Worcestershire County Council

Agenda

Health and Well-Being Board

Tuesday, 27 February 2018, 2.00 pm
County Hall, Worcester

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Health and Well-Being Board
Tuesday, 27 February 2018, 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
Dr R Davies	Redditch and Bromsgrove CCG
Catherine Driscoll	Director of Children, Families and Communities
Mr A I Hardman	Cabinet Member with Responsibility For Adult Social Care
Mr M J Hart	Cabinet Member with Responsibility for Education and Skills
Dr Frances Howie	Director of Public Health
Dr A Kelly	South Worcestershire CCG
Dr C Marley	Wyre Forest CCG
Peter Pinfield	Healthwatch, Worcestershire
Mr A C Roberts	Cabinet Member with Responsibility for Children and Families
Steve Stewart	Chief Executive
Simon Trickett	Redditch & Bromsgrove & wyre Forest Clinical Commissioning Group

Associate Members

Mrs C Cumino	Voluntary and Community Sector
Kevin Dicks	District Local Housing Authorities
Cllr. Gerry O'Donnell	South Worcestershire District Councils
Cllr Margaret Sherrey	North Worcestershire District Councils
Chief Supt. M Travis	West Mercia Police

Agenda

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1	**Apologies and Substitutes**		

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

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Date of Issue: Friday, 16 February 2018

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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 26 February 2018). Enquiries can be made through the telephone number/e-mail address below.*		
4	**Confirmation of Minutes** For the meeting on 5 December 2017		1 - 26
5	**Quality of Acute Hospital Services**	Michelle McKay	27 - 42
6	**Sustainability and Transformation Plan Update**	Sarah Dugan	To Follow
7	**Road Safety Team**	Rod Reynolds	43 - 54
8	**Pharmaceutical Needs Assessment**	Matthew Fung	55 - 68
9	**Children and Young People's Plan**	Sarah Wilkins	To Follow
10	**Suicide Prevention Plan**	Liz Altay	69 - 84
11	**Director of Public Health Report**	Frances Howie	To Follow
12	**Memorandum of Understanding for Housing**	Tim Rice	85 - 90
13	**Future Meeting Dates** **Dates for 2018** **Public meetings** (All at 2pm) • 22 May 2018 • 25 September 2018 • 13 November 2018 **Private Development meetings** (All at 2pm) • 27 March 2018 • 24 April 2018 • 19 June 2018 • 17 July 2018 • 23 October 2018 • 4 December 2018		

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

Minutes

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

Also attended: Liz Altay, Philippa Coleman, Sarah Wilkins and Kate Griffiths

463 Apologies and Substitutes

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

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

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

464 Declarations of Interest

None

465 Public Participation

None

466 Confirmation of Minutes

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

467 Special Education Needs and Disabilities (SEND) Strategy

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

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

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

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

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

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

During the discussion the following points were made:

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

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

RESOLVED that the Health and Well-being Board:

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

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

468 CAMHs Transition Plan

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

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

In the discussion the following points were made:

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

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

RESOLVED that the Health and Well-being Board:

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

469 Sustainability and Transformation Partnership Update

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

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

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

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

Board members made the following points:

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

Developing Accountable Care in Worcestershire

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

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

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

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

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

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

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

RESOLVED that the Health and Well-being Board;

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

470 Development Meeting update

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

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

RESOLVED that the Health and Well-being Board:

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

471 Adverse Childhood Events (ACES)

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

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

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

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

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

RESOLVED that the Health and Well-being Board:

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

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

472 Immunisation Update

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

RESOLVED that the Health and Well-being Board:

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

473 Future Meeting Dates

Dates for 2018

Public meetings (All at 2pm)

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

Private Development meetings (All at 2pm)

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

The meeting ended at 3.50pm

Chairman …………………………………………….

Adverse Childhood Experiences

Liz Altay

Adverse Childhood Experiences

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

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

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

Public Health England

Questions to define health harming behaviours – The ACEs Score Calculator

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

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

ACEs study USA

Adverse Childhood Experiences Are Common

Household dysfunction:

Substance abuse	27%
Parental sep/divorce	23%
Mental illness	17%
Battered mother	13%
Criminal behavior	6%

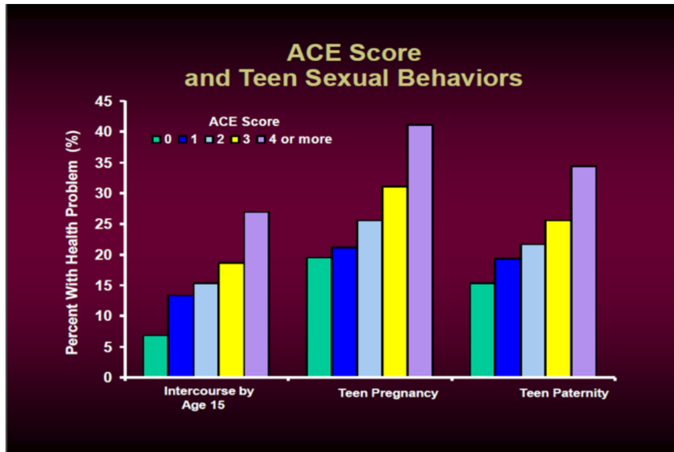
Abuse:

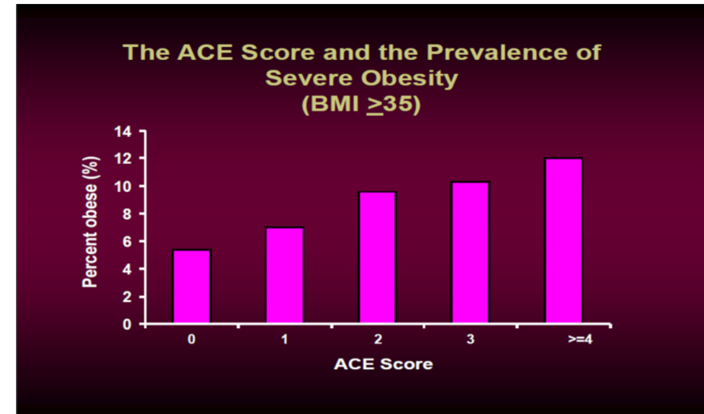
Psychological	11%
Physical	28%
Sexual	21%

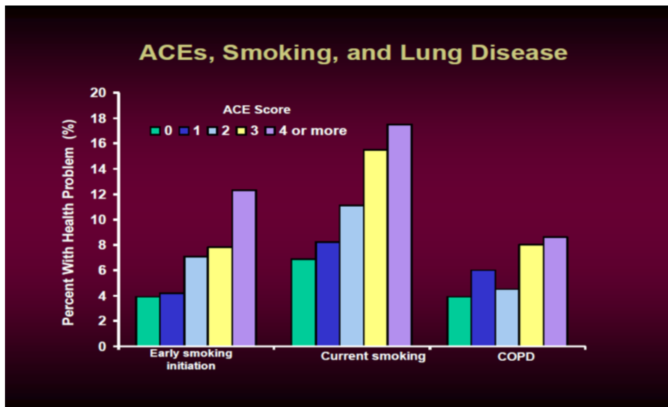
Neglect:

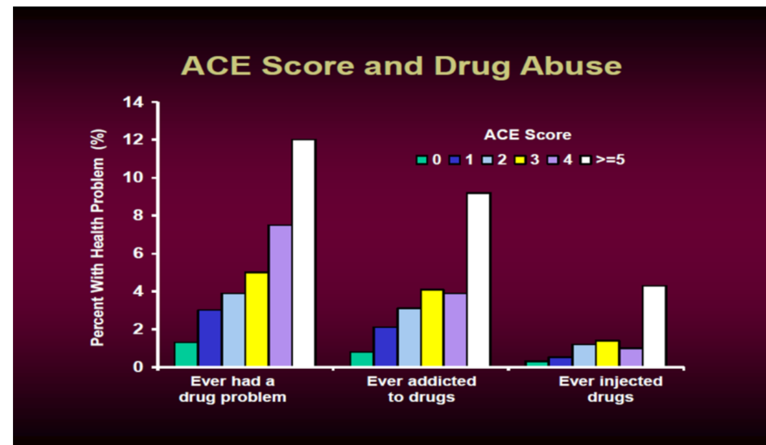
Emotional	15%
Physical	10%

ACEs study USA

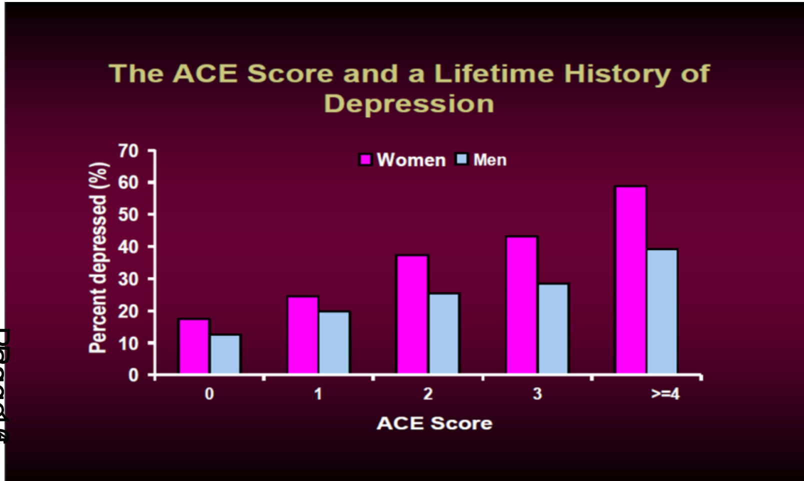


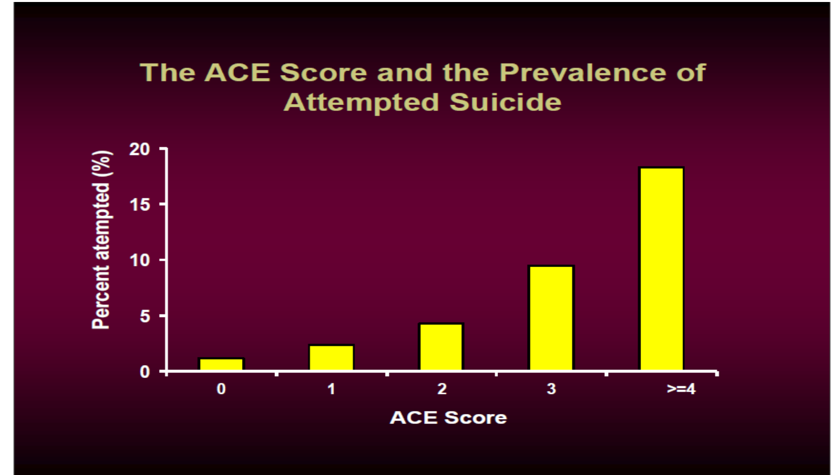


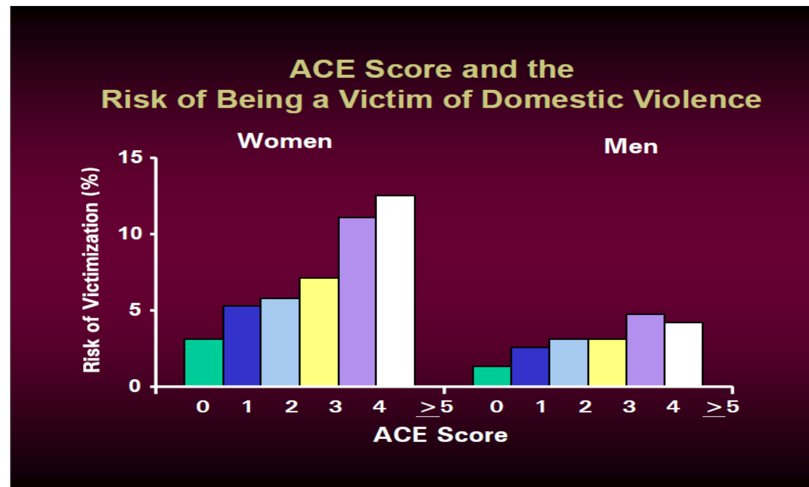




ACEs study USA







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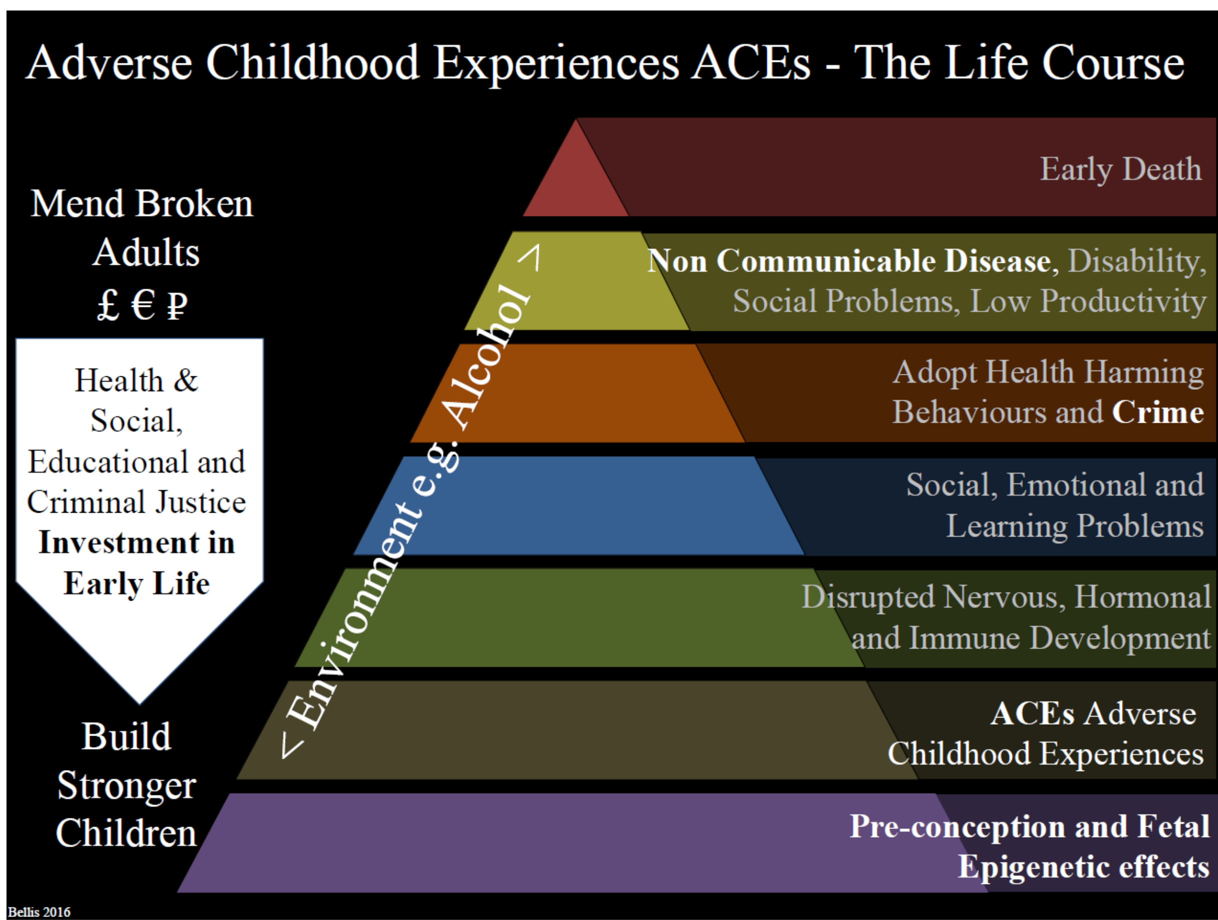
ACEs - the Life Course



ACEs Study - UK

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

ACEs Study - UK

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

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

INDEPENDENT OF POVERTY

If they had no ACEs problems could be reduced by:

Aged 18-70 years

Bellis 2016

Bellis et al. 2014, n=3885

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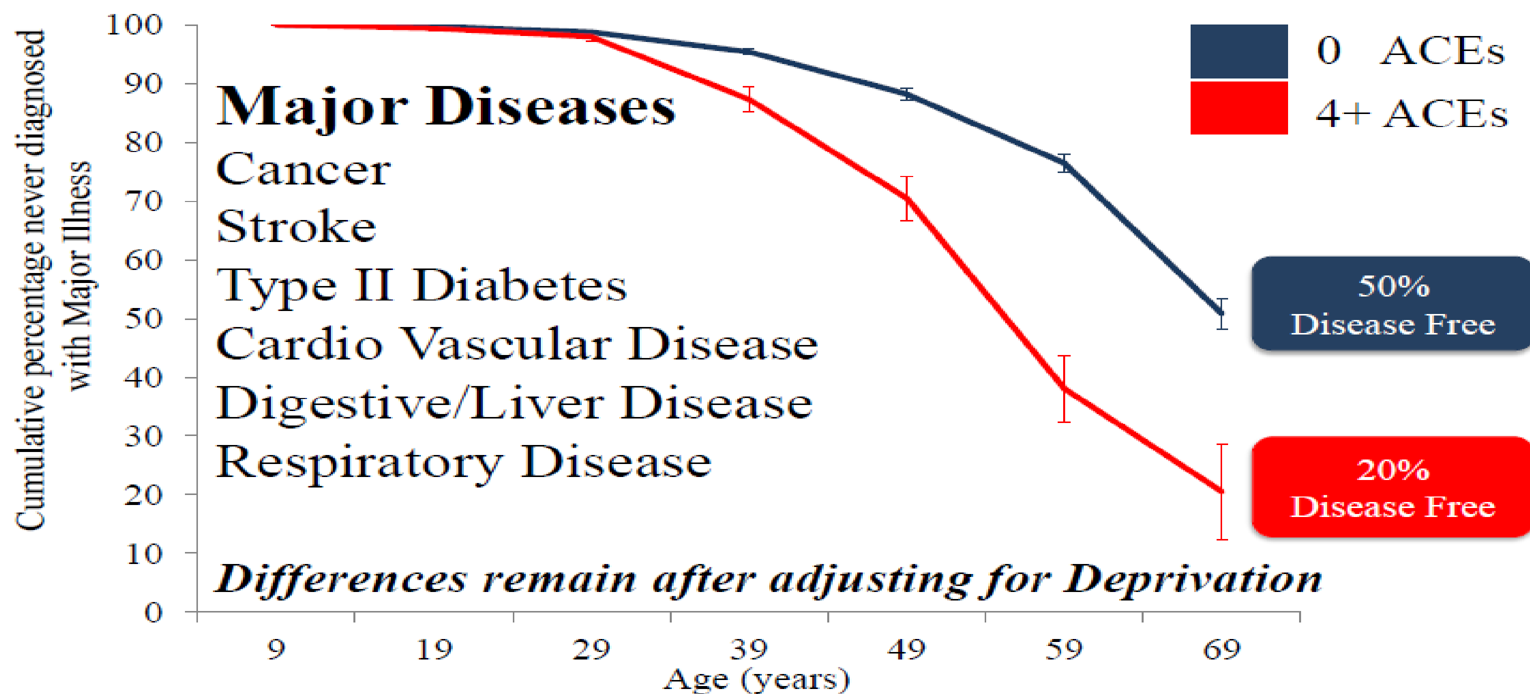
ACEs Study - UK



ACEs study -Hertfordshire, Luton & Northamptonshire

How many adults have suffered each ACE?

CHILD MALTREATMENT

Verbal abuse
23%

Physical abuse
14%

Sexual abuse
6%

CHILDHOOD HOUSEHOLD INCLUDED

Parental separation
18%

Domestic violence
16%

Mental illness
11%

Alcohol abuse
11%

Drug use
4%

Incarceration
3%

For every 100 adults 44 have suffered at least one ACE during their childhood and 9 have suffered 4 or more

0 ACEs 56%

1 ACEs 18%

2-3 ACEs 17%

4+ ACEs 9%

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

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

- 2 times more likely to currently binge drink or have a poor diet
- 3 times more likely to be a current smoker
- 4 times more likely to have had sex while under 16 years old or to have smoked cannabis
- 4 times more likely to have had or caused unintended teenage pregnancy
- 8 times more likely to have been a victim of violence in the last year or ever been incarcerated
- 10 times more likely to have been a perpetrator of violence in the last year

Preventing ACEs in future generations could reduce levels of:

- Early sex (before age 16) by 36%
- Unintended teen pregnancy by 44%
- Smoking (current) by 25%
- Binge drinking (current) by 22%
- Cannabis use (lifetime) by 45%
- Heroin/crack use (lifetime) 54%
- Incarceration (lifetime) 50%
- Violence perpetration (past year) 61%
- Violence victimisation (past year) 56%
- Poor diet (current; <2 fruit & veg portions daily) 14%

Adverse Childhood Experiences (ACEs) in Wales

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

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

CHILD MALTREATMENT

Verbal abuse 23%

Physical abuse 17%

Sexual abuse 10%

Page 20

CHILDHOOD HOUSEHOLD INCLUDED

Parental separation 20%

Domestic violence 16%

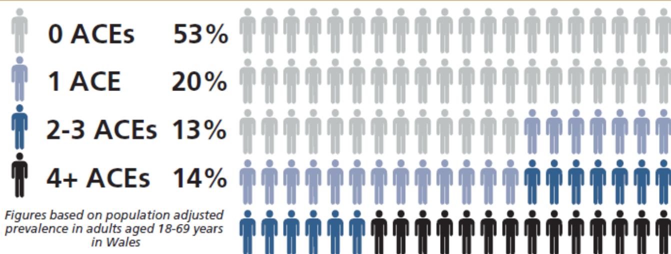
Mental illness 14%

Alcohol abuse 14%

Drug use 5%

Incarceration 5%

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

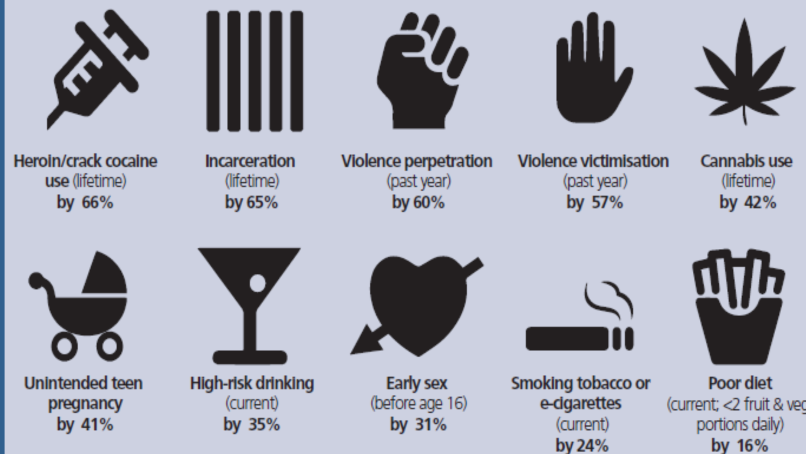


ACEs increase individuals' risks of developing health-harming behaviours

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

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

Preventing ACEs in future generations could reduce levels of:



Systematic Review (2017)

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

What should we do?

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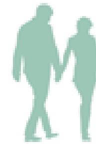
What *can* Be Done About ACES?

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

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

Home visiting to pregnant women and families with newborns

Parenting training programs


Intimate partner violence prevention

Social support for parents

Parent support programs for teens and teen pregnancy prevention programs

Mental illness and substance abuse treatment

High quality child care

Sufficient Income support for lower income families

Routine Enquiry about Adversity in Childhood

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

Public Health – Commissioned LCFT to train front line staff

How can we respond?

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

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AGENDA ITEM 5

HEALTH AND WELL-BEING BOARD
27 FEBRUARY 2018

QUALITY OF ACUTE HOSPITAL SERVICES – WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

Board Sponsor
Name

Author
Michelle McKay
Chief Executive Officer
Worcestershire Acute Hospitals NHS Trust

Priorities

Mental health & well-being	Yes
Being Active	Yes
Reducing harm from Alcohol	Yes
Other (specify below)	

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
Information and assurance

Recommendation

1. **The Health and Well-being Board is asked to note the contents of this report.**

Background

1. The CQC served a section 29A notice on the Trust in January 2017, requiring significant improvement by 10 March 2017. The CQC conducted a focussed assessment in early April to assess progress against the s29A notice and the results of that assessment were released in July 2017.

2. The CQC served a further section 29A notice on the Trust as a result of this assessment, which required significant improvement by 30 September 2017.

3. The CQC conducted core service reviews of four services and a focussed assessment on governance in November 2017. The report from that inspection was released on 17 January 2018.

4. The CQC inspects services by asking five key questions:
    - Is it safe?
    - Is it effective?
    - Is it caring?
    - Is it responsive?
    - Is it well-led?

Progress on Quality Improvement

5. The Care Quality Commission (CQC) published its report on Worcestershire Acute Hospitals NHS Trust on the 18 January following their inspection in November 2017. The inspection assessed the core services of urgent and emergency care and medical care (including older people's care) at the Alexandra and Worcestershire Royal Hospitals.

6. The report shows that all four of the core services inspected have improved from 'inadequate' to 'requires improvement' in the safe domain, urgent and emergency care at the Worcester site now rated 'good' in the effective domain and three of the four services have improved their overall rating from 'inadequate' to 'requires improvement'.

7. Given that only four of the twenty-two core services were rated in this inspection, there have been no changes to the overall ratings of the hospitals individually or the Trust overall as a result of this inspection.

8. The CQC identified outstanding practices in this review including medicines safety work by the Pharmacy Team in the Emergency Department (ED) at Worcestershire Royal Hospital, and care for patients with mental health conditions in the ED at the Alexandra Hospital. Evergreen Ward at Worcestershire Royal Hospital, which provides a rehabilitation area for inpatients waiting for discharge, was also singled out for praise for its outstanding work in promoting holistic care and timely discharge of patients.

9. The CQC also identified areas that the Trust needs to continue to improve. This includes further improvement in the levels of mandatory training, VTE risk assessments at 24 hours post admission, improved responsiveness by specialist doctors for patients in the Emergency Departments, timeframes for resolution of complaints and risk management processes.

10. The CQC has revisited the Trust on 23 – 26 January and 12 – 15 February to conduct more core service reviews. They are required to inspect all core services that are rated as 'inadequate' annually. These services are surgery at the Alexandra Hospital, children and young people at the Worcestershire Royal, urgent and emergency care (MIU) at the Kidderminster site and outpatients and diagnostic imaging at all three sites. They can, of course, inspect any other core services and have decided to review maternity services and surgical services at the Worcestershire Royal. The CQC have also advised that they will conduct a 'well-led' review at the end of February 2018.

11. The Trust's Quality Improvement Plan, will be refreshed following this report.

12. The attached presentation includes detail from the report.

Contact Points

County Council Contact Points
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Specific Contact Points for this report
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Supporting Information

- Appendix 1 – Presentation re CQC findings

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NHS
Worcestershire Acute Hospitals NHS Trust

CQC focused inspection reports

17 January 2018

4ward

NHS
Worcestershire Acute Hospitals
NHS Trust

Reminder of the CQC process

- Trust has been in special measures since December 2015
- Section 29A warning notice: 11 July 2017 requiring significant improvements by 30 September 2017
- 1 – 3 November 2017 – Urgent and Emergency Care and Medical Care (including older people's care) at Worcestershire Royal and Alexandra Hospitals – 4 of 22 core services
- 7 – 9 November 2017 – Governance part of the well-led domain
- Report from November inspections released today
- Unannounced inspection expected January 2018
- Announced inspection 26 – 28 February 2018 – well-led domain

4ward

Worcestershire Acute Hospitals NHS Trust

CQC ratings - August 2017

Urgent & Emergency Care

Worcestershire Acute Hospitals NHS Trust

Domain	Safe	Effective	Caring	Responsive	Well Led	Overall
Worcestershire Royal	Inadequate	Requires Improvement	Good	Inadequate	Inadequate	Inadequate
Alexandra Hospital	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate

CQC ratings - January 2018

Urgent & Emergency Care

Worcestershire Acute Hospitals NHS Trust

Domain	Safe	Effective	Caring	Responsive	Well Led	Overall
Worcestershire Royal	Requires Improvement	Good	Good	Inadequate	Inadequate	Inadequate
Alexandra Hospital	Requires Improvement	Requires Improvement	Good	Requires Improvement	Inadequate	Requires Improvement

Urgent and emergency care – Worcestershire Royal

- Patient risk assessments were completed correctly and in a timely manner
- Administration of pain relief had improved from last inspection
- The service monitored the effectiveness of treatment and compared results with other services to improve
- All nursing staff had an appraisal in the last year
- Staff provided emotional support to patients to minimise distress
- Significant improvement in the number of patients waiting more than 12 hours to be admitted
- Hand hygiene best practice followed
- Local leadership team highly visible

4ward

NHS
Worcestershire Acute Hospitals
NHS Trust

Urgent and emergency care – Alexandra Hospital

- Care pathways and protocols based on NICE guidelines introduced
- Improvement in use of the sepsis guidelines
- Culture now focussed on teamwork and putting patients first
- Ambulatory care and frailty pathways operating effectively
- Nurses considered patients' emotional wellbeing during care and comfort rounds
- Patient flow through the hospital had improved
- Calm, quiet environments were provided for patients with dementia or a learning disability
- Local leadership team were highly visible

4ward

Worcestershire Acute Hospitals NHS Trust

CQC ratings - August 2017

Medical Care (including older people's care)

Worcestershire Acute Hospitals NHS Trust

Domain	Safe	Effective	Caring	Responsive	Well Led	Overall
Worcestershire Royal	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate
Alexandra Hospital	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate

CQC ratings - January 2018

Medical Care (including older people's care)

Worcestershire Acute Hospitals NHS Trust

Domain	Safe	Effective	Caring	Responsive	Well Led	Overall
Worcestershire Royal	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Alexandra Hospital	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

Medical care (including older people) – Worcestershire Royal

- Oversight of deteriorating patients and VTE assessment improved
- Patient safety incidents managed well with robust processes for the recording, escalation and sharing of learnings from incidents
- Nutritional support and pain management improved
- Medicine division dashboard and risk management processes were good
- Care and treatment provided based on national guidelines
- Staff felt supported, able to challenge, and felt listened to

Worcestershire Acute Hospitals NHS Trust

Medical care (including older people) – Alexandra Hospital

- The service used safety monitoring results well, shared it with staff, patients and visitors and used information to improve
- Medical notes contained clear treatment plans
- Staff worked together as a team to benefit patients
- Pain management and nutritional support had improved
- Relatives said they felt well supported and communication with staff was open with clear explanations about treatment
- Governance had improved with frameworks in place from board to ward
- There was good collaboration with partner organisations

4ward

NHS
Worcestershire Acute Hospitals
NHS Trust

Outstanding practice

- Pharmacy team in the ED at Worcestershire Royal undertook medicine reconciliation and ensured safe prescribing
- WRH ED liaison group with local prison to reduce prisoner attendance
- Holistic care provided on the Evergreen ward and the focus on providing as normal a home environment as possible
- Alex ED staff worked with mental health liaison team to improve services for patients
- Improved mental health care for patients through alcohol detox therapy

CCQ ratings for Trust overall

Domain	Safe	Effective	Caring	Responsive	Well led	Overall
Worcestershire Royal	Inadequate	Requires improvement	Good	Inadequate	Inadequate	Inadequate
Alexandra Hospital	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Kidderminster H&TC	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Overall Trust	Inadequate	Requires improvement	Good	Inadequate	Inadequate	Inadequate

Areas for improvement

- Ensure systems are embedded and operating fully effectively in order to assess and monitor the service
- Ensure divisional reporting of improvement plans to address gaps in care provide assurance that learning and improvement from the mortality review process is occurring
- Ensure the corporate risk register is comprehensive, graded, reviewed and includes mitigating actions or control measures
- Improving privacy for patients in ED corridor
- Ensure complaints are responded to in a timely way
- Improving mandatory training
- Improved timeliness for speciality doctor review of patients in ED
- VTE assessments post 24 hour rate is improved
- Variable dose medication are recorded correctly

Next steps

- Refresh the Quality Improvement plan based on findings
- CQC expected imminently to conduct other core service reviews
- CQC must inspect all services rated ‘inadequate’ annually
  - Services for children and young people – WRH
  - Outpatients and diagnostic imaging at all three sites
  - Surgery services at the Alexandra Hospital
  - Urgent and emergency services at Kidderminster
- Can inspect other services
- CQC well led review 26 – 28 February

Road Safety Team in Warwickshire and West Mercia

Rod Reynolds

Manager

Roads Safety Team in

Warwickshire Police and West Mercia Police

Introduction

- Safety Camera Partnership established in 2001 and were managed by DfT through cost recovery with the primary focus on speed enforcement and limited communications activity

- In 2007, the name was changed to Safer Roads Partnership with a focus on working more closely with partners

- ETP and Operations Forums were introduced and DfT were no longer restrictive about criteria for enforcement sites

- In 2011 funding changed again to a different type of cost recovery; through offenders choosing to attend Speed Awareness Courses if they meet criteria for the offer

- Road Safety and Casualty Reduction through Warwickshire and West Mercia is co-ordinated and controlled through the Roads Safety Team with particular attention to the Three E's of Road Safety; Engineering, Education and Enforcement

Warwickshire POLICE West Mercia POLICE

Road casualties in Worcestershire

By Helen Roberts

Business Analyst

Roads Safety Team in

Warwickshire Police and West Mercia Police

RTC casualties in Worcestershire 2012-17

Worcestershire RTC collisions by severity

Severity of accident	2012	2013	2014	2015	2016	2017	Total
Fatal	21	18	12	16	14	25	106
Serious	129	151	138	172	196	183	969
Slight	1022	875	881	912	819	772	5281
KSI Total	150	169	150	188	210	208	606

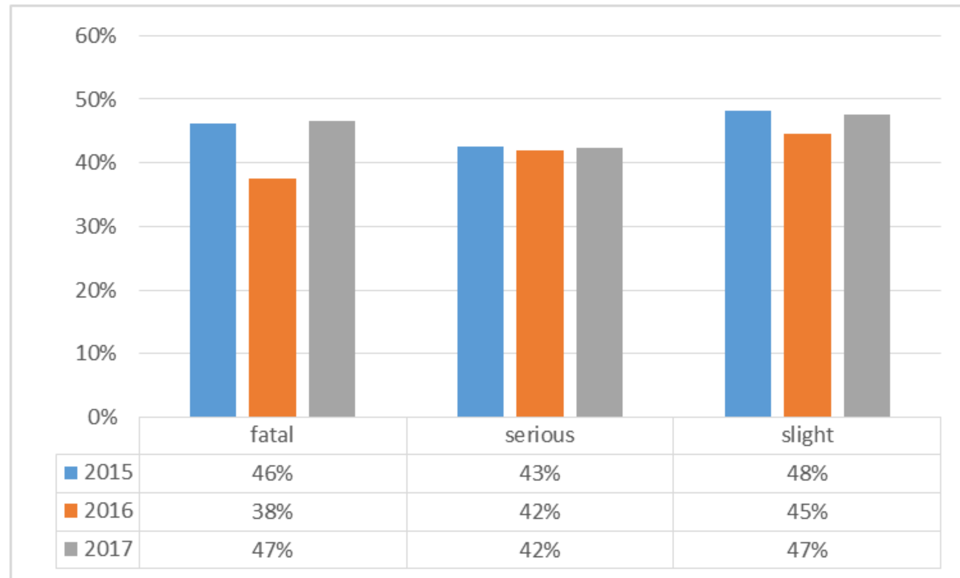
Worcestershire RTC casualties by severity

Severity of casualty	2012	2013	2014	2015	2016	2017	Total
Fatal	23	18	12	18	15	28	114
Serious	139	168	153	193	215	206	1074
Slight	1453	1206	1218	1289	1155	1045	7366
KSI Total	162	186	165	211	230	234	675

Warwickshire POLICE West Mercia POLICE

Injury collisions 2015-17

Percentage of West Mercia casualties by severity

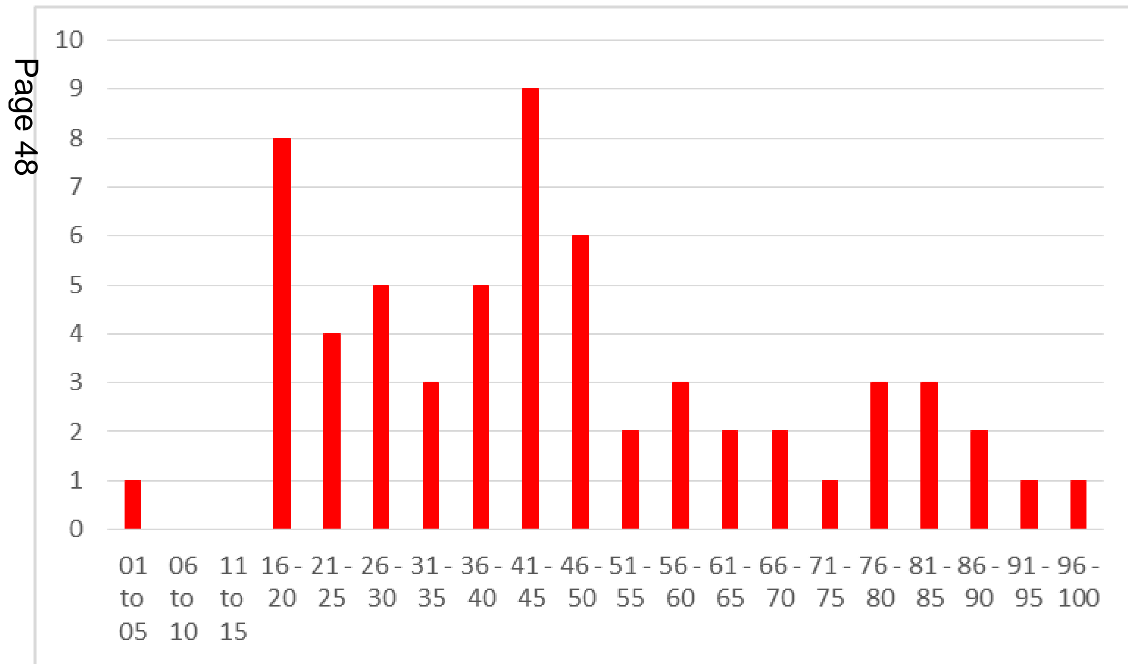


Cost to Worcestershire by collision type and severity

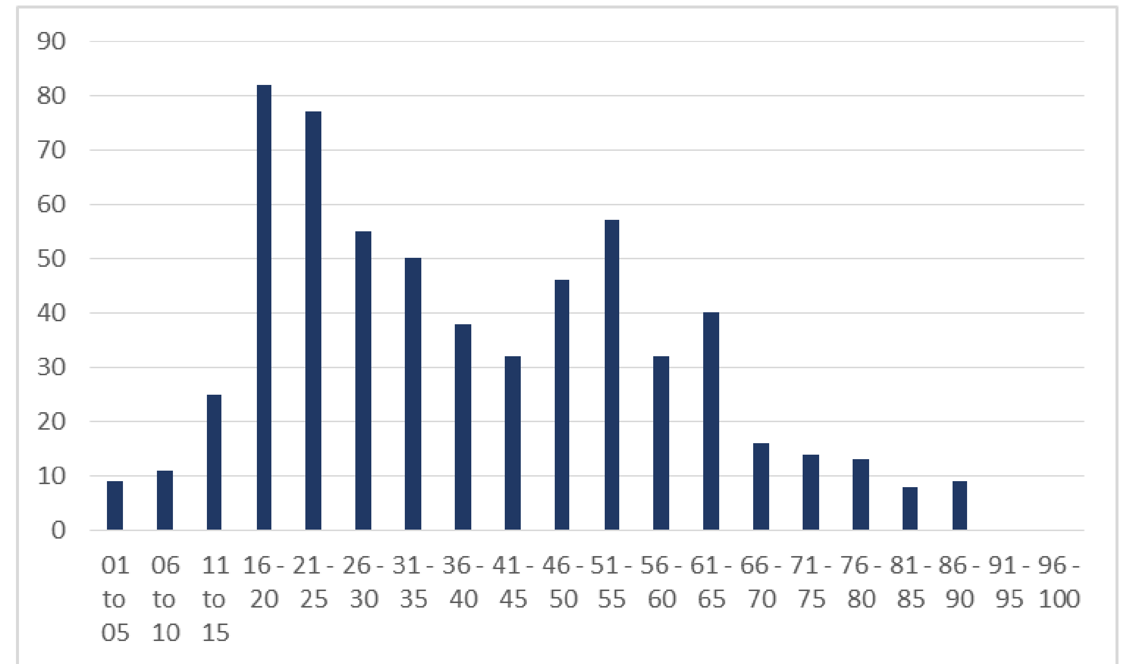
	2015	2016	2017	Total
Fatal	£32,861,027	£28,753,398	£51,345,354	£112,959,780
Serious	£40,854,664	£46,555,315	£43,467,462	£130,877,441
Slight	£22,719,062	£20,402,315	£19,156,753	£62,352,864
Total	£96,434,752	£95,711,028	£113,969,569	£306,190,084

Worcester KSI casualties age groups 2015-17

Deaths by age



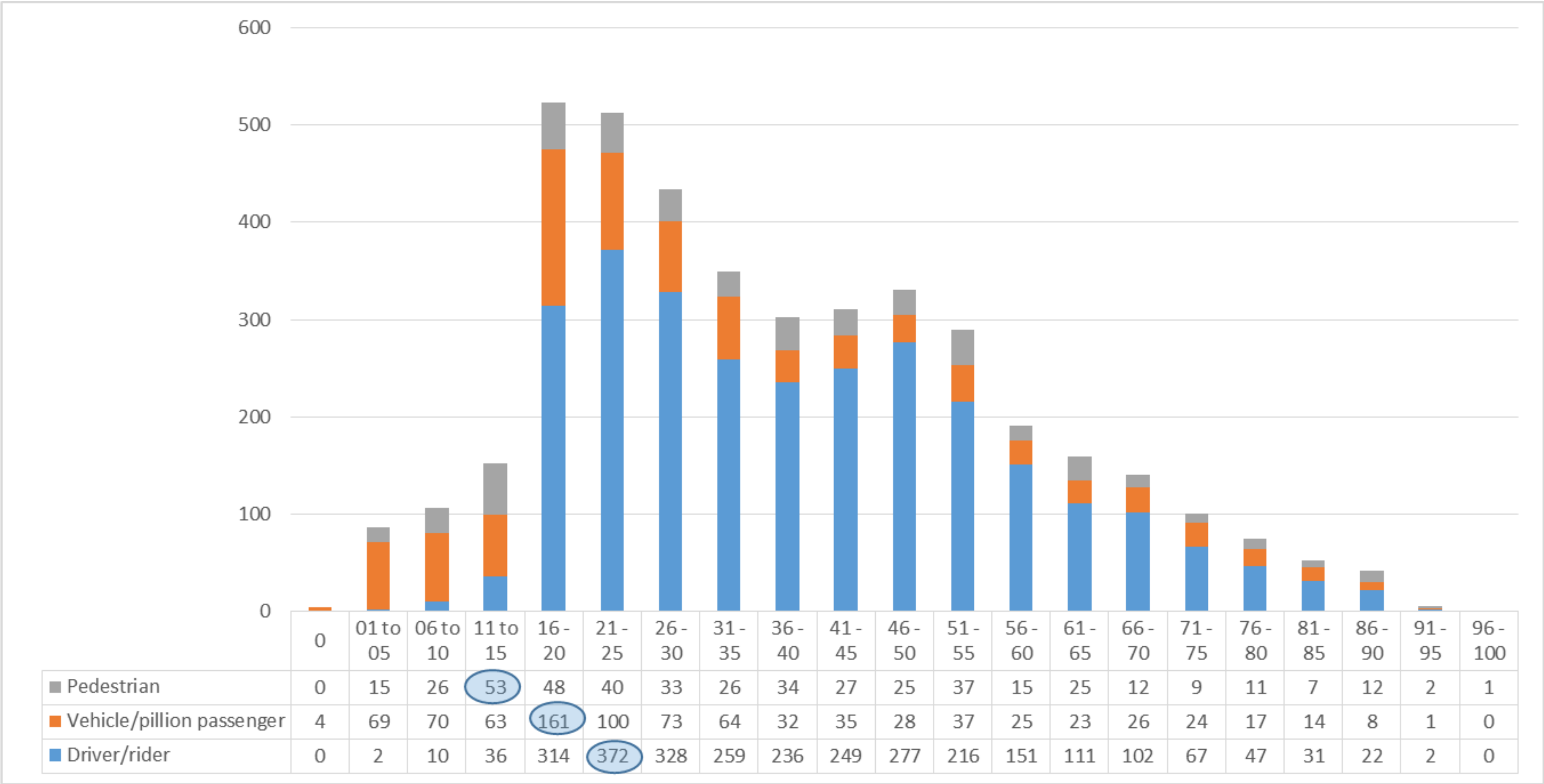
Serious injury casualties by age



Warwickshire POLICE

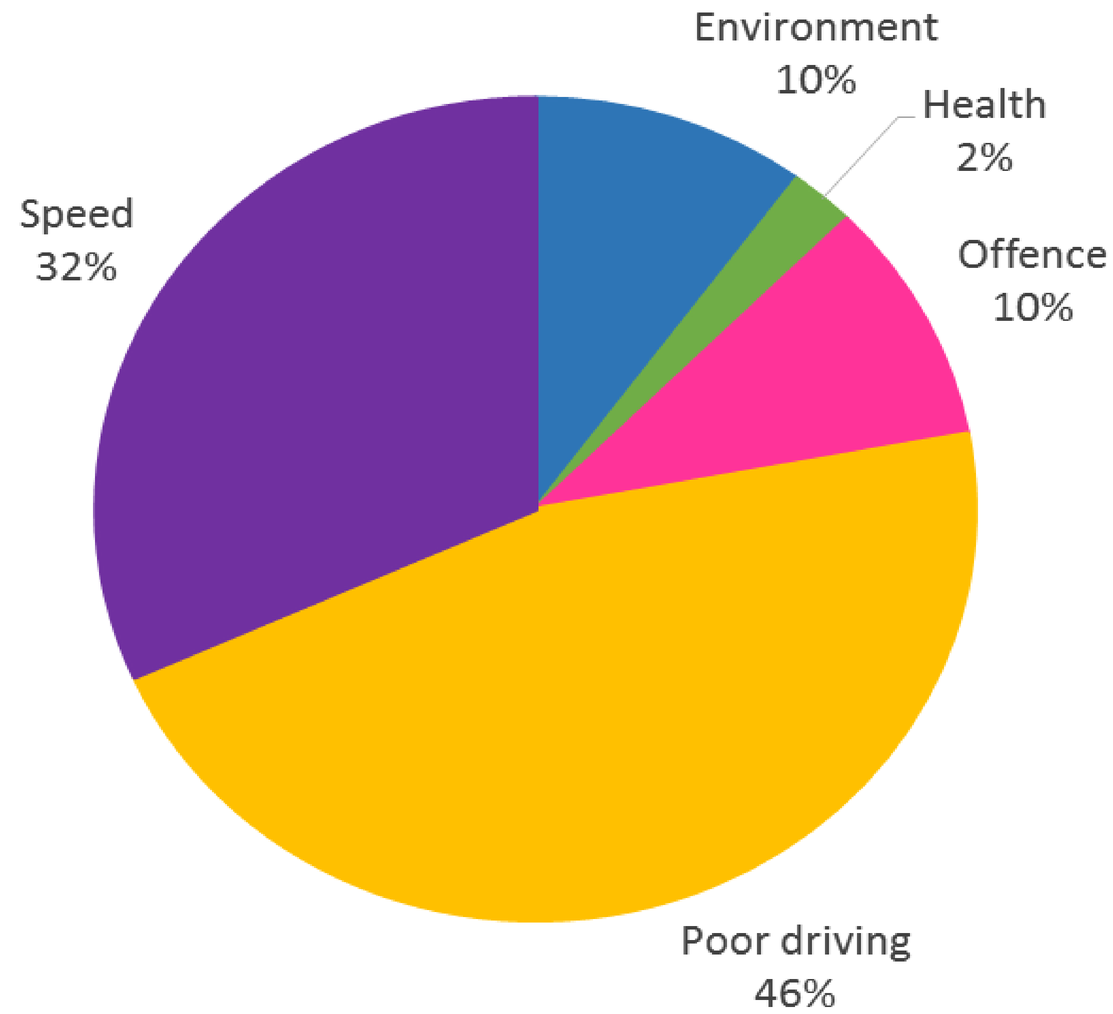
West Mercia POLICE

Casualty class for injury collisions Worcestershire 2015-17



	0	01 to 05	06 to 10	11 to 15	16 - 20	21 - 25	26 - 30	31 - 35	36 - 40	41 - 45	46 - 50	51 - 55	56 - 60	61 - 65	66 - 70	71 - 75	76 - 80	81 - 85	86 - 90	91 - 95	96 - 100
Pedestrian	0	15	26	53	48	40	33	26	34	27	25	37	15	25	12	9	11	7	12	2	1
Vehicle/pillion passenger	4	69	70	63	161	100	73	64	32	35	28	37	25	23	26	24	17	14	8	1	0
Driver/rider	0	2	10	36	314	372	328	259	236	249	277	216	151	111	102	67	47	31	22	2	0

Causation factors



Warwickshire
POLICE

West Mercia
POLICE

Social attitudes

Attitude

56% of people believe that speed cameras save lives (DfT, 2016)

Whilst 50% agree that all use of mobile phones while driving, including hands-free phones, is *dangerous,* only 40% agree that all such use of mobile phones should be *banned*. (DfT, 2016)

80% of the population believe you shouldn't drive after alcohol, but there has been a increase of 11% of those adults who believe they know how much they can drink before they are over the legal limit (DfT 2016)

A willingness to walk a short journey rather than driver has increased to 14% in 2016, and for cyclists the roads feel safer than since 2011

Reasons for the gap

Social norms

Conditions allow it

When late

Peer pressure

Context of different responsibilities and different life stages

Collisions happen to others and not me

Behaviour

48% of people believe speed cameras are there to make money (DfT, 2016)

In 2016 RAC Report on Motoring state that 31% of those surveyed admitted to using taking or receiving calls on mobile phones and 14% admitted to taking photo's or filming while driving

DfT report released in August 2016, stated that 2014 final figures, and 2015 provisional showed that there has been no statistically significant decrease in drink drive fatalities since 2010.

There has been a 10% increase in pedestrian deaths in Great Britain since 2015

There has been a 2% increase in cycle deaths since 2015

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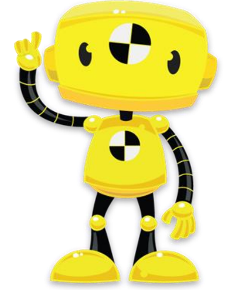
Education and Campaigns



• Young Citizens Challenge safety event	North Worcestershire
• Green Light road safety workshop	Worcestershire
• National and local campaigns	Drink and Drug Drive Seat belts Mobile phones Speeding “Don’t be a road Monster”
• Be Safe Be Seen	Cycle Safety

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Speed Enforcement

Casualty Reduction Programme (CRP)	Areas where high risk of injury or harm is identified along with a proven speeding issue
Community Concern Programme (CCP)	Areas where local people are significantly concerned about a proven speeding issue and their feeling of safety and quality of life is being detrimentally effected
Managed Motorway	West Mercia Police work in partnership with the Highways England to deliver fixed camera speed enforcement on the M5 motorway to compliment the national managed motorways programme.
Temporary road works	Motorway network roads being worked upon with people working in the carriageway. Partner agency policies have determined that enforcement of those limits is essential to public and/or worker safety. Fixed camera enforcement at those sites will be temporary

	CCP	CRP				Grand
Local district	Mobile	Fixed	Fixed-red light	Mobile	HADECS	**Total**
Bromsgrove District	4			3	2	9
Malvern Hills District	11	1		1		13
Redditch Borough	1	2		3		6
Worcester City	2	2	1	4		9
Wychavon District	6	3		9	2	20
Wyre Forest District	5	2		2		9
Grand Total	29	10	1	22	4	66

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Summary

- Injury collisions are increasing throughout Great Britain and Worcestershire is no exception
- Worcestershire makes up 45% of all injury collision over the past 3 years and 42% of all KSI casualties in WMP
- KSI collisions have cost Worcestershire £244m over the past 3 years, and £95m in 2017
- Highest risk areas are Wychavon and Bromsgrove
- Behavioural issue around risk
- Education and campaigns on going delivered and funded by SRP
- Speed Enforcement is targeted and measured

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worcestershire
countycouncil

AGENDA ITEM 8

HEALTH AND WELL-BEING BOARD
27 FEBRUARY 2018

WORCESTERSHIRE PHARMACEUTICAL NEEDS ASSESSMENT (PNA) 2018 UPDATE

Board Sponsor
Dr Frances Howie, Director of Public Health

Author
Matthew Fung, Consultant in Public Health

Priorities

Mental health & well-being	Yes
Being Active	Yes
Reducing harm from Alcohol	Yes
Other (specify below)	

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
Consideration

Recommendation

1. **The Health and Well-being Board is asked to:**
   a) **Note the content of the 2018 pharmaceutical needs assessment.**
   b) **Accept the recommendations and review progress on actions annually.**

Background

1. The Health and Social Care Act 2012 transferred statutory responsibility for the developing and updating of Pharmaceutical Needs Assessments to Health and Well-being Boards. The accompanying NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the legislative basis for developing and updating PNAs.

2. Health and Well-Being Boards (HWB) are required to publish a refreshed assessment within three years of publication of their first assessment. Worcestershire HWB first published a PNA in April 2015, and a refreshed PNA is required to be published in April 2018.

3. The PNA presents an opportunity for representatives of community pharmacy and service commissioners to explore together how the development of pharmaceutical services can further help to deliver the priorities of the HWB in Worcestershire.

4. Following the previous PNA report to this Board in July 2017, a working group was established to steer the development of the PNA. Survey work and consultation took place with service users and the public (614 responses), pharmacy contractors (83/101 responded), and dispensing GPs (21/21 responded). PNA documentation was drafted and put out for a statuary 60 day consultation period between October and December 2017.

Summary of findings and recommendations

5. The PNA has confirmed the importance of the strategic direction set by the HWB strategy. In particular, the growing numbers of older people who are living with frailty and the importance of ageing well both pose challenges to overcome in the drive to improve health and well-being in Worcestershire. To meet these challenges, a stronger emphasis on prevention, early intervention and early help is needed to protect and maintain people's health and independence. Community pharmacies have close links with their communities and are therefore well placed to support the HWB to deliver its priorities.

6. The dispensing of prescriptions remains the cornerstone of pharmaceutical service provision and is a vital local service. 14% of respondents to the survey stated that they visit a pharmacy or dispensing GP at least once per week, and another 50% visit at least once per month. The term "*pharmaceutical services*" however incorporates a range of services that can be commissioned from community pharmacy. It is acknowledged that the PNA presents an opportunity for representatives of community pharmacy and service commissioners to explore together how the development of '*pharmaceutical services'* can further help to deliver the priorities of the HWB in Worcestershire.

7. Contractors should be actively encouraged to address patient need as identified through the engagement survey. A number of respondents suggested allowing easier access to general information about location and times of availability of pharmaceutical services.

8. The total opening hours that contractors cover, provides access from early morning to late evening, during the working week and at weekends. Whilst access is more extensive during normal working hours over the working week, reflecting the rise and fall in demand that normally occurs, access is still considered adequate outside of normal hours and at weekends.

9. The dispensing service provided by pharmacies is complemented by the service provided by dispensing GPs in the more rural areas reducing the distance that users have to travel to access the service.

10. The PNA has found that the level of access to pharmaceutical services currently commissioned across Worcestershire generally meets the needs of the

population. A pharmaceutical service in Worcestershire is provided by a variety of contractors that are appropriately located to meet the needs of the vast majority of the population.

11. **It was concluded therefore that the PNA has not identified any significant gaps or needs in terms of *pharmaceutical* service provision.**

12. Specific recommendations derived from the 2018 PNA are presented below. Many of these recommendations complement the 'Herefordshire and Worcestershire Sustainability and Transformation Partnership (STP) deep dive for Medicines Optimisation'. Where new services are required and/or recommended, lead organisations should commission these appropriately:

Recommendations	Lead organisation(s)
Service quality improvement	
1. Actively support all community pharmacies to achieve standards set out in the national Quality Payments Scheme.	NHSE
2. Continue to consider how community pharmacy can address and respond to patient need as identified through the engagement survey, paying particular consideration to access issues (such as opening times), and accessibility of information about pharmacy services.	NHSE, WCC PH, CCGs, HEE
Access to and utilisation of pharmaceutical services	
3. Provide clear information on opening times, services offered (including provision of confidential consulting space), and alternative provision when pharmacies are not open. This information should be available in easy read form and attention should be paid to meeting the needs of people with visual impairments.	NHSE
4. Recognise that there are a number of information sources and websites which can be confusing to patients wishing to access pharmacy information. Explore the opportunity for creating a Worcestershire wide portal for pharmaceutical services which is user friendly and searchable by services offered (a feature lacking in NHS Choices).	NHSE, CCGs, WCC PH
5. Encourage the integration of pharmacy with the wider healthcare economy to create coherent, system-wide services and pathways through appropriate commissioning and frameworks, such as minor ailments scheme, Healthy Living Pharmacies and Care Navigation.	CCGs
6. Consider existing and new pathways to incorporate referral to community pharmacy, such as offering patients advice and treatment for minor ailments and self-care support. Such changes to services would benefit from a clear communications campaign.	CCGs
7. All providers of pharmaceutical services should consider wider access issues including translation and interpreting services for people whose first language is not English and staff training to increase awareness of the needs of different people using	NHSE, CCGs, WCC PH

the service (e.g. dementia awareness, learning disability awareness, deaf awareness, sight loss and others). Pharmacies should ensure that their communications with the public meet the Accessible Information Standard.	
8. Ensure the potential for community pharmacy to help improve the sustainability and transformation of services is not lost from STPs as they develop. The medicines optimisation workstream within our STP has a focus on community pharmacy which is acknowledged and endorsed.	NHSE, WCC PH, CCGs
Public Health and Primary Care services provided by community pharmacies	
9. As the primary care workforce changes, consider how community pharmacy can address gaps and need in primary care. The NHS five year forward view refers to 'far greater use' of pharmacists to help patients get the right care, at the right time and in the right place.	NHSE, CCGs, WCC PH
10. Continue to work with community pharmacies to support achieving level 1 healthy living pharmacy status (which involves complying with various standards, including pharmacies proactively promoting behaviour change, having an appropriate consulting room for services on offer, and participating in the provision of seasonal flu vaccination).	WCC PH
11. Consider how level 2 healthy living pharmacies could be more integrated into referral pathways, e.g. for minor ailments and self-care support.	CCGs, WCC PH
12. Where new services are commissioned from community pharmacy, ensure that these are related to health need across Worcestershire.	All stakeholders and partner organisations
Medicines optimisation service	
13. Encourage pharmacies to maximise 'Medicines Use Reviews' and the 'New Medicines Service' by targeting appropriate patients who are most likely to derive greatest benefit from these interventions. An example of this would be to focus MURs on patients with long term conditions prior to flu season, and for people in care homes. MURs should be recognised as being part of the management of long term conditions, and may particularly benefit patients who see their pharmacist regularly to collect medications (but who may not see any other healthcare professional regularly). Consideration should be given to extend funding of MURs to ensure sufficient capacity to review all patients in risk groups.	NHSE, CCGs
14. Consider how community pharmacy can be utilised to facilitate admission to and discharge from hospital, particularly their role in discharging efficiently and safely (in regards to prescribing).	CCGs
Information technology improvements	
15. Explore how to improve connectivity between community pharmacy and other services (including sending electronic notifications of flu vaccination in pharmacy settings to GP practice systems).	NHSE

Legal, Financial and HR Implications

13. The Health and Social Care Act 2012 transferred responsibility to develop and update PNAs from PCTs to HWBs. Responsibility for using PNAs as the basis for determining market entry to a pharmaceutical list transferred from PCTs to NHS England from 1 April 2013

The NHS Act (the "2006" Act), amended by the Health and Social Care Act 2012, sets out the requirements for HWBs to develop and update PNAs and gives the Department of Health (DH) powers to make Regulations. HWBs are required to publish a revised assessment within three years of publication of their first assessment.

Privacy Impact Assessment

14. Not applicable

Equality and Diversity Implications

The Council must, during planning, decision-making and implementation, exercise a proportionate level of due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not

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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Worcestershire Hub: 01905 765765

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Supporting Information

- Appendix 1: Executive summary

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:

- Worcestershire Health and Wellbeing Board's Pharmaceutical Needs Assessment Update (2018) & appendices

Appendix 1

Executive Summary

This is the second pharmaceutical needs assessment (PNA) prepared on behalf of the Worcestershire Health and Well-being Board (HWB) and builds on the PNA published in 2015, being updated to reflect current initiatives and standards. Since the publication of the last PNA there have been significant changes to services commissioned locally from pharmacies making this assessment particularly important.

The dispensing of prescriptions remains the cornerstone of pharmaceutical service provision and is a vital local service, clearly valued by patients in Worcestershire and delivered by a range of contractors, including community pharmacies and dispensing GPs. The term 'pharmaceutical services' however incorporates a range of services that can be commissioned from community pharmacy. It is acknowledged that the PNA presents an opportunity for representatives of community pharmacy and service commissioners to explore together how the development of “pharmaceutical services” can further help to deliver the priorities of the HWB in Worcestershire.

The information included throughout is the most current available as of April 2018.

Background – What is a Pharmaceutical Needs Assessment?
A PNA presents a comprehensive picture of current pharmaceutical service provision, which includes dispensing of prescriptions by community pharmacies, dispensing doctors and other providers, as well as a range of other services provided by community pharmacies.

Community pharmacies are based in the heart of local communities, in rural as well as urban areas, where people live, work and shop. With the significant contribution that community pharmacy can make to improve healthcare, it is important to ensure that there are an appropriate number of pharmacies, that they are in the right places and offer an appropriate range of services. The PNA helps to achieve this, by proving a basis for decisions about future provision.

The responsibility for producing PNAs transferred from Primary Care Trusts (PCTs) to HWBs in 2012. The *NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 (The 2013 Regs)* of April 2013 state that HWBs must produce their first PNA by no later than 1st April 2015, and every 3 years thereafter.

Process – how has the Pharmaceutical Needs Assesment been developed and what happens now?
The pharmaceutical services delivered by Worcestershire contractors including 101 pharmacies and 21 dispensing doctors have been evaluated by Worcestershire Directorate of Public Health. Services provided have been surveyed and opening times and locations mapped. The health and well-being needs of the local population are examined and key local strategies summarised. Public and service user views have been sought with 614 responses from the public to a questionnaire on pharmaceutical services.

The picture of current service provision is presented in **Part A** of the PNA. The next section, **Part B,** looks at local health needs and priorities. **Part C** considers the summary of current provision of pharmaceutical services alongside the health needs of the

population and identifies where current service provision may be deemed to be inadequate. This highlights potential gaps or “pharmaceutical needs”.

The PNA then considers how the needs and service gaps that have been identified could be met by the provision and development or extension of existing pharmaceutical services. In this way the PNA acts as a steer for planning and commissioning of relevant future services including whether new pharmacies should be allowed to open or GPs allowed to dispense.

HWBs must consult during the process of developing the PNA for a minimum period of 60 days. The responses received during this period have been considered and incorporated into this report.

Findings

Summary findings from the 2018 PNA are contained in the following table:

Access to pharmaceutical services	
Assessment	**Opportunities / considerations**
Pharmaceutical services are provided by appropriately located contractors, delivering services over an appropriate period to allow reasonable access for the people of Worcestershire. There is a good mix of independent, supermarket and multiple pharmacy contractors providing a good level of choice for dispensing pharmaceutical services. Density of pharmacies, as one might expect, are largely related to density of population (e.g. greater numbers in Worcester & Kidderminster). Dispensing practices are fairly uniformly dispersed across Worcestershire and provide access to medicines in the more rural parts of the County, contributing to the provision of an integrated countywide prescription medicines service together with their pharmacy colleagues. Mapping of locations of pharmacies and travel times by car to pharmacies showed that access to pharmacies is good across the county. We believe that the majority of residents are able to access community pharmacy within 15 minutes by car. Within 20 minutes travelling by car, all residents in Worcestershire should be able to access a community pharmacy between 9am-5pm (though many pharmacies open for longer hours). A sizable proportion can also access community pharmacy within 25 minutes by foot. Some residents will choose to visit pharmacies in neighbouring authority areas. Around a quarter of respondents reported some issues with access in relation to parking. However,	The good levels of access to community pharmacy could be utilised further by Clinical Commissioning Groups (CCGs) or local authorities (LAs) to address local health needs.

the majority of pharmacy contractors and dispensing GP practices indicated that they provided free and disabled parking. Pressures on car parking will be variable depending on day and time of visit. Arguably pressure on car parks will be reduced during non-core times (i.e. pharmacies with extended opening). The vast majority of pharmacies indicate that they are accessible to wheelchairs, pushchairs and walking frames. Around 88% of pharmacies do not have steps to enter premises. No specific issues with access were identified currently for people of a particular race or culture (around 7% of service user survey responses), who are pregnant or who are a particular gender. Pharmacy contractors make an important contribution to services that are not remunerated or reimbursed and are not contracted services, but which are appreciated and relied upon by some service users. An example of this is the prescription home delivery service provided by many contractors which improves access to services particularly for the housebound and those with restricted mobility.	
Although the majority of respondents stated they were satisfied with community pharmacy or GP dispensers' opening times a significant proportion (around 10%) stated that they were either dissatisfied or were not content with these. Late night opening was deemed to be important to a around 33% of respondents. There was a desire expressed by respondents for out-of-hours support with a majority of respondents reporting that they would be very likely or likely to access this service. This provides an opportunity to further build on the service offered by community pharmacy and dispensing GPs.	There is demand and possible associated need with community pharmacies opening later and out of normal working hours. This may provide pharmacies with additional business, as well as being beneficial to patients and the wider health and care system.
What is the extent to which current service provision is adequately responding to the changing needs of the community?	
Assessment	**Opportunities / considerations**
Around 70% of respondents to the contractor survey said that their pharmacy would be willing to undertake consultations in patient's homes.	This prompts consideration of whether this facility could be further utilised particularly in regards to conducting Medicines Use Reviews (MURs) for housebound patients.
There is an increase in the population of Worcestershire and in particular the numbers of people in the older age groups, who may have multiple long-term conditions, is predicted (45.5%	Services need to be aware of changing demographics and an increase in the black, Asian and minority ethnic group population.

increase in people 75 years and older between 2017 and 2027, Office for National Statistics population projections). This means there are some significant challenges to overcome in the drive to improve health and well-being in Worcestershire. The majority of the population is 'white British' with increasing numbers of black, Asian and minority ethnic groups.	
Public health services provided by community pharmacies	
Assessment	**Opportunities / considerations**
Over half of community pharmacies reported that they were part of the Healthy Living Pharmacy programme. Of the pharmacies that were not part of this programme, the majority were planning to join the programme in the next six months. Some pharmacies are providing lifestyle services free of charge. Services provided by a number of contractors include weight and cholesterol management.	This provides an opportunity to positively impact health and well-being in local communities. If pharmacies are to become more central to prevention and primary care services there may be scope to increase the community pharmacy offer, such as commissioning pharmacies to treat a range of conditions and encouraging patients to see a pharmacist first, rather than a GP for these conditions.
Over 90% of patients knew that they could approach their pharmacist for general health advice on disease prevention. Around 280 people stated that they visit their GP for advice about these issues and around the same number sought the same advice from pharmacy. Over 60% of respondents stated that they would be likely or very likely to seek advice from community pharmacy on managing long-term conditions, out of hours support, vaccinations or blood tests.	This highlights a level of trust in pharmacy services and advice, and reinforced by 83% of patients and public stating that their trust in pharmacies was high or very high. This may indicated underutilised potential within community pharmacy to deliver additional advice and services.
Flu vaccination is an extremely important preventative measure that needs more work by partners to achieve the highest possible coverage in eligible and vulnerable groups.	Community pharmacies could play a larger role in achieving this. Locally and nationally, uptake is declining slowly and in Worcestershire the figures is around the 75% national target, but there are significant differences across the County.
Medicines optimisation	
Assessment	**Opportunities / considerations**
A high number of pharmacies are currently performing a high number of Medicines Use Reviews (MURs) with a maximum of 400 per pharmacy per year.	Targeting MURs at the most complex patients, and those with complex prescriptions may yield the greatest benefit.
Information technology improvements	

Assessment	Opportunities / considerations
The pharmacy contractor survey highlighted that around 30% of responding pharmacies do not have their own website.	This emphasises the need for NHS Choices to be up-to-date and prompts consideration of a local electronic solution to access information about local pharmacies. Specifically, pharmacies could be invited to use the 'Your Life Your Choice' (YLYC) website as providers.
Service quality improvement	
Assessment	**Opportunities / considerations**
The majority of patients stated they waited less than 10 minutes to have a prescription dispensed and a minority were waiting more than 30 minutes.	If the role and services offered by community pharmacy were to be extended it would be important that this does not impact on current pharmaceutical provision.
Other findings	
Assessment	**Opportunities / considerations**
A theme emerging from public and service user engagement was a desire for clear information on opening times, services offered and alternative provision when pharmacies are not open.	Clarity of provision of information is deemed to be of importance to patients and the public. GP surgeries, YLYC website and pharmacies themselves all have a role in facilitating access to information about the services offered at pharmacies.
Around 60% of survey respondents return their unwanted medicines to community pharmacy or dispensing GP practice. However, a significant number of people stated that they were currently disposing of unwanted medicines through their household rubbish, down the sink or storing them in their home.	There is a cohort of people in Worcestershire who may benefit from improved awareness that unwanted or out of date medicines can and should be disposed of through their pharmacy.

Conclusions

The PNA has found that the level of access to pharmaceutical services currently commissioned across Worcestershire generally meets the needs of the population, as described in the findings. A pharmaceutical service in Worcestershire is provided by a variety of contractors that are appropriately located to meet the needs of the vast majority of the population. However, it is clear that the role of community pharmacies in preventing ill-health and supporting self-care could be strengthened.

The total opening hours that contractors cover, provides access from early morning to late evening, during the working week and at weekends. Whilst access is more extensive during normal working hours over the working week, reflecting the rise and fall in demand that normally occurs, access is still considered adequate outside of normal hours and at weekends (particularly for those who are able to drive and have access to a car).

The dispensing pharmaceutical service provided by pharmacies is complemented by the service provided by dispensing GPs in the more rural areas reducing the distance that users have to travel to access the service.

The public, patient and service-user engagement process revealed a high level of satisfaction on the part of respondents. Although the response rate was good for this type of survey, this does only provide a sample of views from the population:

- 84% state that they have easy access to services with no problems
- Almost 70% did not identify any barrier to access for services
- Just under 40% need to travel less than a mile to reach a pharmacy
- 70% need to travel less than 2 miles to access a pharmacy
- Over 76% need to travel for less than 15 minutes to reach a pharmacy
- 90% are very or fairly satisfied with opening hours when pharmaceutical services are available, 7% were neither satisfied nor dissatisfied, and 3% were dissatisfied with opening times.

It was concluded therefore that the PNA has not identified any significant gaps or needs in terms of *pharmaceutical* service provision.

It was noted, however, that there is still some capacity within the existing service profile for community pharmacy to provide further support to help meet the needs and address the priorities of the HWB and the local Sustainability and Transformation Partnership (STP). There are also opportunities for service development in community pharmacy.

The developing public health advisory role for community pharmacy particularly within the structure of the Healthy Living Pharmacy programme offers further opportunity for community pharmacies to support the HWB and STP prevention platforms. These platforms are digital inclusion (such as pharmacies allowing public access to online health information, such as self care), making every contact count (MECC), social prescribing and specific behaviour change programmes, each of which can be delivered by pharmacies.

Specific recommendations derived from the 2018 PNA are listed below. Where new services are required and/or recommended, lead organisations should consider commissioning these appropriately:

Recommendations	Lead organisation(s)
Service quality improvement	
1. Actively support all community pharmacies to achieve standards set out in the national Quality Payments Scheme.	NHSE
2. Continue to consider how community pharmacy can address and respond to patient need as identified through the engagement survey, paying particular consideration to access issues (such as opening times), and accessibility of information about pharmacy services.	NHSE, WCC PH, CCGs, HEE
Access to and utilisation of pharmaceutical services	
3. Provide clear information on opening times, services offered (including provision of confidential consulting space), and	NHSE

alternative provision when pharmacies are not open. This information should be available in easy read form and attention should be paid to meeting the needs of people with visual impairments.	
4. Recognise that there are a number of information sources and websites which can be confusing to patients wishing to access pharmacy information. Explore the opportunity for creating a Worcestershire wide portal for pharmaceutical services which is user friendly and searchable by services offered (a feature lacking in NHS Choices).	NHSE, CCGs, WCC PH
5. Encourage the integration of pharmacy with the wider healthcare economy to create coherent, system-wide services and pathways through appropriate commissioning and frameworks, such as minor ailments scheme, Healthy Living Pharmacies and Care Navigation.	CCGs
6. Consider existing and new pathways to incorporate referral to community pharmacy, such as offering patients advice and treatment for minor ailments and self-care support. Such changes to services would benefit from a clear communications campaign.	CCGs
7. All providers of pharmaceutical services should consider wider access issues including translation and interpreting services for people whose first language is not English and staff training to increase awareness of the needs of different people using the service (e.g. dementia awareness, learning disability awareness, deaf awareness, sight loss and others). Pharmacies should ensure that their communications with the public meet the Accessible Information Standard.	NHSE, CCGs, WCC PH
8. Ensure the potential for community pharmacy to help improve the sustainability and transformation of services is not lost from STPs as they develop. The medicines optimisation workstream within our STP has a focus on community pharmacy which is acknowledged and endorsed.	NHSE, WCC PH, CCGs
Public Health and Primary Care services provided by community pharmacies	
9. As the primary care workforce changes, consider how community pharmacy can address gaps and need in primary care. The NHS five year forward view refers to 'far greater use' of pharmacists to help patients get the right care, at the right time and in the right place.	NHSE, CCGs, WCC PH
10. Continue to work with community pharmacies to support achieving level 1 healthy living pharmacy status (which involves complying with various standards, including pharmacies proactively promoting behaviour change, having an appropriate consulting room for services on offer, and participating in the provision of seasonal flu vaccination).	WCC PH
11. Consider how level 2 healthy living pharmacies could be more integrated into referral pathways, e.g. for minor ailments and self-care support.	CCGs, WCC PH
12. Where new services are commissioned from community pharmacy, ensure that these are related to health need across Worcestershire.	All stakeholders and partner organisations

Medicines optimisation service	
13. Encourage pharmacies to maximise 'Medicines Use Reviews' and the 'New Medicines Service' by targeting appropriate patients who are most likely to derive greatest benefit from these interventions. An example of this would be to focus MURs on patients with long term conditions prior to flu season, and for people in care homes. MURs should be recognised as being part of the management of long term conditions, and may particularly benefit patients who see their pharmacist regularly to collect medications (but who may not see any other healthcare professional regularly). Consideration should be given to extend funding of MURs to ensure sufficient capacity to review all patients in risk groups.	NHSE, CCGs
14. Consider how community pharmacy can be utilised to facilitate admission to and discharge from hospital, particularly their role in discharging efficiently and safely (in regards to prescribing).	CCGs
Information technology improvements	
15. Explore how to improve connectivity between community pharmacy and other services (including sending electronic notifications of flu vaccination in pharmacy settings to GP practice systems).	NHSE

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AGENDA ITEM 10

HEALTH AND WELL-BEING BOARD
27 FEBRUARY 2018

SUICIDE PREVENTION PLAN

Board Sponsor
Dr. Frances Howie, Director of Public Health

Author
Liz Altay, Consultant in Public Health

Priorities

Good Mental Health and Well-being throughout life	Yes
Being Active at every age	Choose an item.
Reducing harm from Alcohol at all ages	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
Work to prevent and reduce suicides will mitigate against harm to children

Impact on Safeguarding Adults — Yes
Work to prevent and reduce suicides will mitigate against risk for vulnerable adults

Item for Decision, Consideration or Information
Decision

Recommendation

The Health and Well-being Board is asked to:

1. **Note and approve the Worcestershire Suicide Prevention Plan**
2. **Confirm a system commitment to suicide prevention and that each organisation will contribute to the plans delivery**

Background

3. Every week in Worcestershire around one person dies as a result of suicide. For every person who dies at least 10 people are directly affected. The effects can reach into every community and have a devastating impact on families, friends, colleagues and others. Each one of these deaths is a tragedy. Suicide is preventable and a

whole system and community approach is required. Evidence demonstrates the delivery of a comprehensive prevention strategy is effective in reducing suicides through combining a range of interventions that build community resilience and target groups of people at heightened risk of suicide.

4. The need to develop local suicide prevention action plans is set out in national strategy, *Preventing Suicide in England: a cross-government outcomes strategy to save lives 2012* and is incorporated in the NHS *Five year forward view for mental health*. The Worcestershire Health and Well-being Strategy for 2016-2021 identifies 'Good Mental Health & well-being throughout life ' as one of three areas of priority. The Herefordshire and Worcestershire STP has prioritised improving mental health and will drive the *mental health 5 year forward view*. Suicide prevention builds on these strategies to promote good mental health, in particular amongst men, young people and minorities.

5. National recommendation is to have a suicide prevention plan in place by the end of 2017 and to reduce the number of suicides by 10% by end of 2020/21. Our local short term ambition is to reduce suicides by at least 10% by March 2021 and to improve the care of families of those who have died by suicide. Our longer-term ambition is to adopt and achieve a ‘zero suicide’ mind set in Worcestershire as we believe suicide is largely preventable.

6. This four year Suicide Prevention strategy will ensure a whole system community approach using local intelligence, evidence and best practice. The plan will be led by a multiagency steering group accountable to the Health and Wellbeing Board. The steering group will collate local data and intelligence to understand local patterns of suicide; shape and steer the development and implementation of action; develop and coordinate responses to suicide and activities to reduce suicide; and to monitor progress and evaluate the impact of actions. Progress will be reported annually thought the Health Improvement Group.

7. The plan addresses suicide prevention across the population but includes a focus on groups identified at higher risk in Worcestershire; young and middle aged men, those in care of mental health services, those who self-harm and people living in disadvantaged circumstances. Actions to be delivered across the system in partnership will focus on effort to reduce the risk of suicide amongst high risk groups, tailor approaches to improving mental health in these groups, reduce access to the means of suicide, provide better information and support to those bereaved or affected by suicide, support the media in delivering sensitive approaches to suicide and to support research, data collection and monitoring.

8. For the first year of the plan a number of actions are currently being prioritised by the steering group. To obtain a better understanding of the local characteristics and patterns of suicide in Worcestershire and to use as a baseline to assess progress; to implement better system-wide arrangements for learning lessons following suicides; to map current provision and support particularly for those high risk groups to identify how to provide better support and care and to address any gaps; to ensure all education, criminal justice, health and social care professionals work together to share information and act to prevent suicide; and for Worcestershire to become a "safer suicide" community through raising public awareness, reducing stigma and providing training for a range of groups and individuals which has been shown to be effective in reducing suicide.

Legal, Financial and HR Implications

9. N/A

Privacy Impact Assessment

10. N/A

Equality and Diversity Implications

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

County Council Contact Points
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Specific Contact Points for this report
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Supporting Information

- Appendix 1: Worcestershire Suicide Prevention Plan 2018-2021

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worcestershire county council

Worcestershire Health and Well-being Board

Suicide Prevention Plan

2018-2021

DRAFT

Ambition	The ambition is to reduce the number of suicides and to improve the care of families of those who have died by suicide. Our longer-term ambition is to adopt a 'zero suicide' mind set in Worcestershire as we believe suicide is largely preventable			
Meeting the challenge	requires a co-ordinated whole system community and partnership approach informed by evidence, best practice and local data			
We will focus on	reducing the suicide rate in the general population and to provide better support for those bereaved or affected by suicide. This plan covers suicide prevention across all age groups but includes a focus on key high risk groups:			
Priority Groups	**Young and middle aged men**	**People in the care of mental health services**	**People in disadvantaged circumstances**	**People who self harm**
To do this we will	Work together in partnership to prevent deaths as a result of suicide. We will focus our effort on six areas for action: • reduce the risk of suicide in key high-risk groups • tailor approaches to improve mental health in specific groups • reduce access to the means of suicide • provide better information and support to those bereaved or affected by suicide • support the media in delivering sensitive approaches to suicide and suicidal behaviour • support research, data collection and monitoring			
Local implementation	To achieve this ambition and to work on the six action areas we will: • Establish a multi-agency suicide prevention group involving all key statutory agencies and voluntary organisations. • Complete a local suicide audit to identify high risk groups, trends or issues. • Develop a local action plan with the multi-agency suicide prevention group based on national strategy and best practice but using local data.			
Action Plan Priorities	Our priorities for local action over the next 3 years have been identified from evidence and best practice. Our priorities requiring a co-ordinated whole system approach are: • Reducing risk in men, especially in middle age. • Preventing and responding to self-harm • Mental health of children and young people • Recognition and treatment of depression • People in the care of acute mental health care • Tackling high frequency locations, including working with local media to prevent imitative suicides • Reducing isolation, for example through community-based support and working with third sector • Bereavement support, especially for people bereaved by suicide			

2

Background

Every week in Worcestershire around one person dies as a result of suicide. For every person who dies at least 10 people are directly affected. The death of someone by suicide has a devastating effect on families, friends, workplaces, schools and communities, as well as an economic cost. Suicide is preventable and a whole system approach is required, with local government, primary care, health and criminal justice services, voluntary organisations and local people affected by suicide having a role to play in developing and implementing a local suicide prevention plan.

The need to develop local suicide prevention action plans is set out in national strategy, *Preventing Suicide in England: a cross-government outcomes strategy to save lives 2012* and the NHS *Five year forward view for mental health*. Locally, the Worcestershire Health and Well-being Strategy for 2016-2021 identifies 'Good Mental Health & well-being throughout life (GMHWB)' as one of three areas of priority over the next five years. The Herefordshire and Worcestershire STP has prioritised improving mental health and will drive forward change to address the mental health 5 year forward view.

The case for suicide prevention

Suicide takes a high toll yet it is preventable. Suicide is preventable; it is not an unpredictable, personal, tragedy. Suicide is the biggest killer of men under 50 as well as a leading cause of death in young people and new mothers. On average, 13 people take their own life every day in England, resulting in 4820 deaths in 2015. In Worcestershire there is on average one suicide each week. The death of someone by suicide has a devastating effect on families, friends, workplaces, schools and communities, as well as an economic cost. It is estimated that for every person who dies at least 10 people are directly affected.

There are specific groups of people at higher risk of suicide. Three in four deaths by suicide are men. The highest suicide rates are among middle aged men. In Worcestershire the suicide rate for men is higher than the national average. People in the lowest socio-economic group and living in the most deprived geographical areas are 10 times more at risk of suicide than those in the highest socio-economic group living in the most affluent areas. In Worcestershire suicide rates for those living in the most deprived areas are over double those living in the least deprived.

There are specific risk factors that increase the risk of suicide. Suicide is a major cause of premature death, but there are risk factors, as with any other cause of premature death, we must identify and mitigate those risk factors. The strongest identified predictor of suicide is previous episodes of self-harm. It is estimated that 50% of people who die by suicide had a history of self harm. Mental ill-health and substance misuse also contribute to many suicides. People in the care of mental health services are a high risk group. Evidence shows that 30% of all suicides were by people who had contact with mental health services in the last 12 months. Inpatients, people recently discharged from hospital and those who refuse treatment are at the highest risk. Suicide prevention strategies must consider and link to programmes of early identification and effective management of self-harm, mental ill-health and substance misuse.

Preventing suicide is achievable. Suicide prevention can be achieved through direct intervention, at individual, community and societal level. Evidence demonstrates the delivery of a comprehensive strategy is effective in reducing deaths by suicide through combining a range of integrated interventions that build community resilience and target groups of people at heightened risk of suicide. An example is the successful *Zero Suicide approach* first implemented in the US, where a systems approach is adopted within health and care settings to achieve a bold goal of zero suicide rather than planning for incremental progress.

Suicide is everybody's business. A whole system approach is required, with local government, primary care, health and criminal justice services, voluntary organisations and local people affected by suicide having a role to play. Suicide prevention can also be part of work addressing the wider determinants of

health and wellbeing. An example is the *suicide-safer communities* framework which has been adopted in some areas in England where action focuses on building communities that are committed to talking openly about suicide, promoting wellness and mental health and supporting those bereaved by suicide.

Restricting access to the means for suicide works. This is one of the most evidenced aspects of suicide prevention and can include physical restrictions, as well as improving opportunities for intervention. For example the successful control of analgesics in reducing poisoning deaths.

Supporting those people bereaved by suicide is an important part of suicide prevention. Compared with people bereaved through other causes, individuals bereaved by suicide have an increased risk of suicide and suicidal ideation, depression, psychiatric admission as well as poor social functioning. Those who are bereaved by suicide are three times more likely to take their own lives. It is important to have timely information and support provided to those bereaved or affected by a suicide.

Responsible media reporting is critical. Research shows that inappropriate reporting of suicide may lead to imitative or 'copycat' behaviour. This risk increases if the suicide method is described, if the story is placed prominently and if the coverage is sensationalised or extensive.

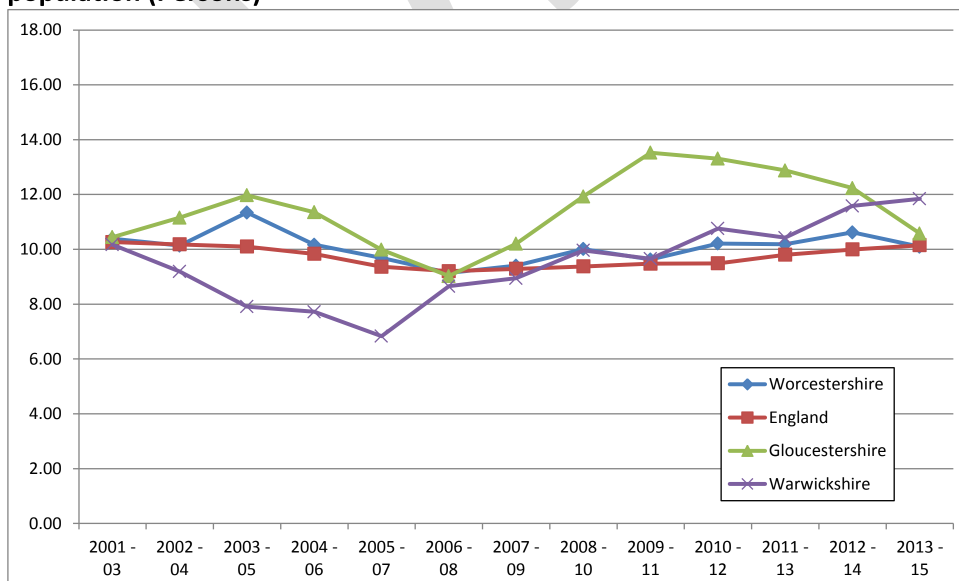
The social and economic cost to suicide is substantial. The economic cost of each death by suicide of someone of working age is estimated to be £1.67 million. This covers the direct costs of care, indirect costs relating to loss of productivity and earnings, and the intangible costs associated with pain, grief and suffering

There is good national evidence available for preventing suicide. This evidence should be used alongside local data and information to ensure local suicide prevention needs are met. Successive reviews, research and guidance identify the need to identify and analyse local suicide data, and to develop an action plan led by a multiagency group.

Suicide in Worcestershire

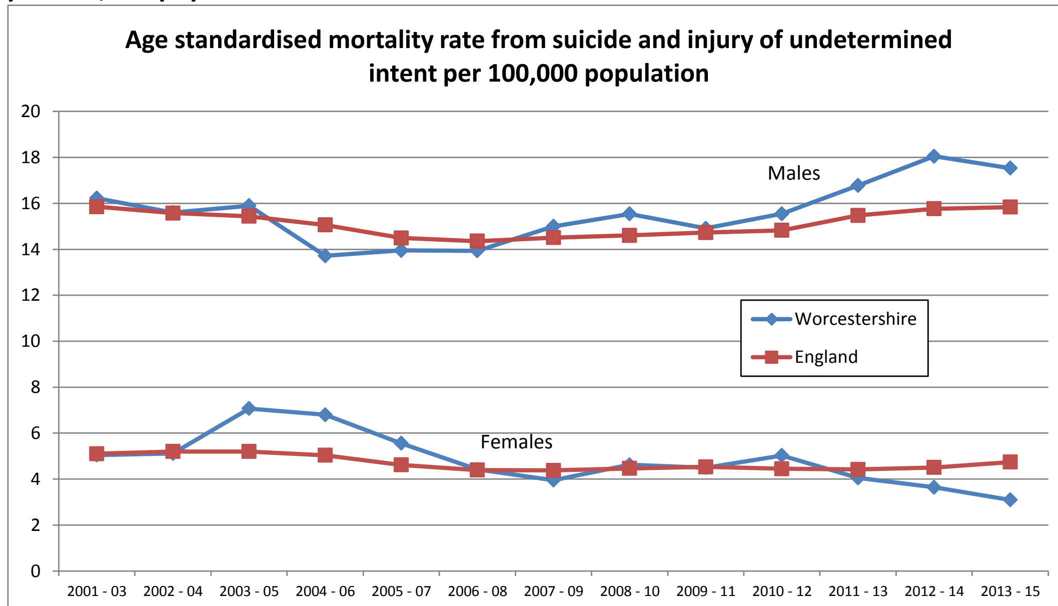
On average one person dies each week as a result of suicide in Worcestershire. There are on average 50 deaths per year and this has been remarkably stable for a number of years. The suicide rate is similar to the England average but lower than statistical neighbours.

Figure 1: Age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population (Persons)



Men are three times more likely to commit suicide than women. In Worcestershire, this is similar with men accounting for 76% of all suicide and undetermined deaths since 1995. Figure 2 shows the 3 year age standardised mortality rate, by Males and Females for both England and Worcestershire. There has been an upturn in the rate for males since 2010 which continues to be monitored. In contrast, the female trend appears to be decreasing. They are, however, based on very small numbers. This means that a few deaths could have a marked impact on the rates.

Figure 2: Gender split of age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population



The most common method of suicide in Worcestershire was hanging which has accounted for just over half of all suicides in Worcestershire, as it does nationally. Hanging accounted for 56% of all male suicide registrations between the 10 year period 2006 and 2015. Poisoning remains the more common method for females accounting for 48% of female suicides

Table 1 - Worcestershire Residents – Number and Percentage of Suicide/Undetermined Deaths by Method 2006 – 2015 Registrations (10 years pooled)

	Gender		
Method	Male	Female	Persons
Hanging	213	43	256
Poisoning	76	52	128
Drowning			25
In front of vehicle - train			18
Jumping			17
Cutting			15
Shooting			12
Fire			6
Crashing of motor vehicle			5
Other			10
Grand Total	**383**	**109**	**492**
Hanging	56%	39%	52%
Poisoning	20%	48%	26%

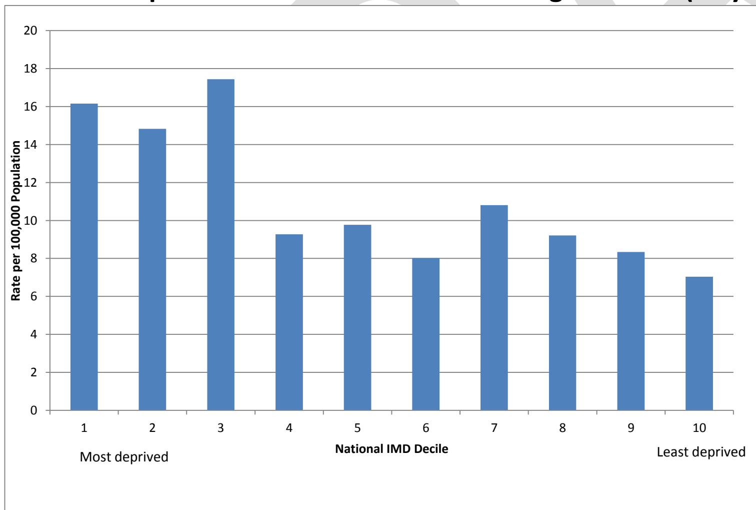
Locally the numbers split by age group are too small to calculate meaningful rates. However, Table 2 provides a view of the overall numbers in the 10 year period by age group along with an age-specific rate per 100,000 population. The highest rate for this period is in the 25-44 age group, however, these rates will have very large confidence intervals.

Table 2 - Worcestershire Residents – Number and Percentage of Suicide/Undetermined Deaths by Age Group 2006 – 2015 Registrations (10 years pooled)

Age Group	10 Year Total	Rate per 100,000 Population
<25	59	7.7
25 – 44	185	15.1
45 – 64	172	12.1
65+	76	7.4
Grand Total	492	11.0

There is a link between deprivation and suicide and people living in the most deprived areas are at ten times more risk. The pattern in Worcestershire has been similar to England and Wales over the last 10 years, with the overall number of suicide/undetermined intent deaths increasing with increasing deprivation (Figure 3). Suicide rates for those living in the most deprived areas were over double those living in the least deprived - 7 per 100,000 population compared with 16 per 100,000 in the more deprived decile (for 10 years pooled data).

Figure 3 - Crude rate of suicide/undetermined deaths per 100,000 population aged 15 and over by National Deprivation Decile:- 2006 – 2015 Registrations (10 years pooled, Worcestershire residents)



Trends by occupation are difficult to analyse due to the small numbers involved, however, a recent ONS analysis identified that males working in the lowest-skilled occupations had a 44% higher risk of suicide than the male national average and the risk among males in skilled trades was 35% higher. Table 3 below gives the numbers and percentages of suicides in Worcestershire between 2006 and 2015 by Occupation Group according to the Standard Occupational Classification 2010 system (SOC2010), along with a comparison of the average percentage employed in each major group over the period.

The group with the highest overall number of deaths is the skilled trades occupations accounting for a quarter of all the suicide/undetermined deaths in the working age group. This group can be further categorised into agricultural trades, metal and electrical trades, construction trades and textiles, printing

and other skilled trades. Of these four groups, by far the greater numbers of deaths were from the construction and building trades. This is a similar result to the national figures, although nationally the elementary trades had the highest rate followed closely by the skilled trades.

Table 3 – Number of Suicide/Undetermined Deaths in Worcestershire by SoC2010 Major Group

Major Occupation Group	Number of Suic/Undet. deaths in working age	% of Suic/Undet. deaths in working age	Average workforce 2006 - 2015
Managers, Directors and Senior Officials	25	7.9%	11.5%
Professional Occupations	37	11.7%	18.8%
Associate professional and technical occupations	21	6.6%	13.0%
Administrative and secretarial occupations	12	3.8%	11.0%
Skilled trades occupations	79	25.0%	12.3%
Caring, Leisure and other Service Occupations	15	4.7%	8.4%
Sales and customer service occupations	12	3.8%	7.4%
Process, plant and machine operatives	57	18.0%	7.2%
Elementary occupations	58	18.4%	9.9%
All occupation groups	316		

There are 2 prisons located within Worcestershire: HMP Hewell located in Bromsgrove Council District and HMP Long Lartin which is based in Wychavon Council District. Over the 10 year period 2006 to 2015 there were 22 suicide deaths of prisoners registered. Of these 22, 8 had a home address outside Worcestershire and do not appear in the Worcestershire numbers but the remaining 14 are attributed to Worcestershire. Of these 12 had the prison as their home address or no fixed abode so were classed as Worcestershire residents.

Our ambition and objectives

National government recommendation is to have a suicide prevention plan in place by the end of 2017 and to reduce the number of suicides by 10% by the year ending March 2021.

Ambition

Our ambition for Worcestershire will be to reduce the number of suicides by at least 10% by March 2021 and to improve the care of families of those who have died by suicide. Our longer-term ambition will be to adopt a 'zero suicide' mind set in Worcestershire as we believe suicide is largely preventable.

Objectives

We shall have two principle objectives:

1. To reduce the suicide rate in the general population
2. To provide better support for those bereaved or affected by suicide.

We will focus effort on six areas for action to achieve this:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide

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5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring

How will we work together to achieve this

To achieve these objectives and to tackle all six areas of action we shall develop and coordinate a whole system community approach using local intelligence, evidence and best practice. We shall engage a wide network of local stakeholders to help develop and implement a robust and evidence based action plan informed by local data and needs and linked to our other mental health & wellbeing plans across the system. The accountability for the suicide prevention plan will lie with the Health and Wellbeing Board, who will shape and support the plan.

We shall establish a formal multi-agency suicide prevention steering group to understand local patterns of suicide and collate local data and intelligence; to steer the development and implementation of the action plan; to develop and coordinate responses to suicide and activities to reduce suicide; to monitor progress towards reducing suicide rates and to evaluate the impact of actions. The multiagency steering group will include representatives from public health, CCGS, primary and secondary care providers (including mental health), emergency services, police, criminal justice, local authorities, the university and voluntary sector organisations. The steering group will report to the Health and Wellbeing Board.

We shall also develop a wider suicide prevention network or partnership so a wider range of representatives can engage with the work at different levels or for specific projects. For example community groups and networks, task and finish groups to oversee projects or areas of work, suicide prevention champions and those with lived experience and other groups to provide access to at risk groups. We will involve bereaved people and people affected by suicide to help identify issues we are not aware of, to participate in campaign work where appropriate, to highlight gaps between policy and practice and to ensure work is grounded in reality.

We shall collect and use local suicide data to identify high risk groups, patterns and trends, locations or issues of concern to develop our plan and use to monitor our outcomes. We will try to undertake a retrospective suicide audit to provide further local intelligence to our available data to inform the development of the suicide prevention action plan. We will set up a separate suicide audit group to review individual suicide cases to identify preventable factors and mitigate suicide risks. The suicide audit group will report to the suicide prevention steering group. We will work closely with the local Child Death Overview Panel (CDOP) with regard to suicides of young people.

Our priority areas for action

Our priorities for action in the short term have been informed by evidence and best practice using the *Local Suicide Prevention Planning Toolkit* (PHE, 2016) which identifies eight priorities:

- Reducing risk in men, especially in middle age, with a focus on: economic factors such as debt; social isolation; drugs and alcohol; developing treatment and support settings that men are prepared to use
- Preventing and responding to self-harm, with a range of services for adults and young people in crisis, and psychosocial assessment for self-harm patients
- Mental health of children and young people, with joint working between health & social care, schools & youth justice, and plans to address the recent increase in suicide risk between 15 to 19 year olds
- Recognition and treatment of depression
- People in the care of acute mental health care
- Tackling high frequency locations, including working with local media to prevent imitative suicides

- Reducing isolation, for example through community-based support, transport links and working with third sector
- Bereavement support, especially for people bereaved by suicide

Men

Local suicide data indicates a priority group for action are men, particularly younger and middle aged men. Men are at three times greater risk of suicide than women. There are a range of factors associated with suicide that are particularly common in men including depression; alcohol and drug misuse; unemployment; family and relationship problems; social isolation and low self-esteem. Actions to encourage men to seek help and to address the impact of these risk factors are vital to effectively reach men.

People in contact with mental health services

We will focus effort on people in contact with mental health services as they are at a higher risk of death by suicide. 30% of all suicides are by people who had contact with mental health services in the last 12 months. It is important to ensure implementation of the NICE guidance on depression as well as education of doctors, and effective treatment of mental health problems.

Research shows reduced patient suicide rates in those organisations who implemented the National Confidential Inquiry into Suicide and Homicide (NCISH) recommendations. The *Zero Suicide* approach has been shown to be effective within health and care settings particularly in the US. This system approach implements a philosophy and practice of 'perfect depression care' which in turn led to a significant drop in suicides and years without a single suicide.

People in disadvantaged circumstances

Reducing health inequalities is an important component to suicide prevention given that people in the lowest socioeconomic group and living in the most deprived areas are ten times more at risk of suicide than those in the most affluent group living in the most affluent areas. We will work with VCS and housing to provide and promote financial and debt support. We will ensure effective suicide awareness training is available for frontline services. We will also continue to develop and roll out evidence based parenting support.

People who self-harm

Local suicide data is not able to identify the prevalence of specific risk factors in Worcestershire. However, we will prioritise for action, people who have self harmed as the national evidence demonstrating these groups of people at high risk is overwhelming. Through our ongoing local audit activities we will start to collect and monitor local suicide data by demographic and social factors and identify underlying risk factors to better inform our priority groups going forward. Self-harm is the highest risk factor for suicide with around 50% of people who die by suicide having a history of self-harm. The true scale of the problem is not known as many people who self-harm do not attend A&E or seek help from services. It is important to ensure implementation of the NICE Standards and pathways for managing patients who self-harm.

Children and young people

We will prioritise improving the mental health of children and young people, including looked-after children, care leavers and children and young people in the youth justice system to reduce deaths by suicide. Suicide is one of the main causes of mortality in young people and for families its impact is particularly traumatic. A recent UK wide investigation into suicides by people aged under 25 reported themes around the following risks: family mental illness; abuse and neglect; bereavement and experience of suicide; bullying; suicide-related internet use; academic pressures, especially related to exams; social isolation or withdrawal; physical health conditions that may have social impact; alcohol and illicit drugs; mental ill-health, self-harm and suicidal ideas. The report highlights the importance of recognising the pattern of cumulative risk and "final straw" stresses, such as exams, that contribute to suicide in children and young people.

School based awareness programmes have shown promise in reducing suicidal ideation that include gatekeeper training for teachers and staff, a youth mental health awareness programme and professional screening of students considered to be at risk. Whole school and college approaches to promoting emotional health and wellbeing and promoting resilience are effective and shall be promoted. We shall raise awareness of the impact of online bullying.

Specific occupational groups

Unemployment is a risk factor for suicide. Certain occupational groups remain a focus in the national prevention strategy including doctors, nurses, farmers, veterinary and agricultural workers. We will encourage employers to promote mental health and reduce stigma in the workplace through campaigns and evidence based support programmes.

Community-based approaches

We will prioritise system wide community-based approaches. Evidence demonstrates that deaths by suicide can be reduced through combining a range of integrated interventions that build community resilience and target groups of people at heightened risk of suicide. Implementing *Suicide Safer* places or environments can be effective where a range of initiatives to enable people to have conversations about suicide and provide life-saving suicide prevention skills, combined with signs or leaflets in appropriate targeted locations or settings and specific support groups or interventions for those at risk.

We will focus on community-based awareness campaigns as they offer the opportunity to improve the mental health of many and to reduce stigma and discrimination. We will prioritise suicide prevention training as training programmes seek to improve the knowledge, skills and ability to intervene and offer support across professionals, frontline workers and community members. Evidence suggests that suicide prevention education for GPs can have an impact as an intervention to prevent suicide.

Reducing access to the means of suicide

Restricting access to means for suicide is one of the most evidenced aspects of suicide prevention and can include physical restrictions, as well as improving opportunities for intervention. We will gather local data from the suicide audits to provide insight into emerging trends with regards to locations and methods.

Working with local media to prevent suicides

Research shows that inappropriate reporting of suicide may lead to imitative behaviour. Best Practice highlights that local media should be adhering to the Samaritans' guidance on responsible media reporting. We will work with the local media to encourage responsible reporting on suicide methods and locations.

Supporting those bereaved or affected by suicide

Evidence suggests that those bereaved by suicide are at a higher risk of depression, suicide attempt, and even suicide. Best Practice highlights that resources should be made available to support those bereaved e.g. *Help is at Hand* cards/booklets via first responders, coroner's, local funeral directors, voluntary sector organisations and within community settings. We will map the current provision of bereavement support services to identify gaps and to help ensure that timely information and support is accessible across the county

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Implementation and governance

The detailed actions across the next three years will be further identified and developed by the multiagency steering group and wider suicide prevention network. Where appropriate wider multi-agency task groups will be established to deliver against the priorities outlined above and to improve communication across sectors and geographies.
Progress against the plan's priorities will be reported to the Health and Wellbeing Board through reporting to the Health Improvement Group (HIG) on an annual basis. The key performance indicators associated with the Suicide Prevention plan are;

Performance Indicators for Suicide Prevention Plan	Measurement
Age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population	Public Health Outcomes Framework (PHOF)
Age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population (Males)	PHOF
Age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population (Females)	PHOF
Emergency Hospital Admissions for Intentional Self-Harm	PHOF
Hospital admissions as a result of self- harm (10-24 years)	PHOF
Hospital admissions as a result of self-harm (all ages)	PHOF

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AGENDA ITEM 12

HEALTH AND WELL- BEING BOARD
27 FEBRUARY 2018

HOUSING MEMORANDUM OF UNDERSTANDING TASK AND FINISH GROUP PROGRESS REPORT

Board Sponsor
Dr Frances Howie
Director of Public Health

Author
Tim Rice
Senior Public Health Practitioner

Priorities

Older people & long term conditions	Yes
Mental health & well-being	Yes
Being Active	No
Alcohol	No
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:**

(a) Note the contents of the report and the progress on joint agency work on the housing and health memorandum of understanding (MoU)
(b) Review current and future commissioning arrangements and opportunities to support the ambition of the MoU.

(c) Formally incorporate Local Housing Authorities into relevant BCF planning.
(d) Ensure that housing is embedded to the development work relating to the new Neighbourhood teams and the Three Conversation model.
(e) To hold a Board development session on housing and embedding the MoU principles and practise, specifically relating to 3-5 above, following which the Board agrees the next steps for the MoU Task and Finish group and/or project managed groups to progress this work.

Background

2. Further to the report to the Health and Wellbeing Board on 10/10/17, this report summarises progress across the partnership in embedding the principles of the MoU and proposes recommendations for the Board to consider and action as necessary.

3. The Board is reminded of the key objectives of the MoU, namely **"to enable improved collaboration and integration of healthcare and housing in planning, commissioning and delivery of homes and services"** and **"developing the workforce across sectors so that they are confident and skilled in understanding the relationships between where people live and their health and well- being and are able to identify suitable outcomes to improve outcomes".** The Government wishes to see enhanced co-operation with housing and is refreshing and relaunching the MoU nationally in 2018.

4. There have been three half day workshops in June and October 2017 with the most recent workshop in January 2018, which included a contribution from the national strategic lead for Foundations, a Government sponsored organisation that supports Care and Repair agencies. There has been attendance at these workshops by the key statutory agencies. Much of the focus has been on setting out and understanding the roles and responsibilities of housing and other agencies and how in the interim practical progress on joint working can be made.

5. What is apparent from the cross agency discussions on the MoU principles is that the system is more complex than had been anticipated, with variable understanding of the current systems and in particular the roles and responsibilities of District Local Housing Authorities (LHA's) and opportunities that closer co-operation would bring, particularly in supporting people's independence at home. It is clear that strategic planning and commissioning is historically fragmented and although there is some effective co-operation between agencies, this is not consistent and led strategically from the MoU perspective.

6. There are some specific developments taking place as a result of the work by the MoU T&F group. A review has been started by Public Health to map the whole system to better understand challenges and inefficiencies relating to adaptations and repairs to people's own homes. This has already started to identified some key themes which, if addressed can improve the cost effectiveness and quality of services in place to help keep people independent at home. Aligned to this work is the current review of community Occupational Therapy (OT) by the Health and Care Trust in conjunction with partners, including LHA's. This should ensure a more collaborative approach to improvement and innovation and assist the OT service which has been struggling with capacity and resulting in delays to parts of the housing system, notably around DFG's. A response to these problems has been for

the employment of additional OT capacity by the LHA's, which while resolving the immediate problem of delays, further fragments an already complex system.

7. A further positive example of progress now being through the MoU is Worcester City Council housing team working with the St John's multi-disciplinary Neighbourhood team and formalising the housing input as part of the single point of access for information, advice and support. It is clear that both health and housing have been supporting the same residents for different purposes and closer co-operation will support more targeted support going forward. Additionally housing is able to provide data on housing conditions, homelessness and affordable warmth, to enhance data that has been mapped in Neighbourhood Team areas.

8. The CCG will now be looking to progress this approach with the other LHA's through the Strategic Housing Officers Group, to consider how this can be developed across the other Neighbourhood Team areas in the County.

9. There is also scope to improve cross professional understanding, provide joint targeted briefings and training in multi-disciplinary teams.

10. Improved strategic governance is required to ensure the MoU principles are embedded and close co-operation with the Worcestershire Strategic Housing Partnership will be required. Positive developments have recently included the Board inviting the chair of the Housing Partnership to join the Board as the representative of the LHA's and a senior CCG representative now attends the Housing Partnership. A key priority for the Worcestershire Housing Partnership Plan is to "create a partnership approach to enable people to live as independently as possible (prevention/early intervention)". The MoU is a bridge to meeting that ambition and offers an opportunity to enhance the system to support Worcestershire residents live more independent and healthy lives. This improvement to governance is essential to cement strategic co-operation on housing matters.

11. The Better Care Fund guidance requires co-operation with the LHA's in the planning of the use of DFG's and the Government is requiring innovation and co-operation to support and relieve the pressures on health and social care. The statutory DFG programme significantly contributes to prevention of those pressures and keeping people independent and this is recognised by Government with significant increases in DFG budgets. The scope and impact of the DFG funding is highlighted in the BCF evaluation returns to the Board for 2016/17, with over 6,100 people estimated to have been supported to remain in their own homes. But there are, by agreement with LHA's, opportunities to be more flexible in the use of grants and join up systems and other services more effectively.

12. The LHA's are already innovating, with the use of DFG funding for dementia dwelling grants (the first such approach nationally and being evaluated by Worcester University), fast track hospital discharge grant funding and direct funding of additional Occupational Therapists for housing grant work to reduce delays in the system. But there is more potential to co-operate and jointly plan through the BCF.

13. The MoU T&F Group are also clear that there are opportunities to better join up commissioned services to further improve health and social care outcomes. It is suggested that the Board and its constituent members will need to consider a more

formal approach to strategic commissioning opportunities and to including the LHA's if the ambition of the MoU is to be met.

14. In scope for instance would be the recommissioning the Care and Repair agency which is about to commence. This is currently commissioned by the DC's and WCC and has a significant impact upon the prevention of hospital admissions and maintaining people in their own homes, through delivery of the DFG and minor works programmes and the provision of a range of advice and information. There is an opportunity to consider how this could be scoped in line with other commissioned services whose outcomes are related to preventing hospital admissions, effective hospital discharge and securing independent living. It is also an opportunity to review the current systems in light of the new Neighbourhood Teams and Three Conversation model.

15. Housing and its prevention focus will also a major consideration for the STP and moving to the Accountable Care system will require Worcestershire to be effective in its systems understanding and co-operation, as required by the MoU. Unlike Herefordshire there are six LHS's which inevitably adds to the complexity and makes it all the more important for strong and clear strategic leadership to provide a clear direction of travel.

Conclusion

16. The T&F group has focused upon the contribution that housing has and can increasingly make to improving health and social care outcomes. Some practical developments are taking place as a result and should enhance cross agency co-operation, thus demonstrating progress against the MoU objectives (see 8 above). But there is a need to embed a stronger strategic governance and commissioning approach to make full use of resources and assets that are available across the Worcestershire system. There is a strong commitment by agencies to build on the good partnership relationships and a history of collaboration across the County. With a commitment to incorporate housing in the STP, it would be timely for the Board members to consider how to embed MoU approaches at a senior leadership level. It is proposed that a Board development session on housing is held, to include a joint agency briefing and consideration of future working options, including what opportunities there are for closer commissioning arrangements, in particular with the LHA's.

Legal, Financial and HR Implications

17. N/A

Privacy Impact Assessment

18. N/A

Equality and Diversity Implications

N/A at present.

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:

Report to Health and Wellbeing Board on Health and Housing, 10 October 2017 at minute no 460 available here

Contact Points

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