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Agenda

Health and Well-Being Board

Tuesday, 28 September 2021, 2.00 pm
County Hall, Worcester

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Agenda produced and published by Abraham Ezekiel, Assistant Director for Legal and Governance, County Hall, Spetchley Road, Worcester WR5 2NP

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

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Date of Issue: Monday, 20 September 2021

Health and Well-Being Board
Tuesday, 28 September 2021, 2.00 pm, Council Chamber, County Hall

Membership

Full Members (Voting):

Cllr Karen May (Chairman)	Cabinet Member for Health and Well-being
Simon Adams	Managing Director, Healthwatch Worcestershire
Dr L Bramble	CCG Locality Lead for Wyre Forest
Dr Kathryn Cobain	Director of Public Health
Dr R Davies	CCG Locality Lead for Redditch and Bromsgrove
Paula Furnival	Strategic Director for People
Julie Grant	NHS England
Cllr Adrian Hardman	Cabinet Member for Adult Social Care
Dr A Kelly (Vice Chairman)	CCG Clinical Director for Mental Health and Well-being
Cllr Andy Roberts	Cabinet Member for Children and Families
Tina Russell	Worcestershire Children First
Dr Ian Tait	NHS Herefordshire and Worcestershire CCG
Simon Trickett	NHS Herefordshire and Worcestershire CCG

Associate Members

Cllr Lynn Denham	South Worcestershire District Councils
Kevin Dicks	District Local Housing Authorities
Sarah Dugan	Worcestershire Health & Care Trust
DCC Julian Moss	West Mercia Police
Cllr Nyear Nazir	North Worcestershire District Councils
Jo Newton	Worcestershire Acute Hospital Trust
Jonathan Sutton	Voluntary and Community Sector

Agenda

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2	**Declarations of Interest**		
3	**Public Participation**		

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	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 27 September 2021). Enquiries can be made through the telephone number/e-mail address below.		
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11	**2020/21 Better Care Fund (BCF) Budget Quarter 1 Update**	Paula Furnival and Simon Trickett	115 - 118
12	**Herefordshire and Worcestershire Learning from Lives and Deaths - People with Learning Disabilities (HW LeDeR) Annual Report 2020/21**	Simon Trickett	119 - 176
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	Private Development meetings (All Tuesday at 2pm) • 19 October 2021		

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Minutes of the Health and Well-being Board

Council Chamber, County Hall

Tuesday, 20 July 2021, 2.00 pm

Present:

Cllr Karen May (Chairman), Simon Adams, Dr Kathryn Cobain, Cllr Lynn Denham, Kevin Dicks, Cllr Adrian Hardman, Sue Harris, Dr A Kelly (Vice Chairman), Kerry McCrossan, Cllr Nyear Nazir, Cllr Andy Roberts, Jonathan Sutton, Dr Ian Tait and Simon Trickett

Also attended:

David Mehaffey, NHS Herefordshire and Worcestershire Clinical Commissioning Group
Richard Stocks, Senior Finance Business Partner, Worcestershire County Council

Available Papers

The members had before them:

A. The Agenda papers (previously circulated);
B. The Minutes of the Meeting held on Tuesday 23 February 2021 (previously circulated).

602 Apologies and Substitutes

Apologies had been received from Sarah Dugan, Paula Furnival, Tina Russell, Julian Moss and Jo Newton.

Sue Harris attended for Sarah Dugan and Kerry McCrossan attended for Paula Furnival.

603 Declarations of Interest

Cllr Lynn Denham declared that she was in receipt of an NHS pension.

604 Public Participation

None

605 Confirmation of Minutes

The minutes of the meeting on Tuesday 23 February 2021 were agreed to be a correct record and were signed by the Chairman.

606 Joint Health and Well-being Strategy

Dr Kathryn Cobain presented the report on behalf of Dr Tanya Richardson.

During the discussion, the following points were made:

It was suggested that with a 10-year timeframe, aspects of the Joint Health and Well-being strategy (JHWS) might become less relevant over time, particularly those relating to mental health, as this was likely to change due to the impact of COVID-19. It was confirmed that pre-COVID-19 evidence was being used to guide the JHWS and it was suggested that COVID-19 had not necessarily created mental health issues but exacerbated them. It was therefore an opportune moment for a 'reset' of the JHWS. The intention was to be dynamic by changing the strategy throughout the 10 years by developing action plans.

Simon Trickett further suggested the opportunity could be taken for the JHWS and required Integrated Care Strategy, due to be developed, to overlap and both to support delivery, with similar and interlinked objectives.

Preventative work to avoid poor mental health in the future was viewed as critical. It was suggested that a two-tier approach would be required. Mental Health and Well-being was linked to social and economic factors and prevention though these aspects should be reflected in the JHWS.

Dr Cobain confirmed the timelines for development of the JHWS, with a longer consultation period starting in September for up to 12 weeks. This would mean the new JHWS would likely be agreed early in the new year and implemented from April 2022. The longer timeline would give partners the opportunity to hone the JHWS and make it more dynamic. It was made clear that this timeline was flexible.

There was discussion around moving the consultation back to allow the board to meet again to review the content prior to its release to the public. While some Board Members asked to be given the opportunity to meet, others deemed it unnecessary to delay the consultation. It was agreed that the consultation would be circulated between meetings for Board Members to provide feedback.

RESOLVED that the Health and Well-being Board:

a) **Note the progress made and the next steps in the development of a new JHWS for Worcestershire.**

b) Approve the plan for public and stakeholder consultation on the priorities for the new JHWS.

607 Integrated Care System Development Update

Simon Trickett introduced the report, explaining that a draft form of the Health and Social Care Bill was due to be presented in Parliament. The Bill contained proposals on the design of Integrated Care Systems. The report also contained a design framework summary providing an overview on how NHS England would like the Bill, if approved, to be implemented. It focused on two key topics:

- the proposal to form an Integrated Care Board which would take on the functions of the Clinical Commissioning Group (CCG); and
- the proposal for the creation of an Integrated Care Partnership. The report described proposals for defining the relationship between Health and Well-being Boards and the Integrated Care Partnership.

In response to a query on whether the Health and Well-being Board would continue to set its own agenda alongside the partnership, it was explained that the Herefordshire and Worcestershire system would have an Integrated Care Strategy. This would require consideration of how services and systems were organised locally to deliver the strategy, which would be overseen by the Health and Well-being Boards. Responsibility would be delegated to each Health and Wellbeing Board to decide their own priorities.

It was asked whether the Integrated Care Strategy would determine the strategy for determinants of health such as economy and housing. Simon Trickett advised that there was nothing to suggest this was the case. Instead, the separate bodies of the Health and Well-being Boards, the Health and Care Partnership and the Integrated Care Board would begin to have an interest in achieving better alignment on the actions taken on the determinants of health.

It was suggested that the Health and Well-being Board might integrate with the Place Board immediately rather than evolve. Simon Trickett responded with concerns that this would make day-to-day delivery of NHS operational issues difficult.

When planning the structures to implement the strategy for the Health and Well-being Board, there was a need to avoid creating inelegant bureaucratic structures. The aim was to keep the Health and Well-being Board focused on the broad agenda of the health and well-being of the population, and the Integrated Care Board on the NHS's contributions to that agenda. It was requested that along the journey of developing the strategy, Board Members were kept up to date on the rationale behind these structures. It was agreed that regular updates would be provided.

RESOLVED that the concept of using the Health and Well-being Board as the basis for creating the Integrated Care Partnership; which will be required by the new Integrated Care System legislation that is currently being considered by Parliament; be supported.

608 Covid Health Protection Board Quarterly Report (Quarter 4 and Quarter 1)

Dr Kathryn Cobain presented the report. She highlighted that the number of cases of COVID-19 were increasing in the community with continuing pressures on the NHS locally.

Board Members thanked all of those involved in the COVID-19 response for their skill and effort in protecting residents.

It was queried whether any COVID-19 advice was due to be delivered regarding holding public engagement events. Dr Cobain confirmed that further national guidance was anticipated. The Local Outbreak Response Team (LORT) could assist with localised risk assessments.

Dr Cobain confirmed that she was working with Department of Health and Social Care (DHSC) on the ongoing local COVID-19 response, including contact tracing. There were ongoing conversations between relevant bodies as to whether further local guidance would be provided.

It was critical that everyone remained cautious about how the coming weeks were managed, as the infection rate was rising, with health and care services under significant pressure. Board Members were urged to be cautious and sensible in the management of the coming months.

The current lack of vaccine uptake was concerning following early success in Worcestershire. The low uptake correlated with those areas with health inequalities and work would continue to encourage increasing vaccine uptake.

RESOLVED that the Health and Wellbeing Board noted the delivery of Worcestershire's Outbreak Control Plan, the arrangements for governance and the current situation of LORT operation.

609 2021/22 Better Care Fund (BCF) Budget Approval and 2020/21 BCF Outturn

Richard Stocks presented the report, after which the following questions were asked:

It was queried how the Disabled Facilities Grant funding listed in Appendix 1 was split between districts. It was confirmed that the allocation of the funding was decided by central Government.

It was asked whether the Disabled Facilities Grant incorporated a Dementia Dwelling Grant. This was confirmed to be the case. A formal response as to whether this funding could be maintained was requested. Kevin Dicks confirmed this as an action, undertaking to report back to the Board.

Board Members asked to what degree the Board was able to influence the spend of the funds detailed in the report. It was explained that a large proportion of the BCF was committed to existing services. For this reason, there was little room to alter the spending levels. If it were decided that a particular service needed to be terminated or changed, the funding could be allocated to a different area, however a transition plan would be required as stranded costs would be likely to be incurred. There was some discretion when there was growth in the BCF, and this was managed by the Integrated Commissioning Executive Officer Group which decided the operational priorities around the integrated care agenda.

RESOLVED that the Health and Well-being Board approved the 2021/2022 BCF budget and the BCF 2020/21 annual return, which includes the year end outturn, in line with national requirements.

610 Future Meeting Dates

Public meetings (All Tuesday at 2pm)

- 28 September 2021
- 16 November 2021

Private Development meetings (All Tuesday at 2pm)

- 19 October 2021

The meeting ended at 3.24 pm

Chairman …….

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AGENDA ITEM 5

HEALTH AND WELL-BEING BOARD
28 SEPTEMBER 2021

HEALTH AND WELL-BEING BOARD GOVERNANCE REVIEW

Board Sponsor
Councillor Karen May, Cabinet Member with responsibility for Health and Wellbeing

Author
Dr Kathryn Cobain, Director of Public Health

	(Please click below then on down arrow)
Priorities	
Mental health & well-being	Yes
Being Active	No
Reducing harm from Alcohol	No
Other (specify below)	
Safeguarding	
Impact on Safeguarding Children	No
Impact on Safeguarding Adults	No

Item for Decision, Consideration or Information
Decision

Recommendation

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

   a) **Note progress on the governance review; and**

   b) **Agree the planned board development to implement recent Local Government Association (LGA) findings.**

Background

2. HWBs are formal committees of the local authority, required by the Health and Social Care Act (2012). They were set up in 2013 and originally seen as the primary engine room for local integration and partnership working across the NHS, Public Health and local government. They have a statutory duty, with Clinical Commissioning Groups (CCGs), to produce a Joint Strategic Needs Assessment (JSNA) and a Joint Health and Well-being Strategy (JHWS). In additional, they have oversight of commissioning plans, the Better Care Fund, and the local Pharmaceutical Needs Assessment. HWBs have limited formal power, being constituted as a partnership forum, but significant and influential system-wide membership.

3. The development of the Integrated Care System (ICS) will have implications for the governance of the HWB. The most recent update to the HWB, at its meeting on 20 July 2022, covered ongoing dialogue regarding forming an Integrated Care Partnership Assembly to facilitate joint working across both Herefordshire Council and Worcestershire County Council (WCC), with each authority retaining its HWB and the emergence of place-based partnerships.

4. In June 2021 at the HWB's private development session, members invited a governance review, supported by the LGA. Findings of the review were presented to HWB members by the LGA associate team on 6 September 2021.

Local Government Association (LGA) Governance Review

5. The intention of the governance review is to bring clarity to the role of the HWB, its purpose, shared priorities and relationships, including those of its sub-groups, and to enable effective delivery of the new JHWS leading to improved health outcomes and reduced health inequalities.

6. The review was facilitated by a team of independent associates, providing an external view, to inform further improvement and reassurance on the HWB's ability to deliver on its plans and ambitions. The process involved a series of remote meetings with HWB members and other key informants, conducted in an open and honest manner, to jointly identify strengths and opportunities. A wide variety of more than 40 stakeholders participated, including senior leaders from across WCC and the district councils, Herefordshire Council, Herefordshire and Worcestershire CCG, Primary Care Networks, and NHS Trust, West Mercia Police, the Local Enterprise Partnership, the Strategic Housing Partnership, the Worcestershire Safeguarding Boards, Health Watch, and voluntary and community organisations.

7. The Associate team highlighted many positive findings from the review, for example, that the HWB has strong connections across Worcestershire and the wider system, that aspects of the JSNA were good and provided insightful information, that the JHWS development sessions had been well received and enabled meaningful engagement.

8. Key reflections for action from the LGA included the need to recognise the HWB as the 'System Leadership Partnership', rather than solely a Council Committee, and develop it to act as such.

9. Key findings were also around the development of the JSNA and JHWS, working to realise the former as a more living asset-based resource that informs all strategies, and position the later as the overarching direction and framework for the wider system, aligned with the newly required Integrated Care Strategy.

10. The HWB will need to work to utilise the feedback from the review to better understand and refine its purpose, relationships, governance structure, membership, engagement and broader role within the Worcestershire system as the ICS evolves.

11. The intention is for HWB members to initially reflect on the findings during a brief series of board development sessions focused on the HWB's purpose, roles and responsibilities, positioning and ambitions. This will be shaped as an organisational

development programme, which is action focused, with clear objectives and outcomes to embed. The next HWB development session is scheduled to take place on 19 October 2021.

Legal, Financial and HR Implications

12. There are no specific legal, financial or HR implications to consider at this stage.

Privacy Impact Assessment

13. There are no privacy issues to report.

Equality and Diversity Implications

14. There are no equality and diversity implications associated with this paper.

Contact Points

Specific Contact Points for this report
Dr Kathryn Cobain, Director of Public health
Telephone: 01905 845863
Email: kcobain@worcestershire.gov.uk

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:

Agenda Document for Health and Well-Being Board, 20/07/2021, agenda item 5

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AGENDA ITEM 6

HEALTH AND WELL-BEING BOARD
28 SEPTEMBER 2021

Engagement approach – mental wellbeing and Joint Health and Wellbeing Strategy Consultation

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Board Sponsor
Councillor Karen May, Cabinet Member with responsibility for Health and Well-being

Author
Dr Kathryn Cobain, Director of Public Health
Elizbeth Griffiths, Public Health Consultant

Priorities	(Please click below then on down arrow)
Mental health & well-being	Yes
Being Active	No
Reducing harm from Alcohol	No
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
Decision

Recommendation

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

    a) **endorse and support the proposed year long conversation on mental wellbeing;**
    b) **approve the revised timetable for the Joint Health and Wellbeing Strategy (JHWS) implementation; and**
    c) **in light of the above, approve a short-term extension to the existing JHWS.**

Background

2. In February 2021 the Health and Wellbeing Board (HWB) agreed to focus on "prevention" and in particular the inequalities as a result of, and exacerbated by the COVID-19 pandemic. A number of potential system-wide themes were presented to the HWB at its meeting in March 2021. These themes were then considered against

a prioritisation matrix based upon the ability to address inequalities and to embed prevention and asset-based approaches.

3. The HWB formally agreed in June 2021 to focus on one overarching theme: "Better mental health and emotional wellbeing", supported by healthy living at all stages in life, safe and healthy homes, and good jobs.

4. Due to the COVID-19 pandemic, much of the development of this overarching theme was done by the HWB in virtual meetings. Whilst the theme was informed by engagement work carried out by Health Watch, Hereford and Worcestershire Health and Care Trust and other champions, the HWB has not yet had the opportunity to publicly engage on this priority.

5. In addition, it is recognised that the COVID-19 pandemic has affected each of the residents of Worcestershire in many varied and complex ways, with a range of short, medium and longer-term impacts. Whilst some of the impacts of the COVID-19 pandemic are known, there are some that may be hidden or not yet understood.

6. To better understand these impacts, Public Health is now commissioning a range of qualitative COVID-19 impact focus groups run by a range of community providers, an in-depth ethnographic research study and is undertaking a detailed COVID-19 impact survey. This data collection exercise will be completed by the end of March 2022.

7. This detail, and evidence of the impact of the COVID-19 pandemic on the wellbeing of Worcestershire's residents will be used to inform the JHWS and supporting the development of its action plans.

System wide Mental Wellbeing engagement

8. There are a wide range of activities planned across the health and care system around mental health in the coming months, centring around World Mental Health Day, Sunday 10 October 2021. System partners have recognised the importance of co-ordinating this work and ensuring that messages are not diluted or saturated. There is work underway across communications and engagement teams to plan and align this activity.

9. Examples of planned mental health activity across the system include:

   a. The launch of the Herefordshire and Worcestershire Mental Health and Wellbeing Strategy;
   b. ongoing promotion of the suicide prevention campaign running throughout September and October 2021;
   c. promotion of the 'Now We're Talking' campaign; and
   d. engagement around the Integrated Wellbeing Offer.

Joint Health and Wellbeing Strategy

10. The HWB is responsible for delivering a number of statutory duties including the requirement to produce a JHWS.

11. The HWB's current strategy, which sets the priority areas as mental health and wellbeing, being active and reducing harm from alcohol, expired in March 2021.

12. The new JHWS will be a 10-year strategy with progressive shorter term action plans / review points. This will enable ambitious, long-term goals for health improvement to be made, assets to be developed and a sustainable approach to reducing health inequalities.

13. It is suggested that rather than launching the JHWS consultation at a time where there will be heightened communications and engagement on a variety of mental health topics, the HWB use this opportunity to conduct a listening exercise and conversation with residents, working with wider system partners to address issues such as what is mental health and wellbeing and to explore the impact of COVID-19 on Worcestershire's populations.

14. The statutory, 12-week consultation on the strategy can then take place post-Christmas, running from January to March 2022. The findings of the consultation can be considered alongside Public Health's qualitative data collection on COVID-19 impact and the results of the communications and engagement activity across the system around mental health. These findings can then be used to inform the final JHWS and its action plans, with a view to the final JHWS being ready for adoption by the HWB in Summer 2022.

15. It is suggested that the JHWS launch is supported by planned communications and engagement around the findings of this programme of work. This will include detailed stories from the qualitative COVID-19 impact research, system mental health communications and engagement activities, and the formal consultation findings. It will also show where this feedback has informed the development of the HWB's JHWS and its action plans.

16. To ensure the HWB has an active JHWS in place for the duration, it is recommended that the HWB extend its existing JHWS until Summer 2022.

Proposed timetable

17. There will be a range of communications and engagement activity launching on World Mental Health Day. Communications and engagement teams across the system are working to co-ordinate this activity.

Indicative Date	**Activity**
10 October 2021	World Mental Health Day
10 October – December 2021	System wide communications and engagement around MH
November-February 2022	Public Health covid impact focus groups
November-March 2022	Public Health covid impact ethnographic study
January – March 2022	Statutory Consultation on Joint Health and Wellbeing Strategy
April-May 2022	Consideration of feedback received and development of final Strategy and Action plans
June – August 2022	Launch of Strategy and feedback on findings from Mental Health conversation and covid impact investigations.

Legal, Financial and HR Implications

18. There is a risk around the timing of the strategy process, informing district and partner strategies. At present, such organisations have been continuing strategy development without alignment to the JHWS.

19. In order to support the communications and engagement campaign for the JHWS strategy and the 'big conversation', funding has been approved to support the development of a small engagement team for which recruitment is underway.

Privacy Impact Assessment

20. There are no privacy issues to report.

Equality and Diversity Implications

21. The conversation approach will be designed with equality, diversity and inclusion in mind. Equality Relevance Screening will be completed for the statutory consultation and full Equality Impact Assessment completed if required.

Contact Points

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Worcestershire Hub: 01905 765765

Specific Contact Points for this report
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AGENDA ITEM 7

HEALTH AND WELL-BEING BOARD
28 SEPTEMBER 2021

Integrated Well-being Offer and Here2Help

Board Sponsor
Cllr Karen May, Cabinet Member with Responsibility for Health and Well-being

Authors
Tanya Richardson, Consultant in Public Health
Hannah Perrott, Assistant Director, Communities

	(Please click below then on down arrow)
Priorities	
Mental health & well-being	Yes
Being Active	Yes
Reducing harm from Alcohol	No
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
Information and assurance

Recommendation

The Health and Well-being Board is asked to:

- **note the progress made in developing an Integrated Well-being Offer for Worcestershire;**
- **note the plans for the future development of Here2Help; and**
- **receive a more detailed update on progress in early 2022.**

Background

1. Creating an Integrated Well-being Offer (IWO) for Worcestershire will support the vision of the Health and Well-being Board:

> ***'People in Worcestershire are healthier, live longer and have a better quality of life, especially those communities and groups with poorest health'.***

2. Worcestershire's IWO will empower people to live well, by addressing the factors that influence their health and well-being and building their capability to be independent, resilient and maintain good well-being for themselves and those around them. It will move beyond focusing on single issues and take a holistic and person-centred approach, addressing the psychosocial determinants of health behaviour. It will augment the collective response to early intervention and prevention to meet people's needs across the life course, improve health and well-being and address inequalities.

3. Initial scoping of an IWO for Worcestershire began in late 2018. The initial aim of the programme was to bring together the many assets and services that offered 'lower level' support for well-being and health to form a comprehensive, holistic pathway through services, where residents could access and move between the services and support they need. Learning was taken from other areas that have developed integrated support for well-being, including Wigan and Leeds.

4. The work on developing an IWO progressed through 2019. Achievements included:

a) development of a social prescribing model;
b) a review of the 'Well-being Hub' and opportunities for support to manage physical and emotional well-being; and
c) a commitment to use community spark funding to develop local assets to support health and well-being.

5. In 2020 Worcestershire County Council (WCC) established the Here2Help programme to help those needing support during the COVID-19 pandemic. The service is now being evolved to offer advice, support and help in accessing a range of Council services across the Council and its system partners.

6. In 2021 work to develop the IWO recommenced, with the establishment of a multi-agency steering group composed of partners from across WCC, District Councils, NHS and the voluntary sector. The group is co-chaired by the Director of Public Health and a voluntary sector representative. The steering group considers system wide developments and interdependencies, including those stimulated by the establishment of the new Mental Health Provider Collaborative and Integrated Care System, and identifies opportunities to create a whole system approach. This includes the Integrated Care System ambition building on the NHS Long Term Plan's vision of health and care joined up locally around people's needs, recognising that decisions taken closer to the communities they affect are likely to lead to better outcomes.

Intended outcomes of the Integrated Well-being Offer

7. There is growing evidence which suggests that multiple health-related behaviours and wider determinants of health can be addressed either simultaneously or sequentially by developing IWO models.

8. Having good health and well-being depends on a lot of different factors, as shown in the graphic over the page. Worcestershire's IWO needs to address all the factors that help to create and protect health and well-being, including those at community level, to achieve positive health outcomes for everyone in the county.

Graphic 1: An illustration of the impact of healthcare and non-healthcare factors on a person's health.
Source: Institute for Clinical Systems Improvement Going Beyond Clinical Walls. Solving Complex Problems (October 2014)

9. Worcestershire's IWO will contribute to the following outcomes:

- evidence of tackling health inequalities;
- improved health and well-being at all ages and stages;
- increased community engagement and support using an asset-based approach;
- enhancement of local assets and reduction in gaps in provision;
- development of a whole system approach to well-being in Worcestershire;
- increased proactive support for mental health and well-being;
- reduced loneliness and isolation;
- comprehensive digital platform including signposting to local assets; and
- provision of integrated services and groups to support people to live well at all stages in life.

10. Worcestershire's IWO will therefore help to deliver the new Joint Health and Well-being Strategy (JHWS) currently being developed by the Health and Well-being Board, with the proposed single overarching priority of good mental health and emotional well-being. Findings from the planned consultation to inform the new JHWS (presented in a separate paper to the Health and Well-being Board) will be used to inform further development of the IWO. Specific engagement work is also planned to support communication and potential re-branding of the IWO.

11. An academic evaluation will be undertaken to establish the impact and reach of the IWO and its related workstreams.

Developing the Model for the Integrated Well-being Offer

12. The diagram below shows the current draft model for the IWO. Workstreams are being established to implement the model, drawing on other relevant local work already being progressed.

Graphic 2: Draft model for the IWO

13. The overall approach is being operationalised initially through the Redditch District Collaborative; taking a life course approach to address their identified priorities. The learning from the work in Redditch will inform further development of the model and other county-wide workstreams.

14. The IWO is working with all District Councils to support the roll out and implementation of an Asset Based Community Development model, with the creation of new Community Builder roles across Worcestershire working in targeted neighbourhoods. This approach will result in individuals and communities that are better connected, and communities that are able to identify and bring about the changes they want to see.

Integrated Well-being Offer and the Future of Here2Help

15. Here2Help has continued to adapt and respond to the changing needs and guidance required to provide appropriate support to residents through the pandemic. Work is underway to build on this experience and success to transform the Here2Help programme into a wider preventative response for the County Council. Here2Help will make a significant contribution to the work of the IWO.

16. The following four values underpin the Here2Help transformation and resonate with the aims of the IWO:

- empower and enable people to make their own choices and find their own solutions;
- connect people with their communities;
- support communities to be strong and resilient; and
- efficient and accessible offering a joined up and transparent experience across all areas of the Council.

17. These values are embedded throughout the Here2Help programme and its future transformation so that it has a strong outcome focused and person-centred foundation to its model. Taking this strength-based community approach Here2Help will build on the connections and partnerships which have evolved throughout the response to COVID-19 and improve the customer journey in how they access information and services, including the transformation of the County Council's 'front door'. The future ambition of

Here2Help is to give individuals clear information to connect to their own community-based solutions and ensure there are clear pathways into other services when required either through self-referrals or Here2Help directly.

18. This will be done in three ways:

- **Digital:** Enhancing the system so that individuals can use it to access the information and support they need. This can include self-referrals, accessing self-help tools and information and online bookings for various community services. The development of a community directory will process residents' access to a range of local organisations and groups who have registered onto Here2Help. Here2Help ambassadors will help to keep this as up to date as accurate as possible.
- **Telephone contact**: The main contact for Here2Help will continue with increased staffing to providing more capacity to respond to the service as it develops. Pathways and processes will also be embedded between Here2Help and the Family Front Door.
- **Face to Face**: Providing the Here2Help community platform, initially using libraries as points where people can access Here2Help in person, making libraries a community asset for residents, community groups and partners. There is also an opportunity to build this support into Family Hubs and services specifically aimed at families with children.

19. A Here2Help ambassador role is being established as part of a community network that will support partners to come together to be the 'eyes and ears' of the Here2Help service, to share ideas, learning and innovation. The role will provide partners an opportunity to co-produce Here2Help developments and work together to find solutions in how to respond to the changing future demands and needs which we all face. This role will demonstrate the community partnership ethos of Here2Help providing challenge and will co-produce ongoing developments.

Legal, Financial and HR Implications

20. Funding has been identified to support the development of the IWO and Here2Help whilst building capacity in communities and across the voluntary sector. A detailed breakdown and profile of spend is currently being prepared and will be included in the next update to Health and Well-being Board.

Privacy Impact Assessment

21. There are no privacy issues to report.

Equality and Diversity Implications

22. An Equality Relevance Screening will be carried out as development of the IWO and Here2Help progresses.

Contact Points

County Council Contact Points
County Council: 01905 763763
Worcestershire Hub: 01905 765765

Specific Contact Points for this report
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worcestershire countycouncil

AGENDA ITEM 8

HEALTH AND WELL-BEING BOARD
28 SEPTEMBER 2021

Mental Health and Wellbeing Strategy

Board Sponsor
ICS Senior Responsible Officer for Mental Health

Author
Jack Lyons-Wainwright, Mental Health Lead

Priorities	(Please click below then on down arrow)
Mental health & well-being	Yes
Being Active	No
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
Decision

Recommendation

1. The Health and Well-being Board is asked to consider and approve the ICS Mental Health and Wellbeing Strategy.

Background

2. In autumn 2019 work commenced on the development of a Mental Health and Wellbeing Strategy for Herefordshire and Worcestershire, overseen by the then STP Mental Health Programme Board.

3. Extensive engagement has been undertaken, through public listening and co-production events (see published summary reports in background papers) and circulation at a wide range of forums. In addition to patients and carers, the project team have consulted with professionals across:

a) Worcestershire County Council
b) Herefordshire County Council
c) Worcestershire District Councils
d) Herefordshire and Worcestershire Health and Care NHS Trust

e) Primary Care
f) Worcestershire Acute Hospitals NHS Trust
g) Wye Valley NHS Trust
h) Voluntary and Community Sector organisations

4. The engagement work led to the development of 5 key priorities underpinning the aims of the strategy:

a) Accessible services
b) Integrated services
c) Community empowerment
d) Person-centred services
e) Prevention and self-care

5. These 5 priorities reflect the local ambition for mental health and wellbeing services, while also aligning with national direction via the NHS Long Term Plan. The strategy also highlights the need to support and build community health assets, utilising existing local enablers such as the Now We're Talking and the development of the Worcestershire Integrated Wellbeing Offer.

6. Delivery of the Mental Health and Wellbeing Strategy will be overseen by the Mental Health Collaborative Committee (previously the STP Mental Health Programme Board), with updates to Health and Wellbeing Boards as required. The strategy is expected to provide a clear direction for mental health service development as Herefordshire and Worcestershire continues its journey to an Integrated Care System, including complimenting the priorities identified by the Health and Wellbeing Board for the Joint Health and Wellbeing Strategy

7. A high level plan for the next 3 years is included within the strategy, which will be augmented by a detailed action plan following completion of the strategy. From 2024 a refreshed action plan will be developed up to 2026, taking into account developments locally and renewed national strategy expected for the second half of the 10 year LTP.

8. The content of the Mental Health and Wellbeing Strategy has been supported by the ICS Mental Health Programme Board and ICS Partnership Board. It will also be submitted to Herefordshire Health and Wellbeing Board for approval, with the final content dependent on agreement at both boards.

Legal, Financial and HR Implications

9. Not applicable.

Privacy Impact Assessment

10. Not applicable.

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
County Council: 01905 763763
Worcestershire Hub: 01905 765765

Specific Contact Points for this report
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Email: jack.wainwright@nhs.net

Supporting Information

- Appendix 1 – Herefordshire & Worcestershire Mental Health and Wellbeing Strategy.

Background Papers

In the opinion of the proper officer (in this case the SRO for Mental Health) the following are the background papers relating to the subject matter of this report:

- Engagement evaluation report Nov 2019 – https://www.herefordshireccg.nhs.uk/who-we-are/publications/consultation-and-engagement/2864-mental-health-strategy-engagement-evaluation-report-final-web-version/file

- Engagement report summary: co-production sessions Jul 2020 - https://www.herefordshireandworcestershireccg.nhs.uk/about-us/publications/engagement/additional-engagement-docs/274-mental-health-strategy-summary-engagement-report-final-july-2020/file

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Herefordshire and Worcestershire Mental Health and Wellbeing Strategy 2021-2026

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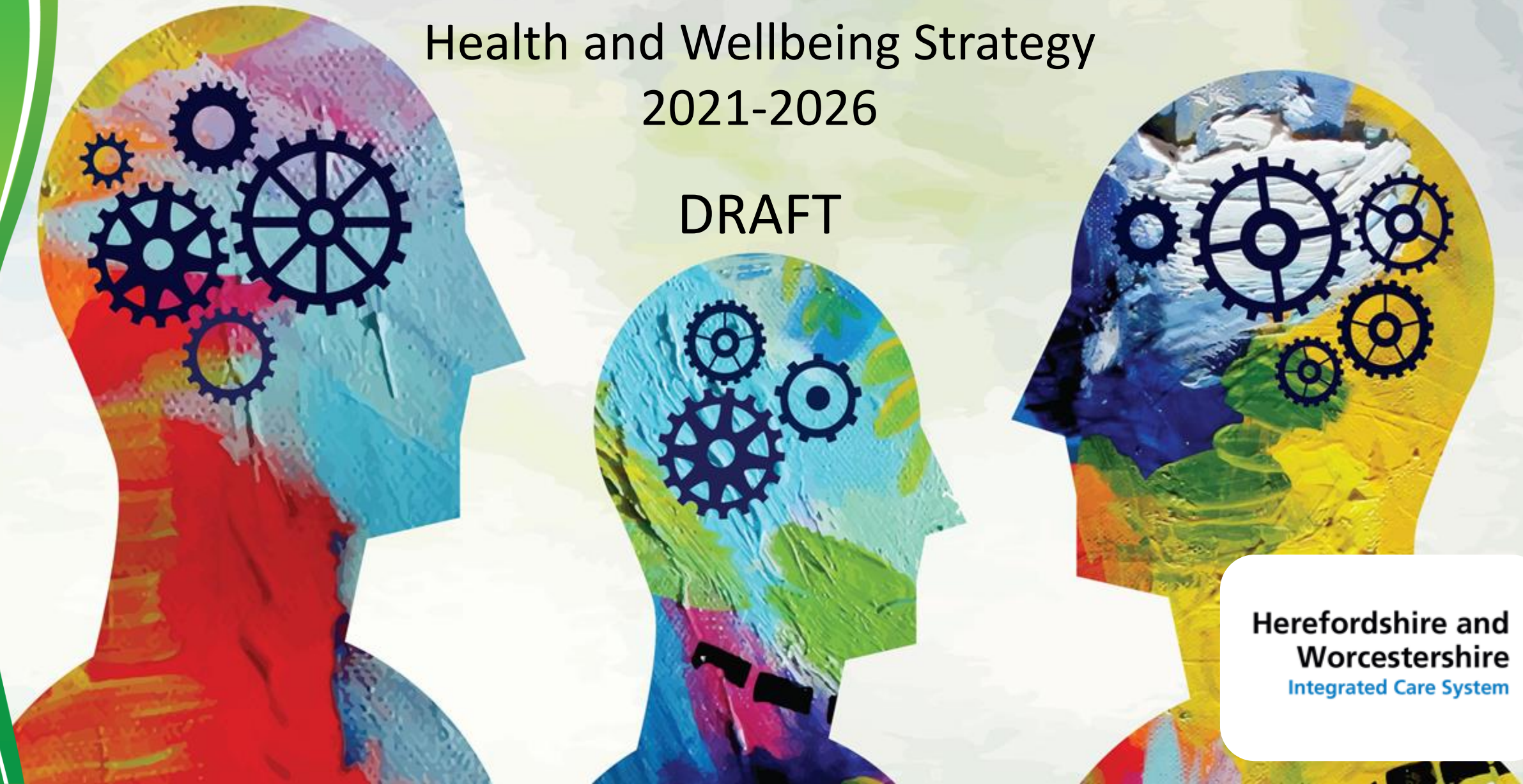


Herefordshire and Worcestershire
Integrated Care System

Introduction

Awareness of mental health and wellbeing is growing in the public consciousness and is a major priority both in Herefordshire and Worcestershire, and nationally. This is reflected in the NHS Long Term Plan, which sets our the strategic direction for mental health services nationally over the next 5-10 years.

Our strategy for Herefordshire and Worcestershire sets out our ambitions to support and treat people with mental health issues over the next 5 years, in terms of delivering the national strategy in a way that works for our area, as well as identifying local priorities to meet our specific needs based on feedback from stakeholders.

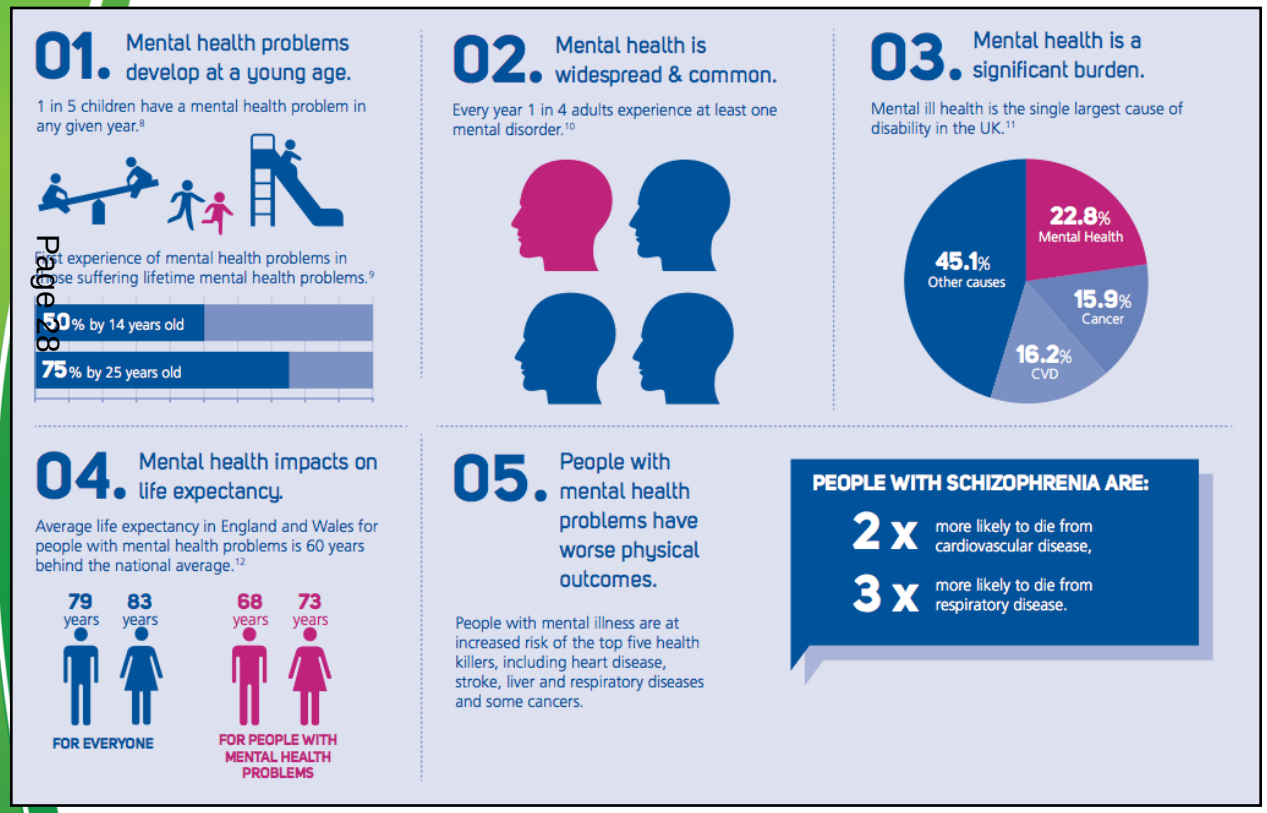
This Strategy is informed by what people have told us about their experiences either as a person who has experienced mental health illness, a carer of someone with a mental health illness, or a member of staff working with people experiencing mental health illness.

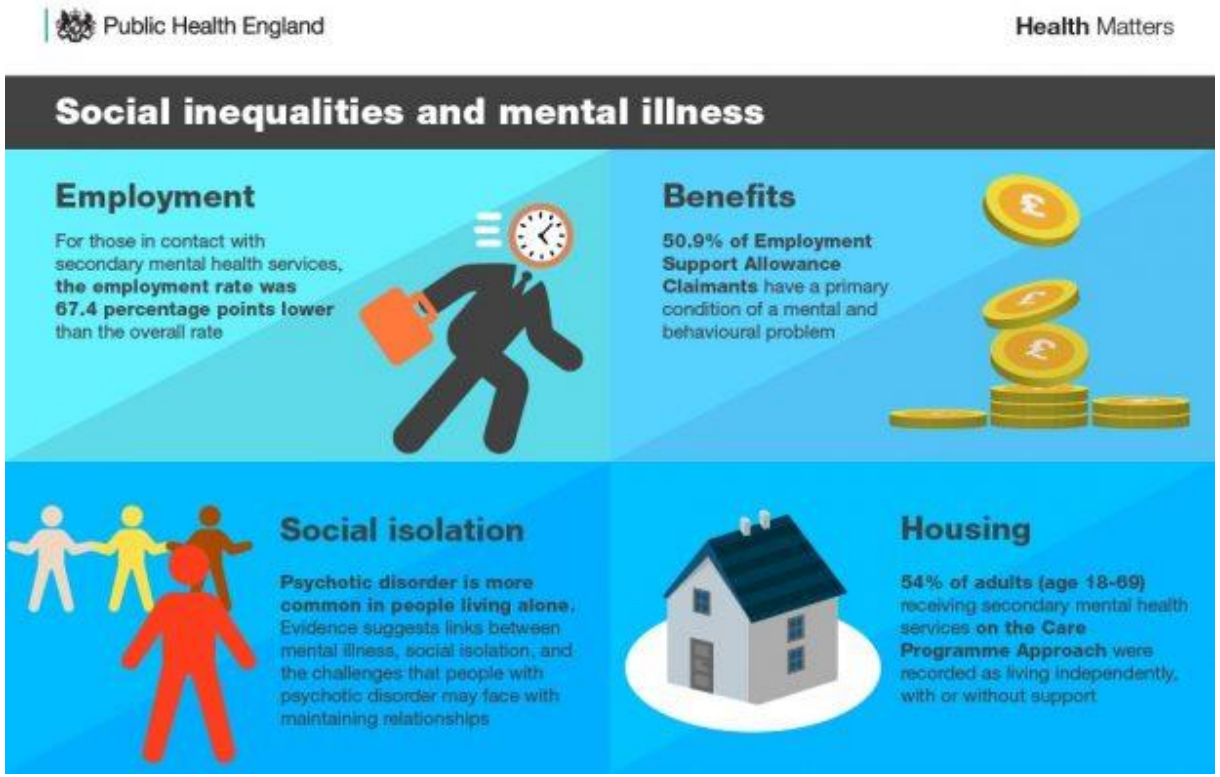
What is mental health and wellbeing?

‘In many ways, mental health is just like physical health; everybody has it and we need to take care of it. Good mental health means being generally able to think, feel and react in the ways that you need and want to live your life. But if you go through a period of poor mental health you might find the ways you're frequently thinking, feeling or reacting become difficult, or even impossible, to cope with. This can feel just as bad as a physical illness, or even worse.’ ‘Mental wellbeing describes your mental state - how you are feeling and how well you can cope with day-to-day life. Our mental wellbeing is dynamic. It can change from moment to moment, day to day, month to month or year to year.’	Mind
‘When our mental health is good, we feel positive about ourselves, enjoy being around others and feel able to deal with life’s challenges. We all go through times when we feel worried, confused or down. But when it starts to feel difficult to do everyday things like hanging out with friends, getting work done or doing the things we normally enjoy, this could mean we have a problem with our mental health.’	Young Minds
‘Mental disorders comprise a broad range of problems, with different symptoms. However, they are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others.’	World Health Organisation
‘There’s a stigma attached to mental health problems. This means that people feel uncomfortable about them and don’t talk about them much. Many people don’t even feel comfortable talking about their feelings. But it’s healthy to know and say how you’re feeling.’	Mental Health Foundation
‘Mental health and mental illness have an impact on all of us, either directly or indirectly – whilst we can all benefit from having good mental health, 1 in 6 adults experienced a common mental health problem in the last week.’	Public Health England
‘One in four adults and one in 10 children experience mental illness, and many more of us know and care for people who do.’	NHS England
‘Mental wellbeing can be described as 'feeling good and functioning well.’	Herefordshire County Council
‘One in four people will experience and mental illness in their lifetime - it is not as uncommon as you think.’	Rethink Mental Illness

National Picture

Mental health illness is widespread and common, and is linked to wider determinants of health. It is also linked to a broad range of inequalities, both with mental health services and in daily life.





National Picture

Adverse Childhood Experiences (**ACEs**): 47% of people report at least 1 ACE, 9% report 4 ACEs or more

1 in 4 adults experience at least one diagnosable mental health problem in any given year

One in six school age children has a mental health problem

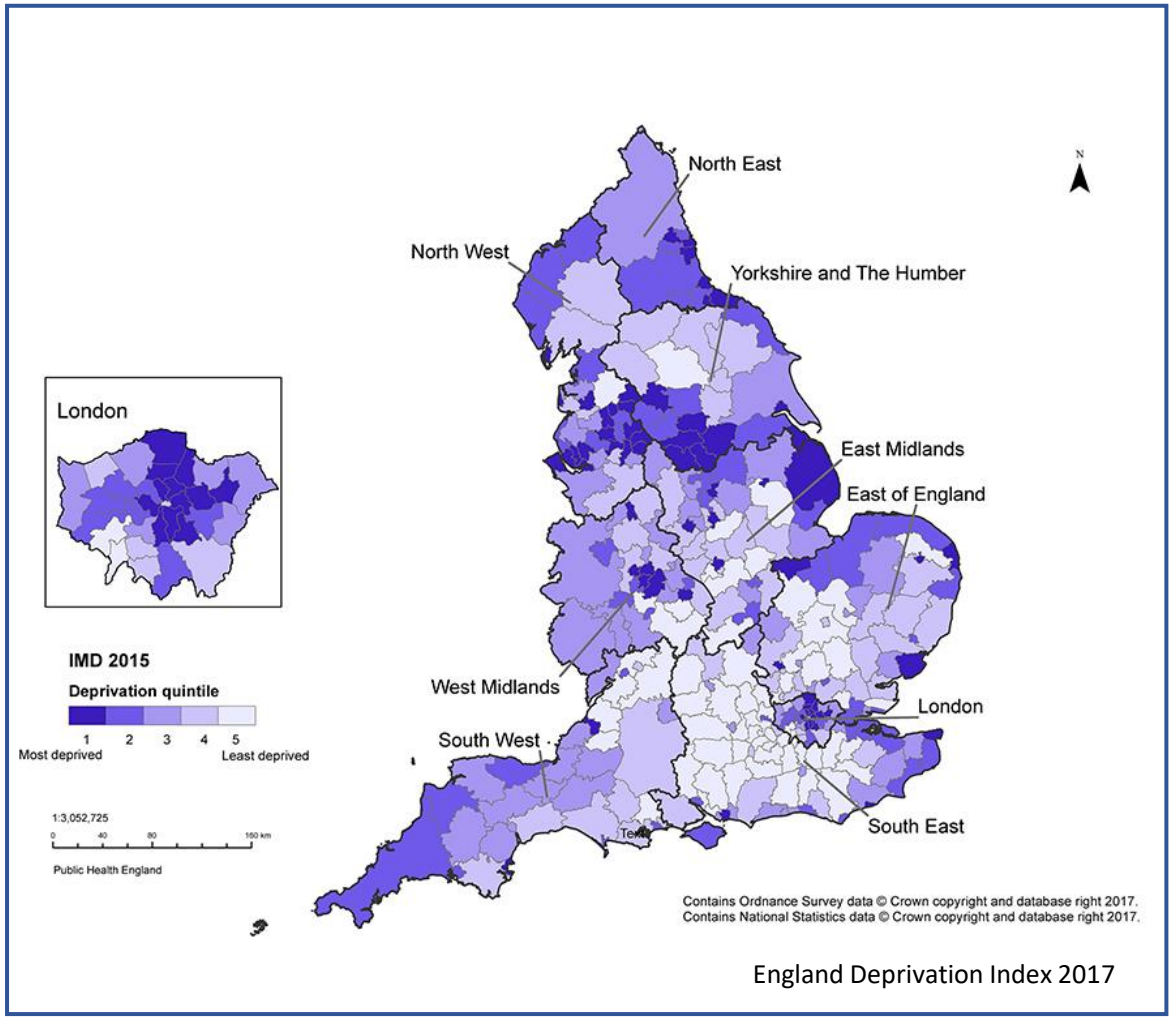
Suicide is the leading cause of death in 15-29 year olds and the second leading cause of maternal death

75% of adults with a diagnosable mental health problem experience the first symptoms by the age of 24

Severe Mental Illnesses affect around **500,000** people in England

1 in 5 older people are affected by depression

1 in 5 mothers suffer with depression, anxiety or psychosis in pregnancy or first year after children



England Deprivation Index 2017

National context and background

There are a number of national drivers that shape and influence the way mental health services are delivered in the UK

'Parity of esteem is the principle by which mental health must be given equal priority to physical health. It was enshrined in law by the Health and Social Care Act 2012.' ***Centre for Mental Health***

'The Mental Health Investment Standard (MHIS) is the requirement for CCGs to increase investment in Mental Health services in line with their overall increase in allocation each year.' ***NHS England***

A 'parity approach' enables NHS and local authority health and social care services to provide a holistic, 'whole-person' response to each individual in need of care and support, with their physical and mental health needs treated equally. The relationship between physical and mental health is such that poor mental health is linked with a higher risk of physical health problems, and poor physical health is linked with poor mental health. ***Mental Health Foundation***

The anticipated Health and Care Bill aims to remove barriers to integration, 'remove much of the transactional bureaucracy' and 'ensure a system that is more accountable and responsive to the people that work in it and the people that use it'. ***Government white paper setting out legislative proposals for a Health and Care Bill***

Legislation
Care Act 2014
Health and Social Care Act 2012
Equalities Act 2010
Mental Health Act 1983
Policing and Crime Act 2017
Children's Act 2004

Context
Five Year Forward View for Mental Health (2016)
NHS Long Term Plan (2019)
NHS & Adult Social Care Outcomes Frameworks
Advancing Mental Health Equality (2019)
Prevention Concordat
Crisis Care Concordat

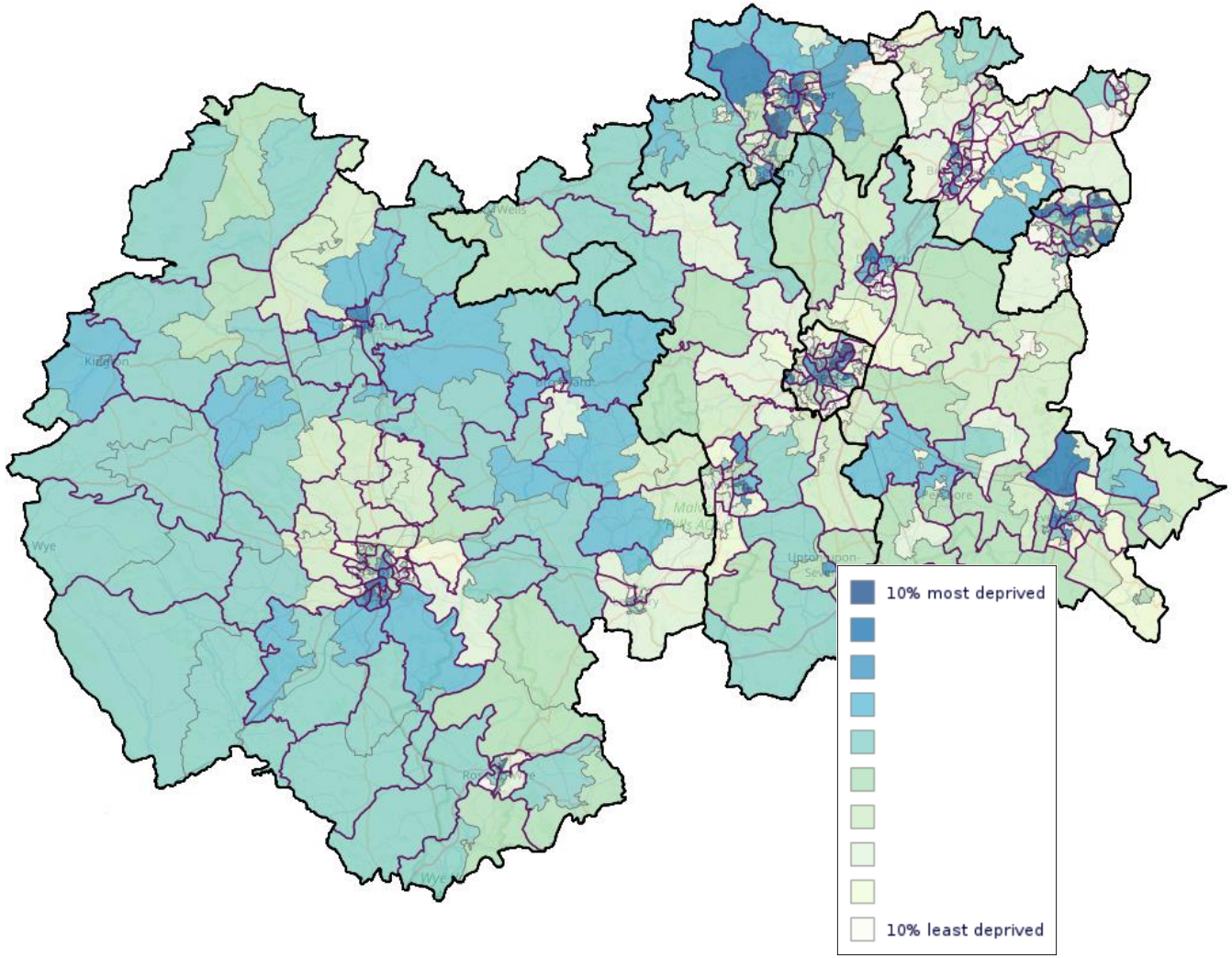
Local Picture

The determinants of mental health are not limited to an individual's attributes but include social, cultural, economic, political and environmental factors. Deprivation, generally described as a relative disadvantage in terms of material and social factors (including money, resources and access to life opportunities) increases the risk of poorer mental health.

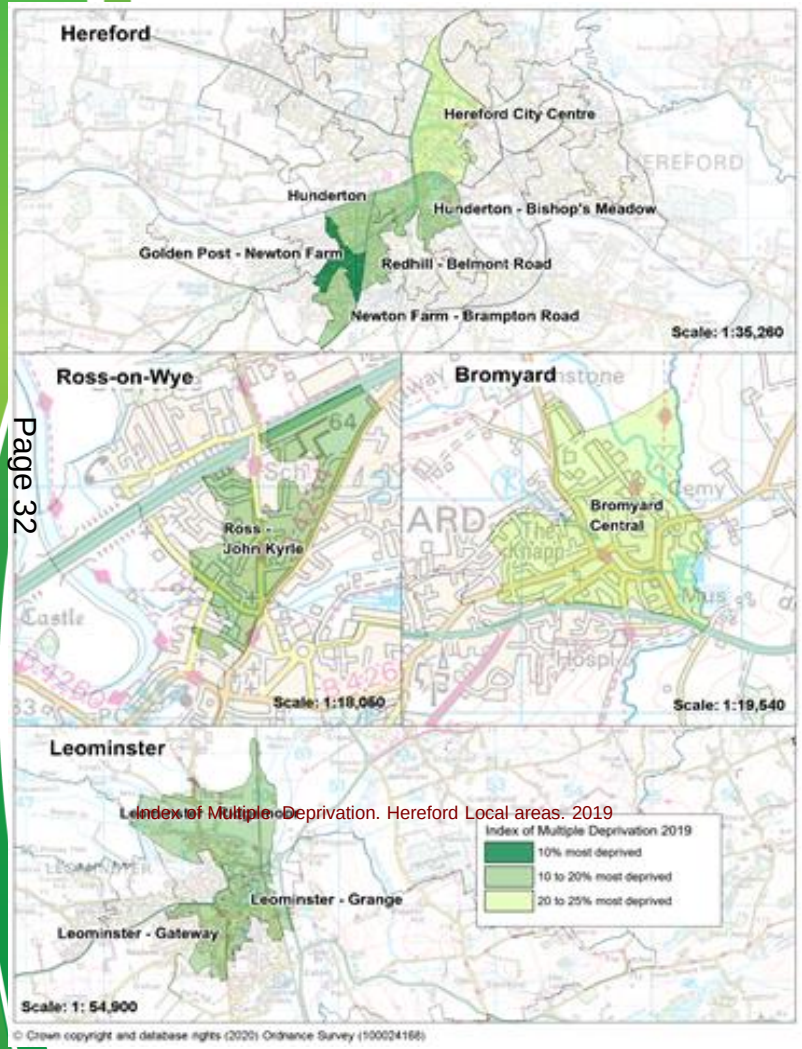
The Index of Multiple Deprivation (IMD) is a combined measure of deprivation reflecting 37 indicators across 7 domains and is used to compare relative deprivation across different geographical areas. Prevalence of psychotic disorders among the lowest fifth of household income is 9 times higher than in the highest and double the level of common mental health problems between the same groups. Children from the poorest 20% of households are four times as likely to have serious mental health difficulties by the age of 11 as those from the wealthiest 20%.

Both Herefordshire and Worcestershire are predominantly rural counties with some urban areas, particularly in Worcestershire. The health of the rural population is on average better than that of urban areas though this is not clear cut, with evidence suggesting very diverse levels of affluence in rural areas also. This is in line with the variation in IMD seen across the two counties (right).

Mental health services need to recognise this variation wherever possible to reflect the diverse needs of different areas in order to deliver services most effectively.



Local Picture - Herefordshire



Index of Multiple Deprivation. Hereford Local areas. 2019

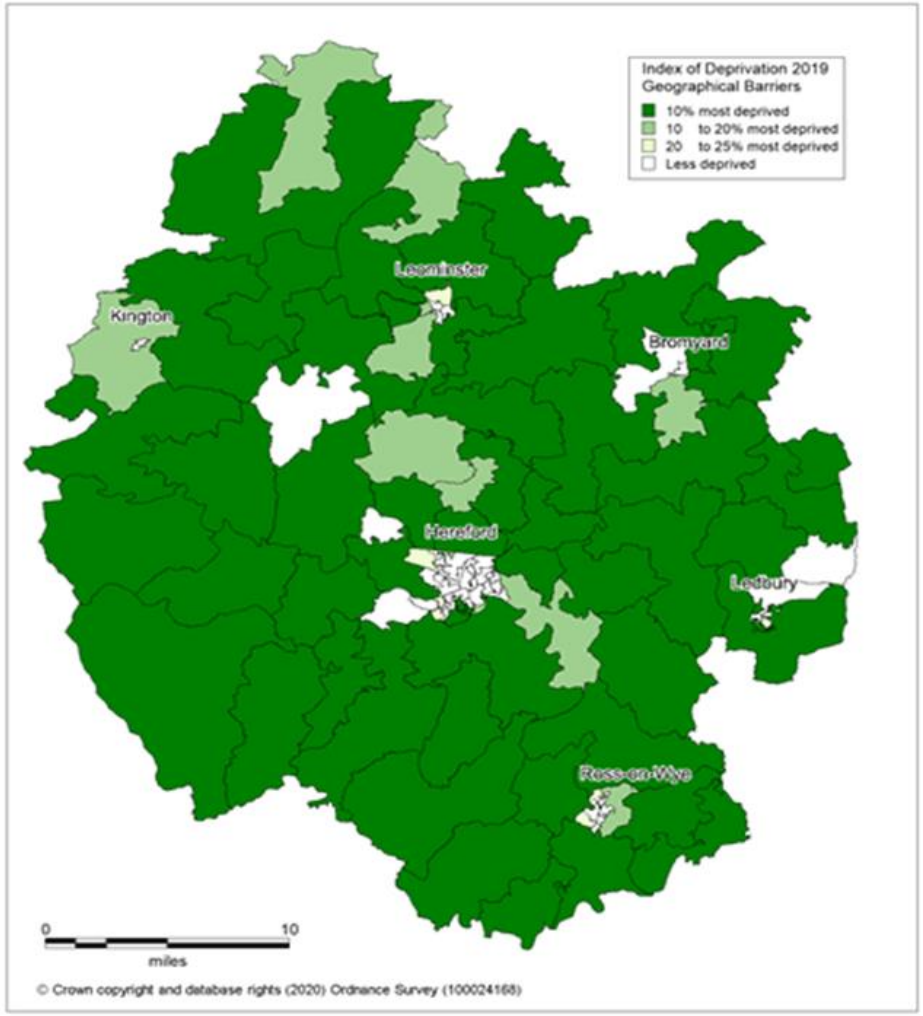
Rurality concerns : Almost half the county's areas are amongst the 10% most deprived in relation to physical distance from essential services and facilities including schools and the GP.

Less than 25% of adult carers receive as much social interaction as they would like.

3% of children have social, emotional or mental health needs (above national benchmark)

69% of adults classed as overweight or obese (above national benchmark)

Index of Deprivation 2019 (Geographical Barriers)



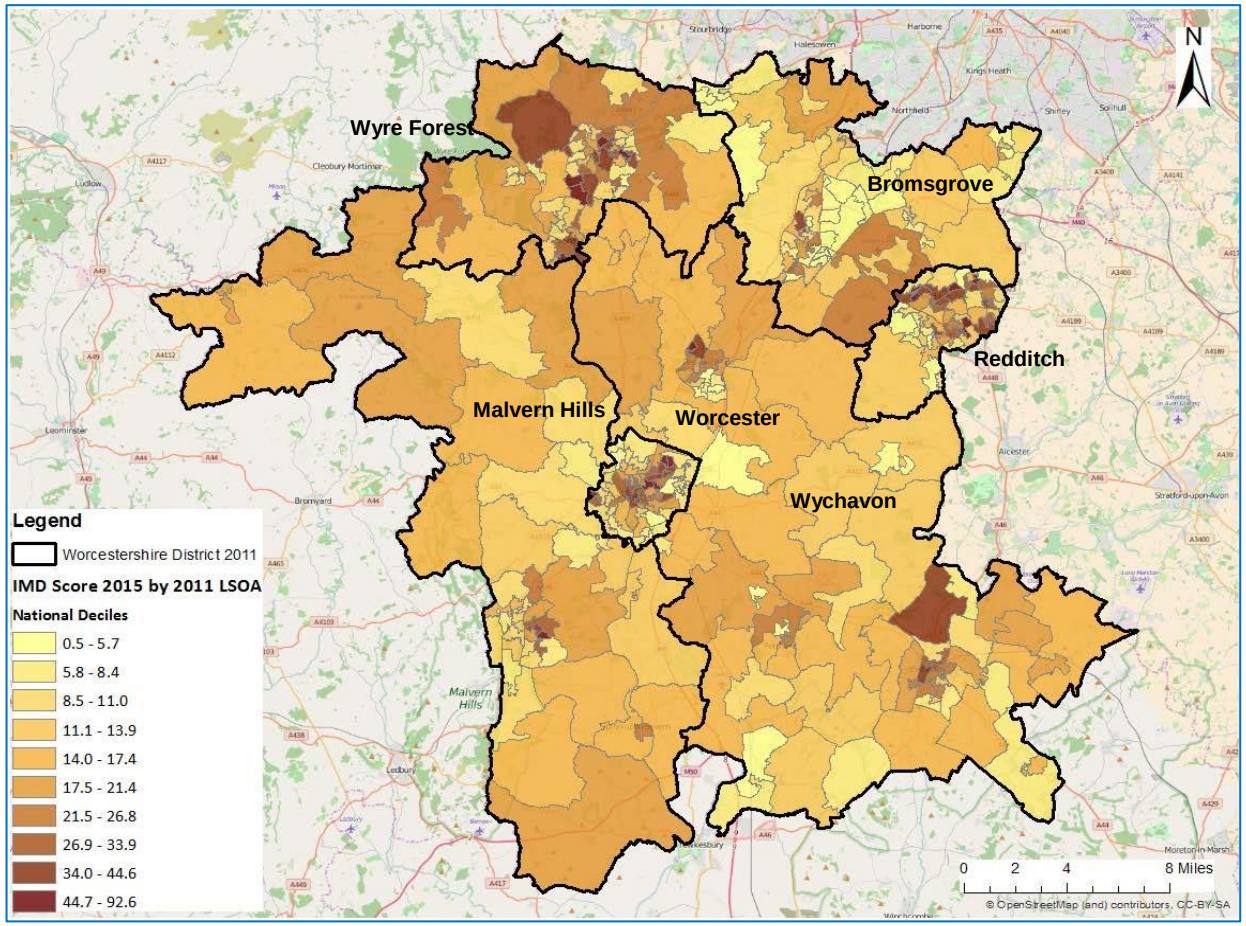
Local Picture - Worcestershire

Worcester = 9th worst area in England for rising deprivation levels

KEY FIGURES

- Higher rates of psychosis (17.5 per 100000)
- Higher rates of family homelessness (13.4 per 10000)
- High reported bullying rates amongst children – 58%
- More children taken into care (71 per 10000)
- 39.9 per 10000 children in need due to disability or illness
- Greater prevalence of mental disorders in children (3.4%)

Source: Indices of Multiple Deprivation 2015



COVID-19

COVID-19 has had, and will continue to have, a major impact on peoples' mental health and wellbeing, and on the way mental health services are delivered. In the short term many mental health services saw a dramatic reduction in referrals, meaning fewer people are receiving the care that they require, though these have largely now returned to normal levels. Conversely there was also increased demand for some services, as a result of the increased stresses brought about by the pandemic and subsequent lockdown.

The scale of the longer term negative impacts of the pandemic on mental health and wellbeing, both direct and indirect, remains unclear. They are expected to be significant however. Issues such as anxiety and depression are expected to become more prevalent, particularly as negative economic effects impact on employment; trauma caused directly by treatment for COVID in Intensive Care Units is also a risk, and it is also being reported that people presenting to services are experiencing a greater acuity of symptoms, suggesting that people are not accessing services as early as previously.

There have however been some positives that have come out of the pandemic, as coronavirus has also forced organisations to think differently about how services are delivered and triggered major rapid transformation of services.

While mental health services in Herefordshire and Worcestershire remained largely operational during the first wave of the pandemic, in contrast to many elective physical health services, many have begun to routinely utilise digital solutions such as appointments by phone or videoconference. An acute mental health ward that was closed to accommodate COVID-positive patients, with staff redeployed to deliver intensive community treatment instead, is proving a success. Estates strategies are being revisited off the back of a more flexible, mobile workforce than ever before, and public awareness of mental health and wellbeing continues to grow. Our local Voluntary, Community and Social Enterprise (VCSE) sector has provided wide-ranging and invaluable support, including closer integration with statutory services, and continues to buck the trend around workforce challenges.

While there remain challenging times to come as a result of COVID-19, it is important that we take advantage of and retain the major positive changes that have been made to how services are delivered wherever possible.

Inequalities

Many inequalities of access, experience and outcomes of services for people with mental health illness are longstanding, but are understood to have been exacerbated by the COVID-19 pandemic. National data shows:

Characteristic	Access	Experience	Outcomes
Age	Older people are a fifth as likely as younger age groups to have access to talking therapies but six times as likely to be on medication Children and young people from BAME communities are less likely to be able to access services which could intervene early to prevent mental health problems escalating	Older people with common mental health problems are more likely to be on drug therapies and less likely to be in receipt of talking therapies	Young people in prison are more likely to take their own lives than others of the same age Older people have better recovery outcomes in IAPT than working-age, but access is lower
Ethnicity	Many black-African and Caribbean people, particularly men, do not have access to psychological treatment at an early stage of their mental health problem People from black-African and Caribbean communities are 40% more likely than white-British people to come into contact with mental health services through the criminal justice system	BAME patients are less likely to rate their overall experience as 8 or above on a 10-point scale (44% vs 49% for white-British) Black adults are more likely than adults in other ethnic groups to have been detained under a section of the Mental Health Act	Though there have been gradual improvements, the IAPT recovery rate for BAME service users is below that of their white-British Counterparts
Gender	Men are less likely to be referred to IAPT services, and enter IAPT treatment, than women	Women are more likely to be restrained than men and girls are more likely to be restrained in a face down position than boys	Women, on average, have a longer length of stay in secure care
Sexual Orientation	LGB people still experience discrimination in healthcare settings and many avoid healthcare for fear of discrimination from staff	LGB patients are far less likely to feel they had been treated with dignity and respect by NHS mental health services (55% vs 73%)	LGB people experience poorer recovery outcomes in IAPT than their heterosexual counterparts
Disability	People with disabilities face unique barriers to accessing care with transportation and cost cited as significant barriers	A Mental Health Foundation survey found that those with a learning disability were not as satisfied with MH care provided	People with disabilities experience poorer recovery outcomes in IAPT than those without a disability
Deprivation	People in lower income households are more likely to have unmet mental health treatment requests compared with the highest	Evidence on differential patient and carer experiences of mental health in deprived localities is still emerging	IAPT recovery rates are generally poorer in the most deprived localities compared to the least deprived
Other	Many health inclusion groups face barriers to accessing healthcare services in the round, including those sleeping rough, sex workers, and migrants	Evidence on differential patient and carer experiences in mental health services is still emerging	People of the Muslim faith experience poorer recovery outcomes in IAPT services than any other faith group

A Herefordshire and Worcestershire Mental Health Inequalities Board has been established to review local intelligence and put in place action plans to address inequalities identified locally.

Local context and background

Mental health services in Herefordshire and Worcestershire have recently undergone a period of significant change, with the move to both a single NHS mental health provider trust and a single NHS Clinical Commissioning Group expected to have a beneficial impact on services across both counties. Further change is expected over the next few years, with health services moving to develop and operate as Integrated Care Systems (ICS) in line with national strategy.

Past	Present	Future
4 Clinical Commissioning Groups • Herefordshire CCG • Redditch & Bromsgrove CCG • South Worcestershire CCG • Wyre Forest CCG	A single Clinical Commissioning Group for both counties	An Integrated Care System (ICS) spanning both counties, dissolving the commissioner / provider divide within health services
2 Mental Health Provider Trusts • Gloucestershire Health and Care Trust • Worcestershire Health and Care Trust	A single Mental Health Provider Trust for both counties	A Mental Health Collaborative in place, to include broad range of stakeholders including VCSE, police and ambulance services

Up to now → **Going forward**

Advantages

1. Economies of scale
2. Greater service resilience and shared expertise
3. Simpler to navigate
4. Reduced commissioning and contracting burden

Local context and background

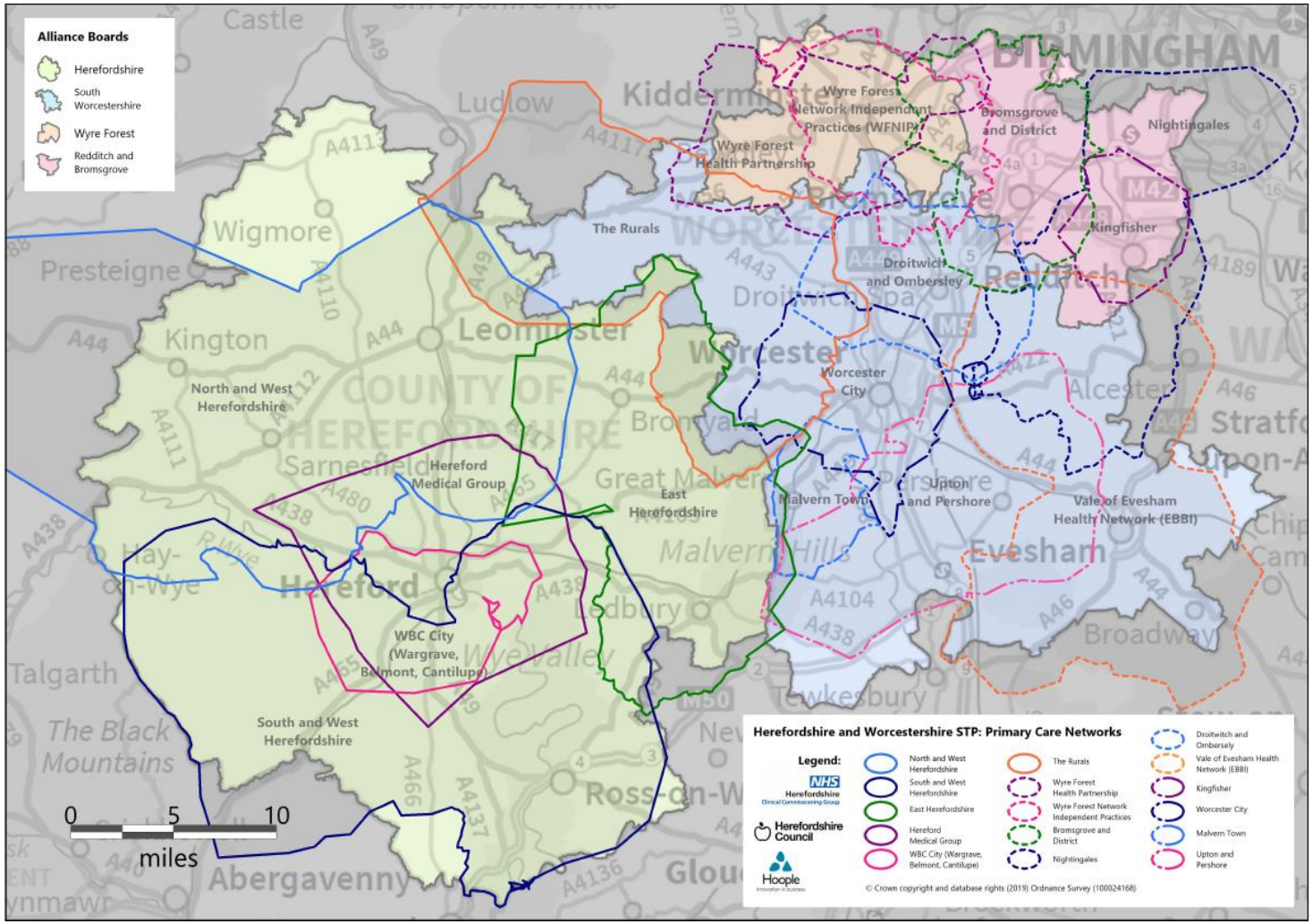
Although Herefordshire and Worcestershire now have a single mental health provider and a single CCG as health commissioner, services that address local needs are essential.

The following statutory commissioning and provider bodies support and ensure localised delivery of services across the ICS:

- 2 County Councils (including Public Health teams)
- 6 District Councils in Worcestershire
- 3 Acute Hospitals
- 8 Community Hospitals
- 16 Primary Care Networks (PCN)
- 85 GP Practices

While some services are best delivered at an ICS-level, such as more specialised services, many are better delivered at different levels such as county, district or PCN-level.

At whatever geography services are delivered, the purpose is to improve health and wellbeing outcomes for all and to reduce the gap between those with the best and worst outcomes by working as equal partners to drive collaboration. This is delivered through the triumvirate of place leadership, provider collaboratives and system leadership, underpinned by the principle of subsidiarity.



Local context and background

Mental health and wellbeing affect people in all walks of life, but has particular links to a number of other issues. This strategy does not seek to replace but to link to these strategies, including those below.

Strategies

- Herefordshire Learning Disability Strategy
- Worcestershire Learning Disability Strategy
- Herefordshire Autism Strategy
- Worcestershire All-Age Autism Strategy
- Herefordshire & Worcestershire CYMPH Transformation Plan
- Herefordshire & Worcestershire Dementia Strategy
- Herefordshire Homelessness Prevention and Rough Sleeping Strategy
- Worcestershire Homelessness and Rough Sleeping Strategy
- Herefordshire Health and Wellbeing Strategy
- Worcestershire Joint Health and Wellbeing Strategy
- Herefordshire Joint Carers Strategy
- Worcestershire Carers Strategy
- Herefordshire Interim Housing Strategy
- Worcestershire Strategy for CYP and SEND
- Herefordshire & Worcestershire Sustainability and Transformation Plan

Local context and background

Below is just some of the work already underway locally that this strategy seeks to support includes:

Worcestershire All-Age Autism Strategy:

Links adult services with services for children and young people for support

Ensure that people with autism spectrum conditions are supported as they progress to more independent living. Enables children, young people and adults with autism spectrum conditions to have access to all universal and health and social care services

Herefordshire and Worcestershire Children and Young People Mental Health and Emotional Wellbeing Transformation Plan:

Plans on improved crisis care and early identification of children in need to prevent escalation or further risks and continued support in recovery

Worcestershire Joint Health and Wellbeing Strategy:

Prioritise building resilience to improving mental wellbeing and dementia. (A higher proportion of adults in Worcestershire are diagnosed with dementia (7.8%) than the national average (5.8%)

Herefordshire Joint Carers Strategy:

Provide support to enable fulfilled lives as 82% carers struggle with their health

Worcestershire homelessness & rough sleeping strategy:

Poor mental health outcomes of homeless people are twice as high compared with the general population

Plans to develop, review and promote local housing and support pathways for groups vulnerable to becoming homeless as a result of mental health problems

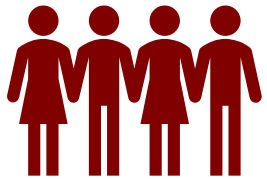
Herefordshire Suicide Prevention Strategy:

Focus on suicide prevention through identifying key areas for development, improving support for those already at risk

Challenges

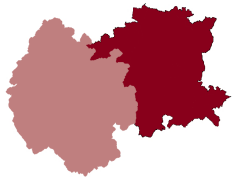
The profile of mental health has risen in recent years, and with it has come greater focus as well as increased funding. While this is welcomed, there remain significant challenges to delivering high quality mental health services to our communities.

Workforce
With a shortage of 40,000 nurses and 10,000 Consultants nationally, finding sufficient workforce is challenging, particularly in rural areas. We need to think differently about our workforce in Herefordshire and Worcestershire to ensure we are able to provide safe, quality services.



Increasing demand
Demand for mental health services is increasing, by as much as a third nationally over the last five years. Our services need to meet the rising and changing profile of demand in across the ICS, while addressing gaps and maintaining quality within existing provision.

Bringing together two counties
Mental health provision looks different depending on whether you live in Herefordshire or Worcestershire. We want to bring both areas closer together so that there is a consistent service offer no matter where you are in our ICS.



Ambitious national agenda
The NHS Long Term Plan is ambitious in what it has set out to achieve over the next 5 and 10 years, with all areas expected to improve and expand mental health services at pace. While this is very welcome, it also poses a challenge to local systems to deliver.

System Financial Recovery
Local authorities and the NHS are under significant financial pressure and Herefordshire and Worcestershire ICS is currently in a financial deficit position. Mental health services need to do their part to drive efficiency and ensure services across the system are sustainable.

Responding to local need
Herefordshire and Worcestershire is a mixed area geographically with both urban and rural areas that pose different questions, and require different solutions. Getting the right services for each local population while also gaining the benefits of ICS-wide services will be key.

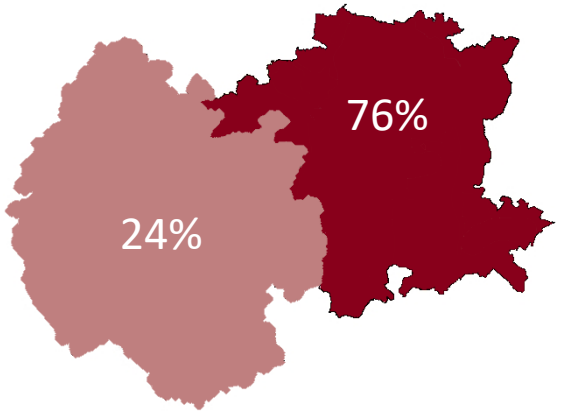
Who we spoke to

Between 1 October 2019 until 12 November 2019 the Engagement Manager on behalf of the Herefordshire and Worcestershire Integrated Care System ran a survey and a series listening events to engage with the Herefordshire and Worcestershire populations, with the purpose of gaining their views on a new ICS Mental Health Strategy. The full Engagement Report is available at http://www.redditchandbromsgroveccg.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=198401 .

192 people responded to the survey and 47 people attended a Listening Event. Respondents were asked to comment on the following three questions:

1. What do you think works well for people with a mental health condition in the area where you live?
2. What doesn't work well?
3. What do you think the mental health strategy should focus on?

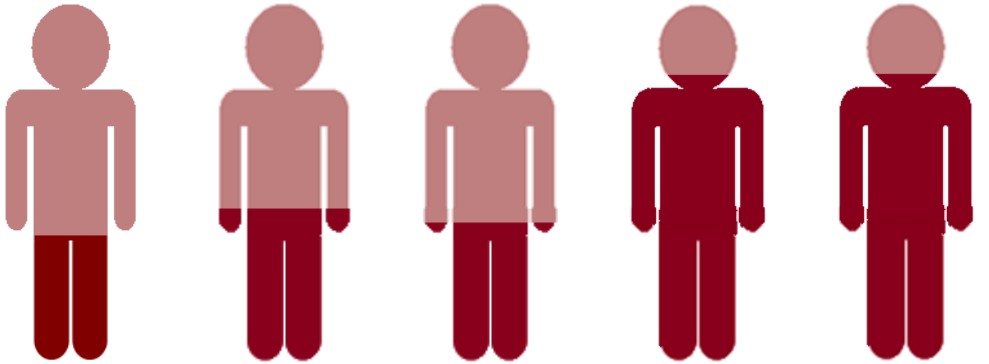
239 Respondents



69% Female
31% Male

34% Disabled

20% Answering on behalf of an organisation



39% Carers

80% Heterosexual

Who we spoke to

Mental health and wellbeing is a broad area covering many issues affecting people in all walks and stages of life, and alongside a wide range of other issues. Though present everywhere, mental health difficulties are particularly prevalent alongside difficulties such as:

- Homelessness and housing issues
- Substance misuse
- Long term physical health conditions
- Autistic Spectrum Condition (ASC)
- Learning disabilities
- Being a Carer
- Bullying
- Unemployment or workplace stress
- Debt issues

Mental health is therefore a regular topic of conversation at a variety of different forums within health and social care. This strategy will impact on, and has therefore been discussed at or shared with, the groups and forums to the right:

- Herefordshire and Worcestershire CCG Clinical Commissioning Committee
- Herefordshire & Worcestershire ICS Mental Health Programme Board
- Herefordshire & Worcestershire CCG Clinical Commissioning Group
- Herefordshire CYP MH and Emotional Wellbeing Partnership Board
- Herefordshire County Council Cabinet Members and Scrutiny Chairs
- Herefordshire Health and Wellbeing Board
- Herefordshire County Council Departmental Leadership Teams
- Herefordshire Mental Health Partnership Board
- Herefordshire Suicide Prevention Sub-Group
- Hereford Autism Partnership
- Herefordshire Homeless Forum
- Worcestershire CCGs Patient Advisory Group
- Worcestershire Health & Care Trust Community Engagement Panel
- Worcestershire Health & Care Trust Youth Board
- Worcestershire County Council Youth Cabinet
- Worcestershire CYP MH and Emotional Wellbeing Partnership Board
- Worcestershire Integrated Commissioning Executive Officers Group
- Worcestershire Health and Wellbeing Board
- Worcestershire CCGs Clinical Innovation Group
- Worcestershire County Council Departmental Leadership Team
- Worcestershire Strategic Housing Partnership
- Worcestershire Suicide Prevention Steering Group
- Worcester Cares Vulnerable People and Homelessness Forum
- Worcestershire Autism Partnership Board

Engagement reports from public events are available here:

- http://www.wyreforestccg.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=198401
- https://www.herefordshireandworcestershireccg.nhs.uk/about-us/publications/engagement/additional-engagement-docs/274-mental-health-strategy-summary-engagement-report-final-july-2020/file

What people told us - what works well?

Question 1 – What do you think works well for people with a mental health condition in the area where you live? [this could be a service, a team, how to access information or help, or anything else that you think works well]

Key Theme 1 - Praise for a specific / individual mental health service
There were various individual services that respondents thought worked well for people with a mental health condition. These included a wide range of services across both counties.

Key Theme 2 - Ability to access the service
Numerous respondents thought that access to a service was good. Comments included praise for the following:

- Self-referral option
- Online and telephone support
- 24/7 availability of the Crisis Team
- Support available in the community

Key Theme 3 - The role or support of staff
The care and support received from staff, featured high in the comments of what people thought works well. Respondents praised various individual staff members and teams.

What people told us - what doesn't work well?

Question 2 – What doesn't work well? [this could be a gap / lack of service, a team, how to access information or help, or anything else that you think that needs improvement]

Key Theme 1 - Access
Many comments highlighted 'access' as being the area of highest concern. Nearly half of the comments received for Question 2 gave feedback about access. Waiting times and access for children and young people all gained the highest criticism.

Key Theme 2 - Shortages – staff and services
Respondents reported various aspects of service where they felt there was a shortage of either staff or services.

Key Theme 3 - Poor communication
Some respondents gave examples of how they felt communication had been poor. Access and lack of information came across as the key areas of concern.

Shortages identified through engagement process:

Staff
- Psychiatrists
- Psychologists
- Nurses
- Mental Health Liaison in A&E
- Mental Health staff across the health system

Service
- Children & Young People's Services
- Voluntary Community Sector
- Drop-in Service
- Bed Availability
- CAMHS Out of Hours
- Personality Disorder Service
- Complex Childhood Abuse Service
- Service for those at risk of offending
- Service for those with a 'medium' mental health need
- Outreach
- Out of hours
- Services for those with multiple diagnoses / health needs

What people told us - what should we focus on?

Question 3 – What do you think the Mental Health Strategy should focus on?

The top five themes that received the most comments were: Improved access, early intervention, children and young people, prevention, and patient-centred care.

"Improving long term care & targeting young children at an early age."

"Making support available, particularly for young people, much more quickly."

"The strategy should focus on mental health support for CYP in schools, colleges, universities. There needs to be support for parents and coping mechanisms so that the child can stay within the family unit."

"Younger children and support to parents."

"Easy quick access to the right support and enough of it."

"Easier and quicker access to services."

"Improving access to community-based mental health services and support, counselling, psychotherapy."

"Access in a reasonable timeframe to all services."

"Prevention to stop mental health moving into crisis."

"Prevention, education, self-help."

"Staying well, prevention."

"Prevention. Maintain good mental health alongside exercise healthy eating etc for all ages."

"Treating clients as individual human beings."

"Helping the individual & getting them settled."

"Individual needs. A good initial assessment and what the patient thinks they think would help and the opportunity to experience 1:1, support group, someone on the end of a phone, online community support etc.to see what they feels helps."

"Using the time they have to focus on a plan of recovery specifically for patients on a one to one basis, rather than the textbook regime."

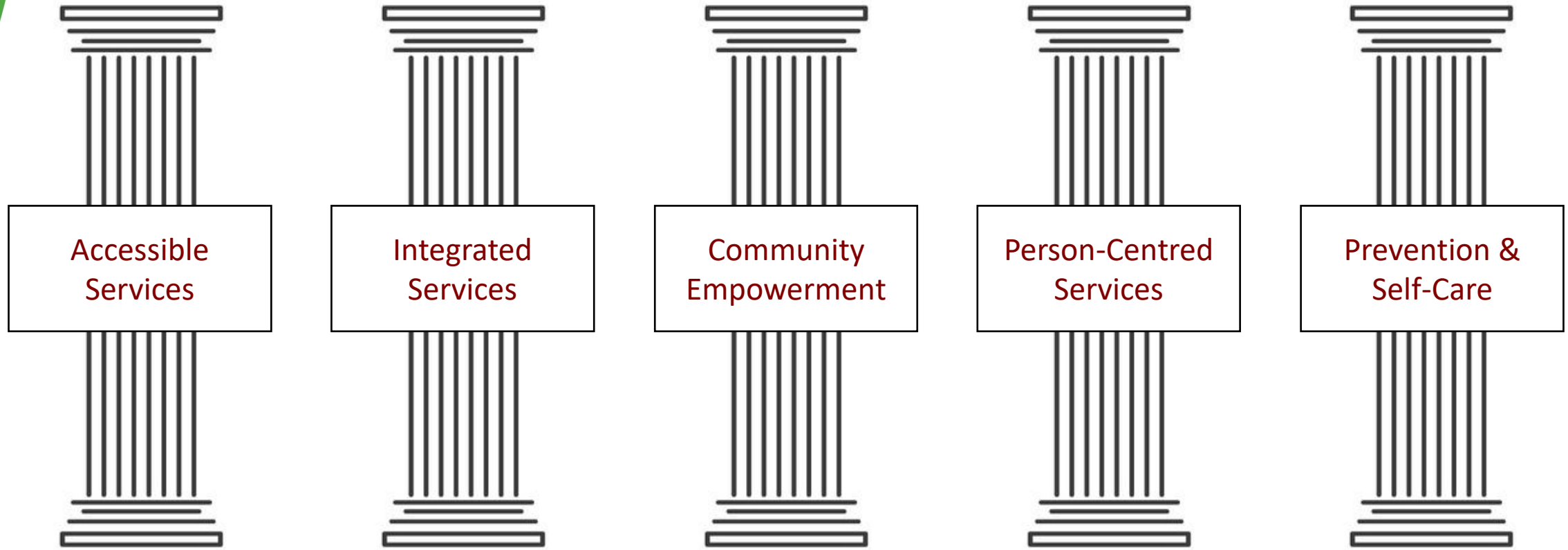
"Early intervention and enough staff to relieve police/A&E and others from responsibility except for reporting"

"Early intervention for any mental condition."

"Early Intervention in Primary and Secondary Schools."

"Early services. Catching people before they get too poorly. Early intervention as the public see it - take pre-emptive action."

Herefordshire and Worcestershire's Vision for Mental Health & Wellbeing



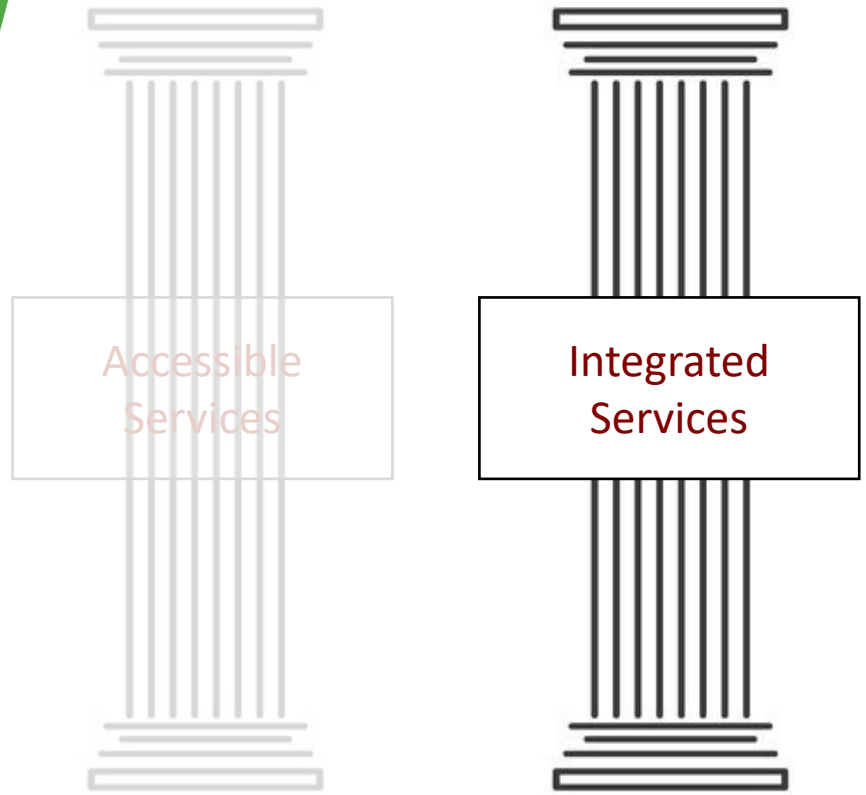
Herefordshire and Worcestershire's Vision for Mental Health & Wellbeing

Accessibility of services was the most frequently talked about issue with mental health services, both positively where particular services are views as accessible and negatively where improvement is needed. Accessibility includes a variety of factors, such as:

- Early Intervention
- Waiting times for a first appointment or assessment
- Waiting times for the start of treatment
- Where a wait is unavoidable, communication from the service during this period
- Thresholds for accessing services
- Transitions from children and young peoples' services, either to wider community networks or to adult services where required
- Barriers to accessing services and reasonable adjustments
- Discharge from services requiring re-referral
- Identified gaps in provision of services

Our aspiration is for mental health services at all levels to be accessible for those who need them, in line with the national aim to move to a 4-week waiting time standard for secondary mental health services. Herefordshire and Worcestershire bid to become, and has been selected as, an Early Implementer site for the Community Mental Health (CMH) Transformation programme which is trialling this. The underlying principle of our proposal for this new model of service was that of inclusivity, seeking to remove barriers to services and based on an assumption of an appropriate offer for all.

Herefordshire and Worcestershire's Vision for Mental Health & Wellbeing



Another key message from public and stakeholder engagement was that many people are 'falling in the gaps' between services. Collaboration between different services is essential to close these gaps and links back to the principle of accessibility of services and removing barriers to services. This was particularly noted for individuals with multiple complex needs such as Autistic Spectrum Condition (ASC), learning disabilities, substance misuse issues and homelessness.

While the investment in mental health services in recent years is valuable and welcomed it is not and can not be the solution for everything, and so much more can be achieved through improved joint working across team and organisational boundaries.

Our ambition is to improve joint-working across organisations through a combination of enablers. These will include moving to an alliance-based model for mental health service provision, targeted investment where necessary for identified groups at risk of falling between services, and supporting the growth and development of the Voluntary, Community and Social Enterprise (VCSE) sector across both counties.

Integration across a range of geographical footprints will also be essential, with mental health and wellbeing services delivered at ICS, county, PCN and community levels, supported by key programmes such as Talk Community.

Herefordshire and Worcestershire's Vision for Mental Health & Wellbeing

Community empowerment is having a mental health aware population. It is about the five ways to wellbeing and preventing mental illness. We want to build on the success of the 'Now We're Talking' campaign in Worcestershire and utilise the Talk Community approach in Herefordshire to continue to expand awareness of mental health and self-care, and promote community asset growth, across both counties.

Community empowerment is also about supporting and empowering our Voluntary, Community and Social Enterprise (VCSE) sector to do more, grow and flourish. There is currently very different infrastructure and capacity within our VCSE across both counties, but a shared goal of supporting the growth of the VCSE across health and local authority organisations in both counties. It will never be possible for commissioners to fund all the activities of the various community organisations across Herefordshire and Worcestershire, nor would this be desirable as it would risk stunting innovation.

Development and growth of supportive communities and the VCSE in Herefordshire and Worcestershire would therefore mean support in a variety of areas, depending on the needs of the organisations in questions, but would focus as much on sustainability and infrastructure as much as direct service delivery. This could include:

- Creating an environment where organisations are encouraged and incentivised to work together
- Build social capital through community asset growth
- Information sharing and awareness raising
- Infrastructure support for small organisations such as standard policies, procedures etc.
- Clinical supervision support
- Sharing of accommodation
- Support to access other funding streams
- Economies of scale for back-office functions
- System-wide training (direct and 'train the trainer')
- Celebrating success

Herefordshire and Worcestershire's Vision for Mental Health & Wellbeing

Another clear message from public and stakeholder engagement was the need for services to wrap around the individual and to prevent patients having to navigate between disparate services, often with no support, which can cause disengagement or deterioration. This extends to carers also, who too often hold the burden of supporting people who are mentally ill with limited support.

This priority links to both accessibility and collaboration above, but goes beyond this to patient choice on when, where and how they wish to receive treatment.

While there is a need to increase the treatment options available where possible, such as expanding the variety of talking therapies available or options available to people experiencing crisis, another important goal is to standardise the treatment offers available across Herefordshire and Worcestershire. To remove the 'postcode lottery' currently in place while continuing to reflect the distinct needs of different localities and communities will be a key challenge of working as an Integrated Care System.

An ambition of this strategy over the next 5 years is to minimise variation in treatment offers across Herefordshire and Worcestershire, continue to expand the treatment and support offers available, and to close the gaps between services through improved collaboration and shared outcomes.

Herefordshire and Worcestershire's Vision for Mental Health & Wellbeing

Linked to all of the above, prevention and self-care for mental health illness in Herefordshire and Worcestershire can provide the best possible outcomes for patients, minimise escalation to acute mental health services, and relieve pressure on secondary services, allowing a faster response for those in urgent need. Though children and young peoples' mental health services are key, prevention and self-care are important across the life course.

The principles of prevention and self care should apply at all levels, from mental health aware communities, to mental health literacy for frontline staff in areas such as housing, right through to self-care skills development and proactive crisis planning for people accessing acute and crisis mental health services.

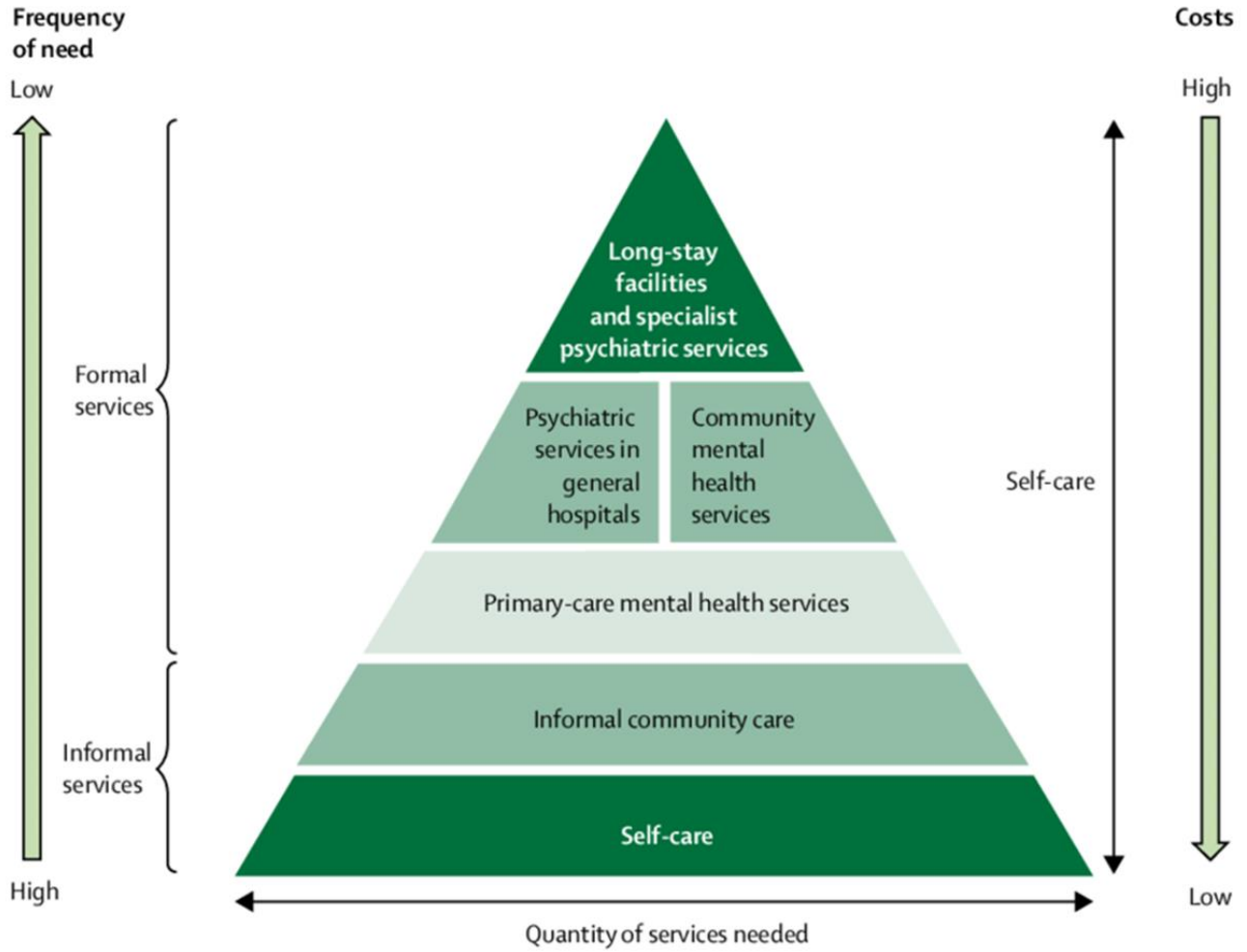
We need to reconfigure funding and services where possible to provide greater focus on prevention, in local communities, to reduce pressure on secondary and acute services, as well as statutory partners. Investment in more preventative services will also help us as a system in terms or recruitment in a challenging environment, and support the growth of the VCSE, while investing in training for frontline staff across statutory and non-statutory partners will help us create mental health aware services more widely. There is a real groundswell of grass routes organisations supporting people with mental health issues, as well as statutory services, who would really benefit from links and training to support the people accessing their services. If we can develop a cohesive network to support these organisations and partners we hope to support and build the resilience of our communities.

Herefordshire and Worcestershire's Vision for Mental Health & Wellbeing

Historically, mental health services have focused more on those with the most acute needs, at the top of the pyramid where frequency of need is lower but costs higher. In recent years focus on the lower tiers of the pyramid of need has increased, but this has largely focused on primary-care mental health services and some inconsistent wellbeing provision across the ICS. To continue this move toward the bottom of the pyramid and preventing mental ill health, there remains much to be done.

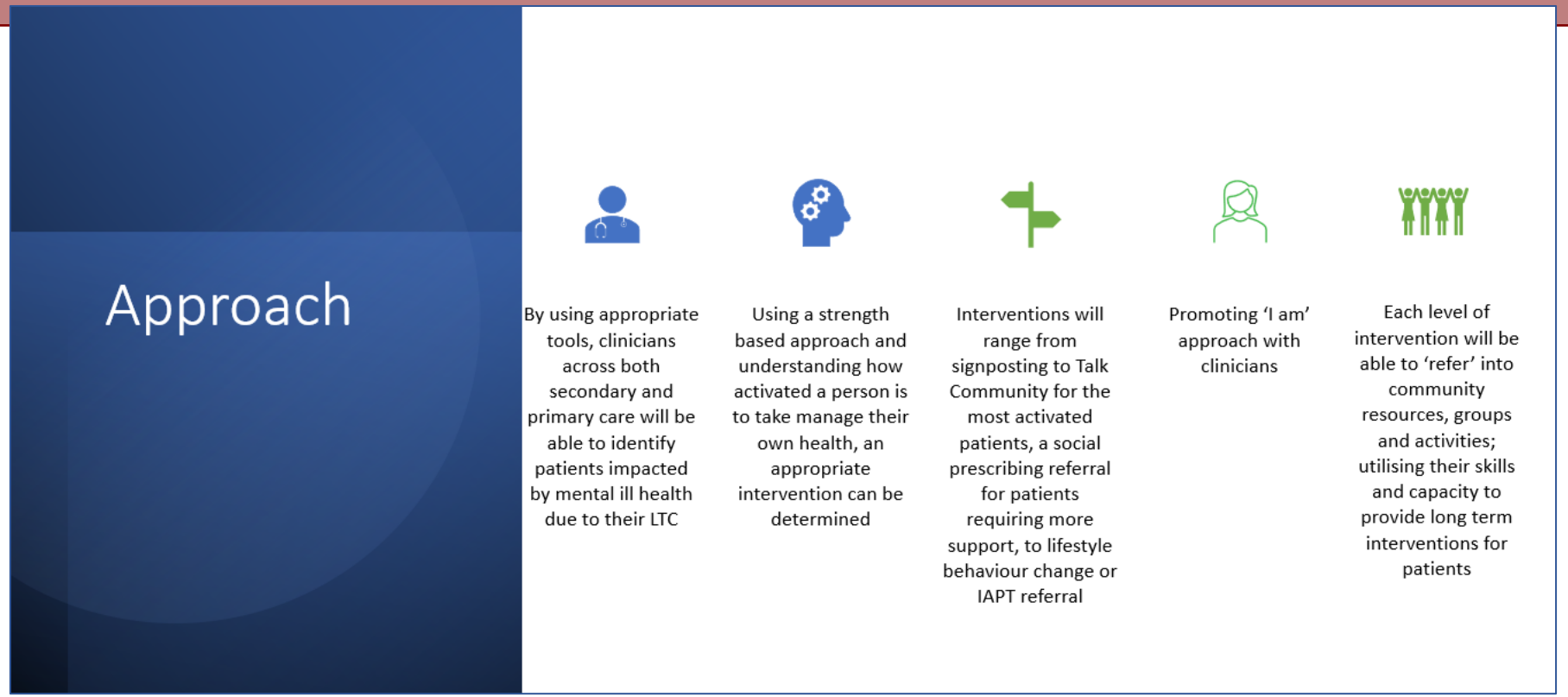
While the majority of the national priorities from the NHS Long Term Plan are rightly focused on increasing resources to and improving secondary care services where specific gaps have been identified, locally there is a real drive to increase wellbeing support, informal community care and self-care options. This has been clear from public engagement events and in some cases is already underway, including Talk Community and Integrated Wellbeing Offer for Worcestershire, as well as the Community Mental Health transformation programme. Mental health is a spectrum and it is important to remember that peoples' mental health can be good or bad, and that it will fluctuate, so self care and learning strategies to support this are essential in preventing mental health from deteriorating.

Transition of resources towards self care and more preventative services will be a gradual process, however this strategy represents a commitment to continue to move investment in this direction.



Herefordshire and Worcestershire's Vision for Mental Health & Wellbeing

Mental health services must not be viewed in isolation, but alongside physical health needs and interventions. While national programmes such as comprehensive physical health checks for people with a severe mental illness rightly focus on the disparity in physical health and premature mortality, the reverse must also be considered. People with physical health illnesses, particularly long term conditions, are also more likely to experience poor mental health. A community wellbeing approach is being developed in Herefordshire to improve mental health support for people with long term conditions, ranging from self-care and community provision utilising the Community First model, to social prescribing and lifestyle advice, to clinical mental health services such as IAPT (Healthy Minds). This community wellbeing approach will utilise the principles below, with an emphases on consistent screening, understanding care pathways and education.



Herefordshire and Worcestershire's Vision for Mental Health & Wellbeing

In order to expand provision and support for self-care and informal community care, we want to utilise a community-centred approach to enhance individual and community capabilities, and support the many community health assets already in place to grow and flourish.

This will mean working closely with community organisations to co-create resources and services that can support people before they become mentally ill, on the principle that prevention is always better than cure. Such an approach, aligned to the principles of 'anchor organisations', will require joint-working across statutory and non-statutory services, NHS and local authority, and utilises a 'family' of approaches including:

- Strengthening communities
- Volunteer and peer roles
- Collaborations and partnerships
- Access to community resources
- ABCD approach for community development projects

Who we spoke to

Following the successful engagement sessions in October 2019, two follow up engagement sessions were coordinated on the 27th Feb 2020 and 5th March 2020 to further discuss the ICS mental health strategy.

The purpose of these sessions were to give attendees an opportunity to voice their opinions on the first draft on the Mental Health strategy and how to develop it further.

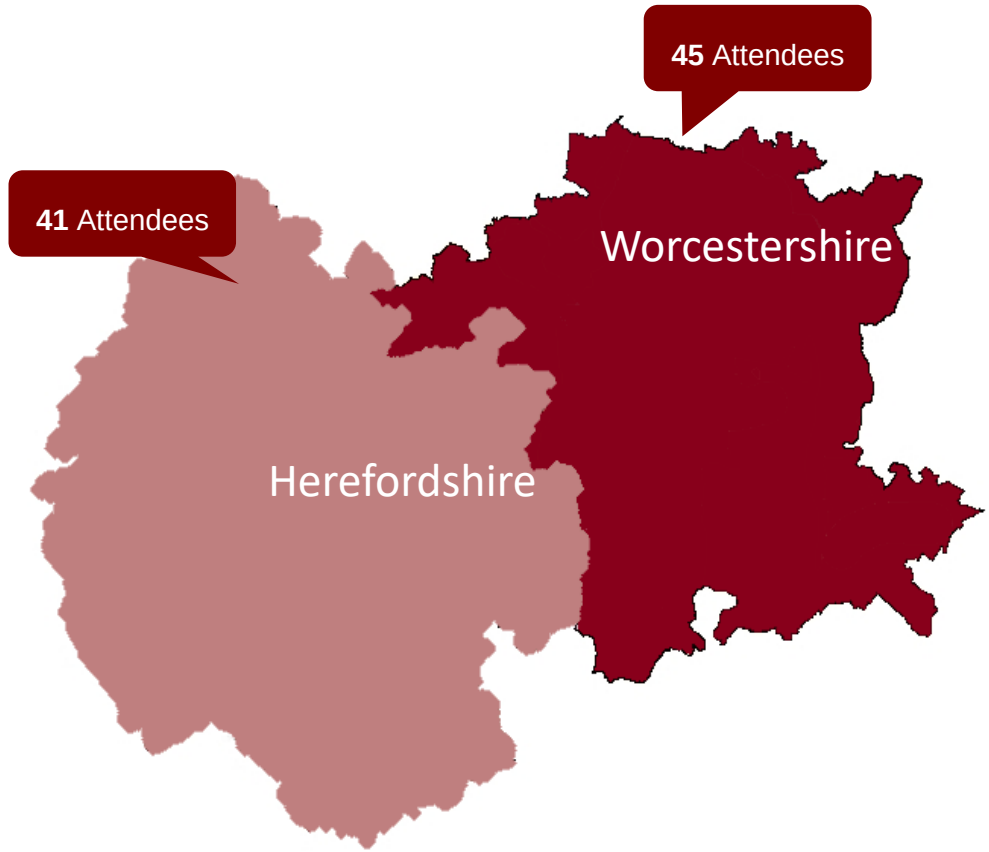
Attendees were asked to participate in the 2 following exercises:

Exercise 1 -
Focus on the 5 pillar themes and discuss:

- *What can be done in each area to move this forward*
- *What would enable these themes' success?*

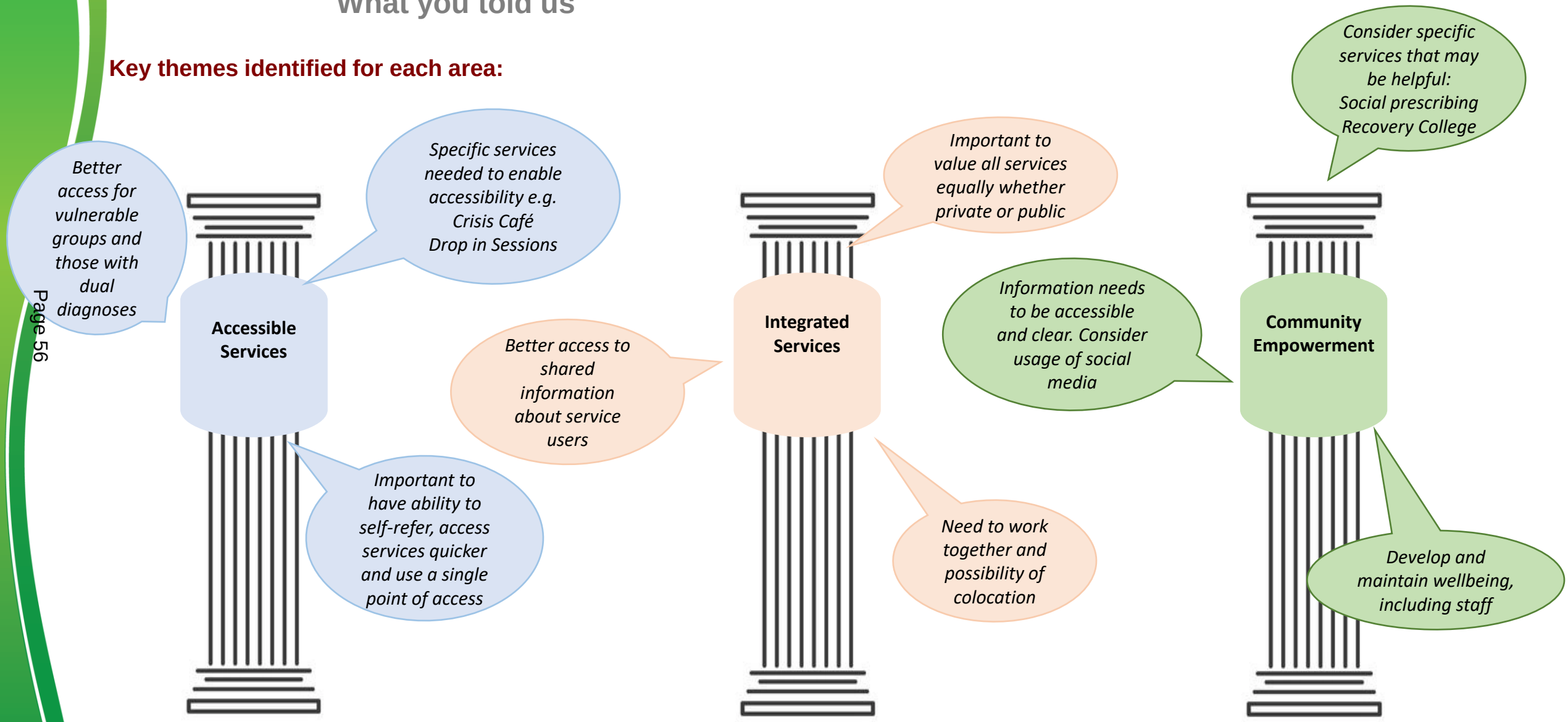
Exercise 2 -
Priorities and timeline plotting:

- *Choose top 3 priorities for each pillar*
- *Plot the priorities on a timeline, in order of what should be achieved in terms of urgency*



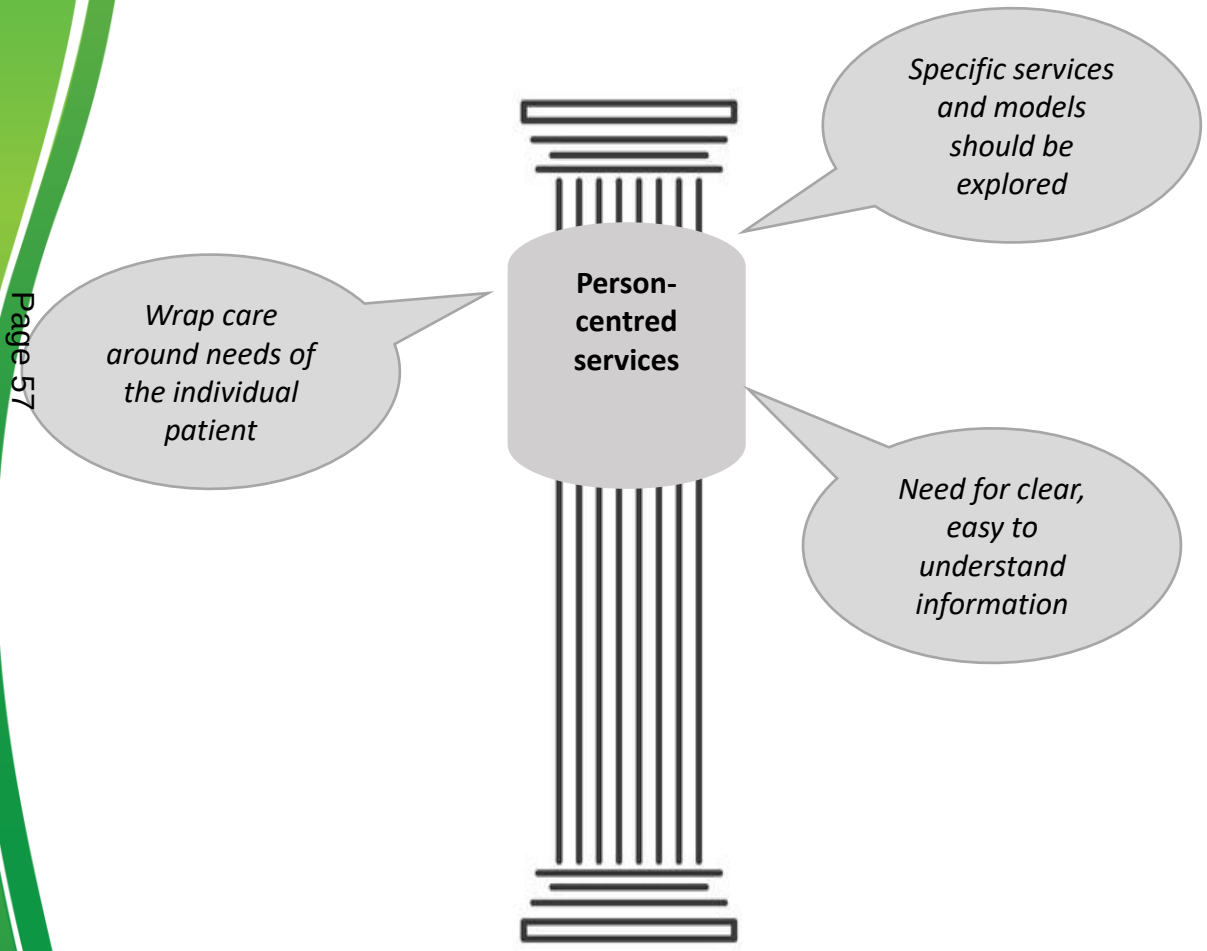
What you told us

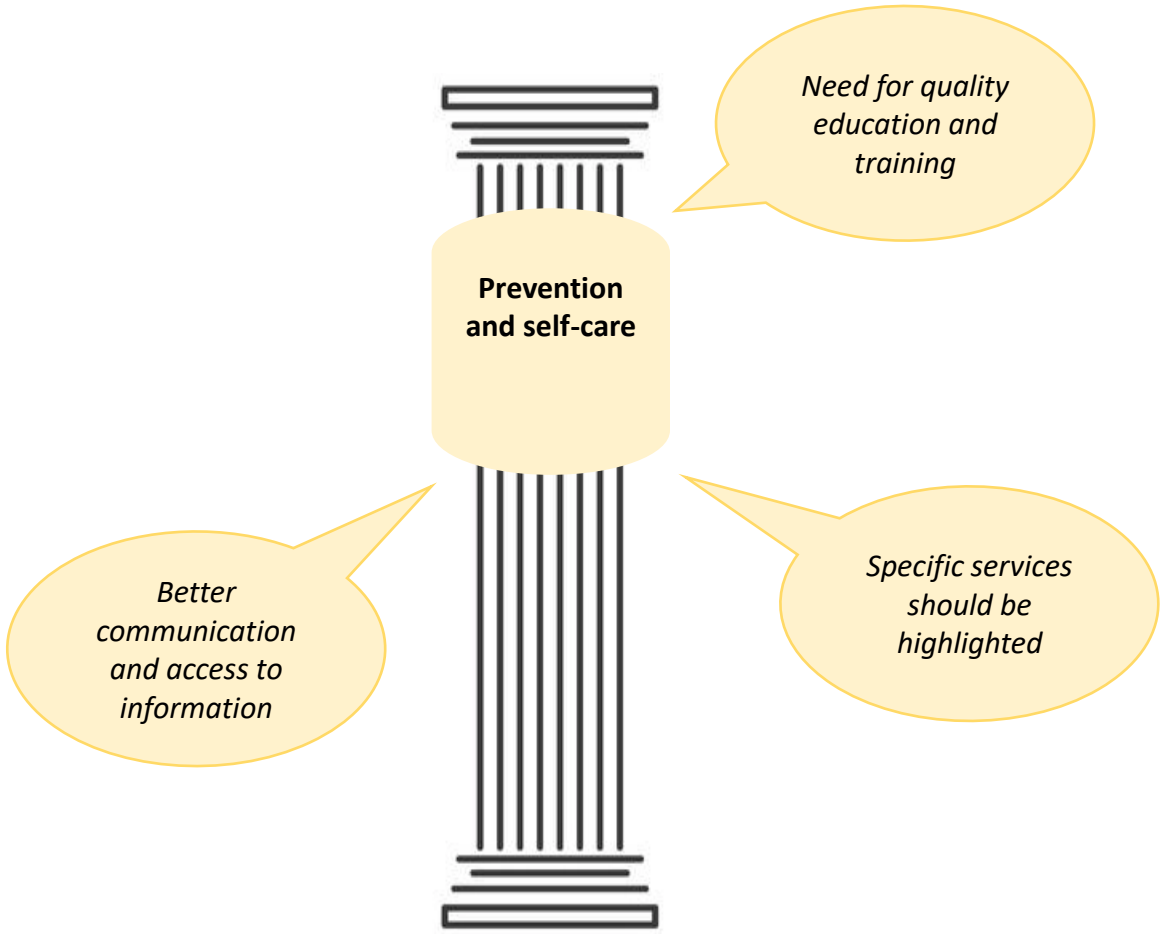
Key themes identified for each area:



What you told us

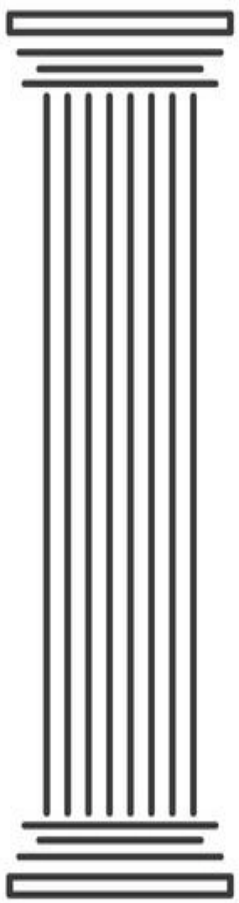
Key themes identified for each area:



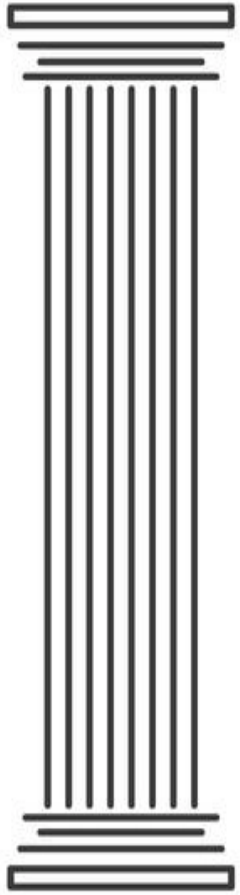


What you told us

Priorities identified:

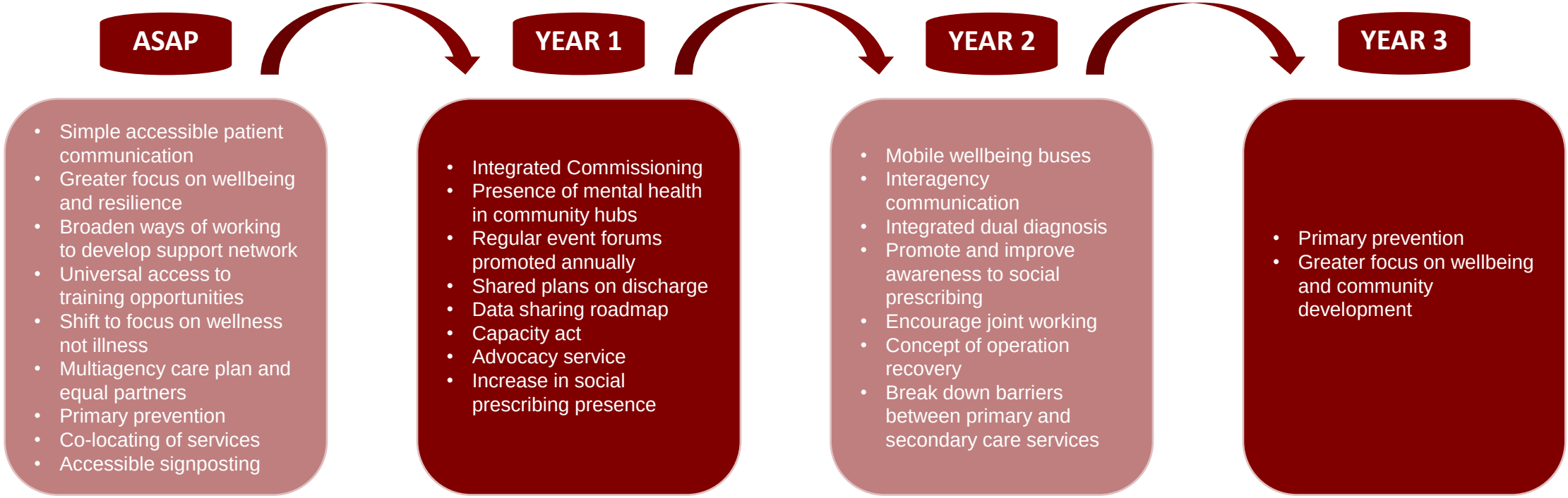


Theme	Priorities
Accessible services	- Video consultations - Recovery college - Improved Information sharing - Increase of community based support i.e. drop-ins
Integrated services	- Co-locating services - Outcome framework - Shared discharge plans - Integrated dual diagnosis
Community empowerment	- Encouragement of joint working - Promotion of social prescribing - Outreach
Person-centred services	- Opportunity for face to face assessments - Create culture of greater compassion - Flexibility in interventions
Prevention and self-care	- Raise awareness of services to dispel stigma - Social media campaigns - Recovery and reablement approach



What you told us

Suggested timeline of priorities from co-production events:



These suggestions will be taken forward through a variety of means, including existing transformation programmes, upcoming change projects such as the VCSE alliance approach work (see local plan for mental health and wellbeing below), and the Mental Health Inequalities Board.

The National Vision for Mental Health & Wellbeing

2021-22	2022-23	2023-24
24/7 crisis provision for CYP which combines crisis assessment, brief response and intensive home treatment functions.	Improved therapeutic offer for inpatients to improve outcomes and experience, and deliver average length of stay of 32 days	Extended period of care, partner assessment and increased psychological therapies in place for perinatal patients
Establish Maternity Outreach Clinics / Maternal Mental Health Services (MMHS)	CYP MH plans aligned with those for learning disability, autism, SEND, children and young people's services, and health and justice	Support roll-out of national programme for health professionals working in ambulance control rooms
Establish 24/7 Mental Health Liaison across all acute hospitals	Comprehensive 0-25 support offer that reaches across mental health services for CYP and adults	24/7 crisis care to be in place for via NHS 111
24/7 crisis provision in place for children and young people		
Community Mental Health (CMH) Transformation Wave 2		
Early Intervention Service to achieve NCAP/CCQI Level 3 Standard		

The National Vision for Mental Health & Wellbeing

2021-22	2022-23	2023-24
Minimum of 733 women accessing community based perinatal mental health treatment	Minimum of 1,017 women accessing community based perinatal mental health treatment	Minimum of 1,301 women accessing community based perinatal mental health treatment
Minimum of 4,937 children and young people receiving treatment from an NHS-funded community mental health service	Minimum of 5,459 children and young people receiving treatment from an NHS-funded community mental health service	Minimum of 6,265 children and young people receiving treatment from an NHS-funded community mental health service
Minimum of 3,366 people with serious mental illness receiving physical health checks	Minimum of 3,856 people with serious mental illness receiving physical health checks	Minimum of 4,347 people with serious mental illness receiving physical health checks
Minimum of 19,089 people starting IAPT treatment	Minimum of 21,541 people starting IAPT treatment	Minimum of 23,658 people starting IAPT treatment
Minimum of 1,696 adults and older adults accessing integrated models of primary and community mental health care	Minimum of 3,464 adults and older adults accessing integrated models of primary and community mental health care	Minimum of 4,991 adults and older adults accessing integrated models of primary and community mental health care
Minimum of 429 adults accessing Individual Placement Support (IPS) services	Minimum of 592 adults accessing Individual Placement Support (IPS) services	Minimum of 742 adults accessing Individual Placement Support (IPS) services

Major programmes

Community mental health (CMH) transformation

In 2019 Herefordshire and Worcestershire was selected as one of 12 Early Implementer sites nationally to transform adult community mental health services in line with the new national framework. The transformation is taking place across approximately half the ICS, based on Primary Care Network footprints, with the new service set to expand to remaining PCNs in October 2021.

The vision for the new service model is to:

- Dissolve the barriers between primary and secondary care
- Be based on cross-sector collaboration, including increased VCSE resource
- Create and improve flexible, easy and clear means of access
- Maximise continuity of care
- Ensure there is no cliff-edge of lost care and support, moving away from current approaches based on referral and discharge
- Ensure timely access by testing 4-week waiting times from initial contact to appropriate care (and testing what appropriate care means)
- Adopt a principal of inclusivity as opposed to exclusions
- Increase access for people who currently fall through the gaps

PCNs trialling the new model for CMH

Herefordshire	Worcestershire
E Herefordshire	Wyre Forest HP
Hereford City	Wyre Forest NIP
Hereford Medical Group	The Rurals
N & W Herefordshire	Malvern Town
S&W Herefordshire	

In addition to the revised ‘core’ model above, further work is underway through the transformation to develop local Eating Disorders and Complex Needs services, to strengthen delivery in these areas.

Major programmes

Mental health support teams (MHST) in schools

In 2020 Herefordshire and Worcestershire successfully bid for national transformation funding to deliver mental health support teams in schools, a national initiative laid out in the NHS Long Term Plan. MHST in schools provide early intervention for mental health and emotional wellbeing issues, such as mild to moderate anxiety, as well as helping staff within a school or college setting to provide a 'whole school approach' to mental health and wellbeing. The teams act as a link with local children and young people's mental health services, supervised by NHS staff.

Four MHST are being established within the ICS, made up of senior clinicians and Education Mental Health Practitioners (EMHPs), and will:

- Work within the mental health supports that already exist, such as counselling, educational psychologisy, school nurses, pastoral care, educational welfare officers, VCSEs, local authority provision and NHS CYPMH services.
- Be responsible for a defined cluster or group of education settings, building a relationship with each, including the senior mental health lead.
- Work with each setting to scope out and co-design the support offer required.
- Work to ensure that the support offer reflects the needs of children and young people and education settings using clearly established expectations and ways of working that fit with the setting and the local system.

Wyre Forest MHST

Primary and High Schools

Rural Worcestershire MHST

High Schools

Redditch MHST

Middle and High Schools, Special School and PRU

Herefordshire MHST

High Schools, Special Schools and PRUs

National Enablers

There are several projects underway or to be undertaken nationally that will act as key enablers to service change and improvement. These form part of the NHS Long Term Plan, and include:

Data Quality
Under the NHS Long Term Plan, providers are required to be compliant with national data quality requirements including MHSDS, DQMI, SNOMED CT and patient-level costing. Having robust, high quality data aids decision-making and ultimately, better services.

Provider Collaboratives
The NHS Long Term Plan requires mental health providers to form collaboratives to take on budget and pathway management for specialist services. These include adult low and medium secure services, CYP inpatient services, and adult eating disorder specialised services, but are expected to expand to additional areas. These are distinct from the local Mental Health Collaborative within the Herefordshire and Worcestershire ICS, often covering a wider geography for more specialist services.

Digitisation
Another NHS Long Term Plan priority is the development of a wider range of self-management apps, consultations, digitally-enabled models of therapy, and digital clinical decision-making. With a Global Digital Exemplar as mental health provider within Herefordshire and Worcestershire, and an award-winning app for children and young people (BESTIE), we have a strong foundation to build on to further enhance our digital offer for people experiencing mental health difficulties.

Mental Health Investment Standard (MHIS)
The Mental Health Investment Standard, previously known as Parity of Esteem, is the requirement for NHS Clinical Commissioning Groups to increase investment in mental health services in line with their overall increase in allocation each year. Under the NHS Long Term Plan, all CCGs are required to achieve the MHIS for at least the next 5 years covered by this strategy.

Local Enablers

In addition to national projects, a variety of local programmes are already in place or being planned that can support the aims of mental health services across the ICS, and with which this strategy will seek to dovetail:

Integrated Wellbeing Offer

The Worcestershire IWO aims to bring together the many assets and services that offer “lower level” support for wellbeing and health to form a comprehensive, holistic pathway through services, where people can access and move between the services and support they need.

Having good health and wellbeing depends on a wide range of factors. We need to address all these factors that protect and create health and wellbeing, including those at community level, to achieve positive health outcomes for Worcestershire.

Building on the response to Covid19, we want to grow an integrated and enhanced health and well-being offer that promotes early intervention and prevention to best meet peoples’ needs, improve health and wellbeing, and reduce inequalities.

Now We're Talking

Now we’re talking is a mental health campaign, launched in 2018, to encourage communities to talk about and seek support when experiencing mental health difficulties.

The campaign aims to raise awareness of mental health issues, fight stigma, and support people to open up and talk about mental health while promoting self-care.

While originally focused on the Healthy Minds (IAPT) service, it has recently expanded to focus on parents’ mental health and children's mental health. Our ambition is to build on the strong foundations in place by continuing to expand this campaign, as a means to broaden awareness around mental health and self-care, to support the drive toward self-care, prevention and early intervention.

Talk Community

Talk Community is a system wide partnership approach focused on managing demand by linking three fundamental elements that promote and maximise independence and wellbeing within Herefordshire’s communities.

Talk Community therefore focuses on the strengths of people and communities; the place and space which those communities occupy; and the economy in which those communities work.

At the heart of Talk Community is a culture and ambition to make independence and wellbeing for Herefordshire citizens inevitable.

The Talk Community approach, and the philosophy it engenders, can be a major vehicle to support the expansion of mental health and wellbeing support, raise awareness, and support the empowerment of local communities to maximise prevention, self-care and independence.

The Plan for Mental Health & Wellbeing

2021-22	2022-23	2023-24
Worcestershire multiagency pathway and collaborative commissioning arrangements for assessment and diagnosis of children with Autism Spectrum Condition to be implemented in Herefordshire.	Review of existing and potential complimentary crisis care alternatives across the ICS, including for CYP.	Establish additional crisis alternative provision, based on local need and co-production approach.
Review and redevelopment of mental health VCSE provision across Herefordshire and Worcestershire.		Move to alliance-based model of provision for mental health services across the ICS.
Review care pathways for Looked After Children, children and young people subject to a child protection plan, and children with ADHD.	Establish system-wide approach to career development, support and training for Peer Support workforce.	
Commission Qwell online mental health support and advice portal across ICS, and Mental Wellbeing service in most deprived schools in Worcestershire (where MHST not in place)	Length of hospital admissions and delayed transfers of care to be reduced for children and young people.	
Consistent service models to be established across Herefordshire and Worcestershire, following move to a single NHS provider.		
Establish ICS Mental Health Inequalities Board to address health inequalities across system, including those exacerbated by COVID	CAMHS waiting times to be reduced utilising Quality Improvement methodology and best practice across two counties and nationally.	
Needs assessments to be undertaken focusing on: • Mental Health • Employability among vulnerable groups • Sexual abuse and trauma	New Drugs and alcohol strategy to be developed for Worcestershire in line with Dame Carol Black review recommendations, including increased training and integration with mental health services.	
Patient Shared Care Record to be developed to provide up to date information for patients and clinicians across organisations	Develop a model of care that will provide rehabilitation, or reduce the need for admissions, for young people who require more intensive support.	

COVID response for Mental Health & Wellbeing

Almost all mental health services in Herefordshire and Worcestershire were maintained throughout the pandemic, with only limited redeployments to support key services such as the 24/7 crisis line. As the impact of the pandemic on peoples' mental health became clear, recovery and restoration planning focused on expanding capacity of services wherever possible. As many of the mental health priorities within the NHS Long Term Plan are focused on expanding provision, many of these ambitions have subsequently been brought forward from 2022-23 to 2021-22 to support with increased demand.

Phase 1: Response

- 24/7 mental health crisis line established
- Systems put in place to segregate COVID positive inpatients. Closure of one older adult mental health ward and set up of hospital at home provision
- Proactive contact and support approach adopted to ensure patients on caseload were supported through first national lockdown
- Single Points of Access established for each county for help and support

Phase 2: Recovery

- Preparation for longer term increase in demand for mental health services, including actively recruiting in line with NHS Long Term Plan
- Establishment of enhanced psychological support for health and social care staff, including process to ensure BAME staff were considered and protected
- Ensuring 24/7 mental health crisis line is made permanent and sustainable
- Review of interagency suicide prevention plans for each county

Phase 3: Restoration

- Re-establishment of transformation programmes including crisis alternative services, mental health support teams in schools, 24/7 psychiatric liaison and phase 2 of the community mental health transformation.
- Early implementation of NHS Long Term Plan ambitions including CYP crisis resolution and home treatment services and increasing access to psychological therapies.
- Recovery trajectories in place for services impacted by COVID (e.g. physical health checks for people with severe mental illness

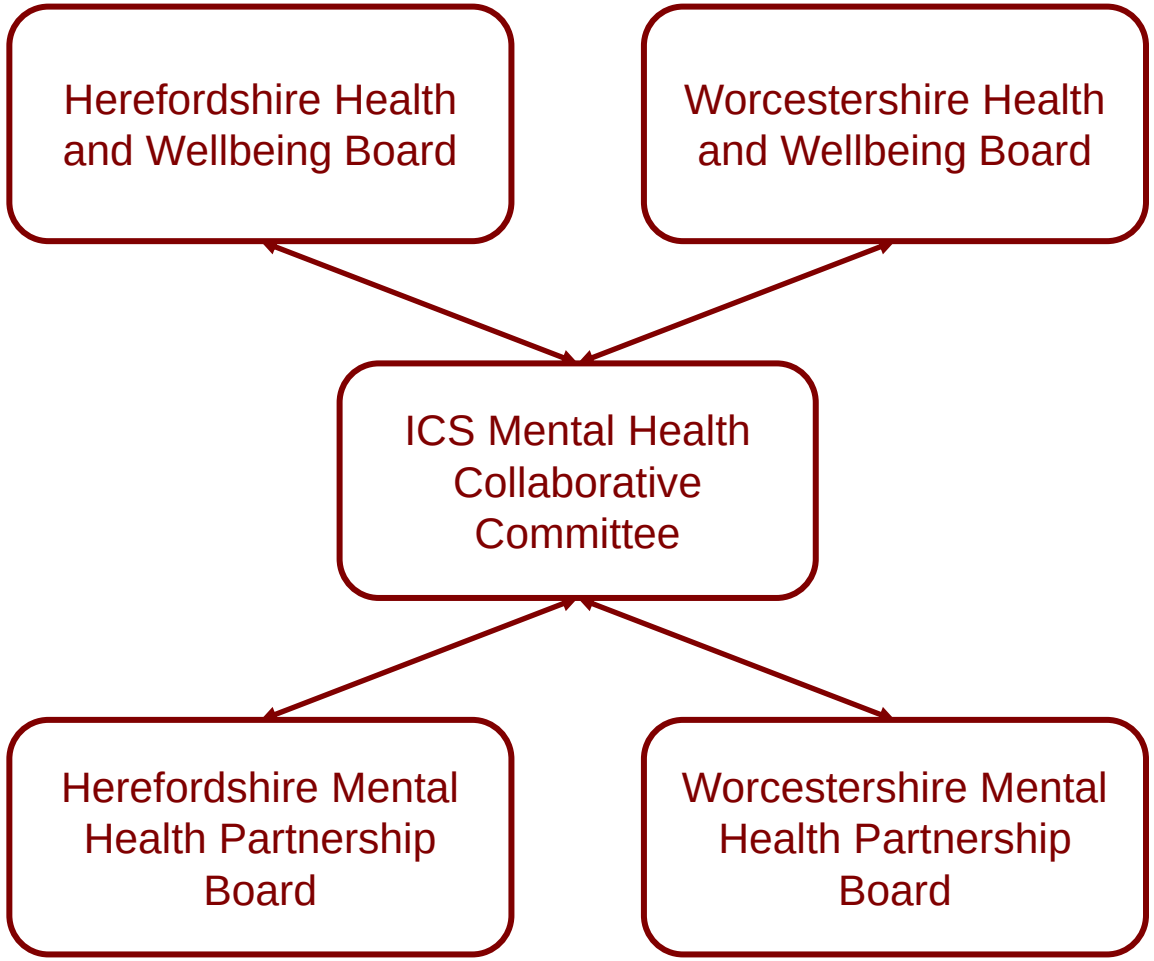
Delivery and accountability

From October 2021 the ICS Mental Health Programme Board will take on the broader remit of the ICS Mental Health Collaborative Committee. This committee will oversee delivery of the strategic aims within this strategy.

The Mental Health Collaborative Committee will work closely with the Health and Wellbeing Boards in both counties, to ensure strong links between mental health and broader wellbeing services are maintained and built upon.

In Herefordshire there is an established Mental Health Partnership Board, comprising broad system partners and Experts by Experience, which will continue to be utilised to drive collaboration on key workstreams.

In Worcestershire a similar county-level Mental Health Partnership Board will be established to fulfil the same role, ensuring a local voice for partners and Experts by Experience.



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AGENDA ITEM 9

HEALTH AND WELL-BEING BOARD
28 SEPTEMBER 2021

DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT

Board Sponsor
Councillor Karen May, Cabinet Member with Responsibility for Health and Well-being

Author
Dr Kathryn Cobain, Director of Public Health

	(Please click below then on down arrow)
Priorities	
Mental Health & Wellbeing	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
Decision

Recommendation

1. **The Health and Well-being Board is asked to note and support the findings of the 2020/21 Director of Public Health Annual Report and to agree to endorse the recommendations stated within.**

Background

2. Directors of Public Health have a statutory requirement to write an independent annual report on the health of their population and the Local Authority is required to publish it. The Director of Public Health Annual Report is a vehicle for informing local people about the health of their community, as well as providing information for decision makers in local health services and authorities on health gaps and priorities that need to be addressed.

The Director of Public Health Annual Report 2020/21

3. The theme of this year's Director of Public Health Annual Report, attached in draft at **Appendix A**, is the role of Primary Care in prevention, population health and narrowing health inequalities.

4. The Director of Public Health Annual Report considers opportunities to improve health and well-being through Primary Care in Worcestershire. This was considered a key area of the health and social care system to focus on, given its important role in ill-health prevention and the unique positioning which enables it to have a positive impact on health inequalities; the significance of which has been highlighted over the past year as a result of COVID-19.

5. The Director of Public Health Annual Report describes how Primary Care services have adapted through the pandemic, and how we access them and the wider services they act as a front door to. It makes recommendations to maximise the role of Primary Care in prevention and population health, to focus on places and assets as we move to a future where we live with COVID-19, tackle the health inequalities that have been exposed, and work together with our communities and partners, as part of new local Integrated Care Systems (ICS).

Dissemination

6. The Health and Well-being Board is asked to consider how the partner organisations represented by its members might best endorse, and respond to, the recommendations of the report.

7. A marketing and communications plan will be prepared to ensure Director of Public Health Annual Report is communicated widely with partners across the health and care system, and Worcestershire residents.

Legal, Financial and HR Implications

8. Every Director of Public Health must produce an annual report. This is a statutory requirement and must be complied with.

Privacy Impact Assessment

9. Not applicable.

Equality and Diversity Implications

10. 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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Specific Contact Points for this report
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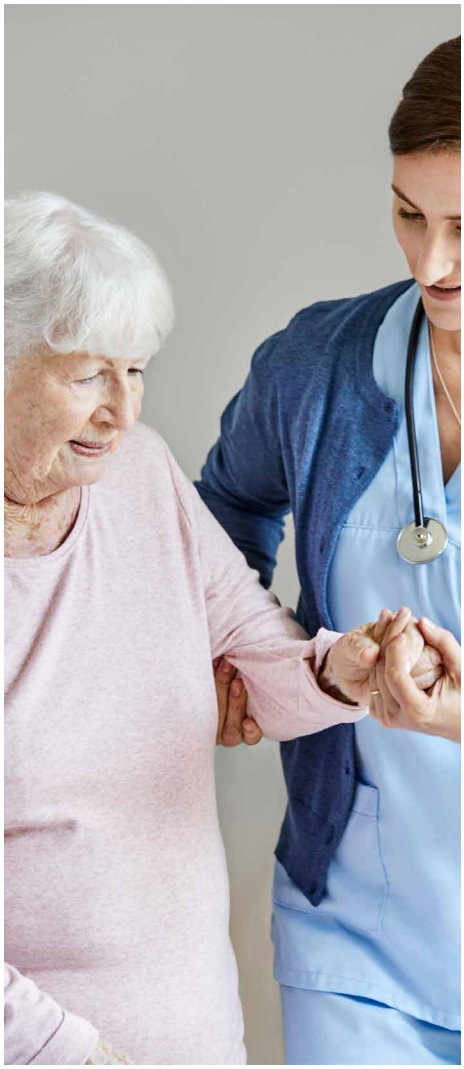
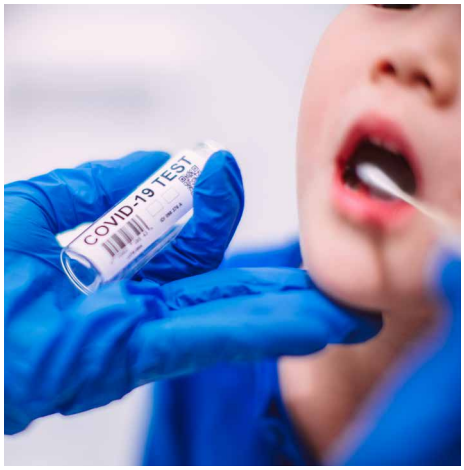
Supporting Information

- **Appendix A** – draft Director of Public Health Annual Report 2020/21





Director of Public Health Annual Report

The Role of Primary Care in Prevention, Population Health and Narrowing Health Inequalities.

2020-2021

worcestershire county council

Contents

Foreword

As the new Cabinet Member with responsibility for Health and Wellbeing in Worcestershire, I am delighted to introduce this annual report of the Director of Public Health. I wish to thank Councillor John Smith for all his hard work during this last year and for championing health and wellbeing during his term as Cabinet Member with responsibility for Health and Wellbeing.

This has been an unprecedented and challenging year, but I am excited to take on this role and build on the many achievements and challenges presented during the pandemic. I look forward to developing the relationships forged together in tackling COVID-19 and continue the focus on improving health and wellbeing. I am aware of the challenges ahead as we work to recover from the pandemic and look forward to working with Kathryn and the team.

Councillor Karen May
Cabinet Member with responsibility for Health and Wellbeing

Overall, health in Worcestershire is good, but we know there are areas where we still struggle with poorer health outcomes for our communities. As a GP and Clinical Director in Redditch, I am really pleased that this year's annual report from the Director of Public Health shines a spotlight on Primary Care. The report highlights well the role and contribution of Primary Care in prevention, and how by working better together we can maximise its impact in improving health, wellbeing and inequalities.

Dr Jonathan Wells
Clinical Director Kingfisher PCN, Redditch

"A stronger focus on prevention across all services can improve the health and wellbeing of all Worcestershire residents and narrow health inequalities".

Dr Kathryn Cobain
Director of Public Health

Executive Summary

Introduction

In March 2020, life for our residents changed dramatically with the arrival of a global pandemic. Public Health officials were faced with unprecedented challenges, which have tested resources, knowledge and skills. The pandemic also starkly highlighted the prevalence of health inequalities in our communities.

Much has been written on the negative impact of the pandemic and on the implications for the health of our communities in the longer term. None of this can be underestimated, but the pandemic has also been an opportunity for improvement, growth and greater awareness for Public Health teams and the wider agencies they work alongside.

Primary Care services are at the heart of this shift. The services have adapted and flexed throughout the pandemic, to continue to have a positive impact on ill-health prevention and improving health inequalities. This report will explore those changes, the impact and lessons to be learned and suggest how we can continue to work with our communities to grow this legacy.

Issues

Prevention is better than cure. But how do we reach communities who face the greatest discrepancies in their health and quality of life? Before COVID-19 there was already a persistent gap in life expectancy and in the number of years people live in good health between the most and least affluent areas. The pandemic has both revealed the extent of the 'health gap' and appears to have increased it. Disruption to children's education, unemployment, food poverty, and mental ill-health are all more apparent and visible. The higher number of COVID-19 deaths among people from certain ethnic minorities has started to uncover the burden of risk factors experienced by ethnic minority communities leading to worse outcomes. The 'gap' is expected to widen further following the pandemic lockdown periods and this has brought health inequalities to the fore.

It has also brought further recognition that the NHS cannot do this alone. The escalating problems need a wholly different approach. All local partners have a role to play, the best outcomes will be achieved when PCNs join other local partners in getting behind community led efforts to address the issues in the long-term. The developing District collaboratives as part of the ICS model also provide that opportunity.

Recommendations

There are a number of key factors to help us as learn the lessons from the pandemic and find better ways to serve our communities. These are set out in detail in this report, with clear steps we can take to ensure success but the main factors are;

- Maximise Primary care in preventing illness
- Create healthy places and stronger communities able to help themselves
- Focus on physical and mental wellbeing in our deprived communities and amongst people who traditionally have experienced poorer health outcomes
- Use the learnings from Covid-19

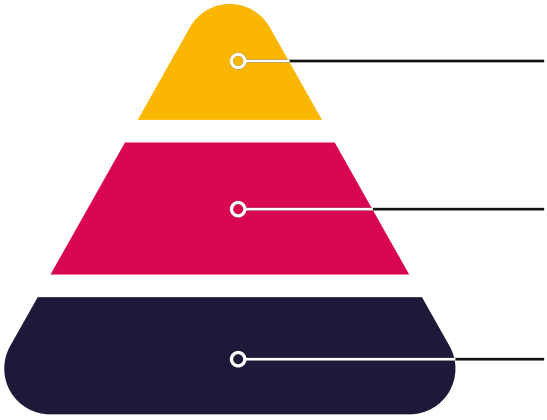
The report makes recommendations to maximise the role of Primary Care in prevention and population health, to focus on places and assets as we move to a future where we live with COVID-19, tackle the health inequalities that have been exposed, and work together with our communities and partners, as part of new local Integrated Care Systems (ICS).

Public Health Principles

Prevention Pyramid

There is strong evidence that it is better and cheaper to prevent problems before they arise. In short, that **prevention is better than cure**. Prevention includes a wide range of activities aimed at reducing risks or threats to health.

Primary prevention aims to prevent disease or ill health before it ever occurs. Secondary prevention aims to reduce the impact of a disease or ill health that has already occurred. Tertiary prevention aims to soften the impact of an ongoing illness or disease that has lasting effects.



Tertiary Prevention:
Improve quality of life and reduce further complications

Secondary Prevention:
Detect disease early and prevent it from getting worse

Primary Prevention:
Prevent ill health, often at a population scale

Health Inequalities

There is a social gradient to life expectancy. People living in more deprived areas are more likely to experience ill health and have shorter lives than those who live in more affluent areas. Health inequalities also exist between genders and different ethnic minority groups, and wider aspects of inclusion, including people who have a disability and people experiencing problems with drugs and alcohol, poor mental health, and homelessness.

Worcestershire Average:

Life expectancy average at birth for people living in Worcestershire is higher than the England average, but there are large differences between the average and most deprived females and males in Worcestershire.

Worcestershire LEAST deprived:

Worcestershire MOST deprived:

Females who live in the most deprived areas of Worcestershire have a life expectancy of 5.1 fewer years than those who live in least deprived areas. For males, there is a difference of 7.5 years.

COVID-19 has highlighted inequities in our communities, and it is likely that the longer term economic and social impacts will affect some communities for an extended period.

Inverse Care Law

People who are in least need of health services tend to use them more often and more efficiently than those in most need of health care services. First described in 1971[1], the inverse relationship between the use of healthcare and the need for it is due to a range of factors, including:

- barriers to accessing services;
- differences in the perception of risk and good health in different socio-economic groups; and
- lower availability of care in deprived areas.

Wider Determinants of Health

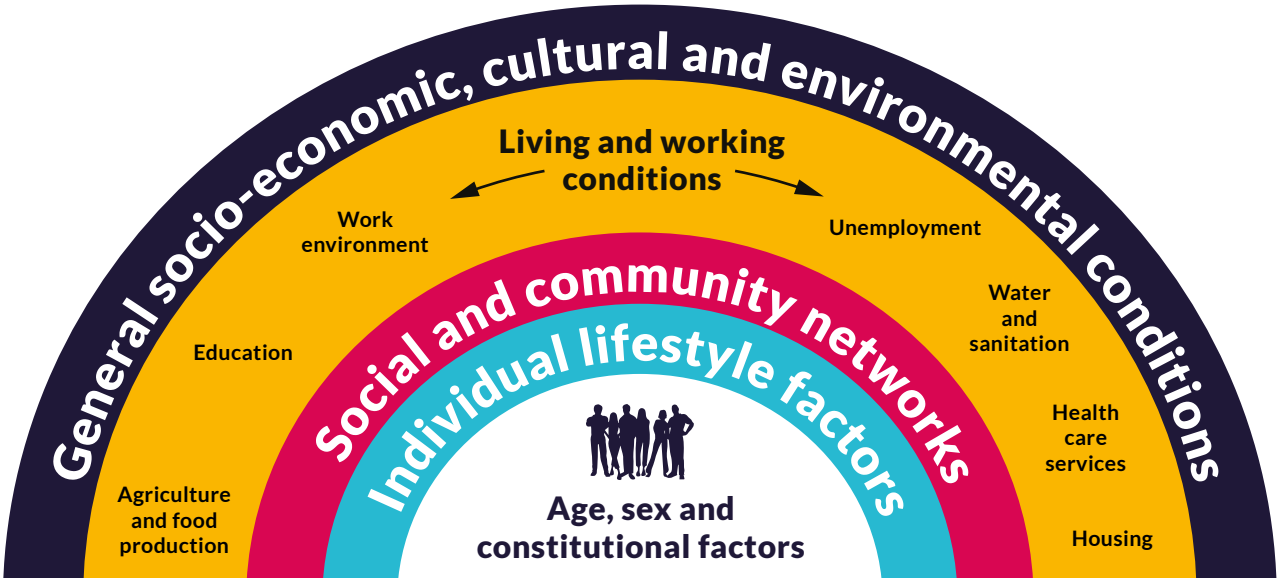
Our health is determined by our genetics, our lifestyle, the health care we receive and the impact of wider determinants such as our physical, social, and economic environment. Although estimates vary, it is accepted that the wider determinants have the largest impact on our health outcomes and only up to 20% of a person's health outcomes are attributed to the ability to access good quality health care. The wider determinants of ill health not only increase the likelihood of illness, but also reduce the likelihood of accessing treatment.

40% **Socioeconomic factors**
Education, employment, income, family & social support, community safety.

10% **Physical Environment**
Housing, access to green space, air quality.

30% **Lifestyle factors**
Diet and physical activity, tobacco use, alcohol use.

20% **Health Care**
Access to good quality health care services.



Source: Dahlgren and Whitehead, 1991

1 Tudor Hart (1971) The Inverse Care Law, The Lancet

Population Health

Substantial improvements in life expectancy over the past 100 years mean that people are living longer, healthier lives than ever before. However, as a nation we lag behind other countries on many key health outcomes, improvements in life expectancy have stalled and health inequalities are widening. To address this, we need to move away from a system just focused on diagnosing and treating illness towards one that is based on promoting wellbeing and preventing ill health.

Population health is an approach that aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population. A population health approach is centred on **four pillars**:

A population health approach can be tackled at scale through General Practice and the developing Primary Care Networks (PCNs).

Proportionate Universalism

Proportionate universalism is the resourcing and delivery of universal services at a scale and intensity proportionate to the degree of need. Services are therefore universally available, not only for the most disadvantaged, and are able to respond to the level of presenting need.

Primary Care

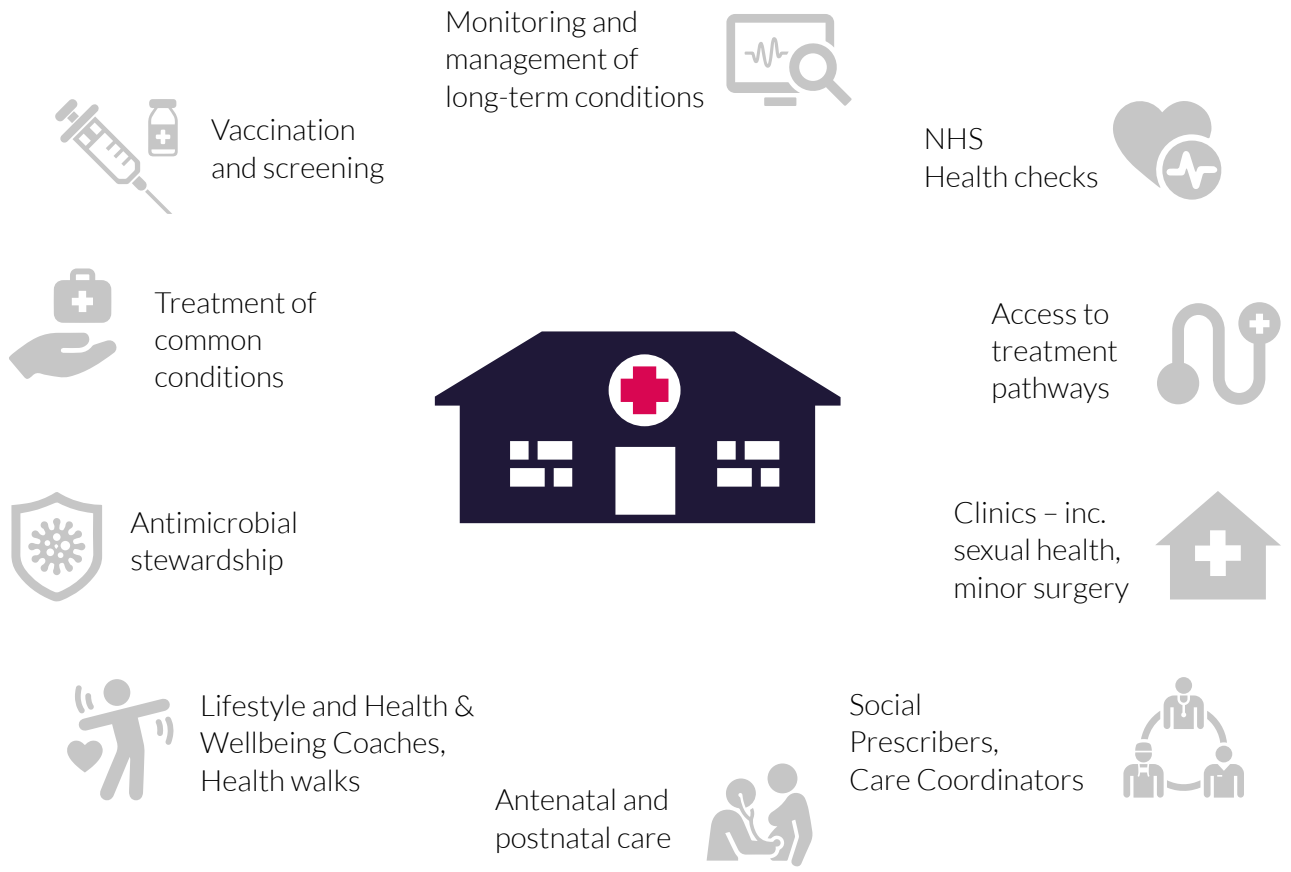
Primary Care services provide the first point of contact in a wider healthcare system. Primary Care includes General Practice, community pharmacy, optometry, and dental services. These services act as a **'front door'** to the NHS, treating common medical conditions and referring patients on for specialist or urgent services at hospitals and other services.

This report focuses on General Practice services and Primary Care Networks (PCNs). General Practitioners (GPs) and their teams look after their registered population and focus on the health of the whole person, their physical and mental health needs and the wider psychological and social influences on health and wellbeing. Over 90 per cent of all contacts with health care professionals occur in Primary Care, and most of the population is registered with a GP. GP services and PCNs provide a universal service from cradle to grave for everyone and as such, are uniquely placed to prevent poor health, promote good health and wellbeing and to tackle and reduce health inequalities.

Primary Care Networks (PCNs)

Since July 2019, almost all GP practices in England have come together to form geographical PCNs, each covering populations of approximately 30,000 to 50,000 patients. PCNs provide a wide range of services, using the skills of a range of professionals and working closely with other services in the community through multidisciplinary teams. This way of working brings many benefits for patients.

Through these developing multidisciplinary teams, pathways of care and dedicated clinics, there is an increased opportunity for prevention of ill health and early intervention. Examples of health promotion, disease prevention and early detection in Primary Care are shown in the picture below.



General Practice Facts & Figures

- In the UK, GP services provide over 300 million patient consultations each year.
- Around 8% of the total NHS budget is allocated to GP services.
- Worcestershire has 10 PCNs and 63 GP practices.
- Worcestershire GP practices look after 614,934 registered patients, although this number can change weekly, with births, deaths and people moving in and out of the area.
- The number of people registered with a Worcestershire GP (sometimes described as the 'practice population'), is greater than the resident population of 595,786. Some of this may be accounted for by people resident close to the borders of Worcestershire choosing a GP.
- List sizes vary by practice, with the largest practice having 21,183 patients and the smallest practice with 2,845 registered patients.
- There is a different pattern of usage for each patient. Some may attend regularly, for example if they have a long-term condition, while others may not need an appointment for many months or even years.

Integrated Care Systems (ICSs)

The next phase of change is the development of an Integrated Care System (ICS) across Herefordshire and Worcestershire. ICSs are partnerships that bring together providers and commissioners of NHS services across a geographical area with local authorities and other local partners, including the voluntary and community sector. The organisations collaborate and work together to plan and integrate services to meet the needs of their population on a local 'place based' scale.

"ICSs focus on places and local populations as the driving forces for improvement".

ICSs are coming together at a time when improvements in life expectancy are stalling and health inequalities are widening. They have the potential to drive improvements in population health at scale by reaching beyond the NHS to work with local authorities and other agencies to tackle the wider determinants of health, or the causes of the causes, that drive longer-term health outcomes and inequalities, such as housing, local planning and education[2].

"Day-to-day care and support needs will be met locally. The right size may vary for different areas but should reflect where meaningful communities live".

Primary Care as an Asset

"GPs should be proactive in carrying out public health activities and interventions".

Royal College of General Practitioners (2010)

General Practice is one of the most important and respected institutions in our communities; it is the foundation of the NHS. The strengths of General Practice in improving population health include:

- organising care based on a registered list, with the vast majority of the population registered with a practice;
- providing care from cradle to grave for everyone;
- knowing more than one generation in a family, having a lifelong medical record;
- having a holistic approach to care, looking after the whole person and not simply focusing on one disease or a single episode of care;
- providing continuity of care where needed; and
- managing the undifferentiated presentation of symptoms.

2 www.england.nhs.uk/integratedcare/what-is-integrated-care

As the most accessed part of the health system, GP practices and wider Primary Care services are well placed to promote health and wellbeing to their patients and support them to access other services for health improvement and disease prevention. This may include:

- encouraging healthy choices and risk avoidance (healthy diet, physical activity);
- targeting high-risk patients or groups (advising on smoking, alcohol and substance misuse);
- providing vaccination programmes to protect health and prevent disease;
- supporting screening programmes to enable early detection and treatment; and
- referring or prescribing treatments for those with illness to prevent further complications (hypertension, high cholesterol).

"As well as providing high quality care and encouraging people to make healthier choices, GPs tackle health inequalities by acting as advocates for patients and providing important links to services including housing and benefits advice".

The King's Fund (2010)

The wider determinants of health; housing, education, employment and income, often described as the causes of the causes of poor health and a driver for health inequalities, have the most impact on our health. GPs cannot address the wider determinants of health directly, but they deal with the physical, mental and social effects daily. The role of the GP as an expert at the heart of the community, means they have a pivotal role to play in combating the causes of health inequalities and dealing with their effects.

Primary Care can have a positive impact on health inequalities of their patients at a number of levels, through clinical care, wider patient advocacy, community engagement and activities and through collaboration with other agencies.

"GPs care about inequalities and want to focus on those with greatest need in their communities".

Royal College of General Practitioners (2020)

The following section celebrates the role of prevention in Primary Care, focusing on immunisations and NHS health checks. A summary of '**Pathways from Practice**' to other health improvement services and opportunities in Worcestershire is also outlined on page 20.

Immunisation

One of the most important public health interventions, vaccination, prevents people from becoming ill, saves lives and stops spread of infection. As well as the new COVID-19 vaccination programme, the NHS has a comprehensive immunisation programme that helps to protect the health of our population. Each year, millions of doses of vaccines are administered to eligible groups in England.

Many vaccinations take place in Primary Care with success measured by uptake in eligible groups. Primary Care professionals and settings have a key role in vaccine advocacy and administration.

Childhood Immunisation

The routine childhood immunisation programme protects infants and children from a wide range of infections, including Measles, Bacterial Meningitis, Polio, Whooping Cough, Hepatitis B and Rotavirus.

In England, the highest childhood vaccination coverage rates were recorded in 2012-13, since then, rates have been declining year on year. Worcestershire has historically performed better than the England average for childhood immunisations. However, for the last two years, rates have been falling and they are below the 95% target coverage rate for many types.

Receiving two doses of Measles, Mumps and Rubella (MMR) vaccine helps to protect individuals against measles and provides protection against rubella, which can cause serious effects to an unborn child if a woman contracts rubella during pregnancy.

Area	MMR Coverage (first dose)		MMR Coverage (second dose)
	Age 2	Age 5	Age 5
Worcestershire	92.9%	97.1%	88.8%
England	90.6%	94.5%	86.8%

Within Worcestershire, there is variation in MMR vaccination uptake by GP practice. Data for 2018/19 shows some practices achieved a 100% uptake of the first dose at age two, however some practices had an uptake rate of 81%. Although the overall uptake rate is higher than the national average, almost a third of practices had uptake rates lower than the national average. In 2018/19, 513 of Worcestershire children had not received their first dose of MMR vaccine by two years of age.

"It is never too late to immunise with MMR. Opportunities to check immunisation history and offer missing immunisations should not be missed. This is particularly important where doses of MMR vaccine have been missed in childhood, leaving a person vulnerable to preventable infection".

Insight with eligible groups has demonstrated that along with patient confidence in childhood immunisation programmes, practicalities in accessing appointments is also an important factor for high vaccine uptake. This includes simple processes for booking appointments and appointment times that suit[3].

Data from Public Health England's attitude surveys shows that parental confidence in immunisation of new-born babies is high and healthcare professionals remain the most trusted source of vaccination information for parents[4].

Seasonal Influenza Vaccination (Flu)

Immunisation protects older people from infections such as influenza, pneumococcal infection, and shingles. Annual 'flu jabs' are offered to people who are at greater risk of developing serious complications if they catch it. Over 65s and other vulnerable groups, including carers, people with certain health conditions and pregnant women are priority groups for receiving a flu jab each year. A school-based vaccination programme, using a nasal spray, aims to reduce transmission of flu in the wider community as well as protecting our children from illness.

GP services are pivotal to the success of the annual influenza immunisation programme for older people and vulnerable groups:

In the 2019/20 flu season:

74.8%

of people aged 65 and over in Worcestershire were immunised, just below the national target value of

75%

but above the national figure (72.4%)

For those under 65 years with underlying health conditions,

50.7%

were vaccinated, below the

55%

target but above the national figure (44.9%).

Despite the high vaccination uptake across Worcestershire, there is room to improve uptake in future cohorts, particularly in practices with lower uptake. This may be as simple as contacting patients by phone, using prompts within IT systems to identify eligible patients, having GPs who will opportunistically vaccinate and trialling different appointment times[5]. Where vaccine uptake is low due to vaccine hesitancy, health care staff are trusted sources of advice and information around vaccination.

3 Royal Society of Public Health (2019) Moving the Needle: Promoting vaccination uptake across the life course
4 PHE survey (2019) **https://www.gov.uk/government/news/phe-offers-support-to-uk-vaccine-heroes**
5 Newby et al (2016) Identifying strategies to increase influenza vaccination in GP practices

NHS Health Checks

The NHS Health Check is a regular health assessment for all adults in England aged 40-74. It is designed to assess cardiovascular risk at an early stage, to prevent:

- Stroke;
- Kidney Disease;
- Heart Disease;
- Type 2 Diabetes; and
- Dementia.

As people age, they have a higher risk of developing one of these conditions. NHS Health Checks support patients to lower this risk, to prevent progression of cardiovascular conditions and diagnose conditions earlier. All eligible adults in Worcestershire should be invited to have an NHS Health Check by their GP every five years.

"NHS Health Checks is one of the largest public health prevention programmes in the world with over six million people in England having had a check since 2013".

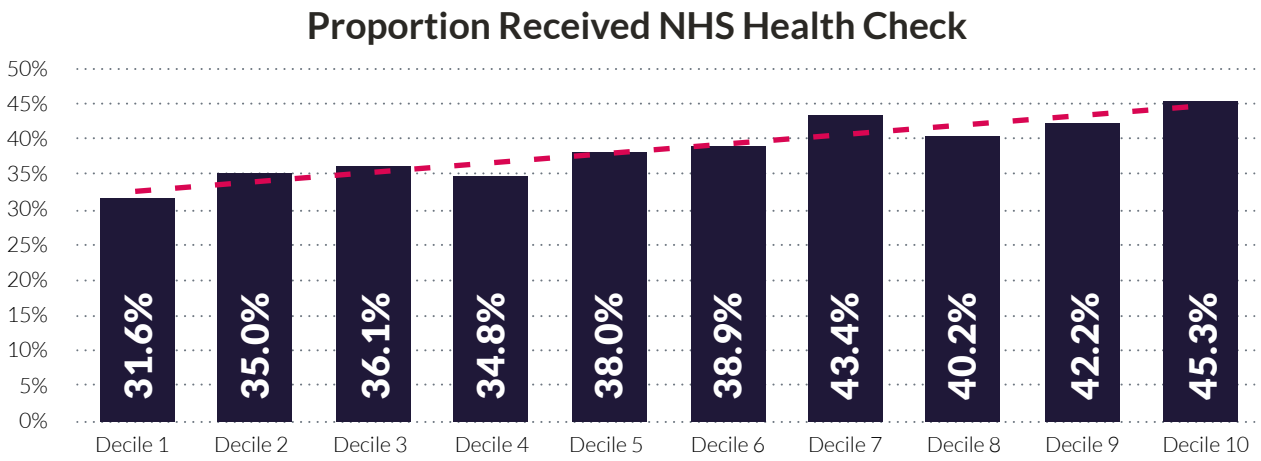
A high-quality NHS Health Check includes assessment and management of key lifestyle risk factors such as excess weight (obesity), physical inactivity, smoking and alcohol intake alongside measurements of blood pressure, blood glucose and cholesterol. There is a considerable opportunity for prevention and management of cardiovascular conditions following an NHS Health Check. Everyone having the check should be provided with individually tailored advice and signposting to relevant services (see **Pathways from Practice**) that will help motivate them to make lifestyle changes to reduce their cardiovascular risk.

"Around 48.2% of the eligible population (89,400 people) aged 40-74 in Worcestershire received an NHS Health Check between 2015/16 and 2019/20. Although this is higher than the England rate of 41.3%, there is opportunity to increase this uptake".

Cardiovascular disease (CVD) is one of the conditions most strongly associated with health inequalities. People who live in the most deprived areas of England are almost four times more likely to die prematurely than those in the least deprived areas. CVD is also more common where a person is male, older, has a severe mental health illness, or ethnicity is of a South Asian or African Caribbean descent. CVD accounts for more than a quarter of deaths in England and is the largest cause of premature mortality in deprived areas.

The Inverse Care Law is demonstrated in analysis of local NHS Health Check data. Attendance at NHS Health Checks is lower for people living in the more deprived areas of Worcestershire, who are more likely to experience the health conditions identified by NHS Health Check.

The graph below shows the percentage of eligible 40 to 74 year olds who received an NHS Check during the five-year period 2013 to 2018 in Worcestershire. The population is split into deprivation deciles where decile 1 live in the most 10% deprived localities in the country and decile 10 the most 10% affluent. The graph demonstrates the social gradient in access to local Health Checks.



The NHS Health Check can, however, successfully engage people with the greatest health needs, actively reducing health inequalities. Individuals having a check are more likely to be diagnosed with a disease and to receive behavioural or clinical management to help them reduce that risk or manage the health condition.

Across Worcestershire there are modifications that could be made to further improve the accessibility and quality of the service. A proportionate universalism approach should be applied, to ensure the programme is primarily targeted at those communities who are either at highest risk of CVD and/or most impacted by COVID-19. These groups include Black, Asian and other ethnic minorities, those who live in more deprived communities, men, and those individuals who have notably not attended a Primary Care appointment for a significant period.

In addition to increased targeting of the service, further consideration could be applied as to where and how the service is delivered. A range of public health services are already effectively delivered in conjunction with community pharmacy, while in other local authority areas the service has been successfully delivered in health promoting settings such as opticians.

Improving the patient experience of an NHS Health Check is a key driver to ensuring that take up increases. The implementation of point of care testing has been shown to reduce the volume of missed appointments and to improve the take up of the service. Accessibility could be further improved through the increased availability of appointments at evenings and weekends.

Scheduled NHS Health Checks should be complemented by all Primary Care staff using a Making Every Contact Count approach to deliver brief, opportunistic advice on healthy lifestyles. Free **Making Every Contact Count E-Learning for all PCN staff** is available. To further enhance the impact on CVD risk for patients attending an NHS Health Check, it is also key to ensure healthcare professionals are able to successfully signpost or refer to health improvement services, such as lifestyle advisors or social prescribers as outlined in '**Pathways from Practice**'.

Spotlight on: Annual Health Checks for People with a Learning Disability

People with a learning disability are more likely to have poorer physical and mental health and have been more vulnerable to worse outcomes from COVID-19 compared to the general population. Risk of premature death is also higher amongst people with learning disabilities and in some circumstances is avoidable.

People with a learning disability often experience discrimination, communication difficulties, reduced health literacy and poorer access to healthcare. Diagnostic overshadowing, where physical symptoms are wrongly attributed to an underlying learning disability, can also result in later diagnosis of a health condition. To narrow this health inequality, a programme of Annual Health Checks (AHC) was developed in 2009 and implemented through a national Directed Enhanced Service.

Adults and young people aged 14 or over, who are on the GP practice learning disability register, should be invited by their GP practice for an AHC each year. The health check is a chance for the GP, the person with learning disabilities and support staff or family carer, if appropriate, to review the individuals' physical and mental health.

All 62 GP practices across Worcestershire are signed up to the AHC Directed Enhanced Service. Each AHC should be completed with a Health Check Action Plan to ensure the individual and their family understand their health needs and have the information and support they need to make improvements in their health. The current NHS England target is for 75% of people on the learning disability Quality and Outcomes Framework register to receive an annual health check in any given year.

In 2018/19, 56.6% (1,670) Quality and Outcomes Framework registered people with a learning disability in Worcestershire received an AHC. This was above the England average of 52.3%, but there is still room for improvement. There was also wide variation amongst practices within Worcestershire, and the percentage ranged from 18% to 100% in 2018/19.

A review of AHCs was completed in 2020. A sample of Worcestershire GP practices, people with learning disabilities and family carers, were interviewed to understand experiences and gather examples of good practice. This review supported the previous recommendations made by **Speakeasy Now**, a Worcestershire based user-led charity. The review made the following recommendations:

- A 'prevalence gap' remains across practices, where estimated community levels of learning disability and Quality and Outcomes Framework register sizes do not match. GP practices should ensure that registers for people with learning disabilities are well maintained. This will ensure all people aged 14 and over with a learning disability will receive an invitation to an AHC.
- The perceived value of learning disability health checks varies among Worcestershire GPs and there can be a high turnover of who is responsible for them. High quality AHCs take place in practices where they are valued by those delivering them. Allocating a lead role to a passionate member of the team with good knowledge of the benefits of high quality AHCs will provide a dedicated focus.
- Practices should ensure that invitations to AHCs are clear and easy to understand by the person with a learning disability. An easy read version of what to expect may be useful for a person attending their first health check. Some flexibility may also be required to amend appointments, particularly if the person would like a personal assistant to join them.
- A standard for a high quality AHC should be set to cover the full AHC experience. Templates used should be flexible to the individual but should cover all aspects of health and wellbeing. Practices should make best use of the wide range of services that can support people to improve their health and wellbeing and should ensure clear information is provided in the Health Check Action Plan and understood by the person and their carer or family member.

Much has been achieved in Worcestershire since this review. This includes a new webpage that has been created to bring together all the recommended resources for AHCs, for GPs and patients. This webpage has been cited as an example of good practice in the national NHS England "2021/22 priorities and operational planning guidance". There has also been a successful pilot of improved, more holistic AHCs in the Wyre Forest Health Partnership, demonstrating new ways of working at the PCN level.

"Since the review the uptake of AHCs across the county has increased to nearly 85% of those on the learning disability register, a huge improvement on both the preceding year's levels (54%) and the NHS England target (67%)".

The Misfits Theatre Company created a short film about how high-quality Annual Health Checks can improve health and wellbeing of a person with a learning disability:

Health Is Everybody's Responsibility – YouTube

A Worcestershire briefing on the health and care of people with learning disabilities was published in 2019 and is available here.

Personalised Care

Around 30% of adults have a long term or complex health condition. Personalised Care gives people choice and control over their mental and physical health, based on what matters to them and their individual strengths and needs. This is done through shared management of their health and care needs and recognising the role of carers and communities. The Royal College of General Physicians explain personalised care in the short video: **Personalised care for people with long term conditions: A changing GP approach – YouTube**.

A comprehensive model of personalised care is being embedded across health and care in Worcestershire. This model features six standard components, outlined in the diagram below:

Source: NHS England

Personalised care seeks to improve people's health and wellbeing and integrating services around a person is seen as critical to this. This includes health and social care as well as public health and wider services and is enabled by the development and embedding of new roles in Primary Care including the Social Prescribing Link Workers, Care Coordinators, Health Coaches, Lifestyle Advisors and Mental Health Coordinators. See '**Pathways from Practice**' on page 20 for more information about these roles.

The evidence shows that when people are more in control of their outcomes, then their outcomes are better. When personalised care is fully in place, people will have a better experience of health and care. Adopting a personalised care approach can also contribute to reducing health inequalities. Most individual long-term conditions are more common in people from lower socioeconomic backgrounds, and multiple conditions are disproportionately concentrated in these groups[6].

When people are supported to increase their knowledge, skills and confidence they benefit from better health outcomes, improved experiences of care and fewer unplanned hospital admissions [7]. People in lower socioeconomic groups can therefore benefit the most from personalised care.

6 King's Fund (2013), Long-term conditions and multi-morbidity. Available online: **https://www.kingsfund.org.uk/projects/time-think-differently/trends-disease-and-disability-long-term-conditions-multi-morbidity**

7 Barker, I. et al. (2017), Patient activation is associated with fewer visits to both General Practice and emergency departments: a cross-sectional study of patients with long-term conditions, Clinical Medicine, 17(3), p.15

Pathways from Practice

"A wide range of services are available across Worcestershire to improve and maintain health and wellbeing. Primary Care professionals can refer or signpost patients to access these services and opportunities".

Worcestershire Mental Health Services

It is estimated that 1 in 4 people will experience a mental health problem each year. The **Worcestershire Healthy Minds** service provides a range of support options that individuals can self-refer in to, and that Primary Care can refer or signpost to. The service supports people aged 16 and over, who are experiencing difficulties such as stress, anxiety, low mood and depression. The service provides a range of self-help guides and resources, educational courses, online therapy and guided self-help, counselling, individual therapy, group therapy, and links to local solutions. GPs can complete an e-referral with the patient, allowing the patient to leave the practice with the date and time of their appointment with the service who then contact the patient directly.

There are a range of mental health and emotional wellbeing services for children and young people, all part of **Worcestershire Child and Adolescent Mental Health Services** (CAMHS). Primary Care can signpost or refer to a range of services for young people, including **Kooth** on-line counselling, **Reach 4 Wellbeing** short-term group programmes and **Specialist CAMHS** multidisciplinary mental health teams. CAMHS has specialist mental health workers trained to work with mental health difficulties that are impacting on activities of daily living for children and young people. Referrals can be sent to CAMHS SPA (Single Point of Access) by Primary Care where there are significant concerns regarding a possible mental health illness.

Worcestershire Drug and Alcohol Service in GP shared care

Cranstoun Worcestershire provides a local drug and alcohol service, which includes many drug and alcohol practitioners based in GP practices in addition to their specialist prescribing service. Across Worcestershire, currently 28 out of 62 GP practices deliver shared care between the local GP and a dedicated Cranstoun worker is linked to the practice.

GPs and patients provide very positive feedback about this arrangement, which enables patients to access specialist prescribing and psychological treatments close to their home. It also allows for improved co-ordination between individuals and health care professionals to facilitate better communication, access to other health promotion, illness prevention and consistent care for associated complex physical or mental health conditions. Patients can access this system via GP reception, online booking or GP/nurse appointment.

Health Walks

Health Walks aims to improve Worcestershire's health and wellbeing by encouraging more people to become more physically active through one of the simplest forms of exercise, walking. As well as improving physical health, organised walks can help improve mental wellbeing by providing an opportunity to socialise and a distraction from everyday stress.

Health Walks are free, easy and local. They are open to all adults in Worcestershire and usually last between 30-90 minutes led by a trained Walk Leader. Health Walks are part of the national **Walking4Health Programme** and are locally supported by Worcestershire County Council Countryside Service and Public Health.

In Worcestershire there are over 30 groups available across the County offering a range of walks.

Strength and Balance for falls prevention

The aim of the Strength and Balance service is to reduce the number of falls in older people, through strength and balance exercise classes across Worcestershire.

The Strength and Balance works directly with older people, to improve their strength and balance through a course of specific, tailored exercise classes which include resistance training, some impact exercise and balance training to reduce the risk of falling.

The service supports participants with appropriate information and advice and signposting to other services where appropriate, to promote health and wellbeing and maintain independence. To book onto a course you can either self-refer or get your GP or Health Professional to contact the Sports Partnership. For more information visit the **Worcestershire County Council falls prevention webpage**.

Libraries

There are 21 public libraries across Worcestershire and two community run library links.
Libraries bring together community services through library co-locations.

Libraries provide a range of services available to all, including;

- Free access to the internet
- Reading well books
- Job clubs
- Digital Inclusion support
- Digital Library Hub available
- 24/7 Mobile Library visiting 175 rural locations

As trusted, safe and welcoming community spaces, libraries offer a route for public services to reach communities, providing access to information, social spaces for people to come together and access services that encourage learning and aspiration, improve skills and confidence, promote wellbeing and independence.

Social Prescribing

Embedded in GP teams, social prescribing link workers connect people to wider community assets and opportunities which that can help improve their health and wellbeing and to engage and deal with some of their underlying causes of ill health. Social prescribing link workers are becoming an integral part of the multi-disciplinary teams in PCNs. There is growing evidence that social prescribing can lead to a range of positive health and wellbeing outcomes for people, such as improved quality of life and emotional wellbeing and can lead to a reduction in the use of NHS services.

Social prescribing can link people with many services in the community. These may include:

- Healthy lifestyles and active lives
- Arts, music, outdoors and creativity
- Befriending, counselling and other support groups
- Housing benefits and financial support and advice
- Employment, training and volunteering
- Education and learning
- Getting involved in local groups and activities
- Accessing specialist services and support.

For social prescribing in the following areas:

Bromsgrove, Wychavon, Wyre Forest, Worcester City; **Onside Advocacy**

Redditch: **Carers Worcestershire**

Malvern: **Citizens Advices**

People Like Us (PLUS)

People Like Us (PLUS) is a service that works across Worcestershire to support adults of all ages who are experiencing loneliness or isolation. PLUS enables individuals to connect with others and supports them to become more active and engaged in their communities.

The PLUS service is open to everyone who is:

- 18 years+
- Registered with a GP Practice in Worcestershire
- Experiencing significant loneliness

Anyone can make a referral, including self-referral. Referrals can be made by phone to the access team or using a simple **referral form**.

Worcestershire Integrated Carers Hub

The **Worcestershire Integrated Carers Hub** supports unpaid adult carers across the County and builds on **Worcestershire Association of Carers** current provision, by providing a one stop shop for carers, which includes a Carers Hub Helpline. Experienced Carer Pathway Advisors can assist by providing local information and advice on all aspects of caring. Carers can **self-refer** or be **referred**.

Lifestyle Advisors

The **Lifestyle Advisor service** is integrated within PCNs across Worcestershire and aims to support service users to make positive changes to their lifestyle, through the use of behaviour change techniques. Lifestyle Advisors can support with a range of issues including, but not limited to, healthy eating, increasing level of physical activity, smoking, reducing alcohol consumption, mental health and wellbeing.

The Lifestyle Advisor service can offer support on a one-to-one basis, as well as group-based support.

The service works alongside services such as NHS Health Checks and Social Prescribing to provide a suite of wellbeing services embedded in Primary Care.

Living Well in Later Life Worcestershire

The Living Well in Later Life project stems from the ICOPE (Integrated Care for Older People) initiative, aiming to create a unified systemwide approach to promoting and embedding active/healthy ageing for the over 50s in Worcestershire.

Living Well in Later Life is introducing a Worcestershire LifeCurve™ website and App; a self-assessment tool to help people understand how well they are ageing and what this means to their future health. By using the LifeCurve™ to make a few small daily lifestyle changes, physical ability can be maintained or improved.

The project is also piloting the use of resistance bands (an exercise aid) to improve muscle strength and functional ability. In a variety of setting, a 12-week resistance band programme offers an effective means to gaining muscle strength and balance.

For more information email: **laterlife@worcestershire.gov.uk**

Worcestershire Advice Network

The **Worcestershire Advice Network** provides supported access to a variety of information and advice. The overarching aim of the service is to provide accessible, accurate, high quality and locally relevant information, advice and guidance for all adults in Worcestershire to help prevent ill health, promote good health and wellbeing and delay the need for care. The network is a partnership of local agencies and helps with everyday problems such as benefits, housing and debt, and to help individuals understand how care and support services work locally and the care and funding options available.

This service especially provides early intervention through good quality and timely information and advice to vulnerable adults and those with protected characteristics. Sessions are delivered on a one-to-one basis from various geographical locations across the whole of the county.

Here2Help Worcestershire

Here2Help is a community action scheme, originally dedicated to helping those who needed support during the COVID-19 pandemic. Here2Help can offer support and coordinates those who are able to volunteer to offer support. Worcestershire County Council is now evolving the service so that it offers advice, support and help to a wide range of services across Worcestershire. Here2Help provides support for people of all ages and is available for both residents and organisations to access information, advice, tools, guidance and local support available to them or others in the local community based on their needs. Here2Help is developing a community directory.

Starting Well Partnership

Starting Well provides information, support and advice for families, parents, children and young people across Worcestershire. The partnership provides the full range of Public Health Nursing services, parenting support and community health connectors. Starting Well provides universal Health Visiting and School Health services who deliver the Healthy Child Programme to identify and address health and wellbeing needs. The partnership provides a range of parenting programmes and peer support and empowers families and young people to access support networks and groups in their local community. Some of the services, clinics and groups are delivered in Family Hubs as well as community centres, health centres and schools.

Our communities

The 2020 Joint Strategic Needs Assessment (JSNA) summary focused on the health impacts of COVID-19 on Worcestershire communities.

In general, the population of Worcestershire is healthy and there are many health-related measures where Worcestershire performs consistently better than the national average. However, there are places in Worcestershire where people's health is not good, and the average measures reported at County and District level masks inequality in health outcomes in some communities. Almost 28,000 Worcestershire residents live in the top 10% of deprived areas in England. People living in these communities are more likely to experience ill health and report poorer wellbeing.

Worcestershire has an ageing population, and it is expected that the number of people in the very oldest age groups is expected to grow in future years.

The map of Worcestershire Districts below shows where outcomes are significantly worse than the England average. This is based on data included in the 2020 **Joint Strategic Needs Assessment (JSNA) summary**.

Bromsgrove

- Hip fractures in people aged 65 and over
- Breastfeeding Initiation

Malvern Hills

- Hip fractures in people aged 65 and over
- Dementia Diagnosis (aged 65 and over)
- Breastfeeding Initiation

Redditch

- Hip fractures in people aged 65 and over
- Dementia Diagnosis (aged 65 and over)
- Alcohol Admissions
- Adults Overweight or Obese
- Breastfeeding Initiation
- Average Attainment 8 Score

Worcester City

- Life Expectancy at Birth (male)
- Under 75 Mortality from Cardiovascular Disease
- Dementia Diagnosis (aged 65 and over)
- Breastfeeding Initiation
- Statutory Homelessness

Wychavon

- Dementia Diagnosis (aged 65 and over)
- Alcohol Admissions (Under 18s)
- Breastfeeding Initiation

Wyre Forest

- Life Expectancy at Birth (male)
- Dementia Diagnosis (aged 65 and over)
- Alcohol Admissions
- Physically Active Adults
- Adults Overweight or Obese
- Smoking at time of delivery
- Breastfeeding Initiation
- Children in low income families
- Average Attainment 8 Score

Data taken from: **Local Authority Health Profiles – Public Health England**

Primary Care Network Profiles

The JNSA includes profiles for each of the 10 PCNs across Worcestershire. The profiles provide a snapshot across a range of indicators and are designed to support a shared understanding of health inequalities within each PCN, enabling a collaborative approach to decision making and allocation of resources and to identify interventions to reduce inequalities.

A link to the profiles is provided below where information is updated and added regularly:

www.worcestershire.gov.uk/info/20862/nhs_intelligence

Community Assets

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

Through COVID-19 response, communities have pulled together in new ways to support the most vulnerable. Local authorities and the NHS can support the legacy of this by supporting emerging community-based assets and strengths and aiding the recovery of assets that have been adversely affected by COVID-19.

Together with partners, Worcestershire County Council are scaling up an Asset Based Community Development (ABCD) approach.

Spotlight on: Asset Based Community Development in Worcestershire

The Asset Based Community Development (ABCD) team has been funded for three years to lead on the adoption of ABCD as a way of working with communities in Worcestershire. This will involve working with partner organisations and communities to identify neighbourhoods where it can be embedded through a test and learn approach. The team will also support learning through facilitating communities of practice and developing monitoring and evaluation frameworks.

The ABCD approach has been successfully adopted by a number of areas across the UK and there is now a wealth of evidence that community and social networks have a fundamental and positive impact upon health and wellbeing. ABCD does this by inverting the existing model of needs and deficits, instead focusing on the skills, knowledge, resources, connections and potentials within the community. It is about building on what is working and what it is that people care about.

The ABCD approach is concerned with building people's social support networks, enabling reciprocity, making best use of the resources and assets which are available in the local area and making sure that people who use services, including people with long-term conditions, get a chance to pursue their own interests and contribute to community life. It is about enabling community self-help and social solidarity to flourish.

ABCD also creates the conditions for developing more effective co-production between people who use services and practitioners. Effective co-production makes full use of the assets and skills that local communities and people who use services can bring to the table alongside those of practitioners.

The ABCD team has been working through local partnerships in district council areas and have identified a number of neighbourhoods where the Test and Learn approach has potential to be developed. At the time of writing these are Woodrow in Redditch, Catshill in Bromsgrove, Droitwich Westlands in Wychavon, and Tolladine in Worcester City. The ABCD team has secured training from Nurture Development, the leading ABCD experts in the UK, which is being delivered to district council partners. This initial training cohort will also form the basis of the first ABCD Community of Practice. Additional planning is being scoped to scale up other ABCD projects and to develop and test community builders.

Challenges and Opportunities

There are a number of challenges facing Primary Care in the future. PCNs will play a key part within ICSs and work collaboratively with statutory and voluntary sector partners, and directly with communities, to tackle these challenges and maximise opportunities.

This section describes the challenge of the expected increase in demand on the health and social care system and the opportunities for Primary Care and the wider system to manage demand through a social model of health.

Opportunities to improve access to Primary Care through a digital offer are described and the development of an **Integrated Wellbeing Offer** for Worcestershire residents is outlined.

Nationally, there has been a reduction in numbers of GPs due to:

- **reduced proportion of funding for General Practice;**
- **period of lower recruitment to GP training schemes; and**
- **increasing number of GPs reaching retirement age.**

The Inverse Care Law can also apply to General Practice itself where "the availability of good medical care tends to vary inversely with the need for it in the population served"[8]. There can be an uneven distribution of GPs in relation to health need, resulting in some areas having less GPs to meet patient need. Individuals with long-term conditions and multiple conditions are more common in areas of increased deprivation. In addition, levels of knowledge, skills, health literacy and confidence to manage their health tend to be lower in such areas. Appointment times are in turn, also likely to be longer for some of these patients.

8 Tudor Hart (1971) The Inverse Care Law, The Lancet

Demands on the Health and Social Care System

The number of people with complex or long-term conditions is expected to grow as the number of older people increases. This is coupled with additional factors such as the development of new technologies, drugs and treatments, high expectations of patients and a period of lower investment in Primary Care. The impact of COVID-19 and COVID-19 recovery will also affect demands on the health and social care system, certainly for the next 10 years.

Mental health issues account for almost a quarter of General Practice consultations and around half of all GP appointments are related to people with long-term conditions.

The table below shows the expected effect of the ageing population on the numbers of older people with key health conditions. Numbers are projected to increase between 2020 and 2035. This increase in numbers is likely to lead to a substantial rise in the demand for social care and health services in future years.

Projected Numbers of People Aged 65 Plus with Key Health Conditions	2020	2035	% change
Dementia	9,757	14,273	46%
Depression	11,835	15,469	31%
Cardiovascular Disease	43,997	58,264	32%
Bronchitis/emphysema	2,342	3,060	31%
Fall	36,685	49,751	36%
Continence (have a bladder problem at least once a week)	22,620	30,349	34%
Visual impairment	4,134	5,920	43%
Hearing loss	84,098	113,619	35%
Mobility (unable to manage at least one mobility activity on their own)	25,264	35,536	41%
Obesity	41,875	54,365	30%
Diabetes	17,228	22,408	30%

Source: Projecting Older People Population Information System

People from lower socio-economic groups are much more likely to have one or more long-term conditions than people in the most affluent groups and they are more likely to become unwell with a long-term condition at a younger age.

Not everyone has felt the impact of COVID-19 equally. The greatest impacts of COVID-19 have fallen on those who are the least privileged. COVID-19 has made the existing differences in health between groups worse. A local survey conducted by Healthwatch Worcestershire[9] found people under 44, carers, people with disabilities and people from the 'White Other' ethnic group were more likely to report COVID-19 was having a great deal or a lot of impact on their mental health. Findings suggest that the impact on people's mental health and emotional well-being may continue to increase. An increased demand for mental health support for children, young people and adults is expected.

Through proactive and preventative health care education, advice and treatment, Primary Care has a responsibility to provide accessible and good quality clinical care to their patients, enabling them to

9 Healthwatch Worcestershire (2020) Peoples Experiences of Health and Social Care Services: https://www.healthwatchworcestershire.co.uk/wp-content/uploads/2020/09/Covid-19-Survey-Final-Report-Vs-1.0.pdf

manage long term conditions taking a personalised care approach. Patients should also be supported to live a healthy lifestyle and access other services that support good health and wellbeing.

Alongside access to health services, the wider determinants of health; the places people live, work and play have an impact on a person's ability to make healthier choices and function well. A stronger focus on prevention, developing assets and taking a place-based approach with the wider system will help to reduce demand in the longer term.

Improving Access through Digital Solutions

The pandemic has brought about an unprecedented situation for Primary Care services across the country. Lockdowns requiring people to stay at home, coupled with understandable nervousness around attending services face to face, amplified the need for a variety of technologies to be implemented rapidly and at scale to ensure services continue to remain accessible and effective.

Herefordshire and Worcestershire Clinical Commissioning Group, in partnership with many other organisations across our county and beyond, engaged with colleagues across Primary Care, as well as people. The aim has been to better understand residents needs with technology and what might help improve their access.

This engagement led to improvements such as online and video consultation systems in practices, iPad provision and training for care homes to support clinicians conducting virtual consultations with residents, enablement of direct appointment booking with practices when calling 111 and investment in practice telephony systems to improve citizen experience and signposting to the most appropriate service.

Since February 2020, there have been over 49,000 online consultations and over 45,000 video consultations taking place, demonstrating a strong level of uptake and usability in accessing services digitally. For the coming year, these technologies and many others will continue to be embedded and enhanced, including additional telehealth solutions for care homes, a patient portal to enable citizen access to a single care record that covers all care settings, and additional analytical capacity to enable practices and partners to target health and care interventions in areas of greatest need.

Although the use of digital solutions to increase access to health services and management of health conditions is positive, there is a potential negative impact on people who are digitally excluded.

A high priority should be placed on Digital Inclusion programmes that support those who may still be digitally excluded. This should include training and access to the internet through community assets. Services should consider that not everyone can access the information and support they need online.

"In an increasingly digital age, those who are not engaging effectively with the digital world are at risk of being left behind. This is often termed 'digital exclusion'. Digital exclusion can be down to a lack of means to access the internet or due to lacking the digital skills to use the internet competently, safely and confidently".

Developing an Integrated Wellbeing Offer

Access to an Integrated Wellbeing offer (IWO) can help empower people to live well, by addressing the factors that influence their health and wellbeing, building their capability to be independent, resilient and maintain good wellbeing for themselves and those around them. Such an offer moves beyond focusing on single issues and takes a holistic and person-centred approach, addressing the psychological determinants of health behaviour.

- There is growing evidence which suggest that multiple poor health-related behaviours and the wider determinants of poorer health can be addressed either simultaneously or sequentially by developing integrated wellbeing models, that prioritise key factors such as good employment, education and living well at older ages.
- There is clear strategic direction across Worcestershire and by the new ICS to move to an integrated and joined up approach to prevention and wellbeing across the health and care system at a place-based level. This will require asset-based approaches, working across health and care systems, and co-production with the voluntary and community sector and the public. This will be a systems approach, aligning resources and skills to build a new offer for Worcestershire. The Integrated Wellbeing Offer (IWO) will be tested at local levels through PCNs and developing District Collaboratives which will be key in local design and implementation.
- A multiagency steering group will work collaboratively to support the design and implementation of the IWO. The group is co-chaired by the Director of Public Health and will include local residents, the Voluntary and Community sector, PCNs, other NHS leads, District Councils, and the County Council.
- It is expected that the IWO will deliver at scale, enabling people to self-help, giving access to comprehensive information and advice, and joining up a wide range of services. The programme will particularly target activity on the poorest health outcomes, supporting the local community and building on local assets.

It is expected that the developing IWO will help to:

- develop a whole system approach to wellbeing in Worcestershire;
- improve health and wellbeing at all ages;
- increase community engagement and support using an asset-based approach;
- build resilient communities;
- enhance local assets and reduce gaps in provision;
- increase proactive support for mental health and wellbeing;
- provide a comprehensive digital platform including signposting to local assets;
- reduce loneliness and isolation;
- tackle health inequalities; and
- provide integrated services and groups to support people to live well at all stages in life.

"Following its creation and implementation four months ago in response to COVID-19, Here2Help has since provided a range of support to over 5000 individuals including emergency food parcels, medication collections, food collections and delivery. It has significantly grown the volunteering offer and strengthened relationships with districts, partners and the Voluntary Community Sector who have worked together to provide a One Worcestershire response. Following this success, there is now an opportunity to build on the Here2Help foundation by developing and evolving the service as part of the IWO".

An Integrated Wellbeing Offer empowers people to live well, by addressing the factors that influence their health and wellbeing and building their capability to be independent, resilient and maintain good wellbeing for themselves and those around them.

We can achieve this by:

Building resilient and thriving communities, utilising local strengths and assets → Empowering individuals with comprehensive and accessible information and advice to self-help → Providing individuals with supported information and advice → Joining-up and integrating services, taking whole system approaches

Built upon the principles of; evidence of need, tackling health inequalities, prevention, co-production, asset-based approaches, and personalisation.

System enables; governance and linkages with ICS and LTP, collaborative commissioning, cultural change and new ways of working.

HERE 2 HELP WORCESTERSHIRE

Primary Care Networks and District Collaboratives

Population health is about improving health across the entire population, this requires both individual and place-based action and activities to improve health, prevent ill health and reduce health inequalities.

To improve health and reduce long term demand PCNs will need to engage beyond the NHS, with other care agencies, the voluntary sector and with their local communities. Local communities are all different, their needs and assets are different requiring differing and tailored approaches and solutions.

To better understand needs, priorities and improve population health, Population Health Management (PHM) techniques can be used by PCNs to understand current, and predict future, health and care needs and to tailor better care and support and design more joined up and sustainable health and care services. PHM uses data to understand what factors are driving poor outcomes amongst different groups as well as to test the impact of new proactive models of care. This could be by stopping people becoming unwell in the first place, or where this is not possible, improving the way the system works together to support them. PHM techniques includes segmentation, stratification and impactability modelling to identify local 'at risk' cohorts and, in turn, designing and targeting

interventions to prevent ill health and to improve care and support for those with ongoing health conditions and reducing unwarranted variations in outcomes.

PHM can help PCNs understand people's health and care needs and how they are likely to change in the future, but PHM can be more effective when applied in partnership across other public services and the voluntary sector. In Worcestershire, the development of emerging District Collaboratives as part of the ICS structure provides the opportunity for PCNs to work with partners and the Voluntary Community Sector using PHM approaches to tailor, join up and improve the local health and care system.

"According to a recent report from the Royal College of General Practitioners, developing the community health function of General Practice is one of three features of the COVID-19 response that has the potential to transform General Practice radically and permanently. And PCNs are NHS England and NHS Improvement's chosen vehicle to drive engagement between Primary Care and communities, supported by the network directed enhanced services contract".

PCNs will build on the core work of current Primary Care services and enable greater provision of proactive, personalised, coordinated and more integrated health and social care for communities. PCNs are formed via sign up to the Network Contract Directed Enhanced Service contract. The contract enables more health professionals such as pharmacists, physiotherapists, paramedics and social prescribing link workers to work across PCNs, as part of community teams, providing tailored care for patients allowing GPs to focus more on those patients with complex needs. The new roles available through the additional roles reimbursement scheme (ARRS) will also help PCNs engage further with their communities, such as Health and Wellbeing Coaches, Care Co-ordinators, Mental Health Practitioners and Social prescribers.

Enabling people to increase their levels of control and confidence, through meaningful and constructive contact with others, helps to build protective factors and keeps people as healthy and productive as possible. PCNs need to build on local community assets and help to strengthen and develop their communities. PCNs should work together with communities and local partners to build relationships, and align their collective efforts, to address health inequalities through community strengthening and action on the wider determinants of health. In Worcestershire, the development of emerging District Collaboratives provides the opportunity for PCNs to work with partners, the Voluntary Community Sector and communities using an asset-based approach for that locality.

"Lasting reductions in health inequalities will only be possible through working in genuine partnership with communities… by seeing them as part of the system and a significant part of the route to lasting solutions".

(Royal College of General Practitioners 2020)

Conclusion

Primary Care is well placed to impact on prevention and inequalities, both at the individual clinical care level and at the wider population health level. GPs already provide a large proportion of prevention and health improving activities, and in Worcestershire, achieve good levels of immunisation and screening uptake. These programmes could be further used as an opportunity to engage patients within a practice area who are not currently actively managing their health and wellbeing.

The status of the GP, having long term and repeated contact with families or individuals at risk, puts them in an ideal position to understand and address the underlying and wider causes of ill health, whether they be medical or social. There are a wide and growing variety of medical and social activities and other services that patients can be signpost or referred to across Worcestershire as demonstrated under **'Pathways from Practice'** on page 20 which should be maximised.

One of the most effective methods Primary Care can undertake for ill health prevention is to take a population-based approach to the health of their 'patient list', by monitoring patients on their list who are judged to be in relative ill health or at risk of becoming so and coordinating a proactive response.

PHM capacity, tools and techniques are being developed in the NHS Clinical Commissioning Group and across the ICS. The risk stratification and monitoring tools that enable GPs and PCNs to fully understand health inequalities within their area could be further promoted and utilised, including providing appropriate training and support to practices. It is vital that these tools and approaches allow data and information to be easily shared with and by other local services to improve and integrate the systemwide response to health and care.

PCNs have a new opportunity to change the way they deliver services to support their local communities. They can explore their own data, develop a thorough understanding of the health needs of their populations and redesign services accordingly using PHM approaches. They can recruit to additional roles, such as social prescribers, to help deliver and provide their communities with services or support recognising the importance of taking a more holistic view of people's health.

PCNs can ensure that people are seen by the right member of the team, and at the right time. Being at a local level, they can engage effectively with other organisations working in their patch, such as the community and voluntary sector, secondary care, and local authorities. The District Collaboratives will also offer additional opportunity to develop effective collaborations with housing, education, social care, economic development and sports and cultural teams.

The development of the IWO, the Here2Help directory and self-help digital platform will further support Primary Care and PCNs to work better together with all local health and care services, voluntary sector organisations and community groups and activities to support their patients.

Before COVID-19 there was already a persistent gap in life expectancy and in the number of years people live in good health between the most and least affluent areas. The pandemic has both revealed the extent of the 'health gap' and appears to have increased it. Disruption to children's education, unemployment, food poverty, and mental ill-health are all more apparent and visible. The higher number of COVID-19 deaths among people from certain ethnic minorities has started to uncover the burden of risk factors experienced by ethnic minority communities leading to worse outcomes. The 'gap' is expected to widen further following the pandemic lockdown periods and this has brought health inequalities to the fore.

It has also brought further recognition that the NHS cannot do this alone. The escalating problems need a wholly different approach. All local partners have a role to play, the best outcomes will be achieved when PCNs join other local partners in getting behind community led efforts to address the issues in the long-term. The developing District Collaboratives as part of the ICS model provide that opportunity.

To support this population health approach, an asset-based model of primary and community care is beginning to be adopted in Worcestershire. One that taps into the existing skills and resources in people and places to help people lead as independent and rich a life as possible. Asset-based care is both a philosophy of how you provide care and a tangible set of interventions and approaches. It does not remove the need for high quality clinical care or health and social care professionals but identifies opportunities for people to help themselves and each other which ultimately reduces pressure on statutory health and social care services. These can be broadly defined into five categories:

1. Holding asset-based conversations with patients for example, understanding motivations, care planning, coaching and shared decision making.
2. Connecting individuals to community assets for example, peer support, social prescribing and link workers.
3. Mapping and growing community assets for example, asset mapping, directories of community assets and seed funding for voluntary sector organisations (ABCD).
4. Mobilising place-based assets for example, local neighbourhood networks.
5. Working with communities to develop local provision for example, co-design and collaborative commissioning.

In every community there are many groups, organisations and networks that are fully bought into tackling health inequalities; addressing the wider determinants and supporting the social processes involved in creating health which mainly happen in people's homes, neighbourhoods, workplaces and wider networks. They are enabling individuals and communities of all ages to have better physical and mental health and a good life and the networks between them have been strengthened, not weakened, through COVID-19. This brings greater opportunity to further build an asset-based approach to primary care.

Recommendations



1. Maximise the Role of Primary Care in Prevention

The 2018 Director of Public Health Annual Report "Prevention is Better than Cure" laid down a call to action to take a systemwide approach to prevention. Primary Care has a key role to play in advocating, and in directly facilitating collective action on prevention. This report makes specific recommendations for Primary Care to maximise their role in preventing ill health.

Primary Care can identify and mitigate behavioural (smoking, physical inactivity) and clinical risk factors (hypertension, obesity). Primary Care provides or facilitates vaccination programmes mainly for influenza and childhood scheduled immunisation and screening programmes for early detection of cancers and other conditions where early intervention can improve outcomes. Primary Care is a universal and key asset within communities and should also identify and mitigate wider social and wellbeing risk factors through the developing integrated wellbeing offer.

Ingredients for success:

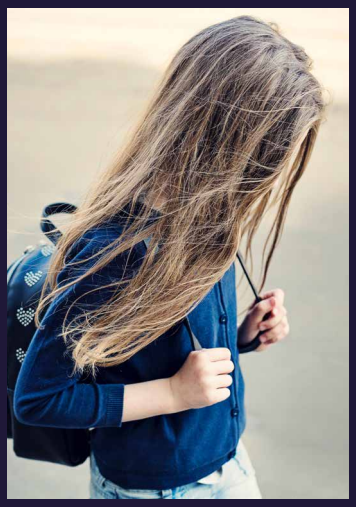
- Make every contact count by routinely delivering healthy lifestyle information to enable patients to engage in meaningful conversations about their health and to direct them to local services and support.
- Increase opportunities to support patients holistically with their health, wellbeing and wider social needs supported by social prescribers, lifestyle advisers, digital and the wider developing integrated wellbeing offer.
- Opportunistically ask about vaccination, screening and Health Checks intent and use these programmes to engage patients who are not currently actively managing their health and wellbeing.
- Increase access to and uptake of Health Checks, weight management and other lifestyle or behaviour change programmes.
- Dedicated PHM and Public Health resource, with appropriate knowledge, experience and skills to enable proactive and targeted approaches.

2. Creating Healthy Places and Stronger Communities

Improving population health requires place-based approaches that utilise and grow existing assets and integrate the wider health and care system within communities. Use Asset Based Community Development approaches to work across partners and directly with communities to grow existing and new assets, creating places for good health and wellbeing. This will support the aims of the developing District Collaboratives and Integrated Care System to take place-based approaches to health and wellbeing and make a positive impact on the wider determinants of health.

Ingredients for success:

- Strategic direction and support provided through the Integrated Care System and Health and Wellbeing Board and delegated to District Collaboratives.
- Expansion and strengthening of community assets and asset-based approaches by connecting individuals to community assets e.g. peer support, social prescribing, health coaches and link workers.
- Recognition and support for communities and assets that responded and shone in the face of COVID-19 and supported recovery of assets negatively affected.
- Scaling up the use of Asset Based Community Development (ABCD) and community builders as a way of working with communities and to strengthen communities to develop, and expand assets available to them.
- Working with communities, voluntary sector and partners to collaboratively co-design holistic provision.

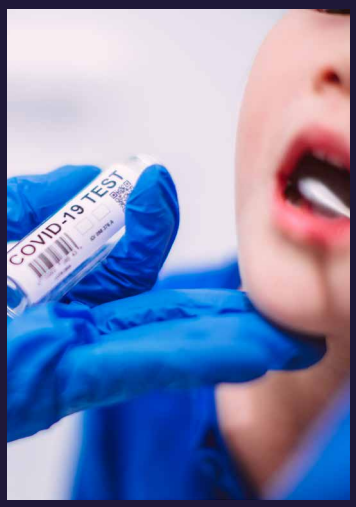


3. A Greater Focus on Inequalities and Deprived Communities

Although inequalities have always been a focus when planning and delivering services, the previous year has demonstrated that existing inequalities were linked with worse health outcomes. A greater focus should be given to improving the physical and mental wellbeing of more deprived communities, older people, children, people with learning disabilities, Black, Asian and other ethnic minority communities and people experiencing problems with drugs and alcohol, poor mental health and homelessness. This will be achieved by working with the communities and social networks in which they live, learn and work in and by improving their access to, and experience of healthcare and other services.

Ingredients for success:

- Focused effort and resource on people, vulnerable groups and communities with the worst health outcomes and commitment to working with communities and vulnerable groups on the aspects of their lives that make them feel good and function well.
- Partners employ equality impact assessment tools and health equity assessment tools in the design, development and improvement of services.
- Learning from COVID-19 is applied, including how Primary Care adapted access to services and the vaccine inequality programme to improve and tailor health and wellbeing communications and improve access and engagement with services.



4. Applying learning from COVID-19

Learn the lessons from the COVID-19 pandemic and continue to build on the enhanced working relationships with internal and external partners and our new partnerships with communities and workplaces.

Ingredients for success:

- Systems are in place for recording and sharing learning and partners are engaged with COVID-19 recovery activities.
- Population needs are well understood and insights from our communities are used to target and focus support for COVID-19 recovery, health and wellbeing.
- Systems are ready and able to provide a local response to the ongoing COVID-19 situation and other possible future public health emergencies, in partnership with the new UK Health Science Agency.

Acknowledgements

Thank you to all our partners across the local primary care networks, and those who contributed to this report:

Brett Jarman, Digital Project & Analytics Manager – Digital Strategy & Infrastructure, NHS Herefordshire and Worcestershire CCG

Emma Fisher, Senior Manager – Personalised Care, Prevention and Population Health Management, NHS Herefordshire and Worcestershire CCG

Misfits Theatre Company, Bristol and Redweather Productions, Bristol for The National Development Team for Inclusion for 'Health is Everybody's Responsibility (YouTube content)

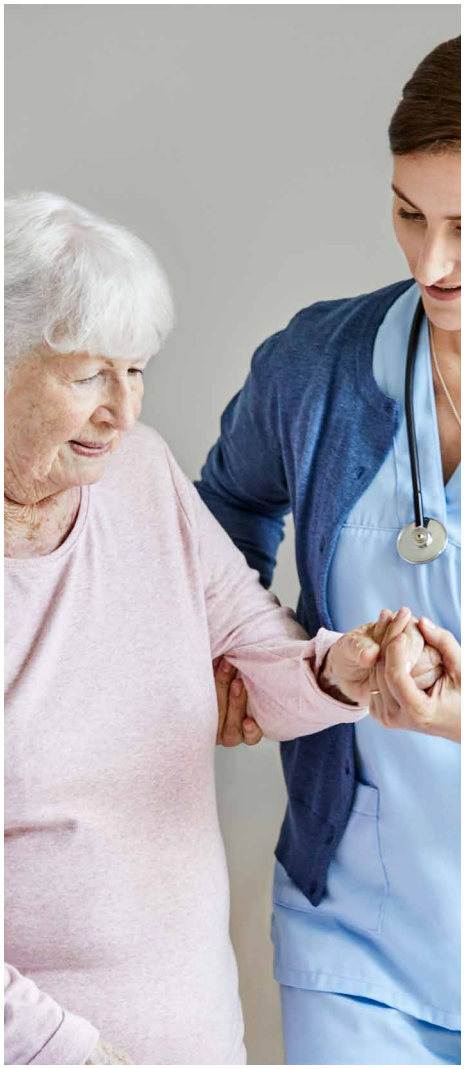
NHS England and NHS Improvement for 'Primary Care Networks Animation' (YouTube content)

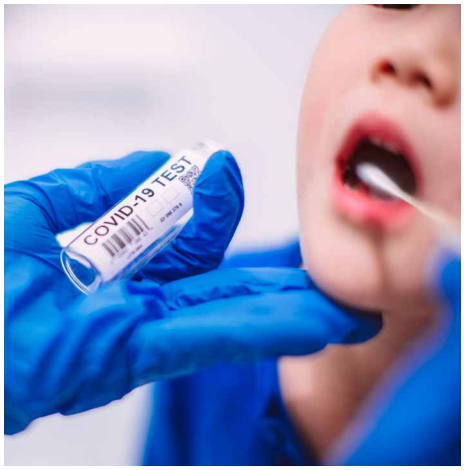
The Royal College of General practitioners for 'Personalised care for people with long term conditions: A changing GP approach' (YouTube content)

Liz Altay and Rachael Leslie, Public Health Consultants, and the wider Worcestershire Public Health Team

Notes on data:

This report utilises the most recently available published information from a variety of data sources as of May 2021. Data for both Herefordshire and Worcestershire is used for some indicators.




COVID-19 TEST

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AGENDA ITEM 10

HEALTH AND WELL-BEING BOARD
28 SEPTEMBER 2021

COVID-19 Health Protection Board Quarterly Report (July and August of Quarter 2 2021): Delivering Worcestershire's Outbreak Control Plan

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Board Sponsor
Dr Kathryn Cobain

Author
Hayley Durnall – Public Health Consultant
Victoria Moulston – Senior Public Health Practitioner

Priorities

Mental health & well-being	
Being Active	
Reducing harm from Alcohol	
Other (specify below)	COVID-19

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 note the delivery of Worcestershire's Outbreak Control Plan (OCP), the arrangements for governance and the current situation of Local Outbreak Response Team (LORT) operation.

Background

2. This quarterly report from the COVID-19 Health Protection Board will describe the delivery of the Outbreak Control Plan in July and August 2021. Therefore, this report will not cover the whole of Q2 (July – September)

3. Quarter 2 has seen many changes in the guidance for how to effectively manage COVID-19 while encouraging a return to business as usual, in line with step 4 of the roadmap.

4. From, 16th August 2021 any contact of a case of COVID-19 who is under the age of 18 and 6 months or is fully vaccinated is no longer required to self-isolate. Coronavirus (COVID-19): guidance and support - GOV.UK (www.gov.uk).

5. A contingency framework has been developed to support schools in the management of cases and outbreaks of COVID-19 Contingency framework: education and childcare settings (publishing.service.gov.uk)

Quarter 2 COVID-19 situation

6. As of 01 September 2021, Worcestershire COVID case rate was 265 per 100,000 population, which has remained high since easing of restrictions from 19th July. As a county, Worcestershire has seen COVID-19 rates stabilise at high rates between 200 and 300 cases per 100,000 population.

7. Due to vaccination, hospitalisations have been reduced, but there is still a relationship between case rates and hospital admissions. There are currently around 1-2 hospital admissions for every 100 COVID cases in Worcestershire.

8. Schools returning following summer holidays pose a risk to case rates in Worcestershire and nationally. When schools reopen, the mitigations in place to limit transmission within schools will be much reduced compared to the spring and summer terms. Additionally, the prevalence of infection in the community and school-age groups will be higher than in May 2021. Therefore, the LORT will be monitoring the situation in education settings very closely and continuing to work with schools across the county as required.

Local Outbreak Control Team Activity

9. In Quarter 2 the LORT dealt with a total of 1,000 situations and 2275 individual cases. This was a significant increase compared to the previous quarter, 492 situations and 958 individual cases observed in Q1. The period in June/July was as busy as the January Peak.

10. During May and June there was a significant increase in the proportion of cases in Schools, this continued to increase in July where 390 schools had situations. This accounted for 50% of the workload for LORT during July.

11. Workplace settings have also experienced a high number of situations compared to Quarter 1 (n.142). With 190 situations reported in July and 107 reported in August. This accounted for approximarely 30% of the workload for LORT during July and August.

12. ASC settings are experiencing an increase in cases for Q2, this is in contrast to Q1 where there were 70 cases. In July 71 situations in ASC settings were observed and 79 situations in ASC settings were observed in August. This is a significant change compared to Q1.

Contact Tracing

13. The LORT and WRS continue to work together to contact trace cases linked to outbreaks and those who NHS Test and Trace are unable to contact.

14. WRS are now piloting contact tracing all positive cases within Redditch and Worcester as part of covid zero. This means that all positive cases in Reditch and Worcester will be contact traced locally by WRS. This is likely to be shortly expanded county-wide.

Local infectious diseases guidance and advice for education settings

15. The LORT have developed localised infectious dieases guidance for education settings, including a template outbreak management plan. Also included is guidance regarding prevenetative measures and actions to be taken if there are outbreaks of Covid-19, diarrheoa and vomiting or suspected influenza.

Legal, Financial and HR Implications

16. The allocation is now an annual allocation of £2.9m with a £13m carry forward from last year leaving total available grants of £15.9m for 21-22. The allocation of spend was agreed at Health Protection Board in May 21. The total spend up to July 2021 is £1.7 million.

Privacy Impact Assessment

17. As appropriate.

Equality and Diversity Implications

18. A full Equality Impact Assessment has been carried out in respect of the overall Outbreak Control Plan. Impacts and mitigations are described for protected groups. The recommendations will further support action to prevent and control outbreaks that may affect protected groups.

Contact Points

County Council Contact Points
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Worcestershire Hub: 01905 765765

Specific Contact Points for this report
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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's Outbreak Control Plan:

https://www.worcestershire.gov.uk/info/20769/coronavirus_covid-19/2273/coronavirus_covid-19_outbreak_control_plan

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AGENDA ITEM 11

HEALTH AND WELL-BEING BOARD
28 SEPTEMBER 2021

2021/22 Better Care Fund (BCF) Budget Quarter 1 Update

Board Sponsor
Paula Furnival & Simon Trickett

Author
Stephanie Simcox – Deputy Chief Finance Officer (Service Finance)

Priorities	(Please click below then on down arrow)
Mental health & well-being	Yes
Being Active	Yes
Reducing harm from Alcohol	No
Other (specify below)	

Safeguarding

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

The Better Care Fund supports the safe and appropriate discharge of patients from the Acute and Community Hospitals.

Item for Decision, Consideration or Information
Information and assurance

Recommendation

1. The Health and Well-being Board is asked to note the forecast break-even position for the financial year 2021/22 as at the end of Quarter 1.

Background

2. In line with national requirements HWB's are required to receive regular reporting on the BCF budget and outturn, as part of their responsibility for overseeing BCF plans locally.

3. At its meeting on 22 June 2021 HWB approved the BCF budget for 2021/22 totalling £66.3 million including the Disabled Facilities Grant and Improved Better Care Fund.

4. This budget included growth of £4.258 million for 2021/22 – against which, whilst not assigned to individual budgets, has pre-commitment of £3.2m against to support Pathways 1-3 of the Discharge to Assess programme.

2021/22 BCF outturn as at Quarter 1

5. Since the approval of the budget, £0.446 million of the BCF growth has been allocated to support the required investment into the Integrated Community Equipment Store, including provision of additional vehicles and staffing. The growth remaining to be allocated therefore stands at £3.802 million, however this is expected to be utilised through the implementation of the revised Discharge to Assess Pathways.

6. To support with the increases in demand relating to COVID, local authorities and CCGs can claim funding from the national Hospital Discharge Programme reimbursement scheme since March 2020. This enables LAs to claim for costs relating to clients for a period post hospital discharge (6 weeks for clients discharged before 30 June 2021 and 4 weeks for clients discharged between 1 July and 30 September 2021). During Quarter 1, WCC claimed £1.42m from this separate funding stream. The scheme is due to cease at the end of September, therefore the ability to claim costs for new clients leaving hospital will end and their costs will need to be funded from the BCF.

7. As at the end of Quarter 1, the forecast is that the 2021/22 BCF will broadly break-even.

Legal, Financial and HR Implications

8. The BCF is a ring-fenced grant. It has been agreed that any over- or underspend will be jointly attributable to Worcestershire CCG and the Council.

Privacy Impact Assessment

9. Non relevant

Equality and Diversity Implications

10. The Equality Relevance Screening did not identify any potential Equality considerations relating specifically to this report.

Contact Points

County Council Contact Points
County Council: 01905 763763
Worcestershire Hub: 01905 765765

Specific Contact Points for this report
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Richard Stocks, Senior Finance Business Partner – Service Finance
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Email: Rstocks@worcestershire.gov.uk

Background Paper - Report to HWB on 22 June 2021

APPENDIX 1 - BETTER CARE FUND BUDGET MONITORING – QUARTER 1 2021/22

Better Care Fund
Budget Monitoring Period 3

Scheme	Funding Split			Total BCF budget for 2021/22	Outturn BCF (£)	Outturn iBCF (£)	Outturn DFG (£)	Outturn (£)
	BCF	iBCF	DFG					
Revenue Schemes from CCG contributions (stay in CCG)								
General Rehab Beds	12,399,850			12,399,850	12,399,850			12,399,850
Intermediate Beds	1,792,767			1,792,767	1,792,767			1,792,767
Neighbourhood Teams	6,359,242			6,359,242	6,359,242			6,359,242
Onward Care Team	692,140			692,140	692,140			692,140
Worcestershire IP Unit- Pathway 2	4,032,602			4,032,602	4,032,602			4,032,602
Total CCG contributions staying in CCG ledger	25,276,601	0	0	25,276,601	25,276,601	0	0	25,276,601
Funding transfer from CCGs to Local Authority (BCF only)								
Pathway 1(UPI)	3,700,837	0	0	3,700,837	3,700,837	0	0	3,700,837
Contingency	310,193	0	0	310,193	310,193	0	0	310,193
Contribution to Pathway 1 Call Centre Admin Costs (WCC)	100,000	0	0	100,000	100,000	0	0	100,000
Rapid Response Social Work Team	370,800	1,263	0	372,063	370,800	1,263	0	372,063
Pathway 3 (SPOT DTA)	1,826,225	719,894	0	2,546,119	1,826,225	719,894	0	2,546,119
External placement contingency (Winter Pressures)	0	758,548	0	758,548	0	758,548	0	758,548
Worcestershire Step-down Unit	185,000	0	0	185,000	185,000	0	0	185,000
ASWC in Community Hospitals, Resource Centres and DtA Beds- Onward Care Team	286,275	0	0	286,275	286,275	0	0	286,275
Carers	1,158,022	101,978	0	1,260,000	1,158,022	101,978	0	1,260,000
Implementation of the Care Act - additional demand for Home Care	2,178,997	298,942	0	2,477,939	2,178,997	298,942	0	2,477,939
LD Complex Cases	803,500	0	0	803,500	803,500	0	0	803,500
ICES	1,162,000	0	0	1,162,000	1,162,000	0	0	1,162,000
Winter Pressures Contingency	0	504,000	0	504,000	0	504,000	0	504,000
Disabled Facilities Grant	0	0	6,163,577	6,163,577	0	0	6,163,577	6,163,577
Contribution towards Community reablement	242,000	0	0	242,000	242,000	0	0	242,000
GP attached Social Workers	310,400	0		310,400	310,400	0	0	310,400
Improved Better Care Fund		16,080,500		16,080,500		16,080,500		16,080,500
Total Funding Transfer from CCGs to Local Authority	12,634,249	18,465,125	6,163,577	37,262,951	12,634,249	18,465,125	6,163,577	37,262,951
20/21 Recurrent Growth	2,158,403	-	-	2,158,403	2,158,403			2,158,403
21/22 Growth	1,643,502	-	-	1,643,502	1,643,502			1,643,502
Total Growth to be allocated	3,801,905	-	-	3,801,905	3,801,905	-	-	3,801,905
TOTAL BCF	41,712,756	18,465,125	6,163,577	66,341,458	41,712,756	18,465,125	6,163,577	66,341,458

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AGENDA ITEM 12

HEALTH AND WELL-BEING BOARD
28 SEPTEMBER 2021

Herefordshire and Worcestershire Learning from Lives and Deaths- People with Learning Disability (HW LeDeR) Annual Report 2020/21

Board Sponsor
Simon Trickett, Chief Executive NHS Herefordshire and Worcestershire CCG/ ICS Lead

Author
Rachael Skinner- Associate Director of Nursing and Quality, NHS Herefordshire and Worcestershire Clinical Commissioning Group

	(Please click below then on down arrow)
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

The HW LeDeR Programme works in alignment with safeguarding processes

Item for Decision, Consideration or Information
Information and assurance

Recommendation

1. The Health and Well-being Board is asked to note the HW LeDeR Annual Report for 2020/21, note the intention to develop a LeDeR Strategy during 2021 and agree to receive an annual update on progress against agreed priorities.

Background

2. People with a Learning Disability continue to be some of the most marginalised individuals within our local communities and experience some of the greatest health inequalities. Data to the end of 2019 (latest available national data) confirms that men with a learning disability die on average 22 years younger than men in the general population and woman die on average 27 years younger. The median age of death is 60 years, the age at which many others may be starting to reflect on and plan for years of happy retirement ahead.

3. LeDeR is a national service improvement programme commissioned by NHS England. The programme was developed following a recommendation of the Confidential Inquiry into the Premature Deaths of People with Learning Disability published in 2013. The programme roll-out was phased across England and commenced in the Midlands during late 2017. The purpose of the programme is to identify and implement learning that will prevent premature death and reduce health inequality for people with a Learning Disability.

4. The programme provides an infrastructure for reviewing the life and death of individuals notified to our system by the national LeDeR web-based platform. Learning, good practice and recommendations are collated from each individual LeDeR Review and analysed into themes to form system priorities for action.

5. The HW LeDeR Annual Report for 2020/21 outlines how as a collaborative partnership we have learnt from the outcomes of reviews, since 2017 and specifically over the last 12 months to April 2021, and how we have started to influence the shaping of services to achieve improvements in outcomes.

6. Key points of learning from 2020/21 data about the lives and deaths of people with a Learning Disability within our Integrated Care System geography

1. 79% of people who died were aged over 50 years- this compares to an England average of 72%. 2% of deaths reported were for those aged 17 years or younger, compared to 7% across England

2. In Worcestershire the median age of death for men improved from 60 years in 2019/20 to 62 years of age in 2020/21.

3. Deaths reported in 2020/21 more closely represented the ethnicity profile of Worcestershire (8% of deaths were for people who represent an Asian, Black or other minority ethnic group). We need to do more to fully understand the ethnicity profile of our Learning Disability population to ensure that we are receiving notifications that reflect the needs of all local people.

4. A greater percentage of people in Worcestershire were able to die in a place other than a hospital bed (less than 40% in 2018/19 to 53% in 20/21). This compares to an average of 41% for LeDeR notifications from across England).

5. As a system we have had a smaller ratio of deaths due to Sudden Death in Epilepsy, sepsis and bowel impaction than the England LeDeR programme average.

6. Deaths linked to cardio-vascular disease have remained fairly static. Analysis of underlying health conditions undertaken this year reflects that all those who had cardio-vascular disease listed in Part 1 of their death certificate also had a high Body Mass Index.

7. The profile of deaths notified during 2020/21 was impacted by COVID-19. Worcestershire reported 9 more deaths during 2020/21 (36 cases) than the average across the previous 2 years. Individuals with COVID-19 listed in Part

1 of their death certificate totalled 8 and were all reported April to June 2020 (one COVID-19 death in wave 2 was reported in 2021/22).

8. LeDeR Rapid Reviews undertaken as part of the LeDeR process enabled us to identify learning that shaped our planning during and following wave 1 of the pandemic and helped us protect more people in wave 2. This included the coordination of COVID-19 testing across Learning Disability care settings ahead of the national offer (to support the identification of asymptomatic cases and reduce outbreaks) and endorsement to offer COVID vaccinations for people with a Learning Disability living in a care setting alongside older people in care settings in JCVI 1.

9. The percentage of cases notified to HW LeDeR with an underlying health condition of epilepsy, cardio-vascular disease, a mental health diagnosis, constipation, dysphagia or for having 3 or more long term health conditions were slightly greater for Worcestershire than the LeDeR England average. We need to do more to understand the profile of health need across the whole of our Learning Disability population to help shape next steps. An updated Joint Strategic Needs Assessment for Learning Disability in 2021 will help us to do this.

7. What we achieved during 2020/21

1. Learning and recommendations extracted from completed reviews are themed to help our LeDeR Learning into Action Group determine key priorities. A workstream (Priority Action Group) is developed for each key priority area.

2. The COVID-19 pandemic resulted in some aspects of workstream activity being paused to enable a focus on emerging areas of significant need.

3. Actions taken (detailed within the Annual Report on pages 34-36) supported the following outcomes:
-84.9% uptake of Annual Health Checks achieved by HW Primary Care Networks
-a coproduced resource pack to support Primary Care Networks to sustain high completion rates and high levels of quality of Annual Health Checks https://herefordshireandworcestershireccg.nhs.uk/our-work/learning-disabilites-and-autism/annual-health-checks
-an increase of 14-25 year olds on GP Learning Disability Registers
-88% uptake of COVID-19 vaccination for people with a Learning Disability by the end of March with further increases to exceed 90% into April 2021.

4. Learning extracted from COVID 19 related Rapid Reviews also increased confidence that national media reports of the discriminatory application of Do Not Resuscitate decisions for people with a learning disability were not widespread within our system.

Next steps

8. A new national LeDeR Policy was published in March 2021. Implementation of the Policy is required during 2021/22 and includes revised governance and workforce

arrangements and a broadening of the scope to include all adults with a diagnosis of Autism. A 3 minute video on the revised LeDeR Programme can be viewed here https://www.youtube.com/watch?v=v2b9ZU-4tRM

9. The LeDeR Policy 2021 requires that we develop a 3 year LeDeR Strategy. Learning from LeDeR has informed the Learning Disability and Autism 3 Year Plan approved by the Learning Disability Partnership Board and ICS Learning Disability and Autism Programme Board in April 2021.

10. Our priorities for supporting people to develop longer, healthier and happier lives will form the basis of our LeDeR Strategy and are outlined below and in table 6 on page 38 of the Annual Report:

- Emotional well-being and good mental health
- Choice and shared decision making for periods of acute ill-health or toward end of life
- Recognising and responding to health need through Annual Health Checks
- Maximising protection from respiratory conditions
- Good bowel health
- Preventing health needs associated with obesity

11. All priorities are underpinned by the following enabling principles:

-people with lived experience remain at the heart of the LeDeR programme
-Meaningful inclusion and choice informs better health outcomes and decisions (including mental capacity assessment and best interest decisions)
-our system workforce need to be equipped to recognise and respond to the personalised adjustments that enable access and equity
- collaborative working and information sharing achieve great things

Legal, Financial and HR Implications

12. Implications of the new LeDeR Policy will be determined during 2021

Privacy Impact Assessment

13. Not applicable

Equality and Diversity Implications

14. The Learning Disability and Autism work programme aims to reduce discrimination and advance equality of opportunity and outcomes for and with people with a learning Disability or Autism. All commissioning decisions that are informed by the outcomes of the LeDeR programme will be subject to a full Equality Impact Assessment.

Contact Points

County Council Contact Points
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Worcestershire Hub: 01905 765765

Specific Contact Points for this report
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Supporting Information

Appendix 1- Herefordshire and Worcestershire Learning from Lives and Deaths- People with Learning Disability (HW LeDeR) Annual Report 2020/21

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Herefordshire and Worcestershire
Integrated Care System

Annual Report 2020/2021

Learning Disabilities Mortality Review **(LeDeR)** Programme (Herefordshire and Worcestershire)

June 2021

Rachael Skinner - Associate Director of Nursing & Quality and LeDeR Lead Area Coordinator

Learning Disabilities Mortality Review (LeDeR) Programme

Table of contents

1. Introduction

The Learning Disabilities Mortality Review (LeDeR) programme was established to support local areas to implement a consistent format for the review of deaths of people with learning disabilities. The key principles of the programme are to identify learning from the review of deaths, for learning to inform service improvement initiatives and for those initiatives to affect meaningful change in improving outcomes for local people.

The LeDeR programme was implemented at a time of considerable focus on the deaths of patients in the NHS. Phased roll-out of the programme reached Herefordshire and Worcestershire in the autumn of 2017. The initial introduction of the programme coincided with the introduction of the Learning from Deaths guidance which made clear the expectation that the LeDeR methodology would be the preferred format for reviewing deaths for people with a learning disability. The LeDeR programme is commissioned on behalf of NHS England (NHSE) and during 2020/2021 continued to be hosted by the University of Bristol.

During 2020/2021 all deaths continued to receive an Initial Review. Where there are areas of concern in relation to the care of the person who has died, or if it is felt that further learning could be gained, a more detailed Multi-Agency Review (MAR) of the person's life and death is facilitated. LeDeR does not replace other statutory formats and processes for reviewing a person's death where concerns exist. On completion of the review (Initial or MAR), recommendations are made and an action planning process identifies service improvements that may be indicated. More information about the national programme can be found on the website for LeDeR hosted by the University of Bristol http://www.bristol.ac.uk/sps/leder/about/ or after 1st June 2021 on the NHS England website https://www.england.nhs.uk/learning-disabilities/improving-health/mortality-review/ . Easy read information about the programme and its publications can be found at http://www.bristol.ac.uk/sps/leder/easy-read-information/

This report provides an update on the progress and impact made across Herefordshire and Worcestershire during the period covering 1st April 2020 to 31st March 2021, the third full year of programme implementation for our system. It builds on the achievements made up to March 2020, and covers local progress for Herefordshire and Worcestershire in our first year as an integrated programme across both counties within our evolving Integrated Care System (ICS). A new national LeDeR Policy was published in March 2021 and the requirements of this are reflected in appendix 3. The report reflects some of the extraordinary efforts of our partners to work together through a year that many will never forget. This includes the initial and subsequent peaks in the number of cases of the COVID-19 pandemic and some of the consequential implications of 'lockdown'. It will undoubtedly take some time to fully appreciate the impact of COVID-19, on individuals health and on the health inequality of people with a learning disability. We will continue to remain mindful of this as we review lives and deaths during 2021/22 and beyond.

2. Delivery of the LeDeR programme in Herefordshire and Worcestershire

2.1 Our Purpose- what we set out to do

The overriding principle, clearly set out in the Terms of Reference for each forum within the meeting structure that supports the LeDeR Programme across Herefordshire and Worcestershire, is to affect meaningful change and improve outcomes for local people. The outcomes that we are aspiring to achieve include supporting longer, healthier and happier lives for people with a Learning Disability across our Integrated Care System. In each previous year we have set out a work plan, agreed in partnership, based on the thematic recommendations arising from LeDeR Reviews. The infrastructure of the LeDeR programme then works closely with partners from and beyond the infrastructure of the Learning Disability Partnership Board arrangements in each county, to collaborate, to form ideas and action solutions.

Partnerships within the LeDeR programme across Herefordshire and Worcestershire (H&W) are built on the firm legacy of inclusion and placing experts by lived experience at the heart of what we do. The foundations of the Learning Disability Partnership Boards and Transforming Care Partnership infrastructure enable representation from people with a Learning Disability, family carers, advocacy, social care, commissioners, Public Health, Safeguarding, specialist Learning Disability Teams and our Acute NHS Trust providers to contribute to our programme outcomes. Local people inform local outcomes and we each hold each other to account for what we set out to achieve.

2.2 Our Governance - The local framework for enabling and assuring delivery of the programme

Over the course of 2020/2021 our local framework for overseeing and gaining assurance about how our programme operates has evolved. Some of our plans to embed an integrated H&W Steering Group and county-based Learning into Action Groups were interrupted by the COVID-19 pandemic. The newly established Steering Group with revised membership formally met only once. Updates on performance were provided by email and communication was maintained with strategic partners through other forums including the STP Mortality Oversight Group, Learning Disability Partnership Boards and the STP Learning Disability and Autism Board.

A focus was placed on continuing to engage with each county-based Learning into Action Group. Updates were provided to the Adult Safeguarding Board in each county on two occasions during this year, such was the concern regarding the impact of the COVID-19 pandemic on the mortality of people with a learning disability.

The LeDeR Steering Group (Appendix one) and Learning into Action Groups each have clear Terms of Reference, agreed by membership, that reflect:

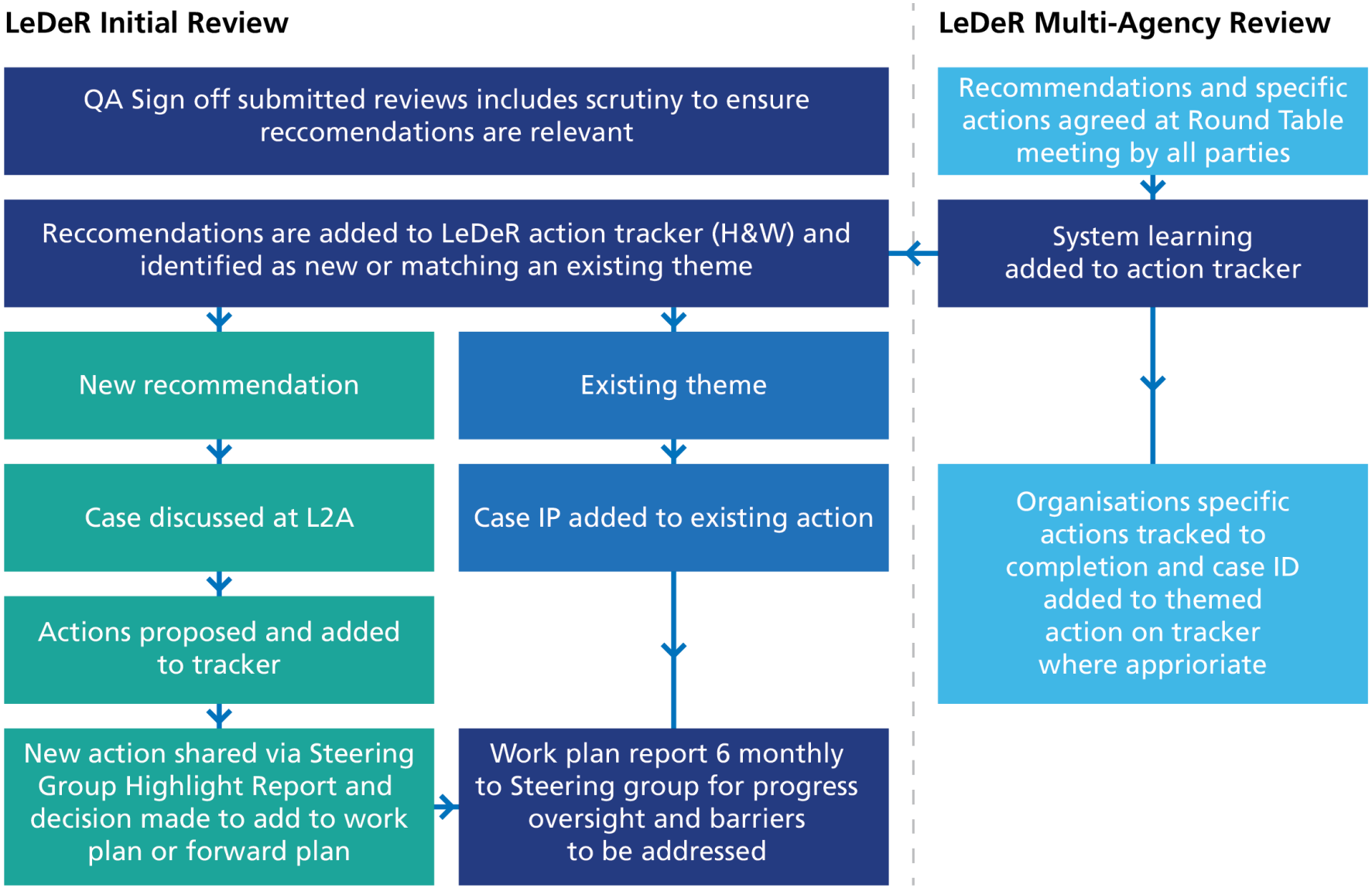
- The scope and purpose of the forum
- Representative membership (predominantly at strategic level for the Steering Group and operational level for the Learning into Action Group)
- Governance arrangements including responsibility, accountability, and reporting arrangements.

The performance of the programme (how well it is meeting NHS England targets for the timely allocation and completion of reviews) and progress with Priority Action workstreams are reported, at different but proportionate levels of detail, to both the Steering Group and the Learning into Action Groups.

The LeDeR Programme Senior Responsible Officer (SRO) is Lisa Levy, HWCCG Chief Nursing Officer. The LeDeR Lead Area Coordinator is Rachael Skinner, HWCCG Associate Director of Nursing & Quality. LeDeR programme updates are reported to the HW Learning Disability and Autism Programme Board. This Annual Report will reported to the Health and Wellbeing Board for each Local Authority in our system, in Public.

Within the reporting period the implementation of the programme has been reviewed and revised in response to emerging best practice to support effective delivery. The consolidated Reviewer group, made up of a dedicated resource of individual's whose body of work is focused solely on the LeDeR programme, has been expanded to ensure consistency across both counties. The Clinical Lead for LeDeR, substantively employed by the CCG, has been joined on an interim basis by a LeDeR Clinical Officer. Their role will be to conduct and lead Review completion, further strengthen Reviewer support and supervision and work with the LeDeR Clinical Lead to oversee and coordinate the sharing of best practice and the progress of Priority Action workstreams in taking forward agreed areas of service improvement. A clear process is in place to ensure that the recommendations arising from LeDeR reviews inform the LeDeR work plan and Priority Action Group themes (see table 1). The LeDeR Team and programme implementation will continue to be supported by an administrative and project support resource.

Figure 1 - How the outcomes of reviews informed H&W LeDeR work plan during 2020/21



Undertaking a review can often result in exposure to distressing details of the circumstances leading up to a person's death. Contact with bereaved relatives and care staff can also be emotionally demanding. It is therefore important that reviewers are supported appropriately in order that they can carry out their role effectively and with compassion. The requirement for remote working and the impact of the pandemic (both emotionally and in terms of the volume of notifications requiring timely completion) has meant that the LeDeR Clinical Lead role has been as vital as ever in supporting Reviewer wellbeing and an outstanding level of timely and consistently high standard completed reviews.

The process for the quality assurance and approval of all completed reviews has been maintained throughout this year, despite periods of redeployment to alternative but vital clinical roles during the pandemic. The length of time taken between the initial submission and approval of a completed LeDeR review is at times longer than we would like and this was particularly true during the period where we worked in close partnership with NHS England and the North East Commissioning Support Unit to address a backlog of reviews to December 2020. The process of quality assurance does however mean that the friends and families of people with a learning disability who lose a loved one can feel confident that relevant aspects of learning are drawn from each LeDeR review with the aim of influencing improvements in the healthy future lives of others. Where the potential for care gaps or failings are apparent within the detail of an individual LeDeR review the LeDeR programme will work alongside colleagues and families to ensure alignment or escalation to appropriate statutory processes including NHS provider Serious Incident reporting, Safeguarding Reviews and Coroners Office proceedings.

Responding to the recommendations of the Oliver McGowan Review

In November 2016 Thomas Oliver McGowan (known as Oliver) died. In May 2017 (when the LeDeR process was in its infancy) a LeDeR Review was commenced by South Gloucestershire CCG following a request by NHS England. Concerns were raised by Oliver's family about the outcomes of the review and the way in which the outcomes had been determined. An independent review was commissioned and in October 2020 the report of that independent review was published. The report made a series of recommendations for the way in which the LeDeR programme should be conducted. Appendix two contains the HWCCG response to these recommendations.

2.3. Collaboration and Partnerships

The contribution of our experts with lived experience, both individuals with a learning disability and family carers, are central to the delivery of the LeDeR programme for H&W. Here is what our partners had to say about how it feels to be involved in LeDeR across Herefordshire and Worcestershire.

'They always ask us what we think - I think it's good they listen to what we have to say.

''Lots of good things have come out of LeDeR and Health Checkers are always involved'.

HealthCheckers, Speak Easy NOW

It's rewarding to sit in LeDeR meetings as equal partners, under inspirational leadership, and to have a voice in making things better for people with learning disabilities. We feel encouraged to use our lived experience to suggest measures to help prevent unnecessary deaths for people with learning disabilities.

Anne Duddington and Alison Price
Family carer representatives,
Worcestershire Association of Carers

'It's not easy to think about dying. It makes me feel sad and a bit upset'.

'Talking about people dying is morbid and makes me sad. I don't want to think about it too much but I know we can learn things from doing it'.

HealthCheckers, Speak Easy NOW

'I liked the lady who made the poo cake. She made me laugh.'

HealthCheckers, Speak Easy NOW

'Some of the information is very complicated.'

'I don't always understand what they're talking about but it's OK to say that. They try to make hard things easier for us to understand'

'LeDeR people talk to us in ways we can tnderstand. I like that,'

HealthCheckers, Speak Easy NOW

"Carer representatives, with a variety of support from WAC, give up huge amounts of time to support the LeDeR work. In recognition of this input, the growing opportunities of carer involvement within LeDeR and the value of being experts by experience in this role, it would be positive to give consideration to offering some sort of honorarium or additional support to continue to fulfil this and future roles."

Jenny Hewitt, Carer Engagement Lead, on behalf of Carer Reps, Worcestershire Association of Carers (WAC).

"Supporting carer reps as part of this work, demonstrates a real sense of collaborative working and really taking on board the views of carers. The co-productive approach is to be celebrated. It is an outstanding approach to collaborative working and sets a standard to other areas of work."

Jenny Hewitt, Carer Engagement Lead, on behalf of Carer Reps, Worcestershire Association of Carers (WAC).

2.4. Performance of Herefordshire and Worcestershire LeDeR

The system for receiving notifications of the deaths of people with a learning disability registered with a Herefordshire or Worcestershire GP went live on 1st October 2017 Notifications continue to be predominantly made by Community Learning Disability Nurses or Learning Disability Acute Liaison Nurses. Unlike in the previous year no family members have initiated a notification during this reporting period.

Any person can make a notification by accessing http://www.bristol.ac.uk/sps/leder/notify-a-death/ The pattern of notifications received by Herefordshire and Worcestershire is detailed in table 2. To the end of February 2021 a total of 160 deaths have been reported to LeDeR for Herefordshire and Worcestershire (due to the transition of the LeDeR platform hosting arrangements no notifications have been received for March 2021 and reported notifications for March will be visible to each CCG on 1st June 2021)

Table 1: Notifications made to Herefordshire and Worcestershire LeDeR. 2018-2021

Herefordshire						Worcestershire					
Notifications received	Q1 (April – June)	Q2 (July – Sept)	Q3 (Oct-Dec	Q4 (Jan-March)	Full Year	Notifications received	Q1 (April – June)	Q2 (July – Sept)	Q3 (Oct-Dec	Q4 (Jan-March)	Full Year
2018-19	3	3	6	6	**18**	2018-19	10	3	7	12	**32**
2019-20	6	4	2	4	**16**	2019-20	7	2	6	8	**23**
2020-21	3	5	0	3	**11**	2020-21	22	6	1	7	**36**

For both counties, but more significantly within Worcestershire, the number of notifications fell overall during 2019-2020. During the first quarter of 2020-21 the COVID pandemic impacted mortality across the UK and the number of notifications for Worcestershire were almost equal to the total number of notifications for the whole of the preceding year. Notifications made from Herefordshire did not increase during the COVID pandemic and were actually lower than the previous year. 2021/22 will bring new opportunities to ensure that all parts of our system are aware of the importance of making notifications to the LeDeR programme. This will strengthen confidence that we are taking every opportunity to learn from peoples lives and deaths.

As part of the LongTerm NHS Plan CCGs are monitored for the number of reviews that are completed within 6 months of notification. Herefordshire and Worcestershire LeDeR are committed to ensuring that reviews are completed within 6 months where able (excludes those cases open to the Coroner or subject to Safeguarding processes, provider Serious Incident investigation or Complaints processes or Child Death Overview panel review).

Before the beginning of this reporting period processes had been refined to support the timeliness of review completion. Administration support was secured to ensure that electronic notes were requested to be available at the commencement of each review. Family and / or residential care provider contact was coordinated by the CCG. In March 2020 however the LAC and LeDeR Clinical lead were redeployed to a COVID Infection Prevention and Control (IPC) cell as part of the Incident Control response. This resulted in delays in allocation with a knock-on impact for timely review completion. Rather than focusing on Review completion the CCG LeDeR Team worked proactively with care settings to support the minimisation of outbreaks and its impact on mortality.

Performance of the Herefordshire and Worcestershire LeDeR programmes is important because of its ability to support the completion of timely mortality reviews to affect meaningful change in areas where contributory or modifiable factors influencing avoidable or premature mortality are identified. Rapid Review templates were completed for all confirmed or suspected COVID-19 deaths to enable the identification of learning to inform the ongoing efforts of the IPC cell.

For cases notified up to 30th June 2020 there was a requirement to complete 100% of reviews by 19th December 2020. H&W achieved this requirement within the agreed timescale.

Figures 2-4 reflect our performance to allocate notifications to Reviewer within 3 months and to complete a review within 6 months.

The time taken to complete reviews varies and a number of cases continued to be on hold due to statutory processes (for example pending Coroner's Inquest or Child Death Overview Panel processes). During 2020/21 the impact of reduced contact for those who lost loved ones who died in a care setting or hospital that they were unable to visit until a dying persons final hours, affected families significantly. The impact on bereavement response led some families to need some time to be able to engage with the LeDeR process. The timeliness of allocation to a Reviewer is also impacted by Reviewer capacity. Performance for timely allocation to a Reviewer and the completion of Reviews has improved significantly over 2020/21. Whole programme performance will continue to reflect challenges experienced in the early stages of the programme and the impact of the pandemic in Q1 of 2020/21. From 1st June 2020 72% of reviews have been completed within 182 days and 90% completed within 190 days.

Figure 2 - Notification to allocation - % within 91 days (Herefordshire and Worcestershire)

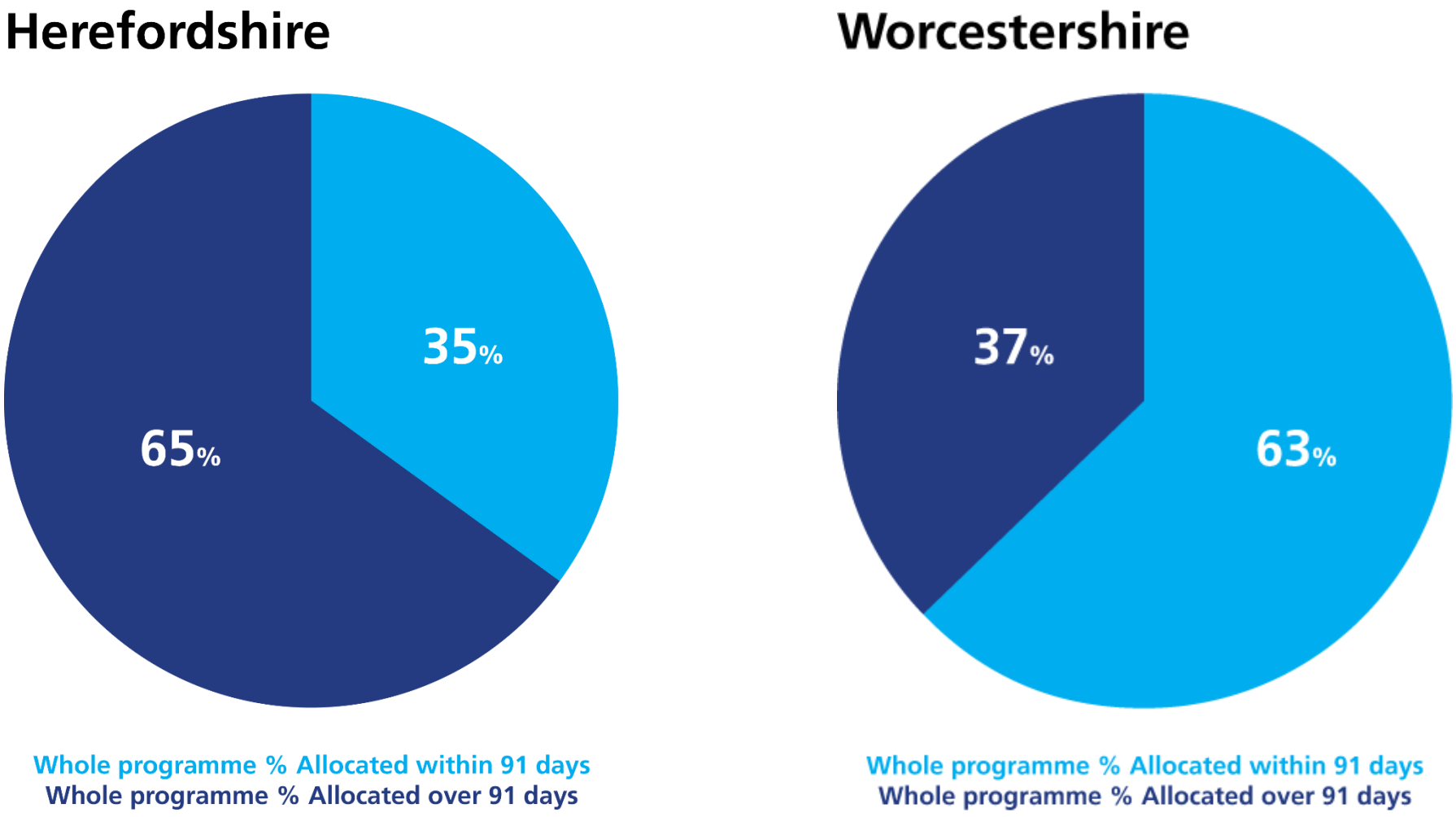


Figure 3 - Average number of days to allocation

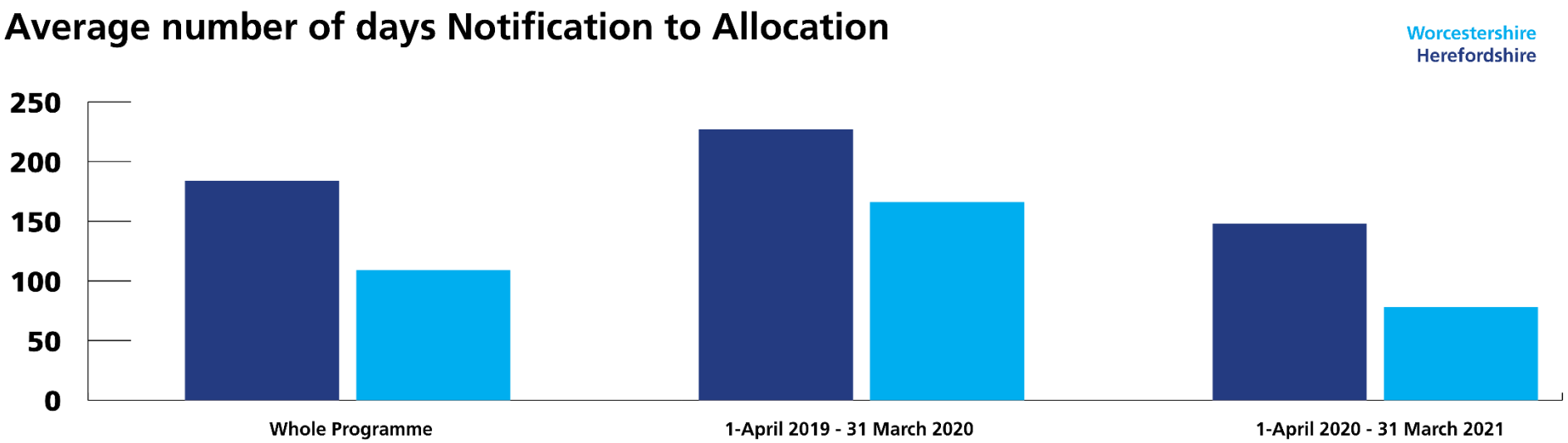
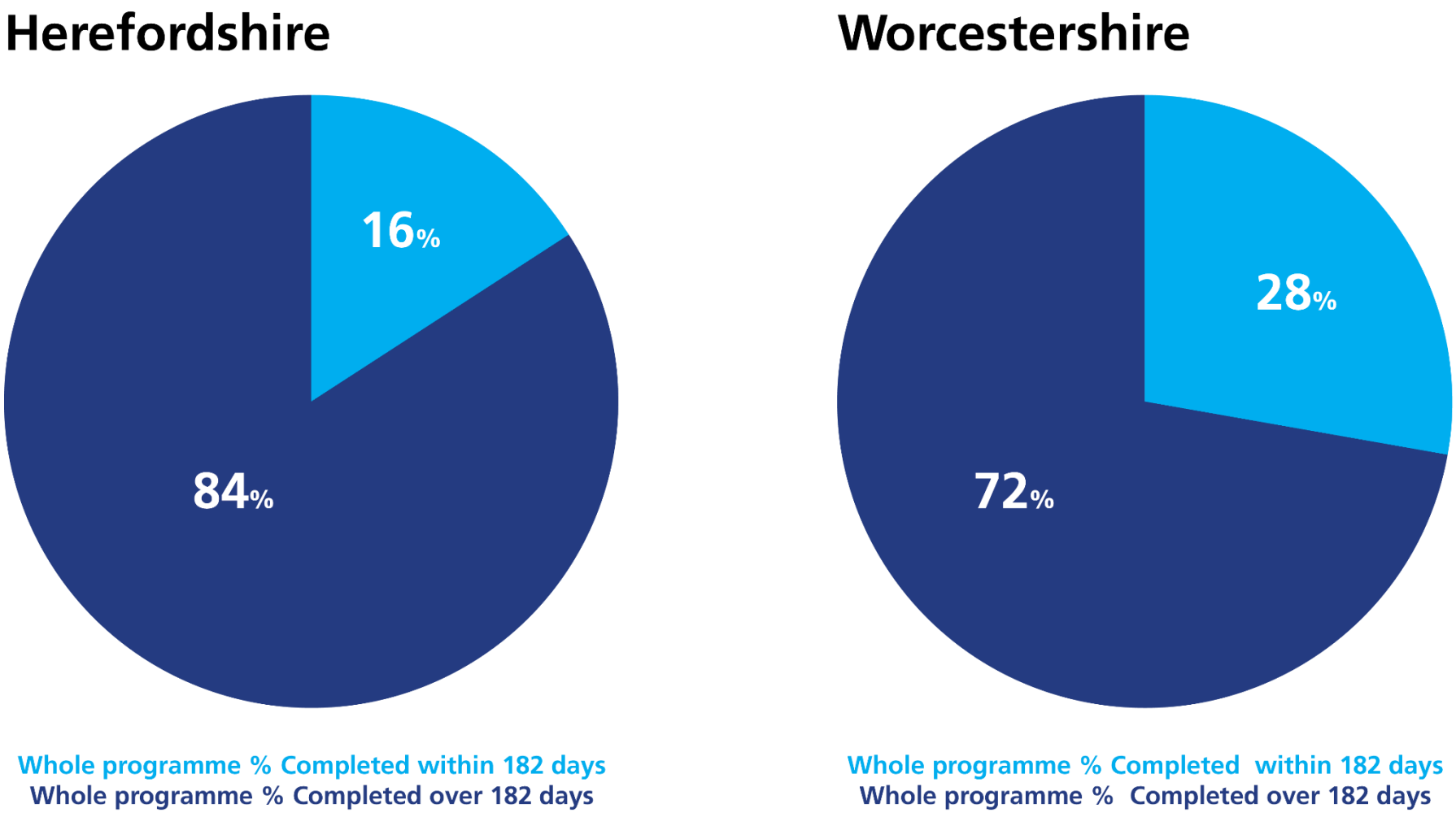
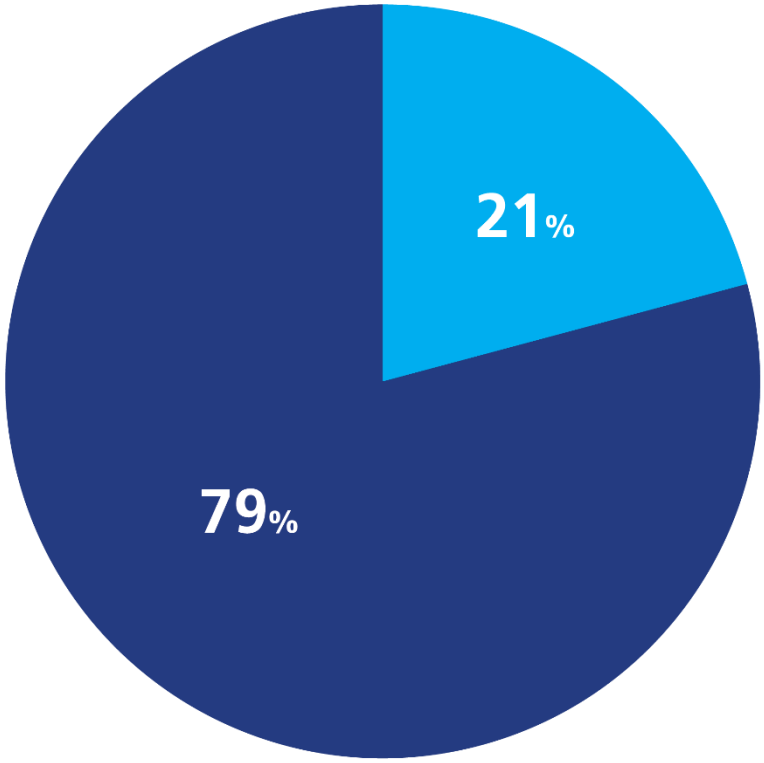


Figure 4 - Notification to completion - % within 182 days

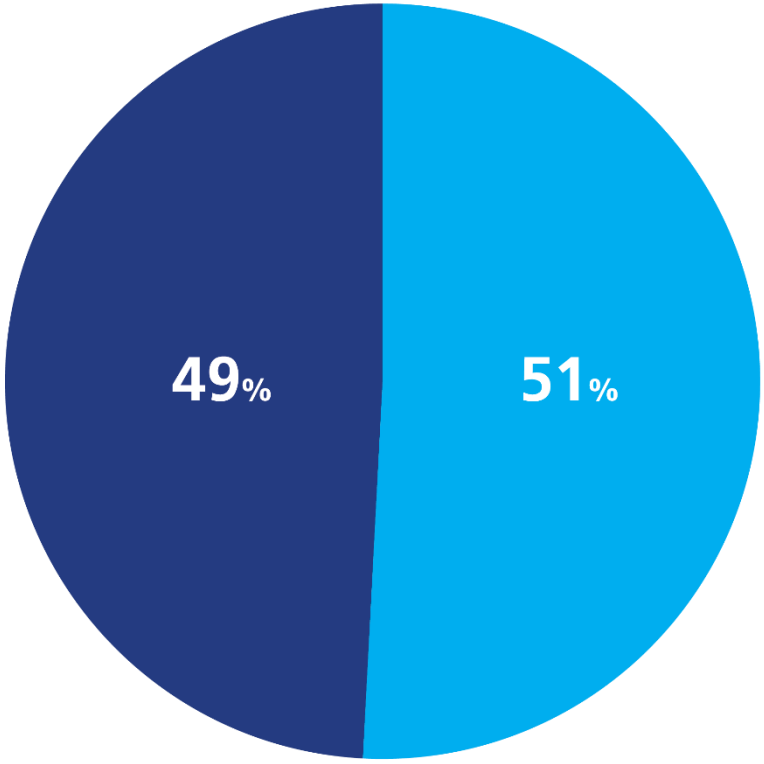


ICS - % Completed within 182 days from notification - 2019/20



April19 - March20 % Completed within 182 days
April19 - March20 % Completed over 182 days

ICS - % Completed within 182 days from notification - 2020/21



April20 - March21 % Completed within 182 days
April20 - March21 % Completed over 182 days

3. Learning from LeDeR Reviews

Learning from the information and recommendations provided by initial notifications and completed reviews is a key focus of the LeDeR programme implementation for Herefordshire and Worcestershire system. It enables us to, where possible, benchmark outcomes or experiences for people within our system compared to the regional or national average and supports us to understand if we are making progress over time. The national LeDeR Annual Report (latest available is for 2019 and was published during 2020) will be used as a benchmark throughout this section where data is available.

3.1 Reflections on the characteristics of deaths of people with a learning disability from Herefordshire and Worcestershire, notified to LeDeR.

Age profile of notifications

Table 2 –median age of death for men and women

	Median age for women (2017-2020)	Median age for men (2017-2020)	Median age for women (2020-2021	Median age for men (2020-2021)
England (2019)	59 years	61 years	Not yet available	Not yet available
Midlands (2019)	59 years	60 years	Not yet available	Not yet available
ICS	61 years	61 years	64 years	63 years
Herefordshire	61 years	64 years	71 years *	67 years
Worcestershire	61 years	60 years	61 years	62 years

*Based on very small numbers of deaths

Table 3 - age group at death as a percentage of all notifications made

Age bracket	4-17 yrs	18-24 yrs	25-49 yrs	50-64 yrs	65 yrs and above
England	7%	4%	16%	35%	37%
ICS	2%	5.6%	13%	40%	39.4%
Herefordshire	2%	4%	12%	40%	46%
Worcestershire	2%	6.5%	14%	40.5%	37%

What does this tell us about the age of death within our system?

For notifications made between 2017 and March 2021 the median age of death across H&W is marginally higher than the Midlands and England average for women with a learning disability and has improved over the period of the programme.

For notifications made between 2017 and March 2021 the median age of death across H&W for men with a learning disability is marginally better than the median for the Midlands region and the same as the England median age.

The median age of death for those residing in Herefordshire continues to be significantly better for both men and women.

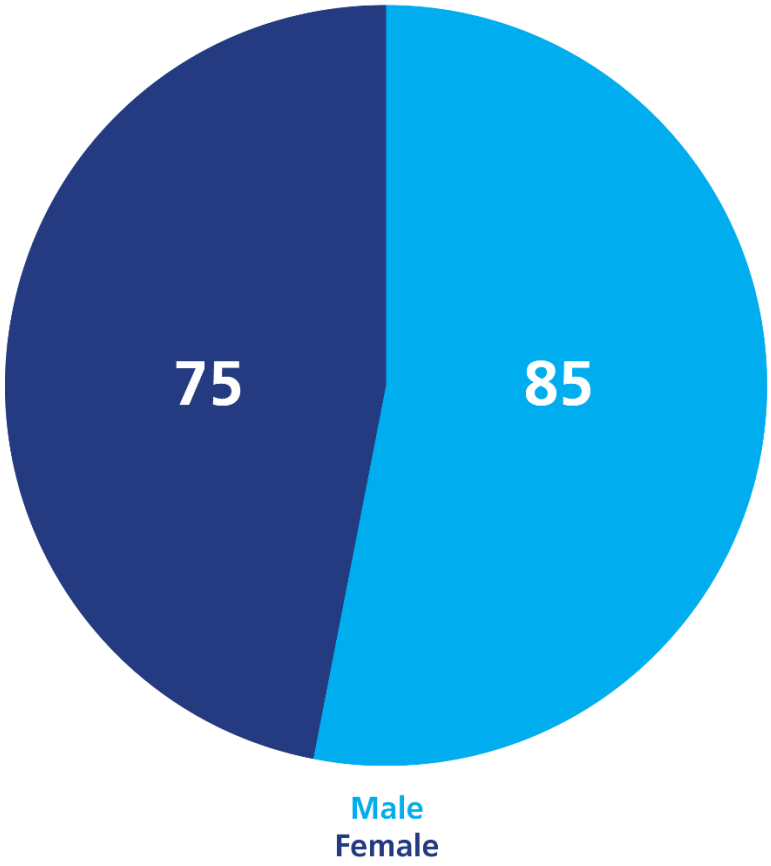
The Midlands and England median age reflects data to 2019 and does not therefore reflect the impact of the COVID-19 pandemic.

The percentage of deaths reported to H&W that are for those aged under 17 years is smaller than for England. The percentage of deaths for those aged 18-24 years in H&W is greater than the England position. This could indicate that either child deaths are under reported to H&W LeDeR or that those with life limiting conditions live into their early adult years. To 31st March 2021 only a very small number of child deaths (4-17 years) have been reported to H&W LeDeR. No concerns have yet been raised for any child death reported to H&W LeDeR and deaths were expected as part of a complex life limiting medical condition. The percentage of deaths for 4-24 year olds is smaller than the England average.

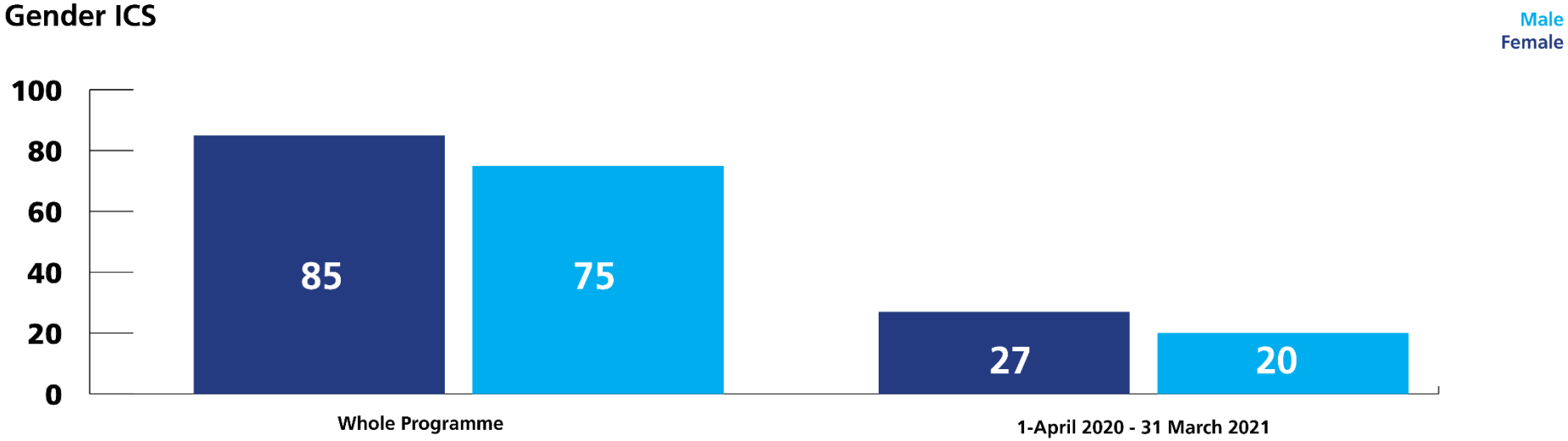
For H&W notifications the percentage or those aged 50-64 years and 65 years and above is greater than the England position, particularly for those residing in Herefordshire. Further analysis is required and caution needs to be applied due to small numbers.

The profile of notifications by gender

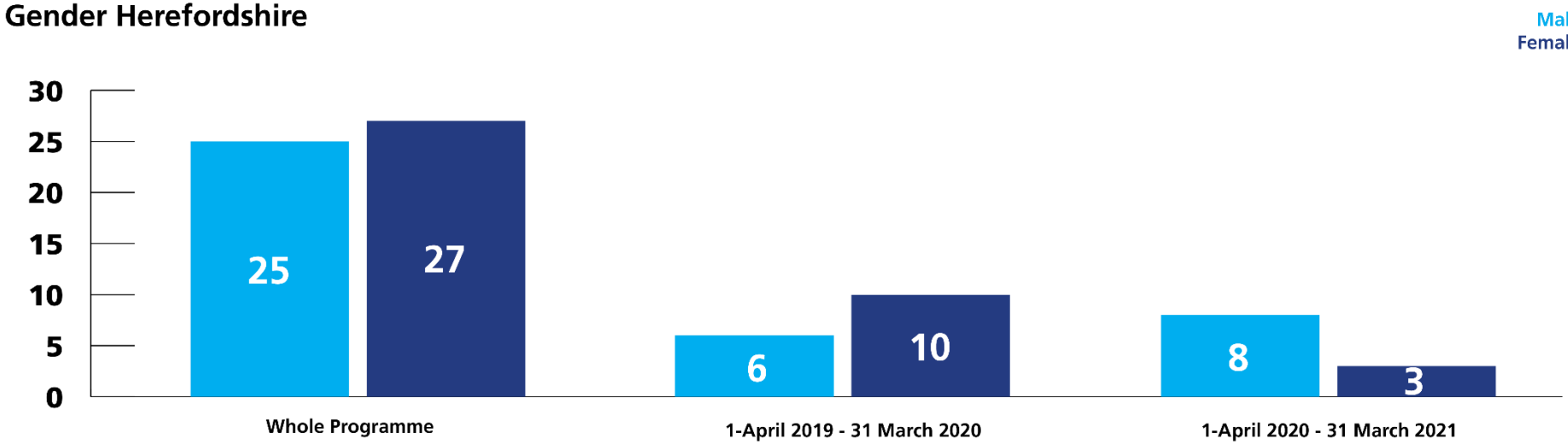
Figure 5 - notifications made for men and women

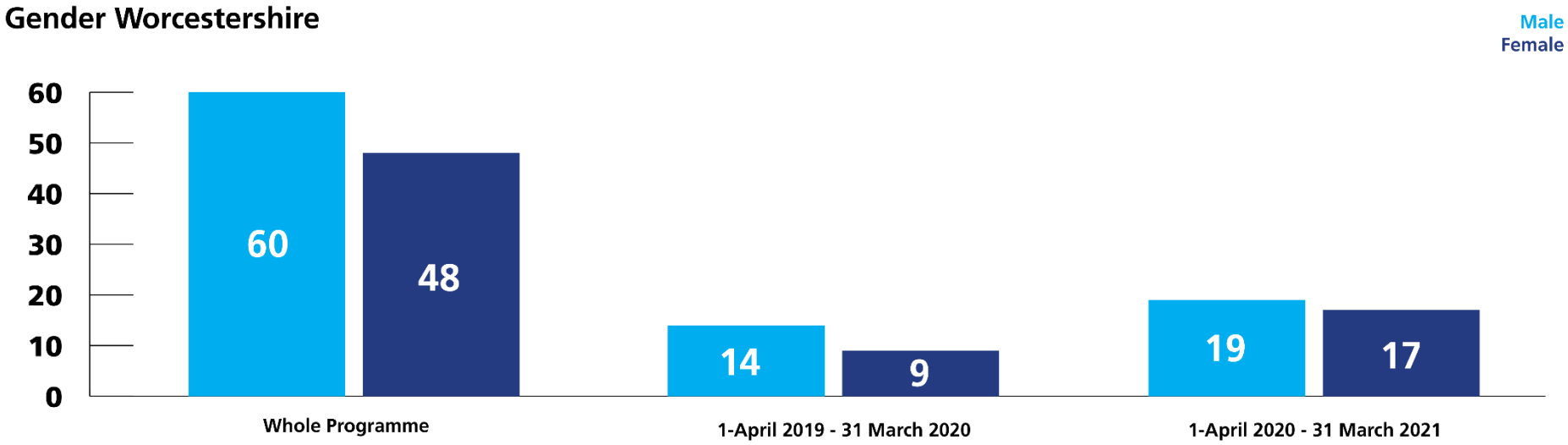


Gender ICS



Gender Herefordshire



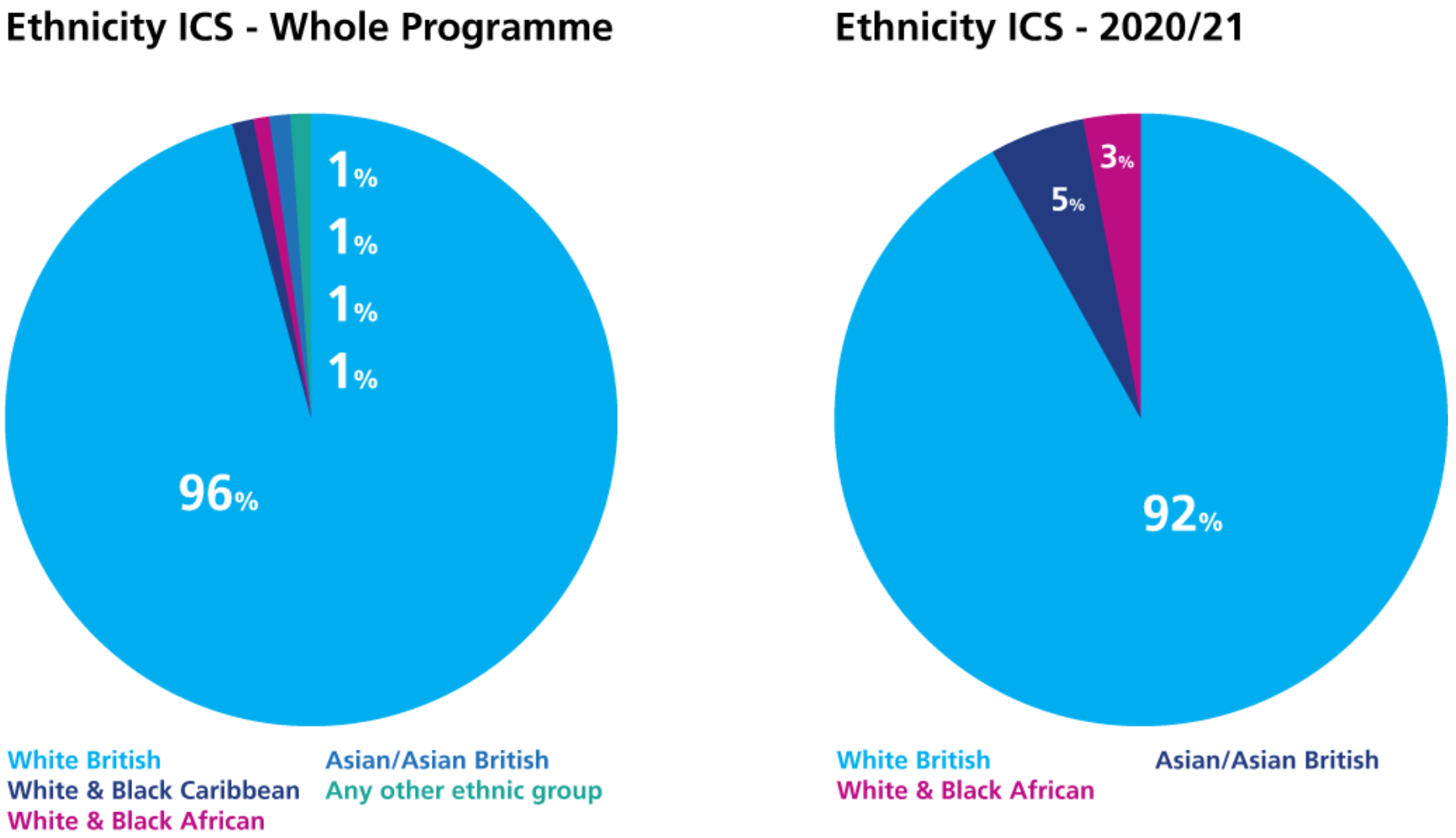


What does this tell us about the impact of gender on lifespan?

The median age of death for men and women is reflected in table 2 and 3. The national report reflects that 58% of notifications were for men. Whilst the overall profile across the ICS since 2017 reflects a more equal distribution (53% men : 47% women), there has in previous years been a higher ratio of notifications for women in Herefordshire. The 2020/21 H&W profile more closely reflects the national distribution of notifications (57% men : 43% women). Data for England across 2020 will be reflected in the national report expected by September 2021.

The ethnicity profile of notifications made to H&W LeDeR

Figure 6 – the ethnicity profile of notifications made to H&W LeDeR since 2017 and for 2020/21

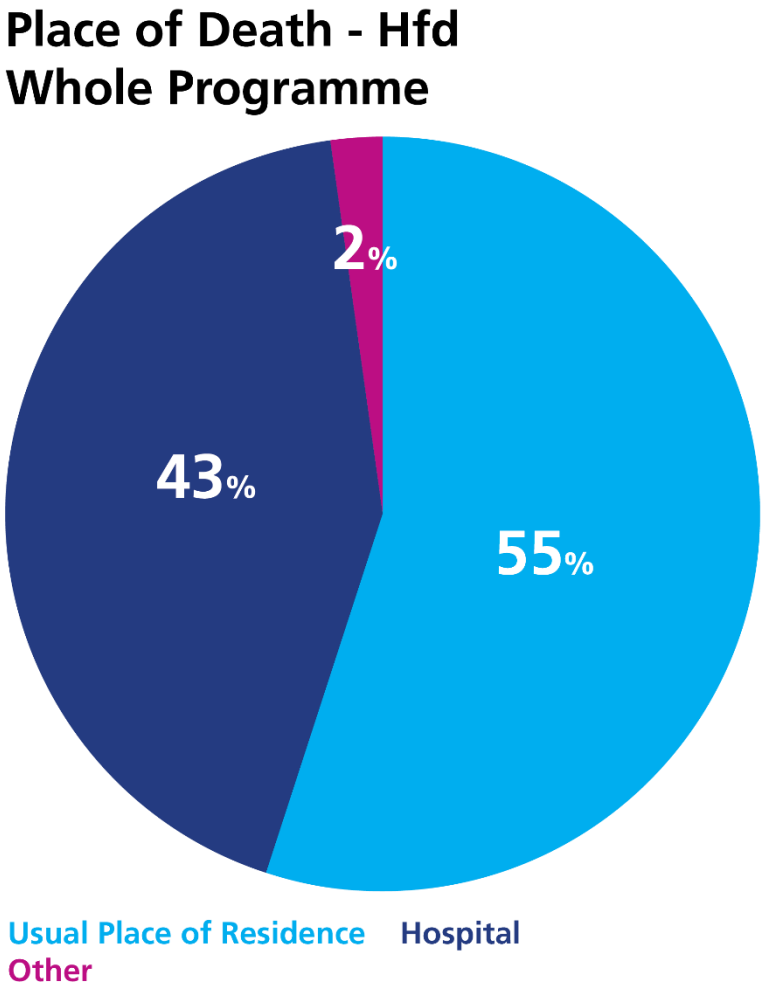


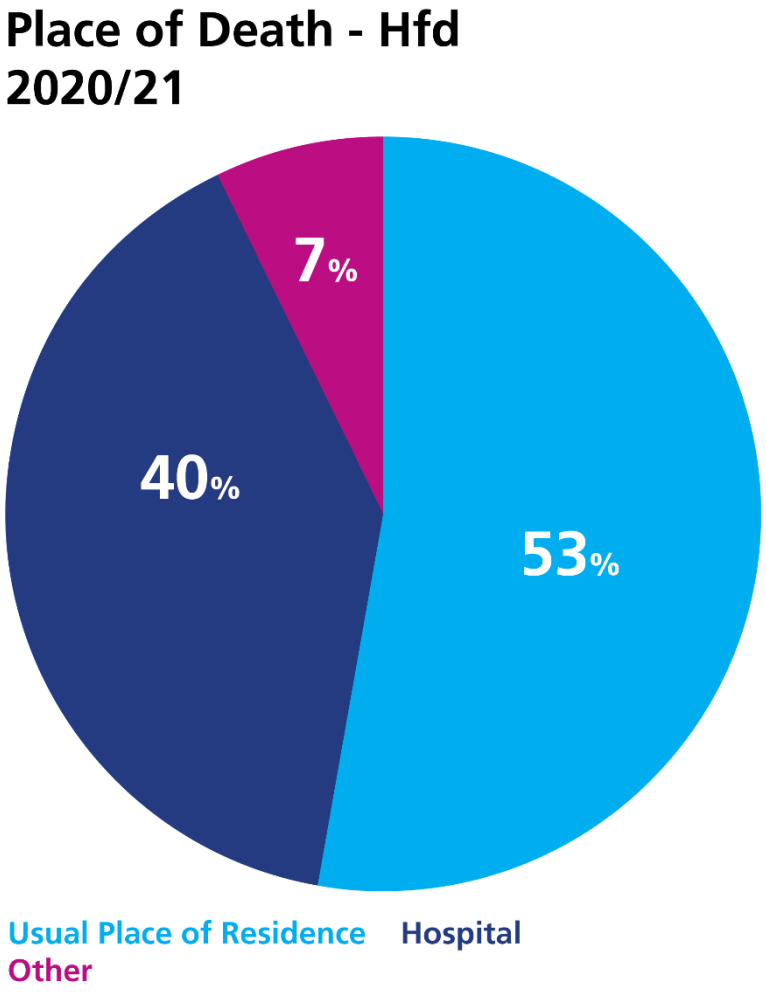
What does this tell us about the impact of ethnicity for deaths reported to H&W LeDeR?

Caution should be applied when making interpretations of the impact of ethnicity due to the small numbers reported for H&W. Within the notifications of individuals who reported their ethnicity as Asian, White and Black African, White and Black Caribbean or other the age range was 18-60 years. From all notifications received for H&W 25% of those aged 24 years or younger reported the persons ethnicity as Asian, White and Black African, White and Black Caribbean or other. As an ICS we need to do more to ensure that are receiving notifications from those with an ethnicity profile that matches our general population and understand more about the potential impact of ethnicity on the health equity and life chances of people with a learning disability.

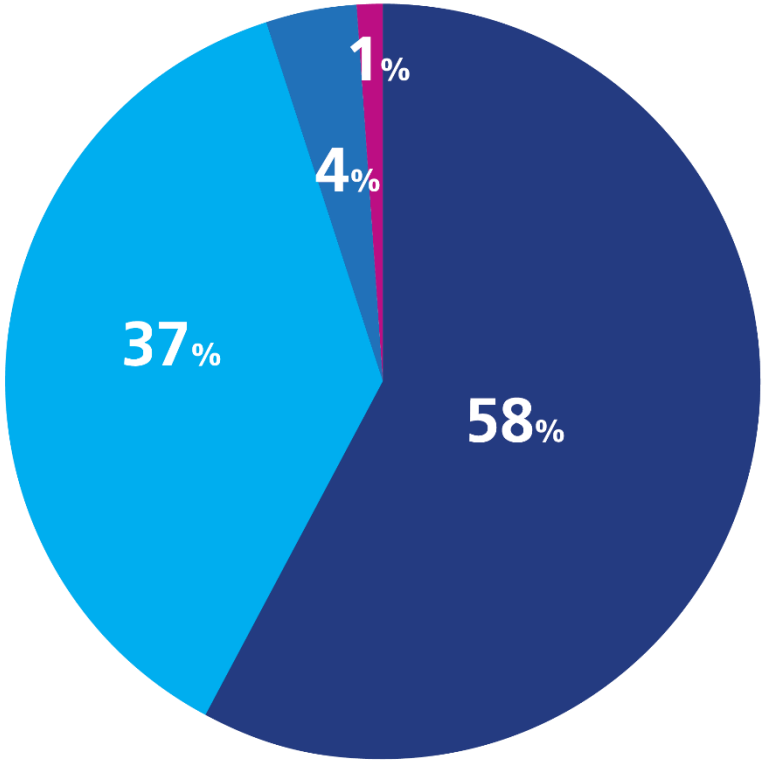
Place of death

Figure 7 – place of death in each county for 2017-2020 compared to 2020/21

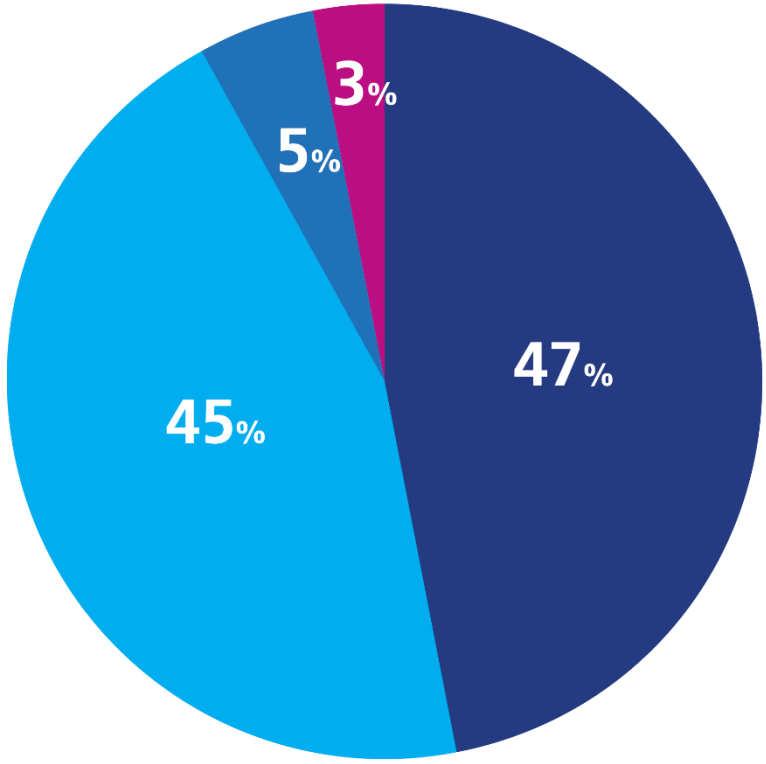




Place of Death - Worcs Whole Programme



Place of Death - Worcs 2020/21



What does this tell us about where people die within our system?

The extent to which deaths occur outside of an acute hospital bed, for people with a learning disability, has improved for both counties across the period of the programme. Worcestershire data for 2020-21 would have reflected a more significant difference were it not for the impact of COVID; 86% of people with a learning disability whose death certificate confirmed COVID-19 in part 1 died in an acute hospital bed but this was likely influenced by the context of testing availability. Additional analysis is required to review if people are achieving death in their 'preferred place'. No completed reviews have identified that acute care was required but was not accessed or the decision to not convey to hospital was found to be contributory to death in any way. Recommendations predominantly support that more people could achieve a different or preferred place of death if the timeliness of the identification of irretrievable deteriorating health or processes for planning and coordinating end of life care, were different. This includes examples where a return to home or an alternative care setting is considered.

3.2 Learning from the outcomes of completed reviews – key data findings

Data from completed LeDeR reviews are collated into a matrix to enable a level of analysis.

Causes of death

Cause of death, as listed on death certification, is compiled into themes. Where an underlying condition is felt to have been a significant contributory factor in the persons death this is reflected (for example end stage dementia might be listed within themed analysis as opposed to pneumonia).

Figure 8 - themes for most frequently reported cause of death for people with a learning disability

	Bowel Related	Respiratory & Pneumonia	Dementia	Cancer	Cardio-vascular	Epilepsy	Sepsis	Other	Covid-19
Cause of death – Hfd & Worcs Whole Programme	*7*	*73*	*9*	*20*	*21*	*3*	*3*	*15*	
Cause of Death – Hfd & Worcs Apr19–March20	*2*	*17*	*2*	*5*	*6*	*1*	*1*	*4*	
Cause of Death – Hfd & Worcs Apr20–March21	*1*	*16*	*5*	*4*	*4*	*1*	*1*	*7*	*8*

What does this tell us about the cause of death for people with a learning disability across our ICS?

Respiratory deaths continue to be the most prominent cause listed on death certification. Deaths due to aspiration pneumonia make up 35% of deaths for all respiratory causes. Of deaths where aspiration pneumonia is listed within part of the death certificate care was rated as poor or of concern (grades 4-6) for 30%. A Priority Action Group will continue to focus on the modifiable factors that can contribute toward aspiration pneumonia so that the ICS can have confidence that aspiration pneumonia need not be seen as an inevitable cause of death for many. Cause of death themes for each county are not reported here as some themes reflect very low numbers or single figures.

Very low numbers of deaths are recorded as being due to sepsis. The ICS has also seen very low numbers of deaths reported due to Sudden Death in Epilepsy (SUDEP) or epilepsy related.

Bowel related deaths have significantly reduced since the first year of the programme (overall less than 2% compared to 6% of all England LeDeR notifications). A review of interventions across both counties is the focus of a Priority Action Group and may identify additional learning to further embed good practice.

Deaths where the cause is listed as due to cancer remain fairly static and reflect a broad range of primary sites. Late stage diagnosis is not uncommon. Death due to cancer appears to be reflected less often for people with a learning disability than for the general population. We do not know how many people may be dying from undiagnosed cancer. Further analysis of screening access is underway and equity of uptake will be a key priority over the next 2-3 years.

Deaths where the cause of death is listed as due to cardio-vascular disease also remain static however all deaths were exclusively compatible with individuals who had a recorded high Body Mass Index.

COVID-19 Pandemic

During 2020/21 a new health condition and cause of death emerged, COVID-19. The pandemic had an unusual impact on the pattern of reported notifications (see figure 9). Only 1 death was notified to LeDeR during quarter 3. Between May 2020 and March 2021, but particularly between October 2020 and March 2021, death notifications were below expected levels.

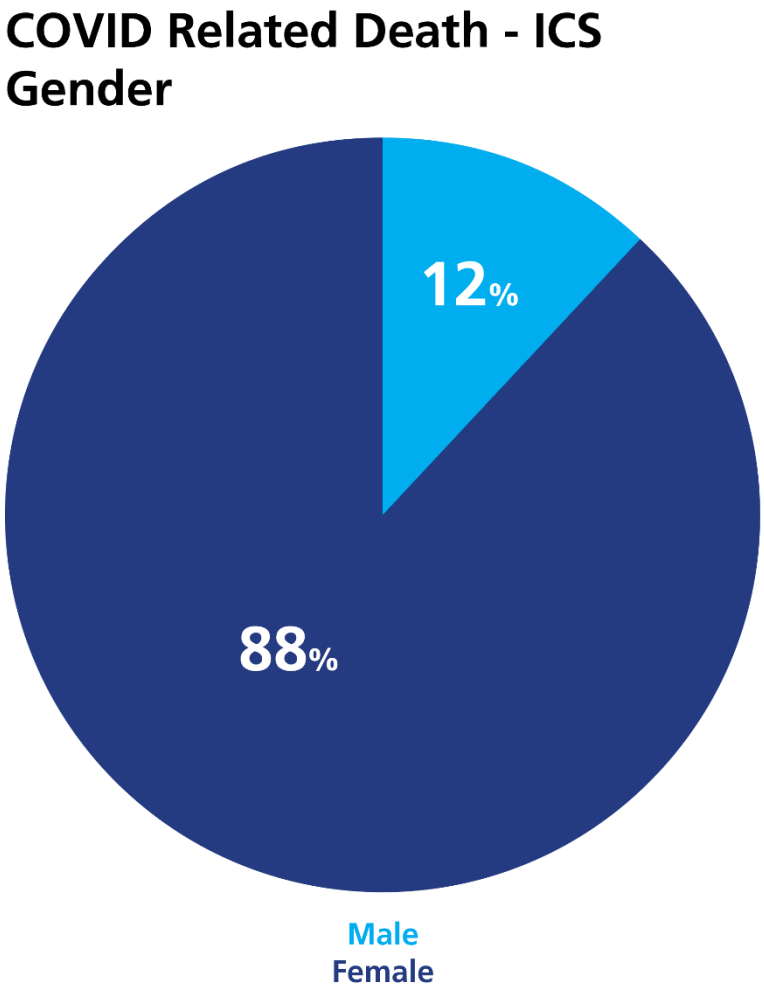
Figure 9 - cause of death profile, by month of the year during 2020/21

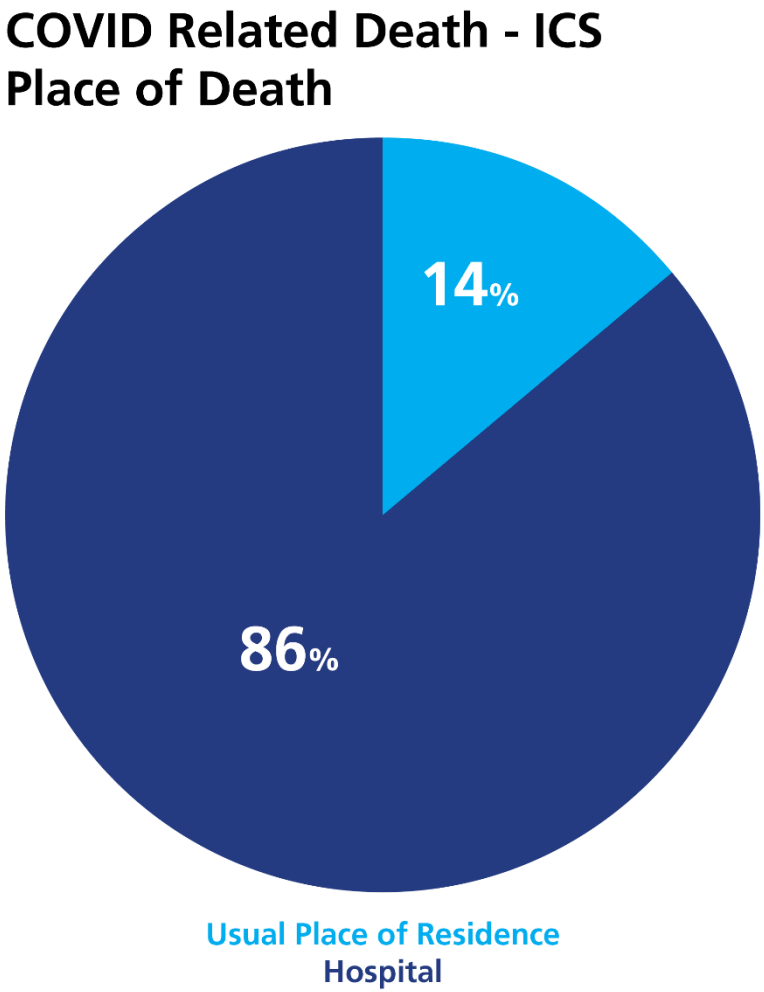
	Mar20	Apr20	May20	Jun20	Jul20	Aug20	Sep20	Oct20	Nov20	Dec20	Jan21	Feb21	Mar21
Respiratory	3	7	0	1	1	1	1	0	0	0	4	2	0
COVID related Death	0	6	0	1	0	0	0	0	0	0	0	1	0
Cardio Related Death	1	2	0	2	0	0	0	0	0	0	0	0	0
Other COD	2	3	2	2	3	2	3	0	1	0	0	3	0

The characteristics and health needs of individuals who had died from confirmed or suspected COVID-19 were subject to an initial Rapid Review to enable the extraction of key learning points in a timely manner. Where a completed review confirmed the cause of death as COVID-19 further analysis of associated factors was undertaken.

Both the gender profile and place of death was different to the trend seen for other causes of death (see figure 10).

Figure 10 - gender and place of death for individuals whose completed reviews confirmed a cause of death as COVID-19





Some patterns of health condition were similar to those seen across the full profile of LeDeR reviews for the ICS. This included 71% of people with a Mental Health need and 43% of people with a history of cardio-vascular disease.

Some areas of health need were underrepresented. No-one who died from COVID-19 had diabetes and 14% had asthma.

Other areas of health need were disproportionately represented, and this included epilepsy (57%) and obesity (71%). The rate of prevalence of underlying health condition is however based on small numbers and so should be interpreted with caution.

Of those who died from COVID-19 75% lived in a multi-occupancy care setting and 71% of individuals had mild or moderate levels of learning disability.

Of those reviews completed (87%) 71% have been given a care grading of 4 (poor care) or 5 (areas of significant concern that may have been contributory to death). Where relevant Serious Incident and / or Safeguarding investigations were triggered, and LeDeR Reviewers worked in close alignment with partners.

The overall grading of care provided

Within the current LeDeR system each review, prior to completion, is graded from 1 (excellent) to 6 (where care gaps contributed toward death). Care grading is approved by the LAC prior to final submission. The care grading should reflect the overall quality of integrated care and the number and significance of areas of learning or recommendations made, not purely the final weeks or days of life.

Figure 11 - overall grading of care as a percentage of completed reviews

	Grade of Care – Whole Programme		
	ICS	Herefordshire	Worcestershire
6	3%	4%	3%
5	4%	2%	5%
4	20%	13%	23%
3	31%	22%	35%
2	33%	40%	30%
1	9%	18%	5%

	Grade of care – 2020-21		
	ICS	Herefordshire	Worcestershire
6	0%	0%	0%
5	6%	0%	6%
4	22%	0	26%
3	17%	20%	16%
2	47%	60%	45%
1	8%	20%	6%

NB- 2020/21 only reflect reviews notified within 2020/21 that have been completed to date.

What does this tell us about the grading of care and how this contributes to premature or avoidable death in our system?
The percentage of cases graded as 1 or 2 (met or exceeded good care) has increased over time. The ratio of care graded as poor (grade 4) often reflects poor end of life care. No reviews notified during 2020/21 have yet required a multi-agency review (MAR). The percentage of cases graded as 5 or 6 compare proportionately to the all England position (7%). Cases graded 6 are usually subject to a Coroner's Inquest. Inconsistent methods for the grading of care across both counties were addressed during 2020/21.

The underlying health conditions of people whose deaths were notified to H&W LeDeR Programme

Underlying health conditions are recorded for each completed review irrespective of whether the condition was felt to be associated with the cause of death.

Figure 12 - themes of common underlying health conditions detailed within completed LeDeR Reviews

Underlying Health Concern - Herefordshire	Whole Programme	1-April-2019 - 31-March-2020	1-April-2020- 31-March-2021
Epilepsy	22	12	5
Cardio – vascular	18	8	5
Dysphagia	15	9	4
Mental illness	27	11	8
Constipation	26	14	8
Diabetes	7	3	2
Obesity	8	4	2
CKD	5	3	0
Asthma	6	5	0

Underlying Health Concern - Worcestershire	Whole Programme	1-April-2019 - 31-March-2020	1-April-2020- 31-March-2021
Epilepsy	55	7	22
Cardio – vascular	47	3	23
Dysphagia	41	4	21
Mental illness	68	4	36
Constipation	72	7	36
Diabetes	21	0	13
Obesity	24	2	16
CKD	8	1	3
Asthma	13	1	5

Figure 13 - the number of health conditions

Number of Underlying Health Concerns - Herefordshire	Whole Programme	1-April-2019 - 31-March-2020	1-April-2020- 31-March-2021
UHC - 2 or less	14	7	4
UHC - 3	11	7	2
UHC - 4 or more	18	8	5

Number of Underlying Health Concern - Worcestershire	Whole Programme	1-April-2019 - 31-March-2020	1-April-2020- 31-March-2021
UHC - 2 or less	22	1	11
UHC - 3	40	5	18
UHC - 4 or more	39	3	19

Table 4 - percentage of individuals notified to LeDeR with specific underlying health conditions recorded (2017 onwards)

Health condition	% of cases England	% of cases Herefordshire	% of cases Worcestershire
Epilepsy	**36%**	**44%**	**51%**
Cardio-vascular disease	**32%**	**36%**	**43%**
Mental Health	**26%**	**52%**	**63%**
Constipation	**23%**	**50%**	**67%**
Dysphagia	**29%**	**33%**	**40%**
Diabetes	**Not available** (general population in UK- 6%)	**14%**	**19%**
Obesity	**Not available** (general adult population UK-26%)	**16%**	**21%**
3 or more long term health conditions	**56%**	**56%**	**72%**

What does this tell us about underlying health conditions and their contribution to premature or avoidable death?

The percentage of notifications received that reflect a long-term health condition for individual's with a Learning Disability residing within our ICS appear to be greater across all reported themes compared to those reported within notifications across England. The variance is most significant for Epilepsy, Mental Health and Constipation. This prevalence data reflects health conditions experienced by those who have died and whose deaths have been reported to LeDeR and may not therefore be an accurate reflection of health condition prevalence for the wider population of people with a learning disability. More analysis is required to understand whether the position is reflective of a good level of health surveillance and recording or whether, for example, medication use for severe or enduring mental health conditions is influencing the prevalence of other health needs.

Over the next 2-3 years we will collaborate with partners within the ICS, particularly Primary Care and Public Health, to understand the health needs and inequalities of people with a learning disability in more detail. This will include a focus on the accurate recognition, recording and clinical coding of health needs in the Annual Health Check. Health surveillance data can then inform population health management that recognises local health need and empowers each locality to address health equity for those who may be more vulnerable to experiencing barriers to happy and healthy lives, including access to programmes aimed to support prevention, diagnosis, earlier intervention or treatment.

3.3 Learning from the outcomes of completed reviews - key themes and what we have achieved during 2020/21

Reviewers are encouraged to make recommendations from the information made available to them when completing an initial review. Recommendations arising from each completed review are then considered by system partners who agree the most effective action that can be taken to improve practice or influence better outcomes for people with learning disability.

Themes have emerged over the course of the programme. The frequency with which a recommendation type is made and the seriousness of the potential outcome supported the Steering Group to agree key priority areas for improvement and the development of Priority Action Groups to take forward each area of required improvement. During 2019/20 there were 5 Priority Action Groups.

- Bowel Health (linked to a key theme of deaths with an underlying factor of chronic mis-management of faecal impaction)
- Respiratory Conditions (linked to the most frequent cause of death and the factors that might influence modifiable factors)
- Annual Health Checks (including a theme in review learning for variability in the uptake and quality of checks)
- Support during an Acute Hospital admission
- Experience of the end of life (including themes relating to ReSPECT and DNACPR decisions and documentation)

In the months prior to the start of 2020/21 the necessary health and social care response to the COVID-19 resulted in the need to quickly review the areas of focus for service improvement linked to LeDeR themes. The work of the Priority Action Groups for Bowel Health was paused.

The focus of group members for ‘Support during a Hospital Stay’ and ‘Experience at end of life’ merged and the focus shifted to respond to growing concerns about the perception of the inappropriate use of ReSPECT forms in acute hospitals and community settings.

The work of the Priority Action Group for Annual Health Checks was temporarily paused during the first few months of 2020/21 but then rapidly gathered momentum in later months during the wave 1 recovery.

The Priority Action Group for Respiratory Conditions rapidly evolved to focus almost solely on COVID-19. Table 5 below summarises what we have collectively achieved during an extraordinary year.

Table 5 – Actions and outcomes of Priority Action workstreams during 2020/21

Priority Action focus	Actions during 2020/21	What we achieved.
The uptake and quality of Annual Health Check completion.	The Priority Action Group, established earlier in the programme, focused on developing an improvement plan based on a gap analysis. The Group is led by the Lead Commissioner for Complex Needs and includes a broad range of partners from Public Health, Primary Care, Learning Disability Community and Liaison teams, family carers and strong links to a consultative group of experts by experience. During 2020/21 the Group achieved: • A co-produced range of accessible resources and guides to support Annual Health Check delivery. Materials were based on examples of national best practice and informed by local people's experience. • Oversight of 'tests of change', funded by LeDeR Learning into Action funds, to support and evaluate effective models and processes for delivering quality Annual Health Checks across Primary Care Networks. This involved examples including the consistent implementation of call, recall and booking processes; the implementation of an MDT approach; the use of a central PCN team; the utilisation of Learning Disability Nurse expertise and support • Oversight of progress with the completion rates of Annual Health Checks by establishing and sharing frequent data updates on progress made. This involved PCN level data shared every two weeks to compare current position and progress made over time.	A co-produced 'resource pack', published at https://herefordshireandworcestershireccg.nhs.uk/our-work/learning-disabilites-and-autism/annual-health-checks By 31st March 2021 a completion rate across H&W of 84.9%. For PCNs involved in 'test of change' projects completion rates exceeded 90%. 91% of individual GP Practices exceeded the national completion rate target of 67% The number of people on the GP Learning Disability Register increased, particularly for people aged 14-25 years, a position that we will build on into 2021/22. This will result in more Annual Health Checks being offered next year.

Priority Action focus	Actions during 2020/21	What we achieved.
The system roll out of the ReSPECT programme.	During wave 1 of the COVID-19 pandemic many were concerned by media reports about the potential for the unlawful use of Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms and Do Not Attempt Resuscitation (DNAR) documentation to justify discriminatory barriers to accessing health care including Intensive care beds. Healthwatch, on behalf of the local population, wrote to the LeDeR LAC to raise these concerns. A review of documentation for people with a learning disability who had died in an acute hospital during wave 1 was undertaken. Areas requiring improvement were noted for some of the ways in which decisions were documented however all decisions were found to have been appropriate to personal need. The ReSPECT Programme Board includes Learning Disability practitioners and Advocacy organisation representation to ensure that the needs of people with a learning disability are reflected. A collation of themed learning from LeDeR reviews was due to be presented in May 2020 but was deferred due to the COVID-19 pandemic. Integrated multi-disciplinary partnership working has been key. Community Learning Disability Teams have been fundamental to raising awareness of ReSPECT for people with a learning disability and their families and have developed accessible information to support the process.	The CCG Medical Director wrote to all GPs and the Trust Medical Directors/ Chief Medical Officer wrote to all clinicians, to reinforce that DNAR and ReSPECT decisions must be individual and personalsied and not be justified solely on the grounds of a person having a Learning Disability. A review of hospital notes determined that all decisions regarding DNAR and access to healthcare intervention during wave 1, for people with a learning disability who had COVID-19 included in part 1 of their death certificate, were appropriate and did not result in discriminatory barriers to healthcare. Completed LeDeR Reviews during 2020/21 have continued to reflect many examples of highly personalised end of life care. Review has also recognised however that most people who required an acute hospital admission during the pandemic had to rely on hospital doctors, who may not have met them before, to make challenging decisions during an emergency situation. 56% of those who died in hospital had a ReSPECT form completed whilst an inpatient. More needs to be done to support people with a learning disability and their families to be encouraged to think about ReSPECT form completion alongside trusted community-based health and social care teams, prior to an episode of deterioration.

Priority Action focus	Actions during 2020/21	What we achieved.
Respiratory Conditions (focus on minimising transmission of the COVID-19 virus and maximising protection)	Learning from COVID-19 LeDeR Rapid Reviews was used to inform work with partners to provide support to minimise COVID-19 outbreaks in care settings. The LeDeR LAC and LeDeR Clinical Lead worked alongside other Registered Nurses within the CCG Quality Team to form an extended Infection Prevention and Control Clinical Cell, coordinating access to testing in care settings during the 1st wave and supporting LD Care Settings to access testing ahead of the national offer. Learning from initial COVID-19 local and national LeDeR reports were shared with partners across the system. Took action from learning identified from COVID-19 related LeDeR reviews to inform a proposal to offer COVID vaccination to people with a learning disability in care settings, alongside older people in care settings in JCVI 1, and therefore ahead of the national offer. This proposal was supported by the system Ethics Forum (established during the COVID-19 pandemic) and approved by the Clinical Commissioning Executive Committee. Promoted use of the LD Register to identify those in JCVI 6 for vaccination, shared easyread resources with PCNs and worked with family carers to coproduce a FAQ factsheet shared through social media Learning Disability Teams were instrumental in facilitating vaccination for those with the most complex needs, including support to coordinate best interest decisions.	Supported access to the whole home testing for care settings supporting people with a learning disability in the weeks ahead of national offer. This helped to identify asymptomatic cases and contribute toward minimising COVID-19 outbreaks. Maintained virtual Learning into Action Group meetings and updates to engage and sustain partnerships during the pandemic. Supported access to vaccination for people living within learning disability care settings ahead of the national offer, with initiation of vaccination at the early stages of wave 2 offering increased protection for people with a learning disability who were amongst those most at risk. Deaths of all causes for people with a learning disability reduced by 60% from 25 (April- June 2020) to 10 (January to March 2021), with a reduction in notifications with a confirmed cause of death of COVID-19 positive from 7 (wave 1 March -May 2020) to 1 (wave 2 January to March 2021). By 31st March 2021 the vaccination uptake rate for people with a learning disability was 88%. Uptake rates continued to grow after this date thanks to the dedicated work of PCNs and Community Learning Disability Teams.

3.4 Affecting meaningful change in Herefordshire and Worcestershire - Our 3 Year Road Map to Longer, Healthier and Happier Lives

The capacity and opportunity to influence meaningful improvements for the health outcomes of people with a learning disability has always been the main driving force and key priority of LeDeR Reviewers and the members of the LeDeR Steering Group and Learning into Action Groups for H&W. Steering Group members agreed that to have effective and sustained influence it was crucial to focus on a relatively small number of key priorities.

During 2020/21 the COVID-19 pandemic brought into sharp focus and in many ways compounded the health inequalities experienced by people with a learning disability. Underlying health conditions that had not previously featured as a significant contributory theme for premature mortality were brought to people's attention. Information and learning gathered from the completion of LeDeR Reviews this year contributed to the wealth of information that we have collectively generated now that we have been undertaking learning from LeDeR Reviews for 3 full annual reporting year cycles.

From the themed learning generated up to and during 2020/21 and the feedback of people with lived experience a number of priorities were felt to be of greatest importance. The agreed areas of focus outlined in table 6 will be a key feature of the milestones within our 3 Year Learning Disability And Autism Plan and in the HW LeDeR 3 Year Strategy that will be developed during 2021.

To enable meaningful and sustainable change that impacts on people's health outcomes and starts to address health equity for our local population we must ensure that we also work together to address a number of underpinning determinants of health. For this reason it is essential that our HW LeDeR Strategy is informed by local Joint Strategic Needs Assessments reflective of our local population of people with Learning Disability or Autism led by local experts in Public Health. It is also critical that a Strategy to outline plans for improving health outcomes is shaped in a meaningful co-produced manner by those who are key to delivering services and people with lived experience. National Policy requires that we achieve the development of a Strategy by the end of June 2021. Table 6 sets out our overarching strategic priorities and we will work together during 2021, as our ICS evolves, to clearly set out a Strategy for achieving this.

Table 6 – Our Priorities

Supporting peoples emotional and mental health needs by:

- training staff in mental health services to recognise and respond to the needs of people with a learning disability or autism
- ensuring that services are accessible to all
- ensuring that peoples needs are met in a manner that does not over rely on medication
- ensuring that the move to increase digital services does not exclude access for vulnerable people

Supporting people with learning disability or autism and their loved ones to make and influence choices about their care when they are very unwell or when they are dying by:

- Increasing the meaningful completion of Summary Plans for Emergency Care and Treatment (ReSPECT) before a crisis situation
- informing plans to make access to the detail of ReSPECT wishes available across the health and social care system
- ensuring that training to support the planning and delivery of end of life care reflects the needs of people with learning disability or autism

Recognising and responding to health need through Annual Health Checks by:

Achieving high rates of Annual Health Check completion (85% or more)
Ensuring all those who may be eligible are on the GP Learning Disability Register, particularly young people aged 14-25 years and those who represent the ethnicity of our wider population in Herefordshire and Worcestershire
Annual Health Checks resulting in a meaningful Health Action Plan that reflects wide ranging need including access to dental services, screening programmes and roles aimed to support health and wellbeing (including coach, trainer or social prescriber roles)
The way that Annual Health Check outcomes are recorded are accurate, consistent and support the system to understand health needs of the population in a better way.

Increasing protection from respiratory conditions to include:

Dysphagia assessment, support and training
Pneumococcal, Influenza and COVID-19 vaccinations
Improving oral health and preventing disease
Understanding the impact of long COVID

Taking a zero tolerance to avoidable deaths related to poor management of constipation or bowel impaction by:

- ensuring that Annual Health Checks lead to advise on healthy lifestyle support that reduces the risk of constipation
- Training people to develop and use bowel management plans for chronic constipation
- raising awareness of how to use laxatives
- supporting access to bowel screening and monitoring uptake.

Prevent a deterioration of health needs by recognising and supporting people to understand the impact of obesity by:

- ensuring that Body Mass Index is recorded in the Annual Health Check
- improve data to understand the extent of diabetes in our local population
- ensure that those on medication for emotional or mental health needs have the right health checks to identify and reduce cardio-vascular disease risks

Underpinning features of all improvements

People at the heart of all we do with service design informed by those with lived experience , that responds to their needs
Meaningful inclusion and choice- including Mental Capacity assessment and facilitated Best Interest decisions
A workforce equipped to recognise and respond to personalised adjustments that enable equity of access and opportunity
A way of working that supports people to collaborate and share information and decision making

4. Conclusion and next steps

The NHS Long Term Plan, published during 2019, and the NHS Oversight Framework for 2019/2020, provided a welcome spotlight on reducing the health inequalities experienced by people with a learning disability. From 1st April 2020 the four Clinical Commissioning Groups across Herefordshire and Worcestershire merged to become one single CCG. The two local programmes for LeDeR across H&W were integrated under one single Local Area Contact to form a cohesive partnership. A single H&W LeDeR Steering Group, with a Learning into Action Group aligned to the geography of each Health and Wellbeing Board at county level, was in place by the end of September 2020.

The remit of Clinical Commissioning Groups, as a key partner and system leader during 2020/21 has been to continue to support partnership working to deliver the LeDeR programme. We believe we have achieved this. We have collaborated, during an extraordinary year, to start to see improvements across programme performance and key outcomes that experts with lived experience and family carers tell us are important to them. This included improving the time within which reviews are completed, significant improvements in Annual Health Check completion rates and equitable access to COVID vaccination. The NHS Priorities and Operational Planning Guidance 2021/22, issued in March 2021, demonstrates that in the year to come there will continue to be a significant focus on reducing health inequalities for people with a learning disability and autism and we very much welcome this.

In March 2021 a national Learning from Lives and Deaths (LeDeR) Policy was published. The Policy signals the introduction of new requirements and standards and as we move toward Integrated Care Systems by 1st April 2022 we will work collaboratively to agree and set out how we will take the LeDeR programme forward. Milestone implementation is required from June 2021 and an outline of our current position is included in appendix 2. We will develop a clear summary of this report, accessible to all, that outlines who we are, what we have learnt this year, what action we have taken and what we plan to do going forward into 2021/22 and beyond. This will form the basis for our HW LeDeR Strategy. 2021/22 presents many uncertainties and this includes the impact of the implementation of a new LeDeR platform from 1st June 2021 and the way in which COVID-19 will influence peoples longer term health, the nature of health inequality, peoples day to day lives and premature death.

HWCCG and the HW LeDeR Steering Group members welcome the current national emphasis and focus on the health needs of people with a learning disability and autism, and look forward to another successful year of improving outcomes so that local people can live longer, happier and healthier lives.

Appendix one - LeDeR Steering Group Terms of Reference (V3 approved June 2020)

Terms of Reference

Herefordshire and Worcestershire Learning Disability Mortality Review (LeDeR) Steering Group

Background

The Learning Disabilities Mortality Review (LeDeR) Programme, delivered by the University of Bristol, is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. The Programme was established as one of the key recommendations of the Confidential Inquiry into the premature deaths of people with learning disabilities (CIPoLD) (2013).

The aim of the Programme is to drive sustainable improvement in the quality of health and social care service delivery for people with learning disabilities, to help reduce premature mortality and health inequalities in this population, through mortality case review. Reviews will be undertaken to help clarify contributory factors for the causes of death that contribute to the overall burden of excess premature and amenable mortality for people with learning disabilities; identify variation and best practice; and identify key recommendations where there is opportunity to influence improved outcomes.

The outputs of the Herefordshire and Worcestershire (H&W) LeDeR Programme will contribute toward the national Programme which will complement and contribute to the work of other agencies and workstreams of the Learning Disability and Autism Programme including Transforming Care and other aspects of Building the Right Support.

In March 2017 ‘National Guidance on Learning from Deaths’, published by the National Quality Board, set out a requirement to providers to use the LeDeR methodology to undertake reviews of all deaths for people with a learning disability in contact with their services.

Core shared values

As members of the H&W LeDeR Steering Group we commit to ensuring that local Programme delivery:

- Keeps the experience of people with a learning disability, whose life and death we will become aware of through the course of the Steering Group, firmly at the center of the review and learning process and the forefront of our mind.
- Engage with families and carers in a manner that is inclusive, values their contribution and is respectful of their experience and bereavement.
- Remain focused on celebrating where end of life experiences are managed well, capturing examples of 'reasonable adjustments' and considering how lessons can be learnt following deaths considered to be premature or amenable to improvements in healthcare.
- Remain open minded and agree not to pre-judge outcomes or contributory factors, giving fair consideration to all available information.
- Support an evolving process that will become sustainable and embedded in local culture.
- Uphold the key principles of cooperation and partnership to ensure that the programme of work affects meaningful change on reducing health inequality and increasing the opportunities for the experience of a 'good' death for people with a learning disability.

The scope of the local reviews of deaths

The LeDeR Programme will support the reviews of all deaths of people with learning disabilities aged 4 years and over, irrespective of the cause or place of death. The H&W LeDeR Programme will ensure oversight of the review of all deaths of people with a learning disability who are registered with a Herefordshire or Worcestershire GP and meet the criteria to be listed upon a GP Register for a Learning Disability Annual Health Check. Children and young people, originating from H&W but placed out of area during the time of their death, will be within the scope of reviews for the H&W LeDeR programme (in alignment with the scope of the Child Death Overview Panel).

Purpose / role of the Steering Group

- To work in partnership with the Regional LeDeR lead for NHS Midlands.and the Learning Disability and Autism Programme
- In partnership with stakeholders, ensure that a nominated Local Area Contact has oversight of the programme activities for H&W.
- To guide the implementation of the programme of local reviews of deaths of people with learning disabilities.
- To receive regular updates from the Local Area Contact about the progress and themed findings of reviews.
- To agree the key benchmarks or indicators from which progress and impact of the LeDeR programme will be evaluated. To re-prioritise or modify benchmarks in response to emerging local themes following the completion and reporting of reviews.
- To agree priority recommendations, based on the themes of reviews and contributory factors that have the potential to make the greatest impact.
- To oversee the tracking of progress toward agreed measurable outcomes where local action is recommended through receipt of updates from the Learning into Action Group for each county of Herefordshire and Worcestershire
- To ensure each identified partner agency is accountable for the delivery of action required from the organisation that they represent.
- To ensure agreed protocols are in place and are adhered to, for information sharing, accessing case records and keeping content confidential and secure.

Each county based Learning into Action (LeDeR) Group will

- Receive a summary of anonymised case reports pertaining to deaths relating to people with learning disabilities in order to contribute to a collective understanding of learning points and recommendations across cases.
- To help interpret and analyse information submitted from local reviews, including areas of good practice in preventing premature mortality, and areas where improvements in practice could be made.
- To consider the recommendations made within completed reviews and agree system or partner agency actions to be taken to ensure improvements in health outcomes and experience
- To gain updates from partner agencies on the progress of agreed actions arising from reviews, escalating actions that are not progressing as expected to the Steering Group

Membership - Membership for the H&W LeDeR Steering Group will include broad representation including health and social care; provider and commissioning organisations; people with a learning disability and those who support them, including family carers and advocacy organisations.

Role of Steering Group Members

Members will continuously review the programme direction and make decisions to make sure that:

- Partners work together to support the success of the programme and make sure that the voice of no single interest will dominate.
- All identified risks are assessed, putting in place actions, mitigations and contingency plans for all high impact risks.
- The time and resources needed for the programme objectives are available.
- The Governance of the programme ensures that information available is recorded and stored safely and accurately.
- Support is available for the Local Area Contact to deliver the programme across H&W.
- The progress of the overall programme is monitored and achieves meaningful and measurable outcomes.

Governance

- Steering Group Meetings will be held quarterly and Learning into Action Groups will be held 4-6 weekly
- Meetings will be quorate when representatives or the nominated deputy from the relevant organisation/ forum marked with * are in attendance. Where meetings are not quorate, key decisions will be agreed virtually by email wherever possible to avoid meeting cancellations.
- Meetings will be organised by the Local Area Contact.
- The Chair will be agreed by the Steering Group.
- The Steering Group will provide themed annual reports to the CCG led Mortality Oversight Group and each county Learning Disability Partnership Board,
- High risks identified that cannot be mitigated will be escalated to the CCG Quality, Performance and Resource Committee via the HWCCG Risk Register and to a relevant partner agency forum
- The Steering Group may request that task and finish working groups be established to focus on resolving specific emerging priorities and issues.

Membership of the Steering Group will include representation from key groups, organisations and forums. Required organisation/ forum representation is outlined below and roles for quoracy indicated *. Where a key representative is unable to attend a suitable deputy should attend.

	Representation
*	HWCCG LeDeR Lead Area Coordinator / CCG Director
*	Safeguarding Adult Board or Child Death Overview Panel representative
	HWCCG LeDeR Clinical Lead
*1	Worcestershire Acute Hospitals NHS Trust Mortality Lead
*1	Worcestershire Health and Care NHS Trust Mortality Lead
*1	Wye Valley NHS Trust Mortality Lead
*1	Primary Care/ CCG GP Quality Lead Worcestershire
*1	Primary Care/ CCG GP Quality Lead Herefordshire
	West Midlands Ambulance Service
*2	Complex Needs Commissioning / Transforming Care Lead
*	Learning Disability Commissioner
*2	Adult Social Care representative
*	Worcestershire Health and Care NHS Trust ,Learning Disability Services
*2	Public Health
*	Speak Easy NOW
*	Family Carer Representatives
	LD Provider Forum
*1 Medical representation from any one agency for quoracy *2 representation of both Herefordshire and Worcestershire County Councils from at least one member	

<u>Experts by Experience</u>

SpeakEasy NOW Worcestershire have consulted with Health Checkers on behalf of the Steering Group to guide a decision about how they may wish to be involved in the work of the LeDeR programme in the most meaningful way. Health Checkers have reached a decision that they would not wish to form part of formal Steering Group meetings where Reviews will be discussed in detail. Health Checkers preference is for a member of Speak Easy NOW to attend the Steering Group and act as a link between the Steering Group and Health Checkers group meetings.

Health Checkers are a key component of the Staying Healthy Sub Group of the Worcestershire Learning Disability Partnership Board. Consultation on the detail of how improved outcomes can be achieved for people with a Learning Disability, as a result of work of Priority Action groups that take forward the themes arising from Reviews, will take place at the Staying healthy Sub Group and LeDeR updates are a standing item on the meeting agenda. The Staying Healthy Sub Group will work closely with the Worcestershire LeDeR Learning into Action Group.

Herefordshire Learning Disability Partnership Board includes key representation of experts by experience including a co-chair arrangement. Consultation is achieved through meaningful engagement with a range of provider supported experts of experience service users between formal meetings. The Herefordshire LeDeR Learning into Action Group will work with the Lead Commissioner for Learning Disabilities to agree the most meaningful way to engage with experts by experience.

Appendix two – HWCCG Response to the Oliver McGowan Independent Review Report Recommendations

Recommendation	CCG Position	Current Gaps	Level of Assurance
All those who are new to the role of reviewer, or Lead Area Coordinator (LAC), must be allocated a 'buddy' who is experienced in the LeDeR process	All reviewers are supported by the LeDeR Clinical Lead, who makes a minimum of weekly contact to ensure that the reviewer is fully supported and supervised. New reviewers are supported through telephone contact and Review template content oversight by the LeDeR Clinical Lead. Supervision on an ongoing basis remains in place until there is mutually agreed confidence that the reviewer can complete a review with reduced frequency of ongoing supervision. Experienced reviewers can also provide peer support and guidance. The LeDeR Clinical Lead receives weekly contact with the Lead Area Coordinator (LAC) for support and supervision.	No gaps identified.	Green.
Dedicated time and administrative support must be given to reviewers and LACs to undertake complex LeDeRs	Dedicated administrative support (substantive contract) is provided to the LeDeR programme. During 2021/22 a review of analyst support to inform programme oversight and progress will need to be undertaken.		Green
There must be a transparent process for LeDeR in each locality, with robust governance and appropriate resources to ensure that each review is properly monitored in terms of procedure and outcomes	LeDeR programme processes across H&W ensure transparency in the following ways:- Close working relationships between the LAC, Clinical Lead and Reviewers that enables oversight of progress and process. Multi-disciplinary scrutiny panel sign-off ensures that the correct procedures and processes have been followed and reviews are quality assured. Recommendations and outcomes are shared with county based Learning into Action Groups with recommendations approved and action agreed. Progress is then tracked and reported to the Learning into Action Group and the LeDeR Steering Group. Progress, outcomes and updates are reported through CCG governance structures, including the CCG Governing Body and Safeguarding Boards. Reporting to Health & Wellbeing Boards in 2021.	No Gaps identified	Green

Recommendation	CCG Position	Current Gaps	Level of Assurance
Each CCG must identify an executive lead to be responsible for the LeDeR programme and for ensuring that the board has full sight of progress.	The Chief Nurse is the Senior Responsible Officer / Executive Lead for LeDeR and ensures that timely updates are provided to the CCG Governing Body and Safeguarding Boards for awareness and assurance.	No Gaps	Green
The CCG executive lead for LeDeR will ensure that LeDeR Reviews are completed in a timely and correct manner and will intervene where problems are escalated, such as the inability to obtain critical information from the relevant agencies.	There is an escalation process in place when critical information has been difficult to obtain in a timely manner. The H&W LeDeR Team have developed and maintained positive, collaborative relationships with partners and it is very rare that we encounter difficulty in acquiring information. During 2020/21 the COVID pandemic placed a level of demand upon services and processes that resulted in delays in completing and sharing Subjective Mortality Reviews, gaining access to Care Home notes and in obtaining GP records on occasions. Processes are now in place, should COVID secure measures be required, to support timely access and avoid delays. No significant avoidable delays have been experienced since wave 1 of the pandemic and delays in 6 month completion during 2020 have been largely due to pandemic redeployment or bereavement impacting on family engagement.	No Gaps	Amber
When a multi-agency review (MAR) is indicated, it is important that the correct process and outcomes are achieved. It is therefore expected that where the reviewer or LAC have no previous experience of a MAR, they will seek support from an experienced 'buddy'	All MARs have been chaired by the LAC who has experience of chairing multi-agency meetings– including those that are highly sensitive. The LAC is supported by the Clinical Lead who is also experienced in chairing highly complex and challenging meetings. Where additional support might be required the Chief Nurse and SRO is available to guide and advise.	No Gaps	Green

Recommendation	CCG Position	Current Gaps	Level of Assurance
In regard to the MAR meeting itself, it is recommended that there is action taken to: -ensure that families are central to the process, are offered full sight of all documents, and are invited to attend all or part of meetings as they wish -review the purpose of the MAR with specific reference to the function of Question 8 (now Question 9 in version R05) and, should this question be retained, provide clear guidance for MAR participants; also, to think through whether this question should be asked in confidence if it is a particularly difficult situation	In all MARs chaired by the CCG to date Family members have been invited and actively encouraged to attend and contribute (in one case the deceased was estranged from their NoK and as this was very well documented it was therefore not appropriate to invite them to the MAR). All LeDeR MAR processes are followed, the meeting documented and shared for accuracy checking before final acceptance/ approval. Much thought and consideration is given to how a MAR will be approached, given the highly sensitive nature of it's purpose. Decisions regarding how Q9 is approached is done on a considered case by case basis, deferring to the Coronial process where relevant and giving due consideration to an organisations capacity to appoint legal representation.	No Gaps	Green

Recommendation	CCG Position	Current Gaps	Level of Assurance
Appropriate support should be available to reviewers, along with strong governance, to ensure that all LeDeR recommendations are robust and actioned in a timely manner, and that lessons learnt are shared nationally.	Appropriate support is available to Reviewers, provided by the LAC and the Clinical Lead, prior to approval via a multi-disciplinary quality assurance process. Leder recommendations are endorsed by the Learning into Action Group and actions agreed. An action tracker is reviewed monthly and progress of a themed work plan is overseen by the Steering Group. Lessons are shared regionally through NHSE/I Forums and locally through a network of Forums connected to the Learning Disability Partnership Board in each county .	Re-prioritisation of work due to the COVID pandemic and vaccination programme has resulted in progress in some areas of Priority Action not progressing as we would have hoped – new areas associated with COVID have however made significant improvements. Learning from wave 1 led to a reduction in deaths of people with a learning disability in wave 2 and this is to be celebrated. Despite the delay in some areas of progress the infrastructure is strong.	Green
Each CCG must formally undertake and document and review its own systems and processes against the learnings and recommendations arising from Oliver's re-review.	This document reflects the review undertaken into systems and processes against the learnings and recommendations arising from Oliver's Independent Review. Further review will be undertaken during 2021/22 in light of the new national LeDeR Policy.	No Gaps	Green

Appendix three- Initial Implementation Plan for the national LeDeR Policy 2021

No	Deliverable and method of measurement	Frequency	Required date of delivery	System position and required action	Lead
1	100% of reviews (both initial and focused) are completed within six months of notification. Monthly dataset will show ICS completion rates. Evidence of robust plans in place to achieve 100% where performance is below this figure.	Monthly	30 June 2021	Reviews notified 1st March to 31st May will not be released to system until 1st June 2021. Twice monthly Review Oversight meeting to be formalised to track progress of each review, monitor days toward deadline and unblock barriers to progress. Data to be collated monthly and reported to Steering Group quarterly. Oversight will monitor and respond to the impact of any 3rd or subsequent waves of the COVID pandemic. Substantial workforce requirements form part of the national Policy. This will be scoped and agreed as part of the implementation plan to be developed by September 2021	LeDeR Clinical Lead
2	ICS will demonstrate each quarter that there is progress against delivery of LeDeR actions which will be monitored using a RAG rating. Quarterly reports to NHS England and NHS Improvement regional teams.	Quarterly	30 September 2021	Agreed reporting template to be in place by end of September 2021, aligned to milestones within LDA 3 Year Plan, themed Priority Actions agreed via Learning into Action Group and in consultation with Experts by Experience.	LeDeR LAC
3	Annual Report agreed at public meeting of CCG/ ICS and local Health and Wellbeing Board by end of Q1 each year. Annual Report, including accessible version published in June each year via ICS website. Documents approved within CCG/ ICS governance and shared with regional teams.	Annually	30 June 2021	Annual Report final draft will be approved by LeDeR Steering Group during May and shared with CCG Governing Body and Health and Wellbeing Boards by the end of June 2021.	LeDeR LAC

No	Deliverable and method of measurement	Frequency	Required date of delivery	System position and required action	Lead
4	A three year strategy demonstrating how the ICS will act strategically to tackle areas identified in aggregated and systematic analysis of LeDeR Reviews and national findings will be shared with NHS England / Improvement and updated annually in June each year. The Strategy will contain section on issues faced by people with learning disability from Black, Asian and minority Ethnic backgrounds who have a learning disability	annually	30 June 2021	Draft three year LDA plan required for submission by 30 April 2021. The plan was informed by LeDeR thematic analysis and consultation with experts by lived experience and family carers. Thematic analysis will be incorporated into a three year Strategy that will include plans to better understand the needs of young people (under 25 years) and people with a learning disability from diverse ethnic backgrounds and ensure equity in uptake of Annual Health Checks and vaccinations.	Lead Commissioner for LDA informed by contribution from LeDeR LAC LeDeR LAC
5	The ICS will demonstrate how they are narrowing the gap in health inequalities and premature mortality. Locally determined targets agreed with NHS England and Improvement regional teams to include measures around: -A reduction in repetition of recurrent themes -Reduced levels of concern and areas for improvement -Reduced frequency of deaths that are potentially avoidable and amenable to good quality healthcare.	Annually	30 June 2021	Key milestones of the three year LDA plan reflect: Reductions in aspiration pneumonia associated with modifiable factors – pneumococcal vaccine, eating and drinking plans, postural care plans Zero tolerance for avoidable deaths Increased uptake and quality of annual health checks Increased vaccination uptake Increased achievement of preferred wishes including place of death and use of ReSPECT	LeDeR LAC
6	Clear and effective governance in place which includes LeDeR governance within ICS quality surveillance arrangements (including minutes of quarterly meeting of ICD governance meeting)	Annually	Plan by 30 September 2021 operational by April 2022	Implementation plan for LeDeR governance and revised Terms of Reference for the LeDeR Steering group will be in place by September 2021 and will take account of evolving ICS governance structures	LeDeR LAC

No	Deliverable and method of measurement	Frequency	Required date of delivery	System position and required action	Lead
7	A named executive lead will act as LeDeR SRO across the ICS by June 2021	Annually	30 June 2021	Existing LeDer SRO is HWCCG Chief Nurse. This position is expected to remain unchanged for 2021/22 but will be reviewed by April 2022.	LeDeR SRO
8	A named lead for Black, Asian and Minority Ethnic inequalities will be part of the LeDeR Steering group. Increased reporting of deaths from people with Black, Asian and Minority Ethnic communities will be proportionate and relative to communities living within the ICS geography (baseline data to be reported by April 2022)	Annually	1 April 2021	The LeDeR Clinical lead is the named Black, Asian and Minority Ethnic Lead for LeDeR and this will continue until the Terms of Reference for the ICS are reviewed during 2021/22. During 2021/22 baseline population data will examine whether the ethnicity profile of deaths reported to LeDeR are proportionate to our local population.	LeDeR Clinical Lead
9	Clear Strategy for the meaningful involvement of people with lived experience in LeDeR governance. Evidence of meaningful engagement in local governance group by September 2021 (including engagement of autistic people proportionately to the number of notifications)	Annually	30 September 2021	Existing arrangements in place are detailed in Terms of Reference for the meaningful engagement of people with a learning disability, in a format determined by individuals themselves. This will be reviewed during 2021/22 to ensure appropriate representation. During 21/22 review Herefordshire expert by lived experience engagement, revise support for family carer involvement and liaise with the Autism Board to ensure proportionate representation for autistic people.	LeDeR LAC
10	Senior ICS leaders, including local authority partners are involved in governance meetings where issues found in local reviews are discussed and actions agreed collaboratively.	Annually	1 April 2022	Terms of Reference for Steering Group and Learning into Action Groups reflect partnerships and collaboration. Review Terms of Reference as ICS structures evolve during 2021/22	LeDeR LAC