant changes in recent times to how local services are funded. The changes provide both a set of opportunities as well as risks as Central Government aims to fully **localise the income from Business Rates.**

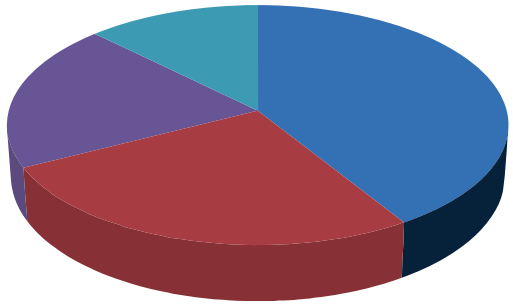
What this does not mean is that all Business Rates raised currently in Worcestershire will remain in Worcestershire, as some element of redistribution will still be required across the country. However, it does mean for the first time, we have an **opportunity to directly link improvements and changes in services to locally generated income** from residents (council tax) and businesses (business rates).

Whilst the financial context in which we operate continues to be challenging, we will still have significant spending power as a Local Authority and we remain absolutely committed to **securing maximum value for your money.**

By the end of this plan, **we will remain a significant player in the public sector,** and **one of the largest employers in the county,** overseeing around £800 million of public expenditure - including schools funding and capital funding - per year.

What we spend your money on

Worcestershire County Council -
Net Revenue Expenditure (2016/17)



- Adult Social Care & Health £133m
- Supporting vulnerable children, Education place planning, libraries and museums £85m
- Highways and planning, transport and household waste £64m
- Support services, debt financing and pensions £40m

Total: £322m

How to: Get in Touch

You can contact Worcestershire County Council in the following ways:

Online by visiting our website:
www.worcestershire.gov.uk

Telephoning:
01905 763763

On the move by accessing our smartphone friendly website.

Following us on twitter:
twitter.com/worcscc to get emergency alerts, updates and changes to services

Joining us on Facebook:
www.facebook.com/YourWorcestershire

Copies of the plan can be downloaded from our website at:
www.worcestershire.gov.uk/corporateplan

This document can be made available in other languages (including British Sign Language) and alternative formats (large print, audio tape, computer disk and Braille) on request from the Consumer Relations Unit on telephone number **01905 766368.**

To the best of our knowledge all information was correct at the time of publication: **October 2016.**

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

worcestershire county council

worcestershire countycouncil

AGENDA ITEM 7

HEALTH AND WELL-BEING
1 NOVEMBER 2016

EMOTIONAL WELL-BEING AND MENTAL HEALTH TRANFORMATION PLAN FOR CHILDREN AND YOUNG PEOPLE

Board Sponsor
Simon Trickett
Chief Officer
NHS Redditch and Bromsgrove Clinical Commissioning Group
NHS Wyre Forest Clinical Commissioning Group

Author
Jessica Glenn, Lead Commissioner

Relevance of Paper - Priorities
Mental health and well-being

Relevance - Groups of Particular Interest
Children and young people

Item for Decision

Recommendation –

1. **The Health and Well-being Board is asked to:**

   a) **Approve the refreshed Transformation Plan and continue to support its development and implementation,**

   b) **Agree to support the dissemination of the refreshed plan across all agencies for comment and further buy in,**

   c) **Note this transformation plan will be implemented as part of the programme of work under the HWB Strategy priority of improving mental health and well-being.**

Background

2. The Department of Health and NHS England published Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing in 2015. This document signalled the National focus on addressing mental health issues for young people.

3. In addition to this, the local needs assessment highlighted several areas for improvement, including investing in the children's workforce (schools, early years,

health and social care services) to address emotional wellbeing at an earlier stage; and investing in a Tier 2 service to avoid the need for specialist mental health services.

The Transformation Plan

4. The attached refreshed transformation plan outlines the progress against each action required to transform the way we address emotional wellbeing and mental health for children and young people.

5. The main actions can be summarised as the following:

- Workforce investment in skills to prevent emotional wellbeing issues and to provide early intervention.
- A one stop shop for information, advice and guidance for young people, parents/carers and professionals.
- Commissioning advice and support for schools to ensure the use of quality providers for addressing emotional wellbeing issues.
- A CAMHS consultation service to provide advice and support to universal services including schools.
- A face to face and on-line emotional wellbeing service.
- A high quality specialist CAMHS service (Tier 3 and Tier 3 plus) where children are able to access assessment and intervention in a timely manner.
- A high quality out of hours service provided across organisations to meet demand.
- A Countywide Community Eating Disorder Service for Children and Young people

Next Steps

6. Continued engagement with the Worcestershire Youth Cabinet to continually update the Transformation and check back with young people through the mental health survey that services are meeting their needs. Current survey is out for responses until December 2016.

7. Continued engagement with stakeholders through the emotional wellbeing and CAMHS partnership board.

8. Launch of the schools toolkit for emotional wellbeing to support schools with their role and responsibility around emotional wellbeing and when commissioning their own services, eg. Counselling within school.

9. Continued redesign of services including a 'tier 2' emotional wellbeing service, specialist CAMHS services and the eating disorder service.

10. Continued promotion of integrated working across all commissioners (children, public health and adult services) to ensure that resources are used effectively across the health, education and social care system.

11. A review point in summer 2017 to assess outcomes of the transformation plan, including demand on CAMHS, demand on the emotional wellbeing service, referrals to inpatient services (the local Acute Trust and Tier 4 CAMHS inpatient units), outcomes for children and young people measured through evidence based measurement tools, and feedback from stakeholders

12. Continued financial commitment to deliver the Transformation Plan in line with NHS England funding allocation to the Clinical Commissioning Groups

Legal, Financial and HR Implications

Financial Implications	Continued investment in children and young people's emotional wellbeing and mental health
Human Resource Implications	Some redesign and recruitment across providers (the main provider being the Health and Care Trust).

Equality and Diversity Implications

13. An Equality Relevance Screening has been carried out in respect of these recommendations. It identified that further equality impact analysis will be required in respect of designing services relating to emotional wellbeing and mental health.

Contact Points

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Jessica Glenn, Lead Commissioner
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Supporting Information

- **Appendix 1** – Refreshed Emotional Wellbeing and Mental Health Transformation Plan

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Worcestershire's Transformation Plan for Children and Young People's Emotional Wellbeing and Mental Health

November 2016

Worcestershire Health and Care NHS Trust

Worcestershire Acute Hospitals NHS Trust

NHS Redditch and Bromsgrove Clinical Commissioning Group

NHS Wyre Forest Clinical Commissioning Group

NHS South Worcestershire Clinical Commissioning Group

Worcestershire's voluntary and community sector

NHS England

worcestershire county council

Contents

Foreword from John Smith, Cabinet Member with responsibility for Health and Wellbeing

It is my pleasure to present Worcestershire's refreshed transformation plan for children and young people's emotional wellbeing and mental health. The Worcestershire plan is based on the recommendations from the Future in Mind report (Department of Health and NHS England, 2015) and forms a key part of delivering one of the key priorities within the Joint Health and Wellbeing Strategy 2016-21: **Good mental health and well-being throughout life**

Our vision is to address the following key themes outlined in Future in Mind:

- **Promoting resilience through a focus on prevention and early intervention**
- **Improving access to effective support**
- **Focus effort on support and care for the most vulnerable**
- **Increased accountability and transparency**
- **Improving the capability and quality of the workforce**

This sits well with the Health and Well-being Strategy's commitment to prevention, and commitment to ensuring that services are effectively targeted and evidence based. The plan requires action by a range of different organisations across health, education and social care. This will enable a joined up approach to improve outcomes for children and young people's emotional wellbeing and mental health. We will ensure that organisations from across the sector will work together on commissioning and providing evidence based services which are targeted at those in greatest need.

We are determined to make a difference and will look at the whole system across Worcestershire to improve outcomes around emotional wellbeing and mental health.

1. Executive Summary

Worcestershire's approach to Prevention is being re-focused to generate a multi-agency response to promoting early identification and intervention in relation to children and young people's needs, in partnership with children, young people and families. This Transformation Plan (2015-2020) is a key part of the wider Prevention agenda with a detailed focus around children and young people's emotional wellbeing and mental health. The focus on emotional wellbeing and mental health is significant as it creates 'a positive sense of wellbeing which enables an individual to be able to function in society and meet the demands of everyday life' (Mental Health Foundation).

We aim to:

- Improve the emotional well-being and mental health of Worcestershire's children and young people; this will also contribute to an improvement in their wider health, social and educational outcomes.

We expect the following outcomes:

- More children and young people will develop resilience as a result of education and support from their families, schools and other settings.
- Children and young people who go on to use an emotional wellbeing or mental health service will report their health has improved as a result
- Service users will give positive feedback on their experience of emotional wellbeing and mental health services
- Referrers will give positive feedback on the emotional wellbeing and mental health services they refer to
- Children and young people will have shorter waiting times for services
- There will be fewer referrals to Tier 3 CAMHS and Tier 4 inpatient beds as a result of more effective early support and preventing escalation of needs.
- Service users transitioning between CAMHS and Adult Mental Health Services will report a positive experience.
- Fewer children and young people will attend A&E or require local hospital admission following self harm.

Our focus in delivering these outcomes will be to:

- Bring commissioners and providers of emotional wellbeing and mental health services together to build strong co-commissioning and partnership agreements with the aim of developing a seamless pathway which delivers evidence-based interventions and services that children, young people and families can access easily.

- Ensure that children, young people and families are actively involved in the processes of commissioning and delivering services so that their views and experiences inform this transformation plan.

- Develop a consistent approach to promoting resilience, prevention and early intervention for mental health and wellbeing in partnership with early help and universal services such as schools, colleges, primary care, youth settings and early years settings.

- Commission a targeted service (at Tier 2 level of need) for children and young people who need support around emotional wellbeing to avoid/prevent the need for specialist mental health services.

- Develop an effective 24/7 mental health crisis response in partnership with other services.

- Develop a CAMHS service which delivers evidence-based specialist mental health interventions directly, builds capacity in the universal workforce and supports children and young people in their local community in a timely manner, avoiding the need for inpatient admission.

- Develop a multi-agency response to support timely hospital discharge, where children and young people have required an admission to Tier 4 inpatient units.

- Commission a specialist community eating disorder service which works with all partners to ensure problems are identified early and treated effectively.

The Case for Change

- Good emotional wellbeing and mental health underpins the achievement of educational, social and wider health outcomes, as well as increasing wellbeing and happiness.

- Preventing or effectively treating mental illness in childhood is likely to prevent longer term illness in adulthood, since half of lifetime cases of mental health disorder start by the age of 14 years.

- There is a strong invest to save argument for using evidence based interventions to treat or prevent mental illness in order to make savings not only in childhood, but throughout the life-course (Chief Medical Officer Annual Report, 2012 'Our Children Deserve Better: Prevention Pays; Chapter 3: The economic case for a shift to prevention).

- Children and young people are given equal priority with adults within the cross-government strategy 'No health without mental health' (HMG/DH 2011), and in the subsequent policy document 'Closing the gap: priorities for essential change in mental health' (DH, 2014). This recognises the importance of early identification and treatment in childhood to help children and young people reach their full potential in all outcome areas as well as preventing long term problems continuing into adulthood.

- In 2014 children's mental health came under close government and media scrutiny. The resulting Task Force report 'Future in mind: promoting, protecting and improving our children and young people's mental health' (NHSE/DH, March 2015), identified the need for change and it laid out the government's national ambition to transform services for children and young people with mental health needs.

- An Early Help Needs Assessment was completed in 2015. This recommended an increased focus on prevention and early intervention to improve children and young people's emotional wellbeing and mental health.

- An emotional wellbeing and mental health needs assessment was also completed in 2015, again emphasising the need for moving the focus towards prevention and earlier intervention.

- The Children and Young People's Plan (2014-2017) and the Health and Care Strategy for Worcestershire (2015-2020) both outline the importance of emotional well-being and a commitment to the provision of a clinically effective CAMH service.

What children, young people and parents/carers tell us they need?

- Young people want to speak to somebody they know and trust
- Young people would value face to face support, but on-line support would be welcomed as an additional choice for support
- Skill up a wide range of professionals and parents to identify issues earlier
- Make use of websites, apps and social media to promote advice and resources for families
- To consider the needs of the whole family
- Make waiting times for services shorter

Children, young people and parent/carers continue to help us shape services through engaging in our Partnership Board, engaging in specific focus groups such as patient experience around the neurodevelopmental pathway, and the Youth Cabinet and Who Cares we Care. The Youth Cabinet survey is out (as at September 2016), with results being collated in January 2017.

2. The Plan – updated October 2016

What we want to achieve?	Lead	Baseline at 3rd November 2015	Milestones	Progress	KPI/ Measureable outcome	RAG
2.1. Create a transformation board to oversee the implementation of the plan.	Lead commissioner	Interface group and Emotional Wellbeing stakeholder group already engaged. CAMHS Youth Board engaged. Transformation plan approved by NHSE	Refresh Local Transformation plan by 31st October 2016 Sign off by the Health and Wellbeing Board at 1st November meeting Youth cabinet survey results analysed by January 2017 Review of action plan post survey results by March 2017	CAMHS partnership board and sub groups established. Meeting bi-monthly with stakeholders, parents and young people. Youth cabinet survey on young people's emotional wellbeing and mental health launched	Active engagement by all partners, regular attendance at Board Meetings and actions to be RAG rated as Green within set timescales. The transformation plan to have children, young people and families involvement.	
2.2. The universal workforce including midwifery, health visitors and school nurses promoting a whole community preventative approach to parenting, promoting resilience and emotional wellbeing and identifying those at risk	Public health commissioner	A survey to be carried out to determine a baseline	Contract extension of heath visiting and school nursing services October 2016 0-19 Transformation board established by October 2016 Transformation board review of 0-19 service progress by March 2017	Due to no compliant bids being received, commissioners for the 0-19 tender are negotiating contract extensions for health visiting and school nursing. A 0-19 transformation board is being established and lead by public health	Service specification in place with KPIs monitored regularly.	

What we want to achieve?	Lead	Baseline at 3rd November 2015	Milestones	Progress	KPI/ Measureable outcome	RAG
2.3 Schools are taking a whole school approach to promoting positive emotional wellbeing. (e.g. Anti-bullying policies, PSHE, peer mentoring, etc) Schools are commissioning high quality, evidence based interventions to improve outcomes for children and young people.	Lead Commissioner/ public health/Connecting Families	100% of schools have a health improvement plan highlighting specific targets identified from the Public Health School Profiles.	School emotional wellbeing toolkit drafted and circulated for consultation by October 2016. Sign off of emotional wellbeing toolkit and implementation begins – February 2017	School input working group continues to meet monthly and is developing commissioning guidance/provider framework for schools. Small group of headteachers are co-designing the guidance/toolkit for schools.	100% schools will have access to good practice guidance on provision of an emotionally healthy school environment and quality evidence-based interventions.	

What we want to achieve?	Lead	Baseline at 3rd November 2015	Milestones	Progress	KPI/ Measureable outcome	RAG
2.4. A one-stop shop for information and advice around emotional wellbeing for children and young people and parent/ carers and professionals. (How to promote resilience and recognise signs of emotional distress/mental health issues/ eating disorders.)	Lead Commissioner	Current referrals to Tier 3 is 2,548 for 2014/15 Current percentage of accepted referrals is 70% for 2014/15	Implementation of the online emotional wellbeing service December 2016 Face to face emotional wellbeing service implemented by February 2017 New emotional wellbeing triage function embedded in to CAMHS SPA to provide a single point of access for both services	The referral process to CAMHS has been updated to include the new eating disorder service The GP referral form has been streamlined and updated in consultation with GPs Additional capacity within CAMHS SPA out to recruitment as at September 2016. The online emotional wellbeing service contract being negotiated this will include information, advice and guidance for children, young people and families.	A reduction in inappropriate referrals to CAMHS A reduction in referrals to specialist CAMHS Improving and understanding thresholds.	

What we want to achieve?	Lead	Baseline at 3rd November 2015	Milestones	Progress	KPI/ Measureable outcome	RAG
2.5. The Children's workforce across all agencies will understand their role in promoting resilience and identifying and supporting emotional wellbeing and will be trained and supervised appropriately.	Lead Commissioner	Mental health first aid training available in the county	Youth mental health first aid to be accessible across the whole of the children's workforce by October 2016 Procurement of further STORM training Procurement of self harm training one day course by January 2017	Early Help staff have been trained by CYP-IAPT Monthly meetings continue with workforce development team to plan the suite of training for the children's workforce	The children's workforce to be trained and feel confident to identify and support emotional well being issues.	
2.6. A robust specialist primary mental health service that provides consultation, advice and support for the wider workforce.	Lead Commissioner	Current referrals to Tier 3 are 2,548 for 2014/15	New specification for Primary Mental Health Service/ consultation service in place by Oct 2016, with robust KPIs. Implementation of consultation service by February 2017	Service development and improvement group have been meeting regularly and have developed the draft service specification for CAMHS.	A reduction in inappropriate referrals to CAMHS A reduction in referrals to specialist CAMHS	

What we want to achieve?	Lead	Baseline at 3rd November 2015	Milestones	Progress	KPI/ Measureable outcome	RAG
2.7. Provide a high quality; evidence based online and face to face county-wide therapeutic counselling service for CYP with lower level emotional wellbeing needs.	Lead Commissioner	Current referrals to Tier 3 are 2,548 for 2014/15	Implementation of the online emotional wellbeing service December 2016 Face to face emotional wellbeing service implemented by February 2017 New emotional wellbeing triage function embedded in to CAMHS SPA to provide a single point of access for both services Clear pathways in place with the emotional wellbeing service, school nursing, family intervention service and schools by February 2017	Emotional wellbeing service specification and contract variation completed Weekly meetings are in progress with the provider to work towards implementation.	A reduction in inappropriate referrals to CAMHS A reduction in referrals to specialist CAMHS.	

What we want to achieve?	Lead	Baseline at 3rd November 2015	Milestones	Progress	KPI/ Measureable outcome	RAG
2.8. High quality specialist CAMHS T3 and T3+ service where children are able to access assessment and intervention in a timely manner, provided by clinicians trained in evidence based NICE compliant practice, with effective supervision. More effective pathways for the most vulnerable children e.g. LAC and YOS	Lead Commissioner	Current baseline 2010-13 424.2 emergency hospital admissions for self-harm per 100,000 population (aged 10-24yrs) 38 admissions into Tier 4 for 14/15	New service specifications and dashboard of KPIs developed for re-designed Tier 3, 3+ LAC/CAMHS, LD/CAMHS, YOS/CAMHS signed off by November 2016	Service development and improvement group has been meeting regularly over the last 12 months. Business cases submitted, negotiated/agreed. Service specification and contract variation completed. This includes pathways for the most vulnerable children eg LAC and YOS Funding agreed and additional capacity in Tier 3/Tier 3+ in place Care Notes a new system within the NHS provider went live in December 2015 it has the ability to record session by session outcomes and more robust data	A reduction in local hospital admissions and in referrals to Tier 4. A reduction in waiting times for CAMHS Tier 3 A reduction in length of stay on paediatric ward	

What we want to achieve?	Lead	Baseline at 3rd November 2015	Milestones	Progress	KPI/ Measureable outcome	RAG
2.9. High quality responsive CAMHS out of hours service	Lead Commissioner	Complete an audit to establish the baseline.	Report to commissioning executive to summarise the key issues/challenges to out of hours services and provider recommendations by December 2016.	Audit in progress to establish the baseline as at September 2016 Urgent care interface group continues to meet to case review any out of hours issues/incidents in order to inform future commissioning. Conversations are continuing with the West Midlands Health Science Network to clarify how they can support us to commission future out of hours services. The provider NHS Trust has consulted with psychiatrists about future on call services	Referrers report positive experiences of out of hours services. Fewer CYP admitted to T4 Fewer inappropriate admissions to paediatric wards Shorter stays in Acute paediatric wards	

What we want to achieve?	Lead	Baseline at 3rd November 2015	Milestones	Progress	KPI/ Measureable outcome	RAG
2.10. Embed the use of Care Treatment Reviews (CTRs) for children and young people with severe learning disabilities or autism and challenging behaviour across the local health and care system.	Lead Commissioner / Complex Cases Commissioner	An assessment of needs and an evaluation of the current multiagency processes will be carried out in 2015-16, to establish a baseline of current performance Updated baseline Oct 16 – In Worcestershire we have led 1 pre admission CTR and 1 discharge from hospital CTR within the last 6 months	Processes and protocols for completion and monitoring of pre-admission CTRs and discharge CTRs developed by December 2016. CAMHS professionals understand the care and treatment review process and know when to alert commissioners that a CTR is required by March 2017 Other professionals understand the care and treatment review process and know when to alert commissioners that a CTR is required by September 2017 Commissioners to ensure that there is access to experts by experience and clinical experts who can contribute to each CTR	Worcestershire's transforming care action plan continues to be reported to NHS England and this includes both children's and adults. A risk register is in place and further work is in progress with clinicians to determine the criteria for risk assessing children and young people The Children's commissioning team continue to monitor the number of children in hospital and ensure that care and treatments review are undertaken in partnership with NHS England.	More people with learning disabilities and/or autism and their families report that they are listened to, and treated as equal partners in their own care and treatment Reduction in unnecessary admissions into inpatient settings and delayed discharges (measured through number of admissions/delayed discharges and audit of case details) All admissions are supported by a clear rationale with measurable outcomes (through audit).	

What we want to achieve?	Lead	Baseline at 3rd November 2015	Milestones	Progress	KPI/ Measureable outcome	RAG
2.11. Countywide Community Eating Disorder Service for Children and Young people	Lead Commissioner	57 eating disorders referrals to CAMHS within 12 months 14 young people admitted to Tier 4 for eating disorders within 12 months	Service specification drafted by October 2016 Service specification signed off and contract variation agreed by December 2016 Recruitment of staff by January 2017. Training plan for new service to commence January 2017. Eating disorder service to be operational from January 2017	Eating disorder model and pathway agreed A CQUIN (payment by results) has been implemented across the Community and Acute NHS Trusts. Ongoing engagement with Health Education England to ensure a skilled workforce in place	A reduction in local hospital admissions and in referrals to Tier 4. National mandatory waiting times for children and young people's community eating disorder service are met A reduction in length of stay on paediatric ward A reduction in late presentations of eating disorders.	
2.12. Develop community perinatal mental health provision to provide treatment and support for mothers identified with or at risk of mental health issues during or after pregnancy to improve parenting capacity and promote emotional well-being of the child.	Public health commissioner Adult mental health commissioner	To be determined through data collection exercise in 2015/2016	Community perinatal mental health provision in place by March 2017	Agreement to integrate future early intervention provision within the 0-19 service	100% of all agencies are implementing the new primary care mental health service redesign. 100% of those surveyed are satisfied with the service	

What we want to achieve?	Lead	Baseline at 3rd November 2015	Milestones	Progress	KPI/ Measureable outcome	RAG
2.13. All agencies who are providing support around emotional wellbeing and mental health to be working towards the same outcome measures, based on CORC/CYP-IAPT. NB: Worcestershire has been successful in gaining CORC support in the cross-sector outcomes and data linkage project	Lead Commissioner	Audit of current outcomes across agencies to establish baseline.	Engagement of commissioner and provide partners – positive activities, schools, early help, school nurses, CAMHS, VCSOs to follow CORC framework to measure improvement in emotional wellbeing and mental health outcomes. Emotional wellbeing pathway and requirement to use CORC/CYP – IAPT outcomes to be included in all WCC/CCG commissioned service specifications by October 2016.	CORC/EBPU project in progress – piloting ways of linking data and sharing outcomes. Draft data sharing agreement in place. Requirement to use CORC/CYP-IAPT outcomes is in all draft WCC/CCG commissioned service specifications.	100% of agencies signed up to and implementing an agreed pathway and outcomes measurement.	

3. Introduction

3.1 Effective Early Help addresses the root causes of social disadvantage, ensuring that everyone is able to realise their full potential by developing the range of skills we all need to thrive. It is about getting extra, effective and timely interventions to all babies, children and young people who need them, allowing them to flourish and preventing harmful and costly long-term consequences (Early Intervention Foundation, 2015). It is estimated that approximately £17billion is spent each year in England and Wales addressing problems such as mental ill health, unemployment and youth crime. This does not take into account the wider social and economic costs (Ibid). The 2015 Worcestershire Early Help needs assessment emphasises the importance of identifying early opportunities for timely, evidence-based interventions. This is important, first and foremost, for improving the life chances of children and young people; and secondly for generating long term savings.

"Knowledge and understanding of human development, especially in childhood, has grown We can identify more problems earlier; some we can even anticipate or identify as clear risk factors".
(Centre for Excellence and Outcomes, 2010)

3.2 **As outlined in local needs assessments evidence suggests that we should:**

- Ensure better identification, prevention and early intervention
- Strengthen parenting advice and support
- Provide intensive support for vulnerable families in early years & beyond if needed.
- Increase focus on emotional health and wellbeing and resilience at school
- Maximise the benefits of community assets
- Target multiple poor adolescent behaviours with evidence-based 'cluster interventions'
- Integrate delivery of service provision (Manchester model, integrated hub approach)
- Review of all commissioned prevention & early intervention services

3.3 **Key Headlines from the 2015 CAMHS Needs Assessment**

- Demand on the emotional health and wellbeing pathway is forecast to increase, particularly in deprived communities.
- 30% of emergency referrals to CAMHS in 2014/15 were not known to specialist services.
- Office for National Statistics (ONS) data estimates that 2,120 young people require Tier 3 CAMHS. 4,642 children may require a service from universal and targeted services.
- Numbers of referrals to CAMHS and the accepted referral rate have both fallen.
- 70% of parents surveyed said it was either difficult or very difficult to get help.
- The most important improvement suggested by parents and carers was wider workforce staff training and support, and mental health promotion in schools.
- Prevalence data for looked after children (LAC) suggests 306 children may require a specialist service for emotional wellbeing and mental health.

- Waiting times for CAMHS were a top concern for all stakeholder groups responding to the surveys, and in particular over 70% of parent/carer service users rated this as poor.
- The numbers admitted to CAMHS Tier 4 are lower (at around 33 per year) than would be expected based on prevalence data which suggests that 90 children at any one time require Tier 4.

Throughout May and June 2015, 97 surveys were completed by children, young people and parents and 115 were completed by professionals. This was to help us shape the Transformation Plan and Commissioning Intentions. In addition to this, we held focus groups across Worcestershire and spoke to 123 children, young people and parents/carers. They told us:

- Young people want to speak to somebody they know and trust
- Young people would value face to face support, but on-line support would be welcomed as an additional choice for support
- Skill up a wide range of professionals and parents to identify issues earlier
- Make use of websites, apps and social media to promote advice and resources for families
- To consider the needs of the whole family

This Transformation Plan reflects the recommendations from the recent Future in Mind report.

> *"Promoting, protecting and improving our children and young people's mental health and wellbeing*
>
> *There is now a welcome recognition of the need to make dramatic improvements in mental health services. Nowhere is that more necessary than in support for children, young people and their families. Need is rising and investment and services haven't kept up. The treatment gap and the funding gap are of course linked.*
>
> *Fortunately that is now changing. However, in taking action there are twin dangers to avoid. One would be to focus too narrowly on targeted clinical care, ignoring the wider influences and causes of rising demand, over medicalising our children along the way. The opposite risk would be to diffuse effort by aiming so broadly, lacking focus and ducking the task of setting clear priorities. This document rightly steers a middle course, charting an agreed direction and mobilising energy and support for the way ahead. I'm pleased to give it NHS England's full support".*
>
> *(*Simon Stevens, *Future in Mind,* March 2015)

3.4 Perinatal Mental Health

Effective Early Help begins before birth with early identification and support for maternal mental health difficulties, continuing into the postnatal period.

The effect of a mother's mental health on the subsequent health of her child is equally important as her physical health. Evidence shows that children born to mothers who experienced antenatal stress, anxiety or depression have more emotional difficulties, especially anxiety and depression, and symptoms of ADHD and conduct disorder than children born to non-stressed mothers. Stress, anxiety and depression during pregnancy are however frequently undetected and so not treated. Research indicates that about 10-20% of pregnant women suffer antenatal depression and anxiety and around 1 in 10 mothers experience mild to moderate postnatal depression.

The action needed to tackle perinatal mental health is twofold. Immediate action is needed to plug the gaps in services and ensure that women with perinatal mental health get the timely expert support that they need. In addition, we need a step-change towards better prevention of perinatal mental illnesses, and early intervention when they do occur.

This transformation plan will ensure effective, evidence-based services for Perinatal Mental Health are part of the whole emotional wellbeing and mental health pathway. The separate guidance and funding expected from NHS England later this year for Perinatal Mental Health will be aligned with this transformation plan.

4. Background/Demographics

4.1 Overview of Worcestershire

Worcestershire is a county located in the West Midlands in the heart of England towards the south of the West Midlands Region. The county borders Herefordshire, Shropshire, Staffordshire, the West Midlands Metropolitan Area, Warwickshire and Gloucestershire. Worcestershire has two main rivers running through it, the Severn and the Avon. To the west the county is bordered by the Malvern Hills, and to the south is bordered by the Cotswolds. The northern part of the county is bordered by the West Midlands area. .

Worcestershire consists of 6 districts, namely Bromsgrove, Malvern Hills, Redditch, Worcester City, Wychavon and Wyre Forest. Worcester City is the main administrative city in Worcestershire, and the main towns of Kidderminster, Redditch, Bromsgrove, Stourport-on-Severn, Malvern, Evesham and Droitwich are also situated in the county.

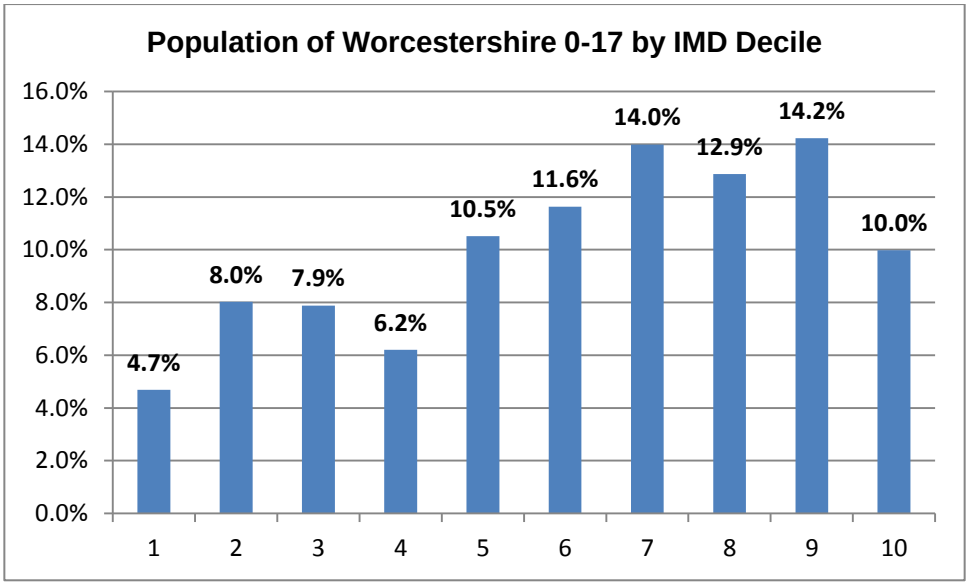
By area Worcestershire is largely a rural county, although around three quarters of the population of Worcestershire is defined as living in an urban area. Wychavon and Malvern Hills are the two most rural districts, whilst Worcester City is a key employment centre and Redditch was designated New Town status in 1964.

Relatively, Worcestershire as a whole is not a deprived county, but pockets of deprivation are present in urban areas. Redditch is the most deprived district within the county, whilst Worcester City, Kidderminster in Wyre Forest and Malvern all have areas that are within the top 10% of deprived areas in England. Approximately 3.5% of the total population in the county live in the 10% most deprived areas in England. This proportion rises to 4.7% when considering the population of children.

It is estimated that 575,400 people live in Worcestershire; including 114,900 children aged 0-17, representing 20% of the total population. Redditch has the highest level of children as a proportion of total population at 22%. Malvern Hills has the lowest at less than 19%. Around 7.6% of the total population of Worcestershire is from a non-White British background. The proportion of children from a non-White British background is 10.4%, illustrating that the Black Minority Ethnic proportion is higher among children than for the total population.

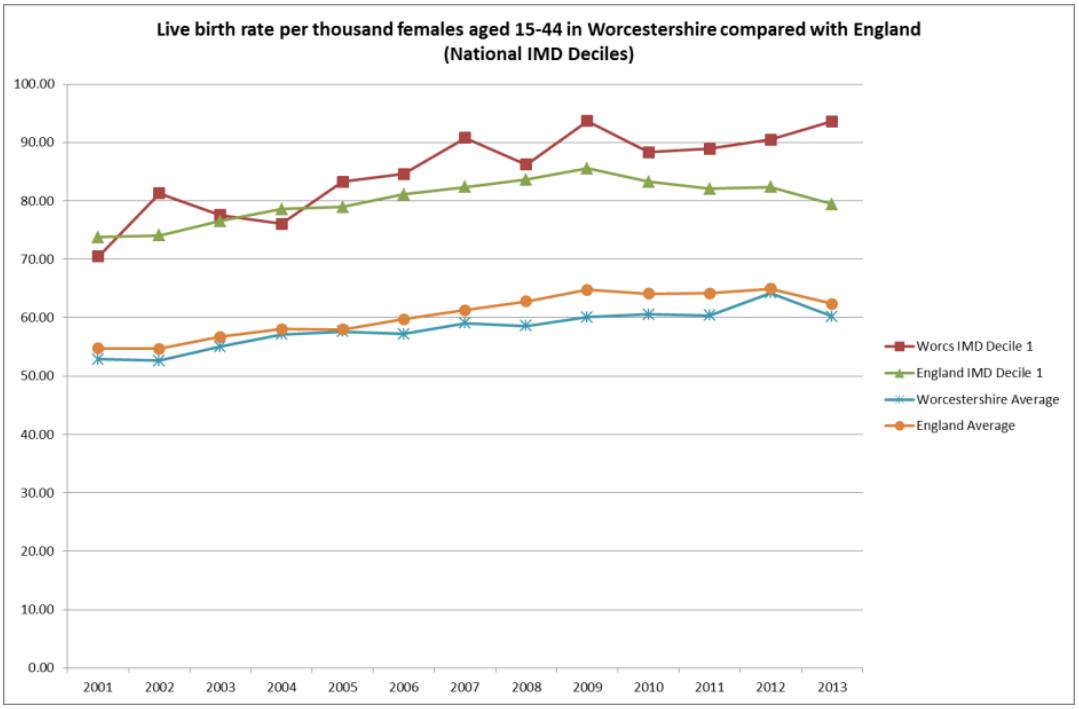
4.2 Deprivation

The Index of Multiple Deprivation (IMD 2010) is commonly used in local areas to measure relative deprivation within a geographical area. The 10% most deprived in England are in decile 1.
Applying this measure in Worcestershire, we can see that a greater proportion of the 0-17s population live in the less deprived areas (decile 7-10) than in the more deprived areas (deciles 1-4).



Source: Worcestershire County Council

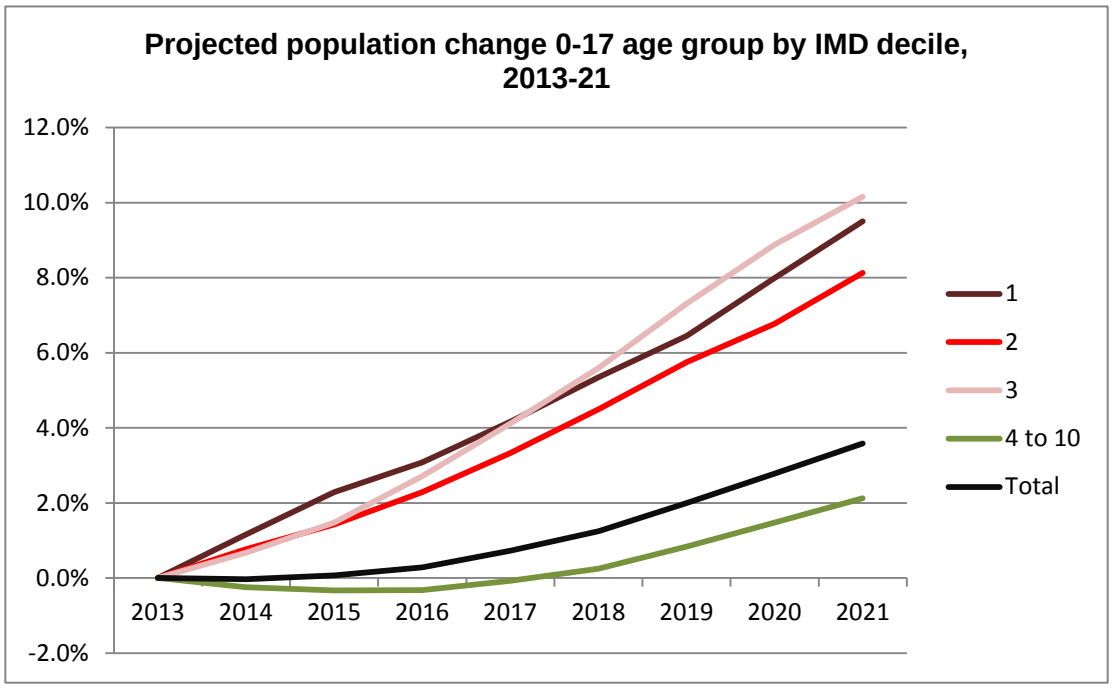
This pattern of deprivation may not stay the same in the future, for example, if housing developments or migration change this picture.
However, on current data, the number of people aged 0-17 in Worcestershire living in the top 30% of deprived areas nationally, according to the 2010 IMD, is projected to increase more over the next few years than the 0-17 population as a whole. This is due at least in part to the high number of births in relatively more deprived areas than in other areas in the county.



The number of Worcestershire 0-17 year olds living in the 10% most deprived areas nationally (decile 1) is projected to increase by over 500 people, representing a rise of

almost 10%. Numbers of children living in decile 2 and decile 3 are also projected to increase by 2021, by 8% and over 10% respectively.

In contrast the number of children in Worcestershire living outside the 30% most deprived areas nationally is projected to increase by just over 2%.



Source: Worcestershire County Council

4.3 Health inequalities

Addressing health inequalities is central to this Transformation Plan, with all partners providing accessible and effective interventions across the spectrum of needs ranging from advice and guidance to specialist intensive support for those most in need. Commissioned services will have due regard to the Equality Act, ensuring that impact assessments are undertaken against service specifications**.**

4.4 Emotional wellbeing and mental health in Worcestershire's children and young people

According to the first National Wellbeing survey of children in 2013, we should expect at least 75% of Worcestershire's children to have moderate to high levels of happiness. Worcestershire is a county with relatively low levels of deprivation and low risk factors for poor mental health in children, but despite this there are indications of higher levels of needs than would be expected with some increase in needs in younger aged groups:

- Worcestershire had higher rates of hospital admissions for self-harm and for alcohol specific conditions in 0-24 year olds than the regional average in 2010-13.

- Rates of hospital admissions for self harm in 0-24 year olds have been stable since 2010/11 and attendance at A&E for self harm fell between 2010/11 to 2012/13. However, there are some signs of a recent increase in A&E attendances and there has been a trend towards an increase in rates of attendance amongst younger females, aged 10-14 years, whilst rates have fallen in older age groups.

5. Service baselines

Specialist CAMHS - Tiers 2, 3, 3+ (age 0-18th birthday)

Specialist Child and Adolescent Mental Health Services in Worcestershire are commissioned to promote, maintain and improve the mental health and psychological well-being of children and young people from 0 to 18 years of age. Where appropriate the service will see over 18s, for example those in transition, if this is required. The service works with other agencies and partners within the 4 tiered CAMHS model to contribute towards improving the emotional wellbeing and mental health of all children and young people in Worcestershire. CAMHS uses a 'stepped care' approach to provide a sequence of intervention and support options that offer simpler and less expensive interventions first, and step up to more complex and expensive interventions only if needs have not been met or have changed. The service provides targeted, specialist and intensive (tier 3+) mental health and emotional wellbeing and mental health services for children and young people at tiers 2 and 3 of need.

Referrals from any professional are made through a Single Point of Access (CAMHS-SPA), open 9-5pm, Mondays to Fridays, co-located with the Family Front Door (previously Early Help Hub).

Out of Hours CAMHS advice is available 24/7 through the all-age Psychiatric Assessment Team and the all-age Mental Health Liaison Team. Both teams have a specialist CAMHS worker who ensures the rest of the team have CAMHS expertise. There is a Multiagency Urgent Care Pathway that details these access points.

The service works to improve outcomes in mental health and wellbeing, with expectations as follows:

- More children and young people say their experience of CAMHS is good (measured using CAMHS Outcomes Research Consortium (CORC) outcomes measures).
- Children and young people have shorter waits for a CAMH service (no child will wait more than 18 weeks for a first appointment and the average wait will be no more than 5 weeks).
- Fewer children and young people will have missed appointments.
- More referrers are advised how to signpost families appropriately when they do not meet referral criteria (through the SPA).
- Fewer children and young people will be placed out of county in either CAMHS Tier 4 or complex needs placements.
- Children and young people who need a hospital bed will spend less time in inappropriate accommodation.
- There is better access for children and young people who are LAC, YO, BME or disadvantaged.
- More young people have a quality planned transition to Adult Mental Health Services when they need it and more are successful transitions.
- More young people say their transition to AMHS was good.

- More partners say they are satisfied with the support they received from CAMHS.
- The service is to meet You're Welcome criteria in all localities teams within specialist CAMHS.

Within CAMHS the majority of staff work with the large number of children and young people that are referred to the service for 'core' CAMHS Tier 3 assessment and treatment. But there are also a number of teams, or individuals embedded in other services, who specialise in working with different groups.

The specialist teams/individuals are:

- CAMHS Tier 2 team, working with universal services to build capacity (the Primary Mental Health Worker role)
- CAMHS 0-5s team,
- CAMHS/LD team for children with learning disabilities and additional mental health needs,
- Integrated Service for Looked After and Adopted Children (ISL)/CAMHS working with looked after and adopted children,
- CAMHS Tier 3 Plus team, working with children and young people with severe and urgent mental health needs to avoid inpatient admission and shorten stay
- A CAMHS specialist works within the Youth Offending Service
- CAMHS specialists work within both the all-age Mental Health Liaison and the all-age Psychiatric Assessment teams providing out of hours cover as part of the urgent mental health care pathway. These are equivalent to one post in each team.

Service model for specialist CAMHS

The core work of CAMHS is managed by applying the Choice and Partnership Approach (CAPA) www.capa.co.uk .

Interventions used during Partnership appointments include:

- Psycho-social interventions
- Psycho-therapeutic interventions
- Cognitive Behavioural Therapy (CBT)
- Systemic Family Therapy
- Occupational Therapy assessments and treatments
- Anxiety and Stress management
- Social work interventions
- Group interventions
- Physical Health Care
- Parenting skills, advice and education
- Family Therapy
- Child Psychotherapy
- Pharmacological intervention
- Monitoring of individuals' responses to medication

Service Transformation through CYP-IAPT (Improving Access to Psychological Therapies)

Worcestershire bid successfully for Children and Young People's IAPT funding in 2014 and CAMHS began implementing the programme in the autumn 2014. CYP-IAPT is a service transformation programme with four key priorities: accessibility, evidence based practice, children and young people's participation and routine outcomes measurement (ROMS). Progress in each area has been made:

- Participation: A Participation worker is employed 2 days per week in CAMHS, focussing on participation, including young people and families overseeing CYP-IAPT at a steering group level.
- ROMS (Routine Outcomes Measures): Building on the CORC measures that have been used since 2012, a new set of routine outcome measures is in use, including new session by session measures, supported by a CYP-IAPT data administrator.
- Accessibility: A working group, which involves young people, is developing open referral to CAMHS.
- Evidence Based Practice: Three Cognitive Behavioural Therapy (CBT) trainees continue their studies and are doing well, as are two supervisors (one for CBT and one for conduct disorder). Three leadership trainees are close to completing their course.

Pathways development

- Commissioners and providers are working together to ensure that there are clear pathways for children and young people to access services. The new emotional wellbeing service will link closely with CAMHS, universal services and other services such as early intervention family support to ensure the right service is provided at the right time
- The eating disorder pathway is in draft and has been shared with key stakeholders ready for the service implementation in January 2017.

Neuro-developmental assessments for ASD/ADHD and associated conditions

In Worcestershire a multiagency pathway and collaborative commissioning arrangements are in place for the assessment and ongoing support for children and young people with autism, ADHD and associated neurodevelopmental conditions. CAMHS specialists, specialist teaching staff, speech and language therapists and paediatricians all contribute to the pathway, which is managed through community paediatrics. This pathway is currently under review to reduce the waiting times for neurodevelopmental assessment and in October 2016, parent/carers will be providing their views on the neurodevelopmental pathway and how this can be improved further. Learning from parent/carers experiences will shape further transformation and inform the all age Autism Strategy.

5.1 Activity Baselines:

There were 2,440 referrals to CAMHS via the CAMHS-SPA during 2015/16. 73% of referrals were accepted. The low rate of acceptance suggests that work should still be done to improve referrers understanding of the CAMHS referral criteria. However, the picture is

complicated by the fact that, if the family has given consent, referrals are able to be passed to the Family Front Door Early Help Hub when they do not meet the criteria for CAMHS.

Table 1: Number of CAMHS referrals and numbers accepted/rejected

	11/12	12/13	13/14	14/15	15/16
All Referrals	**3,333**	**3,139**	**3,294**	**2,548**	**2440**
Accepted Referrals	2,813	2,518	2,437	1,774	1783
Accepted Referrals %	*84%*	*80%*	*74%*	*70%*	*73%*
Rejected Referrals	520	621	857	774	657
Rejected Referrals %	*16%*	*20%*	*26%*	*30%*	*27%*

CAMHS referrals by gender and age

Table 2: CAMHS referrals by gender

	11/12	12/13	13/14	14/15	15/16
All Referrals	**3,333**	**3,139**	**3,294**	**2,548**	**2440**
Male	1756	1558	1533	1163	1162
Female	1572	1579	1759	1383	1278
% female	47%	50%	53%	54%	52%
Unknown/Missing	5	2	2	2	0

Table 3: CAMHS referrals by age at referral

Year	12/13	%	13/14	%	14/15	%	15/16	%
All Referrals	**3,139**		**3,294**		**2,548**		**2440**	
5 and Under	280	8.9	220	6.7	154	6.0	116	4.8
6-9	706	22.4	619	18.8	447	17.5	384	15.7
10-12	633	21.2	642	19.5	490	19.2	477	19.5
13-15	1,041	33.2	1,288	39.1	983	38.6	1015	41.6
16-18	476	15.2	525	15.9	468	18.4	448	18.4
Unknown								

Source: CAMHS database analysed by Worcestershire Children's Services PDT. Note unknown figures have been supressed due to low numbers.

There has been an increase since 2011/12 in the percentage of all CAMHS referrals that are in the older age groups 13-18 years and a corresponding decrease in the proportion of younger age groups.

5.2 CAMHS referrals by CCG area

Over the past 4 years the proportion of CAMHS referrals by CCG has remained stable, with almost 50% (46%, 2014/15) in South Worcestershire, around 30% (32%, 2014/15) Redditch and Bromsgrove Group, and nearly 20% (19%, 2014/15) Wyre Forest, Out of county and unknown referrals equate to a small percentage each year, 3% 2014/15. The data for 2015/16 on out of county/unknown is still being collated.

	12/13	13/14	14/15	15/16
All Referrals	**3,139**	**3,294**	**2,548**	**2440**
Redditch and Bromsgrove group	990	959	811	823
South Worcestershire	1,455	1,563	1,166	1,166
Wyre Forest	632	691	492	451
Out of county/Unknown	62	81	79	tbc

5.4 CAMHS referrals by ethnicity

Referrals data has historically not shown reliable coding for ethnicity and one of the recommendations from the last needs assessment in 2011 was that this should improve. In 2010/11 nearly 50% of records had no ethnicity recorded. There has been an increase in recent years in the proportion of referrals that have an ethnic group recorded, so that by 2015/16 70% of referrals had an ethnic group coded and 30% were either 'not stated', 'refused' or 'unknown'. 65% of referrals were from a white, British background. The next biggest ethnic group was 'mixed' at 1.5%.

According to the 2011 census data, over 10% of the population of children and young people aged 0-17 in Worcestershire would identify as BAME (i.e. Black, Asian and Minority Ethnic Persons - those not of White British origin); this frequency is clearly not reflected in Worcestershire CAMHS referrals, but 30% of these had no ethnicity recorded.

Until more up to date prevalence data is available, together with more complete records of ethnicity in CAMHS referrals, it is very difficult to judge the level of unmet need for mental health services in Worcestershire's minority ethnic groups.

Table 5: CAMHS referrals coded by ethnicity

Year	12/13	13/14	14/15	15/16
All Referrals	**3,139**	**3,294**	**2,548**	**2440**
White British	1,084	1,531	1,423 (56%)	1594 (65%)
Other White Background	18	25	31 (1.2%)	36 (1.5%)
Asian	6	24	20 (0.8%)	21 (0.9%)
Black	5	6	16 (0.6%)	5 (0.2%)
Mixed	43	43	40 (1.6%)	50 (2%)
Other ethnic groups	10	6	6 (0.2%)	6 (0.25%)
Not stated/Refused	1,913 (61%)	1,115 (34%)	362 (14%)	143 (5.9%)
Unknown	60 (2%)	544 (17%)	650 (26%)	585 (24%)

For further baseline information relating to vulnerable groups such as LAC and those known to the youth offending service please refer to the emotional wellbeing and mental health needs assessment, 2015 – available on request. An Equality Impact Screening has been completed and when the CAMHS design phase begins, a full Equality Impact Assessment will be completed in relation to changes to the CAMHS service.

5.5 Waiting times

The average wait from referral to the first 'Choice' appointment (in weeks) is shown below:

Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	June 16	July 16
4.98	5.53	5.31	5.49	5.01	5.08	5.76	5.99	5.99	5.85	4.96	4.69

The KPI data for average wait from referral to partnership from August 2015 (therefore taking account of the waits both from referral to Choice and Choice to Partnership) is shown below

Aug 15	Sept-15	Oct-15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	June 16	July 16
16.47	16.00	16.72	14.97	19.71	21.18	17.13	18.89	17.66	15.02	14.80	15.32

Referral to Partnership Average Waits (in weeks) from August 2015- July 2016

The above figures cover all those patients currently waiting not just those seen in month.

5.6 Workforce baselines, Specialist CAMHS

CAMHS Total Funded WTE
(current plan as at M5 1617)

Staff Group	WTEs Funded
5040 Consultant	5.74
5071 Specialty Doctor	0.40
5236 Nurse band 7	4.93
5268 Nurse band 6	21.78
5269 Nurse band 5	3.00
5271 Nurse band 3	2.38
5285 Nurse Band 8A	1.00
5354 Occ Therapist band 6	0.70
5474 Psychotherapist Band 6	0.83
5477 Psychotherapist Band 7	2.61
5479 Psychologist band 8	9.28
5493 Psychologist band 7	3.40
5495 Psychologist band 5	1.00
5639 Admin & Clerical band 5	1.80
5656 Admin & Clerical band 4	2.00
5657 Admin & Clerical band 3	10.67
5658 Admin & Clerical band 2	4.00
5740 Social Worker Qualified	1.00
5743 Social Worker Unqualified	1.00
5754 Social Worker - Band 7	1.00
5755 Social Worker - Band 8A	1.00
5918 Social Worker - Band 6	1.40
Total	**80.92**

The current service has been benchmarked against similar CAMHS using the NHS Benchmarking toolkit (2014). This shows that the workforce skills mix was similar to other CAMHS in 2013/14, except for a greater % of Band 8c operational managers which have since been reduced in number. The total number of WTE has reduced since last year however this is due to a reduction in admin staff to streamline processes within the Trust.

5.7 Current Baseline KPIs, Specialist CAMHS

The CAMHS service is monitored against a performance indicator dashboard. In line with the new commissioning intentions a suite of outcome-based KPIs will be developed using the national CAMHS specification. The intention is for the KPIs to be more ambitious. In addition, Worcestershire aspires for all children and young people to be able to seek advice immediately from professionals and from high quality online advice and information.

KPIs based on CORC outcomes are in the current dashboard, but session by session service user routine outcomes measures (ROMS), being implemented currently as part of CYP-IAPT service improvements, will be used in the revised service specification.

All data collected by CAMHS will be compliant with the Mental Health Services Data Set (MHSDS) and a new electronic patient administration system, CareNotes, has been commissioned to support the effective collection, analysis and reporting of outcomes measures, KPIs, performance data, case notes and other monitoring data. CareNotes will be operational by December 2015.

5.8 Care and Treatment Review (CTR) Pre-admission

Our transformation plan embeds the use of CTRs for children and young people with moderate to severe learning disabilities or autism and challenging behaviour across the local health and care system in order to:

- ensure people with learning disabilities and/or autism and their families are listened to, and treated as equal partners in their own care and treatment;
- prevent unnecessary admissions into inpatient settings;
- ensure any admission is supported by a clear rationale with measurable outcomes;
- ensure all parties, including local councils, work together with the person and their family to support discharge into the community (or to a more appropriate setting) at the earliest opportunity;
- help people challenge current care and treatment plans where necessary, and;
- identify barriers to progress and to how these could be overcome

The new specification for specialist CAMHS will ensure CTRs are in use and that the CAMHS learning disabilities specialist team works with commissioners, social care partners and inpatient units to ensure continuity of planning, appropriate and effective care and timely discharge planning.

So far, the experience of the pre-admission care and treatment review in Worcestershire has been positive, preventing inpatient admission. The task and finish group for care and treatment reviews continues to develop the approach to monitor children and young people with ASD and/or a learning disability who are at risk of inpatient admission or 52 week residential placement. The focus is keeping young people safe and close to home where possible.

6. Eating disorders

6.1 Specialist Community Eating Disorders Service for Children and Young People (CEDS-CYP)

The current eating disorders service is delivered within specialist CAMHS by clinicians and therapists with specialist experience, training and skills in eating disorders and as such is not monitored separately. The service's waiting times, activity and outcomes are combined within the whole service reporting.

The service sees mainly Anorexia Nervosa, with Bulimia, Avoidant Restrictive Food Intake Disorder (ARFID) and Binge Eating disorders more likely to be seen in core CAMHS if they meet service thresholds. The care model and therapies currently used are partially NICE compliant. They include use of CBT, Family Therapy, Dialectical Behavioural therapy (DBT), EDE diagnostic assessment, Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN), use of Maudsley model. However, there is a need to train more of the current team in EDs specific therapies, e.g. Cognitive Behavioural Therapy, Systemic Family Therapy.

To meet standards in the CEDS-CYP guidance, we need to commission/develop:

- a countywide specialist team with additional capacity, skills and training to meet current and additional needs in all localities.
- a clear multiagency pathway also needs to be developed to promote earlier identification and interventions..
- a separate dashboard of KPIs for the CEDS-CYP to monitor service performance and effectiveness, including service user feedback and ROMS.
- monitoring will include referrals to inpatient, Tier 4, units with targets around reducing these in order to maintain children and young people in their communities.
- A workforce training plan to build capacity in the universal and targeted services within the pathway

Appendix 1 outlines the Eating Disorder checklist which is supporting the developments within Worcestershire.

Current activity

There were 57 referrals for eating disorders to the CAMHS Single Point of Access (SPA) within the 12 months from June 2014 to May 2015. This would be sufficient to maintain a CEDS-CYP according to the guidance. Worcestershire has a population of 575,400 people; including 114,900 children aged 0-17, representing 20% of the total population. This also meets the requirements of the minimum population.

Data from January 2016-July 2016 shows that there were 23 referrals into CAMHS SPA for young people with an eating disorder,

Tier 4 admissions and bed days for children and young people with Eating Disorders are detailed in section 10. Overall there were 14 admissions for eating disorders (37% of all admissions), which accounted for 39% of the total spend in 2014/15.

Baseline Eating Disorder capacity within specialist CAMHS
(data also included in, not additional to, the workforce breakdown in point 5.6)

Estimate of current capacity used on Eating Disorders
1.2 FTE specialist mental health nurse
0.3 FTE Family Therapist
0.2 FTE clinical psychology
0.8 psychiatry

In addition T3+ (Home Treatment) Team time is estimated at 261 patient contacts per year.

The plan in Worcestershire is to commission a specialist CEDS-CYP with a separate specification to deliver a service model and therapies that are compliant with NICE guidelines and standards, which also meet the standard for access and waiting times for children and young people.

In order to meet these standards additional capacity will be needed, bringing the service up to the recommended levels to deliver a wider remit – treating all Bulimia, ARFID, Binge disorders, plus outreaching to universal and targeted services to train and build their capacity to identify, prevent and treat eating disorders at an earlier stage.

Gaps in current capacity
(estimated as a minimum, based on CEDS-CYP guidance for a service seeing 50 referrals per year):
0.6 x FTE Head of Service
3 x FTE therapists/clinicians
0.8 x dietician
0.9 x Band 4 support/assistant psychologist
Plus Acute paediatrician 0.1 x FTE, which is currently provided informally, but needs to be captured in the new specification and improved pathway and protocol.

Resource released by commissioning a CEDS-CYP/benefits realised
A full eating disorders needs assessment will be carried out, which will include a projected quantification of the benefits realised by the commissioning of a specialist CEDS-CYP. Any savings will be invested in crisis/urgent care and self-harm pathways. Savings are expected to derive from:

- Savings in the Tier 4 spend for eating disorder admissions (potential for release of these through co-commissioning agreements)
- Savings in the Acute Paediatrics spend for admissions due to physical health deterioration (potential for release of these through co-commissioning agreements)
- Earlier referral from GPs, other universal and targeted services and families as a result of better information and access to a specialist service. This will allow shorter, less

intensive and costly treatments to be used, preventing Tier 4 referrals. Clinicians in the current service estimate that around 9 out of the 14 Tier 4 referrals in 2014/15 presented late. This is 64%.

7. Governance

7.1 Section 75 Agreement

A Section 75 Partnership Agreement between Worcestershire County Council and Redditch and Bromsgrove, South Worcestershire and Wyre Forest Clinical Commissioning Groups has been in place since April 2013. Prior to this, a Section 75 agreement was in place between Worcestershire County Council and NHS Worcestershire since April 2011.

Section 75 Governance

Body		Role
Health and Wellbeing Board		• Approve strategy • Strategic oversight of S75
CCG Governing bodies	**WCC Cabinet**	• Key decisions in respect of their services • Corporate governance of finance, performance and quality in respect of their funding and services
Accountable Officers (meeting as Integrated Commissioning Executive Officers' Group – ICEOG)		• Agree strategy and key decisions • Ensure implementation of strategy and key decisions • Operational governance of finance, performance and quality in respect of their funding and services
Integrated Commissioning Group		• Coordinate commissioning plans across the system and produce integrated system solutions
Commissioners		• Develop and consult on strategy, liaising with ICG • Implementation of strategy and key decisions • Oversight of commissioned services

7.2 Effective joint working

7.2.1 Children and Families Joint Commissioning Team

- A dedicated team has been established since 2011 to commission health services on behalf of Worcestershire County Council and the three Worcestershire Clinical Commissioning Groups. This team is based within the Early Help and Partnerships Service of Worcestershire County Council's Children's Services directorate.

- The benefit of this team being based within the local authority is having strong links to other key colleagues such as Public Health, early help and education commissioners and social care teams. This integrated approach promotes better outcomes for children and young people.

7.2.2 Worcestershire Integrated Commissioning Officers' Executive Group (ICEOG)

- This Group consists of senior officers from Clinical Commissioning Groups and Worcestershire County Council's Children's and Adult Services.

- The Group is responsible for development and implementation of strategies in respect of service areas covered by the Section 75 Agreement as well as operational governance of finance, performance and quality.

- The Group meets monthly.

7.2.3 Worcestershire's Children and Families Integrated Commissioning Group and Transformation Board

- This Group brings together commissioners of services for children and families to work collaboratively in commissioning efficient and effective services which improve outcomes for Worcestershire’s children and families (pre-birth to 25).

- Membership includes commissioners from Worcestershire County Council, Clinical Commissioning Groups (CCGs), NHS England, West Mercia Youth Offending Service and West Mercia Police and Crime Commissioner's Office.

- This group acts as the Transformation Board for Children and Young People's emotional wellbeing and mental health. Progress on the delivery of the local transformation plan is discussed at each meeting.

- The Group meets monthly.

7.2.4 Worcestershire CAMHS/Social Care/Acute Trust Interface Group

- This Group was originally brought together in July 2012 to establish a forum for agencies involved in the multiagency care pathway for children and young people with urgent, severe and complex mental health needs.

- The Group developed a Protocol for implementing a multi-agency response for the care and discharge plan following hospital admission of a child or young person with urgent and complex mental health needs. Other agencies were brought in to help develop the protocol, including the Ambulance Trust, Police, NHS England. This protocol has now been ratified and launched.

- The Group continues to meet to provide a collaborative forum for commissioners and providers to co-operate to resolve problems in the care pathway.

- Permanent membership includes health and social care commissioners from Worcestershire County Council, Quality and Patient Safety representation from CCGs, together with representatives from the CAMHS service and Worcestershire Acute NHS Hospital Trust.

- The Group meets quarterly.

7.2.5 Tier 4 Issues Group

- This Group was originally established as a Task and Finish Group in January 2014 to address the challenges around the Tier 4 pathway before the national review.

- The Group has ratified the Children and Young People's Multiagency Urgent Mental Health Care Pathway Protocol which guides partners through the pathway and processes where children, young people and their families present in emotional distress or crisis with urgent social, emotional behavioural or mental health needs which may include deliberate self harm.

- The Group was dissolved in November 2014 as waiting times had improved, but reconvened again in May 2015 to look at further issues and associated risks. The Group is chaired by the Chief Nursing Officer for the CCGs and membership includes senior representation from Worcestershire County Council, NHS England, Worcestershire Health and Care NHS Trust and Worcestershire Acute Hospitals NHS Trust.

- The Group is currently dormant, but will reconvene where there is any escalation of risks.

7.2.6 Children and Young People's Emotional Wellbeing and Mental Health Partnership Board

- This group meets quarterly to inform and shape the local transformation plan.
- The membership is wide and includes stakeholders such as schools, colleges, NHS providers, social care, voluntary sector, parents and young people.
- The group has been operational since December 2015 and has focused on the following:-
    - Emotional wellbeing pathway
    - Young people's engagement with the local transformation plan
    - Development of the schools emotional wellbeing toolkit

7.2.7 Provider/Commissioner Quarterly Monitoring

- Across the landscape of providers, regular meetings take place between commissioners and service providers to monitor performance and KPIs. ICEOG oversees performance through quarterly reporting on the commissioners' dashboard.

- Meetings also take place regularly to discuss current issues and challenges and to promote integration between services. For example, promoting the close working between CAMHS and school nursing service eg eating disorders and sexual health and the CAMHS consultation role for early help providers.

- Providers work closely with commissioners to provide relevant information to inform commissioning decisions and to support needs assessments and provision of data through an agreed Information Sharing Protocol between provider and commissioner.

7.2.8 Participation of children and young people and parent/carers

- Many groups of children and young people participate in focus groups (as outlined in section 8), including Worcestershire's two Children in Care Councils, the Youth Cabinet and the CAMHS Youth Board, to tell us their experiences of CAMHS and emotional wellbeing support services and to tell us about the needs of children and young people. The CYP-IAPT programme has the strong and active involvement of children and young people, through the CAMHS Youth Board, who have guided many aspects of the work plan.

- Shared outcomes will be developed across the emotional wellbeing and mental health system, using CYP-IAPT and CORC principles. Worcestershire is taking part in the cross-sector outcomes and data linkage project, led by CORC, to support this development. This will include session-by-session routine outcomes monitoring with child or young person reported measures to increase transparency. This will also enable feedback on effectiveness of treatments to be used by clinicians, service leads and commissioners to ensure the most effective and efficient use of resources within the system.

- The commissioning team are part of a Worcestershire Youth Engagement Group to engage with a variety of groups of young people with the support of Worcestershire Healthwatch and participation and engagement colleagues from the local authority, NHS trust and voluntary sectors.

- All plans for the transformation agenda will be made with the involvement and oversight of children and young people, with a separate KPI for monitoring involvement in plans.

- Parents/carers and young people are members of the Children and Young People's Emotional wellbeing and mental health partnership board and attend meetings to discuss gaps in services and shape specific projects such as schools emotional wellbeing toolkit

8. Aspirations of the population of Worcestershire

8.1 What does Worcestershire think?

An engagement exercise was carried out during February to July 2015. This comprised an electronic survey and focus groups. Stakeholder events were also held in February and July. The survey was designed in 3 formats: for children and young people (including questions for service users), for parents and carers (including questions for parents of service users) and professional stakeholders. The survey was widely promoted by email through health, social care and partner agencies' professional networks, Twitter and Facebook sites, plasma screens, newsletters, the schools' e-black bag and via a press release. Hard copies of flyers and posters promoting the survey link were distributed to clinics (including CAMHS), GP surgeries and schools.

The electronic survey was open from 10th March 2015 to 15th May 2015. This was extended to 12th June 2015 for GPs only, in order to gain more responses, since GPs are the main referrer to CAMHS.

The surveys and focus groups revealed evidence of unmet need for lower level emotional wellbeing support and gaps in the pathway, with a strong call for more earlier intervention, particularly in schools, and better joined up working across the pathway:

Over 85% of parents and carers felt that they had needed help to deal with an emotional or mental health issue in their children, and 70% said it was either difficult or very difficult to get help, with waiting times and high thresholds for CAMHS seen as major barriers.

The most important improvement suggested by parents and carers was staff training and support and mental health promotion in schools. Earlier intervention was seen as particularly important by those parent/carers whose child had seen CAMHS.

Children and young people told commissioners that their biggest problems were: family problems, bullying and school worries. Like parents, they felt the biggest barriers to help were lack of availability of services and long waiting times. The most important prevention strategy they suggested was to provide someone to talk to whom they could trust: more counsellors and more school nurse time.

Professional stakeholders overwhelmingly called for better joined up working across the whole pathway, with 71% of responses saying this, and in particular GPs, schools, early help providers, family support workers and other education professionals expressed this view. They also strongly called for better training to enable greater awareness, prevention and earlier intervention in mental health difficulties.

9. Existing improvement initiatives

9.1 CAMHS School link Pilot Scheme

Worcestershire submitted a bid in 2015 for the CAMHS School link Pilot Scheme. Wyre Forest CCG along with the local CAMHS service and 16 schools expressed an interest in developing a more robust schools/CAMHS link through training and consultation and the development of a virtual team to support emotional health and wellbeing.

Worcestershire was not successful with this bid however it was used as a platform to focus on strengthening the CAMHS school link. The new CAMHS service specification drafted in 2016, has a strong focus on the consultation service. This will be in addition to the schools emotional wellbeing toolkit and the integration worker based in the new emotional wellbeing service.

9.2 Crisis Care Concordat

Worcestershire's Crisis Concordat plan includes actions and KPIs for children and young people as part of the all-age crisis response and urgent care pathway, including the review of transition arrangements (from young people's services to adult services), consideration of a 0-25 CAMHS service, support for young carers crisis and liaison support and use of the Section 136 suite.

Worcestershire's Crisis Care Action Plan was recently noted for its strength in a number of areas, including its actions on peer support, liaison and diversion, children and young people and A&E by the Crisis Care Concordat project lead.

9.3 Mental Health Resilience Funding

The Parity of Esteem funding has been invested into the all age Mental Health Liaison Service, Early Intervention in Psychosis service (which works with young people from 14 years of age) and the Enhanced Primary Mental Health Care Service which accepts referrals from the age of 16 years and is currently in development.

9.4 Local Strategy and Plans

9.4.1 The Worcestershire Children and Young Peoples Plan 2014-17 includes the following priorities all of which are relevant to mental health and emotional wellbeing:

- children and young people have a healthy lifestyle (including a focus on improving emotional wellbeing and access to mental health support) children and young people are helped at an early stage
- children and young people reach their full potential in education
- children and young people grow up in secure and stable families
- children and young people are protected from abuse and neglect

- children and young people and their parents/carers know where to go for information about services and support

9.4.2 Worcestershire Health and Wellbeing Board's 2016-19 strategy includes a focus on children under the age of 5 and their parents/carers, and young people .Good mental health and wellbeing throughout life is a key priority.

9.4.3 Worcestershire Health and Wellbeing Board's Mental Wellbeing and Suicide Prevention Plan, 2014, includes several areas of work to promote mental wellbeing in children and young people.

10. Impact and Outcomes

10.1 Successes

10.1.1 Emotional health and wellbeing service

Since the publication of the transformation plan in November 2015 there has been considerable progress. One of the successes has been the development of the new emotional health and wellbeing service. The CAMHS needs assessment completed in 2015 concluded that there was a gap in emotional wellbeing services at Tier 2 level and that there were young people who required support but didn't reach the threshold for Tier 3 CAMHS. In order to provide the support required for this group of young people a Tier 2 emotional wellbeing service was commissioned. Part of this service is an online counselling service which will be provided by Kooth. This provider has considerable experience in delivering online counselling services to young people and their offer includes forums, secure chat rooms and a young person friendly information, advice and guidance section. They are currently working on an innovative app which will ensure young people can access the service from their tablet or smartphone.

The new service will offer evidence based interventions and ensure any additional vulnerability or inequality suffered by children and young people (e.g. looked after children, those with a learning disability, or victims of child sexual exploitation) is properly considered when identifying appropriate interventions.

10.1.2 Urgent care pathway

There has also been success with the launch of the urgent care pathway for children and young people where we have seen improved relationships between the community NHS Trust and the Acute NHS Trust and both are working to improve crisis care for children and young people, including those with eating disorders. There is more work to do over the coming year around ensuring out of hours services are fit for purpose, especially with pressure on hospital beds – agencies need to work together to ensure children and young people with health and social care needs are safely and speedily discharged from hospital.

10.1.3 Schools emotional wellbeing toolkit

There has been good engagement with headteachers and pastoral staff to produce a schools emotional wellbeing toolkit, to provide practical advice to schools around emotional wellbeing issues. The toolkit for emotional wellbeing is currently in draft and is out for consultation with schools.

10.1.4 Engagement of stakeholders

There is excellent engagement from all stakeholders around the transformation plan to help inform future commissioning of services and service pathways. Stakeholders attend the Children and Young People's emotional wellbeing and mental health partnership board meetings and are provided with regular communication updates.

10.1.5 Workforce development

Development of an agreed workforce development plan for staff across all agencies and settings. A workforce sub group has been meeting regularly to develop the training offer for the whole workforce so that all universal services know how to identify emotional wellbeing issues and know what to do to support them. A new course around self-harm is in development.

10.1.6 Waiting times

There has been a focus on reducing waiting times within the specialist CAMHS service. This focus has resulted in reduced waiting times for young people from referral to treatment. The latest waiting time data shows that the percentage of young people waiting less than 25 weeks for treatment has increased from 67% in August 2015 to 97% in August 2016. There is still more to do in this area, and this transformation plan seeks to reduce waiting times further through investment within CAMHS, but also investment in prevention and early intervention.

10.1.7 Waiting times for ND pathway

There has been a reduction in waiting times for neurodevelopment assessment due to a redesign of the pathway. The NHS Trust and commissioners continue to work together with input from parents and carers to make further improvements and inform the all age Autism Strategy.

10.1.8 Youth justice system

Commissioners have engaged with NHS England on the deep dive in Worcestershire to look at needs of young people who enter the youth justice system. Findings from the deep dive will inform commissioning of services.

The new CAMHS service specification emphasises the requirement for continued provision of the primary mental health worker placed within the Youth Offending Service (YOS). The aim of the service is to facilitate joint working and care pathways between CAMHS and YOS and to build capacity in core YOS staff so that these vulnerable children and young people have early access to support for their emotional wellbeing and any mental health needs that require specialist CAMHS are identified and can be treated in a timely manner before they escalate.

10.1.9 Care and treatment review

Worcestershire has had a successful start to the implementation of care and treatment reviews, preventing inpatient admission for those with ASD and /or a learning disability, and championing care close to home. Across the children's workforce (health, education and social care) we intend to raise further awareness about the introduction of care and treatment reviews for children and young people with a learning disability and/or Autism.

10.1.10 Young people's engagement

There has been good engagement from young people throughout the first year of the transformation plan. Worcestershire's youth cabinet have chosen mental health and wellbeing to be a focus of their campaign, part of this campaign work is a survey written by young people aimed at young people who have accessed mental health services and young people who haven't. The survey is now live and data will be collated early 2017.

Young people are fully involved in the development of the new emotional wellbeing service including participating in recruitment of staff. The participation and engagement worker is a member of the new emotional wellbeing service development group.

The CAMHS service use routine outcome measures which allow children and young people to play active role in monitoring their treatment. These outcome measures also play an important role in supervision of staff. Care plans are written and reviewed collaboratively with children, young people and their families.

10.1.11 Data linkage

There has been a data sharing agreement developed between the NHS provider and the County Council. The data linkage group continues to meet to explore ways in which outcomes data could be shared across organisations to be able to effectively monitor how children's needs are being met across organisations.

10.1.13 Eating disorders

The NHS provider Trust is developing the new Community eating disorder service for children and young people and as part of this has developed excellent working relationships with the Acute NHS Trust paediatric ward. The new service is due to launch from January 2017.

10.2 Challenges

10.2.1 Recruitment

There have also been some challenges; one of these challenges is recruitment. It can be difficult to recruit to some posts in mental health. The risk of the delay in recruitment is that this has an impact on the start time of some of the projects. Commissioners are working with Health Education England to ensure all actions are taken to develop the workforce.

10.2.2 Workforce development

This Transformation Plan will encourage the development of a suite of training across the workforce to increase skills and knowledge for detecting emotional wellbeing issues and ensuring staff know what to do to support a child or young person. A self harm training course is being developed but the pace of implementing this is slower than anticipated due to procurement processes.

Many CAMHS services across the Country want to upskill staff through training. However, this means there is high demand for training courses, such as eating disorder related training, which lengthens timescales to train staff within CAMHS. Again this issue has been highlighted to Health Education England.

10.2.3 Changes within Early Help in Worcestershire

There are significant changes to the early help offer in Worcestershire due to reduction in county council and public health budgets and the need to re-design services to focus greater effort on vulnerable families and communities. This means that the new emotional health and wellbeing service and CAMHS need to work closely with early help partners to get service pathways right for children and young people.

10.2.4 Out of hours service provision

Due to the relatively small numbers of children and young people requiring out of hours support, in comparison to adult services, commissioners are exploring how Worcestershire can further develop out of hours services in a collaborative way across providers to ensure that cover is available out of hours. Commissioners have engaged with the West Midlands Science Network to evaluate out of hours provision.

10.3 How will delivery be different in 2020?

10.3.1 Waiting times

In order to improve the waiting times for Tier 3 CAMHS commissioners have set clear KPI targets for the provider NHS Trust. Waiting times for referral to treatment need to reduce year on year through recruitment of staff and through innovative ways of working with children and young people.

10.3.2 Routine Outcomes Measures

Routine outcomes measures will be embedded into CAMHS provision so that a child or young person's goals will be at the heart of the delivery of service, and if an approach is not working, a different approach can be implemented quickly.

Experience of children, young people and their families will continue to shape service provision.

10.3.3 Worcestershire will have a clear emotional wellbeing pathway

A clear pathway will be in place for young people, parent/carers and professionals to seek support with emotional wellbeing issues. One access point will be available for advice and guidance. Instant information will be available via phone or online/through an app.

Schools will have a practical toolkit to support them with procuring good quality emotional wellbeing services, and to be clear on how to support a child in school with emotional wellbeing issues.

Universal services including schools will feel well supported from a visible CAMHS consultation service.

10.3.4 Workforce

There will be a robust multi agency workforce plan, with a suite of training for the children and young people's workforce.

The workforce will feel confident about identifying emotional wellbeing issues and what to do to help.

Agencies will be working jointly to triage referrals and ensure children and young people are supported by the most appropriate service and prevent a child/young person from having to tell their story over to different professionals.

10.3.5 Vulnerable groups

Vulnerable groups of children and young people, such as those who are looked after by the local authority, those in the youth justice system, and those who have experienced abuse will receive timely assessment and intervention.

10.3.6 Eating disorders

A specialist community eating disorder service for children and young people will be fully operational and will be meeting the access and waiting time standards. Children and young people will be identified as having an eating disorder earlier and fewer young people will be admitted into Tier 4 for an eating disorder.

10.3.7 Tier 4 numbers

Fewer young people will be admitted to Tier 4 units due to an increased in provision in Tier 2 and 3 and hospital stays will be shorter.

11. Finance

11.1 Current Total Spend on specialist CAMHS

The contract with the current provider is paid in block. The current commissioning budget (2015-16) for specialist CAMHS T2/3/3.5 for the 0-18s population has not been reduced since the last needs assessment in 2011, despite local government and CCG savings being made in other service areas. Worcestershire CAMHS has been protected during and following the 2012 service re-design and has had additional investment both from the LA and CCGs.

Table 6:

Year	LA	CCG	Total
2011/12	£705,000	£3,972,670	**£4,632,131**
2016/17	£739,019	£4,401,668	**£5,140,687**

The current CAMHS LA-funded provision includes the specialist mental health service for looked after children.

11.2 Current total spend on Early Help

Worcestershire County Council currently commissions a range of prevention services for children and young people aged 0-19 years old. These services include:

- A 0-19 integrated public health nursing service which will deliver prevention services by providing the universal and targeted requirements of the nationally mandated Healthy Child Programme.
- Parenting and Family Support Providers (one for each district area) who provide evidenced based parenting support, targeted family support, support to those young people who are at risk of becoming not in education, employment and training and community capacity building
- Other prevention and early intervention services such as positive activities for young people and targeted family support.

The total budget available (16/17) for these services is over £12million.

Whilst it isn't currently possible to quantify the actual 'early help' spend on emotional well being and mental health needs, analysis of Early Help Assessments suggests that a large proportion of the current investment into County Council funded early help services is supporting emotional well being and low level mental health needs.

An additional £65K was allocated to the Early Help providers from 2013-14 to support families where parent/carers have low level mental health needs and where early help support is required but not to the extent where specialist mental health services are needed. In addition, Early Help providers receive Mental Health First Aid training to support young people.

11.3 Plans for newly allocated funding

The Eating Disorder transformation funding allocation is £286,427 recurrently.

Further funding allocation across Worcestershire will be £716,955 recurrently for 5 years.

	Eating disorders and planning 15-16	Additional funding available	Total
R&B	84,096	261,718	345,814
SW	144,727	436,197	580,924
WF	57,604	174,479	232,083
	286,427	**872,394**	**1,158,821**

11.4 Current spend by NHS England on Worcestershire children placed in Tier 4 (2014/15)

The total spend on CAMHS Tier 4 admissions for the year 2014/15 was £2,123,788. This covered 38 admissions, with an average cost per admission of £55,889.

This can be broken down to understand where the largest costs are currently and to identify where the biggest 'invest to save' developments can be made. By commissioning more effective interventions in CAMHS Tier 3 and in the urgent care pathway and crisis support, together with an effective specialist CEDS-CYP service, it is proposed that large savings could be made in the Tier 4 spend for Worcestershire. Currently an estimated 39% of Tier 4 spending is on inpatient eating disorders (based on an average bed-day cost of £551), indicating that an effective CEDS-CYP should be commissioned in order to reduce the number of admissions and length of stay.

Table 8: Tier 4 spend 2014/15

	Redditch and Bromsgrove		South Worcestershire		Wyre Forest		Total no. admissions	
2014/15 spend on Tier 4	£666,391		£1,290,679		£166,718		38	**Total** spend £2,123,788
	No. admissions	No. bed days	No. admissions	No. bed days	No. admissions	No. bed days		Spend breakdown based on av. spend per bed day (£551 per day)
Eating disorders	5	467	7	719	Number supressed	311	14	£824,847
General adolescent	8	1,011	8	531	Number supressed	61	17	£873,335
High Dependency Unit			Number supressed	20			Number supressed	£11,020
Low secure unit	Number supressed	20	Number supressed	68			Number supressed	£48,488
Paediatric intensive care			Number supressed	473	Number supressed	176	Number supressed	£357,599
Total	**Number supressed**	**1,498**	**20**	**1,793**	**Number supressed**	**548**	**38**	

Source: NHSE specialised commissioning

= potential focus for invest to save

Table 9: Mean number of Tier 4 bed-days per CCG

Mean number bed days per bed type and CCG:-			
	Redditch and Bromsgrove	South Worcestershire	Wyre Forest
Eating disorders	93	103	156
General adolescent	126	66	61
High Dependency Unit		20	
Low secure unit	20	68	
Paediatric intensive care		158	176

Source: NHSE specialised commissioning

= potential focus for invest to save

11.5 Schools – current spend

Schools through the use of the core budgets, Dedicated Schools Grant and Pupil Premium funding are currently commissioning a variety of services to support emotional wellbeing e.g pastoral staff teams, PSHE, school counsellors, peer mentors and music and art

therapy. However, it is not possible to quantify the level of this funding currently. Once stronger partnerships are forged the aim will be to influence all commissioners within the system to support emotional wellbeing and mental health prevention and treatment to invest in the most effective, evidence-based interventions.

In addition to this, schools invest £1.48 million on an Early Intervention Family Support Service (this amount is included in the 12 million outlined in Section 11.2). This service complements the County Council commissioned 0-19 Early Help Providers and use the Early Help Assessment Framework as the tool to identify and meet need.

worcestershire
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AGENDA ITEM 8

HEALTH AND WELL-BEING BOARD
1 Nov 2016

BI-ANNUAL PROGRESS REPORT FROM THE HEALTH IMPROVEMENT GROUP

Board Sponsor
Cllr. John Smith, Chairman and County Council Cabinet Member for Health and Well-being.

Author
Dr. Frances Howie, Director of Public Health

Relevance of Paper - Priorities
Reducing Harm from Alcohol at all Ages
Good Mental health and Well-being Throughout Life
Being Active at Every Age

Relevance - Groups of Particular Interest
Middle aged people
Older people
Communities and groups with poor health outcomes

Item for Decision, Consideration or Information
Consideration

Recommendation

1. **The Health and Well-being Board is asked to consider and comment on progress made between June 2016- September 2016; and**

Summary of progress: strategic plans

2. Since the bi-annual progress report was presented to the Board in May 2016, the HIG has received updates on the Mental Well-being and Suicide Prevention Plan and the emerging HWB strategic plans 2016-21 (Alcohol, Being Active, Mental Health & Well-being). A summary of progress is set out below.

3. **Mental Well-being and Suicide Prevention Plan – Year 3 progress summary**

4. The Health Improvement group (HIG) received an annual update for the Mental Well-being and Suicide Prevention Plan for Worcestershire (2013-2016) in June 2016.

5. The HIG were requested to note and support the moving of some operational aspects of the then current Mental Well-being and Suicide Prevention Action Plan 2013-2016 into embedded work and services across partner organisations and support the co-production of a new' Good Mental Health & Well-being throughout Life' Action Plan.

6. Work within the plan has been delivered by a diversity of partners including; Voluntary & Community Sector organisations, District Councils, Health and Care NHS Trust, CCGs, University of Worcestershire, County Sports & Community Safety Partnerships in collaboration with Public health and other Directorates across the Council.

7. Selected summary and outcomes of the progress demonstrated during the final year of the plan.

8. Health Chats training promotes the 5 Ways to Well-being to frontline staff & service users ; over 1762 people have received training; 170 university nursing and midwifery students 50 progressing to become trainers.

9. A Primary Care Mental Health Needs Assessment has informed the review and redesign of primary care mental health services by Worcestershire CCG's leading to an enhanced primary care mental health service; enabling self-referrals, information and signposting to provision and providing earlier intervention. Worcestershire Healthy Minds service and Well-being Hub has been designed to support and build resilient communities enabling improved access to services (maintains a well-being directory) through flexibility of online availability and enabling all (including those in recovery) to live well in the community, providing interventions through self-help guides, and on line therapy.

10. Mortality from suicide is similar in Worcestershire to the national average of 8.8%, West Midlands 8.3% and Worcestershire 9.1%; the Worcestershire Suicide Audit Group (SAG) meets quarterly to monitor local trends and data. The SAG is implementing a new pro-forma system to determine the modifiable risk factors of suicides that are audited to move forward with work.

11. University of Worcester multi-agency 'Suicide Safer' Project Group has been running for 2+ years. The project launched an out of working hours Nightline listening service at the University; run and staffed by trained student 'listeners'.

12. A new version of Help is at Hand resource has been published. It has been distributed to first responders (Police and Paramedics), Coroners' Officers, Bereavement support organisation, Public libraries, advice centres, health centres and promoted online and on social media.

HWB Priority Strategic Plans 2017-21

13. A stakeholder event on the 9th June 2016. The event was a follow up to previous events that determined the Joint Health and Well-being Strategy priorities for action;
    - Good mental health and well-being throughout life
    - Being active at every age and
    - Reducing harm from alcohol at all ages.

14. The stakeholder event demonstrated the Board's commitment to engage and involve the widest possible range of partners, professionals and local communities in their work. Action plans for the three priority areas were developed as a result of engagement and co-production with stakeholders. The plans were presented to the HIG at its September meeting.

Summary of Progress: District Plans

15. Since the bi-annual progress report to the Board in May 2016, two districts (Wyre forest, Redditch) have presented their district plans.

Redditch District Council

16. An update of Redditch District Council Health and Well-being Partnership Action Plan 2016 was presented to the HIG in June. The priorities of the plan are:
    - Maternal and Early Years Health
    - Obesity
    - Mental Health & Well-being
    - Alcohol

Key projects include

17. *Wellbeing in partnership fund* - Organisations in Redditch were invited to bid for up to £2.5k from the Redditch Well-being in Partnership one off funding pot. Five bids were successful:

    - Age UK and the Older People's forum – Food for Thought
    - RBC leisure – Playing rounders on green spaces
    - Age UK – Men in Sheds
    - Mental health Action Group Peer Support Project
    - Relate

18. *Starting Well campaign* – A public information and advice event was held in March 2016 for parents to be and parents of babies and young children

19. *Healthy Start* - Promotion aimed at raising awareness of healthy start vitamins

20. *Diabetes Campaign* – A countywide campaign providing information for frontline staff supported by Diabetes UK

21. **Development of ongoing projects includes:**
    - Social prescribing
    - Eating Well on a Budget-frontline Staff Training
    - Connecting Families

22. **Future projects include:**
    - Maternal and Early Years health campaign in early 2017
    - Ongoing support and monitoring of the Redditch wellbeing fund projects
    - Work on directory of services for Redditch
    - Focus on alcohol
    - Upcoming Overview and Scrutiny (CYP mental wellbeing)

Wyre Forest District Council

23. An update of Wyre Forest District Council Health and Wellbeing Partnership Action Plan (2016-20) was presented to the HIG in September. The priorities of the action plan are:

    - improving mental health and well-being
    - increasing physical activity
    - reducing the harm caused by alcohol.

24. The 2016/20 action plan mirrors the three priorities in the Worcestershire Health and Wellbeing Strategy. In addition it addresses the main areas of concern for Wyre Forest and includes some local priorities that will address health issues in the area around statutory homelessness, smoking in pregnancy, fuel poverty and breast feeding that aren't reflected in the countywide strategy.

25. Health inequalities will remain a primary consideration for Wyre Forest and it will continue to support colleagues and partners in providing advice and assistance to the most vulnerable residents whilst also improving employment prospects and facilitating economic growth for all.

26. Good practice initiatives taking place in Wyre forest to improve the Health & Wellbeing of residents include:

    - The annual Showcase of Services for Older People at Kidderminster Town Hall.
    - In 2016, the first Wyre Forest 'Starting Well' event took place, aimed at parents and carers of babies and young children
    - Two Greener Living Shows also took place in 2016 in Bewdley and Kidderminster, organised by WFDC in conjunction with local Transition groups
    - Let's Eat the Park - a community food growing scheme, run by the Friends of St. George's Park in Kidderminster

- Reaching Out; a community based project aiming to reach out to older people who are lonely and isolated living in Wyre Forest
- Wyre Forest Parkrun - Parkrun organise free, weekly 5km timed runs
- Worcestershire Works Well - To date, 7 Wyre Forest businesses and organisations have signed up, with 6 of these having achieved accreditation

Housing Issues

27. **Charter for Homeless Health**

    The HIG discussed key housing issues at its September meeting. The Health and Wellbeing Board agreed to embed the priorities from the Housing Charter into work across the County. This work will be taken forward by the Director of Public Health and key partner agencies It is noted that a new Worcestershire Strategic Housing Partnership plan is at consultation phase and will incorporate a much stronger approach to partnership working on health and housing.

28. Progress against the three commitments in the Charter for Homeless Health signed by the H&WBB include:
    - Identifying need, and inclusion of the health needs of people who are homeless in the Joint Strategic Needs Assessment.
    - Providing leadership on addressing homeless health. The Director of Public Health has a key leadership role to play in tackling health inequalities and will lead in promoting integrated responses and identifying opportunities for cross boundary working
    - Commissioning for inclusion: Working with the local authority and clinical commissioning groups to ensure that local health services meet the needs of people who are homeless, and that they are welcoming and easily accessible

Developing an integrated approach to creating alignment between the Better Care Fund Plan and Disabled Facilities Grant Funding (DFG)

29. The September HIG agreed to work together to effectively use the increased levels of funding being allocated to Disabled Facilities Grants (DFG) and work to deliver more integrated and targeted services. It will receive two DFG performance monitoring reports per year

30. The HIG discussed improving the alignment and strategic planning of the DFG and to work with local housing authorities to incorporate DFG programmes and outcomes as part of the overall Better Care Fund planning process.

31. The Health & Wellbeing Board (HWBB) will be requested to sign up to the Health & Housing Memorandum of Understanding (MoU) to ensure more effective planning and co-operation across the sectors further strengthening BCF alignment.

32. In addition to the updates on the WCC Strategic Health and Well-being Plans and the District Plans, the HIG has considered the following:

- Loneliness Plan 2016-18 update
- Tobacco Control Plan
- Healthier You – Worcestershire Diabetes Prevention Programme
- Supplementary Planning Document

33. Updates on H&WBB priority plans 2016-21, will be provided to the HIG annually.

Contact Points

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worcestershire countycouncil

AGENDA ITEM 9

HEALTH AND WELL-BEING BOARD
1 NOVEMBER 2016

JSNA SUMMARY

Board Sponsor
Frances Howie, Director of Public Health

Author
Peter Fryers, Consultant in Public Health

Priorities	(Please click below then on down arrow)
Older people & long term conditions	Yes
Mental health & well-being	Yes
Obesity	Yes
Alcohol	Yes
Other (specify below)	

Groups of particular interest	
Children & young people	Yes
Communities & groups with poor health outcomes	Yes
People with learning disabilities	Yes

Safeguarding	
Impact on Safeguarding Children	No
If yes please give details	
Impact on Safeguarding Adults	No
If yes please give details	

Item for Decision, Consideration or Information
Information and assurance

Recommendation

1. **The Health and Well-being Board is asked to:**
   a) **Note the information on progress and issues relating to the priorities**
   b) **Note the emerging issues and ask the Health Information Group to consider these for action that may be required**
   c) **Note the briefings and other further reports available**

Background

2. This is the first annual JSNA summary following the update of the Health and Wellbeing strategy earlier this year. It pulls together information relating to the three new priorities:
   - Keeping active at every age
   - Preventing alcohol harm at all ages

- Good mental health and wellbeing at all ages

3. Alongside these data are some brief summaries of some issues that are either starting to show some potential problems locally or that are likely to lead to possible issues in the future. These emerging issues that have been identified are
   - The narrowing gap between Worcestershire and England;
   - The rapid growth in housing;
   - Homelessness;
   - Sexual Violence;
   - Autistic Spectrum Disorder (ASD);
   - Migrant Health/Social Cohesion.

4. Finally the report includes an brief summary of each of the briefings produced for JSNA over the last year and where these can be found on the JSNA website.

Legal, Financial and HR Implications

5. None

Privacy Impact Assessment

6. All data have been prepared according to guidance on disclosure and have been presented in a way that does not allow the identification of individuals.

Equality and Diversity Implications

7. An Equality Relevance Screening has been completed in respect of these recommendations. The screening did not identify any potential Equality considerations requiring further consideration during implementation.

Contact Points

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Supporting Information

- JSNA Summary Report

Background Papers

In the opinion of the proper officer (in this case the Director of Public health) the following are the background papers relating to the subject matter of this report:

- Health and Wellbeing Strategy 2016-2021
  http://www.worcestershire.gov.uk/downloads/file/7051/joint_health_and_well-being_strategy_2016_to_2021

Worcestershire Health and Well-being Board Joint Strategic Needs Assessment (JSNA)

Draft Joint Strategic Needs Assessment Intelligence Update

September 2016

www.worcestershire.gov.uk/jsna

Prepared by the Worcestershire Public Health Intelligence Team

Date:	29/09/16
Version:	V10
Document Location:	U:\U160 ACS\U661 Public Health\G0 Secure\01 PHIT Shared\Projects\JSNA\JSNA summary 2016
Review Date:	September 2017

Executive Summary

This is the first JSNA summary since the adoption of the new Health and Wellbeing Strategy, with the three new priorities, keeping active at every age, preventing alcohol harm at all ages and good mental health and wellbeing at all ages. The report gives a brief overview of information relating to these priorities as well as a short summary of some new issues or issues that are on the horizon that provide challenges for health and wellbeing. Also included is a short summary and link to each of the JSNA products that have been published over the last year.

Keeping active at every age[1]

- The estimated rate of physically active adults in Worcestershire has fallen slightly in 2015. This is now similar to the national average and the rates of the CIPFA nearest neighbours, and better than the regional average.
- The estimated percentage of physically *inactive* adults in Bromsgrove, Malvern Hills and Worcester has increased since 2014.
- Over the last few years the proportion of adults in Worcestershire participating in sport and active recreation has increased slightly, but is still just less than a quarter. In contrast, more than half in the latest survey had not done any sport or active recreation in the previous four weeks.
- When it comes to older people[2] participation in these activities the figures fall further, with only 15% doing so – lower than in other similar areas.

Preventing alcohol harm at all ages

- The rate at which under 18s are admitted to hospital for alcohol-specific conditions has decreased in Worcestershire, bringing us into line with the national average and other similar areas.
- However, the rate for people of all ages has increased and is now also in line with the national average. This increase has been greatest in middle aged women and this rate is now significantly higher than average and is the highest it has been for 6 years.
- The latest rate of males admitted to hospital for alcohol-related conditions in Worcestershire is significantly better than the national average, but it has increased from 729 per 100,000 population in 2011/12 to 791 in 2014/15.
- Both alcohol-specific and the wider definition of alcohol-related mortality have increased steadily in Worcestershire and are at the highest they have been since 2006-08.
- The rate of successful completion of treatment for alcohol clients in Worcestershire is lower than the national average for 2015/16. This has been in steady decline since 2013/14, whilst the national average has remained stable.

[1] Unless otherwise stated this report refers to 'older people' as those aged 65+
[2] In this instance 'older people' means those aged 55+

Good mental health and wellbeing at all ages

- Recorded prevalence[3] of dementia in Worcestershire is lower than the national average.
- Recorded prevalence[3] of depression is significantly higher in Worcestershire than England and has increased from the previous year
- Emergency admissions to hospital for self-harm are similar to the national average.
- Mortality from suicide is similar in Worcestershire to the national average.
- Self-reported well-being in Worcestershire is similar to both the national and regional average.
- Social isolation rates are significantly lower in Worcestershire than England.
- There are a number of 'at risk' groups which include: (i) those with dual diagnosis; (ii) people with long term physical illness or disability; (iii) Looked after children, particularly those in residential care and (iv) carers.

Emerging Issues

As well as giving the background data and analysis for these priorities the report flags up some additional issues that are emerging from routine analysis and data as being new or emerging as challenges for Worcestershire. These emerging issues are:

- *The narrowing gap* between Worcestershire and England; this is important because we must ensure health and wellbeing remains better in Worcestershire than the England average. Currently this differential is reducing in some key areas including cardiovascular disease and cancer mortality.
- *The rapid growth in housing;* this is important as it will potentially mean large changes in the population of the county, most likely a steeper increase than is currently being projected. The housing projects also provide an opportunity to encourage development plans which maximize opportunities for health and wellbeing through the application of health impact assessments (HIA) and a Health SPD.
- *Homelessness* can have a severe impact on health and wellbeing particularly for those who are categorized as 'rough sleepers'. Parts of Worcestershire have higher rates of homelessness than might be expected.
- *Sexual Violence* – Rates and numbers of recorded sexual violence have increased rapidly in Worcestershire as they have nationally. It is thought that this is due to much increased willingness of victims to report such crimes and better recording by the police.
- *Autistic Spectrum Disorder (ASD)* – this is important because children and adults with ASD need specialist support and care, but there is no definitive information about the prevalence of the condition in Worcestershire.
- *Migrant Health/Social Cohesion* – the health and wellbeing of migrant populations can be compromised due to social isolation and difficulties accessing healthcare.

Briefings Summary

Finally the report contains summaries of the data briefings produced for the JSNA over the last year. These briefings, along with other briefings, reports and needs assessments can all be found on the Worcestershire JSNA website at:

http://www.worcestershire.gov.uk/jsna

Briefings this year have been produced on:

[3] Number of people aged 65+ recorded with dementia or depression on GP practice disease registers; this is probably an underestimate of the actual occurrence in the population. However estimated prevalence of dementia is not available at a sub-national level.

(i) *Gender differences in health and wellbeing* – In all conditions (except excess winter deaths) mortality is higher amongst men than women; this is particularly noticeable in suicide and cardiovascular disease. Reasons for this discrepancy are complex and poorly understood but may include differences in access to health services, particularly attending a GP with early signs of poor physical or mental health.

(ii) *Rural health* – Worcestershire is a very rural county; in some districts the population is very dispersed. Isolation and loneliness is a risk to health and wellbeing, particularly for older people living in rural areas.

(iii) *Road Safety* - The latest reported national casualty figures reveal that there has been an increase in the number of older people killed in road traffic collisions in Great Britain.

(iv) *Fuel Poverty* - Malvern Hills is the district with the highest rate of fuel poverty at 14.1% of households, an increase on the previous year and significantly worse than the national average.

(v) *Older People Briefing* – a key point here is that the number of people aged over 65 with a Long Term Limiting Illness (LTLI) in Worcestershire is projected to rise over the next 15 years by 41%. This has potential implications for individual health and wellbeing outcomes and also social care costs.

(vi) *Sexual Health Briefing* – Sexual health outcomes in Worcestershire are better than the national average; however poor sexual health is more common in areas of greater deprivation.

(vii) *Childhood obesity* - focusing on results from the National Childhood Measurement Programme (NCMP) 2014/15. The most deprived areas of Worcestershire have higher rates of children with excess weight than the least deprived areas. The gap between the most and least deprived areas increases with the age of the child.This is important as obesity in childhood frequently endures as obesity into adulthood.

(viii) *Teenage pregnancy* - Higher numbers of teenage conceptions occur in deprived areas. Worcester City, Redditch and Wyre Forest council district areas have the higher teenage conception rates in Worcestershire

(ix) *Smoking in pregnancy* - Despite being higher than the England average, the percentage of women smoking at delivery in Worcestershire is showing a gradual downward trend.

(x) *Self-harm in Children and Young People* - Social deprivation is strongly associated with self-harm, with the highest emergency hospital admission rates. Girls and female adolescents are at higher risk of self-harm compared to males, with evidence of a shift in age distribution towards young females (10-14 years).

(xi) *Early years district profiles* - Considerable inequality in good levels of childhood development is evident, with the most deprived areas having levels less than half those in the least deprived areas. New data for those eligible for free school meals shows much lower levels of attainment in this group than the general population (regardless of where they live).

(xii) *Learning Disabilities* - National estimates of prevalence suggest that there could be as many as 8,000 adults aged 18-64 with a learning disability; but only around 2,413 people are recorded on GP registers as having a learning disability. Approximately 1,275 adults (aged 18-64) with a learning disability are getting long term support from the Local Authority and these numbers are falling.

(xiii) *Domestic abuse and violence* - There is a clear positive association between deprivation and reported incidents and crimes; in Worcestershire the rate of domestic abuse in the most deprived areas is almost 25 times that in the least deprived areas.

(xiv) *Sexual violence* – (To be added)

(xv) *Viewpoint survey results* - In Worcestershire as a whole, *overweight and obesity* is seen as by far the greatest threat to health (mentioned by 59% of respondents), followed by *physical inactivity* (37%). When asked about the importance of a healthy lifestyle; two thirds strongly agree that "a healthy lifestyle will reduce their chances of getting ill" but only a quarter of Worcestershire residents strongly agree they "live a healthy lifestyle".

Contents

Introduction

Purpose of the JSNA Annual Summary

The JSNA Annual Summary is intended to provide a 'one stop shop' for the latest information and data on public health topics, namely the three Health and Wellbeing Board priorities and any emerging issues. A link is provided to the relevant documents on the JSNA website if people are interested in finding out more detail about the topic.

Demographics

Population now

Table 1: 2015 Mid-year estimates by Worcestershire district

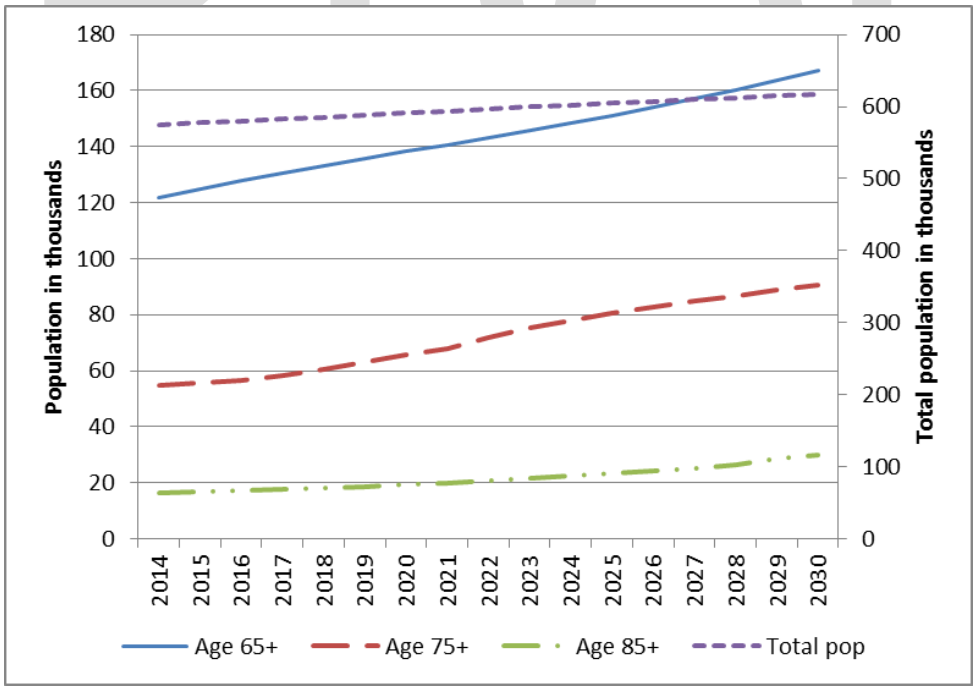
District in Worcestershire	Total Population
Bromsgrove	95,800
Malvern Hills	75,700
Redditch	84,700
Worcester City	101,300
Wychavon	121,500
Wyre Forest	99,500
Worcestershire	**578,600**

Source: Office for National Statistics

The current population in Worcestershire is estimated to be around 578,600; a breakdown by district is included (Table 1) revealing Wychavon as having the largest proportion of the total population in the county followed by Worcester City and Wyre Forest.

Population in the future

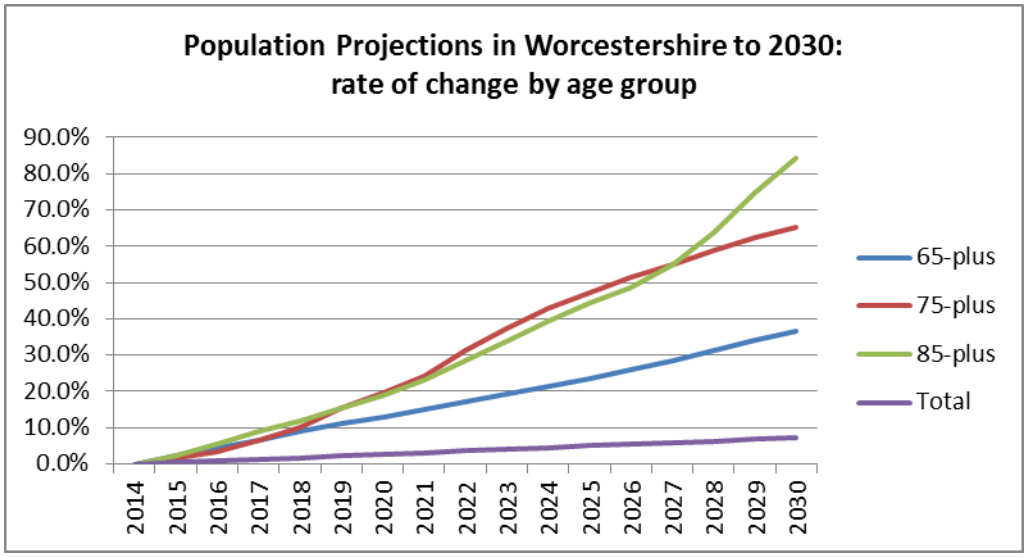
Figure 1: Aged 65+ Population projections in Worcestershire to 2030



Source: Office for National Statistics 2014 based population projections

The population aged 65+ is projected to increase steeply to 2030 and beyond in Worcestershire; a slower increase is expected when all age groups are included (Figure 1). Within the older population (65+ age groups), the rate of increase is steeper for oldest age groups (Figure 2), with the rate of change for the 75+ population predicted to increase steeply post 2021, and the rate of change for the 85+ population to show a sharp increase from around 2027.

Figure 2: Aged 65+ Population projections to 2030: rate of change by age group



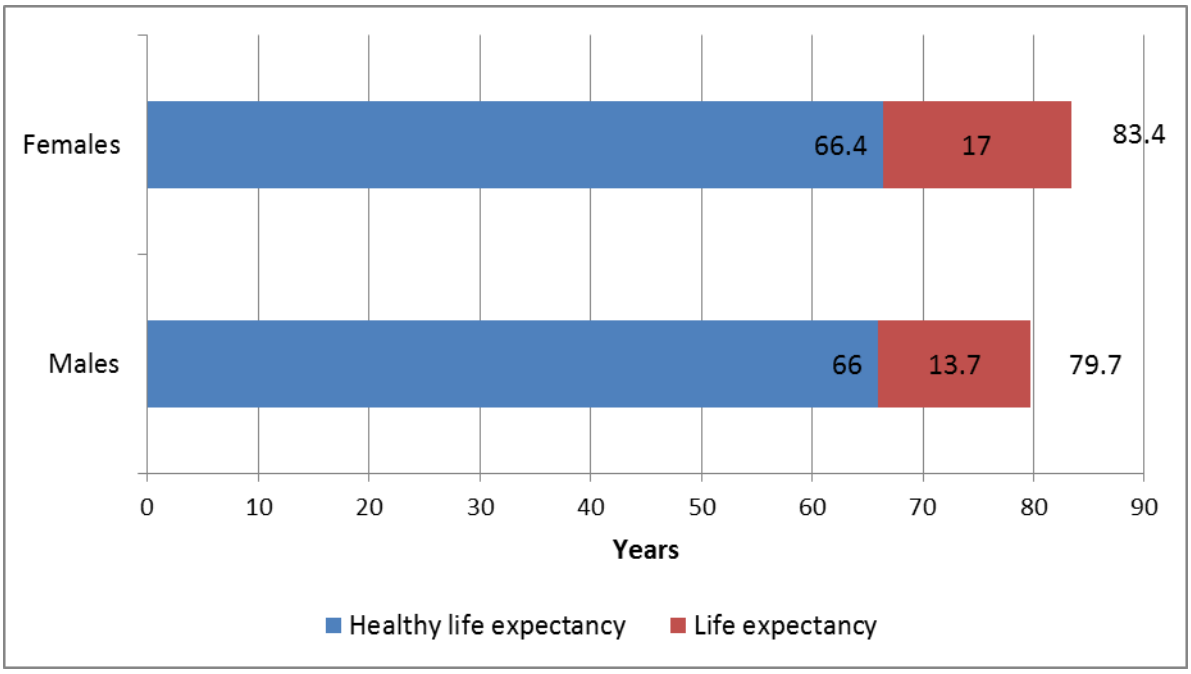
Source: Office for National Statistics 2014 based population projections

These population projections are estimated nationally by the Office for National Statistics and do not necessarily take into account any local conditions, such as planned housing developments. Local estimation work to model the potential impact of these local conditions on the projected population is underway at Worcestershire County Council and is due for completion in 2017. From initial work, we expect that the ONS projections shown above are likely to be an underestimation of the future Worcestershire population.

Life expectancy/HLE

The continued improvement in life expectancy, particularly for women, has been widely documented (ONS, 2015) and is a welcome by-product of modern medical and social care advances. Women are generally expected to live longer than men; this is true at Worcestershire county level where life expectancy is greater than the national average. Reasons for this can be complex, encompassing considerations including variance in lifestyles, free time and money availability and occupational hazards. However there is much more parity in healthy life expectancy between genders; women are living longer but in poorer health (Figure 3).

Figure 3: Healthy life expectancy shows parity between genders in Worcestershire 2012-14



Source: Public Health Outcomes Framework

New Health and Wellbeing Priorities

1. Keeping active at every age

Summary

- The estimated rate of physically active adults in Worcestershire has fallen slightly from 59.9% in 2014 to 58.3% in 2015. This is now similar to the national average and the rates of the CIPFA nearest neighbours, and better than the regional average[4].
- The estimated rate of physically inactive adults in Worcestershire has risen slightly from 24.8% in 2014 to 26.4% in 2015. This is still significantly better than the national and regional average, and similar to the rates of the CIPFA nearest neighbours.
- The rate of adults that participate in sport and active recreation in Worcestershire increased from 21.7% for the period October 2005-October 2006 to around 24% in the period April 2015-March 2016[5].
- Worcestershire has a higher percentage of adults that have not participated in any sport and recreation over the previous four weeks (51.9%) when compared to Warwickshire (49.9%) and Gloucestershire (49.8%). There are also noticeable differences in the rates of participation in sport and active recreation at the Worcestershire district level.
- Worcestershire has a lower percentage of adults aged 55 and over participating in sport and active recreation (14.9%) when compared to Warwickshire (16.7%), Gloucestershire (16.9%) and Suffolk (16.0%). There are also noticeable differences in participation rates in sport and active recreation between different age groups at the Worcestershire district level.
- The estimated utilisation of outdoor space for exercise/health reasons in Worcestershire has fallen over the period 2011-12 to 2014-15, but is not significantly different from the national and regional averages or the rates of the Chartered Institute of Public Finance and Accountancy (CIPFA) nearest neighbours.

Key indicators

Table 2 below shows the key indicators around physical activity from the Public Health Outcomes Framework for Worcestershire, the West Midlands and England in 2015.

Table 2: Comparison of Worcestershire against national and regional averages on key physical activity indicators from the PHOF

PHOF Indicator	Period	Units	England	West Midlands	Worcestershire	Trend
2.13i - Percentage of physically active and inactive adults - active adults	2015	%	**57.0** (LCI 56.8 - 57.3 UCI)	**55.1** (LCI 54.3 - 55.8 UCI)	**58.3** (LCI 56.5 - 60.0 UCI)	↓
2.13ii - Percentage of physically active and inactive adults - inactive adults	2015	%	**28.7** (LCI 28.4 - 28.9 UCI)	**30.9** (LCI 30.2 - 31.6 UCI)	**26.4** (LCI 24.8 - 27.9 UCI)	↑

Source: Public Health Outcomes Framework, http://www.phoutcomes.info/, August 2016

[4] As these data are synthetic estimates based on survey sample data these changes may represent 'regression to the mean'; i.e. any change is merely return to the average response and tends to even out over time.

[5] The participation rates are defined as the percentage of the adult population (age 16 and over) who participate in sport and active recreation, at moderate intensity, for at least 30 minutes on at least 12 days out of the last 4 weeks (equivalent to 30 minutes on 3 or more days a week). This includes light intensity activities (bowls, archery, croquet, yoga and Pilates) for those age 65 and over.

Key

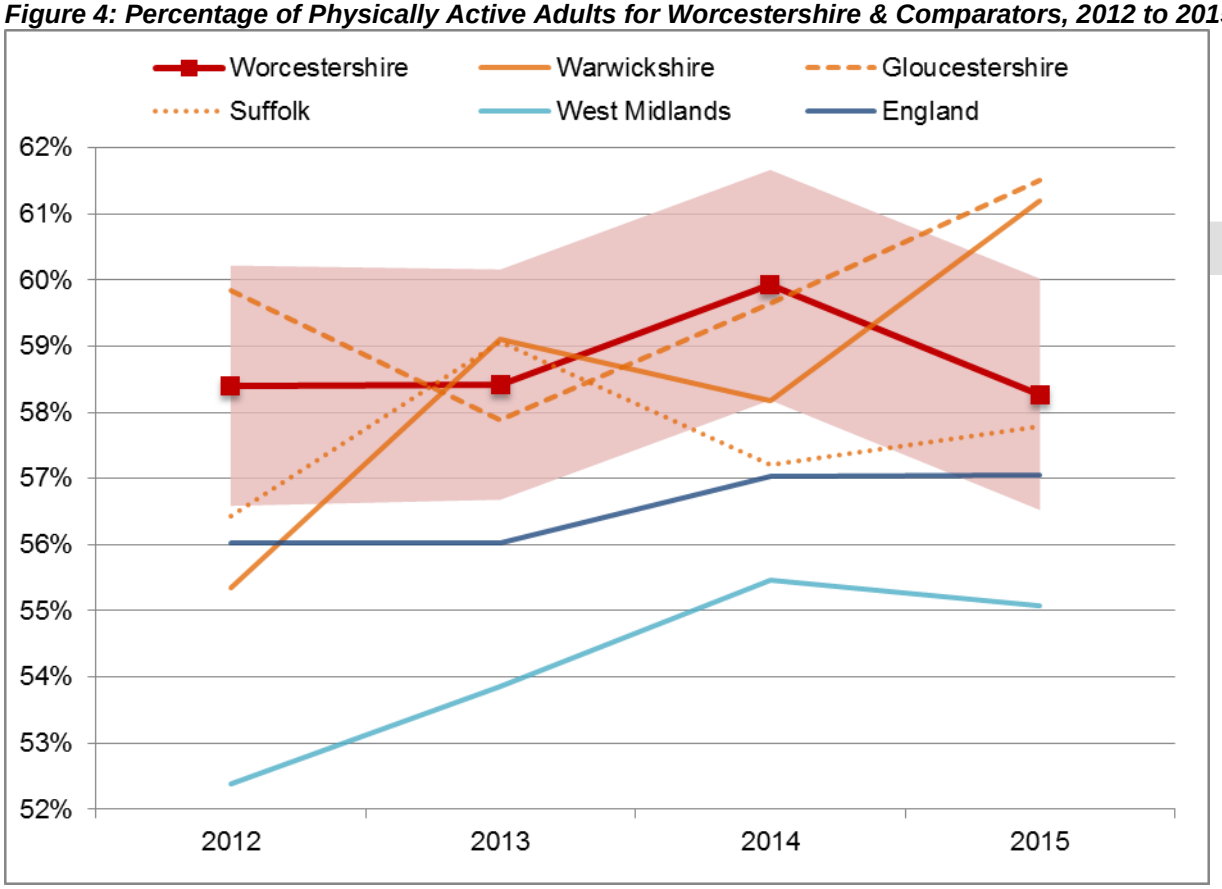
Compared with National benchmark:	Better	Similar	Worse	Lower	Similar	Higher	Not Compared

Note: LCI refers to Lower Confidence Interval and UCI refers to Upper Confidence Interval.

It can be seen from the table that, compared to the national averages, Worcestershire currently has a similar rate of physically active adults and a significantly better rate of inactive adults. However, the trend for both indicators in Worcestershire shows that performance is deteriorating. It is important to note the definitions of physically active and inactive[6].

Figure 4 below shows the estimated percentage of physically active adults for Worcestershire and comparators for the period 2012 to 2015.

Figure 4: Percentage of Physically Active Adults for Worcestershire & Comparators, 2012 to 2015



Source: Public Health Outcomes Framework, http://www.phoutcomes.info/, August 2016

It can be seen that;

- The level of active adults in Worcestershire has decreased slightly from 58.9% in 2014 to 58.3% in 2015. This is now similar to the national average and previous levels experienced in Worcestershire.
- The percentage of active adults in Worcestershire also remains similar to that of CIPFA nearest statistical neighbours Warwickshire, Gloucestershire and Suffolk, although it is worth noticing that levels of activity in Warwickshire and Gloucestershire have increased over the time period.

[6] Active is defined as the number of respondents aged 16 and over, with valid responses to questions on physical activity, doing at least 150 "equivalent" minutes of at least moderate intensity physical activity per week in bouts of 10 minutes or more in the previous 28 days expressed as a percentage of the total number of respondents aged 16 and over. Inactive is defined as the number of respondents aged 16 and over, with valid responses to questions on physical activity, doing less than 30 "equivalent" minutes of at least moderate intensity physical activity per week in bouts of 10 minutes or more in the previous 28 days.

It is also worth noting that;

- The estimated percentage of physically active adults in Bromsgrove, Malvern Hills and Worcester has fallen in 2015 compared to 2014. Each of these areas has moved from having an estimated percentage of physically active adults that was significantly better than the national average in 2014, to one that is similar to the national average in 2015.
- All of the Worcestershire districts now have a similar percentage of physically active adults to that of the National average when confidence intervals are taken into account.
- The level of inactive adults in Worcestershire has increased from 24.8% in 2014 to 26.4% in 2015, but remains significantly better than the national average.
- Rates of inactive adults in Worcestershire are similar to those of CIPFA nearest neighbours Warwickshire, Gloucestershire and Suffolk, although it is worth noticing that levels of inactivity in Warwickshire and Gloucestershire have decreased over the time period.

It is also worth noting that;

- The estimated percentage of physically inactive adults in Wychavon has fallen since 2013 and is now significantly better than the national average.
- The estimated percentage of physically inactive adults in Bromsgrove, Malvern Hills and Worcester has increased since 2014. Each of these areas has moved from having an estimated percentage of physically inactive adults that was significantly better than the National average to one that is similar to the national average.
- All of the Worcestershire districts, with the exception of Wychavon, now have a similar percentage of physically inactive adults to that of the national average when confidence intervals are taken into account.

Full report available on the JSNA website at: http://www.worcestershire.gov.uk/downloads/file/6471/2015_briefing_on_physical_activity

To find out more about Sport England's Active People Survey and the local area estimates of adult participation in sport and active recreation, see http://www.sportengland.org/research/about-our-research/what-is-the-active-people-survey/.

2. Preventing alcohol harm at all ages

Summary

- The rate of under-18s admitted to hospital for alcohol-specific conditions in Worcestershire has fallen considerably from 86.8 per 100,000 population in 2006/07 – 2008/09 to 34.0 in 2012/13 – 2014/15. This is now similar to the National average, the regional average, and the rates of the CIPFA nearest neighbours.
- Although the latest rate of all persons admitted to hospital for alcohol-related conditions in Worcestershire is similar to the National average, it has increased from 598 per 100,000 population in 2013/14 to 641 in 2014/15.
- The latest rate of females admitted to hospital for alcohol-related conditions in Worcestershire is significantly worse than the national average, and has increased to 505 per 100,000 population in 2014/15 compared to 467 in the previous year. It is now at its highest level over the period 2008/09 to 2014/15.
- The latest rate of males admitted to hospital for alcohol-related conditions in Worcestershire is significantly better than the national average, but it has increased from 729 per 100,000 population in 2011/12 to 791 in 2014/15.
- The latest rate of alcohol-specific mortality in Worcestershire is similar to the national average, but has steadily increased from 10.1 per 100,000 population in 2009-11 to 12.0 in 2012-14. It is now at its highest level over the period 2006-08 to 2012-14.
- The latest rate of alcohol-related mortality in Worcestershire is similar to the national average, but has steadily increased from 40.8 per 100,000 population in 2011 to 47.3 in 2014. It is now at its highest level over the period 2008 to 2014.
- The rate of successful completion of treatment for alcohol clients in Worcestershire is lower than the national average at 26.7% for 2015/16. This has been in steady decline since 2013/14, whilst the national average has remained stable.

Key indicators

Table 3 below shows the key indicators around alcohol from the Public Health Outcomes Framework (PHOF) and the Local Alcohol Profiles for England (LAPE) for Worcestershire, the West Midlands and England in 2015/16.

Table 3: Key Alcohol Indicators for Worcestershire and West Midlands and National comparators

PHOF/LAPE Indicator	Period	Units	England	West Midlands	Worcs	Trend
2.18 Admission episodes for alcohol-related conditions - narrow definition (Persons)	2014/15	DSR per 100,000 pop	**640.78** (LCI 638.59 – 642.97 UCI)	**697.04** (LCI 690.01 – 704.12 UCI)	**641.24** (LCI 620.72 – 662.25 UCI)	↑
2.18 Admission episodes for alcohol-related conditions - narrow definition (Male)	2014/15	DSR per 100,000 pop	**826.92** (LCI 823.30 – 830.54 UCI)	**873.00** (LCI 861.57 – 884.54 UCI)	**790.87** (LCI 758.10 – 824.67 UCI)	↑
2.18 Admission episodes for alcohol-related conditions - narrow definition (Female)	2014/15	DSR per 100,000 pop	**474.24** (LCI 471.63 – 476.87 UCI)	**539.88** (LCI 531.26 – 548.60 UCI)	**505.17** (LCI 479.77 – 531.56 UCI)	↑
2.01 Alcohol-specific mortality	2012-14	DSR per 100,000 pop	**11.61** (LCI 11.44 – 11.78 UCI)	**13.69** (LCI 13.12 – 14.27 UCI)	**12.03** (LCI 10.45 – 13.76 UCI)	↑
4.01 Alcohol-related mortality	2014	DSR per 100,000 pop	**45.54** (LCI 44.95 – 46.13 UCI)	**50.96** (LCI 49.05 – 52.92 UCI)	**47.34** (LCI 41.97 – 53.18 UCI)	↔

PHOF/LAPE Indicator	Period	Units	England	West Midlands	Worcs	Trend
9.01 Admission episodes for alcohol-related conditions (Broad)	2014/15	DSR per 100,000 pop	**2,139** (LCI 2,135 – 2,143 UCI)	**2,231** (LCI 2,218 – 2,244 UCI)	**1,855** (LCI 1,820 – 1,890 UCI)	↑
6.01 Persons admitted to hospital for alcohol-specific conditions	2014/15	DSR per 100,000 pop	**364.44** (LCI 362.80 – 366.08 UCI)	**340.27** (LCI 335.38 – 345.21 UCI)	**285.82** (LCI 272.04 – 300.11 UCI)	↔
5.01 Persons under-18 admitted to hospital for alcohol-specific conditions	2012/13 – 14/15	DSR per 100,000 pop	**36.61** (LCI 35.97 – 37.25 UCI)	**32.78** (LCI 30.97 – 34.67 UCI)	**33.97** (LCI 28.09 – 40.71 UCI)	↓
15.01 Successful completion of treatment for alcohol*	2015/16	%	**39.2**	**n/a**	**26.7**	↓

Source: Public Health Outcomes Framework, http://www.phoutcomes.info/, June 2016, and Local Alcohol Profiles for England, http://fingertips.phe.org.uk/profile/local-alcohol-profiles, June 2016.

* Taken from National Drug Treatment Monitoring System (NDTMS), https://www.ndtms.net, July 2016

Key

Compared with National benchmark:	Better	Similar	Worse	Lower	Similar	Higher	Not Compared

Note: LCI refers to Lower Confidence Interval and UCI refers to Upper Confidence Interval.

It can be seen from the table that, compared to the national average, Worcestershire currently has significantly better rate of hospital admissions for alcohol-related conditions for males, but a significantly worse rate for females.

Examining the data in more detail, the increasing rate of alcohol-related conditions for females in Worcestershire is largely driven by an increase in the rate of women aged 40-64 year old and over 64 admitted to hospital for alcohol-related conditions (see LAPE indicator '10.07 - Admission episodes for alcohol-related conditions (Narrow) - 40-64 years. (Female)' http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/3/gid/1938132982/pat/6/par/E12000005/ati/102/are/E10000034/iid/92320/age/287/sex/2).

Alcohol Specific Hospital Admissions for Under-18 year olds

Figure 5 below shows the rate of under-18s admitted to hospital for alcohol-specific conditions (narrow definition) per 100,000 population for Worcestershire, the CIPFA nearest neighbours of Warwickshire, Gloucestershire, and Suffolk, the West Midlands, and England.

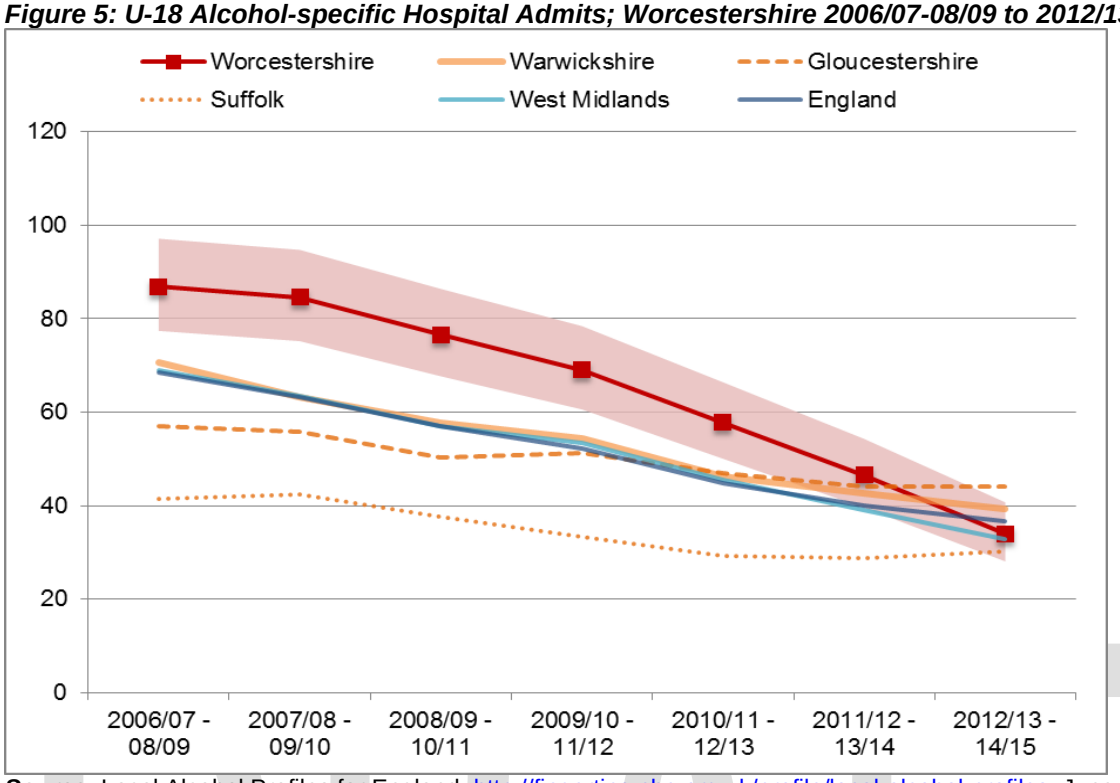
It can be seen that;

- The rate of under-18s admitted to hospital for alcohol-specific conditions in Worcestershire has fallen considerably over the time period and is now similar to the national average, the rates of the CIPFA nearest statistical neighbours, and the West Midlands.

It is worth noting that;

- The number of under-18s admitted to hospital for alcohol-specific conditions in Worcestershire was 117 in 2012/13-14/15 compared to 307 in 2006/07-08/09.
- At the District level, the rate of under-18s admitted to hospital for alcohol-specific conditions in Redditch is no longer significantly worse than the national average, as it was in previous years. The current rates for each district are now all similar to that of the national average.

Figure 5: U-18 Alcohol-specific Hospital Admits; Worcestershire 2006/07-08/09 to 2012/13-14/15

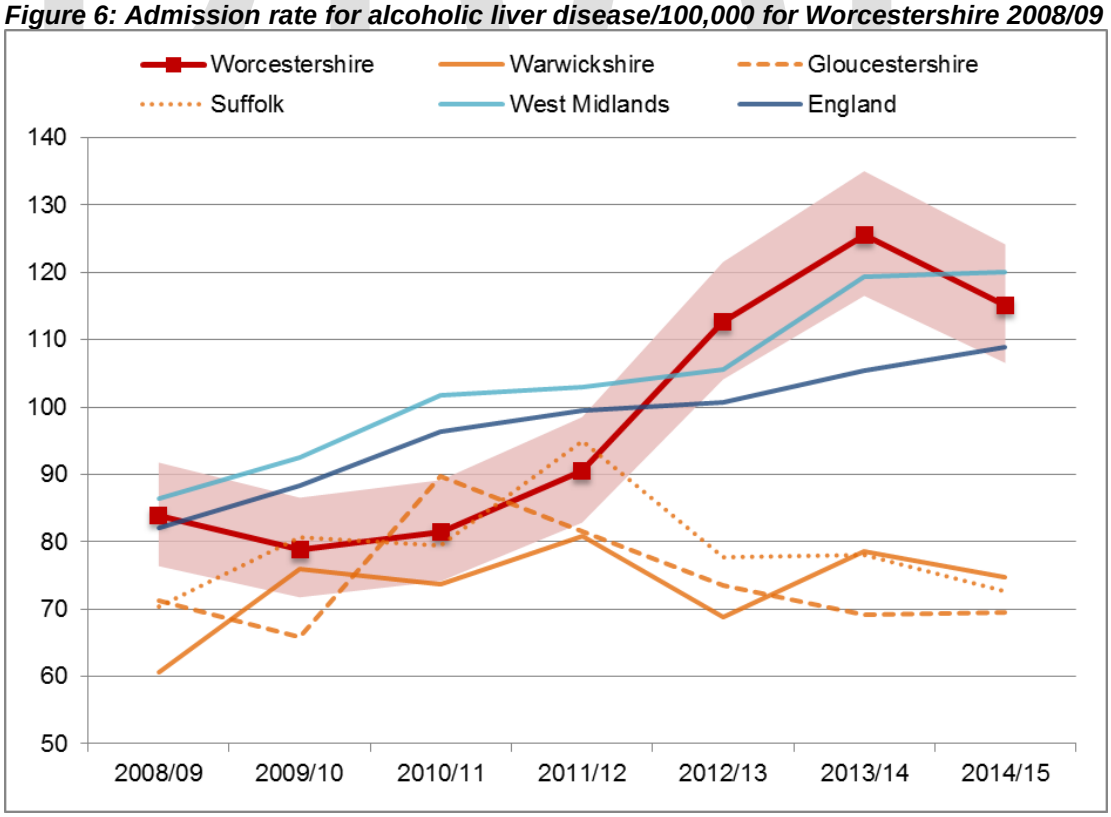


Source: Local Alcohol Profiles for England, http://fingertips.phe.org.uk/profile/local-alcohol-profiles, June 2016

Hospital Admission Episodes for Alcoholic Liver Disease Condition

Figure 6 below shows the rate of hospital admission episodes for alcoholic liver disease condition (broad definition) per 100,000 population for Worcestershire, the CIPFA nearest neighbours of Warwickshire, Gloucestershire, and Suffolk, the West Midlands, and England.

Figure 6: Admission rate for alcoholic liver disease/100,000 for Worcestershire 2008/09 to 2014/15



Source: Local Alcohol Profiles for England, http://fingertips.phe.org.uk/profile/local-alcohol-profiles, June 2016

It can be seen that;

- The rate of hospital admission episodes for alcoholic live disease condition (broad definition) in Worcestershire has fallen from 125.5 per 100,000 population in 2013/14 to 115.1 per 100,000 population in 2014/15. This is now similar to the national and West Midlands averages, but significantly higher than the rates of the CIPFA nearest neighbours.
- The rate of hospital admission episodes for alcoholic liver disease condition (broad definition) in Worcestershire was significantly higher than the national average in 2012/13 and 2013/14.

Full report available on the JSNA website at: http://www.worcestershire.gov.uk/downloads/file/2874/2016_briefing_on_alcohol

3. Good mental health and wellbeing at all ages

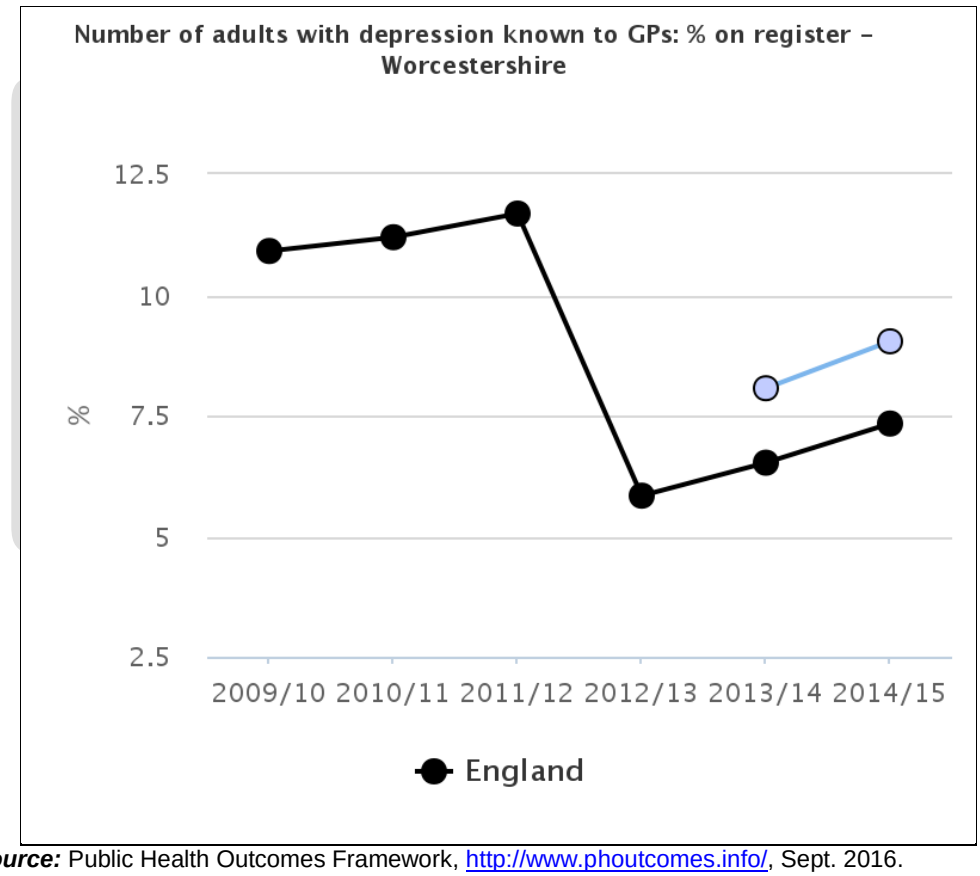
Summary

Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can deal with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his own community.

Mental health underlies physical health. Compared with the general population, individuals with mental illness die prematurely, particularly those with schizophrenic and bipolar disorders who experience on average 25 years shorter life expectancy (RCPsych, 2010).

- Prevalence of dementia[7] in Worcestershire is lower than the national average
- Prevalence of depression[8] is significantly higher in Worcestershire than England, at 9.0% and has increased from the previous year (Figure 7).

Figure 7 – Depression in Worcestershire is significantly higher than the national average



Source: Public Health Outcomes Framework, http://www.phoutcomes.info/, Sept. 2016.

- Emergency admissions to hospital for self-harm are similar to the national average.
- Mortality from suicide is similar in Worcestershire to the national average
- Self-reported well-being in Worcestershire is similar to both the national and regional average.
- Social isolation rates are significantly lower in Worcestershire than England

[7] Proportion of patients with dementia within a GP registered population.
[2] Proportion of adult patients diagnosed with depression.
[3] Proportion of patients with schizophrenia, bipolar affective disorder and other psychoses in GP registered population

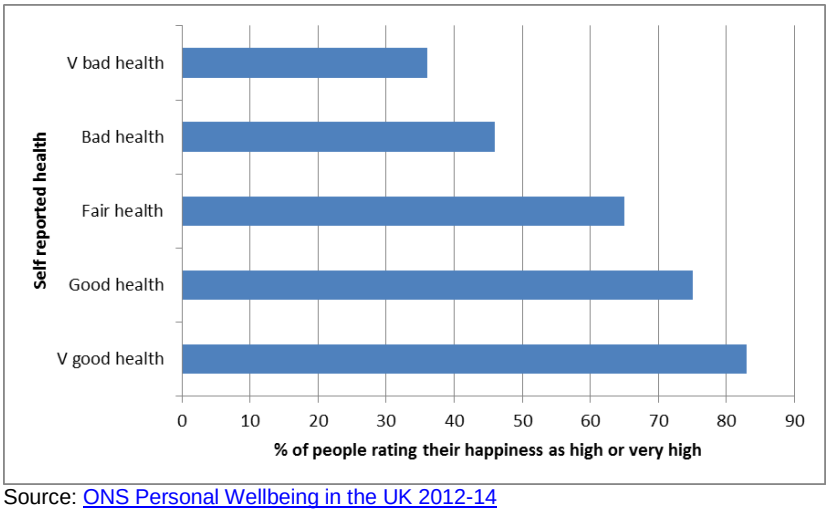
- Proportion of population using outdoor space for exercise/health reasons is similar to national average but lower than the West Midlands average. It is also much lower than similar areas including Shropshire.

Background: protective factors and vulnerable groups

The World Health Organization highlights the fact that mental health and well-being needs to be firmly embedded in the public health agenda.

- There is a higher prevalence of common mental disorders such as depression and anxiety in Worcestershire and many cases go undiagnosed as many people do not seek treatment; either due to difficulty in recognizing anxiety disorder or due to the stigma attached to mental illness (NICE, 2011).
- Awareness of the essential elements of wellbeing 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).
- 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.
- The mental and physical health of carers is a major concern: better support is needed for people who care for others. People caring for 50 or more hours per week are twice as likely to report their general health as "not good" (DoH, 2014).
- There are a number of 'at risk' groups (McManus et al, 2007) which include:
  - those with dual diagnosis (comorbid substance misuse);
  - people with long term physical illness or disability.
- An estimated 45% of looked after children having 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).
- There is strong evidence to suggest that green spaces have a beneficial impact on physical and mental wellbeing and cognitive function through both physical access and usage (Marmot, 2010 and Maas et al, 2009).
- Health and happiness are closely connected – a higher proportion of people who report their health to be 'very good' also rate 'high' or 'very high' happiness (Figure 8).

Figure 8 – Happiness is linked with good self-reported health



Source: ONS Personal Wellbeing in the UK 2012-14

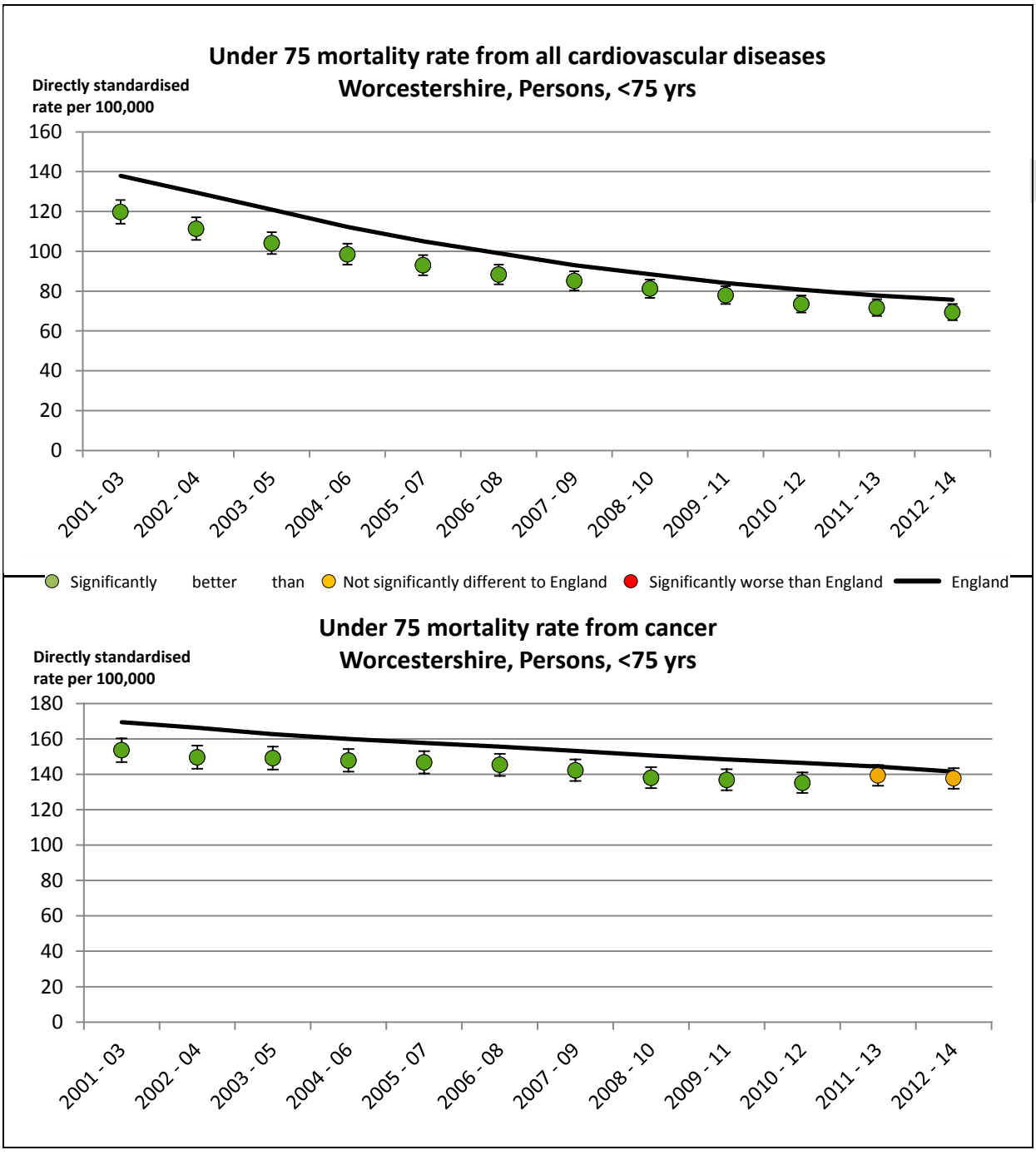
Full report available on the JSNA website at: http://www.worcestershire.gov.uk/downloads/file/2885/2015_briefing_on_mental_health

Emerging Issues

1. The narrowing gap between Worcestershire and England

Overall Worcestershire has good health outcomes; however there is a general pattern of decreasing the gap between ourselves and England, particularly for the principal mortality measures. As can be seen in the charts below (Figure 9) for cardiovascular diseases and cancers (the two biggest causes of mortality) for under 75s, the gap between the England average and Worcestershire has narrowed over a long period. For cancers the latest two years are no longer significantly below average.

Figure 9 - The gap between England and Worcestershire is narrowing – U75 mortality rates

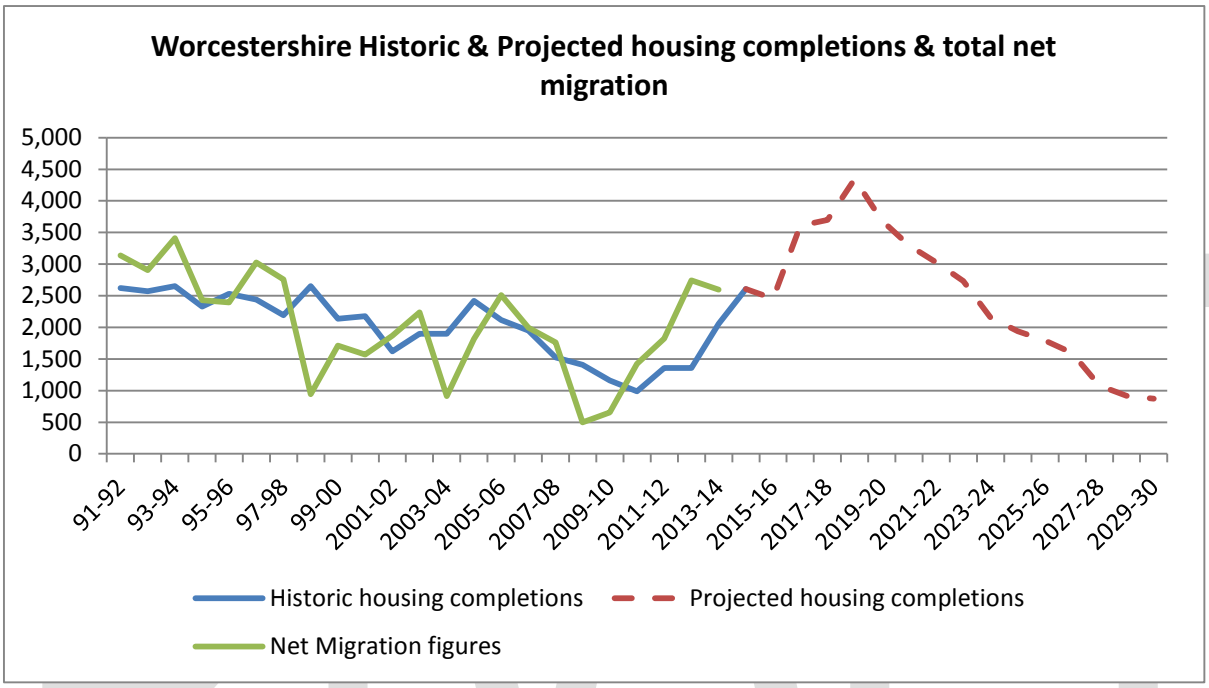


Data Source: Public Health England

2. Rapid growth in housing

One issue over the next few years in Worcestershire as in many other areas will be the projected rapid increase in house building in the local plans. For Worcestershire, if the housing projections contained in the plans are fulfilled it will mean an unprecedented increase in the number of new houses built in the County over the next 10-15 years. In total there are 37,622 new homes to be built in the 2014-30 period[9] at an average of 2,351 per year. However these will be front-loaded, such that in each of the next 9 years, more houses will be built than in any one year previously, as seen in the chart below (Figure 10).

Figure 10 – Projected change in housing completions in Worcestershire



Source: Housing completions taken from DCLG live tables on house building & Worcestershire Strategic Housing Market Assessment Monitoring Reports. Migration figures taken from ONS components of change 1991-2015

Such a rapid increase in housing, especially in those areas with the big new developments, will have a big impact on local infrastructure and especially transport. Having large new developments can also be an opportunity to plan in infrastructure that can have a positive impact on health such as good opportunities for active travel, well designed access to green space and leisure and open play spaces and developments which can encourage healthy lifestyles and support independent living for older people.

[9] Source: District Housing plans, as available at:
Redditch: http://www.bromsgrove.gov.uk/media/1665216/Redditch%20Updated%20Five%20Year%20Housing%20Land%20Supply.pdf
Bromsgrove: http://www.bromsgrove.gov.uk/media/748665/CD-12-BDP-Proposed-Submission-tracked-changes.pdf
Wyre Forest: http://www.wyreforestdc.gov.uk/media/1294518/SHLAAA-2015-Final-document2.pdf
South Worcestershire (covers Malvern Hills, Worcester City and Wychavon): http://www.swdevelopmentplan.org/wp-content/uploads/2015/09/Updated_Housing_Trajectories_17August2015.pdf

3. Homelessness

- Homelessness is an important social determinant of health and is associated with severe poverty, adverse mental and physical health and, particularly for children, poor social outcomes (including poor educational outcomes).
- Homelessness can contribute to health inequalities.
- Typically there are a higher proportion of men recorded as single homeless; however, slightly more female single homeless people were recorded in the most recent year (2014).
- Latest data suggests that Worcester City and Wyre Forest districts have homelessness rates significantly higher than the England average. However, the other districts in Worcestershire have homelessness rates significantly lower, and numbers are small.
- People who experience homelessness generally have a shorter life expectancy; for example the life expectancy of a rough sleeper in the UK is equivalent to a person living in a nation that has the lowest life expectancy in the world (NHS, 2013; ONS, 2014).
- The average age of death of a rough sleeper is 30 years earlier than average population (Source: Sheffield University/Crisis, 2012).
- 80% of homeless people report some form of mental health issue, 45% have a diagnosed mental health condition, compared to 25% of the general population (Homeless Link, 2014; Mental Health Network, 2014).
- Homeless people are also at higher risk of suicide; one in four will commit suicide (Mental Health Foundation, 2007).
- Despite the higher rates of mental ill health, less than a third of homeless people receive treatment (Mental Health Foundation, 2007).
- 41% of homeless people report a long-term health condition, compared with 28% of the general population.

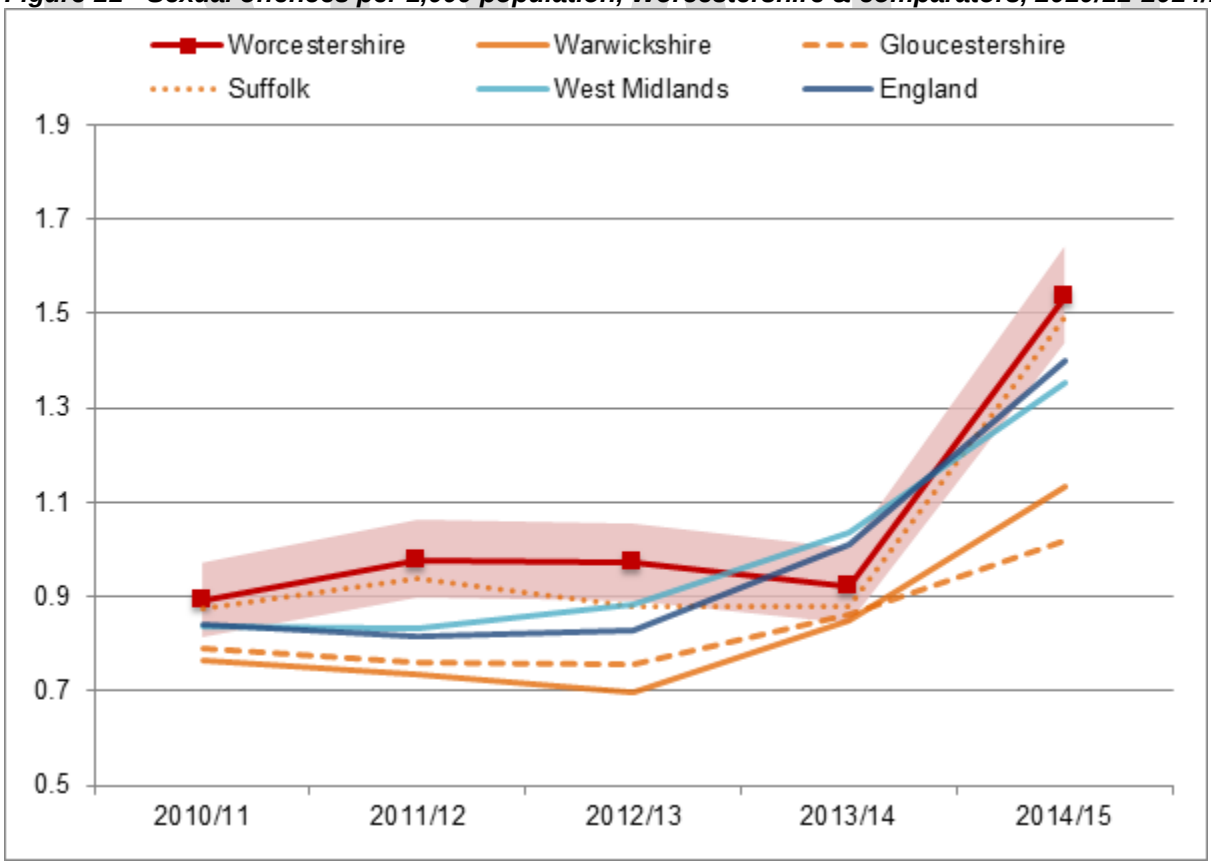
4. Sexual Violence

Estimates of the prevalence of sexual abuse are wide-ranging. The latest Crime Survey for England and Wales reported that 2.5% of females and 0.4% of males said that they had been a victim of a sexual offence (including attempts) in the previous 12 months.

Nationally the numbers of police recorded sexual offences have risen to their highest numbers ever recorded. These increases are considered to be due to greater victim confidence and a willingness of victims to report such crimes together with improved recording by the police rather than more sexual assaults taking place. It is also important that these increases are viewed in the context of the effects of police operations such as Operation Yewtree and other high profile cases involving sexual abuse that increased the willingness of people to report abuse and improved compliance with recording standards. Nonetheless, only about 11% of sexual abuse is estimated to be reported to the Police.

The rate of sexual offences significantly increased in Worcestershire in 14/15 to 1.54 per 1000 as it did nationally but this rate was higher than the national average (1.40) and our statistical neighbours. The number of sexual offences recorded in Worcestershire was 880 in 2014/15 compared to 524 in the previous year.

Figure 11 - Sexual offences per 1,000 population, Worcestershire & comparators, 2010/11-2014/15



Source: Public Health Outcomes Framework, http://www.phoutcomes.info/, May 2016

Sexual offences are governed by the Sexual Offences Act 2003 (England and Wales) and include sexual activity with a child under 18 years of age. The definitions of sexual offences outlined in the Act include rape, sexual assault, serious sexual assault and sexual activity with a child under 16. Child sexual exploitation (CSE) is a form of child sexual abuse and is covered by the Sexual Offences Act 2003. People can also experience sexual violence through intimate partner violence and abuse, chiefly domestic violence.

5. Autism Spectrum Disorder[10]

- 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.
- The latest prevalence studies of ASD (2007) indicate that 1.1%* of the population in the UK may have autism. This means that over 695,000 people in the UK may have autism, an estimate derived from the 1.1% prevalence rate applied to the 2011 UK census figures.
- There are no estimates of the overall numbers of people with ASD in Worcestershire. An epidemiological survey would be needed to provide this figure.
- According to the Department for Education, the number of pupils in January 2016 with an SEN statement for Autistic Spectrum Disorder (ASD) in Worcestershire were 173 (138 in Jan 2010) and 238 (242 in Jan 2010) for primary and secondary schools respectively. (https://www.gov.uk/government/statistics/special-educational-needs-in-england-january-2016). This data refers only to those giving ASD as a primary type of need so is likely to under-represent the numbers with ASD.
- Information from reports received by Health watch Worcestershire from four service users (Feb 2016) suggested the following issues:
  - A need for better ASD specific training for social care staff that are assessing support needs.
  - Need for better provision of appropriate ways for people with ASD to be meaningfully engaged.
  - Need for supported living which meets the specific needs of adults with ASD.
  - Lack of appropriate support for mental health issues for adults with Asperger syndrome.
- Further research is needed to better assess the needs of those with ASD in Worcestershire.

[10] 'Autism spectrum disorder' (ASD) is now likely to become the most commonly given diagnostic term Source: National Autistic Society website

6. Migrant Health/Social Cohesion

- The numbers of migrants from EU countries – particularly accession states - have been increasing in Worcestershire.
- Accurate numbers are hard to come by but some indication is given by figures from the Census of Population showing an increase from 7,000 to 14,500 between 2001 and 2011 in the numbers of people with "white other" ethnicity (most but not all EU migrants will have this ethnicity).
- In 2008 it is estimated that around 4,000 nationals of EU accession states were living in Worcestershire. The highest population rates were in the Worcester, Kidderminster, Redditch and Evesham areas.
- Other migrants include refugees fleeing conflicts around the world. In 2016 Worcestershire is expected to receive 50 refugees from the Syrian crisis for example. The needs of these groups will often be greater than those for economic migrants,
- According to a recent report (Migration Observatory, 2014) barriers to access and use of health care for migrants include:
  - inadequate information, particularly for new migrants unfamiliar with health care systems in the UK.
  - insufficient support in interpreting and translating for people with limited English fluency, lack of access to reliable transport because of poverty and poor services in areas of deprivation where many recent migrants live,
  - confusion around entitlement to some types of services particularly among migrants with insecure immigration status as well as among service providers.
  - cultural insensitivity of some front line health care providers.
- Action to alleviate the above barriers can help to improve social cohesion and health of migrants in Worcestershire.

Summary of New JSNA products 2015/16

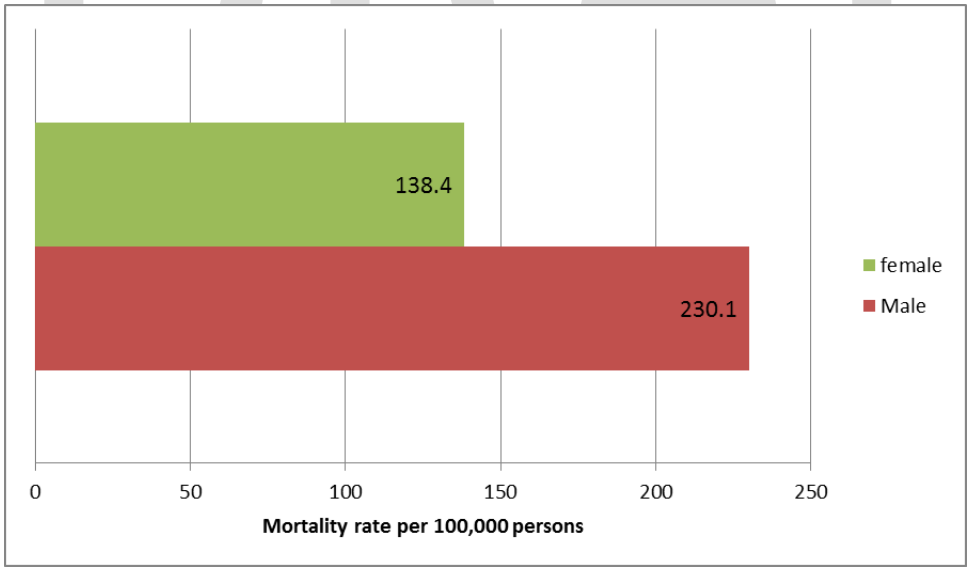
(i) JSNA Profile on gender differences in health and wellbeing

"Gender equality in health means that men and women across the life course and in all their diversity, have the same opportunities to realize their full rights and potential to be healthy…Achieving gender equality in health often requires specific measures to mitigate barriers" (WHO, 2015a)

Summary

- Gender differences in health and well-being endure but are changing. For example, although life expectancy is still higher amongst women, years spent in good health (healthy life expectancy) is now similar for women and men.
- Smoking, traditionally, is more common amongst men with consequent higher mortality; however, evidence suggests that the rate of smoking is now highest in young women.
- There are gender-specific reasons for certain conditions; for example weight gain; these differences need to be taken into account when tackling overweight and obesity.
- More cancers are registered in males than females across most cancer sites; there are also gender differences in the experience of cancer care, with men being more positive.
- Men are less likely to have common mental disorders than women. Gender stereotypes affect the diagnosis of mental ill health with women more likely to be diagnosed with depression than men, even when presenting with identical symptoms.
- In all conditions (except excess winter deaths) mortality is higher amongst men than women; this is particularly noticeable in suicide and cardiovascular disease (Figure 12). Reasons for this discrepancy are complex and poorly understood but may include differences in access to health services, particularly attending a GP with early signs of poor physical or mental health.

Figure 12 – All cause mortality (England) and suicide is higher amongst men 2012



Source: Public Health Outcomes Framework

Full report available on the JSNA website at: http://www.worcestershire.gov.uk/downloads/file/7159/2016_august_gender_differences_profile

(ii) Rural health

Summary

- Worcestershire is a predominantly rural county with some urban areas (categorized as having over 10,000 population). 85% of the area of Worcestershire is categorised as rural; 74% of the population of Worcestershire live in urban areas. Rural areas may have specific health and wellbeing challenges frequently related to access to services e.g. high stroke mortality and social isolation.
- From the physical activity perspective, active travel has been found to be 65% higher amongst urban residents than rural residents (Hutchinson et al, 2014), with a resulting inequality in health and wellbeing benefits.
- Previous research suggests that there are significant differences in health between urban and rural areas. For example research in Scotland established large ratios for ischemic heart disease (IHD) and cancer amongst the remote elderly (Levin & Leyland, 2006). Analysis of cancer rates reveals lower age standardized incidence of lung cancer and higher rates of breast, prostate and colorectal cancers in rural areas (NCIN, 2011).
- Social isolation and loneliness is more of an issue in rural areas (Bernard, 2013) and is of particular concern because of the ageing population in Worcestershire. Loneliness has a significant impact on health and wellbeing (SCIE, 2012) adversely affecting cardiovascular health and immune function.

Full report available on the JSNA website at: http://www.worcestershire.gov.uk/downloads/file/6594/2016_Briefing_on_rural_health

(iii) Road Safety

Summary

- Research has found that people over 70 years old in Britain make more journeys on foot than as car drivers (except in rural areas). This means there is a higher proportion of elderly pedestrians than in other age groups. Their vulnerability is increased by the fact that damage caused by collisions is more severe for older pedestrians with the risk of fatality increasing rapidly from aged 70 years due to physical frailty.
- The latest reported national casualty figures (DfT, 2015) reveal that there has been an increase in the number of older people killed in road traffic collisions in Great Britain. The reasons for this are twofold:
  (i) The proportion of the population aged 65+ is increasing, particularly amongst the older old (85+) – this will impact on the numbers of casualties and is particularly relevant to Worcestershire demographic projections.
  (ii) This increase is expected to be particularly large amongst the oldest old – i.e. those aged 85+. These people are most vulnerable to serious injury or death in road traffic collisions and as pedestrians due to frailty.
- Fear of swift traffic is common amongst older people as well as fears of falling (NICE, 2012); this fear may be due to uneven pavements and car parks not designed for pedestrians. Another factor is the slower walking speed in this group, meaning they have difficulty walking across pedestrian crossings in time before the lights change (Asher et al, 2012).

Full report available on the JSNA website at: http://www.worcestershire.gov.uk/downloads/file/6591/2016_briefing_on_road_safety_and_older_people

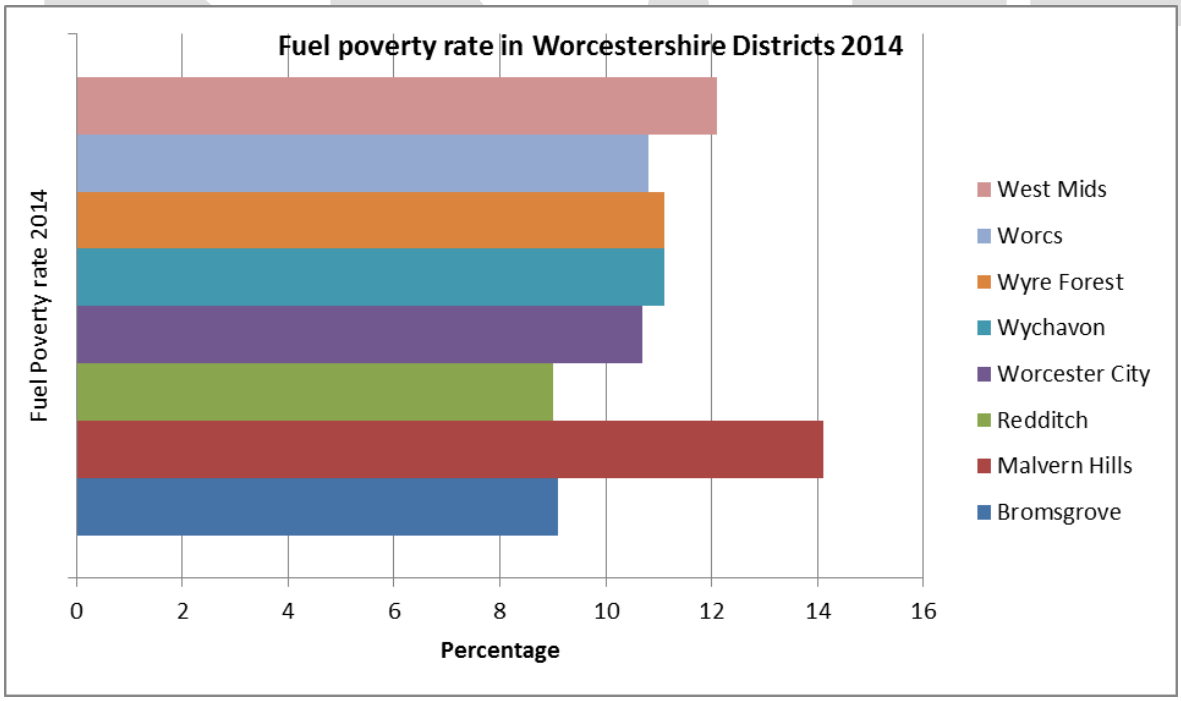
(iv) Fuel Poverty

"Addressing fuel poverty is essential for creating a more equitable and healthy society where all households are able to keep themselves warm and healthy" [11]

Summary

- Fuel poverty is driven by three main factors: income, current cost of energy and energy efficiency of the home (PHE, 2014). Consequently, a social gradient in fuel poverty exists, contributing to social and health inequalities (PHE, 2014).
- Fuel poverty is similar in Worcestershire to the England average, affecting just under 11% (around 26,000 in total) of households in 2014 compared with 10.4% in England as a whole. This is an improvement on the 2013 situation when Worcestershire was significantly worse.
- However, Malvern Hills has experienced an increase in the fuel poverty rate on the previous year and is significantly worse than the national average (Figure 13).
- Fuel poverty is focused in dwellings occupied by older householders (aged over 65) which are three times more likely to be fuel poor than dwellings with younger residents (13.9% versus 3.4%).

Figure 13 - Comparison of fuel poverty rate in Worcestershire districts



Source: Department for Energy and Climate Change

- It is estimated that fuel poverty and cold homes cost the NHS around £200 million per year; the actual costs may be a lot higher if other factors are considered, including educational underperformance of children in fuel poverty.

Full report available on the JSNA website at: http://www.worcestershire.gov.uk/downloads/file/6902/2016_Briefing_on_fuel_poverty

[11] Source: climatejust.org.uk

(v) Older People Briefing

Summary

- In 2014 Worcestershire had an older population than nationally (17.3%). The highest proportion of older people is in Malvern Hills, and the lowest proportion is in Worcester.
- The population of people aged 65 and over in Worcestershire is projected to grow by over a third between 2015 and 2030. This increase will be concentrated in the oldest age groups.
- The population of ethnic minority older people in Worcestershire is relatively small (966 or just under 1% in 2011).
- Life expectancy for men and women is higher than regionally and nationally. By 2019-21, male life expectancy in Worcestershire is projected to rise from its 2011-13 level by 2 years to 81.8 years and female life expectancy to rise by 1.5 years to 85 years.
- Smoking prevalence, while below national levels, is a major cause of premature deaths in the county. Redditch has a significantly high smoking prevalence compared to national levels.
- The number of people aged over 65 with a Long Term Limiting Illness (LTLI) in Worcestershire is projected to rise over the next 15 years by 41%.

Full report available on the JSNA website at:
http://www.worcestershire.gov.uk/downloads/file/3773/2016_briefing_on_older_people

(vi) Sexual Health Briefing

Summary

- The 15-44 population (reproductive age) in 2015 of Worcestershire is estimated to total 198,000. Over the next 10-15 years the population aged 15-44 is projected to decrease slightly.
- Sexual health outcomes in Worcestershire are better than the national average with lower rates of sexually transmitted infections (STIs), HIV, unintended pregnancies and abortions and high rates of prescribing of all methods of contraception. However, of concern are teenage pregnancy rates in some parts of the county, poor chlamydia screening rates amongst young people and the variability of sex and relationship education provision.
- In Worcestershire poorer sexual health is more common amongst young people/adults, men who have sex with men (MSM), black and minority ethnic (BME) populations and in areas of greater deprivation. The sexual health needs of more at risk groups such as deprived young people, looked after children & care leavers, MSM, BME and needs of the rising older population are likely to increase.
- Within the county sexual health outcomes are poorer in Worcester and Redditch districts, with significantly higher STI and teenage conception rates and lower rates of contraceptive and long acting reversible contraception (LARC) prescribing in primary care. In comparison Wyre Forest has similar STI and teenage conception rates to the rest of the county and has high rates of contraception and LARC prescribing.

Full report available on the JSNA website at:
http://www.worcestershire.gov.uk/downloads/file/7007/2016_briefing_on_sexual_health

(vii) JSNA Briefing on childhood obesity focusing on Results from the National Childhood Measurement Programme (NCMP) 2014/15

Summary
The National Child Measurement Programme (NCMP) measures the height and weight of children in reception class (aged 4 to 5 years) and year 6 (aged 10 to 11 years) to assess overweight and obesity levels in children. This data is used both at a national and local level to support local public health initiatives and inform the local planning and delivery of services for children. The NCMP was set up in line with the Government's strategy to tackle obesity.

- Coverage in Worcestershire has been consistently higher than the target of 85% of the eligible population since 2008/09.
- In Worcestershire the percentage of children with excess weight (overweight and obese combined) in Reception year has decreased during 2014/15 bringing them to their lowest levels since measuring began. This has narrowed the gap considerably between Worcestershire and England as a whole, however, Worcestershire still has a higher percentage than England.
- For the first time since data collection started, Worcestershire had a lower percentage of overweight children in Year 6 (age 10-11) in 2014/15 than England. This, combined with Worcestershire continuing to have a lower percentage of obese Year 6 children, meant that the overall percentage of children with excess weight for Year 6 in Worcestershire dropped to 30.7% compared to 33.2% in England as a whole. This is 2.5 percentage points difference which is the widest gap since data collection began.
- In both year groups, boys have higher percentages of excess weight than girls. The gap widens between the sexes between Reception and Year 6.
- Wyre Forest and Wychavon have significantly higher percentages of children with excess weight for Reception year than the Worcestershire average in the 3 years pooled data 2012/13 – 2014/15. However, the time trend for Wyre Forest does indicate an improvement in the percentage of Reception children with excess weight.
- In the same time period, Wyre Forest had the highest percentage of Year 6 overweight and obese children.
- The most deprived areas of Worcestershire have higher rates of children with excess weight than the least deprived areas. The gap between the most and least deprived areas increases with the age of the child.
- Encouragingly, if we treat 2009/10 as the first year of measurement, as this was the first year in which coverage exceeded 90% for both year groups, the percentage excess weight (overweight and obese) trend looks steadily downward.

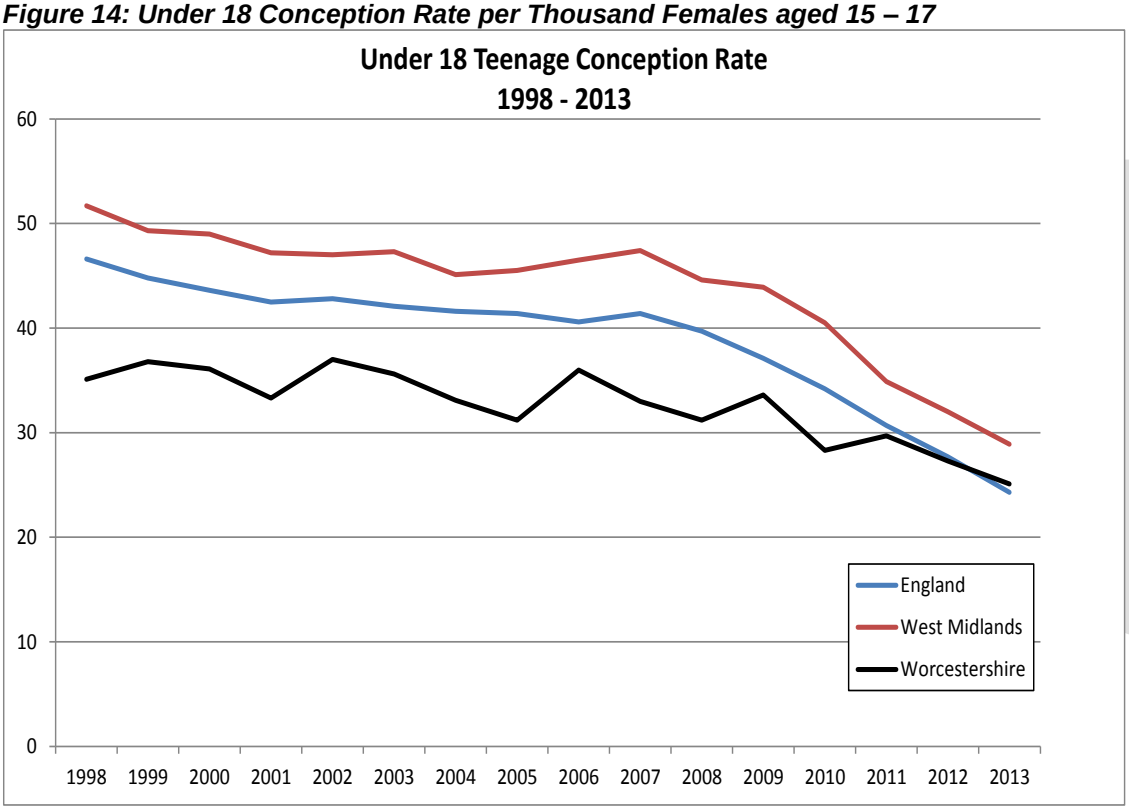
Full report available on the JSNA website at:
http://www.worcestershire.gov.uk/downloads/file/6553/2015_briefing_on_childhood_obesity

(viii) JSNA Briefing on Teenage pregnancy

Summary

- Most teenage pregnancies are unplanned and around half end in an abortion. For some young women having a child when young can represent a positive turning point in their lives.
- Having a child at a young age often results in poor outcomes for both the teenage parent and the child; in terms of the baby's health, the mother's emotional health and well-being and the likelihood of both the parent and child living in long-term poverty.
- The teenage pregnancy rate in Worcestershire was statistically significantly lower than England, until the last 3 years. This does not mean that the rate in Worcestershire is getting worse, just that the rate in England has decreased more rapidly than the Worcestershire rate in recent years (Figure 14).

Figure 14: Under 18 Conception Rate per Thousand Females aged 15 – 17



Source: National and local data analysed by Worcestershire PHIT

- Each year there are is an average of 280 teenage conceptions in Worcestershire of which approximately half of these lead to an abortion.
- This means that every year, 140 mothers aged under 18 make the choice to have a child in Worcestershire.
- Higher numbers of teenage conceptions occur in deprived areas.
- Worcester City, Redditch and Wyre Forest council district areas have the higher teenage conception rates in Worcestershire

Update: Since publishing the briefing more recent figures have just been published which show that the Worcestershire rate for 2014 is now once again lower than England.

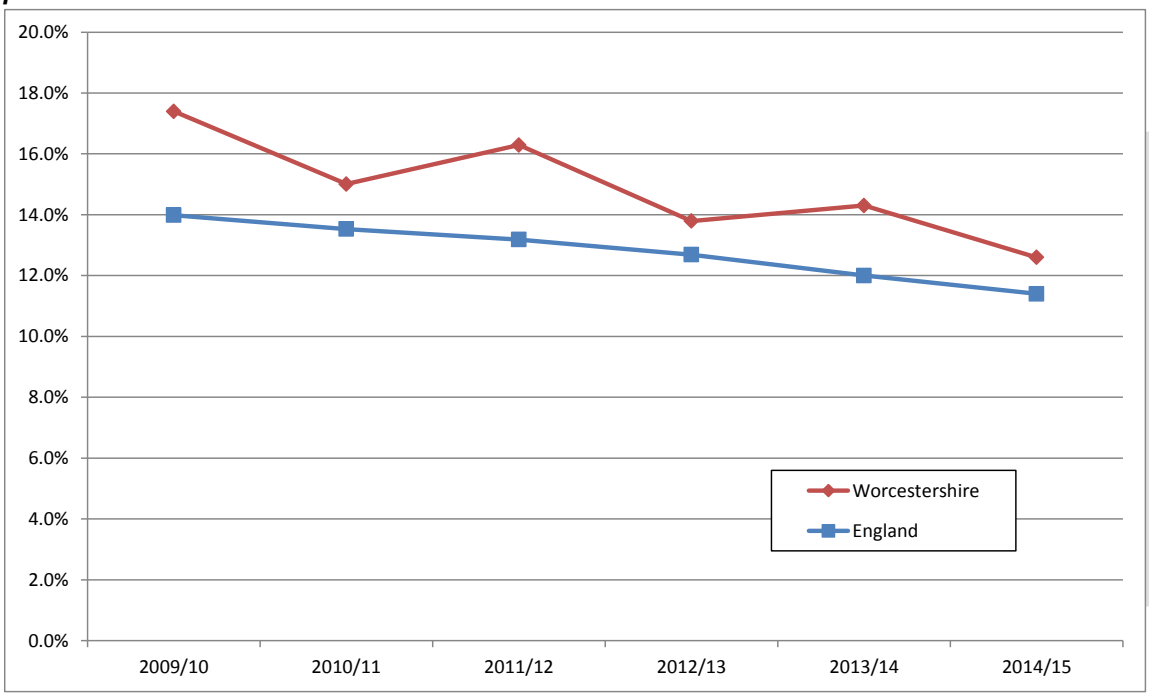
Full report available on the JSNA website at:
http://www.worcestershire.gov.uk/downloads/file/6245/2015_briefing_on_teenage_pregnancy

(ix) JSNA Briefing on Smoking in pregnancy

Summary

- Smoking during pregnancy has many serious health implications for both the mother and unborn child, causing up to 2,200 premature births, up to 5,000 miscarriages and 300 perinatal deaths every year in the UK. It is the major modifiable risk factor in relation to low birth weight and increases the risk of developing a range of longer term conditions.
- Although rates are lower than in the past, over 12% of women in Worcestershire still smoke at the time of delivery, which translates into more than 660 infants born to smoking mothers each year. Across the UK the figure is a shocking 76,000 infants.
- In Worcestershire as nationally, smoking in pregnancy is strongly linked to deprivation and age, with mothers under 20 years showing higher rates of smoking compared to older mothers.

Figure 15: Smoking in Pregnancy (Percentage of women who currently smoke at time of delivery per 100 maternities)



Source: National and local data analysed by Worcestershire PHIT

- Reducing smoking during pregnancy is one of the three national ambitions in the Tobacco Control Plan published in March 2011, which is "to reduce rates of smoking throughout pregnancy to 11 per cent or less by the end of 2015 (measured at time of giving birth)".
- Worcestershire has consistently been statistically significantly worse than the England average over the last 5 years. However, despite this, the percentage of women smoking at delivery in Worcestershire is showing a gradual downward trend (Figure 15).
- In line with national trends mothers aged under 20 years in Worcestershire are showing higher rates of smoking at delivery compared to older mothers. Mothers living in deprived areas are more likely to be smoking at delivery compared with mothers in less deprived areas.

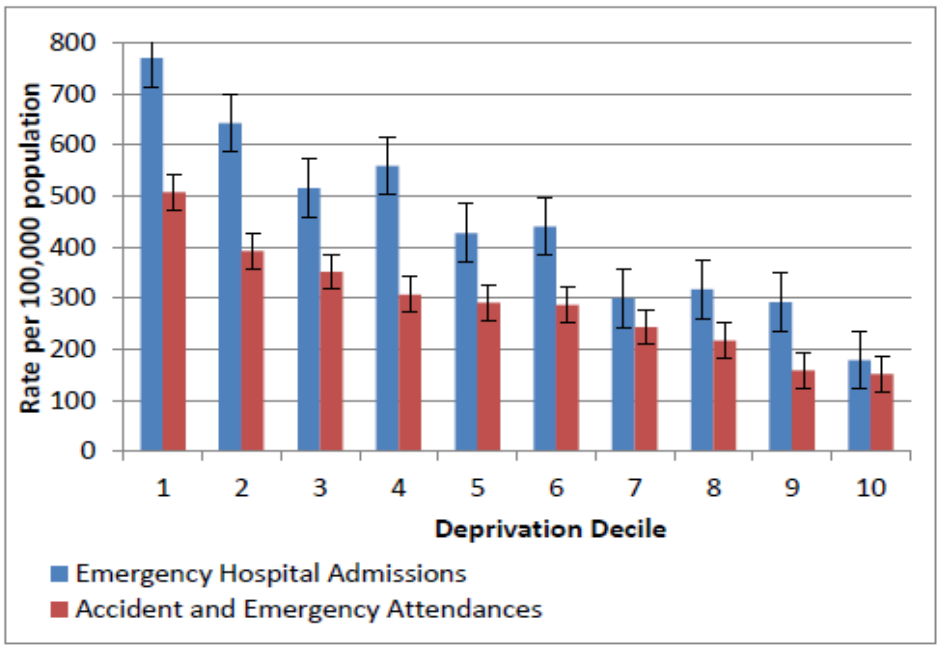
Full report available on the JSNA website at:
http://www.worcestershire.gov.uk/downloads/file/6983/2016_briefingon_smoking_in_pregnancy

(x) JSNA Briefing on Self-harm in Children and Young People

Summary

- Self-harm is defined as any act of self-poisoning or self-injury carried out by an individual irrespective of motivation. Rates of self-harm have increased over the past decade in the UK and are among the highest in Europe.
- The majority of people who self-harm are aged between 10 and 24 years, with the highest risk occurring in female adolescents.
- Self-harm in children and young people is considered to be an expression of personal distress and is frequently an indicator of other adverse influences on mental wellbeing including psychiatric illness, dysfunctional family relationships, substance misuse, bullying and physical or sexual abuse.
- Self-harm is also a significant and persistent risk factor for future suicide, increasing the lifetime risk by between 50 and 100-fold above baseline population risk.
- Girls and female adolescents are at higher risk of self-harm compared to males, accounting for 72% of emergency hospital admissions and 63% of Accident and Emergency attendances between 2011 and 2014.
- There is evidence of a change in the age distribution of self-harm, with an increase among young females (10-14 years), and a decline among young adults of both sexes (aged 20-24 years) between 2010 and 2014.
- Social deprivation is strongly associated with self-harm, with the highest emergency hospital admission rates and Accident and Emergency attendances occurring among the most socially deprived population groups (Figure 16).
- Self-poisoning accounts for approximately 90% of self-harm episodes.
- Approximately three-quarters of self-harm incidents resulting in a hospital admission occur in the home setting.

Figure 16: Emergency hospital admission and Accident and Emergency attendance rates for self-harm in children and young people aged 10-24 years in Worcestershire are highest in more deprived deciles (Pooled data 2011-2014)



Source: SUS Hospital admissions and A&E data supplied by Arden Commissioning Support Unit, analysed by Public Health Intelligence Team at Worcestershire County Council.

Full report available on the JSNA website at: http://www.worcestershire.gov.uk/downloads/file/6364/2015_briefing_on_self_harm

(xi) Early years district profiles

Summary

- The population of 0-4 year olds is expected to decrease in Worcestershire between 2015 and 2030. All the districts are expected to see a decline in population with the exception of Bromsgrove where levels will remain stable.
- High level indicators such as life expectancy and infant mortality tend to be similar to or better than national benchmarks.
- Considerable inequality in levels of childhood development (good level of development or GLD) is evident, with the most deprived areas having levels less than half those in the least deprived areas. New data for those eligible for free school meals shows much lower levels of attainment in this group than the general population (regardless of where they live). All districts are below the national level on this indicator.
- Indicators for phonics in year 1 show a similar pattern with good overall figures but subpar values for children who are eligible for school meals.
- Other areas of concern are the levels of teenage pregnancy in Worcester and Redditch, and variable take up of breastfeeding.

Full reports available on the JSNA website at: http://www.worcestershire.gov.uk/downloads/download/572/joint_strategic_thematic_needs_assessments_and_profiles

(xii) Learning Disabilities

Background

The term 'learning disability' can be defined as:

- A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence); with
- A reduced ability to cope independently (impaired social functioning);
- Which started before adulthood (18 years) with a lasting effect on development.

It covers a range of disabilities including Downs Syndrome and chromosomal disorders, but does not include specific 'learning difficulties' such as dyslexia. Many people with a learning disability have additional health, sensory and mobility problems, and a number have additional mental health problems. People with a learning disability are frequently marginalised and discriminated against in society.

Summary

In Worcestershire:

- There are around 2,413 people recorded on GP registers as having a learning disability, and approximately 1,275 adults (aged 18-64) with a learning disability getting long term support from the Local Authority.
- National estimates of prevalence suggest that there could be as many as 8,000 adults aged 18-64 with a learning disability[12].
- National research indicates that between 2015 and 2030, there will be a 3.5% decrease in the total number of adults aged 18-64 with a learning disability.
- 1,109 adults with a learning disability received a GP health check in 2013-14. This represents almost 54% of all eligible adults with a learning disability.
- In 2014-15 there were 950 adults with a learning disability receiving community services supported by the Local Authority. These numbers are steadily falling.
- The number of supported adults with a learning disability who are in paid employment is less than 100.

Full report available on the JSNA website at:
http://www.worcestershire.gov.uk/downloads/file/5724/2015_briefing_on_learning_disabilities

[12] PANSI, www.pansi.org.uk, 2015.

(xiii) Domestic abuse and violence

Summary

- There are significant limitations to the reliability of data relating to domestic abuse incidents and crimes. These stem from differences in definitions used across the system and over time, and mean that some caution should be exerted in conclusions drawn from the data.
- Local and national figures are known to be an under-reporting of the true incidence of domestic abuse and violence. One study has found that women typically experience 35 incidents of abuse or violence before reporting this to authorities[13].
- Changes in estimated and actual numbers are difficult to interpret because an increase in reported rates may be a sign that police are more able to recognise and deal with domestic abuse than they were in the past, meaning that historically established criminal behaviours are now being addressed assertively by police, so there is no significant change in incidence.
- However, as awareness grows about more engaged policing on domestic abuse, women and other agencies may be more likely to involve the police. Conclusions about the validity or significance of increased rates are hard to draw.
- Despite the estimated nature of the data, it seems likely that 28% of women and 15% of men will experience domestic abuse or violence at some time between the ages of 16 and 59 years. Local estimates using national data would suggest about 19,000 female victims in the past year in Worcestershire[14]
- The issue of under-reporting is supported by actual data though which shows that 9,200 domestic abuse incidents were reported to police in Worcestershire in 2014/15, representing only 2,485 victims. In Emergency Departments, only 50 victims of domestic abuse were reported in a 9 month period.
- Police data shows the rates of domestic abuse incidents per 1,000 population were stabilising and reducing slightly in Worcestershire, but increased in 2014/15 (17.8 from 15.5).
- Of those who do report to the police, there are some clear patterns:
    - women are far more likely to be a victim than are men (1,840 women and 644 men);
    - men are far more likely to be perpetrators (695 male and 93 female perpetrators).

- There is clear positive association between deprivation and reported incidents and crimes, and in Worcestershire the rate of domestic abuse in the most deprived areas is almost 25 times that in the least deprived areas. It should be noted again that these figures are based on incidents being reported to the police and this may itself be heavily influenced by deprivation.

Full report available on the JSNA website at:
http://www.worcestershire.gov.uk/downloads/file/7081/2016_domestic_abuse_and_violence_needs_assessment

[13] Yearnshaw, S (1997) "Analysis of Cohort", in Bewley, S, Friend J and Mezey G (eds.) Violence Against Women, London: Royal College of Obstetricians and Gynaecologists.

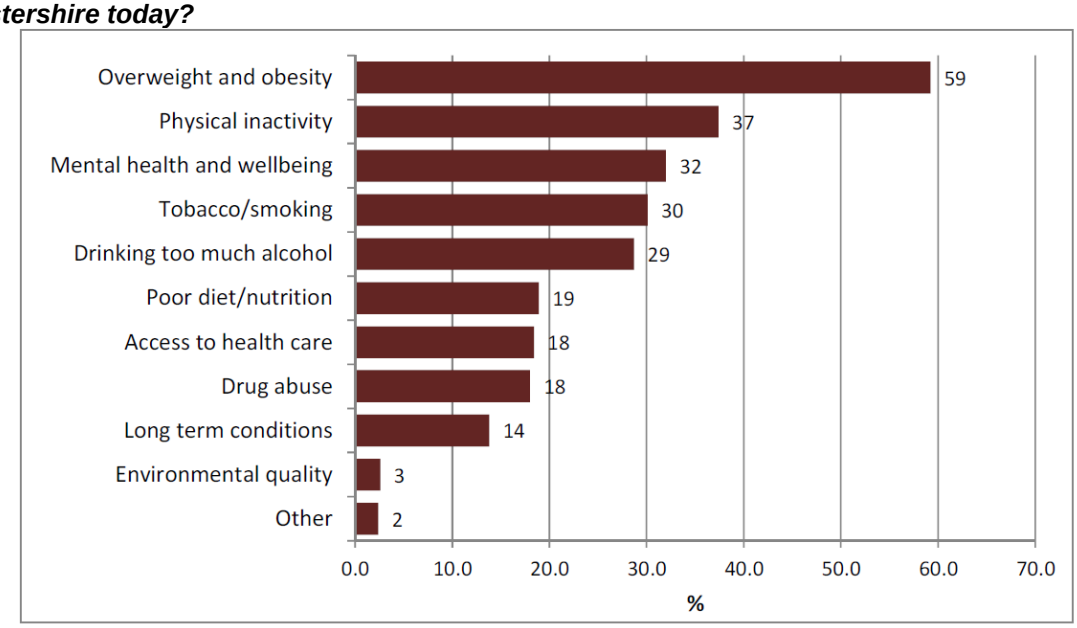
[14] Violence Against Women and Girls Ready Reckoner, http://webarchive.nationalarchives.gov.uk/20100104215220/http:/crimereduction.homeoffice.gov.uk/domesticviolence/domesticviolence072.htm

(xiv) Viewpoint survey results

Summary

- This survey represents an important strand of community engagement, as prescribed by the 2012 Health and Social Care Act; the legislation demands that the Joint Strategic Needs Assessment (JSNA) should "involve the people who live or work in the area". There were over 2,750 responses to the survey.

Figure 17 - What do you consider to be the three most important threats to health facing people in Worcestershire today?



Source: Worcestershire Viewpoint May 2015 Analysis

- In Worcestershire as a whole, there is resonance between the public opinion of the greatest threat to public health and the health and wellbeing priorities in the county (Figure 17).
- When asked about the importance of a healthy lifestyle the responses reveal a good deal about the attitudes to people's own health and wellbeing. While two thirds strongly agree that "a healthy lifestyle will reduce their chances of getting ill"; only a quarter of Worcestershire residents strongly agree they "live a healthy lifestyle" and even fewer "intend to change to a healthier lifestyle".

Full report available on the JSNA website at: http://www.worcestershire.gov.uk/downloads/file/4593/viewpoint_residents_survey_2015

Summary of current JSNA reports on website

JSNA Summary documents

Viewpoint Residents Survey 2015

2015 JSNA Summary

2014 JSNA Summary

2013 JSNA Summary

Strategic guidance on JSNAs and HWB strategies

Worcestershire Census atlas 2014

JSNA Briefings

2016 briefing on alcohol
2016 Briefing on fuel poverty
2016 Briefing on older people
2016 Briefing on road safety and older people
2016 Briefing on rural health
2016 Briefing on sexual health
2016 Briefing on smoking in pregnancy
2016 Briefing on childhood obesity
2016 Briefing on early help
2015 Briefing on homelessness
2015 Briefing on learning disabilities
2015 Briefing on mental health
2015 Briefing on physical activity
2015 Briefing on self-harm
2015 Briefing on teenage pregnancy
2014 Briefing on alcohol
2014 Briefing on Bromsgrove district
2016 Briefing on physical activity
2014 Briefing on excess winter deaths
2014 Briefing on obesity
2014 Briefing on substance misuse
2014 Briefing on Wyre forest district
2014 Briefing on wellbeing in older people
2013 Briefing on breastfeeding
2013 Briefing on cancers
2013 Briefing on cardiovascular disease
2013 Briefing on COPD
2013 Briefing on communicable disease
2013 Briefing on Malvern Hills district
2013 Briefing on Redditch district
2013 Briefing on sensory impairment
2013 Briefing on Wychavon district
2013 Briefing on smoking
2013 Briefing on Worcester City district

Needs assessments and profiles

2016 Bromsgrove early years district profile
2016 Bromsgrove Health and wellbeing profile
2016 Domestic abuse needs assessment
2016 Malvern Hills early years district profile
2016 Redditch and Bromsgrove CCG profile
2016 Redditch early years district profile
2016 sexual health profile
2016 South Worcestershire CCG profile
2015 Primary care mental health NA
2015 Pharmaceutical needs assessment
2015 Sexual health needs assessment
2015 Worcester City HWB profile
2015 Wychavon HWB profile
2014 Adult MH needs assessment
2014 Ophthalmology profile
2014 R&B Dermatology profile

2016 SALT needs assessment
2016 Worcester City early years profile
2016 Wychavon early years profile
2016 Wyre Forest early years profile
2016 Wyre Forest early years profile
2015 Early help needs assessment
2015 Malvern Hills health and wellbeing profile
2013 Wyre Forest CCG needs assessment
2014 Wyre Forest Dermatology Profile
2014 Substance misuse needs assessment
2014 Wellbeing in older people profile
2013 Ageing Well needs assessment
2013 Redditch HWB profile
2013 R & B CCG needs assessment
2013 SW CCG needs assessment
2012 Obesity Needs Assessment

Glossary

BME = Black and ethnic minority
BRE = Building Research Establishment
CIPFA = Chartered Institute of Public Finance and Accountancy
CYP = Children and young people
DECC = Dept. of Energy and Climate Change
DfT = Department for Transport
DoH = Department of Health
DSR = Directly standardized rate
EWD = Excess winter deaths
GP = General practitioner
HLE = Healthy life expectancy
HWB = Health and wellbeing
IHD = Ischemic heart disease
JSNA = Joint strategic needs assessment
LAC = Looked after children
LAPE = Local alcohol profiles England
LARC = Long acting reversible contraception
LD = Learning disability
LTLI = Long term limiting illness
MSM = Men who have sex with men
NCIN = National cancer intelligence network
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
PACTS = Parliamentary advisory council for transport safety
PANSI = Projecting adult needs/service information system
PHE = Public Health England
PHIT = Public health information team
PHOF = Public Health Outcomes framework
POPPI = Projecting older people population information system
SCIE = Social care institute for excellence
SH = Sexual health
SRE = Sex and relationship education
STI = Sexually transmitted infections
WHO = World health organization

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Associated documents and information:

ALL JSNA PRODUCTS ARE AVAILABLE ON THE WORCESTERSHIRE JSNA WEBSITE AT http://www.worcestershire.gov.uk/homepage/109/joint_strategic_needs_assessment

Further information & feedback

This profile has been created by Worcestershire County Council's Public Health Intelligence Team with contributions from members of the JSNA Working Group. We welcome your comments on our work please do contact us if you have any:
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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.

worcestershire countycouncil

AGENDA ITEM 10

HEALTH AND WELL-BEING BOARD
1 NOVEMBER 2016

BETTER CARE FUND UPDATE

Board Sponsor
Sander Kristel, Interim Director, Adult Services

Author
Anne Clarke, Assistant Director, Adult Services
Chris Bird, Principal Accountant, Adult Services

Priorities

Older people & long term conditions	Yes
Mental health & well-being	Yes

Item for Information and Assurance

Recommendation

1. **The Health and Well-being Board is asked to:**

   a) Note the current Better Care Fund (BCF) forecast for an underspend of £615k

   b) Note the current plans for use of the reserve created by the 2015/16 underspend

   c) Note the latest updated for BCF planning 2017/18

Background

2. In 2015/16, the BCF underspent by £141k. This underspend was transferred into a reserves held by WCC. The BCF budget for 2016/17 totals £38.142m

Better Care Fund Client Areas

3. The detailed monitoring for the four BCF funded urgent care schemes of Urgent and Unplanned Placements (UUPS), Plaster of Paris Placements (PoPs), Pathway 3 and Enhanced Interim Packages of Care is presented to the Integrated Commissioning Executive Officers Group (ICEOG) each month. These schemes focus on admission prevention and facilitate discharge from hospital.

4. The current forecast, based on actual costs and client numbers incurred for periods 1-5, is that **these four schemes combined** will underspend by £411k.

5. There have been quite low levels of activity this financial year, particularly in UUPS, where only 37 placements have been made. At the same point in 2015/16, 182 UUPs placements had been made.

6. The forecasts for UUPs, POPs and Pathway 3 assume that the volume of clients for 2016/17 will continue at roughly the same level as we have seen in Periods 1-5.

7. The forecast also assumes average length of stay (ALOS) of 14 days for UUPS, and 42 days for PoPs and Pathway 3. The current ALOS for each scheme can be seen in Appendix A, and at present they are slightly lower than those used in the forecasting methodology. If ALOS hold at current levels, the forecast could improve further.

8. The forecast for these client placements has worsened this month by £105k. This is due to the increase in FNC rates. The contracts with homes for UUPs, PoPs and Pathway 3 are linked to Nursing banding rates, plus 5%. Therefore the FNC increase of £44.25 per week will increase the daily rate of BCF placements by £6.64 per day.

9. The weekly BCF panel meetings are still in place to scrutinise the use of these budgets and keep length of stay within the agreed limits wherever possible.

10. The Enhanced Interim Packages of Care budget has also seen low activity in periods 1-5, with only 7 packages purchased.

Better Care Fund Overall Monitoring

11. The overall monitoring position for the BCF is attached as Appendix A.

12. The current forecast is that **the BCF overall would underspend by £615k**. This is an improvement of £115k on the P4 forecast. Aside from the client schemes the other variances to note are:

- £18k overspend currently forecast in the Rapid Response Team due to vacancies being covered by agency staff, which is a higher per-post cost.
- £22k overspend in The Grange, due to agency staff covering vacant posts.
- £36k under-spend in Howbury. The budget for Howbury has been reduced to 6 months to reflect the change in use of, and funding source for, Howbury from October 2016.
- This means that £683k is currently available for 6 months of recovery services to replace the Howbury recovery beds.
- The figure agreed for reimbursement of the BCF for the 5 permanent residents at Howbury will be confirmed following the end of September monitoring. In 2015/16 the reimbursement figure was £130k for the year.
- An under-spend on the UPI team of £208k has been brought into monitoring. The service is underspending due to staff vacancies.
- All other BCF schemes are forecast to budget at this stage.

Use of BCF Reserve

13. The current value of the BCF reserve is £141k (paragraph 1). At May 2016 ICEOG, the following use of the reserve was agreed:

	£000
Band 6 Nurse in UPI team (interim funding to maintain current situation prior to service redesign)	45
Recruitment of a Social Worker to be responsible for BCF placements process	38
12-month secondment for coordinator post in Pathway 1 team, necessary for the SW CCG pilot linked to Pathway 1 budget	25
Funding for remaining 6 weeks of HCA to support Community Delays pilot	21
Total agreed use of reserve	**129**
Total Reserve remaining	12

BCF Planning 2017/18

14. The publication of the 2017/18 Policy Framework has been delayed. Information received on 23 September from the West Midlands Better Care Fund Support Team indicated that the target date for publication is mid-November. The planning guidance typically follows within a few weeks of the Policy Framework.

15. The guidance will likely confirm that a 2-year plan must be submitted, to align with NHS operational planning and contracting.

16. There is a December deadline for CCG contracts, and these may be affected by the BCF plan.

- Appendix A – BCF Budget Monitoring (Period 5)

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Better Care Fund
Budget Monitoring Period 5 5

Scheme	16/17 Budget (£)	CCG Split			Total BCF budget for 2016/17	Line in s75	Actual (£)	Forecast Outturn (£)	Forcast Variance (£)	Previous Variance (£)	Change (£)	Comments
		SW	RB	WF								
Revenue Schemes from CCG contributions												
Stay within CCG Leder												
Timberdine Nursing and Rehabilitation Unit	**1,805,000**	**1,805,000**	**0**	**0**	**1,805,000**	**Adult Recovery Services**	752,083	**1,805,000**	**0**	0	0	
UUPs at Timberdine	**218,000**	**218,000**	**0**	**0**	**218,000**	**Patient Flow and Admission Prevention Beds**	90,833	**218,000**	**0**	0	0	
Therapy Support to Timberdine	**42,000**	**42,000**	**0**	**0**	**42,000**	**Adult Recovery Services**	17,500	**42,000**	**0**	0	0	
SW Enhanced Care Team	**3,866,000**	**3,866,000**	**0**	**0**	**3,866,000**	**Community Health Services**	1,610,833	**3,866,000**	**0**	0	0	
Health Support for Step-down	**61,200**	**30,600**	**18,360**	**12,240**	**61,200**	**Patient Flow and Admission Prevention Beds**	25,500	**61,200**	**0**	0	0	
Stroke Rehabilitation - North	**220,000**	**0**	**132,000**	**88,000**	**220,000**	**Community Health Services**	91,667	**220,000**	**0**	0	0	
WF/RB Virtual Ward	**4,381,300**	**0**	**2,628,780**	**1,752,520**	**4,381,300**	**Community Health Services**	1,825,542	**4,381,300**	**0**	0	0	
Intermediate Care Night Sitters	**110,000**	**55,000**	**33,000**	**22,000**	**110,000**	**Adult Recovery Services**	45,833	**110,000**	**0**	0	0	
Palliative care	**522,000**	**261,000**	**156,600**	**104,400**	**522,000**	**Community Health Services**	217,500	**522,000**	**0**	0	0	
Winter Pressures County-wide	**167,000**	**83,500**	**50,100**	**33,400**	**167,000**	**Winter Pressures**	69,583	**167,000**	**0**	0	0	
NHS Commissioned out-of-hospital services	**9,635,000**	**4,372,243**	**4,021,784**	**1,240,973**	**9,635,000**	**Community Health Services**	4,014,583	**9,635,000**	**0**	0	0	
Total CCG contributions staying in CCG ledger	**21,027,500**	**10,733,343**	**7,040,624**	**3,253,533**	**21,027,500**		8,761,458	**21,027,500**	**0**	0	0	
Funding transfer from CCGs to Local Authority												
UUPs placements	**508,000**	**145,000**	**218,000**	**145,000**	**508,000**	**Patient Flow and Admission Prevention Beds**	36,308	**107,377**	**-400,623**	-398,258	-2,365	**See Appendix A for detailed forecast**
PoP Placements	**442,000**	**221,000**	**132,600**	**88,400**	**442,000**	**Patient Flow and Admission Prevention Beds**	183,953	**497,679**	**55,679**	23,128	32,551	**See Appendix A for detailed forecast**
Pathway 3 beds	**1,167,500**	**583,750**	**350,250**	**233,500**	**1,167,500**	**Patient Flow and Admission Prevention Beds**	420,384	**1,183,877**	**16,377**	-58,350	74,727	**See Appendix A for detailed forecast**
Enhanced Interim Packages of Care	**92,800**	**46,400**	**27,840**	**18,560**	**92,800**	**Patient Flow and Admission Prevention Beds**	3,370	**10,128**	**-82,672**	-82,672	0	**Very low activity in periods 1-4**
Access Centre extension (call handling)	**131,300**	**65,650**	**39,390**	**26,260**	**131,300**	**Access Services**	54,708	**131,300**	**0**	0	0	
WHASCAS Extension (Nursing)	**220,700**	**110,350**	**66,210**	**44,140**	**220,700**	**Access Services**	91,960	**220,700**	**0**	0	0	
Resource Centres - Howbury	**683,000**	**683,000**	**0**	**0**	**683,000**	**Adult Recovery Services**	269,752	**647,405**	**-35,595**	0	-35,595	**Underspend due to vacancies**
Integrated Recovery Project - South Worcestershire (Howbury replacement)	**683,000**	**683,000**	**0**	**0**	**683,000**	**Adult Recovery Services**	0	**683,000**	**0**	0	0	
Resource Centres - The Grange	**1,162,000**	**0**	**0**	**1,162,000**	**1,162,000**	**Adult Recovery Services**	493,285	**1,183,884**	**21,884**	0	21,884	**Overspend due to agency costs**
Therapy Support to Resource Centres and WICU	**86,000**	**44,000**	**0**	**42,000**	**86,000**	**Adult Recovery Services**	14,001	**86,000**	**0**	0	0	
SPOA/Rapid Response Nurses	**235,400**	**117,700**	**70,620**	**47,080**	**235,400**	**Community Health Services**	57,088	**235,400**	**0**	0	0	
Pathway 1 (BCF element)	**217,000**	**108,500**	**65,100**	**43,400**	**217,000**	**Adult Recovery Services**	90,417	**217,000**	**0**	0	0	
UPI	**2,214,400**	**1,107,200**	**664,320**	**442,880**	**2,214,400**	**Adult Recovery Services**	836,186	**2,006,846**	**-207,554**	0	-207,554	**Underspend due to vacancies**
ASWC in Community Hospitals, Resource Centres and DtA Beds	**237,000**	**118,500**	**71,100**	**47,400**	**237,000**	**Hospital and Rapid Response Assessment**	98,750	**237,000**	**0**	0	0	
Rapid Response Social Work Team	**660,800**	**330,400**	**198,240**	**132,160**	**660,800**	**Hospital and Rapid Response Assessment**	255,785	**678,522**	**17,722**	16,333	1,389	**Agency cover for vacancies causing forecast overspend**
Dementia/RMNs in Intermediate Care	**310,000**	**155,000**	**93,000**	**62,000**	**310,000**	**Adult Recovery Services**	129,165	**310,000**	**0**	0	0	
Carers	**1,260,000**	**630,000**	**378,000**	**252,000**	**1,260,000**	**Carers**	525,000	**1,260,000**	**0**	0	0	
Implementation of the Care Act - additional demand for Home Care	**1,371,000**	**685,500**	**411,300**	**274,200**	**1,371,000**	**Care Bill Implementation**	571,250	**1,371,000**	**0**	0	0	
Additional amount for WCC Home Care Pressures	**740,521**	**370,261**	**222,156**	**148,104**	**740,521**	**Care Bill Implementation**	308,550	**740,521**	**0**	0	0	
ICES	**456,000**	**228,000**	**136,800**	**91,200**	**456,000**	**Integrated Community Equipment Services**	190,000	**456,000**	**0**	0	0	
Total Funding Transfer from CCGs to Local Authority	**12,878,421**	**6,433,211**	**3,144,926**	**3,300,284**	**12,878,421**		4,629,912	**12,263,639**	**-614,782**	-499,819	-114,963	
Total from CCG contributions	**33,905,921**	**17,166,554**	**10,185,550**	**6,553,817**	**33,905,921**		13,391,370	**33,291,139**	**-614,782**	-499,819	-114,963	

Capital Allocations and Other												
DFG	**4,235,741**	**1,874,713**	**1,358,406**	**1,002,622**	**4,235,741**	**Disabled Facilities Capital Grant**	4,235,741	**4,235,741**	**0**	0	0	**Passported to districts**
Total Capital Allocations and Other	**4,235,741**	**1,874,713**	**1,358,406**	**1,002,622**	**4,235,741**		4,235,741	**4,235,741**	**0**	0	0	
BCF expenditure	**38,141,662**	**19,041,267**	**11,543,956**	**7,556,439**	**38,141,662**		17,627,111	**37,526,880**	**-614,782**	-499,819	-114,963	

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