Directorate of Corporate Resources

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Your ref:	Our ref:	Please ask for:	Telephone No.
	JJ/jj	Mr J Jablonski	815243

22nd September, 2014

Dear Member

Dudley Health and Wellbeing Board

You are requested to attend a meeting of the Dudley Health and Wellbeing Board to be held on Tuesday, 30th September, 2014 at 3.00 pm at St Thomas's Community Network (Main Hall),Beechwood Road, Dudley,DY2 7QA to consider the business set out in the agenda below.

The agenda is available on the Council's Website www.dudley.gov.uk and follow the links to Councillors in Dudley and Committee Management Information System.

Yours sincerely

Director of Corporate Resources

AGENDA

1. APOLOGIES FOR ABSENCE

   To receive apologies for absence from the meeting

2. APPOINTMENT OF SUBSTITUTE MEMBERS (IF ANY)

   To report the appointment of any substitute Members for this meeting of the committee.

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3. DECLARATIONS OF INTEREST

To receive Declarations of Interest in accordance with the Members' Code of Conduct

The attention of Members is drawn to the wording in the protocols regarding the general dispensation granted to Elected Members and the voting non-elected representative from requirements relating to other interests set out in the Members' Code of Conduct given the nature of the business to be transacted at meetings.

However, Members and the voting non-elected representative (and his potential substitutes) are required to disclose any disclosable pecuniary interests. In such circumstances, the voting Member would be required to withdraw from the meeting.

If Members have any queries regarding interests would they please contact the Director of Corporate Resources, Philip Tart, prior to the meeting.

4. MINUTES

To approved as a correct record and sign the minutes of the meeting of the Board held on 17th June, 2014 (copy herewith)

INFORMATION ITEMS

5. Interim Performance Report (Pages 1 –14)

6. Health and Wellbeing Board Communications and Community Engagement Plan (Pages 15 -26)

7. Troubled Families Programme (Pages 27 – 32)

STRATEGIC ITEMS

8. Better Care Fund (Pages 33 –36)

9. Care Act Implications and Implementation (Pages 37 –42)

10. Alcohol Strategic Framework 2014-2017 (Pages 43 -64)

DISCUSSION ITEMS

11. Healthwatch - Visiting the Doctors – Young Peoples' Views - Presentation

12. JSNA Key Priorities – Presentation (Pages 65 - 82)

13 Peer Challenge Debrief – Oral report

14 TO CONSIDER ANY QUESTIONS FROM MEMBERS TO THE CHAIR WHERE TWO CLEAR DAYS NOTICE HAS BEEN GIVEN TO THE DIRECTOR OF CORPORATE RESOURCES(COUNCIL PROCEDURE RULE 11.8)

MEMBERSHIP OF THE BOARD

Councillors D.Branwood, T.Crumpton, R.Harris and N. Neale

Director of Adult, Community and Housing Services, Interim Director of Children's Services and Assistant Director of Planning and Environmental Health

Ms K.Jackson – Interim Director of Public Health

Roger Clayton – Chair of Safeguarding Boards

Dudley GP Clinical Commissioning Group

Dr. D Hegarty, Dr S.Cartwright and Mr P Maubach

Alison Taylor – Local Area Team - NHS Commissioning Board – Lead Director for Dudley

Andy Gray – Dudley CVS CEO

Pam Bradbury – Chair of Healthwatch Dudley

Chief Superintendent Johnson – West Midlands Police

Neil Griffiths – Fire Service

OFFICER SUPPORT

Brendan Clifford Assistant Director, Adult Social Care (DACHS)

Ian McGuff Assistant Director Quality and Partnership (Children's Services)

Mr N. Bucktin,Head of Partnership Commissioning.(CCG)

Minutes of the Dudley Health and Well-Being Board

Thursday, 17th June, 2014 at 5.00 pm
At the Wrens Nest Community Centre,
Summer Road, Wrens Nest, Dudley

Present:

Councillors D Branwood, R Harris, T Crumpton and N Neale.
Interim Director of Children's Services, Director of Public Health, Assistant Director, Planning and Environmental Health, Pam Bradbury – Chair of Healthwatch Dudley, Mr A Gray – Dudley CVS CEO, Chief Superintendant Johnson – West Midlands Police.
Mr. P. Maubach - Dudley Clinical Commissioning Group and Alison Taylor, Local Area Team, NHS Commissioning Board.

In attendance:

B Clifford, Assistant Director, Adult Social Care (Directorate of Adult, Community and Housing Services), K Jackson, Deputy Director of Public Health (Office of Public Health), H Powell, Acting Assistant Director Educational Services (Directorate of Children's Services) and Mrs K Buckle, (Directorate of Corporate Resources).

Also in attendance:

Dr R Dalzeil (for Agenda Item 7), Mrs P MacDonald (for Agenda Item 9) and Mr N Griffiths, West Midlands Fire Service (for Agenda Item 14).

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1 **Election of Chair**

Resolved

That Councillor R Harris be elected Chair of the Board for the 2014/15 Municipal Year.

(Councillor R Harris in the Chair)

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2 **Appointment of Vice-Chair**

Resolved

That Councillor T Crumpton be appointed as Vice-Chair of the Board for the 2014/15 Municipal Year.

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3 **Welcome and Introductions.**

The Chair welcomed those present and Members introduced themselves.

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4 **Apologies for Absence**

Apologies for absence from the meeting were submitted on behalf of the Director of Adult, Community and Housing Services and Mr N Bucktin, Head of Partnership Commissioning, Clinical Commissioning Group.

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5 **Declarations of Interest**

No Member declared an interest in any matter to be considered by the Board at this meeting.

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6 **Minutes**

Arising from Minute No. 40 Ms K Jackson, Deputy Director of Public Health advised that she would email Members to determine whether there was a preferable start time for future meetings of the Board.

It was also noted that a set of further activities of the Board would be agreed with a further development session with Members to be scheduled prior to 30th September, 2014 to examine the outcomes following the Annual Conference of Dudley's Health and Wellbeing Board and further key areas of work.

Resolved

> That the minutes of the meeting of the Board held on 26th March, 2014, be approved as a correct record and signed.

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7 **Healthwatch Dudley Activity Report**

A report of the Chief Officer of Healthwatch Dudley was submitted updating the Board on Healthwatch activities and key areas of work.

Resolved

> That the information contained in the report submitted, updating the Board on Healthwatch Dudley activities, be noted.

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8 **Healthwatch and Wellbeing Board Annual Account – The First Chapter 2013/14 and Overview of the Health and Wellbeing Board's Annual Conference 2014/15**

A joint report of Officers was submitted introducing the Health and Wellbeing Board's Annual Account for 2013/14 and providing an overview of the key objectives and themes for the 2014/15 annual accountability conference.

Ms K Jackson, Deputy Director of Public Health distributed details of the Overview of the Health and Wellbeing Board's Annual Conference 2014/15 which provided an annual account of work and a tabled overview of what to expect at the conference.

It was noted that the conference would take place on 4th July, 2014 with the main theme being to provide a steer around inspiring, engaging and stimulating collaboration.

Ms Jackson advised that further details in relation to themes and guest speakers would emerge shortly and feedback following the conference would be captured by a survey.

Resolved

> That the information contained in the report submitted and as reported at the meeting be noted and approval be given to the dissemination method for the Annual Account.

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9 **Dudley Health Protection Cooperation Agreement.**

A report of the Director of Public Health was submitted on the Dudley Health Protection Cooperation Agreement. Appended to the report submitted was the Agreement, the standard contract clause pertaining to Emergency Preparedness and Resilience requirements for NHS Organisations, Local Contract Arrangements and agreed responsibilities in a Health Protection Incident (Communicable Disease).

The Director for Public Health introduced Mrs P MacDonald, Nurse Consultant, Communicable Disease.

In presenting the report submitted, Mrs MacDonald referred to the background in relation to the Dudley Health Protection Cooperation Agreement advising of the planning and meeting that had taken place in early 2013 which gathered assurances from those involved parties on their roles in the event of a health protection incident. It was noted that Appendix 1 contained the signatories to the Cooperation Agreement.

Mrs MacDonald referred Members to page 9 of the Agreement, which detailed the roles and responsibilities of organisations in Dudley and their responses should a significant/major public health incident occur.

The Director of Public Health advised that she was responsible for overseeing and assuring the adequacy of the responses but the Director of Public Health had no powers to command National Health resources. A Dudley Health Resilience Partnership Group, (a subgroup of the Dudley Resilience Forum) had been established.

Arising from the presentation of the report submitted, concerns were raised in relation to capacity and the need for a table top exercise to test the resilience of arrangements put in place in order to deal with a major public health incident. The Director of Public Health advised that arrangements for exercising emergency plans were part of the ongoing work programme for the Office of Public Health.

Councillor T Crumpton advised that the map of the borough contained in the Agreement required updating as some Ward boundaries had changed and commented that the impact on health may affect a particular demographic group for example in relation to communication issues for those whose first language may not be English.

The Director of Public Health accepted the observation and agreed that it will be important to take this into account in ay response to a major communicable disease incident.

In response to a request from Councillor D Branwood the Director of Public Health confirmed that a review and debrief would take place following a major public health incident occurring and that any such review would be reported to the Board.

In responding to further questions the Director of Public Health and Mrs MacDonald advised that there was at least one incident each week of small local communicable disease for example an outbreak of food poisoning and in order to limit these incidents more preventative work had and was being undertaken.

The Assistant Director for Adult Social Care queried the role of social care in the process. The Director of Public Health advised that there was no expectation on Care Homes to provide extra resources to deal with incidents referred to above; however the staff may form part of an incident management team in certain circumstances.

Resolved

(1) That the information contained in report, and Appendices to the report, submitted together with Members comments be noted and the Cooperation Agreement for use in Dudley be endorsed.

(2) That the Director of Public Heath be requested to update the map referred to above in relation to the changes to Ward Boundaries.

10 Better Care Fund Update

Mr P Maubach, Dudley Clinical Commissioning Group gave a verbal update on the Better Care Fund, which had been discussed and approved at the last meeting of the Board.

He advised that although concerns had been raised nationally he believed that the plan was robust and should go ahead as agreed. It was noted that further work was required with integrated parties in relation to possible consequences of non-delivery of the plan.

Mr Maubach reported that the plan had been approved by NHS England and he would provide regular updates on progress with the Plan to future meetings of the Board.

Resolved

> That the information reported on in relation to the Better Care Fund be noted.

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11 Special Educational Needs (SEN) Reforms

A presentation on the SEN Reforms, a copy of which had been circulated with the papers for this meeting and was available on the Council's Committee Management Information site, was presented by Mr H Powell, Acting Assistant Director of Educational Services.

Councillor T Crumpton referred to meetings that had taken place with a large number of parents in order to prepare them for the reforms together with a Parent Partnership Advice Service that had been established.

Councillor T Crumpton commented that as a direct result of the Reforms there may be an increase in applications for Special School places and raised concerns on the time and resources required in order to process Education, Health and Care Plans.

In responding to questions in relation to the Local Offer and what it was expected to achieve regarding the provision of services and information, Mr Powell advised that three large school consultations had been undertaken, a Parent Partnership Service had been organised with some parents engaging with the Council's Parent Groups.

In responding to a request of Mr Powell that the designation of a Health Officer was required Mr P Maubach, Chief Accountable Officer of the Dudley Clinical Commissioning Group confirmed that he would locate a designated Health Officer.

Arising from the presentation, Members made suggestions as follows:-

- Developing methods in which and how to address peoples needs and providing a whole life approach by establishing clear linkages and working in partnership;

- Other children working with those children who had special educational needs;

- How the education and health care needs were embraced to meet objectives and investigate options to examine these needs more closely in the future;

- Working with the Council's transport and leisure services to provide universal services which could be investigated by the Corporate Assistant Directors Group.

Resolved

(1) That the information contained in the presentation and comments made arising from the presentation, as indicated above on SEN Reforms, be noted.

(2) That SEN Reforms and the suggestions of Members be discussed and considered further at the first development session of the Board.

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12 **Dudley Clinical Commissioning Group Strategic Plan 2014-2019.**

A report of the Mr P Maubach, Chief Accountable Officer, Dudley Clinical Commissioning Group's was submitted on the Dudley Clinical Commissioning Group Strategic Plan 2014-2019.

Mr P Maubach outlined the content of the report submitted advising that Members comments would be added to the final submission of the Plan to NHS England.

Arising from the presentation of the Plan submitted and with specific reference to the five year plan, the Director of Public Health suggested that a picture needed to be painted on how health care may feel different in 5 years time and what in particular people were doing for themselves and the requirement for people to work on their own health.

Resolved

That the information contained in the report submitted, and Appendices to the report submitted, on the Dudley Clinical Commissioning Group's Strategic Plan 2014-19 be noted and approved.

13 **Maximising the role of Healthwatch on the Health and Wellbeing Board.**

Ms P Bradbury, Chair of Healthwatch, Dudley gave a verbal presentation on maximising the role for Healthwatch on the Dudley Health and Wellbeing Board.

Ms Bradbury referred to the work conducted by Healthwatch. It was noted that Healthwatch had thirty active volunteers involved in collecting patients stories and Healthwatch wished to recite those stories to the Board and there followed a request of Members on how they would wish to access patients stories.

Dr R Dalziel advised that patients stories would include investigating their complexities and the impacts on patients' lives in order to track their journeys through health and social care and believed that working with the Council would allow people to access services through information directories.

Dr R Dalziel referred to the urgent care centre project which examined how people use walk in centres and accident and emergency departments and the need to address access to GP Surgeries. He suggested that further information could be submitted to the Board on how those issues had impacted on individuals, including the difficulties they faced and the barriers encountered in accessing services.

Ms Bradbury advised that Healthwatch and the Board could work together on homelessness, the elderly and those with mental health problems.

Arising from the presentation Members made suggestions as follows:-

- That Healthwatch could provide advice to the Board on how to communicate various changes to the public in relation to health and adult social care provision;

- Work could be conducted with Healthwatch to develop the Better Care Fund;

- The Council could communicate details to Healthwatch of the projects they were involved in regarding hospital discharges;

The Chair advised that Healthwatch could have a key role in the development of the Board and could demonstrate key issues in the Dudley Borough where the Board could make a difference working with independent organisations such as Healthwatch whose role would be pivotal to the development work of the Board.

The Director of Public Health stated that it was important for the Board to have a facilitator such as Healthwatch and the work of the Board encompassed what happened outside the meeting and developing relationships in order for the continued improvement of work that the Board carried out.

The Assistant Director of Planning and Environmental Health referred to preventative work such as the spotlight on neighbourhoods project and the work on environmental impacts on health and wellbeing which had recently commenced.

The Chair suggested that this issue could be included in the first personal development session of the Board including what work the Board conducted.

Resolved

> That the information reported on and comments made arising from the presentation on maximising the role of Healthwatch on the Board, be noted.

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14 **Membership of the Board.**

Arising from consideration as to whether to include a Fire Service Representative as a Member of the Board, it was

Resolved

That Neil Griffiths be appointed to serve as the Fire Service representative on the Board.

Resolved

> That the Director of Corporate Resources, in consultation with the Cabinet Members for Adult and Community Services and Human Resources, Legal, Property and Health, be recommended to amend the membership of the Dudley Health and Wellbeing Board to include a representative of the Fire Service and that subsequently Mr Neil Griffiths be appointed to serve on the Board for the 2014/15 municipal year.

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15 **Items to Note**

It was noted that (a) the Dudley Group NHS Foundation Trust – Quality Report had been received and commented on by the Board and (b) Pharmaceutical Needs Assessment: Briefing on process for completing April, 1st 2015 had been received and noted by Board Members.

The meeting ended at 7.00 p.m.

CHAIR

DUDLEY HEALTH AND WELLBEING BOARD Agenda Item no. 5

REPORT SUMMARY SHEET

DATE	**30th September 2014**
TITLE OF REPORT	**Interim Performance Report**
Organisation and Author	Joint Report of the Director of Public Health, Director of Adult, Community and Housing Services, Director of Children's Services, Director of the Urban Environment and the Chief Officer of the Dudley Clinical Commissioning Group
Purpose of the report	To update the Board on the progress made against the Board's strategic priorities as set out in the H&WB strategy and also the half year position against the health and wellbeing outcomes frameworks.
Key points to note	• We have seen improvements in 8 of the national indicators bringing us to up to being similar or better than the England average for the time periods covered in the national data sets. • We remain significantly below the England average for a number of indicators particularly those with a lifestyle element such as alcohol outcomes, obesity or breast feeding and also socio-economic circumstances such as fuel poverty and child poverty, pupil absence, rates of permanent admissions to residential/nursing homes of older people and the number of young people not in employment, education or training • There are 9 indicators where we have dropped below the England average since the previous year- which are detailed in the report appendix. • All the priority issues identified last year through the spotlight sessions are being actioned.
Recommendations for the Board	That the Dudley Health and Well-Being Board note the current performance status for Dudley borough.
Item type	*Information, discussion , strategy*
H&WB strategy priority area	*All*

DUDLEY HEALTH AND WELLBEING BOARD

30TH SEPTEMBER 2014

REPORT OF: Joint Report of the Director of Public Health, Director of Adult, Community and Housing Services, Director of Children's Services, Director of the Urban Environment and the Chief Officer of the Dudley Clinical Commissioning Group

INTERIM PERFORMANCE REPORT

HEALTH AND WELLBEING STRATEGY PRIORITY

1. The report covers all 5 priority areas in the Health and Wellbeing Strategy.

PURPOSE OF REPORT

2. The report gives an update on the progress made against the Board's strategic priorities as set out in the H&WB strategy and also shows the half year position against the health and wellbeing outcomes framework.

3. The Dudley Health and Wellbeing Board (H&WBB) is required to note the current performance status.

BACKGROUND

4. At the January 28th 2014 Board meeting, the board reviewed performance and agreed a performance monitoring process that can:
    a. Demonstrate what impact it is having on the health and wellbeing of the people of Dudley borough.
    b. Demonstrate what progress is being made with the implementation of a Joint Health and Wellbeing Strategy and
    c. Provide a good understanding of how the H&WB Board is functioning.

5. It was agreed that the overarching performance outcomes frameworks for Public Health, Adult Social Care and the NHS, organised according to Dudley borough's 5 strategic priorities would be used to monitor overall impact on an annual basis. In year, it was agreed that the Health and Wellbeing Development Group would monitor the outcomes frameworks and inform the Board of any additional performance outliers.

6. This report gives an in-year position against these frameworks and also highlights any indicators where there has been significant deterioration in performance since the January 2014 position.

7. It also updates the Board on progress being made on the Health and Wellbeing Strategy priorities – specifically the 7 issues identified to be worked on locally through last years' series of spotlight events.

8. It also updates on the process being used this year to review how the Board is functioning- specifically the peer challenge scheduled for 15th-18th September 2014.

CURRENT PERFORMANCE STATUS

Overarching Impact on Health and Wellbeing

9. The attached report –Dudley H&WBB Framework Spine Chart August 2014, details a dashboard of performance for Dudley against the national indictor sets for Public Health, Adult Social Care and the NHS, mapped against Dudley borough's five local priorities. Please note that national benchmarking does not include the most current data available locally- often being 1 to 2 years old.

10. In summary, we have seen improvements in children achieving a good level of development at end of reception, the rate of hospital admissions for injuries in children, peoples self reported wellbeing, the proportion of adults with mental health problems living independently and in paid employment, in the rate of emergency admissions due to violent crime, pneumococcal polysaccharide vaccine (PPV) coverage, social care related quality of life and the proportion of people who use adult social care services who feel safe and secure.

11. We remain significantly worse than the England average for alcohol outcomes, child poverty, pupil absence, the number of young people not in employment, education or training, excess weight for adults and children, breast feeding rates, smoking during pregnancy, physical inactivity, breast screening uptake, flu vaccination coverage, uptake of the NHS health check, fuel poverty, emergency admissions due to falls, site loss certifications and rates of permanent admissions to residential/nursing homes of older people.

12. There are 9 indicators where we have dropped below the England average- mortality rates from cancer, rate of first time entrants into the youth justice system, 2 year average infant mortality rate, emergency admissions for children with lower respiratory tract infections, under 18 conceptions, emergency hospital admissions for injuries due to falls in 65 to 79 years, unplanned hospitalisation for chronic ambulatory care sensitive conditions, site loss due to age related macular degeneration in 65+ years and delayed transfers of care from hospital attributable to adult social care services. A commentary on the local situation for these is detailed in Appendix 1.

Progress of the Joint Health and Wellbeing Strategy Priorities

Healthy Services

13. The Urgent Care Working Group took on leadership for follow-through on actions arising from early Spotlight event on this theme. Within the year a "Quality Transfers of Care" Action Plan has been developed and maintained. This addressed a range of issues including 'flow' within the hospital system itself as well as interface issues such as joint work with Dudley MBC Adult Social Care and Dudley CCG. This Plan has been further developed through the response of the Dudley health and care community to the Emergency Care Improvement Support Team (ECIST) which has provided challenge to the internal flow within the Dudley Group of

Hospital and including the way partners work together in the emergency services. Improvements which have occurred and are taken forward in these plans include the establishment of a "7-day working" arrangement including adult social care in the hospital. Closer liaison has been maintained during peak times through peak time involving more flexibility by CCG and MBC staff concerning timely decision-making. A "Safeguarding Protocol" has also been agreed by all parties so that the twin demands of making best use of scarce hospital bed capacity is maintained alongside the need to ensure appropriate and timely safeguarding decisions. Dudley CCG has, through both the outcome of the Spotlight event and its own consultation processes, developed a new service specification for the development of an urgent care centre at the Russells Hall site. This is now the subject of a procurement process and will be operational from April 2015. In addition the CCG has commissioned a community rapid response service as a real alternative to hospital admission. At the time of writing this Report, work is underway to agree a "Discharge to Assess" model and implementation as a further means to support appropriate discharge and avoidance of admission where possible.

14. To continue leadership under the Health and Well-Being Board of the interface between health and care providers and commissioners, the Dudley Health and Care Leadership Group has been re-designated as the "Dudley Systems Resilience Group" in line with national guidance. This development serves to strengthen the focus for the Health and Well-Being Board on a "whole-systems" approach to the challenges we face in improving health services and the health of Dudley people. A specific focus which the Group has worked on has been the Better Care Fund and the challenge of reducing avoidable admissions. This is the subject of a separate report to the Board.

Healthy Lifestyles

Breast Feeding

15. The following table provide an overview of the actions that came from the spotlight session on increasing breast-feeding in the Borough and have been taken forward by the Strategic Breastfeeding Group:
    a. **Social marketing plan to address issues identified in the spotlight -need for a cultural shift and attitudes towards breastfeeding:** A 'normalising breastfeeding' social research and behaviour change campaign has been commissioned, targeting areas such as Brierley Hill Brockmoor & Pensnett; St Thomas; Castle & Priory; Coseley East. The Campaign engaged local volunteers, mothers and families to develop local resources with involvement and participation from local people. It went live July 2014 via website, face book, posters on bill boards, buses, in GP surgeries, health clinics, libraries, leisure centres, pharmacies, radio adverts, appointment cards and emery boards. Post research campaign has demonstrated a positive shift in attitude towards breastfeeding.
    b. **Volunteer Buddies from the Childrens centres to be integrated into OPH volunteer programme by March 2014:** 23 buddies completed the transition. Overall there are 34 active volunteer buddies in operation, 11 new volunteers trained during 2014. There is a recognition that partnership with children's centres is at the heart of delivery.

c. **GP engagement:** The CCG GP Engagement Lead agreed to facilitate involvement with the GPs. This is in process of follow up and is a priority.
d. **UNICEF Stage 3 achieved across hospital and community-** Accreditation in hospital has been maintained and annual audits are to be submitted. Assessment for stage 3 achieved Aug 2014 and reassessment will take place in February 2015.
e. **Mainstreaming community buddies in health visiting teams-** At present Buddies are based at Central clinic, at a single location. It is envisaged that each HV team will have a buddy attached. Service leadership and commitment from the provider has been agreed, but the service is still not having the level of contact and impact expected. This is to be reviewed March 2015.

Alcohol Misuse

16. The recommendations from the Health and Wellbeing Spotlight event on alcohol were added to the recommendations made by service users and providers, key stakeholders and community focus groups. The Alcohol Needs Assessment identified gaps in service provision as well as highlighting the wealth of prevention work that had taken place to raise awareness and reduce alcohol related harm within the Borough. A large campaign, co-ordinated with the CCG and other partners, called 'Let's Talk Drink' ran from November 2013 to March 2014. The campaign was designed to get local people thinking and talking about alcohol. This has now been developed into more targeted approaches for specific groups to help individuals to reduce their alcohol consumption to within safe levels.

17. There has been alcohol specific work offered to all schools across all the key stages, starting with 5-7 year olds, and to colleges for the 16-18+, as well as some innovative work on perceptions and risk taking amongst adolescents. The latter has been found to challenge the views held by pupils about the amount of alcohol they consume and the findings also challenged the perceptions of teachers and parents. Fewer young people drink than was previously thought and the majority consume small amounts. It is the small number of young people drinking large amounts of alcohol that give rise to the view that binge drinking is a big problem in Dudley.

18. The affordability and availability of cheap alcohol is the biggest driver in alcohol consumption and alcohol has become relatively cheap compared with income in recent years. Advocating for a minimum unit price would have a large impact on reducing the amount of cheap alcohol available. There has been some very successful work carried out by Trading Standards on reducing underage sales and preventing counterfeit alcohol sales. The Licensing Committee has recognised the health harm alcohol causes to adolescents and has been proactive in imposing additional conditions on Licensees who sell to children.

19. A new integrated substance misuse service was tendered during 2013-14 and came into place in April 2014. The number of referrals from primary care and by self referral has been maintained and waiting times for community and inpatient alcohol detoxification have now reduced after a slight increase after transfer.

20. The alcohol strategy group held an alcohol prioritisation event and this formed the basis of the Alcohol Strategic Framework for 2014-2017. Detailed implementation plans are currently being finalised which set out the details on how these priorities will will be delivered. The strategy is being discussed at the September meeting of the Health and Wellbeing Board.

Healthy Children

21. Priorities identified in the spotlight event on children and young people are being progressed by the Children and Young People's Partnership Board. In particular, these themes will be integrated into the Early Help Strategy and the CCG's review of emotional and mental health services for the 0 – 25s. This has been covered in the mental health report in paragraph 22.

Healthy Minds

Dementia

18. The nationally recognised Dudley dementia pathway and gateways support over 1,800 people across Dudley. However there is still a considerable amount of work required to be improve services for the increasing numbers of people with and affected by dementia. The key initiatives for this year are highlighted below and priorities are to ensure more people are correctly diagnosed and to raise awareness of dementia among both public and health/social care workers to ensure greater access and utilisation of services. Opportunities are arsing to improve coordination of care for people with dementia particularly with the forthcoming developments on integrated working across health, social care and the voluntary sector.

19. The Dudley Dementia Strategy largely captures the issues raised within the spotlight event report (see responses below). The Dudley Dementia Strategy has 24 objectives taken from the National Dementia Strategy, NICE Quality standards, Joint Commissioning Panel for Mental Health and The Prime Minister Dementia Challenge. Each of the objectives sets out what we have in place, what we need to deliver, what we will do and outcomes. Progress against these is monitored by the Dudley dementia strategy group on a twice yearly basis.

20. The key issues raised within the Spotlight event report:

    a. **Prevention of vascular dementia** – Dudley has a higher prevalence rate of vascular dementia when compared with the national prevalence rate. Prevention of dementia is one of the key objectives in the Dudley Dementia Strategy, with an emphasis of the public health role including raising awareness in schools and with black and minority ethnic groups, articles in local publications, online resources, keeping active, weight management programmes, smoking cessation and alcohol. Dementia awareness was added to the NHS Health Check nationally in April 2013 and adopted locally. As part of the checks any person over the age of 65 is given information on the signs and symptoms of dementia, the link between cardiovascular risk factors and dementia, links to national resources, supporting leaflets and prompts to see their GP if they have any concerns.

The 'Making Every Contact Count' key behaviours changes are obesity, physical activity, alcohol and smoking are the same risk areas for reducing vascular dementia and therefore need to be further reinforced in dementia awareness raising in Dudley.

Dementia care and awareness was also included in the Dudley CCG GP education programme.

b. **Dementia friendly people and places in Dudley-** Dudley MBC is developing a local Dudley Dementia Alliance and participating in the Alzheimer's Society initiative of 'Dementia Friendly Communities' to improve inclusion and quality of life for people living with dementia. This has included participating in the Dementia Friends Campaign across health and social care with a number of local dementia champions running courses and awareness programmes. There is also ongoing public and professional awareness of dementia via numerous training and education programmes for example with staff at Dudley Group of Hospitals to ensure a more informed and effective workforce.

c. **Expert patients for dementia carers and patients** – Over a 150 carers have attended the bespoke Expert Patient Programme (EPP) for Carers looking after someone with a diagnosis of dementia. To ensure that more people can access the 'Looking After Me' course. Dudley Alzheimer's Society also run a CrISP (Carers Information and Support programme) programme and identify people to participate in the EPP. All carers of people diagnosed with dementia are offered a carers assessment via the Dementia Gateways. Dementia Advisors are undertaking screening for those carers who may need a more comprehensive assessment by a social worker. Carers respite is provided via the gateways and Dudley Alzheimer's Society.

21. The key focus in 2014/15 is:-

- Ensuring every patient with dementia is offered the opportunity to have an **advanced care plan.** Supporting the 'difficult conversations' -planning for the future end of life support.
- To deliver **training** to the wider multi-disciplinary integrated teams on caring and managing people affected by dementia.
- To recruit a **community psychiatric nurse** for care homes to work alongside the care home nurse practitioners with a remit of training staff in care homes to manage people with challenging behaviour, take referrals from Community Rapid Response Team (CRRT) where there are complex mental health issues and facilitate discharge from hospital.
- Developing the new **extra care housing scheme** with a set number of rooms for people with dementia
- Supporting GPs to identify more people to be referred and assessed for dementia, to achieve the **national target of 67%** against the suggested prevalence for Dudley.
- To **reduce unplanned admissions and re-admissions** to Dudley Group and Bushey Fields from both homes and care homes by improving access to support in the community.
- **Pre diagnosis counselling** – Support for those people presenting with symptoms that could help prepare for the diagnosis process –

- **Post diagnosis counselling** for people with a confirmed diagnosis of dementia
- To consider **Occupational Therapy/Physiotherapy** in the dementia gateways for supporting patients to return home post injury, balance and stability control to reduce risk of falls, improve sleep patterns and therapeutic input.
- For Dudley Group and DWMHT to have an agreement on a **minimum time from referral to psychiatric assessment.**
- To work collaboratively across the Black Country for specialist support for **young onset dementia**/working age dementia to improve efficiencies and quality.
- To implement an **acute care pathway** for patients admitted with dementia in Russells Hall Hospital.

Mental Health and Emotional and Well Being Service

22. Currently, Dudley CCG, Dudley Council and partners have

a) commissioned a resilience training programme for young people aged 16 to 25 which aims to develop a body of champions and mentors who will train future trainers to ensure the program is self-sustaining. This commenced in July 2014

b) commissioned the National Development Team for Innovation (NDTI) to provide Recovery training for all providers of mental health services in the borough. This commenced in August 2014

c) exploring the possibility of recommissioning the Big White Wall which provides on line access to psychological therapies. September 2014

d) commissioned the Glass House College to provide a programme of therapeutic interventions for people who are on the Autistic spectrum. To commence October 2014

e) developing Woodside as a central hub for mental health, emotional health and well-being services. This work commenced in 2013 and is on-going.

f) commissioning a local voluntary organisation to provide a mental health, emotional wellbeing telephone support line for Dudley people. Due to start late 2014.

g) commissioning a local voluntary organisation to provide a transition support service for people being discharged from hospital. Due to start in the final quarter of 2014

h) commissioned DWMHT to provide 24 hour psychiatric liaison January 2014

i) engaged with service users and carers in a number of ways during the past 12 months including-: Woodside consultation, Mental Health Crisis, Personalisation, Personal Budgets and Market Shaping.

j) commissioned DWMHT to provide a Community Development Worker Service targeting the needs of minority ethnic communities and other vulnerable groups to improve their experience and access to mental health services and recovery, as well as supporting their mental wellbeing and addressing stigma and discrimination.

k) Delivered an ongoing Public Mental Health Programme which aims to promote positive mental health and wellbeing across Dudley through raising awareness of the ‘Five Ways to Wellbeing’ key messages; providing self-help resources for individual stress management; providing an annual small grant fund to build capacity for mental health promotion activity across all sectors. This includes work on suicide prevention through strategy development and training initiatives.

l) The Healthy Schools Programme has a dedicated initiative to integrate emotional health and wellbeing in primary and secondary schools.

23. Planned developments include:
    a) an all age primary care emotional health and wellbeing service to include triage and build on the local authorities Early Helpers programme.
    b) Redesign of how secondary mental health services are configured so that there is a 0 – 25 service, a 25 plus service and specialist dementia service.
    c) a child and adolescent mental health tier 3 ‘plus’ service
    d) a mental health urgent care pathway which will avoid necessity for attendance at the emergency department for people experiencing mental health problems unless there is a clear physical health need at presentation
    e) aspiration to build capacity within all mental health and emotional and wellbeing services in 3 areas- helping the helpers, education, and prevention and resilience.

Healthy Neighbourhoods- Developing Strong Inclusive Communities

23. A spotlight event was delivered in February at the Wren’s Nest Community Centre which was attended by over 50 people from local organisations and communities. The focus of the event was to explore how to build community capacity and resilience beginning with the identification of what makes a strong inclusive community, and what that means in practice. Key findings emphasised local people want approaches that uncover and use their own strengths and resources to make healthy, informed decisions around their own wellbeing (referred to as asset based approaches) and that they want to be involved in the production and design of services and programmes (referred to as co-production). An outcomes report from the event was produced from which the Health and Wellbeing Board development group agreed key actions for 2014/15. This included taking the theme of asset based working and co-production to a wider and bigger number of stakeholders at the 2014 annual conference. Going forward, a training programme and guide for commissioners on how to co-produce is planned alongside the production of a case-study report to illustrate how asset based working is already being utilised within Dudley.

24. A set of local environment indicators were also identified for the neighbourhood’s priority. Progress against target for these is detailed in Appendix 2.

Health and Wellbeing Board Functioning

25. Dudley Health and Wellbeing Board has been peer reviewed during September 2014. The peer team focused on 3 elements:

    - establishment of effective HWBs as a forum for senior leaders to come together and take action to improve the health and wellbeing of their local population and to promote integration across health and social care
    - transfer of the public health function to councils
    - establishment of a local healthwatch.

    The peer team were with us for 4 days (15th-18th September) during which time they interviewed a range of staff from across the health and social care system. A report on their conclusions and recommendations will be forwarded shortly that the board and Dudley Council will be able to respond to, before finalisation.

FINANCE

26. Any financial implications resulting from these proposals will be met within existing budget arrangements.

LAW

27. The statutory duties of the Health and Wellbeing Board are detailed in the Health and Social Care Act 2012 and related guidance.

EQUALITY IMPACT

28. Improving equality and tackling health inequalities are key priorities of the Health and Wellbeing Board and will be discharged through implementation of the Board's Joint Health and Wellbeing Strategy. The establishment of the Dudley Health and Well-Being Board provides an opportunity to extend the influence of the Council in working more closely with partners, particularly GP and Clinical Commissioners, to consider equality issues through the work of the Board

RECOMMENDATIONS

29. That the Dudley Health and Well-Being Board note the current performance status for Dudley borough

Valerie A Little
Director of Public Health

Andrea Pope- Smith
Director – DACHS

Pauline Sharratt
Interim Director – DCS

John Millar
Director – DUE

Paul Maubach
Chief Officer
Dudley CCG

Contact Officers:

Karen Jackson

Brendan Clifford

Consultant in Public Health Office of Public Health, DMBC	Assistant Director –DACHS DMBC
Ian McGuff Assistant Director –DCS DMBC	Sue Holmyard Assistant Director –DUE DMBC
Neill Bucktin Head of Commissioning Dudley CCG	Josef Jablonski Principal Officer –CRD DMBC

Appendix 1: Supporting Commentary for Indicators showing significant deterioration in performance since the January 2014 position. (Accompanies the Outcomes Frameworks Report).

Indicator	Lead	Priority	Commentary
4.5i- Mortality rate from all cancers for persons less than 75 yrs (2010-12) /100,000	All	Overarching	The mortality rate has risen locally from 111.4 (2009/11) to 155.9 and Dudley is now significantly worse than the England average and our Black Country peers. The outcome suggests the issue is greater for males (4.5i). This indicator is underpinned by the whole pathway- public awareness, early identification, access to treatment and prevention in terms of lifestyles and obesity. A cancer position statement is being developed by public health to inform planning.
1.4- first time entrants to the youth justice system (2013) /100,000	DCS?/ Cexec?	Healthy children	Although the local rate has decreased from 403.3 (2011) to 384.5(2012), the whole of England has seen a bigger improvement so Dudley's benchmarked position has changed from being significantly better than England to being the same as England. Local work continues in relation to supporting young people in the justice system as well as prevention/ early identification of issues through work with schools.
4.1 infant mortality 2010/12 (/1000 live births)	Public health	Healthy children	The 2 year average infant mortality rate has increased locally from 4.0 to 4.4 and Dudley is now significantly worse than the England average, but better than our Black Country peers. However it must be remembered that we are looking at very small numbers. The office of public health is in the process of updating the Infant Mortality Needs analysis and expanding it to cover death between (0-5) and (6-18) years and update the multiagency infant mortality action plan. The Office of public health is also in the process of formulating an infant mortality group to sit underneath the Child Death Overview Panel to oversee the implementation of the infant mortality action plan.
3.2 Emergency admissions -children with Lower Respiratory Tract Infections 2012/13 (/100,000)	CCG	Healthy children	In January 2014, only Q4 data was available and Dudley was benchmarked as the same as England. However, a full years' data has now been benchmarked showing our position to be significantly worse than England. This has been identified as an issue by the CCG in their operational plan
2.4i Under 18 conceptions 2012 (/1000 females 15-17)	DCS	Healthy children	Although the local rate has reduced from 35.6 (2011) to 34.6 (2012), England overall has improved at a faster rate. However it must be remembered that we are looking at very small numbers. Locally there is a teenage pregnancy service in place to support teenage parents and prevention work such as risk taking behaviour educational programmes with young people.
2.24ii Emergency hospital admissions	Public	Healthy	For 2011/12, the admissions rate due to falls for this age range was 906 and we were benchmarked as the same as England, however for 2012/13 this has risen to 1194.9 and we are now

for injuries due to falls in persons aged 65 to 79 (2012-13) (/100,000)	Health	Services	benchmarked as significantly worse than the England average. Falls are the largest cause of emergency hospital admissions for older people, and significantly impact on long term outcomes, e.g. being a major precipitant of people moving from their own home to long-term nursing or residential care. Interventions for recently retired and active older people are likely to be different in provision and uptake for frailer older people. Locally, an evidence based integrated falls pathway, with single point of referral for those at risk of falls has been implemented in quarter 3 of 2013. An initial review of the falls service has identified some areas that require further development and an action plan produced to implement those changes . The review has identified a need for a more comprehensive falls needs assessment which is being undertaken and will help identify areas of priority and development, in particular focusing on primary prevention of falls.
2.3i unplanned hospitalisation for chronic ambulatory care sensitive conditions 2012/13 (/100,000)	CCG	Healthy services	It is possible to avoid unnecessary hospital admissions for patients with some conditions by giving them good quality preventive and primary care – their illnesses are known as ambulatory care-sensitive conditions. In January 2014, only Q4 data was available, a full year's data is now available and Dudley is benchmarked as significantly worse than the England average. This has been identified as an issue by the CCG. Avoiding unnecessary admissions is a key strategic priority in the CCG's Operational Plan, the Strategic Plan and the Better Care Fund Plan. Further analysis in relation to this forms part if the CCG/OPH core offer.
4.12i Crude rate of site loss due to age related macular degeneration in 65+ years (2012/13) (/100,0000	CCG	Healthy Services	The local rate has increased from 134.8 to 155.6 and Dudley is now benchmarked as significantly worse than the England average. Further analysis is required to understand this.
2Cii delayed transfers of care from hospital attributable to adult social care services 2013/14 (/100,000)	DACHS	Healthy Services	The percentage has increased from 5.7 to 7.3. In terms of actual numbers, this is a small increase 14 to 18. As a result, Dudley is currently below benchmarked England and Black Country average. Improvement plans and actions are in place amongst partners including (a) the re-design of adult social care service delivery under a "Customer Journey" model to improve people's access to care; (b) a multi-agency plan responding to the ECIST Report including (i) development of a "discharge to assess" model - to allow for recovery time in a more appropriate setting to support long term support decisions to be made outside of an acute setting; and (ii) an updated better recording and monitoring of delays through the DISCO database; amongst many other actions.

Appendix 2: Local Environment Indicators

Performance Indicator	Target	2012/13 out-turn	2013/14 out-turn
Improved street and environmental cleanliness (National indicator 195) a: litter b:detritus c:Graffiti d:fly-posting)	 3.3% (2014/15) 5.7% 1.3% 0%	 3.3% 6.3% 1.3% 0.1%	 3.44% 5.15% 1.06% 0.06%
Gross affordable housing completions (Core Output Indicator HOU3)	Between yrs 2006-2026) 2479 affordable dwellings (15% of gross completions) (116 /year)	312 (49% of gross completions (2011/12)	143 (19% of total gross completions) (2012/13)
Increase in cycle use of monitored routes (LOI TRAN4a)	1% increase in cycling	14,272	14,098
Implementation of missing links and overcoming barriers identified in sub regional cycle network map (LOITRAN4b)	N/A	10 new links via healthy towns project – 7.26km (2012)	No further information

DUDLEY HEALTH AND WELLBEING BOARD

REPORT SUMMARY SHEET

DATE	**30th September**
TITLE OF REPORT	**Health and Wellbeing Board Communications and Community Engagement Plan**
Organisation and Author	**Valerie. A. Little** — **Director of Public Health Dudley Council** **Andrea Pope-Smith** — **Director of Adult Community and Housing Services Dudley Council** **Pauline Sharratt** — **Interim Director of Children's Services Dudley Council** **John Millar** — **Director of Urban Environment** **Paul Maubach** — **Chief Officer Clinical Commissioning Group Dudley Council**
Purpose of the report	To present the communications and community engagement plan for the Health And Wellbeing Board
Key points to note	• This plan is underpinned by our engagement and involvement principles within the strategy and the additional ones signed up by the Board in January 2014. • It takes account of the needs of people involved at different levels with the Board, both within partner organisations and also within communities. • The main aims of the plan are to: o increase awareness about the Board, its role, how to access it and the contribution it makes o Engage partners and the public in health and wellbeing priority setting and delivery o Coordinate elemtns of engagement across partners where possible o Make use of existing user and community networks within partner organisations • It details a timetabled plan of activities over the coming year
Recommendations for the Board	For the board to note and support the proposed activities and ratify the plan
Item type	*Information*
H&WB strategy priority area	*Community engagement*

Communications and engagement plan 2014-15

Draft framework

1. Principles

Dudley Health and Wellbeing Board has already articulated seven principles which inform the delivery of the vision in Dudley's Health and Wellbeing Strategy. One of these is: **we will work in empowering ways, appreciating the potential of individuals and their communities to maintain and sustain health and wellbeing and the contribution they can make to shaping and delivering services.**

It has been agreed that this principle will underpin engagement and involvement activities, and in addition the following principles be used to guide engagement and involvement.

Engagement is the business and responsibility of every board member
Engagement is the business of every board member and collectively the board has responsibility to ensure effective engagement is embedded within its day-to-day business and is taking place through the commissioning and delivery of services. Activity and issues should be routinely screened by the board in terms of engagement implications and required actions, the board's capability (and the capability of their partners) to involve local people, and local communities' interest and capability to be involved. ***This will be built in to Quality Assurance activity of the board.***

There will be different types and levels of appropriate engagement, depending on the situation
The board needs a consistent and rigorous mechanism by which it can assess the form that engagement should take as each new issue arises, and to evaluate its success. ***Existing community engagement guidance and tools are being reviewed and updated by Dudley MBC and partners, and will be used to help such assessment.***

Engagement activities should be based on evidence of what works
There are a variety of traditional and innovative ways to connect with the local community, including those people who may be from seldom heard groups. Consideration should be given to the most appropriate methodology and medium for engaging the particular target group concerned. It is important that individuals and communities receive feedback on how engagement activities have influenced the development of board policy, priorities and actions. ***Community engagement guidance and standards being developed by Dudley MBC and partners will support officers to do this.***

We will open ourselves to learning about the reach, impact and effectiveness of our engagement
All engagement activity needs to be evaluated, and the learning collected used to plan and develop future engagement. Any evaluation undertaken should actively involve the key audience for the engagement activity concerned. ***Community engagement guidance and standards being developed by Dudley MBC and partners will support officers to do this.***

2. Four types of involvement

We can group the involvement of people in the strategic work of Dudley Health & Wellbeing Board in to four types.

- Strategic: Members of the public and staff who get involved at a strategic level, often due to the position they hold in an organisation. This includes people on boards which have been asked to drive forward specific activity in relation to Health & Wellbeing Board priorities.
- Supportive: Members of the public and staff who are involved by doing, carrying out activity in relation to H&WB priorities.
- Generative: Members of the public and staff who have set up projects or activities independently which support the work or priorities of Dudley Health & Wellbeing Board.
- Responsive: Members of the public and staff from organisations who respond to to H&WB communications, opportunities to observe meetings, or invitations to events such as the annual event and spotlight events.

By considering what these types of involvement mean people do, and what they might need, we can consider ways to support each type of involvement :

Type of involvement	What I do	What I need	Our Plan to support engagement
Strategic	Involved at a strategic level, such as being a member of a board, or having responsibilities in relation to commissioning services.	To know what DH&WB expects of me and the board I am part of. To be involved in H&WB priority setting To be given necessary training and support to focus on the priorities within my work where applicable	Website Community engagement standards. Learning opportunities e.g. co-production Planned stakeholder engagement activities
Supportive	Involved through doing, delivering services, activities or projects which are directly contributing to specific areas of focus in relation DH&WB priorities.	As above	As above
Generative	Have set up a project/scheme to fill the gap I have identified.	To be given necessary training and support to be effective in my role. To have a say in H&WB priority setting	Website Community engagement standards. Learning opportunities re asset based

Type of involvement	What I do	What I need	Our Plan to support engagement
		To know how to feed in to DH&WB (via other boards etc.) To be appreciated for my contribution to DH&WB priorities.	working Planned stakeholder engagement activities
Responsive	Attend meetings or events in relation to DH&WB work. Respond to DH&WB communications. Willing to make myself available to give my opinion.	To know what is going on. To be asked and encouraged. To know that what I say makes a difference and to get feedback. Opportunity to get involved Opportunity to get involved in services I use Be able to take responsibility for my own health	Website Also links to other groups/forums e.g. Healthcare Forum, PPGs, Community Forums Social media channels Clear vision and messages Planned stakeholder engagement activities and public consultation events using the existing networks of public and user groups within partner organisations

3. Our Aims

We are aware there is much engagement activity that occurs within Dudley Borough, and that all partners have networks set up for this purpose. Through the Board's community engagement plan and activity we intend to

- Increase awareness of the Board, its role, how to access it and the contribution it makes to the health and wellbeing agenda
- Engage partners and the public in health and wellbeing priority setting and in delivery
- Coordinate elements of engagement across partners in terms of strategic priorities where possible
- Make use of existing user and community networks and staff communication and engagement systems rather than invent new ones. (appendix 1 details examples of networks we can use that are already in place for users and communities and appendix 2 details examples for staff)

4. Key engagement activities 2014-15: goals, targets and resources

Timescales	July 2014	Start June 2014	Oct 2014	Sept to Jan 2014	Feb - Mar 2015
Activity	**Annual accountability event**	**Use of social media as a routine communication for the Board**	**Develop and maintain H&WB Board website**	**H&WB priorities in response to JSNA refresh- engagement**	**Consolidating issues to take forward and approaches**
Direct goals	Host an annual event to inspire and engage partners, & to reinforce the role of the Board and the work of the Board during 2013/14	For the H&WB Board and its members to have a presence on social media: twitter, blogging via partner accounts.	Set up website and direct people to it in various ways	Gaining wider perspectives on JSNA and health and wellbeing priorities for people	Feedback to stakeholders involved and check plans
Indirect goals	Promote collaboration	Another channel to engage – especially for younger age groups	People begin to engage more with H&WB agenda. Awareness raised re Board and it's role.	Glean information about approaches to address emerging priorities	Informs 2015-16 implementation plans
Who starts the process	Event planning group	Annual event social media group	H&WB Development Group + DMBC web development team	H&WB Development Group	H&WB Development Group
Resources	Event budget Event planning team Speakers Workshop leads	Partners who use twitter and blogging - organisation/ personal accounts to use a twitter hashtag for DHWB	H&WB Development Group + DMBC web development team	H&WB partner organisations and their user/public networks and volunteers.	H&WB Development Group H&WB partner organisations and their networks and volunteers.
Targets	Involve 150 people across all partners, including at least 50 lay people who work with partner organisations or who receive services.	People who use twitter and blogs	Anyone using the web - general public and partner organisations. Ensure accessibility of site. Make site social Particularly want to engage with councillors and staff within the council and partner agencies	Public and officers in partner organisations Specifically to reach people with physical, mental or learning difficulties, carers, people living in poverty, elderly groups, black and minority ethnic communities, children and young people	People engaged in stage before

Appendix One:
Existing user and community networks linked to communities of interest (not exhaustive)

Partners	General Public/ locality networks	Physical, mental and learning difficulties	Black and Minority Ethnic Communities	People living in poverty/ areas of high deprivation	Children and Young People	Elderly	Carers
Council	Public Health Volunteers Community Health Champions Social Media OPH Twitter has over 500 followers Budget engagement and consultation undertaken focussed on services related to adult social care.(DACHS) Annual Adult Social Care Survey provides an understanding of people's satisfaction and outcomes of adult social care	Public Mental Health e-bulletin – distributed quarterly to over 650 community contacts Learning disability Partnership Board comprises a range of agencies, stakeholders and carers of people with learning disabilities.	BME annual event- Oct (DACHS) Community Cohesion Group – Meets Bi-monthly with15 core members representing front line services engaging with Minority Ethnic communities across the borough	Health and Homelessness Group- Bi monthly meeting of 15 core staff from front line services engaging with service users.	Dudley youth council	Age Alliance comprised of a range of local organizations that focus on key issues related to older people.	Expert Patient's Programme (EPP) Volunteers Carers network that provides regular bulletins and information to over 3,000 carers. 7,500 newsletters have been delivered by the end of 2013.
CCG	A network of 42 Patient participation groups (PPGs) –run in GP surgeries Dudley Borough Healthcare forum –100 members of the public						

Partners	General Public/ locality networks	Physical, mental and learning difficulties	Black and Minority Ethnic Communities	People living in poverty/ areas of high deprivation	Children and Young People	Elderly	Carers
	that meet quarterly Patient Opportunity Panel – (POPs) Strategic meeting of the chairs / vice chairs of all PPGs across the borough. Engagement newsletter – A target audience of 500 – 600 members of the public Dudley CCG Social media channels – Dudley CCG twitter has close to 2000 followers. Feet on the Street – Real people giving their views out and about in Dudley to the camera which is shown at our CCG board meeting.						
DCVS	Health network of local organisations						

Partners	General Public/ locality networks	Physical, mental and learning difficulties	Black and Minority Ethnic Communities	People living in poverty/ areas of high deprivation	Children and Young People	Elderly	Carers
Healthwatch	Community Information Champions						
Fire Service	The 3 fire stations in Dudley all have an active twitter account We are contributors across a wider range of services targeting the most vulnerable Regular press releases regarding fire and road safety	We have various programmes in place that assist in this area especially around children.	A key element to our prevention strategy allows us to target the demographic that are vulnerable to fire from a evidence based approach.	A high risk group relating to fire and a demographic that we specifically target on an ongoing basis through home safety visits	A wider range of activities from key stage 2 visits relating to fire in the home and general safety through to targeted programs working on interpersonal skills and behaviors linking to the Marmot principles.	A high risk group relating to fire and a demographic that we specifically target on an ongoing basis through home safety visits	Working closely with carers to help us identify the most vulnerable to fire through the principles of making every contact count.
Police Service							
DGFT,							
D&WMHT	**D&WMH Trust members** Over 7,000 public members. A proportion are service users and carers (they state this on	**One-in-4 newsletter** To engage with trust members – providing updates about what is	**Community Development Workers Team** Working with local marginalised communities to		**Mental Health Youth Forum** In planning stages – gives young service users the opportunity to		**Mental Health Forum** Network of carers groups and others organisations that support people with

Partners	General Public/ locality networks	Physical, mental and learning difficulties	Black and Minority Ethnic Communities	People living in poverty/ areas of high deprivation	Children and Young People	Elderly	Carers
	their membership form). We send out various communications, such as surveys, invites to events, other information from stake holders	happening in the trust, events and courses, reducing stigma, sharing patient stories. Opportunity for members to feedback about Trust services. **Stakeholder Engagement Events** Inviting local groups and organisations to take part in a Trust stakeholder event/workshops to help us plan for the future provision of mental health services in Dudley and Walsall. Using ideas from our partner organisations to help us to develop our Clinical and Social Care Strategic Vision for 2015-20.	promote mental health and improve equity of access/raise awareness of barriers among service providers		share their views, opinions and ideas		mental health difficulties - to share information and gather feedback about trust services.

Partners	General Public/ locality networks	Physical, mental and learning difficulties	Black and Minority Ethnic Communities	People living in poverty/ areas of high deprivation	Children and Young People	Elderly	Carers
BCPFT							

Appendix Two: Existing staff communication and engagement mechanisms (not exhaustive) (to be completed)

Partners	Staff Communication and Engagement Mechanisms
Council	Quarterly Managers forum Cascade email Management meetings
CCG	
DCVS	

Partners	Staff Communication and Engagement Mechanisms
Healthwatch	
Fire Service	
Police Service	
DGFT,	
D&WMHT	
BCPFT	

DUDLEY HEALTH AND WELLBEING BOARD

REPORT SUMMARY SHEET **Agenda Item No 7**

DATE	**30 September 2014**
TITLE OF REPORT	**Troubled Families Programme**
Organisation and Author	**Children's Services** **Pauline Sharratt – Interim Director of Children's Services**
Purpose of the report	**To update colleagues on the experience of the first phase of the Troubled Families Programme and the context for phase two**
Key points to note	Dudley has been accepted as an early adopter phase 2. Some suggested issues for the Health and Wellbeing Board to consider are: - The challenge of scaling up and redesign. - Requires cross council, cross directorate and partner planning and management. - Cross agency/partner/directorate commissioning based on the Payments by Results (PbR) targets for Troubled Families Phase 2. - Ongoing commissioning which is influenced by cost calculator evidence of intervention efficacy. - Cross directorate and partner organisation and management of targeted Troubled Family interventions. - Joint planning for best use of Phase 2 funding and Payment by Results (PbR) flows. - Agree structure of data flows from partners, agencies and directorates linking to a central Troubled Families data function.
Recommendations for the Board	- The need to ensure cross directorate and partner commitment to the re-design of services and joint Troubled Families phase 2 planning

	- The importance of reviewing joint commissioning and de-commissioning and for the flow of data and information to a central coordination ready to feed into the cost calculator
Item type	Information and discussion
H&WB strategy priority area	Services to children and families

DUDLEY HEALTH AND WELLBEING BOARD

30 SEPTEMBER 2014

REPORT OF INTERIM DIRECTOR OF CHILDREN'S SERVICES

TROUBLED FAMILIES PROGRAMME

HEALTH AND WELLBEING STRATEGY PRIORITY

1. This programme has the potential to meet all of the health and wellbeing strategies as it addresses inter-generational needs within families and promotes resilience and self support for families to reduce reliance on high cost interventions.

PURPOSE OF REPORT

2. To update Health and Wellbeing Board on the experience of the first phase of the troubled families programme and the context for phase two.

BACKGROUND

3. **Phase One of the Troubled Families Programme – 2012/2015**

The current Troubled Families Programme set up in 2012 has led the way for the first systematic identification of families with multiple problems across England. It was established by the Department for Communities and Local Government (DCLG) recognising the drain on the public purse of a small number of families with multiple problems who required high cost interventions across a range of indicators.

The first phase was not an open referral programme and access to the service was defined by specific criteria:

- A family member not in employment
- Children not regularly attending school
- Families engaging in crime and anti social behaviour

In addition, Dudley was able to identify a fourth local criteria which was determined as children on the edge of care. The target group in Dudley was identified through these criteria as having 740 families eligible for the programme between 2012 and 2015.

A team of multi-agency key workers was established including children social care, police, job centre plus, housing and Barnardos, with strong links to the Youth Offending Service, Probation, Education Investigation Service, Fire Service, Public Health and health providers and commissioners.

The working model was based on one key worker per family co-ordinating the range of specialist support required and intervening directly on an intensive basis with the family. The programme has already "turned around" 63% of the families against the success criteria and has received payment by results of around £0.5m. The success of the programme is down to the inter-relationships and dedication of the key workers providing assertive practical support to families. The co-location of the workers has facilitated good information exchange and the support from data analysts has been invaluable in achieving the payment by results and required data submissions to the DCLG.

4. Phase 2 of the Troubled Families Programme – 2015/2020

The expanded Troubled Families Programme will retain the current programme's focus on families with multiple high cost problems and continue to include families affected by poor school attendance, youth crime, anti social behaviour and unemployment. However, it will also reach out to families with a broader range of problems including those affected by domestic violence and abuse with younger children who need help and a range of physical and mental health problems.

The formula for identifying families allows for a level of discretion and local authorities must be satisfied that the programme's resources are being used for families who will most benefit from an integrated whole family approach to their problems and the highest cost families are being prioritised for support. For Dudley we will need to scale up the programme by a factor of 3 to meet the needs of approximately 2,500 families. This will require a radical public service transformation and systems change to ensure we maximise capacity to deliver the programme.

The key implications of this second phase are:

- Reduce number of services circling around families.

- Whole family approach from public services.

- Universal services more attuned to needs of troubled families.

- Ensure data sharing not a barrier.

- Demonstrate ways of working that result in lower costs and savings.

- Use cost savings calculator to drive evidenced based commissioning and de-commissioning.

FINANCE

5. A significant new development of the second phase is the introduction of a cost/savings calculator:

- To tell the story in fiscal terms to influence local commissioning, de-commissioning, and integrated local authority and partner budgets – with integrated management structures.

- To drive public sector reform and a deeper understanding of cost account.

- A picture of evidence to drive local and national policy.

- Identify cost savings to drive service transformation.

- The Phase 2 funding is expected to be around £2K per family plus annual co-ordination funding. Payment by results will also be a feature of the programme.

- In return DCLG will wish to see increased investments in and expectation of local co-ordination, analysis and oversight across partner agencies.

- There is also an attachment fee for early starters in this financial year. The exact details are yet to be determined.

LAW

6. The 2000 Local Government Act places a duty on local councils to promote the well-being of their communities.

EQUALITY IMPACT

7. The Troubled Families Programme is designed to offer targeted support to the most vulnerable families who meet the specific criteria outlined by the Department for Communities and Local Government.

RECOMMENDATIONS

8. Dudley has been selected to be an early adopter of the phase 2 programme as we have met the thresholds for phase 1 of turning around over 50% of phase 1 families and working with 90% of phase 1 families by the end of June 2014. The early adopter programme commenced in September 2014.

9. The Health and Wellbeing Board is asked to consider:

- The need to ensure cross directorate and partner commitment to the re-design of services and joint Troubled Families phase 2 planning
- The importance of reviewing joint commissioning and de-commissioning and for the flow of data and information to a central coordination ready to feed into the cost calculator
- The need to review future links to the Troubled Families phase 2 programmes in order to ensure the best fit with the corporate restructure
- The council commitment to be an early adopter of Phase 2
- The appropriate process to engage with elected members with regard to Troubled Families Phase 2

Pauline Sharratt
Interim Director of Children's Services

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DUDLEY HEALTH AND WELLBEING BOARD **Agenda Item No 8**

REPORT SUMMARY SHEET

DATE	**30th September 2014**
TITLE OF REPORT	**Better Care Fund**
Organisation and Author	Joint Report of the Director of Adult, Community and Housing Services and the Chief Officer of the Dudley Clinical Commissioning Group
Purpose of the report	To update the Board on the progress made on the Better Care Fund (BCF) in Dudley
Key points to note	• The national BCF initiative has provides focus for continued development of the integrated care theme. • The Board will note that national policy development during the last few months has sharpened the focus of the BCF on avoidable admission to hospital. • Updated submissions to the NHS Local Area Team (LAT) have been required of all localities • Partners in Dudley have worked very closely to establish shared understandings and agree approaches for their submission of 19th September. • A Power Point Presentation which will be given at the Board to share the detail for debate which was not confirmed at the time of preparing this Report.
Recommendations for the Board	That the Dudley Health and Well-Being Board comment on and note the current status of the BCF submission for Dudley.
Item type	*Information, discussion , strategy*
H&WB strategy priority area	*All*

DUDLEY HEALTH AND WELLBEING BOARD

30TH SEPTEMBER 2014

REPORT OF: Joint Report of the Director of Adult, Community and Housing Services and the Chief Officer of the Dudley Clinical Commissioning Group

BETTER CARE FUND

Purpose of Report

1. For the Dudley Health and Well-Being Board (DHWBB) to receive the latest up-date on Dudley's Better Care Fund (BCF) proposals and to confirm direction and next-steps

Background

2. One of the purposes of Health and Well-Being Boards has been to strengthen local leadership to integrate social care and health services even more closely. The intention has been to improve the experience of people using health and care services.

3. The national BCF initiative has provided a focus for the continued development of the integrated care theme. The DHWBB has debated reports during 2014 on the Dudley model. In particular, the Board has considered detailed financial, performance and service design issues alongside the practical requirement to respond to national and local deadlines.

4. The development of the national policy agenda during the last few months has sharpened the focus of the BCF even more clearly on the single issue of avoidable admission to hospital. Updated submissions to the NHS Local Area Team (LAT) have been required of all localities nationally and new national leads have been appointed to oversee implementation. A range of communications as well as regional-level support offers have been made available and officers from across partner agencies have taken these up.

5. Partners in Dudley have worked very closely to establish shared understandings and agree approaches. The national changes have not always made local implementation easy. Dudley agencies decided that the risks of further engagement with the offer of a place amongst a national group of "early implementers" would be too constricting for our local aspirations. For instance, partners remain committed to a broad suite of activities based on evidence to be included in a performance management framework focussed on the singe issues of avoiding admission to hospital where it is not needed.

6. Dudley's updated submission was sent to the LAT as per their timetable on 19th September. The submission was signed-off by the Chair on behalf of the Board. Through a Power Point Presentation which will be made for the BCF item, the agreed updated detail which was not available at the time at which this covering Report was prepared will be shared with the Board for further debate.

7. The main areas of the presentation cover:

    - an update on the proposed model and developed performance framework to improve appropriate avoidance of hospital admission
    - the overall funding levels, taking account of current allocations e.g. "Section 256." The net total fund is indicated to be £23.84 million.
    - Dudley's overall approach including a shared understanding and practical arrangements for risk-sharing

Finance

8. Any financial implications arising from the content of this Report will be met from within existing budgets between the agencies.

9. Those resources are as indicated in the Power Point Presentation.

Law

9. The background to the development of Health and Well Being Boards and the production of Joint Health and Well-Being Strategies lies in the guidance issued to date leading up to the enactment of the Health and Social Care Act 2012 and associated regulations.

Equality Impact

10. The aims of the Better Care Fund are consistent with principles of health and social care to improve the health of people living in Dudley and the quality of health services which they experience. The appropriate avoidance of hospital admission is designed to benefit all sectors of the population..

Recommendation

11.That the Dudley Health and Well-Being Board: -

- comment on the further shaping of Dudley's Better Care Fund proposals to confirm direction and next-steps

Andrea Pope- Smith
Director of Adult, Community & Housing Services
Dudley MBC

Paul Maubach
Chief Officer
Dudley CCG

Contact Officers:

Brendan Clifford / Matt Bowsher

Assistant Directors – DMBC DACHS

Neill Bucktin

Head of Commissioning –Dudley CCG

Agenda Item No 9

DUDLEY HEALTH AND WELLBEING BOARD

REPORT SUMMARY SHEET

Date	30.09.2014
Title of Report	Care Act implications and implementation
Organisation and Author	Brendan Clifford Assistant Director DACHS Matt Bowsher Assistant Director DACHS Shobha Asar-Paul Head of Policy and Performance DACHS
Purpose of the report	This report sets out the key requirements of the Care Act, the potential impact on the Council and local progress on its implementation.
Key points to note	Whilst the Care Act will necessitate changes in practice and service delivery, it should be noted that a large number of clauses are modernising or consolidating existing legislation or are new in law but not in practice. It introduces a cap on care costs, new rights for carers and a national eligibility threshold for care and support.
Recommendations for the Board	That the Board accept the report and notes the progress being made in preparing for Care Act implementation from April 2015.
Item type	Information
H&WB strategy priority area	Cross cutting

DUDLEY HEALTH AND WELLBEING BOARD

DATE: 30th September 2014

REPORT OF: Andrea Pope-Smith, Director of Adult, Community and Housing Services

TITLE OF REPORT: Care Act implications and implementation

HEALTH AND WELLBEING STRATEGY PRIORITY
Cross cutting

1. PURPOSE OF REPORT

1.1 The Care Act 2014 received Royal Assent on 14 May 2014. It is the most significant reform of health and adult social care for 60 years, its consequence makes it an important area for the Board to consider.

2. BACKGROUND

2.1 The current social care legislation has evolved over a number of decades and in a piecemeal manner. The Care Act sets out to consolidate several pieces of legislation with one Act and makes several new provisions. The new legislation is designed to be less complex and easier to apply for all concerned including local authorities, partner agencies, the public and lawyers and, in the case of legal challenge, the Courts.

3. THE MAIN ITEM/S OF THE REPORT

3.1 The Act is the Government's legal response to the recommendations made by the Dilnot Commission on social care funding and the Law Commission's examination of how a social care system could be sustained given increased demand.

3.2 Regulations and guidance for application will follow in October in preparation for implementation from April 2015 onwards.

3.3 The Act comprises three sections:

- Care and Support,
- Care Standards- following on from the Francis Inquiry into the failings at Mid-Staffordshire hospital, and
- Health Education England and the Health Research Authority.

3.4 It introduces a cap on care costs, new rights for carers and a national eligibility threshold for care and support.

3.5 Key themes of the Care Act are wellbeing, prevention, carers' rights, choice and personalisation. Underlining the Care Act reforms is a vision of a more integrated approach to the design and delivery of social care and health care services. The Better Care Fund is a vehicle for this.

4. KEY MESSAGES

Part One – Care and Support
This section of the Act covers a wide range of new (in law) provisions for adults needing care and support, and their carers. It emphasises an approach to social care that promotes wellbeing and asset-based methodology. It strengthens carers' rights and introduces an adult safeguarding framework. This section-(highlights below) also contains powers to introduce a system of capped care costs and a universal deferred payment scheme.

4.1. The wellbeing principle in the Act includes a specific reference to the dignity of the adult and the availability of safe and settled accommodation. Applying to carers as well as adults who use care and support.

4.2. The provision of universal information and advice and the market-shaping role are linked to the duty of prevention.

4.3. As part of assessments of needs, care and support plans, councils must consider whether other support is available that could contribute to the outcomes the adult wishes to achieve, and provide information on this.

4.4. The local authority must, as part of its general information and advice provision, provide advice about how to access independent financial advice.

4.5. A duty on local authorities to promote the diversity and quality of local services -market-shaping

4.6. Councils should consider the importance of enabling carers and people who use care and support to undertake work, education or training.

4.7. There are new clauses that contain duties on the local authority and other authorities which have functions relevant to care and support to cooperate. This will not cover independent and private organisations but does now include the director of public health.

4.8. The 'regular and substantial test' for carers has been removed, a carer's assessment should focus on the impact of caring and on the outcomes they want to achieve.

4.9. A provision has been introduced for local authorities to be required to refer adults who they believe have a primary health need to the NHS for assessment for NHS continuing healthcare.

4.10. The clause on the national minimum eligibility threshold makes it clear that an assets-based approach will be taken on this. Councils will have to make clear that everyone with needs for care and support who is assessed, whether they meet the threshold or not, will be informed of the local community preventative support available.

4.11. The Act contains regulation-making powers to set the level of the Care Cap and prevents local authorities from being able to charge for the costs of meeting eligible needs once people have reached the cap. This will allow the Secretary of State to amend the cap and to set

different levels of cap for different age groups. The cap will be adjusted once a year in line with inflation.

4.12. The Government has clarified concerns over the boundary between the care and support system and the NHS, which enables the existing boundaries to be maintained.

4.13 People have the right to request direct payments, rather than being forced to use them.

4.14. There will be a new regime of central oversight, which will be operated by CQC, to monitor the financial position of the most 'difficult to replace' providers in England.

5. PART TWO – CARE STANDARDS

5.1 Part Two of the Act takes forward the measures within the Government's five-point plan in response to the Francis Report. Measures include requirements for the CQC to develop a system of performance reviews and assessments which will allow for comparison of organisations against a single version of performance. It also gives CQC powers to appoint a new Chief Inspector of Hospitals to instigate a new failure regime. The Act makes it an offence for care providers to supply or publish certain types of false or misleading information and introduce additional legal sanctions.

6. PART THREE- HEALTH EDUCATION ENGLAND

6.1 Part Three sees HEE established to provide national leadership for education and training. HEE has appointed and supported the development of Local Education and Training Boards (LETBs) which have taken on responsibility for the workforce planning and education and training functions as previously provided by SHAs.

7. LOCAL PROGRESS IN IMPLEMENTATION

7.1 The implementation of the Customer Journey remodelling of adult social care has been developed in line with the principles of the Care Act- ensuring wellbeing, support and prevention are embedded throughout the Customer Journey; the Better Care Fund and integrating services with local health economies is a strand of the Care Act- the Dudley submission was one of the few that was highly regarded and the local economy is working to meet further milestones in its submission. Health and Wellbeing partners agreed not to pursue fast track submission pending receipt of clear guidance, the BCF plan submission date is 19th September following which there will be an assurance period conducted by NHS England. The schemes associated with the BCF again are completely linked to Care Act requirements and local Health and Wellbeing priorities.

7.2 We have fully participated in regional and national Care Act programme initiatives which seek to facilitate greater local clarity on implications and a benchmarked assessment of progress towards compliance- some examples include the LGA Stocktake surveys, financial and demand modelling and workforce development planning. We have developed a workforce development plan which includes leadership and culture change and are awaiting national products to be delivered between November 2014- March 15, once these are published we will assess what additional local approaches need to be provided.

7.3 Internal and external facing web pages have been developed to keep staff, public and partners updated and engaged.

7.4 We commissioned specialist training for operational staff on legal aspects of the Care Act and continue to work with regional bodies as resources and tools are developed to further equip staff and support providers.

7.5 We will be delivering a series of "Care Act in a nutshell" workshops for the public and partners on key aspects of the Care Act from October 2014 onwards. These events will also welcome elected members, stakeholders; we envisage facilitating a further workshop for members to consider the issues and policy implications arising from the In A Nutshell sessions.

8. FINANCE

8.1 There are potentially significant financial implications of implementing the Care Act funding reforms which are still not fully defined. It is likely that the following areas will incur additional expenditure for the local authority:

a. providing additional support to and increased no of assessments for carers
b. providing assessments for those who are self-funders and providing monitoring arrangements for costs in readiness for the introduction of the care cap;
c. Universal deferred payments which will allow people to defer when they pay their assessed contributions towards the cost of their care.
d. increased access to information, advise and preventative services (for people currently not supported).

8.2 The Act introduces new duties on Councils in the event of a social care provider's financial failure. The local council would be temporarily responsible for the people affected irrespective of the type of care and including those who are self-funders.

8.3 Everyone with eligible needs will also have a care account that will show the total cost of meeting those needs over time.

8.4 From April 2016 a cap on care costs of £72,000 will be introduced; in addition the threshold below which people will receive support from the Local authority towards their care costs will increase to £118,000 of assets (savings and or property).

8.5 People would have their needs assessed by their local council as usual, if they are found to have eligible needs and they qualify for local authority support they will be given a personal budget; an independent personal budget in the event a person is eligible for support but does not receive council support.

8.6 The Association of Directors of Adult Social Services, the LGA and other regional and national bodies have been working with Councils in encouraging the completion of toolkits and surveys to facilitate a better understanding of financial impacts.

8.7 Further financial modelling will take place in October and this will clarify and assist with local budget planning. At this time there will also be greater certainty on secondary legislation.

8.8 No announcements have yet been made on the funding to be made available from central Government however the Government are consulting on potential funding streams that could be made available to support some of the costs of the care bill and the basis on which those funding streams will be made available.

8.9 Consultation on the Care Cap and part of the Care Act thresholds and their financial impacts for local councils will be issued in late 2014.

8.10 As alluded to above; the Better Care Fund ties in closely to delivering key strands of the Care Act reform.

9. LAW

The Care Act will change the legislative framework for care, as outlined above. The Care Act places new duties and responsibilities on local authorities, many of which are placing in law what was policy. The Department of Health will be issuing regulations and guidance to the Act in October 2014.

10. EQUALITY IMPACT

Some strands of the Care Bill requirements will need consultation and engagement with local people and those who use our services. Equality impact assessments will be undertaken to enable us to ensure that we are implementing change in a way that

11. RECOMMENDATIONS

Accept the report and consider progress in preparing for the implementation of the Care Act.

Background Papers
Care Act 2014 factsheets
https://www.gov.uk/government/publications/care-act-2014-part-1-factsheets

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DUDLEY HEALTH AND WELLBEING BOARD **Agenda Item No 10**

REPORT SUMMARY SHEET

DATE	**15th September 2014**
TITLE OF REPORT	**Alcohol Strategic Framework 2014-2017**
Organisation and Author	**Office of Public Health, DMBC** **Diane McNulty** **Public Health Programme Manager**
Purpose of the report	**To inform the Health and Wellbeing Board of the priorities for reducing alcohol related harm in Dudley over the next three years.**
Key points to note	A comprehensive alcohol needs assessment was undertaken during 2012-2013 as a result of the publication of the Government's Alcohol Strategy. This refreshed alcohol strategy also takes account of the Health and Wellbeing Strategy 2013-2016 and Dudley's Health Inequalities Strategy 2010-2015. The framework has been developed after a comprehensive consultation and prioritisation process to identify the high level priorities to be taken forward. The framework takes a life stage approach to tackling alcohol related harm and draws particular attention to the need to address the wider determinants of health, as well as continuing to deliver evidence based interventions at population and individual level.
Recommendations for the Board	To consider the revised alcohol strategy framework and approve the key priorities for implementation over the next three years.
Item type	*Information, discussion ,* ***strategy***
H&WB strategy priority area	***Services****,* ***children****,* ***mental wellbeing****,* ***lifestyles****,* ***neighbourhoods****, integration,* ***health inequalities****, quality assurance, community engagement,*

An Alcohol Strategy Framework for Dudley

2014-2017

FOREWORD

If alcohol was introduced today as a new substance, like the novel psychoactive substances (legal highs) that are appearing now, it would probably be classified as an illegal substance based on its effects on the body and the social and economic harm it causes.

Alcohol has been brewed and consumed for thousands of years and various attempts to control its use or make it illegal have mostly failed. In this country it is a

licensed substance that is widely available and is part of the social fabric of our society. It is drunk in moderation and enjoyed by a large part of the population with no ill effects.

There is a darker side to alcohol consumption that is reflected in its role in violent crime, domestic violence and anti-social behaviour. It plays a role in increased divorces and there are a large number of children affected by parental alcohol misuse. It is estimated that the costs to the health service of treating people affected by alcohol is £1.2 billion per annum.

Dudley has higher than regional and national rates of premature mortality from alcohol specific conditions and whilst the rate of male mortality has decreased slightly, the rate of premature mortality for females has increased. The rate of alcohol related admissions to hospital has been used as an outcome measure to assess the level of alcohol harm in the population. At one time in Dudley, between 2004 and 2008, this rate was increasing between 20% and 25% per annum. For the last three years the rate of increase has slowed to less than 1% per annum, however Dudley's rate is still above West Midlands and England averages and there is more to be done to reduce rates below the regional and national averages.

This strategic framework builds upon the work done to reduce alcohol related harm and retains a focus on evidence based interventions to raise awareness and change lifestyles. The real change that would make the biggest difference is to tackle the affordability and availability of cheap alcohol and there are some limited actions that can be taken at a local level through voluntary agreements and greater use of existing flexibilities in the licensing laws. Advocating for a 50p minimum unit price would deliver noticeable health gains for those that consume large amounts of cheap alcohol.

The strategic framework sets out the actions to be taken using the Life Course Stages and identifies the priorities based on the wider social determinants of health as well as downstream interventions.

Ultimately the success of this strategy depends on all partners committing to addressing the alcohol problem at their individual and collective level of engagement.

Valerie Little

Director of Public Health

ALCOHOL STRATEGY

2014-2017

The aim of this alcohol framework is to implement priority actions that will improve the health and well-being of people in Dudley by reducing the harm that alcohol can do to individuals, families and the whole community.

It shares the vision of Dudley's Health and Wellbeing Strategy to reduce health inequalities by seeking to reduce premature mortality from alcohol related conditions and to reduce alcohol related admissions to hospital.

It contributes to the Safe and Sound Board's vision of making Dudley a safer place to live by reducing alcohol related crime and disorder.

ACKNOWLEDGEMENTS

Thanks go to everyone who has given their time to write, read and comment towards the development of the Alcohol Strategy.

EDITORIAL TEAM

The Alcohol Strategy Group:

Audrey Heer, Substance Misuse Team, Office of Public Health, Dudley MBC

Adrian McNulty, Probation Service

Bob Dimmock, Community Safety Team, Dudley MBC

Brian Hughes, Licensing, Dudley MBC

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Sue Haywood, Community Safety Team, Dudley MBC
Stuart Johnson, West Midlands Police

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Intervening in the social determinants of health to improve health harms related to alcohol and reduce health inequalities.

Health and well-being outcomes are linked to wider determinants such as education, work and the environment. The Government's Public Health Outcomes Framework (DH 2012) emphasises the importance of planning and delivering services in the broader context of delivering health such as early years, poverty, education, employment, and the social and physical environment. Major reductions in health inequalities will not occur without action to reduce inequalities in the social determinants of health.

If we want to see a reduction in premature alcohol mortality and alcohol related morbidity (as measured by alcohol related admissions to hospital) then we need to do more than invest in improved services and 'downstream' targeted interventions and awareness. The Marmot Review (DH 2010) proposed intervening in six areas:

- Early years
- Skills and education

- Employment and work
- A minimum income for healthy living
- The physical and social environment
- Ill health prevention

It is beyond the scope of a strategy that is focused on reducing alcohol harm to achieve this, which is why this framework draws on the Dudley Health and Wellbeing Strategy (2013-2016) and Dudley's Health Inequalities Strategy (2010-2015) to show that broader actions to improve the social determinants of health will impact on improving alcohol harm.

Because it is more difficult to address the 'causes of the causes' of health inequalities and address the social determinants of health through the life-course, most health improvement strategies, including previous alcohol strategies, have focused on intervening downstream and in changing lifestyle behaviours, resulting in 'lifestyle drift', where the responsibility for reducing alcohol related harm rests with the individual. This is because of the pressure to achieve pre-ordained targets or outcomes in a relatively short time frame, or to show value for money in investment. This results in approaches that focus on behaviour change and interventions that are easier to measure their health and impact those which can be numerically or financially quantifiable.

Inevitably, this new alcohol framework will also have a focus on downstream interventions and activities that are evidence based and outcome focused. It is based on the life-course approach proposed by Marmot (DH 2012) and reflected in Dudley's Health and Wellbeing strategy 2013-2016.

However, because alcohol is a background theme to so many of our lives and celebrations, with the vast majority using and enjoying a legal substance safely, in order to address the misuse of alcohol we need to understand that the causes of alcohol misuse lie in the wider social determinants of health and the social and economic factors that make alcohol affordable, available and socially acceptable. For this reason the framework shows where interventions in the wider social determinants of health will have an impact on reducing alcohol health inequalities.

There is clear evidence that there is a social gradient in alcohol harm. Someone in a lower socio-economic group who consumes the same amount of alcohol as someone in a higher socio-economic group is more likely to be involved in crime and disorder, anti-social behaviour, attend A&E and suffer from more alcohol related conditions and potentially die prematurely.

It is acknowledged that this new framework will be implemented at a time of unprecedented budget cuts and this will make focusing on the key areas of social determinants even more challenging, but focusing on lifestyle change and dealing with the consequences of alcohol misuse, whilst necessary, will not bring about the long term change required to deal with this issue.

Developing the Strategy

A comprehensive alcohol needs assessment was undertaken during 2012-2013 which compiled all the available data at the time. Service reviews were carried out and gaps in provision and knowledge were identified.

A stakeholder and service user consultation was carried out and their views were collated. There was also a series of focus groups engaged to elicit the views of young people, BME groups and focus groups targeted at the known age groups for at risk drinking.

Alcohol was identified as a key issue by the Health and Wellbeing Board and the CCG, and there was a Spotlight event organised by the Health and Wellbeing Board in July 2013 to encourage discussion and debate amongst a varied audience. This was later followed up by an alcohol workshop which identified some key actions that the Health and Wellbeing Board wished to see implemented.

A prioritisation event was also held with members of the alcohol strategy group and other partners to agree on the key deliverables.

All of these findings have been compiled into a set of recommendations (Appendix 1) and the main priorities that emerged can be found in the strategic framework. There are also more detailed implementation plans that partners are committed to delivering that will contribute to achieving the desired outcomes. These actions will be monitored by the substance misuse commissioning group and reported to the Safe and Sound Board and Health and Wellbeing Board as appropriate.

The Strategic Framework

The strategic framework is based around the life-course and covers priorities for each of the key life stages: 0-11, 12-24, 25-39, 40-59, 60-74, and 75+ years. For each stage the main priorities for action are identified – the 'downstream' actions – and actions to address the wider social determinants of health – the 'upstream' actions. The alcohol action plans will focus on the outcomes of the downstream interventions, but will ultimately be dependent on how successful we can be in tackling the wider determinants of health to reduce health inequalities which necessarily includes premature mortality from alcohol and alcohol morbidity.

The Life Course and Alcohol related plans

<table>
<tr><th>0-11 years</th><th>12-24 years</th><th>25-39 years</th><th>40-59 years</th><th>60-74 years</th><th>75+ years</th></tr>
<tr><td colspan="2">Children and Young People's Strategy</td><td colspan="2" rowspan="2">Adult Substance Misuse Treatment plan</td><td colspan="2" rowspan="2">Older People's Strategy</td></tr>
<tr><td colspan="2">Young People's Substance Misuse Plan</td></tr>
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<tr><td colspan="6">Community Safety Plan</td></tr>
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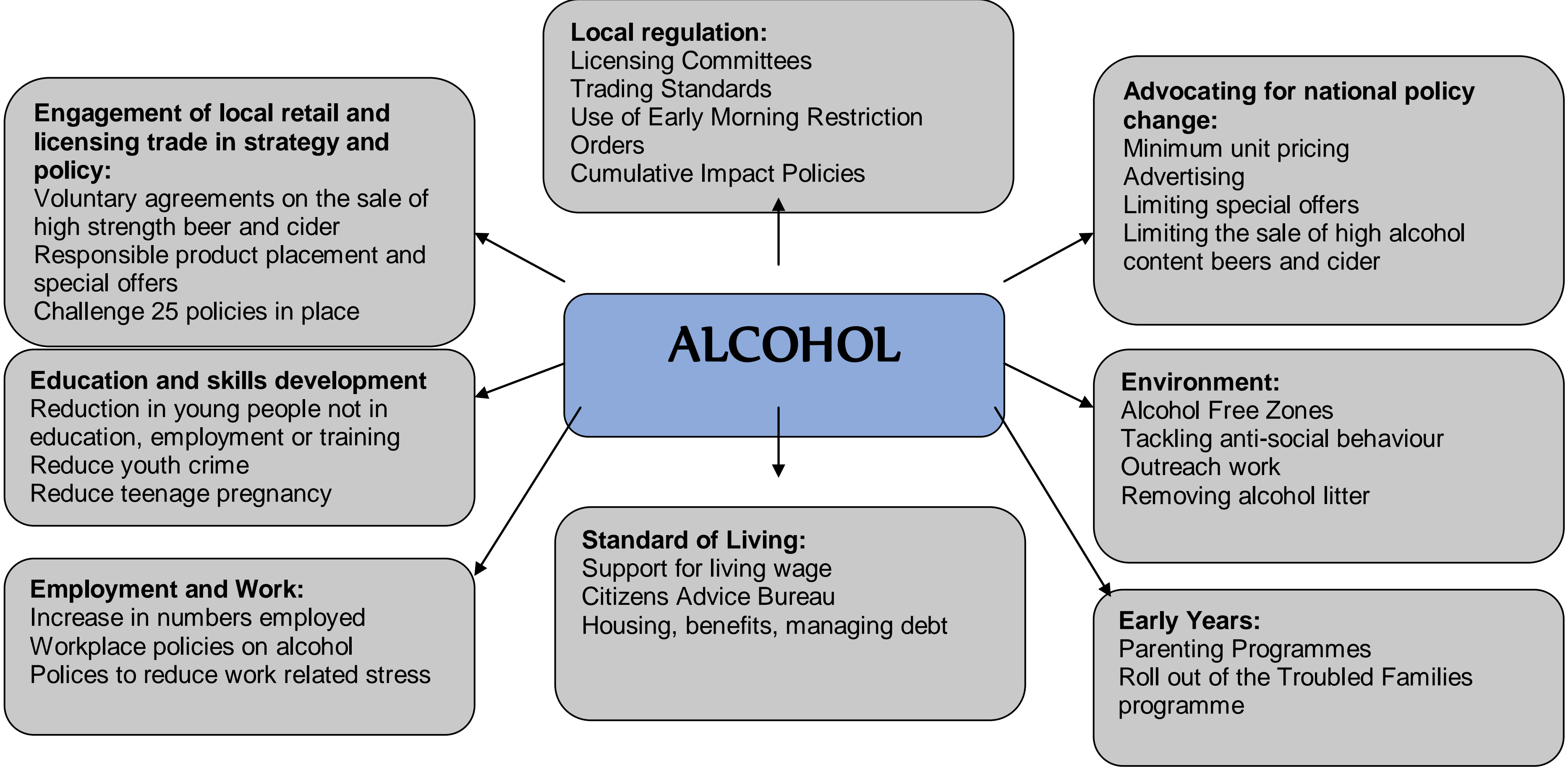
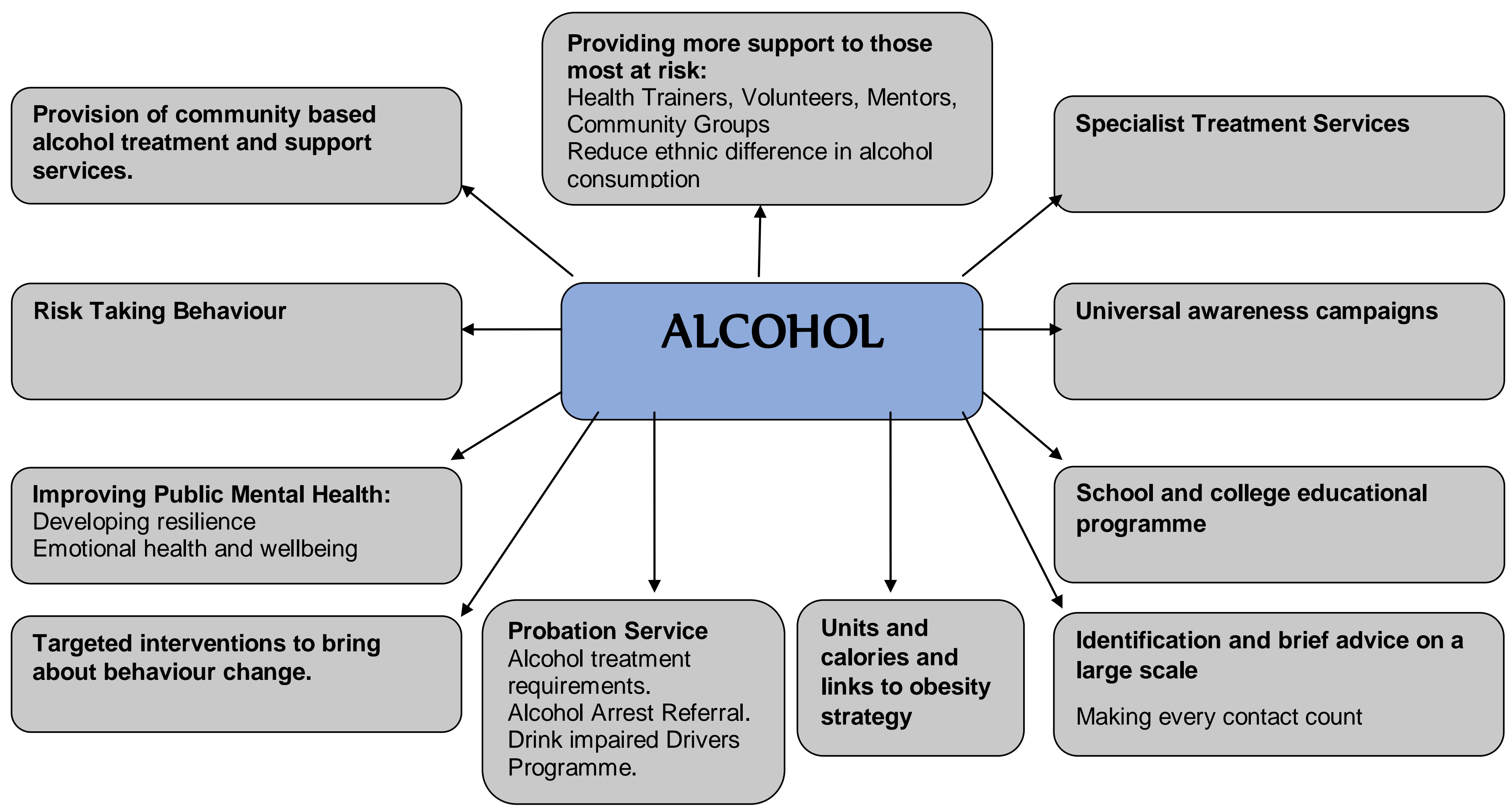
Tackling Health Inequalities Strategy
Health and Wellbeing Strategy

Tackling the Wider Social Determinants



Downstream Interventions



Life-stage - 0-11 years

Pregnancy and Early Years

Downstream Interventions:
- Awareness of Foetal Alcohol Syndrome Disorder (FASD) for professionals and parents.
- Guidance on identification and treatment of hazardous and harmful drinking for professionals.
- Awareness of the risks of drinking during pregnancy.
- Identification and brief advice (IBA) delivered in a wide variety of settings to help to reduce consumption to safe levels.

Wider Social Determinants:
- Evidence based Parenting Programmes.
- Understanding and intervening in the role of alcohol in Troubled Families.
- Applying learning from the Troubled Families to support other families where alcohol is misused.
- Supporting the Respect Yourself Campaign to reduce teenage pregnancies and reduce the risk of alcohol misuse and unplanned sex.

Childhood 4-11 yrs

Downstream Interventions:
- KS1 and KS2 risk taking programmes.
- Introduction to some alcohol specific work in primary schools.
- Training for teachers - awareness, risks, safeguarding.
- Awareness for parents on how their attitudes to drinking can lead to early experimentation with alcohol.
- Programmes to develop resilience and emotional health and wellbeing.
- Services to support children and parents where alcohol is a problem.

Wider Determinants:
- Improvements in educational attainment.
- Evidence based Parenting Programmes.

Life-stage – 12-24 years

Discovery Teens 12-15 years

Downstream Interventions:

- Risk Taking Behaviour approach, eg. Perceptions work.
- More specific work on alcohol to understand risks and challenge behaviour.
- Training and support for teachers to deliver alcohol education programmes.
- Awareness for parents on impact of alcohol on developing adolescents.
- Programmes to build on primary school work on resilience and emotional health and wellbeing.
- Provision of services to support children and parents where alcohol is a problem.
- Trading standards role in preventing under age sales of tobacco and alcohol

Wider Determinants:

- Continued improvements in educational attainment. Monitor GCSE results.
- Reduction in number of children leaving school as NEETS
- Impact of changing school leaving age
- Reduction in youth crime and those in contact with the youth justice system where alcohol is a contributory factor.
- Reduction in teenage pregnancy where alcohol was a factor.
- Licensing and proactively tackling under age sales.
- Work with the on and off-trade to discourage the promotion of alcohol to young people.

Freedom Years 16-24 years

Downstream Interventions:

- College programmes – still focusing on risky behaviour but more information on alcohol – units, strength of drinks, and the impact on health.
- Population based awareness campaigns on binge drinking and multiple risk taking e.g. alcohol and crack cocaine
- Targeted interventions to reduce binge drinking.
- Greater use of IBA and promotion of alcohol treatment services.
- Programmes to promote resilience and emotional health and wellbeing, coping strategies for stress and where to get help.

Wider Determinants:

- Improve educational attainment.
- Help young people to find training and employment (especially NEETS).
- Support colleges to develop alcohol policies and emotional Health and Wellbeing strategies.
- Work with licensing trade and supermarkets to prevent irresponsible sales, marketing and promotion of alcohol that causes heavy drinking, subsidised bars in colleges and universities.
- Probation service to increase alcohol treatment referrals (ATRs) and offer drink impaired drivers (DiDs) courses.
- Tackling anti-social behaviour.

Life-stage – 25-39 years

Younger Settlers

Downstream Interventions:

- Population based alcohol awareness campaigns.
- Targeted interventions for identified groups of increasing risk drinking:
    - Young males
    - Young women
    - Pregnant Women
    - Drug users
    - People with mental health problems
    - Identified community groups or vulnerable groups
- Training for professional and a wide range of workers in making every contact count (MECC) and IBA to increase opportunities for early identification and advice.
- Responsive alcohol treatment services for early intervention as well as specialist treatment.
- Accessible services, including outreach.

Wider Determinants:

- Local regulation of licensed premises.
- Tackle availability of cheap alcohol.
- Engagement of local licensing and retail trade in strategy and policy.
- Increase the number of people in employment.
- Workplace policies for alcohol and policies to reduce stress at work.
- Advocating for a minimum unit price for alcohol.
- Increase the number of alcohol free zones.
- Tackle anti-social behaviour and make use of local flexibilities in licensing laws and byelaws.

Life-stage – 40-59 years

Older Settlers

Downstream Interventions:

- Improve screening in primary care and outpatients to identify people with alcohol related conditions.
- Ensure the Health checks provide IBA and referrals to services.
- Responsive services in non-clinical settings.
- Population based alcohol awareness campaigns.
- Targeted interventions for identified groups of increasing risk drinking:
  - Males
  - Females
  - Drug users
  - People with mental health problems
  - Identified community groups or vulnerable groups
- Training in MECC and IBA to increase opportunities for early identification and advice.
- Responsive alcohol treatment services for early intervention as well as specialist treatment.
- Put in measures to deal with treatment resistant drinkers
- Accessible services, including outreach.

Wider Determinants:

- Support for debt and housing issues.
- Re-training for returning to work place.
- Local regulation of licensed premises.
- Tackle the availability of cheap alcohol.
- Engagement of local licensing and retail trade in strategy and policy.
- Increase the number of people in employment.
- Workplace policies for alcohol and policies to reduce stress at work.
- Advocating for a minimum unit price for alcohol.
- Increase the number of alcohol free zones.
- Tackle anti-social behaviour and make use of local flexibilities in licensing.

Life-stage – 60-74 years

Active Retirement

Downstream Interventions:

- Targeted interventions for identified groups of increasing risk drinking in retirement.
- Campaigns to increase awareness of the risk of drinking for the elderly, slips, trips and falls, fire risks and reduced tolerance to high alcohol concentrations.
- Early identification of at risk drinkers, particularly those regularly presenting in Primary Care or at A&E and provide easy access to community treatment.

Wider Determinants:

- Increase opportunities for keeping physically and mentally active.
- Encourage positive social networks to reduce loneliness and depression.

Life-stage – 75+ years

Ageing Retirement

Downstream Interventions:

- Awareness for professionals of the links with alcohol and memory loss that may be confused with dementia and the possibility of dual diagnosis for alcohol and mental ill health.

Wider Determinants:

- Increase opportunities for keeping physically and mentally active.
- Encourage positive social networks to reduce loneliness and depression.

RECOMMENDATIONS

The following recommendations for action arise from the key findings identified from the needs assessment, stakeholder engagement, service user views and specific focus groups. It also includes responses from the Health and Wellbeing spotlight events. These have informed the priorities for the strategic framework on tackling the scale of the alcohol problem that Dudley faces. The needs assessment identified the progress that has been made since 2008 when alcohol became an important partnership issue to be addressed, However, there now needs to be a step change in activity in order to capitalise on the changes that have already been implemented and to address the gaps that have emerged.

STRATEGY AND CO-ORDINATION

- Review the terms of reference of the Substance Misuse Commissioning and Implementation groups to reflect an integrated approach to all substance misuse issues.
- Agree a new performance reporting structure in the light of changes in national and regional data collection and reporting and the Public Health Outcomes Framework.
- Develop a revised alcohol strategic framework that reflects the National Alcohol Strategy recommendations; the ambitions of the Health and Wellbeing Board, addresses the wider detriments of health in reducing health inequalities and the role that alcohol plays in achieving the aims of the Crime and Disorder Strategy.

THE SCALE OF ALCOHOL MISUSE IN DUDLEY

- It is proposed that a risk taking behaviour approach should be taken with young people, starting with Key Stages 1 and 2 in primary School and developing into more specific activities for Key Stages 3 and 4. Targeted interventions focusing on risk taking behaviour should also be developed for 16-24 year old binge drinkers.
- The targeted interventions that have been implemented for at risk male drinkers aged 35-54 should be evaluated and the most effective approaches should be taken forward
- Currently work with females in all categories is underdeveloped and a social marketing approach should be used to better understand the factors that influence female drinking at different life stages and develop specific interventions to reduce hazardous and harmful drinking.

THE HEALTH IMPACTS OF ALCOHOL MISUSE

- A focused, intensive piece of work is needed to tackle the 60 people with chronic alcohol dependence who have attended A & E on 307 occasions,

mostly by ambulance. This is a difficult group to work with and they consume a disproportionate amount of resource. A review of best practice should be undertaken and implement actions that have been shown to have success elsewhere. The outcomes of the 'Blue Light' project should be agreed with partners and implemented.

- Engagement of Primary Care in early identification and referral is essential and the learning from the single point of contact and the role of a GPwSI for alcohol should be re-considered to take this work forward
- The larger than expected number of unplanned admissions for alcohol related conditions and inadequate arrangements for early discharge suggests that current pathways are not working effectively and should be revisited,
- The programme of awareness of foetal alcohol syndrome for professionals and women of child bearing age should continue to be rolled out.

THE SOCIAL IMPACTS OF ALCOHOL MISUSE

- The work streams currently in place on alcohol and the criminal justice system need to remain a priority, even though major changes are being planned. The alcohol arrest referral scheme, the use of alcohol treatment requirements and the drink impaired drivers programme are all recommended for continued implementation.
- Work is currently being scoped on the role of alcohol in domestic abuse and the most effective ways to intervene. This should be implemented when the planning is completed.
- The current economic climate may mean that alcohol consumption will increase. It is estimated that a 1% increase in unemployment relates to a 17% increase in alcohol consumption. In an effort to counteract this it is important to address the wider determinants of health that impact on alcohol misuse. It is recommended that action should be taken from the following areas:
    - Gaining skills and qualifications. It is particularly important to address the skills and employment gap for NEETs.
    - Helping people to find employment.
    - Reducing stress at work (uncertainty about employment is linked to increased alcohol consumption).
    - Helping people to cope with housing and debt problems.
- There needs to be better data collection locally to link alcohol with unemployment, uptake of welfare benefits, domestic abuse, teenage pregnancy and sexual exploitation.
- The role of alcohol in troubled families needs to be better understood to ensure appropriate interventions to reduce risk are implemented. The learning from the Troubled Families programme can then be rolled out to other families where alcohol misuse is an issue but the family is not classified as 'troubled'.

ALCOHOL AND HEALTH INEQUALITIES

- New interventions should be assessed for their impact on health inequalities. Assessments that rely solely on judgements about the amount of alcohol consumed may miss the disproportionate harm that alcohol can do to those in the lowest quintile of deprivation.
- Scoping work should be undertaken to address the ethnic differences in alcohol consumption and ensure appropriate interventions are in place to reduce inequalities.

- Consideration needs to be given to the role of alcohol and mental health, both as a cause of alcohol consumption and as a consequence of mental health problems. There needs to be a co-ordinated approach to health improvement approaches and also earlier intervention to identify where mental health problems are related to alcohol misuse but are not serious enough to require dual diagnosis treatment services.
- New work needs to focus on the marketing and product placement of alcohol in shops and supermarkets. Innovative ways of engaging with supermarkets and the licensed trade need to be developed to limit the sale of high strength lager and cider.
- Consideration should be given to increasing the number of alcohol free zones and to extending the cumulative impact policy.
- Greater use could be made of local flexibilities in enforcement e.g. consider prosecution of landlords for serving someone who is clearly drunk, or imposing early morning restriction orders where there are health or crime and disorder concerns.
- Consider banning alcohol in parks and on-street drinking where there are identified issues with regards to anti-social behaviour. As well as reducing alcohol litter from cans and bottles a cleaner, safer environment contributes to improving people's health and wellbeing.
- Opportunities should be sought to advocate for a 50p minimum unit price for alcohol.

TREATMENT SERVICES

- Update and renegotiate data sharing protocols in light of recent service changes and availability of data.
- Continue to work on improving data collection from A&E for community safety and public health purposes, whilst acknowledging the work already undertaken to improve data downloads.
- Monitor the changes to young people's treatment services and ensure that agencies refer appropriately and then provide support to young people engaged with specialist services.
- Agree performance monitoring data with providers via contracting arrangements and how that data is shared for service improvements and achievement of Public Health outcomes.
- Improve patient flow along the pathway and ensure there are robust plans are in place for planned treatment exits or step down in treatment prior to exit.
- Develop a zero value framework for the purchase of in-patient detox post April 2014.

PREVENTING ALCOHOL MISUSE

- Develop an agreed developmental plan for alcohol consumption that takes account of national and regional campaigns and locally identified needs.
- Ensure interventions are evidence based, evaluated and reported and that the lessons learned inform future commissions.

- The work that has been done with cultural groups needs to be further developed and extended.
- The small grants scheme is an effective way of supporting small community projects and is recommended for continuation
- A training programme should be developed with specific alcohol modules where appropriate.
- The work with trading standards and under age sales has proved very effective and should continue to be commissioned.

The Alcohol Needs Assessment can be downloaded from All About Dudley from:-

http://www.allaboutdudley.info/AODB/publications/Alcohol%20Needs%20Assessment%202012.pdf.

The detailed report on the Consultation process is also available on All About Dudley:-

http://allaboutdudley.info/AODB/publications/Dudley%20Alcohol%20Consultation%20Document%202013.pdf

APPENDIX 2

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DUDLEY HEALTH AND WELLBEING BOARD Agenda Item No.12

REPORT SUMMARY SHEET

DATE	**30th September 2014**
TITLE OF REPORT	**JSNA Synthesis 2014 Executive Summary**
Organisation and Author	**Office of Public Health, Dudley MBC**
Purpose of the report	**To provide the Health and Well-being board with an overview of the JSNA synthesis 2014 document with actions needed**
Key points to note	**There have been some key areas where improvements in health and well-being of the Dudley population have occurred since the 2012 JSNA synthesis. Of note are improvements in: life expectancy, childhood immunisation uptake, numbers of killed and seriously injured casualties, hospital admissions for unintentional and deliberate injury in the 0-24 age group, excess winter deaths, first time entrants to the youth justice system and re-offending rates, fruit and vegetable intake of school age children, users of adult social care feel safe and services have made them feel safer.** **The main areas of concern continue to be health inequalities particularly in life expectancy. Obesity, alcohol and substance misuse, smoking, breastfeeding, falls, infant mortality are all major contributors to the health inequalities gap. The levels of child and fuel poverty in the borough continue to be of concern as does the level of employment opportunities in the borough particularly for young people. The rate of sight loss certifications are increasing. The rate of delayed transfers of care from hospital has increased.**
Recommendations for the Board	**That the board considers the 'actions needed' identified from the JSNA Synthesis 2014 for prioritisation for the Health and Well-being Board Strategy and commissioning plans.**
Item type	*Needs assessment*
H&WB strategy priority area	*Services, children, mental wellbeing, lifestyles, neighbourhoods, integration, health inequalities, quality assurance, community engagement,*

DUDLEY HEALTH AND WELLBEING BOARD

DATE 3rd September 2014

REPORT OF: Office of Public Health, Dudley MBC, Director of Public Health

TITLE OF REPORT JSNA Synthesis 2014 Executive Summary

HEALTH AND WELLBEING STRATEGY PRIORITY

1. *The JSNA Executive Summary*

PURPOSE OF REPORT

2. *The main purpose of this report is to summarise the key findings from the 2014 JSNA Synthesis and identify actions needed to help inform future strategy and commissioning plans*

BACKGROUND

3. *The JSNA brings together, in a single, continuous iterative process, all the information on the health and wellbeing needs of Dudley's population. It examines current and predicted health and social care needs, as well as the other main things that affect people's life-chances, quality of life and health and wellbeing. By identifying the major issues that need to be addressed regarding people's health and wellbeing it provides the evidence base needed to develop Dudley's Joint Health and Well-being Strategy (JHWBS). This summary should provide commissioners with the high level initial evidence that will point to the further analysis required for them to make effective commissioning decisions.*

THE MAIN ITEM/S OF THE REPORT

4. *It is proposed that the board agree the JSNA Synthesis 2014, and consider the actions identified in the executive summary for prioritisation to inform future strategy and commissioning plans.*

FINANCE

5. *Any financial implications arising from the implementation of the JSNA would be met from within existing budgets between the agencies.*

LAW

6. *A statement of any legal requirements or implications*

EQUALITY IMPACT

7. *The JSNA where the information was available has considered for different demographic groups. Future strategy development would include equality impact assessments.*

RECOMMENDATIONS

It is proposed that the board agree the JSNA Synthesis 2014, and consider the actions identified in the executive summary for prioritisation to inform future strategy and commissioning plans.

Signature of author/s

Contact officer details

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Greg Barbosa, Senior Public Health Intelligence Analyst

ALL
ABOUT DUDLEY BOROUGH

Joint Strategic Needs Assessment 2014
Executive Summary

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Preface

Welcome to the executive summary of Dudley's Joint Strategic Needs Assessment (JSNA) 2014. The JSNA 2014 Synthesis document follows the same basic structure as the first JSNA Synthesis document produced for 2012. This executive summary is in place of the key questions for commissioners asked in the previous document. This executive summary starts with an introduction describing what a JSNA is and how it is developed.

This document gives a brief summary of the key points in each of the 10 chapters. The first two chapter summaries provide an overview of Dudley the Place and the People of Dudley and how it is anticipated this may change in the future. The remaining chapters follow the Marmot life-course approach and the summary for each describes the key issues for that segment of the population. The final section identifies actions to be considered further.

The full version of the JSNA can be found on All About Dudley Borough website:

www.allaboutdudleyborough.info

We hope you find this helpful and interesting. We are grateful for any comments and feedback you might have on the JSNA in order to improve it in future years.

Valerie A. Little
Director of Public Health

Pauline Sharratt
Interim Director of Children's Services

Andrea Pope-Smith
Director of Adult, Community and Housing Services

Paul Maubach
Chief Officer Dudley Clinical Commissioning Group

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What is a JSNA?

The Joint Strategic Needs Assessment is a means of drawing together information about the population, in order to identify the most important health and well-being issues, and helping local decision-makers to make informed decisions about how to address these issues and at the same time reduce inequalities.

The Department of Health defines the Joint Strategic Needs Assessment as:

- a process that identifies current and future health and well-being needs in light of existing services, and informs future service planning taking into account effectiveness;
- a means to identify the "big picture" in terms of the health and well-being needs and inequalities of a local population;
- a document that informs strategic planning and commissioning to achieve better health and well-being outcomes.

The JSNA brings together, in a single, continuous iterative process, all the information on the health and wellbeing needs of Dudley's population. It examines current and predicted health and social care needs, as well as the other main things that affect people's life-chances, quality of life and health and wellbeing. By identifying the major issues that need to be addressed regarding people's health and wellbeing it provides the evidence base needed to develop Dudley's Joint Health and Well-being Strategy (JHWBS). Its aim therefore is to underpin the work of the HWBB and be a tool that can be used to help make difficult decisions about investment and prioritisation such as "do you prioritise service responses which could be improved most quickly and cheaply or do you put more effort into slow burn activities with longer term outcomes?" There is a clear expectation within the Health & Social Care Act 2012 that the JSNA and JHWBS will provide the basis for all health and social care commissioning in the local area. This synthesis should provide commissioners with the high level initial evidence that will point to the further analysis required for them to make effective commissioning decisions.

In the future we aim to develop our JSNA to include more of a focus on health-enhancing assets – the things which support the creation of health. In doing so, we hope to achieve a more integrated approach which recognises both the risk and the protective factors contributing to a healthy life expectancy. This will provide a richer, more insightful account of what it is like to live in Dudley borough.

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DUDLEY "THE PLACE"

- Large metropolitan borough of 98 square kilometres. A quarter of which is open green space, and 17% is green belt. Dudley has 4 main town centres surrounded by smaller towns and urban villages providing a very local feel with strong communities.

DEPRIVATION

- 24.5% of Dudley's population (using IMD 2010) now live within the 20% most deprived areas of England, compared with 22.9% in 2007
- The most deprived lower level super output area (LLSOA) in Dudley is in St James's Ward. This is the 824th most deprived in England out of 32,482 LLSOA's.

ECONOMY

- Number of people of working age has increased to 193,900 (0.8% increase) though the number of jobs has decreased to 109,600 jobs (9.4% decrease).
- In 2012 Dudley had £3.95bn gross value added (GVA), a 2.8% reduction from 2011, and still lower than the 2007 peak of £4.5bn. England and the other areas of Black Country continue to see a year on year rise in GVA.
- In 2011 Dudley had £3.88bn gross domestic household income (GDHI) and in line with England there has been a year on year increase. Per head GDHI index for UK = 100, England 101.4 and Dudley is 78.7 and this remains static.
- There has been a reduction in the numbers of self employed people in Dudley in the past year which differs from the trend regionally and nationally.
- Dudley has shown a slight increase in it's manufacturing base (14.6%) and remains above the nationally declining percentage (8.4%).
- Business confidence in the borough is relatively high with 47% of all businesses expecting turnover to increase. 68% of Dudley businesses have a business base outside of Dudley. Rate of business start-ups is low.
- 19.7% of people aged 16-64 in Dudley had no qualifications (14.8% England) Census 2011.
- Dudley ranks 346/379 for business competiveness index in 2013 and has dropped 12 places since 2010.

LOW GROWTH ECONOMY

- 6.6% of 16-18 year olds in Dudley were not in education, employment or training (NEET) in 2012, and unlike the region showed an increase compared to 2011.
- Unemployment in people aged under 25 (JSA claimants) has started to decline but remain at a level higher than the West Midlands region and nationally 6.9% (January 2014) and nearly one quarter of these have been claiming for more than one year (England 18.1%)

EDUCATION

- 59.7% of pupils in Dudley borough attained 5 or more A*-C GCSE grades including maths and English in 2012/13 in line with England average of 59.2%
- Adult learning is accessible to a wide cross-section of the population including unemployed, older people, ethnicity, disability, deprivation. Nearly one quarter of learners attended family learning programmes.

CHILD POVERTY

- Child poverty has remained static in Dudley with 22.1% (~15,000) dependent children under 20 years of age and remains higher than national figure of 20.1%.

HOUSING TENURE

- As seen nationally, Dudley since 2001 has seen a decline in the proportion of owner-

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- occupiers but remains above the national level (68.7%, 63.4% of households respectively)
- Dudley residents are more reliant on the council for housing provision than nationally reported at 16.8%
- In 2011 9% of Dudley residents reported their accommodation was not adequate for their needs. This was nearly 20% for those living in the private rented sector.
- In 2012/13 Dudley delivered 143 new affordable housing dwellings ahead of the target of 102.

HOMESLESSNESS

- The number of households unable to avoid becoming homeless has stayed relatively static (171 households 2012/13). In line with national data 71% of these households contained dependent children or pregnant women.
- There has been a year on year rise in the proportion of households becoming homeless due to termination of assured short hold tenancy (32% 2012/13).

FUEL POVERTY

- In the last two years Dudley has moved its position from being worse than E&W for excess winter death index to being the same. The Winter Warmth Programme and funding secured for improvements in the energy efficiency of housing stock is proving worthwhile.

CLEAN SPACE

- Overall Dudley has scored better than nationally for the cleanliness of the local environment. There has been an increase in the number of sites failing for litter.

GREEN SPACE

- The 17 parks within the borough continue to receive between 300,000 and 900,000 visits per year.
- The total public access network has increased from 208,618 metres in 2009 to 224,804 metres in 2014 with a significant increase in cycle paths.

CRIME

- Dudley borough is the safest borough within the West Midlands conurbation with crimes per 1,000 population continuing to fall. Despite this fall in overall crime level the number attributable to violent crime has not followed this trend.
- There has been an increase in the proportion of crimes attributable to theft from shop or stall.

TRAVEL

- Woman are more likely then men to walk or use public transport to get to work. For both genders cars remain the transport of choice for work.
- More than 50% of children walk to school, with one third using a car. There has been no increase in proportion walking or cycling to school despite the work to provide safer routes to school.

ENVIRONMENT

- The Dudley borough remains an Air Quality Management Area with 17 areas identified exceeding nitrogen dioxide objectives in 2012.
- Nitrogen dioxide concentrations are monitored at 99 sites across the borough. In 2012, 42 of these sites showed an exceedance of the annual mean concentration of nitrogen dioxide objective.
- There were fewer industrial and commercial noise complaints (352) and odour complaints (137) dealt with by Environmental Health in 2012/13 compared with 2011/12.
- 578 new food premise registrations were received in 2012/13 (+26% on 2011/12). High turnover of small food businesses and an increase in mobile traders and home caterers.

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DUDLEY "THE PEOPLE"

- Dudley is the 3rd most populous metropolitan authority in the West Midlands and the 12th in England.
- Following the 2011 census and the latest population projections (2012) suggest the population of Dudley will increase by 6.4% (20,000) by 2037. This is a third lower then 2010 projections.
- The largest projected population increases are in the 60+ age band (26,000) with 12,000 expected in the 85+ age band.

MIGRATION

- The 2011 census shows that 6518 (2.1%) Dudley residents migrated into the UK since 2001 two and half times more than the previous decade.
- One third of these migrants originated from Southern Asia, nearly 20% from new European Union (EU) countries and 10% from Eastern and Southern Africa.
- The migrants have tended to settle in Dudley centre, Brierley Hill, Lye and Halesowen.
- 11.8% of primary school aged children and 7.7% of secondary school pupils have a non-English first language.
- Dudley births have increased since 2001 and births to non-UK born mothers accounted for one fifth of this increase.
- The number of new national insurance number registrations for migrants has reduced by 174 to 556 in 2012. The majority of these were from Poland, Pakistan and India.

ETHNICITY

- Census 2011 recorded 88.5% of the Dudley population as white British ethnic group. Black and minority ethnic (BME) group has increased since census 2001 to 11.5%.
- The BME group have a much younger age profile where by 20.7% of those aged 0-9 are in this group.
- Areas with the highest number of people who are from BME backgrounds are Blowers Green, Kates Hill, Netherton, Brierley Hill, Lye, Halesowen and Hurst Green.

LIMITING LONG TERM ILLNESS

- Nearly 20% of the Dudley population have a limiting long term illness or disability (census 2011) an increase from census 2001 (18.5%). Poorer than national.
- This increase has occurred across the age ranges and is particularly notable in the 75+ age band where 71.3% have a limiting long term illness.

CRIME

- Being a victim of crime is more likely if you are male and in the 18-34 age band. Ethnicity has a slight influence on risk of victimisation.
- 4.5% of victims of crime were repeat victims within the year. These people account for 0.2% of the population but experience 13% of the crime. They tend to be from vulnerable groups.

LIFE EXPECTANCY

Female life expectancy

- Female life expectancy is 82.7 years (2010-2012) in Dudley which is similar to The average female life expectancy across England of 82.8 years.
- Female life expectancy varies across the borough with Castle and Priory Ward having the lowest at 79 years and Belle Vale having the highest of 86.7 years (a gap of 7.7 years)
- The slope index of inequality for female life expectancy has stayed constant over the last few years at 5.8 years.
- To close the inequalities gap in life expectancy across Dudley 113 female deaths would need to be prevented.

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- Cancer particularly lung cancer, circulatory and respiratory diseases should be targeted.

- Female healthy life expectancy at birth is 64.7 years (2010-12) and similar to England.

Male life expectancy

- Male life expectancy is 78.5 years (2008-12) in Dudley which is lower than the average male life expectancy across England of 78.9 years.

- Male life expectancy varies across the borough with Netherton, Woodside and St Andrews. having the lowest of 73.9 years and Halesowen South having the highest of 82.1 years (a gap of 8.2 years)

- The slope index of inequality for male life expectancy has stayed consistent over the last few years and still remains at 9.5 years.

- To close the inequalities gap in life expectancy across Dudley 151 male deaths would need to be prevented. Circulatory diseases, cancer particularly lung cancer, respiratory diseases and chronic liver disease should be targeted.

- Male healthy life expectancy at birth is 62.8 years (2010-2012) and similar to England.

SIGHT LOSS

- In 2011, 3.15% of the Dudley population are estimated to be living with sightloss which is higher than the England (2.95%) and is projected to increase.

PHYSICAL ACTIVITY

- Dudley has 44 leisure and recreation facilities per 100,000 people, this is lower than West Midlands region (53 per 100,000) and national average (60 per 100,000)

- As recorded by the Active People Survey 2012/13 12.1% of adults (aged 16+) participate in sport for 30 minutes three or more times a week, this is showing a downward trend and is below the national average (17.4%)

GIVE EVERY CHILD THE BEST START IN LIFE

INFANT MORTALITY

- The infant mortality rate in Dudley is 4.5 deaths per 1,000 live births for 2010-2012. This is higher than for England and Wales (4.3 deaths per 1,000 live births).

- The infant mortality rate represents very small numbers of deaths and each one of these are reviewed in order to ascertain the cause and any lessons to be learned.

- Babies born in the most deprived areas of England can be up to 6 times more likely to die than those from more affluent areas. Male babies born in the most deprived areas of Dudley are up to four times more likely to die than those from the more affluent areas.

TEENAGE PREGNANCY

- Teenage pregnancy rates in Dudley have continued their downward trend reaching 34.6 per 1,000 aged 15-17 years in 2012, but this rate is still above the England and Wales average (27.9 per 1,000).

- The levels of teenage pregnancy within the borough remain high in St. James, Brockmoor and Pensnett and Netherton, Woodside and St. Andrew's wards.

SMOKING IN PREGNANCY

- Smoking at delivery was 14.3% in Dudley, higher than both the West Midlands and England (14.2 and 12.7% respectively, 2012/13). However the trend over time is downward.

BREASTFEEDING

- Initiation rates of breastfeeding at birth and rates of breastfeeding at 6-8 weeks for Dudley are both lower than in England. Rates are lower in the more deprived areas of the borough and in the younger mothers.

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- A rise in the rates is projected for continuation of breastfeeding over the next three years.

IMMUNISATION

- Primary immunisation coverage in Dudley continues to be above the WHO national target of 95%.

CHILDHOOD HOSPITAL ADMISSIONS

- Emergency hospital admissions have risen slightly in the last year for 0-4 year olds (2012/13). This is particularly prominent for lower respiratory tract infections, especially in the most deprived areas of Dudley.

- A disproportionate amount of A & E attendances for unintentional and undetermined injuries are from the most deprived areas of the borough for 0-4 year olds. There were approximately 240 admissions with over 50% of these resulting from falls.

Weight

- Numbers of children who are overweight or obese attending Dudley borough schools have stabilised in line with the national average in Reception and Year 6.

- Children aged10-11 years in Dudley have a higher rate of obesity than the national average.

- The proportion of obese children is higher in the most deprived areas of Dudley.

DIET

- For 9-11 year olds nearly 40% now (2014) report eating the recommended 5 or more portions of fruit and vegetables per day. This is an upward trend.

WELL-BEING

- Self-esteem is continuing to improve in 9-11 year olds, though bullying remains at 25% of pupils.

LOOKED AFTER CHILDREN (LAC)

- The national trend has seen increases in the number of LAC and this change has been matched in Dudley borough, though the rate is nearly double the national rate (108, 60 per 10,000 aged under 18 respectively, 2012/13).

- The largest increase in LAC has been in the under 5 age group. The main reason for being admitted in to care was due to abuse or neglect.

- The trend in length of stay in care is upward and has increased by one third over the last four years.

- LAC are known to be a particularly vulnerable group and are at a high risk of inequalities. They are more likely to have a statement of special education needs.

CHILD PROTECTION

- The rate of children who became the subject of a child protection plan is increasing in Dudley, though this rate still remains in line with the national rate.

EDUCATION

- Outcomes for pupils at the end of early years foundation stage in Dudley are in line with the national levels. 51% of children achieved a good level of development in Dudley.

- The proportion achieving a good level of development is strongly affected by levels of deprivation.

- Children's Centres in Dudley have 79% of 0-4 year olds registered.

- At key stage 2, achievement of level 4 or above in reading, writing and mathematics is improving in line with the national average. The improvement has been in the most deprived areas.

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DISCOVERY TEENS, DEVELOPING INTO YOUNG ADULTHOOD

MORTALITY

- Mortality rates for the 10-19 age group are in line with national figures and the trend is downward.
- Accidents including suicide and undetermined injury account for 36% of the deaths in this age band and the rate is higher in males.

HOSPITAL ADMISSIONS

- Emergency hospital admissions have increased for the 10-19 age group. The proportion due to injury or poisoning has shown a downward trend.
- Despite a low rate of emergency hospital admissions for asthma, but this is higher for Asian and black ethnic groups.
- The rate of A & E attendances and admissions for accidents in this age group has stabilised. Health inequalities for this indicator still remains.

IMMUNISATION

- School leaver booster vaccination uptake continues to exceed the WHO target of 95%.
- In Dudley the uptake of HPV vaccine exceeds that for the West Midlands and England but continues to be below the 95% target.

WELL-BEING

- The proportion of 13-15 year olds reporting being bullied has increased to nearly 20%.

LOOKED AFTER CHILDREN

- Looked after children in the 10-17 age band has increased.

CHILD PROTECTION

- One quarter of the children on a child protection plan are in the 10-17 age band in Dudley.

EDUCATION

- Outcome for pupils at the end of key stage 4 at school in Dudley is now similar to national levels.
- There is a widening gap in attainment between the most and least deprived areas in Dudley (35.6% points) and also between non-white British and white British (6.2% points).

CRIME

- Victimisation increases across this the 12-16 age group with most theft occurring away from the home.

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FREEDOM YEARS - YOUNG ADULTHOOD

MORTALITY

- The mortality rate for persons aged 15-24 in Dudley is equivalent to national rates. Two-thirds of the deaths occur in the 40% most deprived areas of the borough.
- The rate of drug-related deaths has stayed static but remains above the national rate.
- The rate of suicide and undetermined injury mortality in Dudley remains high in males.

HOSPITAL ADMISSIONS

- Rates of hospital admissions for accidents continues to rise with 36% due to poisonings and 25% for being struck by an object or foreign body piercing the skin.

SEXUALLY TRANSMITTED DISEASES

- Diagnosis rates of sexually transmitted diseases have declined in this age group.

ECONOMY

- The numbers of 16-24 year olds claiming job seekers allowance is now on a downward trend, but the proportion claiming is still double that of the working age population.

YOUNGER JUGGLERS AND SETTLERS

MORTALITY

- Mortality rates for alcohol related diseases continues to be significantly higher than national and the rate is rising for females aged 25-39. The rates are higher in the most deprived areas of Dudley.
- Although the number of deaths are low for epilepsy, the rate is higher than the national rate.

HOSPITAL ADMISSIONS

- Approximately 15% of emergency hospital admissions are due to injury or poisoning from external causes and a further 15% due to pregnancy related conditions.
- Nearly two-thirds of A & E attendances are for people living in the 40% most deprived group in the borough.

ECONOMY

- The 25 to 39 years age group continues to have a higher job seekers claimant rate than those of working age at 4.6%. It is now on a downward trend.

CRIME

- Victimisation remains high for the 25 to 40 age group. Criminal damage is at its highest rate along with vehicle crime and burglary.

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OLDER JUGGLERS AND SETTLERS

MORTALITY

- The Dudley mortality rate for the 40-59 age band is higher than the national rate and is higher for males.
- Nearly 40% of deaths were due to cancer. Colorectal cancer is the third most common cause of cancer mortality with an increasing trend in Dudley, against the decreasing national trend.
- Mortality due to smoking related diseases is important in this age group and for males the rate in Dudley is higher than the national rate. Smoking related diseases mortality is correlated with deprivation.

HOSPITAL ADMISSIONS

- Emergency admissions for alcohol specific conditions increases from the 40-59 age group. The increasing trend with time is beginning to level.
- The proportion of A & E attendances fro accidents that result in a hospital admission begins to increase for the 40-59 age group (8.6%).
- The proportion of admissions from accidents relating to falls increases for this age group.

CANCER SCREENING

- Uptake for both cervical and breast cancer screening in Dudley is below the national target of 80%

DEMENTIA

- It is estimated that there are currently 80 people aged 30-64 years with early onset dementia and this is projected to increase.

ECONOMY

- The rate of people in the 40-59 age group claiming job seekers allowance has declined in the last year to 3.5% for the age group.

CRIME

- Victimisation from crime begins to decline across the 40-59 age group, with a reduction in violent crime and an emphasis on burglary and vehicle crime.

ALONE AGAIN AND ACTIVE RETIREMENT

MORTALITY

- The mortality rate for the 60-74 age group is similar to the national rate. There are clear health inequalities with a quarter of deaths occurring in the 20% most deprived group.
- Cancers account for 45% of the deaths. Death rates from stomach cancer are higher for Dudley than nationally and is also higher in males.
- Mortality rate for respiratory diseases in males is higher in Dudley than nationally. The rate is higher in the most deprived group. COPD is the main contributing disease to this rise.
- Mortality rate for alcohol related conditions in Dudley males is significantly higher than the national rate and the trend is continuing upwards.

HOSPITAL ADMISSIONS

- Numbers of emergency hospital admissions have an increasing trend wit time.
- Emergency admissions for alcohol specific conditions are lower in the 60-74 age group, but the trend continues upwards.
- The percentage of A & E attendances for accidents resulting in an admission rises further across this age band and the majority of these admissions are for falls.

CANCER SCREENING

- The uptake continues to be below the target of 80% and is reducing with time. Uptake is also lower in the more deprived areas of the borough.

DEMENTIA

- In Dudley it is estimated that 644 people

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aged 65-74 have late onset dementia.

DISEASE PREVALENCE

- Estimated prevalence of diseases in Dudley against the actual recorded prevalence have improved for coronary heart disease, hypertension, diabetes, chronic obstructive pulmonary disease (COPD) and asthma. This has been most marked for COPD.

ECONOMIC

- A small percentage of people aged 60-64 years are claiming job seekers allowance (1.1%), but this has not declined as has been the case in the other age groups.

AGEING RETIREMENT

MORTALITY

- The mortality rate for those aged 75+ years is the highest of all the age groups. And in Dudley is higher than the national rate. In 2012 there were 1,998 deaths in the 75+ age group in Dudley.

- One third of the deaths are attributable to circulatory diseases. The deprivation gradient is low for this age group.

- Mortality from breast cancer in Dudley is higher than the national rate in the 75+ age group.

- Mortality rate for stroke and hypertensive disease in Dudley still remains higher than the national rate.

- Mortality rate for respiratory diseases in Dudley is above the national rate. This rate is higher in the most deprived groups.

HOSPITAL ADMISSIONS

- The number of emergency admissions for Dudley residents aged 75+ have increased year on year and account for 10,000 admissions.

- Emergency admissions for angina, heart failure and diabetes are higher in the Asian, black and Chinese ethnic minority groups.

- Emergency admissions for diabetes have risen in the last 3 years.

- Emergency admissions for lower respiratory tract infections have been increasing and are higher in the most deprived quintile group and in the Asian ethnic group.

- A & E attendances for unintentional and deliberate injury have declined and a lower proportion resulted in an admission.

- The majoring of admissions from A & E are for falls.

DEMENTIA

- It is estimated that Dudley has 3,594 people aged 75+ with dementia.

IMMUNISATION

- Dudley seasonal flu vaccination uptake in the 65+ age group was below the national rate at 72.7%.

- Pneumococcal vaccination uptake was 69% in Dudley in 2012/13.

HEALTHCARE ASSOCIATED INFECTIONS

- The level of reported cases of *Clostridium difficile* in the Dudley responsible population has been declining, but the rate remains higher than the national rate.

END OF LIFE CARE

- The rate of deaths at home and in care homes has remained static for Dudley with levels similar to the national average.

- Dudley has a higher percentage of terminal admissions that are emergencies then England.

- Dudley has a very low total spend per death on end of life care when compared to England.

CRIME

- In the 70+ age group there is an increase in the number of burglary related to distraction burglary.

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ACTIONS NEEDED

This section provides a summary of the actions needed as determined by the review of healthcare, social care and health improvement needs of the population included in the JSNA synthesis document for 2014. These are not recommendations as these will be developed within the Joint Health and Well-being strategy and commissioning plans.

ACTIONS NEEDED FOR DUDLEY "THE PLACE"

- Support economic development and businesses in Dudley to maximise employment for everyone particularly young people.
- Continue to develop higher level skills in order to build a competitive knowledge based economy.
- Raise the levels of educational attainment and training across the borough, concentrating on those areas and communities where attainment is currently lower.
- The Dudley population is projected to increase proportionately in the 65+ age group which suggests a contracting working age population and a need to take on increased caring and financial responsibility for the ageing population.
- Continue to tackle child poverty in line with the child poverty strategy.
- Take opportunities to maintain an environment that enables people to be physically active and enhances mental health through strategic planning.
- Look to raise the standard of housing to adequate for all particularly within the private rental sector.
- Investigate the reasons for termination of assured shorthold tenancies that impact on homelessness.
- Continue to support the winter warmth programme.
- Maintain the standard of Dudley borough being the safest within the West Midlands. Support retailers to combat the rise in thefts from shops and stalls.
- Within transport planning consider the road user hierarchy of pedestrians (disabled and able bodied), cyclists, public transport and motorists.
- Work to reduce the number of air quality exceedances in the borough, to minimise the impact of air quality on health.

ACTIONS NEEDED FOR DUDLEY "THE PEOPLE"

- Although Dudley has an ageing population, it is prudent to acknowledge the needs of children and young people as well as the older and vulnerable adults as they are inter-related.
- Our services need to account for the differences in population demographics across the neighbourhoods of Dudley.
- Ensure that commissioners include a requirement to record all statutory data in contracts to maximise the ability to analyse and understand the changing population and their needs.
- Services should take account of and meet the needs of the increasing size and growing diversity of the population.

ACTIONS NEEDED FOR CHILDREN AND YOUNG PEOPLE

- Improve antenatal care across all services.
- Continue to fund the work to improve the uptake and continuation of breastfeeding across all maternities.
- Ensure learning from child death reviews are implemented.

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- The focus should be maintained to support vulnerable teenagers to continue the reduction in teenage conception rates.
- Ensure services are maintained to continue to reduce the risks of smoking and obesity in pregnancy and to reduce child health inequalities.
- Continue to deliver evidence based interventions as informed by NICE guidelines to address childhood obesity and ensure the referral pathway to these services are incorporated into service specifications of services for children and families (maternity, health visiting, school nursing, early years and children's centres).
- Deprivation and poverty are the major drivers of health inequalities in children and these need to be addressed further.
- Schools should continue to address the levels of bullying.
- The numbers of looked after children and those with child protection plans continues to increase and it is therefore important to address this through preventative and early intervention services.
- There is an inequalities gap in outcomes for early years foundation stage which needs to be addressed.
- The suicide prevention strategy should be implemented and be extended to cover self-harm.

ACTIONS NEEDED FOR ADULTHOOD

- The key health and well-being challenges in this age group are chronic conditions and diseases resulting from poor lifestyle choices.
- There is a need to fully implement the alcohol harm strategy to tackle the current and future impact of alcohol consumption.
- Continue to implement the Dudley stop smoking service, assuring provision in the most deprived areas.
- Obesity and its two major components food and physical activity is a major problem and the obesity strategy should be fully implemented.
- Cancer continues to be a leading cause of death, but many cancers are preventable or have improved outcomes with early diagnosis. Should ensure improved uptake of national screening programmes across the lifecourse. Raise awareness of cancer symptoms to support early detection.
- Continue to improve case finding for the major diseases e.g. hypertension, COPD etc. and the uptake of health checks.
- Review the COPD care pathway to reduce unnecessary hospital admissions.

ACTIONS NEEDED FOR OLDER PEOPLE

- Dudley has an ageing population, with over 70% of the 75+ age group having a limiting long term illness or disability. The gap between healthy life expectancy and life expectancy is 16.1 and 18.3 years for males and females respectively.
- Emphasis on supporting people to continue to live independently by engaging with local community organisations and the voluntary sector.
- Early interventions for falls prevention are required.
- The self-management programme should be further developed.
- Housing plans will need to consider the ageing population and the potential need for more single occupant dwellings.
- Dementia case finding should be implemented.
- Improve the uptake of flu and pneumococcal vaccinations in the 65+ age group and in vulnerable groups.
- Investigate the end of life care pathway to minimise terminal admissions as emergencies.

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