Herefordshire Council

Agenda

Health and wellbeing board

Date:	**Monday 13 March 2023**
Time:	**9.30 am**
Place:	**Plough Lane, Mordiford/Fownhope Rooms**
Notes:	Please note the time, date and venue of the meeting. For any further information please contact: **Simon Cann Democratic Services** Tel: 01432 260667 Email: simon.cann@herefordshire.gov.uk

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Agenda for the Meeting of the Health and wellbeing board

Membership

Chairperson	Councillor Pauline Crockett	Cabinet Member - Health and Adult Wellbeing
Vice-Chairperson	Jane Ives	Managing Director, Wye Valley NHS Trust
	Ross Cook	Corporate Director Economy and Environment
	Anna Davidson	Assistant Director (Prevention), Hereford & Worcester Fire and Rescue Service
	Darryl Freeman	Corporate Director for Children and Families
	Hayley Allison / Julie Grant	Assistant Director of Strategic Transformation / Head of Delivery and Improvement at NHS Improvement, NHS England
	Hilary Hall	Corporate Director Community Wellbeing
	Dr Mike Hearne	Managing Director, Taurus Healthcare
	Councillor David Hitchiner	Leader of the Council, Herefordshire Council
	Councillor Phillip Howells	Herefordshire Council
	Jane Ives	Managing Director, Wye Valley NHS Trust
	Matt Pearce	Director of Public Health, Herefordshire Council
	Ivan Powell	Chair of the Herefordshire Safeguarding Adults Board
	Christine Price	Chief Officer, Healthwatch Herefordshire
	Councillor Elissa Swinglehurst	
	Councillor Diana Toynbee	Cabinet Member - Children and Families, Herefordshire Council
	Simon Trickett	Chief Executive/STP ICS Lead, NHS Herefordshire and Worcestershire CCG
	Councillor Ange Tyler	Herefordshire Community Safety Partnership / Cabinet member - Housing, Regulatory Services, and Community Safety
	Superintendent Edd Williams	Superintendent for Herefordshire, West Mercia Police
	Mark Yates	Chair of Herefordshire and Worcestershire Health and Care NHS Trust

Agenda

Pages

THE PUBLICS RIGHTS TO INFORMATION AND ATTENDANCE AT MEETING

1. APOLOGIES FOR ABSENCE

To receive apologies for absence.

2. NAMED SUBSTITUTES (IF ANY)

To receive details of any member nominated to attend the meeting in place of a member of the board.

3. DECLARATIONS OF INTEREST

To receive any declarations of interests of interest in respect of schedule 1, schedule 2 or other interests from members of the board in respect of items on the agenda.

4. MINUTES 11 - 20

To approve and sign the minutes of the meeting held on 26 September 2022.

5. QUESTIONS FROM MEMBERS OF THE PUBLIC

To receive any written questions from members of the public.

For details of how to ask a question at a public meeting, please see:

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The deadline for the receipt of a question from a member of the public is 8th March at 9:30 am.

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6. QUESTIONS FROM COUNCILLORS

To receive any written questions from councillors.

The deadline for the receipt of a question from a councillor is 8th March at 9.30 am, unless the question relates to an urgent matter.

To submit a question, please email councillorservices@herefordshire.gov.uk

7. THE HEALTH AND WELLBEING STRATEGY 21 - 108

A presentation welcoming feedback on the draft version of the Herefordshire Health and Wellbeing Strategy ahead of the final version sign-off later in the year.

8. THEMATIC REVIEW: PREMATURE DEATHS 109 - 176

A presentation of the Herefordshire Safeguarding Adults Board Thematic Review: Premature Deaths.

9. PROJECT BRAVE STRATEGIC APPROACH 177 - 208

A presentation of the draft version of the Project Brave Strategic approach.

10. HEREFORDSHIRE INEQUALITIES STRATEGY 2023-2026 209 - 234

A report outlining the Herefordshire Inequalities Strategy for 2023-2026.

11.	**CHILD DEATH OVERVIEW PANEL ANNUAL REPORT 2021-22** A presentation of the Herefordshire and Worcestershire Child Death Overview Panel's (CDOP) Annual Report for 2021-2022.	235 - 260
12.	**COMMUNITY PARADIGM** A slide presentation introducing the Community Paradigm approach.	261 - 272
13.	**HEALTH PROTECTION** A presentation and update from the Health Protection team.	
14.	**WORK PROGRAMME 2023-2024** An opportunity for the board to review and populate the work programme for 2023-2024.	273 - 274
15.	**AOB** Any other business.	
16.	**DATE OF NEXT MEETING** The next scheduled meeting is 27 April 2023, 14:00-17:00	

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Do not delay your vacation of the building by stopping or returning to collect coats or other personal belongings.

The chairperson or an attendee at the meeting must take the signing in sheet so it can be checked when everyone is at the fire assembly point.

Herefordshire Council

The Seven Principles of Public Life

(Nolan Principles)

1. Selflessness

Holders of public office should act solely in terms of the public interest.

2. Integrity

Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

3. Objectivity

Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

4. Accountability

Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

5. Openness

Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

6. Honesty

Holders of public office should be truthful.

7. Leadership

Holders of public office should exhibit these principles in their own behaviour and treat others with respect. They should actively promote and robustly support the principles and challenge poor behaviour wherever it occurs.

Minutes of the meeting of Health and wellbeing board held in Plough Lane on Monday 26 September 2022 at 3.30 pm

Board members present in person, voting:

Board members in attendance remotely, non-voting:

Councillor Pauline Crockett	Cabinet Member - Health and Adult Wellbeing
Hilary Hall	Corporate Director Community Wellbeing
Jane Ives	Managing Director, Wye Valley NHS Trust
Matt Pearce	Director of Public Health
Christine Price	Chief Officer, Healthwatch Herefordshire
Councillor Diana Toynbee	Cabinet Member - Children and Families, Herefordshire Council
Superintendent Edd Williams	Superintendent for Herefordshire, West Mercia Police

Note: Board members in attendance remotely, e.g. through video conference facilities, may not vote on any decisions taken.

Others present in person:

Luke Bennett	Public Health	Herefordshire Council
Stephen Brewster		VCS
Simon Cann	Democratic Services	Herefordshire Council
Miriam Gardner	Project Manager All-Ages	
Cllr Elissa Swinglehurst	Scrutiny	

Others in attendance remotely:

Ewen Archibald	Assistant Director, All Ages Commissioning	Herefordshire Council
Samantha Evans	Acting Head of Law and Business Partner – Community Wellbeing	
Marie Gallagher	Project Manager – All Age Commissioning	
Adrian Griffith	Head of Commercial Development	Herefordshire Council
Emma Lydall	Registrar	
David Mehaffey	Director for ICS Development	
Pete Norton		Herefordshire Food Alliance
Kristan Pritchard	Health Improvement Practitioner	Herefordshire Council

50. INTRODUCTION

The chair welcomed board members and attendees to the meeting.

51. APOLOGIES FOR ABSENCE

Apologies were received from: Susan Harris, Anna Davidson, Cllr Ange Tyler and Simon Trickett.

52. NAMED SUBSTITUTES (IF ANY)

There were no named substitutes.

53. DECLARATIONS OF INTEREST

There were no declarations.

54. MINUTES

The board approved the minutes of the meeting of the 21st July 2022.

55. QUESTIONS FROM MEMBERS OF THE PUBLIC

No questions received.

56. QUESTIONS FROM COUNCILLORS

No questions received.

Councillor Pauline Crockett (the chair of the board) introduced and welcomed Mr Stephen Brewster as a representative for the Voluntary Community Sector (VCS) and explained he would be participating as a contributor until the VCS role had been discussed and ratified by the board in a future meeting.

The chair also noted the inclusion of several slide decks that had been added to the agenda, but stressed they did not interfere or disrupt reports already on the main agenda.

57. REPORT ON HEREFORDSHIRE PHARMACEUTICAL NEEDS ASSESSMENT 2022

The chair introduced the final draft version of the Pharmaceutical Needs Assessment (PNA) for approval by the board, it was explained that a 60-day consultation period was still in effect and that the report would be subject to any amendments in relation to responses that may be received in the final days of the consultation.

Emma Lydall (Public Health Training Specialist Registrar), provided a detailed verbal presentation on the report based on the slides included in the agenda Herefordshire 2022 PNA HWB Presentation.

The board asked questions about:

- The possibility of returning to the report in 18 rather than 12 months, to allow adequate time to monitor the impact of the changing role of the pharmacist?
- Whether the review covered off anything about the value for money of the services that were already commissioned?
- Who was responsible for ensuring the recommendations within the report were actioned and who was responsible for feeding back?

The registrar explained that a PNA working group was going to be established in Herefordshire and Worcestershire and that public health would work closely with this group and feedback to the Health and wellbeing board (HWB).

Matt Pearce (Director of Public Health, Herefordshire) explained that it fell to the HWB to provide a level of assurance. The actual delivery of the recommendations would be overseen by the public health team and partners and then approval would be sought from the HWB.

Jane Ives (Managing Director Wye Valley NHS Trust) felt that the relative urgency of the recommendations meant that it would be prudent to come back to them in 12 months rather than 18.

The director of public health noted that many papers were recommending the formation of task and finish groups and that in these instances a joined up approach with Worcestershire would be advisable as there would be potential shared ambitions. The director of public health emphasised the importance of maximising the use of pharmacies, and noted that they have a great reach especially in deprived communities.

The chair suggested that it was important that new GP surgeries should, whenever possible, have a pharmacy in them.

David Mehaffey (Director for Integrated Care System Development) noted the slide in the presentation pack with the map detailing 10 minute travel times. This showed the reach of Herefordshire facilities across the border of other counties, but did not show their reach into Herefordshire. It was possible that this gave a distorted view of the health inequality gap.

The registrar acknowledged that the report did only look at Herefordshire pharmacies, but that it might be possible to look at the cross-border picture. However, the population of Herefordshire was adequately serviced by pharmacies and dispensing practices. The registrar and director for ICS agreed that more work on cross-county reach would be a valuable addition to the mapping of future assessments.

Councillor Diana Toynbee noted that pharmacies are businesses and enquired as to whether if a pharmacy decides to close there is any leverage to stop this happening. The registrar deferred to the director of public health for an answer. The director said he understood that the pharmacies had to get permission to close from NHS England, but it they're not financially viable there might not be a choice. The director said he would take the question away and seek a definitive answer.

The managing director Wye Valley NHS Trust emphasised the importance of working jointly with Worcestershire when it was appropriate and cost-effective to do so. The board agreed to keep the annual review timeline in place.

The report recommendations were proposed and seconded and approved unanimously:

RESOLVED:
That:

a) Members note the PNA consultation responses received to date.
b) Members are asked to note the consultation responses received to date (Appendix 1) and to delegate final approval for publication to the PNA working group, subject to any minor or technical amendments recommended by the working group.

58. TOBACCO CONTROL 2022

The chair introduced the report and Luke Bennett (Senior Commissioning Officer) presented, providing a summary of the Khan review: Appendix 1 The Khan Review Summary , which broadly recommended:

- Increased investment for interventions
- Increasing the age of sale
- Offering vaping as a substitute for smoking
- Improving prevention in the NHS

A local context was then provided, including a brief overview of work being undertaken in the area.

The senior officer went through recommendations for the board, which included:

1. That the Health and wellbeing Board welcomes the publication of Javed Khan's Independent Review into smoking
2. Health and wellbeing board supports the recommendations from the Khan review and the resulting actions to help make smoking obsolete in England and Herefordshire.
3. Health and wellbeing board member organisations are asked to actively promote and engage in activity to work towards making smoking obsolete in Herefordshire.

The chair thanked the senior officer for his presentation. Concerns were raised about the available manpower to implement some of the recommendations in the Khan review.

The chair asked the managing director of Wye Valley NHS Trust about the Wye Valley Trust's response to smoking in pregnancy figures in Herefordshire, which were above the national average.

The managing director of Wye Valley NHS Trust explained that recent data showed the number of pregnant smokers was going in the right direction and that hopefully this would be a trend. Carbon monoxide monitoring of pregnant women was also helping the situation.

The managing director of Wye Valley NHS Trust said that this was a broad area and that what they were already doing was working, but there was a need to prioritize and focus on areas of concern.

Hilary Hall (Corporate Director Community Wellbeing) endorsed what the managing director of Wye Valley NHS Trust had said and suggested that trying to do everything could result in things generally being done less well. By focusing on one or two priorities, such as smoking in pregnancy it would be possible to achieve something significant and make a demonstrable gain.

Cllr Toynbee also agreed with the need for focus on key areas of concern. Additionally, Cllr Toynbee raised concerns about the promotion of vaping contained with the Khan review. She acknowledged the argument that vaping was an alternative to smoking or an aid to giving up, but she had serious concerns about the explosion in popularity of vaping in school children and the damaging chemicals they were being exposed to as a result.

The director of public health agreed with the need for focus on areas of concerns, but also urged mindfulness in relation to areas where Herefordshire was faring well on a national basis, as this could potentially mask important inequalities in the population and that a business as usual approach was also needed to ensure those areas where Herefordshire was in the average range were still monitored closely, as they could often have significant impact on death rates and illness.

The director of public health noted Cllr Toynbee's comments about vaping and pointed out that in public health vaping is often seen from a harm reduction perspective rather than as being a gateway into smoking and it was important that messages about vaping were framed properly.
The senior officer also emphasised the importance of not neglecting fundamental issues relating to smoking such as the fact that 66% of smokers start before the age of 18.

Getting to the root and stopping people before they start would have broad and wide benefits.

The director for ICS development noted that the local maternity and neonatal system (LMNS) would have stopping smoking during pregnancy as one of their priority work areas, so it was already a business as usual priority that was operating within the system.

A discussion took place about recommendation 'd' it was felt that there were existing mechanisms in place including; ongoing NHS tobacco dependency work, steering groups and the forthcoming Integrated Care Strategy that would help in promoting and engaging in activity to work towards making smoking obsolete in Herefordshire, but it was not felt necessary to amend the recommendation.

The report recommendations were proposed, seconded and approved unanimously.
APPROVED
That:

a) Health and Wellbeing Board welcomes the publication of Javed Khan's Independent Review into smoking and supports the development of an action plan to help make smoking obsolete in Herefordshire;
b) Health and Wellbeing Board acknowledge the findings from the recent smoking needs assessment and commit to supporting Herefordshire to become Smoke Free;
c) Health and Wellbeing Board actively support the need for a whole system approach to smoking at primary, secondary and tertiary prevention levels, and
d) Health and Wellbeing Board member organisations are asked to actively promote and engage in activity to work towards making smoking obsolete in Herefordshire, including supporting the establishment of a working group to produce an action plan reporting into the board annually.

59. UPDATE ON THE WORK OF THE ORAL HEALTH IMPROVEMENT PARTNERSHIP BOARD

The chair introduced the item and passed over to the director of public health to present the update. The director provided a verbal update referencing the Herefordshire Oral Health Improvement Action Plan (2020-2023) and the Herefordshire Oral health Needs Assessment

The director highlighted a wealth of positive activity relating to children, adults in care homes and early years staff giving out brushing packs to children.

The director cited one omission from the report as being the change in legislation contained in the Health and Care Act 2022 relating to water fluoridation arrangements being moved away from local authorities to the secretary of state and central government. The director considered water fluoridation to be one of the strongest evidence-based measures for improving oral health in Herefordshire and wanted to establish the most effective way of lobbying the government on this issue.

Christine Price (Healthwatch) enquired about commissioning being delegated down to the ICS for dental services, as to date there hadn't been much traction at the oral health improvement board around commissioning.

The director for ICS development said the responsibility of commissioning services would become the responsibility of the ICB, but this wouldn't happen until at least April 2023. At the moment work was underway to establish what will be inherited from the current commissioners at NHS England in the region. The integrated Care Board was

currently carrying out proper due diligence to make sure it struck the right funding allocation, as well as understanding the baselines, key risks and challenges. The intention of making commissioning services more local was to ensure that they could be integrated with the wider work around improving population health and wellbeing. This would necessitate greater integration input with local partners.

The chair emphasised the importance of prevention and praised public health incentives being taking into schools such as 'Brush, book and bed'.

The managing director of the Wye Valley NHS Trust enquired about what form the lobbying of government would take. The director of public health explained that this was something that would need to be looked into, but an understanding of the process was needed to get Herefordshire at or near the top of the list for fluoridation.

Stephen Brewster asked whether the voluntary sector was being used to enable cross-pollination and amplification of messaging in relation to delivering aspiration within reports - such as bringing the oral health advice and incentives to schools visited by the voluntary sector.

Christine Price (Chief Officer, Healthwatch Herefordshire) echoed the need to make greater use of the voluntary sector, in addition to statutory bodies, schools and health visitors in delivering health and wellbeing related messages to the community. There was a need to make all the messages count.

The director for ICS development explained that the Integrated Care Partnership was focused on working more closely and effectively with the partners in the voluntary sector.

The report recommendations were proposed, seconded and approved unanimously.

APPROVED

That:

a) The committee note the progress of the Oral Health Improvement Partnership Board; and

b) Adopt the recommendations set out the Oral Health Improvement Plan by their own organisations, and support the delivery of the plan at system level, wherever possible; and
c) Make a recommendation to the Oral Health Improvement Board to investigate the best way of lobbying the government on the issue of water fluoridation, with a view to encouraging positive interaction between the water firms and the government, which would lead to a positive adoption of best practice in relation to fluoridation of water in Herefordshire.

60. HEREFORDSHIRE'S BETTER CARE FUND (BCF) INTEGRATION PLAN 2022-23

The chair introduced the item and Ewen Archibald (Service Director All Age Commissioning) and Adrian Griffith (Head of Commercial Development) led the presentation.

The service director explained that frustratingly the deadlines meant the plan was due to be submitted to the Department of Health this same day and that the board would therefore only be able to suggest minor amendments (if it wanted to make changes). It was noted that there was not a significant change in the: documentation, the overall profile of the proposed spending and the metrics from last year. Some minor changes to the metrics were in evidence and the narrative report contained slightly more detail on the disabled facilities grant, regarding how that was spent.

The service director also discussed an announcement from the Department of Health to say that it was introducing a new funding stream, which appeared to have similarities to the previous hospital discharge fund, but the details had not been published.

The head of commercial development provided a brief overview to the change of the metrics and explained that the timeframes involved meant the planning guidance came out halfway through the year to which the plan refers, which meant there was very little time to put together a plan and consult with everybody who might have sensible and relevant input. It was also stated that as soon as this plan was submitted, planning would commence on the next plan in a bid to avoid a reoccurrence of the situation.

The head of commercial development set out the report recommendations and opened discussion up to the board:

The managing director of Wye Valley NHS Trust noted that next year reviewing discharge to assess pathways and funding and reshaping that would be very important and would provide better value and outcomes from what had been put in place during Covid.

The managing director of Wye Valley NHS Trust highlighted the need to make the role of the One Herefordshire Partnership clearer in terms of its relationship with the BCF. The Integrated Care Executive (ICE) and its performance management/scrutiny function was also brought to the attention of the board.

The service director asked the board to note the work done by Adrian Griffith and Marie Gallagher in putting the plan together.

The report recommendations were proposed, seconded and approved unanimously.

APPROVED

That:

a) the Herefordshire Better Care Fund narrative plan, planning template and capacity and demand template be approved; and
b) note work ongoing to support integrated health and care provision that is funded via the BCF.

61. HEREFORDSHIRE FOOD CHARTER

Pete Norton (Herefordshire Food Alliance Coordinator) provided the board with an update on briefing of the Herefordshire Food Charter It was explained that were over 40 signees and that the alliance was hoping to create an ‘umbrella for food activity’ in the county with a focus on health, local economy, community and environment.
The coordinator then urged board members to sign up to the charter and to circulate it with their partner organisations.

The development of a Marches Regional Food Procurement Hub with Monmouthshire, Shropshire, Powys, Telford & Wrekin councils was also reported. This was being led by Monmouthshire council and it had received an initial £10,000 grant from the Dixon Foundation to carry out a feasibility study, which if successful could in principle lead to up to a £100,000 further investment.

The alliance would also be applying for a sustainable food places bronze award in the next available round in Spring 2023.

The coordinator also informed the board that his colleague Rebecca Tully would be taking over the role of coordinator from November 2022.

The board applauded the work that had been done on the charter and the procurement hub and noted that good food was often neglected as being a key driver for health and sustainability.

Kristan Pritchard (Health Improvement Practitioner) highlighted the importance of this work particularly in relation to the healthy weight agenda. It was also a good example of how a whole systems approach to food could be used across the county.

The chair concluded the item and thanked the team for its excellent work.

62. COST OF LIVING REPORT SEPTEMBER 2022

Hilary Hall (Corporate Director Community Wellbeing) presented slides on the Cost of Living - Herefordshire Response . The director explained that she felt a cost of living commission, pulled together under the auspices of the Health and wellbeing board, would allow all the partners of the board to come together and say what could be done together and as individuals. A commission would also allow the voice of residents to be heard directly, which would avoiding second guessing how the cost of living crisis impacts individuals, families and communities. By coming together as a set of partners including housing associations and the volunteering community sector, it might be possible to get an accurate sense of what's going on and then to engage with residents via talk community hubs. The slides contained four recommendations and the Director invited discussion on these from the board.

The board welcomed the recommendations and felt that a commission that could assist in creating a place where all available advice and support was in one place would be of enormous value. It was also stated that the ICB was very keen to work with the board and the council in this area. The voluntary community sector attendee highlighted the pressure the sector was under as people tightened their belts and said the VCS would welcome the opportunity to be involved in a broader discussion about the cost of living.

The recommendations were proposed, seconded and approved unanimously.

APPROVED

That:

a) **Continue to promote the range of ways in which the council and its partners supports residents in need, particularly through Talk Community and Money on your Mind.**
b) **Ensure that specific support is in place for those for whom Herefordshire Council is a corporate parent.**
c) **Establish a Cost of Living Commission to gather information and identify other actions that the council and its partners can take to support residents. D)**
d) **Develop a longer term strategy for working with the voluntary and community sector, building on the foundations established over the last two years.**

63. JOINT HEALTH AND WELLBEING BOARD STRATEGY UPDATE

The director of public health introduced the item and explained that the presentation was to update the board in terms of progress to date and that there was still plenty of time for the board to contribute to and shape the priorities of the strategy.

Miriam Gardner talked the board through the Joint Health and Wellbeing Strategy Progress Update

The board noted the update and highlighted the need to get the strategy priorities right. Limited financial resources would likely necessitate a review of what kind of strategy would offer best value and the board felt that a future workshop on the strategy would allow for interesting discussion especially with regards to areas such as resilience, vulnerability and prevention.

64. HEALTH AND WELLBEING BOARD WORK PROGRAMME

The board noted the Work Programme and the chair asked for meeting dates to be set for the next 6 months.

65. DATE OF NEXT MEETING

Date of next meeting: 12th December 2022

The meeting ended at Time Not Specified **Chairperson**

Herefordshire Council

Title of report: Joint Local Health and Wellbeing Strategy

Meeting: Health and Wellbeing Board

Meeting date: 13 March 2023

Report by: Director of Public Health

Classification

Decision type
This is not an executive decision

Wards affected

Purpose:

- To provide the Board with an update on the progress of the Joint Local Health and Wellbeing Strategy 2023-2033
- To receive feedback from the Board on the draft strategy

Recommendation(s)

- That the Board consider the report and note its progress.
- That the Board consider its response to the draft and suggest changes for consideration as appropriate.

Alternative options

There are no alternative options - it is a function of the Health and Wellbeing Board (HWB) to produce a Joint Health and Wellbeing Strategy (HWBS).

Key considerations

- Herefordshire Council and partners have produced the attached draft strategy in March 2023, following several months of preparation that involved collating national and local data, and consulting with partners and the community about the issues that affect the wellbeing of residents. It is a ten year strategy that proposes realistic change over the longer term.

- In winter 2022 public consultation was undertaken to collect residents' views on a number of potential priorities for the focus of the strategy. The majority of the

participants felt that all the proposed priorities were important but two in particular were consistently ranked as the most important; these were ‘Best start in life’ and ‘Good mental health’

- The draft strategy therefore proposes that the central focus of the strategy at the beginning of this ten year period should be on ‘Best start in life for children’ and ‘Good mental wellbeing throughout life’.

- The other proposed priorities will not be disregarded; they are important in their own right as well as being interlinked with the central two. It is our recommendation that the HWBB keep a ‘watching brief’ on the progress with addressing these issues.

- Appendix 1 contains the Herefordshire Council draft document in full for the HWB to consider

Community Impact

The purpose of the strategy is to help improve the wellbeing of Herefordshire residents and for it to have a real impact on our communities. One of the key principles upon which the strategy has been developed is that of community empowerment, which in practice means that we must continue to involve our communities in any action that is taken, so that the community own it and the impact on that community is maximised.

Environmental Impact

There are no general implications for the environment arising from this report; however the strategy does feature the reduction in our carbon footprint as one of its priorities, therefore further along in the delivery of the strategy it is expected that there could be some environmental impact. There will also be co-benefits to the environment through ambitions to reduce levels of obesity, eat more healthily and increase levels of physical activity through active travel.

Equality duty

- Under section 149 of the Equality Act 2010, the ‘general duty’ on public authorities is set out as follows:

A public authority must, in the exercise of its functions, have due regard to the need to –

a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
c) Facilitate good relations between persons who share a relevant protected characteristic and persons who do not share it.

- The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services.
- The principles of equality and the reversal of health inequalities are key strands of the strategy
- To be effective in delivering good population outcomes and helping those most in need, the strategy calls for intervention by working together at system, place, and community levels to tackle issues reflecting whole system priorities as well as specific concerns at the right scale.

Resource implications

- There are no resource implications associated with this report. However, the resource implications of any recommendations made by the HWB will need to be considered by the responsible party in response to those recommendations or subsequent decisions

Legal implications

- Health and wellbeing boards are responsible for encouraging integrated working between health and social care commissioners, including partnership arrangements such as pooled budgets, lead commissioning and integrated provision.
- Their purpose is to establish collaborative decision making, planning and commissioning across councils and the NHS, informed by the views of patients, people who use services and other partners.
- The functions of the Health and Wellbeing Board are set out in paragraph 3.5.24 of the constitution.
- The production of a Joint Local Health and Wellbeing strategy is a statutory requirement and therefore its endorsement and support is required.

Risk management

There are no risk implications identified emerging from the recommendations in this report

Consultees

Matt Pearce (Director of Public Health), Hilary Hall (Corporate Director Community Wellbeing), Corporate Leadership Team, One Herefordshire Partnership, Simon Cann (Democratic Services Manager)

Appendices

Appendix 1 – Herefordshire Joint Local Health and Wellbeing Strategy 2023-33

Appendix 2 – Consultation Report

Background papers

3

None identified

Main report

1.0 Introduction

The Health and Social Care Act 2012 requires every local authority to produce a Joint Health and Wellbeing Strategy (HWBS). The HWBS sets out how the Council and its local partners plan to address the health and wellbeing needs of its population and as such, is a key document that is jointly owned and one that promotes collective action to meet those needs.

In July 2022 The HWBB met to agree a set of design principles, taking into account the emerging landscape of health and social care and its needs in the future. These principles were:

1. The strategy should be short and concise
2. We should aim for a long term strategy (10 years)
3. The strategy itself should be high level
4. It should be supported by shared and local action plans that set out the detail of how the strategic goals will be delivered across all the partners
5. The strategy should be focussed on prevention and integration, and in doing so provide a strong basis for producing chapter 1 of the ICP Integrated Care Strategy
6. A lifetime approach should be maintained

Other principles agreed by the HWB were:

1. That the priorities in the strategy will be based on need
2. Planned actions will be based on evidence of effectiveness.
3. Prevention (in all its forms) will be at the heart of all we do
4. A 'proportionate universalist' approach – something for everyone and more for those who need it the most
5. The strategy will focus on areas where partnership action adds value and there is commitment across the system
6. Narrowing health inequalities is a core aim
7. The strategy is developed in close collaboration with residents and local partners from health, social care, local authorities and voluntary sector.

We set out a vision for the strategy which is:

'Everyone in Herefordshire leads a happy, healthy and fulfilling life'

3.0 Developing the Health and Wellbeing Strategy

The development of the strategy is being project managed by a designated council officer under the direction of the Director of Public Health. A dedicated task and finish group was formed and has been meeting fortnightly to update its members on progress and to discuss the issues that have shaped development of the strategy. This group is made up of representatives from key partners i.e. Council, Health Watch, Herefordshire and Worcestershire ICB, Integrated Partnership Board and Wye Valley Trust.

The strategy has been developed through the HWB engaging with wider stakeholders, including our communities. Initial work focused on looking at the factors across Herefordshire which are having the greatest impact on people's health and wellbeing, and which account for some of the biggest inequalities.

We spent time speaking and listening to members of the public and hearing from organisations involved in health, care and community and voluntary services about what they think matters most. Once all the available information had been collected we drew up a list of 12 potential priorities that would be the focus of the strategy.

3.1. Public Consultation

During winter 2022 a consultation exercise was undertaken to collect residents' opinions about the importance of the 12 priorities; they were as follows:

1. Good mental wellbeing across throughout lifetime
2. Support people addicted to substance misuse/support those who smoke
3. Support vulnerable people to lead healthy lives
4. Improve education outcomes for disadvantaged children and young people
5. Every child has the best start in life
6. Good work for everyone
7. Increase access to healthy and sustainable food and physical activity
8. Reduce our carbon footprint
9. Improve housing quality and reduce homelessness
10. Reduce loneliness and social isolation across all ages
11. Support people to age well
12. Improve access to local services, particularly in rural areas

Approximately 1000 residents and organisations responded to the survey and a further 14 focus groups were undertaken with seldom heard communities including Carers, Care experienced young people, Older people, people living with disabilities and LGBTQ+. Overall this represents a good level of participation for a survey of this kind.

The majority of respondents expressed the view that all the priorities were very important and there was recognition from many people that the priorities were interlinked and had a mutual inter-dependence. However, there were two main priorities that were consistently ranked above the others;

These were:

- Every Child has the best start in life
- Good mental health throughout lifetime

There were also comments made about other issues that people said were important to them:

Residents needed better access to:

- Information, county-wide and local
- GPs, dentists and other health services
- Transport

Residents needed help with:

- Cost of living issues
- Childcare

Residents would like to see more focus on:

- Prevention
- Community Safety
- Equality and diversity

A detailed report on the consultation is included with this report as Appendix 2

5

4.0 Deciding the Priorities

A HWB workshop was held in January 2023 to discuss the priorities and what these would mean for the strategy and its delivery. Following this and having taken into account the views and comments from residents and partners and what we know about the issues from our Herefordshire data, it was decided that the central focus of the strategy at the beginning of this ten year period should be on 'Best start in life for children' and 'Good mental wellbeing throughout life'.

This does not mean that the other priorities will be disregarded. We recognise that they are also critically important in how they affect wellbeing, but that they also support and contribute towards giving children the best start, as well as the development and retention of good mental health. We have therefore retained some of the initial 12 priorities (as supporting/secondary priorities) to emphasise the important role that they play in our overall health and wellbeing

As part of plans to review the progress of the strategy during the ten year term, there will be opportunity, if deemed appropriate, to switch our focus more to the other priorities for a period of time. In this regard we recognise that the strategy needs to be a 'living' document that is flexible in its response to changing times and changing circumstances, rather than having a fixed focus in one area.

5.0 Delivering the Strategy

If we are to achieve our ambition to improve health and wellbeing and reduce health inequalities in Herefordshire, we need to share our collective resource and act as one voice. The HWB will oversee and drive the implementation of the strategy through its member organisations and partnerships, which in turn will be accountable to the Board for progress. Health and Wellbeing Board members will act as champions for the areas for collective action across Herefordshire.

Delivering the changes needed identified in the strategy will not be easy and will require a 'whole system' approach that brings partners, communities and individuals together toward a common purpose. In order to ensure good governance and oversight of the key priorities, there will be an identified partnership and a named 'champion' from Health and Wellbeing Board responsible for the two priority areas. However, it is recognised that work to deliver on these priorities will span a number of groups and partnerships. Work continues around reviewing our local governance and best to deliver the strategy.

6.0 Governance

The Strategy is ambitious and touches on much of the work of each organisation represented on the Health and Wellbeing Board. The two priorities and associated objectives provide a framework against which the partnership and organisational strategies will deliver.

Experience from the previous health and wellbeing strategy suggests that a clear delivery/ implementation plan and governance process needs to be developed in order for this strategy to be an effective working document that will produce measurable outcomes and help improve peoples' lives.

The development of the strategy is an iterative process. We have produced this draft that is now being circulated to partners and expert groups so that we can collect feedback about what is realistic and achievable; but this is part of the journey, together with our partners, towards making it a document that is real, relevant and that will make a difference.

Once the strategy is ratified by the Health and Wellbeing Board in April 2023, the partnership subgroups of the Health and Wellbeing Board will be tasked with translating the high level objectives across the two priority areas (Best Start in Life and Good mental health across the lifetime) into meaningful delivery plans and further understand the outcomes we want to achieve together. Ongoing discussions are being held with regards to the role of the One Herefordshire Partnership potentially having oversight of the delivery of the strategy on behalf of the Health and Wellbeing Board

7.0 Next Steps

Feedback will be taken from the HWB, other partners and experts by experience and additions/changes will be incorporated into the strategy as appropriate. Following this process the final version of the strategy will be prepared for approval by the HWB in late April.

There will be 2/3 feedback sessions to residents regarding the consultation results in early March, undertaken by Impact Consultancy and the results of the online survey will be posted on the council website.

8.0 Outcomes Framework

An initial outcomes framework has been developed and mapped across the two central priority areas and the other priorities that support them, but there is ongoing work with the Intelligence Team and other experts to review and refine them.

7

Herefordshire

Joint Local Health and Wellbeing Strategy 2023 - 2033

'Everyone in Herefordshire leads a happy, healthy and fulfilling life'

Forward

Herefordshire Council, together with our partners is pleased to publish this Joint Local Health and Wellbeing Strategy. The document presents an outline for improving the health and wellbeing of the population in Herefordshire over the next 10 years and has been put together following a period of consultation with our partners in health, education, the voluntary sector and other key services and also with our residents from many different walks of life and ages who have told us what they need to help them feel healthier and achieve a greater sense of wellbeing.

Through the creation of this strategy many of our residents have told us that Herefordshire is a great place to live and in general Herefordshire residents experience good health and wellbeing, and a sense of connection with their community. We have wide, open spaces of beautiful countryside on our doorstep and supplies of locally grown food and produce. We also have a strong and diverse voluntary and community sector that is comprised of circa 2,300 organisations and which make significant, positive contribution to the lives of Herefordshire residents.

Since the publication of the last Strategy in 2017 we have experienced an event of seismic proportion in the form of the Covid-19 pandemic, which has changed many aspects of our day to day routines and has adversely changed the lives of so many for ever. For the first time in years, we have seen life expectancy stalling, plus several other adverse consequences for our health.

It has also become increasingly clear that the Covid-19 pandemic has had a disproportionate impact on the groups of people that already face disadvantages and discrimination. This strategy therefore presents an opportunity to tackle the issue of health inequality as part of our post pandemic recovery and to help those most in need to attain better wellbeing. However, we all have a role to play in improving physical and mental health and wellbeing; though health, education and economic institutions need to do their part, it cannot be achieved without input from us as individuals and without the involvement of the communities that we are part of.

Our place within the Herefordshire and Worcestershire Integrated Care System, set up in summer 2022 enables us to work together as equal partners to implement effective and sustainable plans that will improve health and wellbeing for the long term. As a partnership we remain committed to the priorities for action that we have identified and are willing to work together, in order that we can maximise the potential for achieving the desired outcomes for our Herefordshire residents.

Our ambition cannot be achieved by any one single agency and must be rooted in people's lived experiences and shaped with and by our local communities who are the best placed to determine what it is that they need to improve their lives and wellbeing.

Cllr Pauline Crockett
Chair of the Health and Wellbeing Board

1.0 Introduction

The Health and Social Care Act 2012 requires every local authority to produce a Joint Local Health and Wellbeing Strategy (HWBS). The Health and Wellbeing Board (HWBB) brings together the organisations responsible for improving health and wellbeing in Herefordshire. Its members include elected councillors, representatives from local NHS organisations, including the Integrated Care Board (ICB), Primary Care Networks and Wye Valley Trust, Healthwatch, the local voluntary and community sector, West Mercia Police and Hereford and Worcester Fire and Rescue Service.

The HWBS sets out how the Council and its local partners plan to address the health and wellbeing needs of its population (identified through the Joint Strategic Needs Assessment) and as such, is a key document that is jointly owned and one that promotes collective action to meet those needs. The implementation of the Health and Care Act of 2022 and the consequent establishment of the Integrated Care System (ICS) for Herefordshire and Worcestershire provides a timely opportunity for this new strategy to deliver action by any of the partners within the Herefordshire and Worcestershire ICS or more locally within Herefordshire, according to what is most appropriate to the issue.

The publication of the NHS long Term Plan in 2019 also signified a commitment to place-based care, population health and prevention, areas of work that local authorities have been involved with for a number of years; it is therefore encouraging that all parts of the health and social care system, including the Primary Care Networks now have a remit requiring them to have regard for prevention and a focus on communities as key ingredients, in the drive to help improve wellbeing.

This new joined up way of working has helped Herefordshire and the ICS (the same applying to Worcestershire), to align strategies, commit to those priorities that are jointly owned and which contribute to the overall system goals. For that reason the Herefordshire HWBS and the Worcestershire HWBS have been incorporated into the Integrated Care Strategy document; a statement of our intention to work in synergy with one another.

This strategy will be accompanied by a monitoring and implementation plan, setting out the responsibilities of all partners. The intention is that it is ambitious in aspiration but realistic and measurable in its objectives and makes a tangible difference to peoples' lives.

2.0 What makes us healthy?

Health and wellbeing are fundamental for individuals and communities to be happy and healthy, providing the foundations to prosperous societies. The World Health Organisation defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.[1] Wellbeing is not necessarily dependent on physical health status, though good health is one important factor.

[1] https://www.who.int/

A sense of wellbeing depends on many other factors in our lives, such as:

- Where we live and the homes we have
- What work we do and our material comfort
- Our relationships with others.

Good or bad health is not simply the result of individual behaviours, genetics and health care. A substantial part of the difference in health outcomes is down to the social, economic and environmental factors that shape people's lives. These factors are collectively described as the wider determinants of health. The diagram below shows a dissection of the factors that influence our health and wellbeing.

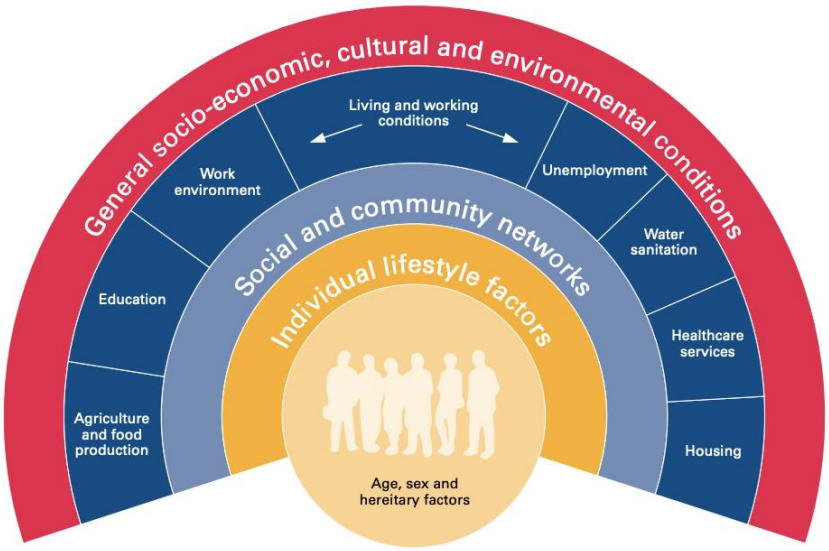


Figure 1. Factors that influence health and wellbeing (Dahlgren and Whitehead 1992)

3.0 Our Community

Overall Herefordshire residents experience a good quality of life and live longer than the England average. However people born in the most deprived 10% of areas in Herefordshire have a shorter life expectancy at birth than those living in the least deprived 10% cent by an average of 4.2 years for males and an average of 3.0 years for females.

Herefordshire is one of England's most sparsely populated counties, with 95% of the land area classified as 'rural' and over half of the population living in these rural areas. Almost all its land area falls in the 25% most deprived in England in relation to geographical barriers to services. Herefordshire has an older population than nationally, with around a quarter (26%) of the resident population aged 65 or over, compared with 19% in England & Wales. The following page summaries some key facts about our County.

3.1 Key facts

Herefordshire ranked 271 out of 324 LA's for social mobility

Private housing: worse than England for excess cold

Relatively low productivity

Ageing population - Doubling of over 65s in next two decades

Higher than the national rates for smoking in pregnancy

Life expectancy better than England average

for women 82.8 for men 79.8

Higher than the national rates for obesity in adults and children

5,600 children living in relative poverty

1 in 3 jobs pay less than the living wage

93.5% of schools rated as good or outstanding

2 designated Areas of Outstanding Natural Beauty

One of the happiest places to live

116,000 adults have 1 or more long term condition/s

15.6% of adults have a common mental health disorder

5.4 year (males) and 4.0 year (females) gap in life expectancy between most/least deprived

1 in 3 children have tooth decay

3.2 COVID-19 recovery

This strategy could not be developed without consideration of the profound effects that the Covid-19 pandemic has had upon us individually and as a society. There have certainly been positive news stories that emerged during the long periods of lockdown – whether that be the kindness of neighbours and people looking out for one another, the reduction in air pollution, or the dedication of health and care staff, amongst other inspired good deeds.

However, there has been emerging evidence that the pandemic has also had a serious negative impact on our health and wellbeing, affecting outcomes across all ages. These are some of the ways in which the pandemic has affected the population[2].

- The delay in diagnosis/treatment has resulted in the need for more urgent care, particularly for cancer, heart disease and long-term conditions
- An increase in alcohol and illicit drug use and a disruption to services that provide help and support
- An increase in people experiencing anxiety and depression, again compounded by a disruption to Primary Care services and other means of support.

Its effect has also shone a light on some of the health and wider inequalities that persist in our society and it has become increasingly clear that COVID-19 has had a disproportionate impact on many who already face disadvantage and discrimination; these are some examples:

- People living in the most deprived areas within Herefordshire were 1.5 times more likely to die with Covid-19 than those living in wealthier areas.
- The digital divide has accentuated the disadvantage of not having internet facilities at a time of lockdown, when many services and sources of information were only available online. Lack of internet impacts on isolation, access to services, educational and employment opportunities
- The Covid-19 pandemic disrupted two years of children's development; social contact, education and life experiences were all affected. Lasting impacts will not be known for some time, but it has undoubtedly widened pre-existing, deep-rooted inequalities, including for disadvantaged children and those living in deprived areas.

When these issues are combined with the growing cost of living crisis, it is not surprising to see how difficult life has become for many people. We therefore have an opportunity and an obligation within the boundaries of this strategy, as part of the post Covid-19 recovery process, to identify actions that will firstly, continue and promote the positive dimensions of life and community that we have seen during the pandemic; and secondly, to tackle the widened inequality gaps that exist across health, education and employment, housing and other key areas of life that affect wellbeing.

[2] Director of Public Health report 2020: Impacts of Covid-19 (herefordshire.gov.uk)

4.0 Developing our Health and Wellbeing Strategy

The strategy has been developed through the HWBB engaging with wider stakeholders, including our communities. We have looked at the factors across Herefordshire, which are having the greatest impact on people's health and wellbeing, and which account for some of the biggest inequalities. We spent time speaking and listening to members of the public and hearing from organisations involved in health, care and community and voluntary services about what they think matters most.

Once we had collected all the available information and consulted with our partners, we were then in a position to formulate an initial list of potential priorities that would be the focus of the strategy. These priorities were determined by taking account of need, impact, effectiveness, inequalities and how the Health and Wellbeing Board could add value to existing work to achieve better outcomes through the strategy.

Figure 2. The steps taken in developing the strategy

4.1 Involving our residents

A consultation exercise was undertaken to collect public opinions on our priorities. The consultation consisted of an online survey plus a series of face to face engagement sessions with a broad cross-section of groups from the community. We asked people to consider twelve priorities and to tell us if there were any issues that were missing from the priorities list and about any concerns that they had.

The majority of respondents expressed the view that all the priorities were very important and there was recognition from many people that the priorities were interlinked and had a mutual inter-dependence. However, there were two main priorities that were consistently ranked above the others;

1. Every child has the best start in life
2. Good mental health throughout lifetime

Other comments that our residents gave us were about the following:

Residents need better access to:

- Information, county and local
- GPs, dentists and other health services
- Transport

Residents need help with:

- Cost of living issues
- Childcare

Residents would like to see more focus on:

- Prevention
- Community Safety
- Equality and diversity

A detailed engagement report can be found as an addendum to this strategy.

5.0 Our vision, goals and principles

5.1 Our vision

‘Everyone in Herefordshire leads a happy, healthy and fulfilling life’

What do we want Herefordshire to look like in 10 years?

- We will have reduced the differences in health between different groups of people
- Everyone has good emotional health and wellbeing, happiness and resilience
- We will have sustainable and thriving communities that provide a sense of belonging, identity and community
- Where everyone has the same opportunity to lead healthy lives
- Where people stay as healthy as possible for as long as possible
- The places where we live ensure the healthy choice is the easy choice
- People who need help, have access to the services and support they need
- All children and young people feel safe, loved, and valued, and grow up with the confidence and skills to be the best they can be
- Economic prosperity and inclusive growth

5.2 Our goals

We have identified four goals that reflect the wider factors that determine our health and wellbeing as detailed in section 2.0, recognising that good health and wellbeing is more than individual choices and behaviours

1. **Thriving Communities**: People live in communities that foster wellbeing and resilience

2. **Healthy and Sustainable Places:** People can live and work in sustainable, safe and healthy environments

3. **Opportunity for all:** Opportunities exist for everyone through fair employment for all, education and social mobility

4. **Healthy People:** People are supported to be in control of their health and make healthy choices

5.3 Our principles

Our intention is to make this strategy an effective, living document and one that over the course of its 10 year lifetime is able to steer a course towards consistent improvement in the wellbeing of Herefordshire residents. At the heart of enabling this to happen we have identified a number of principles that will underpin our plans:

Prevention first approach

The Health and Wellbeing Board has a key role in ensuring that there is a sustained focus on embedding prevention across the health and social care system, taking a place-based approach (looking at communities and neighbourhoods) that goes beyond just thinking about what public sector services provide.

Prevention and early intervention are critical to the long-term sustainability of our health and wellbeing system and an investment in the future economically, morally and socially. This means taking action to help prevent problems arising in the first place, whether that might be identifying difficulties that a new parent may be having with a baby, or an issue that an employee is having with paying his housing rent; if we can direct people to the right help early on and target those in high risk groups we can prevent worse problems developing. Prevention can normally be described at three levels as illustrated in the diagram below.

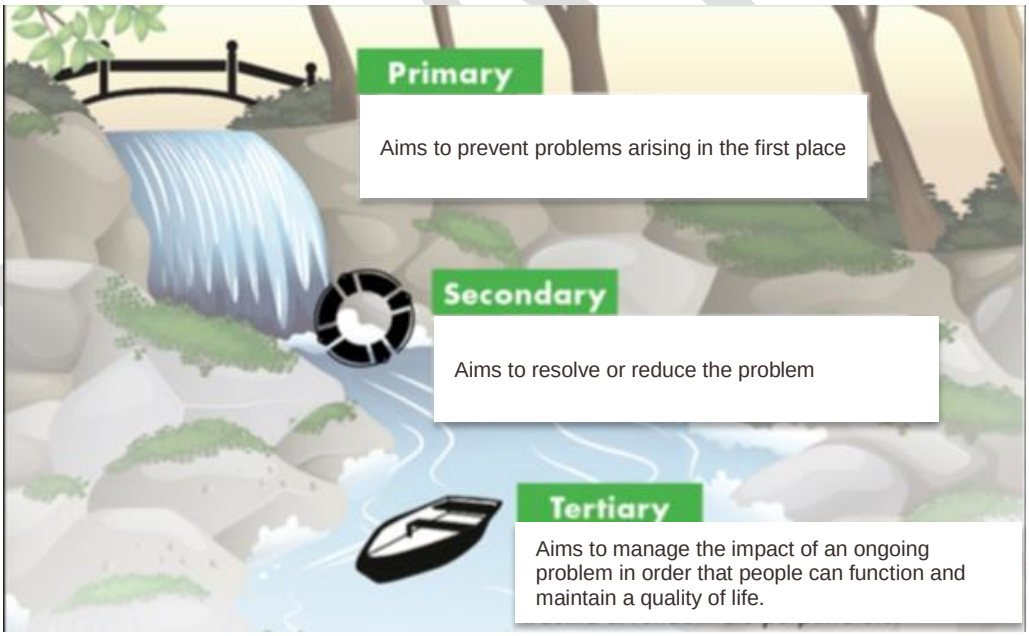


Figure 3. A diagram showing the three levels of prevention

Whilst recognising the value and importance of having healthcare or emergency support when needed, ultimately the intention of this strategy is to focus on 'upstream' issues i.e. social determinants, before problems appear, when people become unwell, or depressed, or unable to cope with daily life.

Community Empowerment

As we have stated previously, our ambitions cannot be achieved by any single agency and if we are to effectively address systemic inequalities it must be tackled through co-production and collective action; This means citizens and communities will be at the centre of change; people with lived experience are expected to be involved in our actions, from the developmental stages, through to the delivery of our actions. We will also make best use of community assets and local leadership to create local solutions. This is the true nature of co-production and spans much wider than just working with our professional partners to achieve the intended goals, though it is crucial that we continue with the latter.

In Herefordshire we call this a 'community paradigm' where we will build on our Talk Communities approach to enable a different way of working with individuals and communities, recognising that local communities have the knowledge, skills and assets to know how best to respond to challenges and to thrive.

Spotlight - Talk Community

Herefordshire has 70 Talk Community Hubs which are located across Herefordshire and provide a safe place where people can access up to date wellbeing information and signposting to local and national resources. They also connect people to services, groups and activities, either within the local area or across the county, which can help them support their own wellbeing and independence.

Amanda* visited a Warm Space after seeing a Talk Community Poster promoting them on a local noticeboard. She had been homeless for 2 months and went along to charge her phone, for a hot lunch of soup and sandwiches (services provided at this particular Warm Space) and to get warm for the afternoon. Whilst at the Warm Space, Amanda chatted to a volunteer over lunch and disclosed her circumstances. She was connected to the food bank (also a Warm Space) who provided a food parcel, and where she also met with a Housing Officer who provides outreach support from the venue.

Reducing Health Inequalities

Health inequalities are unfair and avoidable differences in health across the population and between different groups of people[3]. A range of individual characteristics and societal factors that have been identified as contributing to health inequalities including deprivation, vulnerable or inclusion health groups, protected characteristics or where people live. For those affected this can often mean poor quality of housing, poor educational attainment, lack of physical comfort such as an adequately heated home and nutritional food. These obstacles are often very difficult to overcome without support and help. In addition people in disadvantaged groups also experience inequality and inequity in trying to access the support they need. The result is that these groups of people develop poor health and ultimately have a decreased life span as well as fewer healthy living years. Herefordshire also has unique challenges due to its rurality which often mask significant pockets of deprivation and poor health outcomes.

[3] Health disparities and health inequalities: applying All Our Health - GOV.UK (www.gov.uk)

We recognise that together, we need to deliver effective interventions, to break the cycle, mobilise communities and ensure the most vulnerable children and adults are protected. To be effective in delivering good population outcomes we need to help those most in need and intervene by working together at system, place, and community levels to tackle issues reflecting whole system priorities as well as specific concerns at the right scale. An inequalities Strategy has been completed by a designated working group which will report into the HWBB and provide updates on progress.

A valued, well-trained and supported workforce

Our workforce, many of whom live as well as work in the county, are a huge asset for making change happen. We want to work as one workforce in Herefordshire. Shared values and collaborative working will support joined-up services. New population-based models of care will require the development of multi-disciplinary working across organisational boundaries. Better workforce planning can ensure the workforce is the right size and has the knowledge and skills needed to meet future demographic challenges. Working fully in partnership with the third sector and those in caring and volunteer roles in the community will be crucial to making the most of our county wide assets. There are also opportunities to maximise the everyday interactions our workforce has with the public through making every contact count and signposting people to local support

Integrated way of working

Whole systems integrated care is about ensuring every person in Herefordshire can have their needs placed at the centre – this is done through joining up the range of health, social care services and relevant community partners. Herefordshire has a strong history of partnership working that has benefited from having a number of coterminous organisations with one local authority, one acute/community provider, one mental health trust (shared with neighbouring Worcestershire) and one "mature" GP federation. The aim is to increase access to quality and timely care, supporting people to be more independent in managing their conditions and becoming less likely to require emergency care. .

Evidence informed

Data and intelligence informed – we will use the best available evidence from population and public health data and information to inform decision making. Programmes will be developed based upon needs assessments, population health management data and local intelligence. This will enable us to make decisions about the best use of resources and ensure that any programmes are effective for the resources invested.

Outcomes focused and continuous improvement

All programmes will be monitored and evaluated with a focus on ensuring that successes can be built into ‘business as usual’ practice. We will continually challenge ourselves about what we are all doing to reduce health inequalities and ensuring a proportionate universalism approach to programmes. Programmes will be developed with a shared set of outcomes which are jointly

developed and owned by partners. Partners will share accountability for the outcomes of the programmes (see also section 7.0)

6.0 Deciding our priorities

6.1 What does being a priority mean?

The members of the HWBB came together to agree on the following key features, though not all of these may apply all of the time:

- It is of greatest importance to a community
- There is a significant impact for wellbeing and society
- It will mean that all partners will recognise and own the priority
- It tackles inequalities – to reduce the gap between best and worst.
- The HWBB spends dedicated time on it and keeps hold of it
- There will be meaningful and measurable outcomes that will make a difference
- There is a detailed delivery plan identified that is costed and targeted
- There is accountability for change across the sub-groups of the health and wellbeing board
- Resources are identified for it, which may be funding, staff, time

Having taken into account the views and comments from residents and partners and what we know about the issues from our Herefordshire data, it felt right that the central focus of the strategy at the beginning of this ten year period should be on **'Best start in life for children'** and '**Good mental wellbeing throughout life'**.

In addition to these primary priorities, we have identified a further six secondary priorities recognising that they are also critically important in how they affect our broader wellbeing, but that they also support and contribute towards giving children the best start, as well as the development and retention of good mental health.

All of the other six priorities have a role in reducing inequalities by addressing the wider issues that affect health, including housing, employment, and crime. Employing community-based approaches these need to be driven by partnerships at a place level involving the council, health services, the voluntary sector, police, public sector employers and businesses. As part of plans to review the progress of the strategy during the ten year term, there will be opportunity, if deemed appropriate, to switch our focus more to the other priorities for a period of time. Below is a summary of the importance of the other six priorities:

Improving access to local services: Over half of our residents live in rural areas and as we have seen there are benefits to living in a rural setting However as the COVID-19 pandemic highlighted, when our geographical movement is restricted, it is important that we have access to services and support locally or online. Having access to local support is also important for reducing loneliness and isolation which in turn helps mental health.

Inequalities Fact: 17,000 adults do not use the internet, 71% of which live in the most deprived areas, so this issue has a significant adverse effect on them being able to access services, education and employment.

Support people to live and age well: 25% of residents, about 48,500 people are aged 65 and over. This number is predicted to increase 11% by 2025 and is expected to continue increasing. As a result we have increasing rates of dementia and long term conditions. We also continue to have rising obesity levels in both the adult and child populations, with not enough physical activity taken and not eating the recommended portions of fruit and vegetables

Inequalities Fact: The gap in life expectancy between those in the most and least deprived areas is 6.3 years for men and 4.0 for women

Good work for everyone: Rewarding and fulfilling work supports good physical and mental wellbeing. It fairly rewards peoples' efforts, enables them to earn a decent living wage and provides opportunity for personal development and financial security. Low wages are a significant issue in Herefordshire, with earnings being consistently the lowest in the region. This impacts upon families who are affected and consequently on their ability to give children the care and nurture they need to thrive. We are also seeing a consequence of growing ill health with more and more people reporting poor health as their reason for no longer participating in the workforce which can impact economic growth[4].

Inequalities Fact: There are barriers for certain groups of people being able to access good quality jobs that are suitable for their needs and circumstances e.g. those with poor educational attainment, those with mental health issues and those with learning difficulties.

Support those with complex vulnerabilities: There are small groups of people who are subject to multiple risk factors (alcohol and drug use, sever mental illness, homelessness, at risk of violence and abuse), that in combination are likely to have a severely adverse effect on their mental and physical wellbeing. Often these vulnerabilities stem from negative childhood experiences, but the impact of trauma can be experienced at any age and can prevent people from thriving and being able to function.

Improve housing / reduce homelessness: There are well established links between poverty and homelessness or unsuitable housing and which impacts mental health. It also again has an impact on children of all ages and adversely affects their potential to thrive. Due to the age and nature of Herefordshire's housing stock, we have significant issues with fuel poverty and cold homes, especially in more isolated rural areas.

Reducing our carbon footprint: The global climate crisis is also an unfolding health crisis, as we see the increasing problems of flooding and poorer air quality. It is also likely that we will see an increase in the frequency and severity of heatwaves which will lead to a rise in the number of heat-related deaths.

[4] Is poor health driving a rise in economic inactivity?

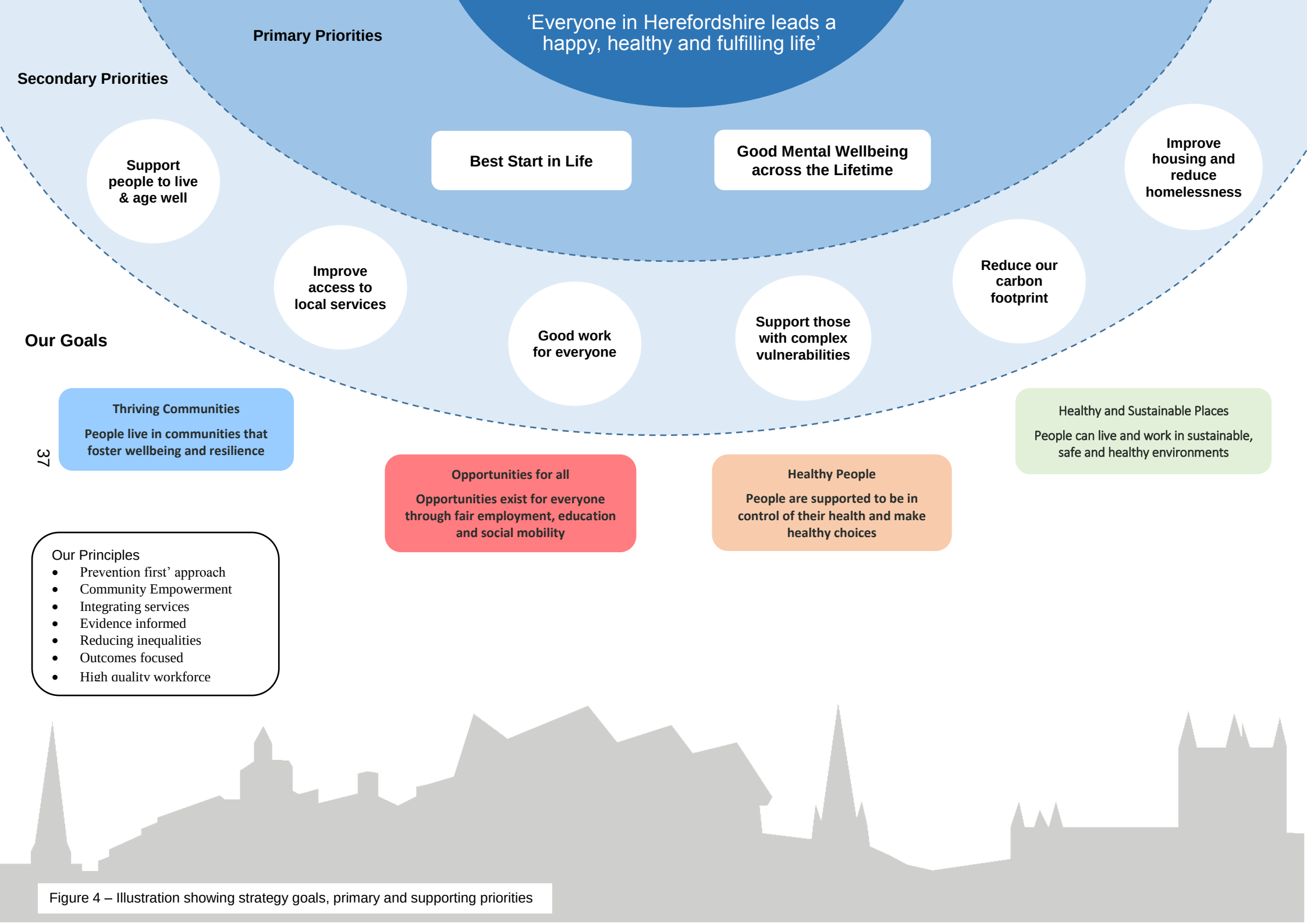


Figure 4 – Illustration showing strategy goals, primary and supporting priorities

6.2 Delivering the strategy

If we are to achieve our ambition to improve health and wellbeing and reduce health inequalities in Herefordshire, we need to share our collective resource and act as one voice. The HWBB will oversee and drive the implementation of the strategy through its member organisations and partnerships, which in turn will be accountable to the Board for progress. Health and Wellbeing Board members will act as champions for the areas for collective action across Herefordshire.

Delivering the changes needed identified in the strategy will not be easy and will require a 'whole system' approach that brings partners, communities and individuals together toward a common purpose. In order to ensure good governance and oversight of the key priorities, there will be an identified partnership and a named 'champion' from Health and Wellbeing Board responsible for the two priority areas. However, it is recognised that work to deliver on these priorities will span a number of groups and partnerships. Following the publication of the strategy detailed plans and actions will be developed and delivered through a number of partnership groups, together with a dashboard that will be subject to monitoring and review

7.0 Best Start in Life

What do we mean?

Best start in life will mean that children have access to all the means that ensure adequate levels of physical and emotional provision which enables them to fulfil their potential.

For this strategy we are referring to the 0-5 year age group. However, we also recognise the importance of the 5+ years, especially the times of major transition where the quality of support is of equal importance.

Why is it important?

The early years of a child's life have a huge impact on their future development and physical and mental wellbeing. As Marmot(2020)[5] tells us the foundations for virtually every aspect of human development start from preconception and what happens from this point forward has lifelong effects on many aspects of health and well-being – from obesity, heart disease and mental health, to educational achievement and economic status. The attachment that children form with their caregivers is also of crucial significance for their future emotional health and the formation of healthy relationships (Bowlby 1997)[6]

Children in Herefordshire generally thrive and rates of child poverty are lower than the national average. However there are some areas of significant concern. The percentage of babies who die at birth or shortly after is higher than the national average and the rates of smoking in pregnancy are also above the national average. Rates of childhood vaccinations remain below the national average and the dental health of young children is worse than the national average. The percentage

[5] Marmot M. 'Health Equity in England: The Marmot Review 10 years on'. 2020
[6] Bowlby, J. Attachment and loss. Volume 1. 1997

of Reception Year who are overweight or obese is also significantly higher than the national average.

Children are part of families and families are part of the wider community. Creating supporting environments for families where children can both socially and physically grow requires a whole system approach and should underpin any actions. As there is a social gradient in health, i.e. the lower the persons social position the worse their health, action should be taken to reduce this gradient by following the principles of proportionate universalism, as recommended by Marmot (2020)[7]

We want to promote communities and environments that support children to make healthier choices and which will ensure our children thrive and achieve. However, we recognise that some children, young people and their families will need additional support and we are committed to working together to provide joined up services to enable these children and young people to reach their full potential.

There is continuing statutory work with children and their families to provide additional support for those families that need it the most. The Herefordshire statutory children's team are engaged with Ofsted to implement an improvement plan for the service and this is a key piece of work that will continue to develop.

However, to have a lasting impact on the future and lifelong physical and emotional health and wellbeing of children and reduce health inequality, there is a need to work in partnership with a range of other public services, private sector, voluntary and community organisations and of course children and young people themselves, along with their families and caregivers to address the social determinants of health. This strategy presents an opportunity to take a holistic view of the needs of children and through the HWBB, to bring together all key agencies and partners who can add value and impetus to the existing services and help escalate a path towards improvement.

What are we already doing?

The majority of work to promote the best start in life is through the local delivery of the Healthy Child programme, as well as in other statutory settings such as early year's providers and schools. There is also work undertaken throughout the borough by the community and voluntary sector.

A summary of just some of the activity undertaken is as follows:

- Health visiting and school nursing
- Children's centre services – universal and targeted offer for families with young children
- Active Families
- Family Coach pilot project
- First Steps for under 21s
- Solihull Parenting Programme
- Oral Health Programme
- Holiday activity programme
- Children Health and Advice Team

[7] Health Equity in England: The Marmot Review 10 Years On - The Health Foundation

Spotlight: Parenting in Herefordshire; The Solihull Approach

The Solihull Approach is a team of professionals within the NHS, passionate about preventative mental health and encouraging sensitive, attuned relationships within the family leading to better parent-child relationships and happier families. The Roll-out started in 2019 and Herefordshire Council have a 4 year multi-user license to make online parenting courses available for all the county residents. To date over 2000 people have accessed the online courses

There is also a course to help parents understand their teenagers and recently a new course has been released just for teenagers, introducing them to the fundamentals of good mental health and how to process their feelings in the context of relationships.

How will we make a difference?

Evidence tells us that there are six high impact areas[8] that have been identified as being key to giving children the best start in life. These collectively make up the national Healthy Child Programme and include:

1. Supporting transition to parenthood
2. Supporting maternal and family mental health
3. Supporting breastfeeding
4. Supporting healthy weight and nutrition
5. Improving health literacy
6. Supporting health, wellbeing, development and readiness to learn

These high impact areas provide an overarching framework from which we can identify relevant outcomes as outline below:

1. The number of women who receive effective support for their mental health during pregnancy and after their baby is born will increase.
2. The number of pregnant women who have a healthy pregnancy, including those living in more deprived areas and those from targeted minority ethnic groups will increase
3. More children will be equipped with the social and emotional skills to manage their lives and to be able to cope with life's challenges
4. We will reduce the level of childhood obesity in Herefordshire through a whole system approach to obesity
5. We will reduce the numbers of children with tooth decay
6. We will enhance our early help and prevention offer across our communities to improve outcomes and reduce demand for statutory services
7. The number of children achieving their early development milestones on the way to school readiness will increase, especially in our most deprived communities
8. We will improve outcomes for all children by adopt a 'child health in all policies' approach to decision-making and policy development

[8] Overview of the 6 early years and school aged year's high impact areas. PHE. Department of Health & Social Care. 2018

8.0 Good mental wellbeing throughout life

What does it mean?

Mental wellbeing can be described as 'feeling good and functioning well; it means being able to think, feel and react in the ways that you need and want to live your life. When you have poor mental health, ways of thinking, feeling and reacting become difficult and sometimes impossible to cope with.

Why is it important?

Good mental health and resilience is fundamental to achieving our potential. It affects our physical health, relationships, education and our work. People with higher levels of wellbeing are likely to live longer and are less likely to engage in health risk behaviours, such as smoking and excessive alcohol consumption; the life expectancy of someone with a serious mental health problem is 15 to 20 years less than the general population. In any given year, one in six adults experiences a common mental health problem. We also know that the Covid-19 pandemic has resulted in an increase in people experiencing anxiety and depression.

Findings from the 2021 Herefordshire Community Wellbeing Survey indicate that the average wellbeing scores for adults in the county are above the England average. However, an estimated 24,800 adults in Herefordshire have a common mental health disorder. Results from the 2021 Herefordshire Children and Young People Quality of Life Survey revealed 1 in 4 primary aged children have low to medium mental wellbeing scores, rising to nearly half in secondary aged pupils.

People with mental health issues can face significant disadvantages throughout their lives and those affected are unevenly distributed across society with disproportionate impacts on people living in poverty, those who are unemployed and identified population groups including sexual and gender minority groups and ethnic minorities in the community. In addition to these health inequalities, the stigma associated with mental health problems persist, making it harder for those needing help to seek it; this continues to be especially true amongst the male population.

Tackling mental ill health remains a difficult challenge which, in order to be effectively addressed requires an approach that takes account of the whole person and their social context – looking at both needs and strengths. It also requires a mix of primary, secondary and tertiary prevention interventions

What are we already doing?

Improving mental health and wellbeing is currently overseen by a number of partnerships across Herefordshire and the wider ICS. The main commissioning/delivery mechanism is through the Herefordshire and Worcestershire Mental Health Collaborative

Though the Collaborative has a duty, through the NHS Long-term Plan, to secure improvement in current secondary care services, it has, through the reallocation of existing resources, been able to initiate new ways of working with firstly, the PCNs to build better local mental health support services and secondly, with the voluntary sector to deliver non-medical models of care.

A summary of current activity is below

- Mental Health First Aid Training
- Mental Health in Schools Programme
- IAPT – low level mental health programmes
- Now We're Talking Support programme

Spotlight – Professionals Portal

Herefordshire and Worcestershire Health and Care Trust have launched a professionals' portal that hosts resources to help people who may come in contact with staff or clients struggling with mental health or suicide. It includes free training resources and tips and tools to help start a conversation It also includes advice and signposting to more practical support with concerns such as the cost of living crisis, domestic abuse, housing issues and relationships.

How will we make a difference?

We have identified the high level outcomes we want to achieve to improve mental wellbeing:

1. More people are better equipped with the social and emotional skills to manage their lives and to be able to cope with life's challenges.
2. More people are supported to live and age well and are able to make healthy choices through the five ways to wellbeing
3. There is increased access to, better experience of and better outcomes from services that support mental health for children and adults
4. There is less stigma around mental health issues, especially amongst men and marginalised groups
5. We will have built resilient communities that prevent the potential lifelong impacts of adverse childhood experiences and support those who have experienced trauma.
6. There are better recovery rates from illness and we have improved the life expectancy for those who have severe mental illness
7. Increase awareness and understanding of dementia, and ensure support for people for who have dementia is accessible and in place for them and their unpaid carers.
8. A county where families, friends and communities support each other, especially at vulnerable points where people are at greater risk of loneliness and isolation

9.0 Governance

The Joint Health and Wellbeing Strategy is ambitious and touches on much of the work of each organisation represented on the Health and Wellbeing Board. The two priorities and associated objectives provide a framework against which the partnership and organisational strategies will deliver.

The Health and Wellbeing Board will maintain strategic oversight of the strategy, and monitor progress through the draft outcomes framework summarised in appendix 2. Although the strategy focuses on two primary priorities, its scope is wide and delivery will require a "health in all policies"

approach, advocating for health considerations to be incorporated into decision making across sectors, policy and service areas.

The supporting priorities in the strategy are the responsibilities of a number of organisations and partnerships and some are already included in existing strategies and commissioning and action plans. These are summarised in table 1 and implementation of these will be key to delivery of the vision and outcomes of this strategy.

Many of the priorities are interlinked - for instance, increasing opportunities for active travel, or promoting healthy sustainable diets, will have knock-on effects on air quality and on reducing carbon emissions. By bringing these objectives together, there is an opportunity for the Health and Wellbeing Board, as a local system leaders, to identify where the system is working together effectively to improve health and wellbeing and where further attention is required.

For each of the two priorities 'best start in life' and 'Good Mental Health across the lifetime', delivery plans be developed co-produced with partners, communities and those with lived experience.

10.0 Refreshing and reviewing the strategy

Whilst this is a 10-year strategy, our work to improve health and wellbeing will evolve over time. The Health and Wellbeing Board's ambitions to work closely with communities on the delivery of this strategy will further shape our knowledge about addressing health inequalities. Delivery of this strategy must therefore be flexible and responsive. The strategy will be updated and refreshed as our knowledge and evidence base extend, to ensure that the Herefordshire system continues to improve health and wellbeing of our communities.

Primary Priorities

Priority	Lead Partnership(s) responsible for delivery	Existing plans
Best Start in Life	Children and Young People Partnership	Children and Young People Plan SEND Strategy Early Help and Prevention Strategy
Good Mental Health and Wellbeing	Emotional and Wellbeing Partnership Board (children) Adult Mental Health Partnership Board (adults)	Children & Young People Mental Health Transformation Plan Hfds & Worcs Mental Health & Wellbeing Strategy 22-26 Suicide Prevention Strategy

Secondary Priorities

Priority	Lead Partnership(s) responsible for delivery	Existing plans
Reduce carbon footprint	Climate, Nature and Partnership Board Herefordshire Local Nature Partnership	Herefordshire Council Carbon Management Plan 21-25 Air quality strategy for Herefordshire and Worcestershire
Improve access to local services	Local Transport Project Board Communities Board	Local Transport Plan Herefordshire City Masterplan ICS Strategy and NHS Forward Plan
Ensure good work for everyone	Economy and Place Board	Big Economic Plan
Improve housing & reduce homelessness	Strategic Housing Forum Homelessness Forum	Affordable Warmth Strategy Local Housing Strategy 2021-26
Support those with complex vulnerabilities	Project Brave Board	Project Brave Strategy Domestic Abuse Strategy
Support people to live and age well	Physical Activity Strategic Partnership Sustainable Food Partnership	Physical Activity Strategy Herefordshire City Masterplan Health Inequalities, Personalisation and Self-Care Board

Table 1. How our existing partnerships, strategies and partners are helping to deliver outcomes against the priorities

Appendix 1- Summary of delivery at system, place and neighbourhood

Integrated Care System (ICS)

Through the Herefordshire and Worcestershire Integrated Care Partnership, local leaders have been working together with local people to join up and improve health and care within the budgets available. There has been considerable progress in recent years towards working in a more integrated way. There is a collective ambition to build on this progress and expand the scale and nature of the opportunities for integration. The publication of a new Integrated Care Strategy has coincided with this new strategy.

One Herefordshire Partnership (1HP)

The One Herefordshire Partnership will support the Health and Wellbeing Board in delivering the ambition set out in this strategy. The One Herefordshire Partnership will provide regular oversight of:

1. Ensuring action plans are place across the partnership groups to delivery against the priority areas
2. The outcomes achieved through the strategy, via the data, monitoring and intelligence programme;
3. Ensuring that the strategy continues to reflect the priorities of all of our stakeholders
4. Continue to build upon the many conversations we have had with local people and continue directly engaging and involving residents as a way of empowering communities to have a say, take control of their health, find solutions that work for everyone and support one another in this time of crisis

Primary Care Networks (PCN)

To support the delivery of the NHS Long Term Plan, Primary Care Networks were formed - five across Herefordshire. Primary Care Networks are groups of GP practices based around GP registered lists of approximately 30,000 to 50,000 patients. The network brings practices together in order to offer care on a scale which is small enough for patients to get the continuous and personalised care they value, but large enough to be resilient, through the sharing of workforce, administration and other functions of general practice. The benefits of these services working together include longer opening hours; better access to specialist health professionals; and services closer to home. Primary Care Networks are an important building block to develop current community services to support better delivery of hands-on, proactive, personalised, coordinated and more joined-up health and social care.

Appendix 2 - Strategy Outcomes Framework (working draft)

High Level Strategic Outcomes
Indicators
Healthy life expectancy at birth (male)
Healthy life expectancy at birth (female)
Under 75 mortality rate from all causes
Inequality in life expectancy at birth (male)
Inequality in life expectancy at birth (female)

Primary Priority Outcomes	
Best Start in Life	**Mental Wellbeing**
Indicators	**Indicators**
Increase the mothers who receive ante-natal visit	Increase the dementia diagnosis rate (aged 65 and over)
Improve maternal health at 1 year post-partum	Increase the employment rate for those who are in contact with secondary mental health services
Reduce smoking status at time of delivery	Decrease in the % of adults who feel lonely always or often
Reduce Infant mortality rate	Decrease in the % of adults reporting moderate to high levels of anxiety
Increase the number of children achieving a good level of development at 2-2½	Increase in the % of children and adults with good mental wellbeing
Reduce the prevalence of being overweight (including obesity) at Reception age	Reduce the number of people with a serious mental health condition who die prematurely
Reduce the percentage of 5 year olds with experience of dental decay	
Increase childhood vaccination rates	
Reduce the number of children in living in poverty	

Secondary Priority Outcomes	
Indicators	
Reduce the number of homeless people	Improve social mobility
Improve the completion rates of drug and alcohol treatment programmes	
Reduce the smoking prevalence across all ages	
Reduce the average household consumption emissions estimate in Herefordshire	
Reduce the proportion of adults who are obese	
Reduce the proportion of adults and children who are inactive	

Herefordshire Health & Wellbeing Strategy Engagement Report

DRAFT

February 2023

Version 1.0

Contents

1.0 Executive Summary

Health and Wellbeing Boards are required by law to produce a Health and Wellbeing Strategy which sets out how the Council and partners intends to fulfil its role in promoting health and wellbeing and the actions it will take to do this. Based on local data sources the Health and Wellbeing Board identified 12 priorities that are issues of increasing concern within the county and have a negative impact on health and wellbeing.

Consultation on the priority areas outlined in the draft strategy was undertaken in three areas including an online survey, engagement activities with partners and face to face to sessions with 14 seldom heard groups

960 responses were received for the online survey with 17 of these responses coming from organisations. Overall this represents a good level of participation for a survey of this kind. 77% of respondents were females with 41% of respondents being aged 45-64 year olds. Analysis of respondents by deprivation showed a broad geographical distribution.

The vast majority of respondents to the online survey rated all the priorities as “very” or “fairly important” but the three most favoured were:

1. Ensure every child has the best start in life
2. Support good mental wellbeing throughout life
3. Improve education outcomes for disadvantaged children and young people.

Other priorities suggested by respondents included improvements and access to health and care services, tackling inequalities, greater support for schools, children and families and easier access to community wellbeing, leisure and active travel resources and activities.

A range of face to face engagement sessions were undertaken with the following groups: carers, care experienced young people, Eastern Europeans, Gypsy and Romany travellers, LGBTQ+, older people, people living in social housing, women, young people, veterans, refugees, people with learning or physical disabilities. Whilst responses between the groups varied, there were similarities to the online survey with respondents identifying, good mental health and wellbeing, every child has the best start in life and reduce loneliness and social isolation. Whilst there was a level of consensus from these group, there were subtle and the nuanced needs of specific groups that were expressed. Other priorities suggest included access to GPs, Dentists, Access to information, Transport and Community Safety.

Engagement was also undertaken with the voluntary and community sector through the Community Partnership which bring together organisations across Herefordshire to improve the health and wellbeing of residents. Partnership views (n=54) also reflected those of the online survey and seldom heard groups with good mental wellbeing throughout life, Every child gets the best start in life, and reduce loneliness and social isolation as their top 3 priorities.

2.0 Introduction

Part of any council's business is to pay attention to the health and wellbeing of its residents and to take action that will help people to lead healthier and happier lives and with a sense of wellbeing.

Health and Wellbeing Boards are required by law to produce a Health and Wellbeing Strategy which sets out how the Council and partners intends to fulfil its role in promoting health and wellbeing and the actions it will take to do this. Based on local data sources the Health and Wellbeing Board identified 12 priorities (see below) that are issues of increasing concern within the county and have a negative impact on health and wellbeing (see appendix 1).

The Council and partners were keen to consult with its residents about what they thought the important issues for Herefordshire were and embarked on a consultation exercise to engage a wide cross-section of the community. This report presents the feedback from the engagement with partners and stakeholders and the targeted engagement activity with seldom heard groups. A separate report is being prepared by the Intelligence Unit of Herefordshire Council which will present the findings of the online survey.

3.0 Methodology

Consultation on the priority areas outlined in the draft strategy was undertaken in three areas:

- Public consultation via an online survey
- Engagement with partners and stakeholders
- Targeted engagement activity with seldom heard / key group

3.1 Online survey

An online survey was undertaken that involved asking residents and organisations a range of questions on the priorities. The survey was open for 6 weeks and 960 responses were received.

3.2 Engagement with partners and stakeholders

Engagement with partners took place through a range of mechanisms. This included lead officers developing the strategy meeting with organisations to discuss the priorities. A consultation workshop was held as part of the Community Partnership meeting on 23rd

November. This was an opportunity to gather insight and reflections from people working within the voluntary, community and social enterprise (VCSE) sector.

A workshop with the Health & Wellbeing Board will be undertaken early in 2023 in order to share the findings of the consultation and to explore how the findings may shape the strategy's priorities.

3.3 Targeted engagement activity with seldom heard / key groups

In order to ensure that the consultation was inclusive and that issues relating to specific parts of the community were taken into account a series of consultation workshops were undertaken with seldom heard groups. Summary findings for each of these workshops is included in section 8.

3.4 Promotion of the survey and face to face sessions

The online survey was promoted via a range of channels including social media (Twitter, Facebook) and through Council and NHS newsletters. A link to the survey was also distributed through schools, talk communities and the voluntary and community sector. Face to face sessions were organised directly with special interest voluntary groups who promoted via their own channels to encourage people to attend.

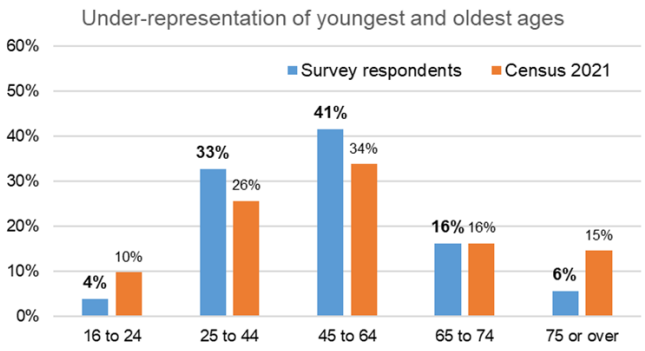
4.0 Results from the Online Survey

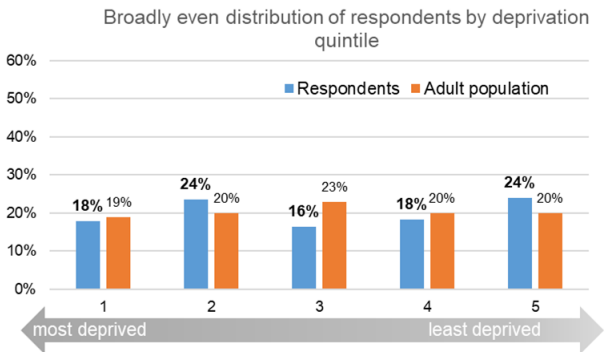
The survey involved a mixture of tick-box and free text questions (see appendix 2) designed to gather views of the relative importance of the proposed priority areas. Supplemented by more detailed background information. The survey ran from 31 October - 18 December 2022 via an open web link. The survey was a self-selecting survey open to anyone aged 16 or over who lives, works, or receives care in Herefordshire and interested groups and organisations. 960 responses were received: 934 from individuals, 17 from groups and organisations (9 didn't answer). Overall this represents a good level of participation for a survey of this kind. Ran in conjunction with face-to-face engagement events with seldom heard groups held by Impact Consulting. Attendees of these events were invited to complete the online survey – the relationship with responses is shown in the chart.

4.1 Representativeness of survey responses

Among individual participants who provided characteristics, compared to the Herefordshire population aged 16+ there was:

- Marked under-representation of males (23% vs. 51% in population).
- Marked under-representation of younger people aged 16-24 (4%) and of older people aged 75 and over (6%) with a corresponding over-representation of 45-64 year olds (41% of participants)
- Over-representation who said they were from a 'White British' ethnic group (95% vs. 91% in 2021 Census).
- Similar proportion said they were disabled (22% vs. 21% in 2011 Census).
- Broadly even geographical distribution by deprivation quintiles (based on the 72% of responses with complete postcodes) and similar urban / rural classification split to the general population.

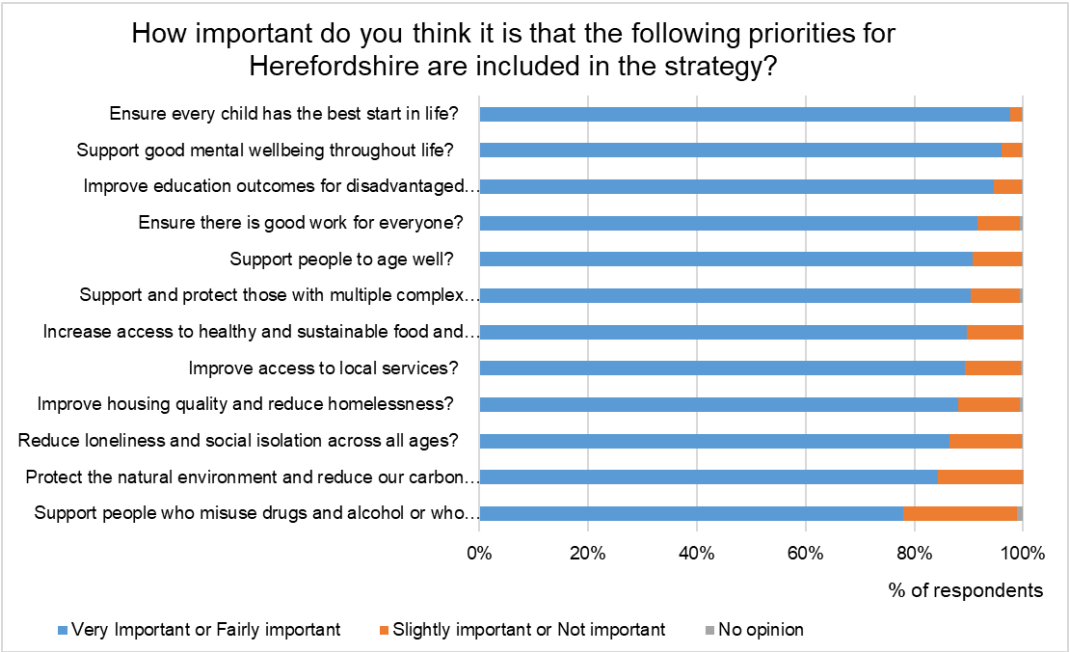




4.2 Most important priorities overall (Q1-Q12)

Participants were asked how important it was that each of the 12 priorities be included in the strategy.

- Very few respondents ranked any priorities as other than “very” or “fairly important”.
- Three priorities stood out as having strongest support (very / fairly important):
  - Ensure every child has the best start in life (98%)
  - Support good mental wellbeing throughout life (96%)
  - Improve education outcomes for disadvantaged children and young people (95%)
- Lowest ranking: Support people who misuse drugs and alcohol or who smoke (78%).
- Weighting to account for strength of feeling shows a similar pattern - just some variation amongst mid-ranking ones.



Note: The base from which percentages are calculated is participants who answered the question. Weighted average was calculated by applying weighting to each level of preference as follows: very important – 3; fairly important – 2; slightly important – 1; not important – 0; no opinion – 0.

4.4 Top three priorities (Q13)

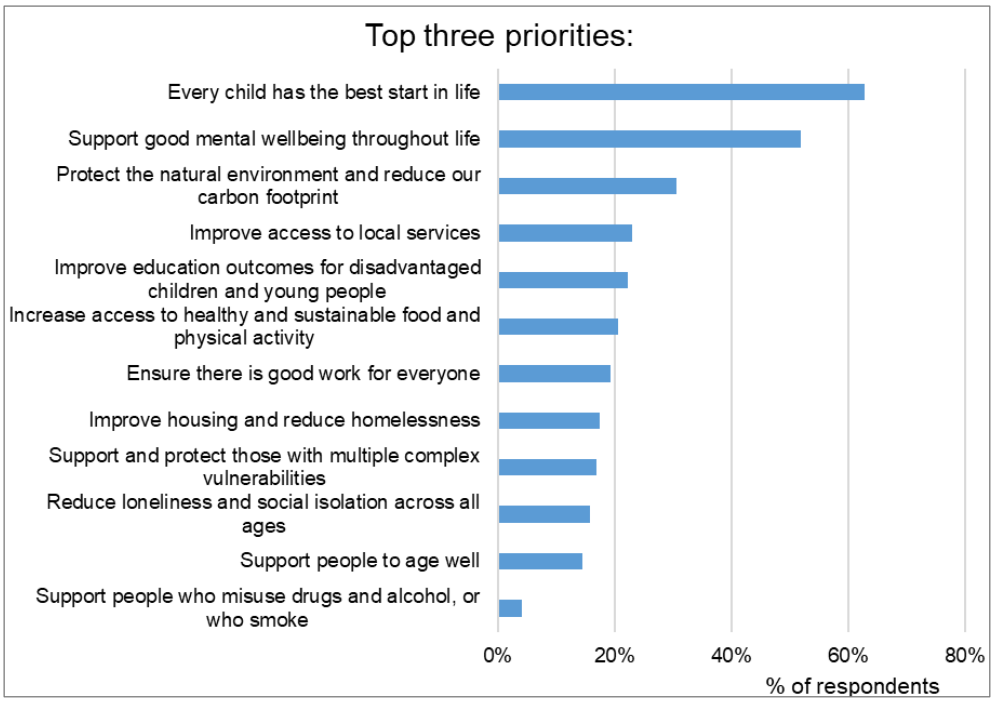
Participants were then asked if they had to choose their three top priorities, what these would be.

- Clear support for two of the same priorities as when asked about importance:
    - Every child has the best start in life (63%)
    - Support for good mental wellbeing throughout life (52%)
- Third was Protect the natural environment and reduce our carbon footprint (31%).
- Improve educational outcomes for disadvantaged young people chosen less often (fifth = 21%).
- Support people who misuse drugs and alcohol, or who smoke was least supported (4%).

There was broad consensus that most priorities were 'very important' but when forced to choose three, support stiffened around some e.g. protect the natural environment… and dissipated for others e.g. support people to age well.

Some evidence of a split universalists vs. targeted approach, e.g.:

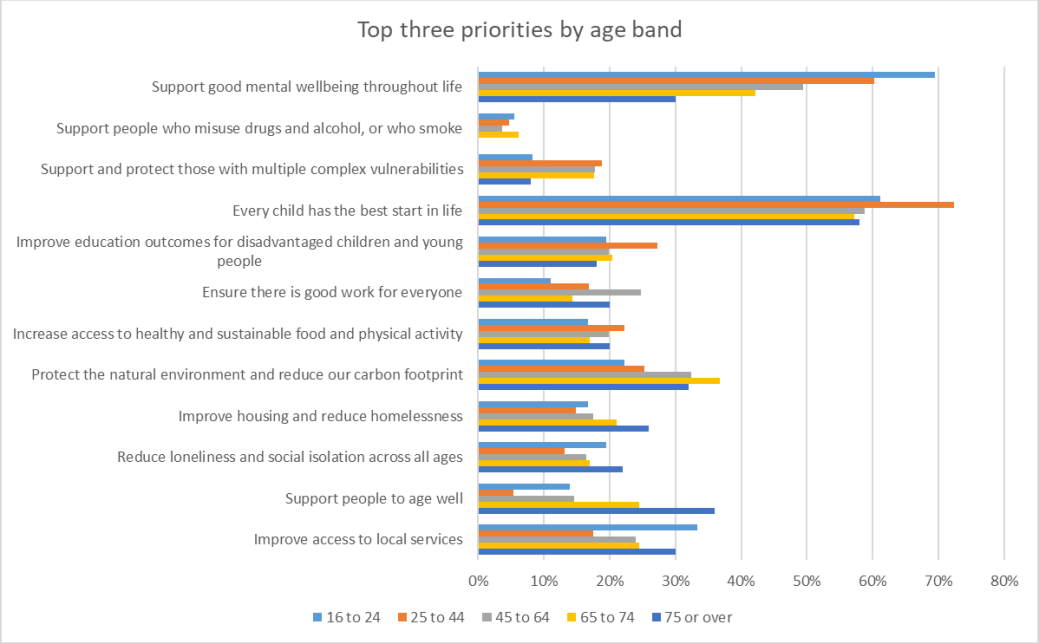
- Two-thirds of those who chose …educational outcomes for disadvantaged young people also chose …every child has the best start in life, but not the other way round.
- Minority who did choose support people who misuse drugs and alcohol in their top three were more likely to choose other targeted interventions, e.g. improve housing and reduce homelessness and …multiple complex vulnerabilities.



4.5 Variation in priorities: age (based on responses to Q1-12 and Q13)

There were some notable variations to responses based on the age profile of respondents:

- Support for ensure every child has the best start in life was a clear priority for all age groups; only beaten by support good mental wellbeing throughout life for 16-24s.
- Proportions favouring support good mental wellbeing throughout life fell with age, but it was still second highest priority for all except those aged 75+.
- For this group, support people to age well was a higher priority. The importance of this rose with age.
- Support for protect the natural environment and reduce our carbon footprint was highest amongst over 45s (3rd highest priority).
- For 16-24s improve access to local services was more important, whilst improve education outcomes for disadvantaged children and young people was favoured by 25-44s.
- Improve access to local services was also relatively important to over 75s.
- The oldest and youngest age groups were most likely to favour reduce loneliness and social isolation across all ages.
- 16-24s were least likely to prioritise the natural environment, good work and education outcomes options.
- Support people who misuse drugs and alcohol, or who smoke was the least favoured across all ages.



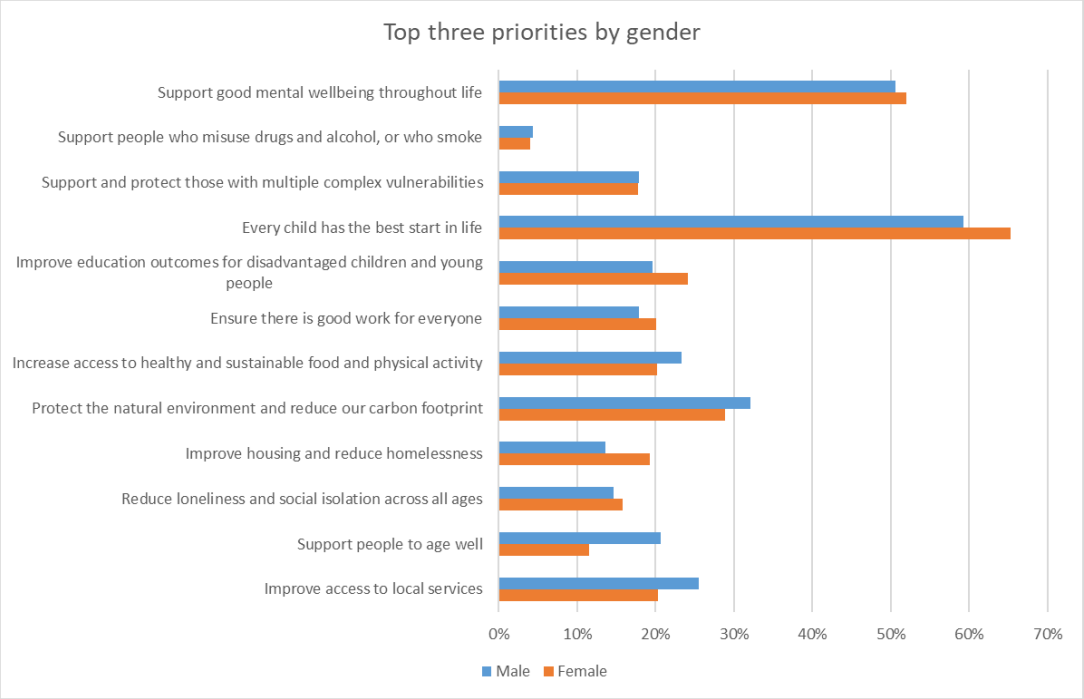
4.6 Variation in priorities: gender (based on responses to Q1-12 and Q13)

When looking at responses by gender, females were markedly more likely than males to rate any priority as “very important”. The largest gap was for ‘reduce loneliness and social isolation across all ages’ (21 percentage points). The smallest gap was for ‘protect the natural environment and reduce our carbon footprint’ (4 percentage points).

The top priorities for both males and females were the same which included ‘best start in life’, ‘support good mental health wellbeing’, followed some by ‘protect the natural environment’

There were marked differences amongst other ‘top three’ choices:

- Females more likely to select every child has the best start in life, improve housing and reduce homelessness and improve education outcomes for disadvantaged children and young people.
- Males more likely to select support people to age well and improve access to local services.



4.7 Variation in priorities: disability (based on responses to Q1-13)

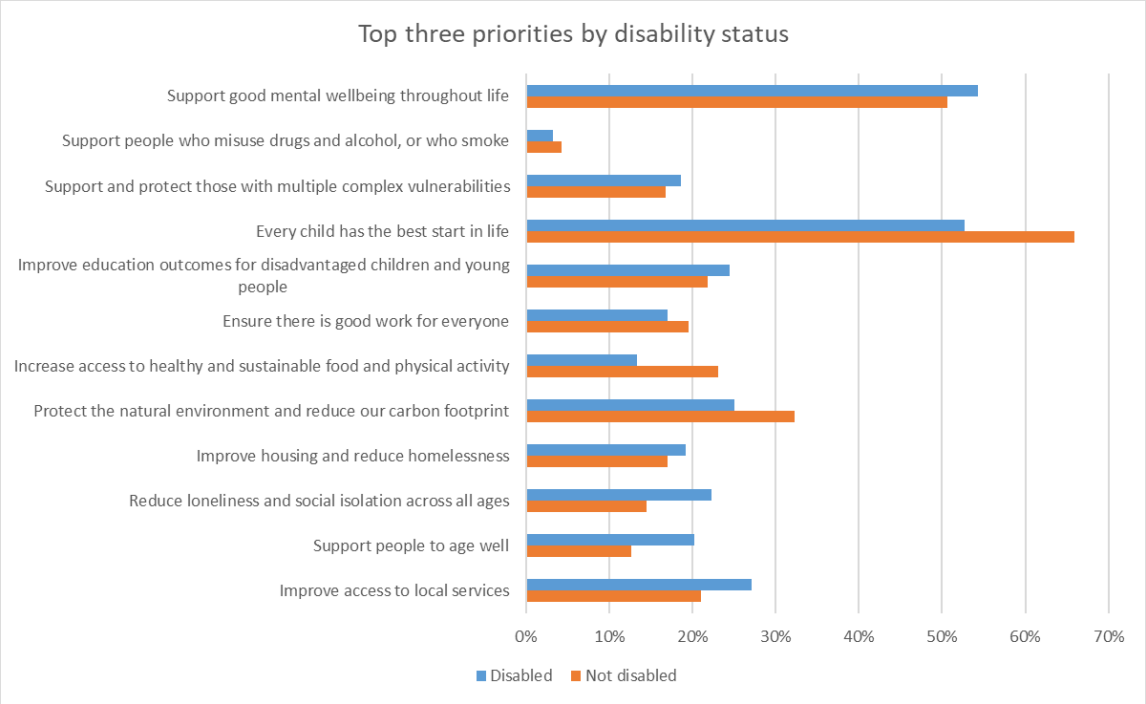
Top two priorities were the same regardless of disability status, although participants who said they were disabled:

- Slightly favoured support good mental wellbeing throughout life (54% in top three) over every child has the best start in life (53%).
- Were less likely to say that the priorities related to children were ‘very important’:
    - Every child has the best start: 82% vs 91% non-disabled.
    - Improve education outcomes for disadvantaged children and young people: 68% vs 76% of non-disabled.

There was less of a clear themes from disabled participants about other priorities:

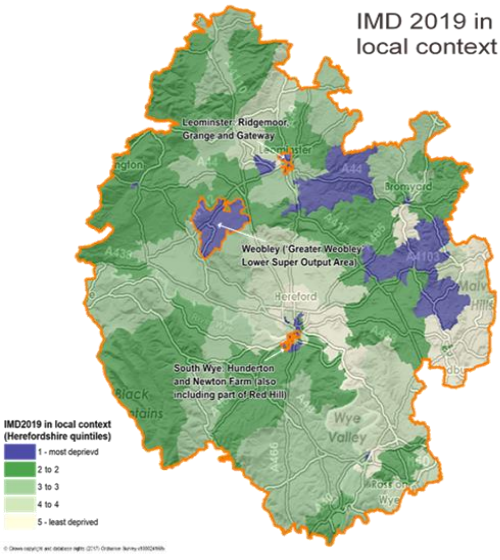
- Similar proportions (20 to 30%) prioritising improve access to local services, improve education outcomes for disadvantaged CYP, reduce loneliness, support people to age well. All more likely to be priorities than amongst non-disabled.
- Also protect the natural environment… – although less likely to be a priority than amongst non-disabled.

Disabled participants were notably more likely to consider improve housing… as 'very important': 67% vs 56% of non-disabled.



4.8 Variation in priorities: area of deprivation (based on responses to Q13)

Differences according to deprivation quintile were generally less marked than other characteristics, however:



- Participants from the most deprived areas (quintile 1) were least likely to select protect the natural environment and reduce our carbon footprint as a top-three priority. They were also the most likely to select support people who misuse drugs and alcohol, or who smoke.
- Participants from the least deprived areas (quintile 5) were the least likely to select improve housing and reduce homelessness. They were also the most likely to select support mental wellbeing…, ensure there is good work for everyone, increase access to healthy and sustainable food and physical activity, reduce loneliness and social isolation and support people to age well.

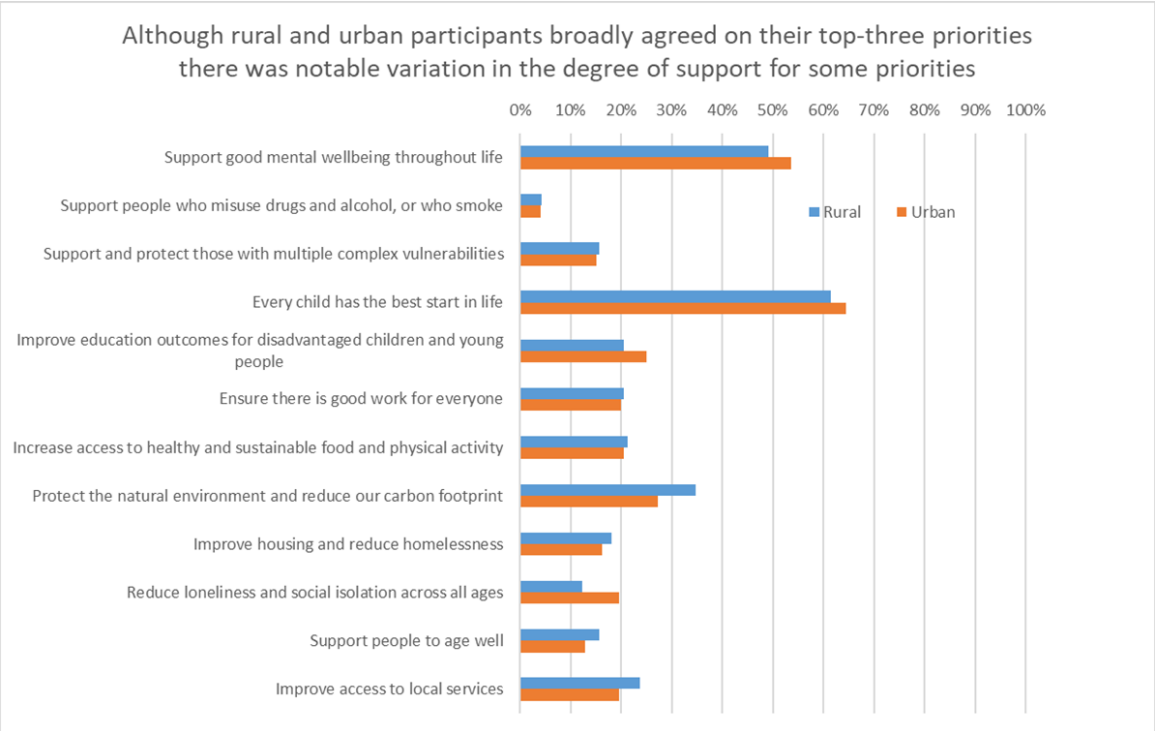
Every child has the best start in life and support good mental wellbeing throughout life were the most favoured top-three priorities across all quintiles. Whereas for questions 2-5 protect the natural environment and reduce our carbon footprint was 3rd most favoured, for q1 it was improve education outcomes for disadvantaged children and young people.

4.9 Variation in priorities: urban vs rural classification (Q13)

Both rural and urban participants agreed on the three most favoured top three priorities i.e. every child has the best start in life, support good mental wellbeing throughout life and protect the natural environment and reduce our carbon footprint. For both support people who misuse drugs and alcohol, or who smoke was lowest.

However, beneath these headlines there were notable variations in the degree of support for some priorities:

1. Reduce loneliness and social isolation across all ages (12% rural, 20% urban; a 7 percentage point difference)
2. Protect the natural environment and reduce our carbon footprint (35% rural, 27% urban; a 7pp difference)
3. Support good mental wellbeing throughout life (49% rural, 54% urban; 5pp difference).



4.10 Distribution of priorities (Q13)

Based on patterns in preference selection (i.e. if someone selects a certain priority how likely are they to select another), there were some important associations between priorities. Indicating that participants can broadly be divided into 'universalists' and those who favour more targeted support for the most vulnerable.

 Universalists	 Targeted
• Support good mental wellbeing through life and every child has the best start in life had widespread support regardless of other priorities selected and were most often selected together. • People who prioritised …mental wellbeing… and …best start in life were more likely to select protect the natural environment and reduce our carbon footprint. • People who prioritised …environment… were the most likely to select increase access to healthy and sustainable food and physical activity and *visa versa*. • Those selecting reduce loneliness and social isolation across all ages were most likely to select support people to age well and *visa versa*. Those who prioritised both of these were also more likely to choose improve access to local services. • Interestingly, those selecting improve education outcomes for disadvantaged children and young people were among the *least* likely to choose ensure there is good work for everyone.	• While every child has the best start in life was the most favoured option for those who selected improve education outcomes for disadvantaged children and young people, the reverse was not the case (only the third most favoured for that group). • Association between support people who misuse drugs and alcohol, or who smoke and support and protect those with multiple complex vulnerabilities – people who selected one more likely to select the other. • Association between support and protect those with multiple complex vulnerabilities and improve education outcomes for disadvantaged children and young people.

4.11 Why have you chosen your top three priorities? (Q13a)

Overall themes emerging from just the priorities that stood out as having most support.

Every child has the best start in life

- A good start in life underpins future life chances and health and wellbeing outcomes. Children are the future. Investing in children early has multiple benefits.
- Support for parents and activities / facilities for children and families are lacking or inadequate.

Support for good mental wellbeing throughout life

- Mental wellbeing is really important - poor mental health affects life chances, employment, education, leads to worse physical health and is linked to loneliness and poor lifestyle choices eg. substance misuse
- Mental health services in the county are inadequate, under-resourced, or not prioritised. Those with personal experience of mental ill-health were generally critical of mental health services.

Protect the natural environment and reduce our carbon footprint

- Recognition that nothing else will matter / there is no future if we fail to protect the environment and tackle climate change.
- Frustration with a perceived lack of sufficient environmental protections, or climate action, at a local level.
- The natural environment is essential to people's mental and physical wellbeing

Improve educational outcomes for disadvantaged children and young people (less support as a 'top 3' priority, but high importance)

- Young people are the future. Intervening early / improving educational opportunities will have benefits throughout life course
- Important / right thing to do. Need to protect vulnerable/tackle inequality
- Current support/services inadequate
- Matters to me personally or professionally

4.12 Comments on why respondents chose the most favoured priorities (Q13a)

4.13 Other health and wellbeing priorities not covered in the proposals (Q14)

Most common themes emerging from the 506 comments provided in response to this question:

- Need for improvement to, and criticisms of, various health or social care services.
- More / better / easier access to community wellbeing, leisure and active travel resources and activities.
- Invest in prevention and encouraging healthy lifestyles.
- More support needed for schools, children and families.
- Tackle inequalities including geographical inequality and digital exclusion.
- Need for improvements to public transport services, road infrastructure, cycle paths and tackle congestion.
- Provide more support to mitigate the cost-of-living crisis, support the economy and jobs.
- Tackle environmental problems, including promoting sustainability and tackling air and water pollution, littering and fly-tipping.
- More help for older people.
- More support for women, including during maternity and menopause and doing more to stop domestic abuse.

4.14 Comments illustrating common themes regarding other priorities (Q14)

Dentistry in Hereford is non-existent without private paying. We pay NI contributions, this should be a right for all that require it. I have worked all my life 52 years, paid all taxes & contributions yet get no NHS Dentist. Appalling in the century. We are going backwards. No dental health results in bad mouths, stomachs, intestinal diseases. This needs urgent attention.

Support and access to the community for people with disabilities. More activities and positive engagement with young people and young adults.

School teachers need more training in Children's mental health and it should be a priority over any test results! Children shouldn't be under so much pressure.

With an ever increasing elderly and frail population, more needs to be done to support the elderly and frail to keep them at home and out of hospital. This involved better health and social care but also tackling loneliness and isolation. The council must do more to harness the expertise, resources and experience of the voluntary sector in Herefordshire.

Obesity is a huge issue and can be the cause of multiple health and wellbeing issues. Confidence to walk in safe traffic free environments would be a catalyst to healthier lifestyles

The state of the roads, and pavements so far in the last few weeks 2 people that I know have had very nasty falls which could have been a lot worse on our local road/ pavement due to the condition of the road/ pavement and lack of lighting. We are awaiting our first death due to a lack of good roads, lighting and signage to reduce speed and visibility.

4.15 Is there anything else you would like to add? (Q15)

By far the most common themes emerging from the 371 comments provided in response to this question can be summarised as:

- Complaints about, or suggestions for improvements to, services.
- Disillusionment with the Council / NHS / government and/or cynicism about the process, and scepticism as to whether the priorities are achievable and what, if anything, will actually be done, or improve.
- Complaints about, or suggestions for improvements to, public transport, roads, infrastructure.

5.0 Summary of Findings from the face-to-face sessions

The workshops encompassed 4 activities:

Activity A – People were asked to look at each priority and identify how important each of them were to them.

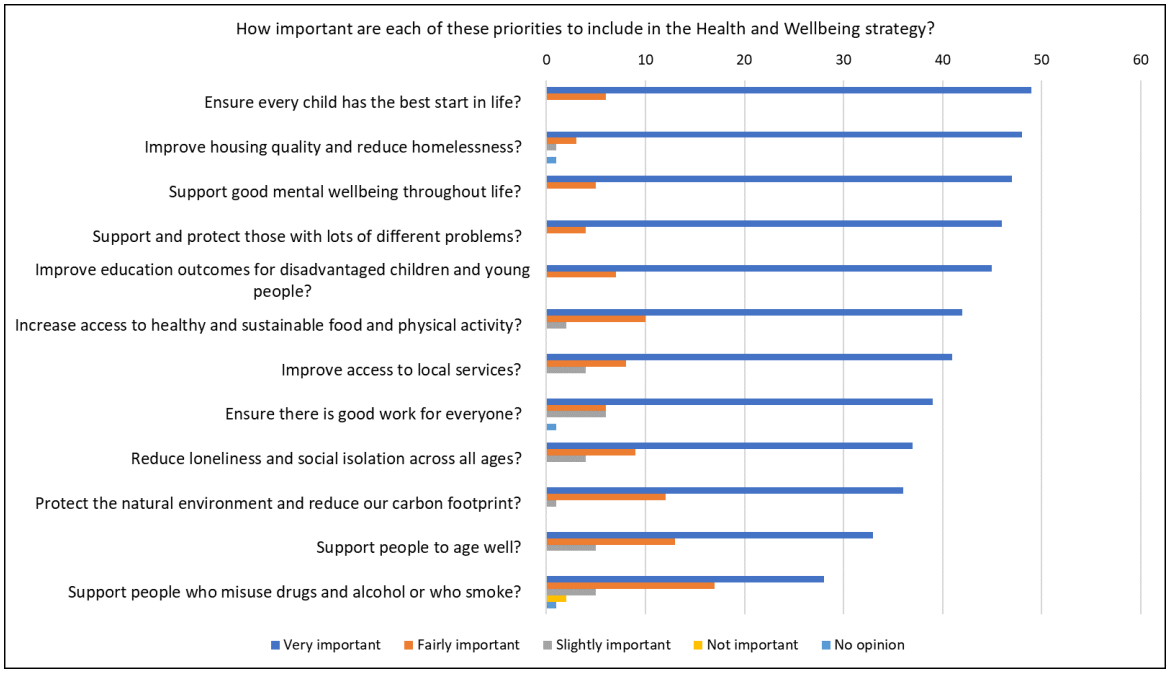
Activity B – People were asked to vote for their top 3 priorities and were asked why they had chosen them and why they were important to them.

Activity C – People were asked what they felt was missing from the priorities and why these issues should be included.

Activity D – People were asked what key message they would take back to the people writing the strategy and organising services.

Adaptations to the workshop format were made based on the time available, the size and nature of the group. In addition, given the short timescales attached to the consultation where it was not possible to bring groups together face-to-face workshops were delivered online, or Peer Research methodology was used, where an individual from that community is recruited to complete the research with peers.

The graph below shows a summary of how important each of the priorities were across all of the seldom heard groups consulted.



The graph shows that for seldom heard the groups the priorities seen to be of greatest importance were:

1. Ensure every child has the best start in life
2. Improve housing quality and reduce homelessness
3. Support good mental health throughout life

Support people who misuse drugs and alcohol received the least overall support and the most variation. Comments suggest that this is primarily because there was a view that people needed to take responsibility for their own actions (particularly in relation to smoking). It was felt that support is available if people choose to make use of it.

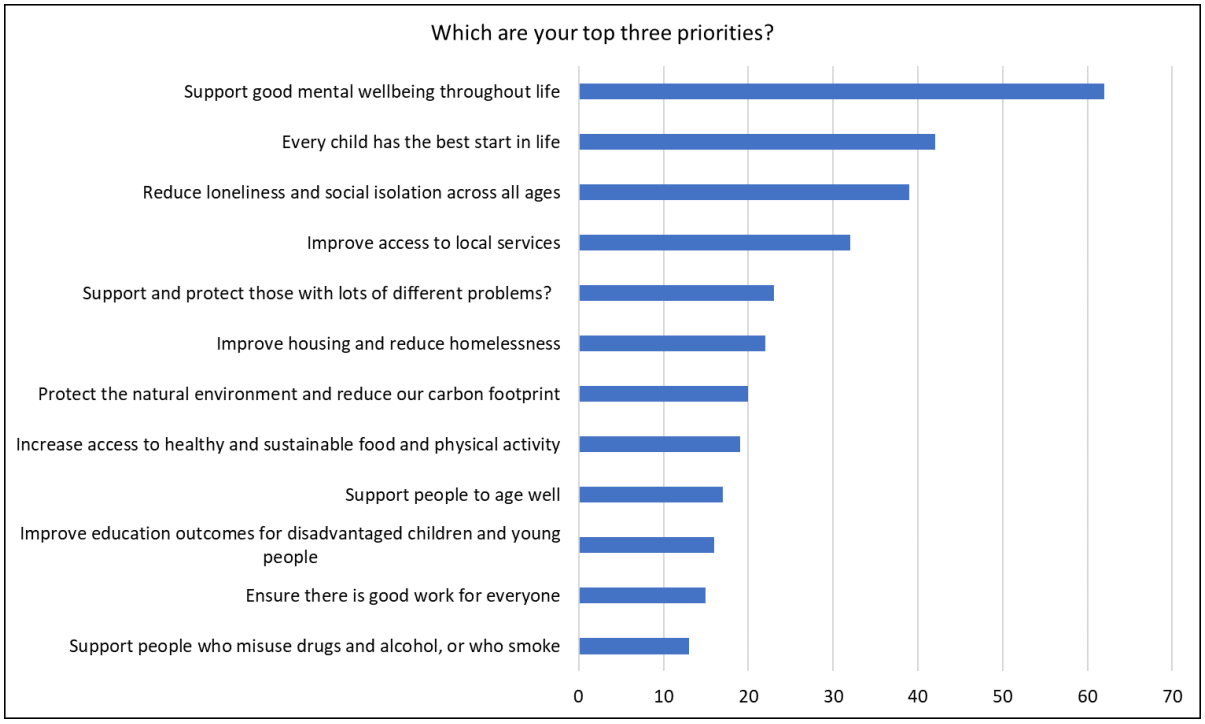
Supporting people to age well was also one of the lowest supported overall, in terms of it being very important. Again, comments from participants suggest there is an element of people needing to look after themselves, and also a view of 'that's just life'.

There were a few of the priorities that participants felt were important in general but the need for it to be in the Health and Wellbeing Strategy was less clear. This was mentioned in relation to the following priorities:

- Protecting the natural environment and reducing our carbon footprint
- Ensure there is good work for everyone
- Improve educational outcomes for disadvantaged children

These views were generally reflected in the following graph where participants had to narrow down their choices and pick their top three priorities that they felt should be a focus.

The graph below shows what the top 3 priorities were across all of the seldom heard groups consulted.



This identifies that across all seldom heard the groups the most significant priorities are:

1. Support good mental health and wellbeing throughout health
2. Every child has the best start in life
3. Reduce loneliness and social isolation

Improve access to local services was highlighted as the next most commonly chosen priority. This one sits slightly below the top three but slightly higher than the rest of the suggested priorities, suggesting that there could be an argument for including this as a top priority.

As discussed above, those priorities that were chosen less frequently likely reflects the view that either:

- it should not be tackled as part of the Health and Wellbeing strategy
- there needs to be more emphasis on people taking responsibility for themselves
- some of these priorities would be outcomes of achieving other priorities e.g. improved educational outcomes for disadvantaged children and young people would likely be achieved if the priority ensure every child had the best start in life was achieved.

5.1 Other suggested priorities

All consultees were given the opportunity to highlight any specific issues or services that they felt were not currently reflected in the priorities. These were:

- Access to GPs, Dentists and other health care
- Access to information
- Transport
- Community Safety
- Supporting people through the cost-of-living crisis
- Childcare
- A stronger focus on preventative services

These areas are discussed in more detail below.

5.11 Access to GPs and Dentists and other health care services

A**ccess to GPs** came up at nearly every session with the difficulty in getting through to speak or see a GP adding to the stress people were feeling. Additional issues raised were long call waiting times and also where appointments were offered and whether these could be accessed by public transport.

Access to dentists was also raised as an issue in that people found it very difficult to get an NHS dentist and get appointments for routine check-ups and for treatment when problems occurred. This had resulted in many people having to access emergency dentistry services.

There were concerns about how difficult it was to access local **sexual health services**. This was specifically raised by young people and the women's equality group.

Health care professionals for specific service users such as care leavers, veterans, was also suggested as good way to support people accessing health care. For example, a nurse or metal health professional specifically trained or experienced in being in the care system or dealing with combat stress. The aim being to have someone who would be more likely to understand the barriers to accessing health care, and able to quickly and empathetically direct the service user to the most appropriate health service. Note: There is a veteran specific mental health nurse service which is reported to be highly valued.

Concerns were raised around **specific mental health services** such as CAMHs (Child and Adolescent Mental Health Services) and specific mental health services for people

experiencing Combat Stress and PTSD. The concerns were around lack of availability in general, long waiting lists, and specifically gaps in services at certain points or stages in their lives/recovery. For example, the CAMHs service stops at 17 years and 6 months but the adult mental health service does not start until aged 18 years. Specific mental health support for medication reviews, and support for mental health related to alcohol and substance misuse were raised as examples of when it is difficult to access mental health support.

5.12 Access to information

Access to information came up during many of the sessions, and was perceived to create a real barrier in people being able to help themselves. Not knowing what is available, where to get help, or even where to start looking were all raised as issues. Specific examples were:

Veterans highlighted a lack of knowledge about activities available at weekends to prevent the feelings of loneliness.

Available services such as the Street Pastor scheme which would reassure young people that there was support available when out in Hereford City in the evenings.

5.13 Transport

Transport was commonly raised as a key barrier to accessing services. Limited access to public transport, or community transport, particularly for those living in rural areas, as well as the cost of public transport were specifically raised. Public transport was mentioned as a barrier to education, reducing loneliness and social isolation, accessing GPs and other health services.

Traffic congestion was also mentioned, specifically in relation to Hereford City, in terms of the impact of air pollution and the negative effect this has on health and the environment.

5.14 Community Safety

Community safety issues were raised in several of the sessions but specifically by older people, younger people and for the Gypsy and Romany Traveller community.

The issues younger people raised were specifically about not feeling safe on the streets during the day and night. They spoke about street harassment, such as cat calling and verbal abuse. There was also concern about safety late at night, particularly referring to the recent sexual assaults that had happened in Hereford City, which had left lasting concerns with the young people. Young people were unaware of certain schemes that run alongside the night-time economy with the specific purpose of keeping people safe from harm, e.g. street pastors run by Vennture.

Similarly, older people also felt Community Safety was as a problem. Particularly feeling unsafe when outside particularly at night, and the lack of a police presence was also mentioned.

Hate crime, including racism and attacks on the GRT and LGBTQ+ communities, was mentioned as a concern for a number of groups, with examples including physical and verbal abuse within public services such as schools and in the wider community.

5.15 Supporting people through cost-of-living crisis

The cost of living was raised across many of the groups, many feeling that the situation was frightening and a cause of stress and anxiety. Many consultees said they were not sure how they were going to meet the ongoing financial challenges being faced and felt they needed practical help and support in this area.

5.16 Childcare

Access to affordable, good quality childcare was seen as a barrier to certain aspects of health and wellbeing, such as access to work and as a break for parents/carers for mental health reasons. It was also recognised as a good opportunity for the children attending in terms of meeting their social and development needs.

5.17 A stronger focus on preventative services

There was strong support for the Board to consider taking a much stronger focus on the preventative agenda.

5.18 Other issues and common themes

Other issues and common themes that were raised across the groups were:

- People feeling unsupported and left to cope alone at times of crisis
- The need for better communication between health professionals
- Concerns about health services
- The need for equality and inclusivity

5.19 People feeling unsupported and left to cope alone at times of crisis

The fact that people often feel unsupported at points in their life when support is most needed was highlighted in many of the group discussions. For many people this was as a result of themselves or someone they care for going through a period of poor health. Examples that were given included a lack of support for people caring for those that are at end of life. This appeared to be particularly a problem when a late diagnosis was received as this limited the time available to access any relevant support. However one participant reported caring for his terminally ill brother for 5 years, he said that it was only in his final 2 years that he had been able to find out about support and then access it. They had both found the support (which was available through a charity) beneficial but it would have also been beneficial to them in the previous 3 years and would have meant that they had struggled less.

This lack of support also applied to other scenarios, for example for those who have a neuro-diversity accessing support to obtain a diagnosis can be very difficult and it is very much up to the individual to try to access this. Similarly support for those recovering from trauma is perceived to be scarce.

The impact of people feeling unsupported also leads to other negative feelings. The older people that were consulted perceived that support is not available and therefore said that this made them feel scared and anxious.

5.20 The need for better communication between health professionals

Participants often expressed frustration at the apparent lack of sharing of information and medical history between health professionals. This was particularly frustrating for those with multiple and complex problems.

5.21 Concerns about health services

Some of the concerns related to accessing GP Services (see above) but there were also concerns expressed about the quality of healthcare services. Older people also mentioned concerns about emergency services. They felt that if they needed to call an ambulance there was a likelihood that they would be left waiting for many hours before it arrived. This was a real concern and many reported feeling unsafe and insecure as a result.

5.22 The need for equality and inclusivity

The need for equality and diversity was raised across the groups. It was suggested that this should be an underpinning theme for the strategy. Some participants reported feeling discriminated against within society but also by people working within healthcare services.

Acknowledging and addressing the inequalities that are present across groups of people and the services they access was seen as key to removing the barriers that prevent people from having equal access to services. Being able to access services with the right support in place was seen as fundamental in order to reduce the inequalities experienced by some.

6.0 Summary findings from each group

Below are some of the key issues that each group particularly highlighted, these range from the most serious issues affecting individuals, issues of concern for the population and also what approaches need to be taken or changes made to have the most significant positive impact on their lives.

- Carers – support and understanding for both themselves and who they are caring for, access to suitable housing and pavements being suitable for mobility scooters.
- Care experienced young people – specific support with understanding of their needs and what they have been through, with the knowledge of where to access the right support
- Eastern European church attendees - traffic congestion really affects this group (people interviewed live in South Wye), other issues that particularly affect them were support for children with additional needs and their families and a need for more social care/prevention services.
- GRT – mental health and suicide rates were high priorities that affect this group. Experience of racism is also an issue for the group.
- LGBTQ+ - equality and inclusion and more understanding, particularly around a persons right not to specify gender.
- Older people – concerns were expressed around access to GPs and availability of care in the community.
- People living in social housing – access to GPs, transport and cost of living were the biggest concerns raised by this group.
- People with disabilities – equality, inclusion and support services to make this happen

- People with learning disabilities – recognised the value of face to face social and support sessions, supported by charities.
- Refugees – work, language, housing and childcare were critical issues affecting this group, as well as equality and access to health services, without feeling like they were discriminated against.
- Veterans – access to specialised mental health services, and support to access all other services.
- Women's – children as a priority in general, equality and support services for domestic abuse were the highest priorities for this group.
- Young people – raised concerns about community safety, access to sexual health services, availability and suitability of mental health services.
- Community Partnership – improve access to primary health services, be more inclusive and equitable, taking a holistic approach to mental health, focus on helping people to help themselves as well as providing support for those who cant. Better working together and communication are key to services more effective.

7.0 Detailed notes from each of the group discussions

The detailed findings from the discussions with each group can be found below.

7.1 Carers

Name/Profile of Group
Herefordshire Carers A mixed gender and mixed age group of carers - predominantly female. Approximately 25 in attendance – the consultation was part of a wreath making workshop organised by Herefordshire Carers.
Top priorities of group and rating of each priority
Priorities identified in order of popularity were: • Every child has the best start in life (4 votes) • Reduce loneliness and social isolation across all ages (4 votes) • Improve housing and reduce homelessness (3 votes) • Support and protect those with lots of different problems (1 vote) • Protect the natural environment and reduce our carbon footprint (1 vote) • Support people to age well (1 vote)
Reasons for selecting priorities
People reported feeling lonely and isolated as carers and also feeling unsupported. The role of Herefordshire Carers in giving people the opportunity to socialise was seen as invaluable. Some people reported feeling abandoned and left to cope alone. This has a considerable impact on health and wellbeing.

Despite the fact that many carers were caring for older people the importance of **ensuring that 'every child has the best start in life' was seen as fundamental**. This was seen as ensuring the foundations were in place and that children felt supported and able to reach their potential. The comments in relation to the need to improve housing related to the need to ensure that properties are sufficiently adapted for people living with a disability or illness.
Missing Priorities
A specific focus on dementia – it was felt that dementia can get lost in a general heading of 'mental health' and a specific focus is needed to support people with dementia and also their carers. It was suggested that Herefordshire should become a dementia friendly city. **Improve pavements for people in wheelchairs** – the state of the pavements prevents people from being able to go out. **Improved communication between agencies** – people reported the need to repeat medical history to different professionals due to the apparent lack of ability to share medical notes. This was particularly difficult for those with multiple and complex needs and also in terms of crisis. **More support for people with a neuro – diversity –** it was felt that there was insufficient support available for those with a neuro-diversity. In particular people struggled to receive support prior to diagnosis and also to actually obtain a diagnosis. It was felt that this impacted on people of all ages. **Specific support is needed for those at the end of life –** one person reported feeling completely unsupported when caring for their partner at end of life.
Key issues highlighted by the group
The most significant comments related to a lack of support available. For carers this was particularly concerning if they, themselves become ill i.e. who would replace their role as carer?
Any other relevant comments
• Carers often feel vulnerable due to a lack of support and the fact that they are carrying the responsibility of caring for someone else. • Sometimes carers are caring for more than one person in their family and may also be experiencing health issues themselves.

7.2 Care experienced young people and care leavers

Name/Profile of Group
Consultation with care experience young people and care leavers.

Due to absences due to sickness and time constraints, evidence from previous ad-hoc consultations and information collated as a result of groups with Care Leavers which occurred this year, has been used.

The groups were brought together to discuss the Care Leavers Offer and/ or consultation for the Corporate Parenting Strategy and/ or Pathway Planning for Care Experienced Children and Young People and Care Leavers.

Top priorities of group and rating of each priority

The general consensus around priorities are:

- loneliness
- mental health services
- best start in life in order to give support to prevent children and young people coming into care
- but access to internet and transport to access the priorities are hugely impactful.

Reasons for selecting priorities

Missing Priorities

Key issues highlighted by the group

Quotes from engagements

- We need help at all times, parenting is just not 9 to 5 Monday to Friday – this impacts on us doing well in life. I am lonely and I know a lot of us are
- I can't get to appointments in Hereford – or if I can I can't get home – buses are crap and there isn't a train in B
- I want to be live near my family, friends and near my school – we don't have enough housing options
- I have been promised counselling but I have been waiting for ages
- I like my foster mum, she loves me like her own children, she does not treat me differently – they have given me what my birth family couldn't
- We don't like too many changes of social workers – this impacts on us doing well in life
- It would be nice to have a nurse for care leavers – I find it hard to go to the doctors,
- We need to be kept in the loop about our entitlements – this doesn't happen
- We need Memory boxes – life story work for all children – if we know our story our mental health can be supported properly

• We want apprenticeships programs coz sometimes normal education is hard for us”
Any other relevant comments

7.3 Eastern European attendees at Our Lady’s Church

Name/Profile of Group
A mix of Eastern European and British people attending Mass at Our Lady’s Queen of Martyrs Church, Hereford City. A mixed gender group of people, older people and younger families 14 people spoken with
Top priorities of group and rating of each priority
Each individual voted for their top three priorities those with the most votes as being in the top 3 were: • Every child has the best start in life • Protect the natural environment and reduce our carbon footprint
Reasons for selecting priorities
Congestion and traffic pollution was an issue raised by a number of people, which is unsurprising as the church is based on the Belmont Road which often experiences traffic congestion.
Missing Priorities
Services for families of children with additional needs were identified, right the way through from early diagnosis and support, the education they receive and the support that is provided when children/young people are not able to receive mainstream education and end up in Pupil Referral Units.

Social care, community care and prevention resources were all highlighted as missing and would no doubt have a positive impact on many of these priorities.
Key issues highlighted by the group
Any other relevant comments
Better communication between agencies was highlighted as a need.

7.4 Gypsy and Romany Traveller Community

Name/Profile of Group
20 people from the GRT community were interviewed via a peer researcher from within the community. Interviewees were mixed gender ranging in age from 23-75.
Top priorities of group and rating of each priority
Each individual voted for their top three priorities. There were four clear priorities that all participants supported: • Supporting good mental wellbeing throughout life • Ensuring every child has the best start in life • Improving education outcomes for disadvantaged children and young people • Increasing access to healthy and sustainable food and physical activity None of the other priorities considered a priority by this group.
Reasons for selecting priorities
Supporting good mental wellbeing throughout life – Good mental health is at the core of everything and it means people can get / stay in work. People are still ashamed to say they have mental health problems whilst other people think it is the 'norm' now so they don't address it. Mental health has got worse since COVID.

Ensuring every child has the best start in life – the role of parents / support for parents needs to be considered in this priority. Children's lives are complex – how can we ensure children are allowed to be children. **Improving education outcomes for disadvantaged children and young people** – this was about ensuring that children / young people are not disadvantaged and labelled as a failure early in their lives as this sets the tone for adulthood. This was about equality of opportunity. **Increasing access to healthy and sustainable food and physical activity –** main focus was on access to healthy food. People felt they needed help to know how to cook healthily and on a budget rather than going to the chip shop.
Missing Priorities
Racism
Key issues highlighted by the group
Group saw a strong link between many of the priorities job = house = fitness= mental health improves The priority 'Support and protect those with lots of different problems' is difficult to prioritise because it covers so many of the other areas.
Any other relevant comments *Mental health isn't normal yet this day and age its made to be normal. In the GRT community the death rate from suicide are at an all time high more then any other ethnic minority.*

7.5 LGBTQ+

Name/Profile of Group
Members of the International LGBTQ+ group. Attended by 2 female members (12 were expected).
Top priorities of group and rating of each priority
Due to the nature of the group individuals chose not to do the rating of each priority but instead collectively reached consensus that the top 3 priorities for the group were: • Every child has the best start in life • Support good mental wellbeing throughout life

• Improve housing and reduce homelessness
Reasons for selecting priorities
It was recognised that all priorities are important but the three selected are those considered fundamental. It was noted that people from the LGBTQ+ community may have poor mental health as a result of experiencing prejudice etc, this was therefore seen as particularly important. As parents those present prioritised the needs of children above all else. Those present were also aware of poor living conditions of family members and felt that social housing stock should be improved.
Missing Priorities
Although there weren't any specific priorities highlighted it was felt that the approach of healthcare professionals implementing the strategy was very important. Members of the group had experienced prejudice from healthcare professionals and therefore would like them to be educated about the LGBTQ+ community to ensure that this doesn't happen in the future. In particular it was considered that there should not be a need to specify gender and that if a person does not want to be referred to as male or female this should be respected. It was also noted that there are very few public toilets in Hereford City which prevents people from staying in Town for long.
Key issues highlighted by the group
Inclusivity was the key issue highlighted - those present wanted there to be no discrimination against people regardless of gender, sexuality, race, age, disability, socio economic background etc.
Any other relevant comments
The importance of communities supporting each other and the need to educate people in terms of inclusive approaches.

7.6 Older people

Name/Profile of Group
Age UK ICT training group A mixed gender group of older people who have enrolled on an ICT training course.

9 people attended
Top priorities of group and rating of each priority
Due to the nature of the group individuals chose not to do the rating of each priority but instead collectively reached consensus that the top 3 priorities for the group were: • Improve access to local services • Reduce loneliness and social isolation across all ages • Support people to age well
Reasons for selecting priorities
The group reported that one of the main issues causing concern is **access to local GP services**. **Accessing information and advice** was also seen as a significant problem. For example one member of the group had cared for his terminally ill brother for 5 years. He said that it was not until the 12 months prior to his death that he was made aware of support that was available which would have been useful to them both in the previous years. He also said that it was due to contacting a relevant charity that he was able to access support, as opposed to receiving information through the statutory services. It was felt that there needed to be better communication between health care professionals and that information about support for carers and for those living with illness needed to be more readily available. The group also said that often older people felt lonely and if living alone may not speak to anyone for several days. The importance of social groups that offered people the opportunity to socialise was also mentioned. For example attendees reported feeling a sense of cohesion as a result of being part of the training group. Concern was also raised about older people living in their own homes without adequate support. It was felt that there is inadequate care available to older people and part of supporting people to 'age well' should be to ensure that this support is available.
Missing Priorities
Access to health services and specifically GPs was seen as a significant problem by the group. They felt that this should be included as a separate priority. **Community Safety** was also seen as a problem. The group reported sometimes feeling unsafe when outside particularly at night. The lack of a police presence was also mentioned. **Opportunities for people to socialise**, for example community projects which provide a focal point and a reason for people to come together – needs greater emphasis in the priorities as this is seen as key in supporting people to 'age well'

Key issues highlighted by the group
The most significant issue highlighted by the group was access to GP services. Attendees reported having to wait several days for a GP appointment. They felt that this has negative impact on their health but also makes them feel unsafe and unsupported and impacts negatively on their wellbeing.
Any other relevant comments
The importance of charities and volunteers in providing services was recognised. There were significant concerns relating to health and social care and people generally feeling worried about the future when they may need support services. It was also perceived that the lack of affordable homes making it difficult for people to buy their own home and pushing people into the private rental market which is often expensive. Other comments were also made about the need to clear drains and generally ensure that the environment is cared for.

7.7 People living in social housing

Name/Profile of Group
A mixed gender group of mainly older people who living in social housing owned by Connexus Housing. 9 people attended
Top priorities of group and rating of each priority
Each individual voted for their top three priorities. There was one clear priority that came out with many choosing it within their top 3: - Support good mental wellbeing throughout life
Reasons for selecting priorities
Support good mental wellbeing was thought by the majority of the group but not all, that it was a very important factor and one that impacted across all the rest of the priorities.
Missing Priorities

Access to health services and specifically GPs was seen as a significant problem by the group. They felt that this should be included as a separate priority. There was concern highlighted that risks were that people were attending to see a GP as a solution to social isolation. The LIFT programme previously run through GPs was an excellent service but now stopped. **Access to services/Transport** was also felt to be an issue with how expensive it is to use and the fact that it is less frequent and accessible as it previously was. Historically the bus service has almost come right up to the door to pick up residents of the one of the Housing Association properties but this does not happen anymore. There is also a lack of community transport. Many do not have the skills/ability to use the internet. **Cost of living** was a concern, particularly around heating homes, costs of buying healthier food which was typically more expensive, and cost of activities to promote physical activity and reduce social isolation. This also added more risk to those children living in disadvantaged households.
Key issues highlighted by the group
Any other relevant comments
The group highlighted the role having pets have in helping mental health, creating routines for people, getting them out and about, and as a companion for people. A concern was when pets are not allowed in rented properties, and the negative impact this has. There was concern around the traffic congestion in the city, particularly on the impact it has on air pollution. The bypass was suggested as a solution for this.

7.8 People with disabilities

Name/Profile of Group
Making it Real Board A mixed gender group of people with disabilities. 12 people attended, there was limited time for discussion, roughly 30 minutes and this was finished with a fire alarm ending the meeting.
Top priorities of group and rating of each priority

After explaining all the priorities, the group discussed those that they had stronger opinions on. Those discussed were:

- Support good mental wellbeing throughout life
- Every child has the best start in life – but linked with improving educational outcomes for disadvantaged children and young people
- Access to local services, particularly support services for disabilities
- Protect the natural environment and reduce our carbon footprint including sustainability
- Improve housing and reduce homelessness

Reasons for selecting priorities

The group particularly felt that **access to support services** (or not being able to) directly impacts on people with disabilities. Access for people with disabilities should be embedded across all aspects of services.

All priorities were seen as important and some very much interlinked, such as **Every child having the best start in life and improving educational outcomes for disadvantaged children**. It felt inequalities were still very much present in the systems such as schools against minority groups such as GRT. There was concern that there were not many support services out there such as children's centres/sure start centres. There was concern that families were required to fight for services for disabled children. Opportunities needed to be offered for children outside of school to provide positive safe opportunities for them, including transport and not too expensive.

There would be less risks from **Environmental flooding** if rivers were dredged.

Missing Priorities

It was acknowledged that services needed to **work together more** and that budgets should be shared across teams/organisations for better outcomes for children, but that this required leadership from above, e.g. Chief Executive down.

Key issues highlighted by the group

There was potential to link with the 7 priorities identified in the Autism Strategy for Herefordshire, however it was identified that this Health and Wellbeing strategy sat higher than that one.

Other key issues highlighted were that these were all connected.

Sharing resources was an opportunity.

Minimising inequality

Acknowledging that most expensive is not always the best Any terms used within the strategy needed to be fully explained, e.g. environment. Commissioners should be told about changes in contracts from those who sub-contract e.g. changes to staff contracts without the commissioners being told. Better contract monitoring.
Any other relevant comments

7.9 People with Learning Disabilities

Name/Profile of Group
A mixed gender group ranging from 30 – 60 all attend Echo. 6 people attended (one remotely)
Top priorities of group and rating of each priority
Each individual voted for their top three priorities. There were 4 clear priorities that came out with all participants choosing it within their top options: • Support good mental wellbeing throughout life • Every child has the best start in life • Reduce loneliness and social isolation across all ages • Supporting people to age well Increasing access to healthy and sustainable food and physical activity, good work for everyone, protecting the natural environment and reduce our carbon footprint and accessing services were not considered a priority by this group.
Reasons for selecting priorities
Missing Priorities
Key issues highlighted by the group

The accessibility of buildings / services for people in wheelchairs was raised as a concern. The value of face-to face services and group support sessions like Echo run. The group saw the value of digital participation but really valued coming together as a group. Loss of the shared life scheme.
Any other relevant comments

7.10 Afghan & Syrian Refugees

Name/Profile of Group
Two all female groups were run one of Afghan women and one of Syrian women between the ages of 20 – 40 One all male session was run with 4 participants one of whom provided translation support – attendees were between the ages of 25 - 45 All those that participated were attendees of the City of Sanctuary support group. In total 12 people attended
Top priorities of group and rating of each priority
Each individual voted for their top three priorities. There were three clear priority that came out across the groups - Ensure there is good work for everyone - Support good mental wellbeing throughout life - Improve education outcomes for disadvantaged children and young people Supporting people who misuse drugs and alcohol and smoke, increasing access to healthy and sustainable food and physical activity, reducing loneliness and social isolation across all ages. Supporting people to age well and accessing services were not considered a priority by this group.

Reasons for selecting priorities
Ensuring there is good work for everyone – This priority was selected as access to work was seen as a big barrier for this group (see below for the specific challenges they face.) The group also felt that there was a very strong connection between having work and good mental health. **Supporting good mental wellbeing throughout life** – The group felt that if you had poor mental health then life was very difficult to deal with and that this impact on all aspects of your life. **Improve education outcomes for disadvantaged children and young people** – This priority was selected as the group felt that if you educated children well that this would mean they would be more likely to have good jobs that paid well and were less likely to experience poverty. The groups saw a strong link between poverty and poor health.
Missing Priorities
Support for new mums.
Key issues highlighted by the group
Language as a barrier to accessing services specifically doctors and dentists. They need translation support for health appointments. For the womeniImproving their English language skills allows them to give wider help back, help them to understand rights and prevents abuse. All the men in the group were struggling with mental health issues and didn't know where to get help. They said they would prefer group help to share experiences with other refugees in their situation. Men were struggling to find work, previous military experience and driving. Trying to find work but their qualifications are not recognised here, nor are their driving licences. Poor mental health for women was about being isolated due to the language issue and being away from their friends and family. Issues with poor quality housing accommodation (Connexus) and having to wait a long time to get maintenance issues resolved. They need one point of contact that can advocate for them and help them to navigate their way through the system. Particular help is need with filling in forms. Language is a big barrier, more intensive ESOL courses would help them get them into work sooner. Currently only 1 day a week. Having no childcare is a barrier, a creche to support language classes would be helpful.
Any other relevant comments

7.11 Veterans

Name/Profile of Group
People attending the Veteran Support Centre in Hereford. A mostly male, but 1 female drop in workshop. Mostly of working age, but a couple were of pensioner age. 7 people attended
Top priorities of group and rating of each priority
It was a drop in workshop due to the nature of how people attended the Veteran Support Centre. Groups of people were spoken to together often overlapping with the next set of people arriving. Most manged to pick their top three priorities. There was not a clear consensus of what was a top priority. Other than marginally more votes for: - Improve access to local services
Reasons for selecting priorities
After much discussion around the **protect and support those with lots of different problems**, the veterans felt that they themselves fell into that category as they felt they often had many different challenges in life, with very little support. Many had experience themselves of friends with mental health issues, alcohol or substance misuse problems, physical difficulties as a result of being in the armed forces which had a knock on effect on their ability to find and remain in work, their families lives and their housing situation. There are also difficulty accessing some services and benefits if multiple complexities are at play such as mental health issues and alcohol/drug misuse may lead to less services being involved or unable to claim certain benefits. **Access to services** was identified as it was a particular challenge in a variety of ways, challenges identified were around: - cost of parking and transport as a barrier to accessing services. - PIP benefits were not specifically designed to recognise the challenges of coming out of the armed forces, as mental health is not always recognised. - Accessing a blue badge for parking - Not enough specialist support for veterans, difficulty in filling in forms, needed medication reviewed. - Information about what is available is not easy to find “knowing is key”

Support around **mental health** was a big one, particularly around combat stress which is very specific to veterans, PTSD and anxiety. This has a knock-on negative impact on ability to use transport and hold down jobs and relationships.
Missing Priorities
Preventative services to stop problems before they start.
Key issues highlighted by the group
There is no de-training on exiting the armed forces, therefore that adaptation into civilian life can be extremely difficult.
Any other relevant comments
The importance of charities and volunteers in providing services was recognised. Some of the services they provide such as short breaks for respite run through the Royal British Legion for veterans provided opportunities to have breaks with people who had similar experiences (respite and reducing social isolation); and specialist mental health support such as Combat Stress, the Warrior Programme, therapy that provided friends for life, befriending phone calls, buddy checks. Very much feel forgotten about coming out of the army, particularly in comparison to refugees that appear to receive many services including free hotels, compared to some veterans that end up homeless sue to complex issues not being addressed.

7.12 Women's Equality Group

Name/Profile of Group
All female group between the ages of 30 – 65 who belong to the Women's Equality Group. 6 people attended
Top priorities of group and rating of each priority
Each individual voted for their top three priorities. There was one clear priority that came out with all participants choosing it within their top 3: • Ensuring every child has the best start in life

There was less consensus amongst the other priorities. Protecting the natural environment was the next most commonly supported priority with 3 votes.

Supporting people with lots of different problems, people who misuse drugs and alcohol and smoke and improving education outcomes for disadvantaged children and young people were not considered a priority by this group.

Reasons for selecting priorities

Ensuring every child has the best start in life – It was felt that it was better to invest in education and prevention to ensure that people made better choices about their health and wellbeing and knowing how to manage their health so that they did not end up needing support or crisis interventions later in life.

Group felt it was important that this priority included families, parents / carers, teachers and wider society.

Missing Priorities

- Recognising inequalities
- Access to childcare
- Sexual health
- Support for survivors of domestic violence and abuse including the safety and security of children
- Access to dentists
- Ante-natal care
- Road traffic accidents

Key issues highlighted by the group

Service delivered by NHS for children with acute mental health issues was felt to be poor.

Focus should be on dealing with the cause of issues and ensuring people's basic needs are met – shelter, food etc…

Addiction needs to be cured before mental health issues are addressed – tackling things in the right order.

The most vulnerable people don't have access to online technology so face-to-face support is essential. Also need to consider the link between the internet and it causing mental health issues.

Please to see environment represented but links to health need to be made explicit e.g. impact of pollution on air quality.

Any other relevant comments

People were not in support of the joint county approach of the ICS – felt that Worcestershire would get the lions share and Herefordshire would be the poor relation. What can be done to alleviate issues of bed blocking – people are ready to be discharged but are not able to be looked after at home? Care workers need better pay. Communication with patience under the NHS is very poor and adds to the stress.

7.13 Young people

Name/Profile of Group
A mixed gender group of young people attending Hereford Sixth Form College. 8 young people attended
Top priorities of group and rating of each priority
Each individual voted for their top three priorities. There was one clear priority that came out with many choosing it within their top 3: • Support good mental wellbeing throughout life
Reasons for selecting priorities
Support good mental wellbeing was a very important factor and one that impacted across all the rest of the priorities.
Missing Priorities
Specific services where they felt improvements were needed include: Sexual health and contraception advice and services. Children's social services Child and adolescent mental health (CAMHs) including the transition into adult mental health services. Police patrols, CCTV and information to help keep themselves safe in light of recent Sexual assaults and street harassment (Including hate crimes). Better access to religious resources, such as Hindu Temple

More information about what services are available such as Ventures Street Pastors.
Key issues highlighted by the group
Public transport was a problem for the group as many of them used it and found it challenging.
Any other relevant comments
Cost of living was highlighted in terms of how much it costs to run a house.

7.14 Community Partnership

As part of a quarterly Community Partnership meeting, attendees were given the opportunity to take part in this consultation. The format was slightly different from the other workshops, given the time allowed and that those attending were on behalf of specific community and voluntary groups. Attendees were asked to:

A: vote for their top three priorities

B: identify what was missing from the priorities

C: agree what key messages should be given to commissioners

54 people voted for their top three priorities, with the following coming out with the most votes:

- Support good mental wellbeing throughout life
- Every child gets the best start in life
- Reduce loneliness and social isolation across all ages
- Improve access to local services


Please vote for your top 3 priorities
Mentimeter
30
Support good mental wellbeing throughout life
6
Support people who misuse drugs and alcohol, or who smoke
12
Support and protect those with lots of different problems
23
Every child has the best start in life
3
Improve education outcomes for disadvantaged CYP
5
Ensure there is good work for everyone
13
Increase access to healthy & sustainable food, & physical activity
5
Protect the natural environment & reduce our carbon footprint
11
Improve housing & reduce homelessness
22
Reduce loneliness & social isolation across all ages
10
Support people to age well
20
Improve access to local services
54

In terms of what was missing from the priorities, the standout issues were:

transport, education, digital inclusion, dementia, dental access.

The summary table below highlights the key points from the session.

Name/Profile of Group
A consultation workshop was undertaken as part of Community Partnership meeting which was attended by approximately 80 people of mixed gender and age. Attendees were professionals mainly working for social care, health and community-based voluntary organisations and community focused public sector workers.
Top priorities of group and rating of each priority
Members of the Community Partnership voted on their top 3 priorities which resulted in 4 clear areas for support: • Support good mental wellbeing throughout life • Ensure every child has the best start in life • Reduce loneliness and social isolation across all ages • Improve access to local services
Reasons for selecting priorities
Support good mental wellbeing throughout life – People saw a strong connection between Mental health and many of the other priorities specifically loneliness and isolation. Felt that services were not available and there was disparity of access to services across the county.

Access to services for children was particularly mentioned and the need for better mental health provision in schools and more preventative MH services.

Ensure every child has the best start in life - This was about providing the foundations of a happy and healthy life. Children Centres were seen as central to this as well as work to support parents.

Reduce loneliness and social isolation across all ages - People felt that this has been exacerbated by COVID. The rurality of the county (lack of public transport) was seen as another factor that made this more of a priority. This was a particular issue for those already isolated due to other factors such as language barriers e.g. refugees. It was felt there was a need to reduce the stigma about accessing support for people that are lonely.

Improve access to local services – The rurality of the county and poor public transport infrastructure are key to why this was selected as a priority.

Missing Priorities

Transport – Compounds other issues e.g. lack of access to services results in isolation

Digital inclusion - Face to face is still really important we are excluding people by pushing the digital agenda. Real need for human interaction. 50% of stroke customers lose ability to use digital devices.

Education / ETOS – those not able to access education offers, reasonable adjustments e.g. schools and transport. Specialist education outlets, access to training

Dentists - National issue, need to encourage dentists to Herefordshire, prevention is cheaper than emergency care.

Dementia

Support for families - In schools and out of schools. Whole family support needs to be normalised so parents can dip in and out throughout all stages of childhood.

More focus on carers and recognition of the role they play - Gaps in domiciliary care providers in certain geographic areas. Respite opportunities for unpaid family carers

Ethnic groups – The need for translated materials inc. personal medical records

Child obesity

Prevention - Be bold enough to direct resources to the preventative agenda.

Lack of advocacy for vulnerable people - People with specialist needs do not get access to specialists until they are very ill.

Key issues highlighted by the group

The need to improve access to primary services - Less waiting times. Fewer criteria / eligibility barriers

Transition for children to adulthood - In school – education and health particularly SEND but also careers advice, options etc…

Remember the hard to reach and be more inclusive - This should be a key principle of how you work

Take a holistic approach to mental health - Longer term mental health support is needed

Children are our legacy

Education system is not working – too many leaving with poor or no qualifications resulting in low level jobs – effects on mental health

Longer term support interventions - Prevents the revolving door

Focus on prevention more

Avoid duplication of services - Through open conversations and transparency. Need a much more integrated approach.

Stronger focus on equality and equity - Needs to underpin the strategy

Person-centred care - Focus on long-term needs of people

Improve self-reliance - Equip people with the skills and information to help themselves

Any other relevant comments

Need to work together - Collaboration is the only way these priorities can be addressed

Involve the 3rd sector - VCS can deliver more quickly and cheaply but be aware that the VCS doesn't have the capacity to fill all the gaps without further investment.

Publication campaign - If you don't know it exists you can't access it, learn how other services promote their services, Talk Community website not achieving its aims, struggle to find information – would benefit from a tool to filter relevant information. Information needs to be up to date.

Communication -Keep communicating in an accessible way. Consider language and more frequent use of Easy Read

8.0 Feedback sessions held with the public

To be completed

Appendix 1: Supporting narrative on why 12 priorities were identified

1. Reduce loneliness and social isolation across all ages

There is an established link between loneliness and poor health, both mental and physical. Research tells us that loneliness is associated with a greater risk of unhealthy behaviours and increases early death by 30%. In our 2021 Community well-being survey 1:10 adult residents said that they felt lonely, approximately 15,800 of the population. This issue has been exacerbated by Covid19, reflecting its effect nationally and affects greater numbers of young people than previously. However in our well-being survey, 88% of residents also said that they feel a strong sense of belonging where they live and are generally happy, which compares favorably with other areas of the country. We therefore have a positive base upon which to build, but we know there is room to improve how we help people to connect better with each other, whether that is through physical local networks or digital connectivity.

2. Support people to age well

Herefordshire has an ageing population, with 25% of residents aged 65 and over which equates to about 48,500 people. This number is predicted to increase 11% by 2025 and is expected to continue increasing. In keeping with the characteristics of an elderly population we have increasing rates of dementia and long term conditions. We want people to enjoy good health and independence for as long as possible and to stay healthier in old age, which includes being able to get diagnosed quicker if they have symptoms of dementia or another long-term condition.

3. Improve access to local services

Herefordshire is one of England's most rural counties. Over half of our residents live in rural areas, about 93,000 people. There are benefits to living in a rural setting, with 92% of people reporting being satisfied with where they live. However as the COVID-19 pandemic highlighted, when our geographical movement is restricted, it's important that we have good access to services, as well as effective broadband connectivity. The 'Fastershire' Broadband project is working to develop greater digital connectivity, but we also want to see expansion of our community services and local networks which provide vital support to people in a variety of ways.

4. Increase access to healthy and sustainable food and physical activity

A healthy balanced diet and remaining physically active are two of the most important ways of staying healthy. Obesity rates have continued to steadily increase and Herefordshire rates are above the national average, with more than two thirds of adults, about 105,600 people and over a quarter of reception age children classed as overweight or obese. Being overweight also has adverse consequences for our mental well-being, not just physical. However we know that if people are helped to make better and easier choices with healthy eating and are enabled to be more physically active, they can improve their all-round health and well-being.

5. Protect the natural environment and reduce our carbon footprint

The global climate crisis is also an unfolding health crisis, as we see the increasing problems of flooding and poorer air quality. It's also likely that we'll see an increase in the frequency and severity of heatwaves which will lead to a rise in the number of heat-related deaths. Herefordshire has declared a climate and ecological emergency, committing to work with partners with the aim of the county becoming carbon neutral by 2030. One of the Council's pioneering projects has been in the wetlands, to improve the polluted water in sections of the river Lugg and Wye and to reduce flood risk.

6. Improve housing and reduce homelessness

The links between poverty, inadequate or unsuitable housing and ill-health are well-established. Due to the age and nature of Herefordshire's housing stock, we have significant issues with fuel poverty and

cold homes, especially in more isolated rural areas. It's estimated that 30% of winter deaths are caused by cold living conditions and our fuel poverty rates are above the national average, affecting around 14,100 homes. There has also been an increase in homelessness, partly due to the Covid-19 pandemic and the cost of living crisis. However a specialist project set up during the pandemic helped to accommodate 239 individuals, of whom 148 were moved into long-term housing, or were waiting to be moved into long term accommodation. The project is still operational and our ambition is that it continues to build upon the work already done.

7. Every child has the best start in life

The early years of a child's life have a huge impact on their future development and physical and mental wellbeing. Children in Herefordshire generally thrive and rates of child poverty are lower than the national average. However there are some areas of significant concern. The rates of babies who die at birth or shortly after is higher than the national average, rates of childhood vaccinations are below the national average and the dental health of young children remains poor. In keeping with the national programme, we have a dedicated Children and Families Team that work with young children and their families. These services are there to help families cope with the challenges of raising children, help them have positive parenting experiences and thereby helping children to thrive The Council is currently working closely with Ofsted (a government regular and inspection agency) to implement better practices within our Children and Families services and we anticipate that this will help us improve our care for families that are most in need.

8. Improve education outcomes for disadvantaged children and young people

The quality of a child's education is one of the most important determinants of their future life chances. Generally, children in Herefordshire do well at school, but there are significant differences in achievement between disadvantaged children and their peers. The COVID-19 pandemic has widened these differences and has resulted in more children not being ready for school We want to see all children and young people have an equal chance to do well in education and develop the kind of life skills that will equip them to live a fulfilled life in society and to be able to contribute positively to it.

9. Good work for everyone

Rewarding and fulfilling work supports good physical and mental wellbeing. It fairly rewards peoples' efforts, enables them to earn a decent living wage and provides opportunity for personal development and financial security. In Herefordshire the economy is dominated by small businesses and the agriculture industry. The County has one of the lowest unemployment rates in the West Midlands, 3.4%. However, productivity per hours worked is the second lowest of all economic areas and earnings are consistently the lowest in the region and amongst the lowest in England and Wales. We know that there are barriers for certain groups of people being able to access good quality jobs that are suitable for their needs and circumstances e.g. those with poor educational attainment, those with mental health issues and those with learning difficulties. We want to improve the opportunities for these people as well as for the population in general.

10. Good mental wellbeing across the lifecourse

Good mental health and resilience are fundamental to our physical health, our relationships, our education, our training, our work and to achieving our potential. People with mental health issues can face significant disadvantages throughout their lives. Findings from the 2021 Herefordshire Community Wellbeing Survey indicate that the average wellbeing scores for adults in the county are above the England average. However, an estimated 24,800 adults in Herefordshire have a common mental health disorder. Results from the 2021 Herefordshire CYP Quality of Life Survey revealed 1 in 4 primary aged children have low to medium mental wellbeing scores, rising to nearly half in secondary aged pupils. We also know that the Covid-19 pandemic has resulted in an increase in people experiencing anxiety

and depression. We want to continue to support the expansion of projects across the County that support peoples' mental well-being.

11. Support people addicted to substance misuse

People involved in substance misuse are very likely to have significantly worse mental and physical wellbeing compared to those who don't have this lifestyle. Nationally, during the COVID-19 pandemic we saw a rise in alcohol and cannabis use and there was disruption in access to support services. Herefordshire has made good progress in reducing smoking rates across the county (X% reduction in x years). However, smoking remains the leading cause for differences in life expectancy in the county, and there are challenges within certain population groups such as pregnant women where smoking rates is higher than the national and regional average

12. Support vulnerable to lead healthy lives

There are small groups of people who are subject to multiple risk factors (alcohol and drug use, sever mental illness, homelessness, at risk of violence and abuse) that in combination are likely to have a severely adverse effect on their mental and physical wellbeing. Often these vulnerabilities stem from negative childhood experiences, hence the important work of the Children and Families Team, but the impact of trauma can be experienced at any age and can prevent people from thriving and being able to function. These people need significant levels of coordinated and sustained support in order to live their lives safely, independently and with fulfilment.

Further information on the population of Herefordshire can be accessed via our Understanding Herefordshire webpages

Appendix 2: Online survey questionnaire

Herefordshire Council

Herefordshire Health and Wellbeing Strategy consultation

Herefordshire Council is working with health services, the voluntary sector and other partner organisations, to develop a strategy to improve health and wellbeing in the county over the next 10 years.

Whether you live, work, or receive care in the county, or if you represent an interested group or organisation in the county, we want your voice to be at the heart of the new health and wellbeing strategy. We would like to know your thoughts and views on what should be included.

This survey is open to anyone aged 16 or over.

For your views to be taken into account, please complete this survey by 11 December 2022.

Any information you provide will be kept confidential and used only for the purposes of this consultation. For more information see our privacy notice at www.herefordshire.gov.uk/directory-record/5880/consultations_and_surveys_privacy_notice

Any comments you provide may be put in our report, but we will make sure you cannot be identified. If you want to talk to us about how we use your information you can email informationgovernance@herefordshire.gov.uk.

If you have any queries or would like this questionnaire in an alternative format or language, please contact HWBS@herefordshire.gov.uk.

Section 1 - Our priorities

The following is a list of areas that local evidence tells us we should consider for our focus over the next 10 years. We now would like your help to decide which of these should be considered in the final strategy. Further information on the population of Herefordshire can be accessed via our https://understanding.herefordshire.gov.uk/ webpages.

How important do you think it is that the following priorities for Herefordshire are included in the strategy?

Q1 **Support good mental wellbeing throughout life?** Good mental health and resilience are vital to our physical health, relationships, education, work and to achieving our potential. People with mental health issues can face significant disadvantages throughout their lives. An estimated 24,800 adults in Herefordshire have a common mental health disorder.

○ Very important ○ Fairly important ○ Slightly important ○ Not important ○ No opinion

Q2 **Support people who misuse drugs and alcohol or who smoke?** People who misuse drugs or who are alcohol dependent are very likely to have significantly worse mental and physical wellbeing. Nationally, during the Covid-19 pandemic there was a rise in alcohol and cannabis use, though there has been some progress with local projects that help people with rehabilitation. Smoking also remains a leading cause for differences in life expectancy and smoking in pregnancy increases the risk to health of both mother and baby.

○ Very important ○ Fairly important ○ Slightly important ○ Not important ○ No opinion

Q3 **Support and protect those with multiple complex vulnerabilities?** There are groups of people who have multiple risk factors (such as alcohol and drug use, severe mental illness, homelessness , risk of violence and abuse) that in combination are likely to have a significant impact on their mental and physical wellbeing. Significant levels of coordinated and sustained support is needed for them to live their lives safely, independently and with fulfilment.

○ Very important ○ Fairly important ○ Slightly important ○ Not important ○ No opinion

Q4 **Ensure every child has the best start in life?** The early years of a child's life have a huge impact on their future development and wellbeing. We have a dedicated Children and Families Team that help families cope with the challenges of raising children, which in turn helps children to thrive. However there are still areas of concern; the rates of babies who die at birth or shortly after is higher than the national average, rates of childhood vaccinations are below the national average and the dental health of young children remains poor.

○ Very important ○ Fairly important ○ Slightly important ○ Not important ○ No opinion

Q5 **Improve education outcomes for disadvantaged children and young people?** The quality of a child's education is very important to their future life chances. There are significant differences in achievement between disadvantaged children and their peers. All children and young people need an equal chance to do well in education in order to develop the kind of life skills that will equip them to live a fulfilled life in society and to be able to contribute positively to it.

○ Very important ○ Fairly important ○ Slightly important ○ Not important ○ No opinion

Q6 **Ensure there is good work for everyone?** Rewarding and fulfilling work supports good physical and mental wellbeing. Wages in the county are consistently the lowest in the region and amongst the lowest in England and Wales. We also know that there are barriers for certain groups of people being able to access good quality jobs that are suitable for their needs and circumstances including those with a poor education, mental health issues and learning difficulties.

○ Very important ○ Fairly important ○ Slightly important ○ Not important ○ No opinion

Q7 **Increase access to healthy and sustainable food and physical activity?** A healthy balanced diet and keeping active are two of the most important ways of staying healthy. Obesity rates in Herefordshire are above the national average, both for adults and children. We know that if people are helped to make better and easier choices with eating and taking exercise, they can improve their all-round health and wellbeing.

○ Very important ○ Fairly important ○ Slightly important ○ Not important ○ No opinion

Q8 **Protect the natural environment and reduce our carbon footprint?** Extreme and unpredictable weather events are becoming more likely, leading to more flooding and an increase in the number and severity of heatwaves. Herefordshire has declared a climate and ecological emergency and has committed to working towards the county being carbon neutral and nature rich by 2030.

○ Very important ○ Fairly important ○ Slightly important ○ Not important ○ No opinion

Q9 **Improve housing quality and reduce homelessness?** Due to the age and type of housing in Herefordshire, we have significant issues with fuel poverty and cold homes, especially in more isolated rural areas. In addition, housing affordability is a longstanding issue, with the cost of living crisis making these challenges worse and which may result in more people being at risk of homelessness.

○ Very important ○ Fairly important ○ Slightly important ○ Not important ○ No opinion

Q10 **Reduce loneliness and social isolation across all ages?** Loneliness can lead to unhealthy behaviours and therefore poorer health, both physical and mental and can increase the chance of early death. In our recent community wellbeing survey 1:10 people said they felt lonely. If people can connect better with each other through local networks and digitally it will improve their wellbeing.

○ Very important ○ Fairly important ○ Slightly important ○ Not important ○ No opinion

Q11 **Support people to age well?** Herefordshire has an ageing population and has increasing rates of dementia and long-term conditions. If people are helped to stay healthy they will remain independent and enjoy a better quality of life for longer.

○ Very important ○ Fairly important ○ Slightly important ○ Not important ○ No opinion

Q12 **Improve access to local services?** Over half of Herefordshire's residents live in rural areas. It's important that there is good access to services, whether that be health and community services, or effective broadband connectivity to help people better connect digitally.

○ Very important ○ Fairly important ○ Slightly important ○ Not important ○ No opinion

Q13 If you had to choose your **three** top priorities, what would they be?

- ☐ Support good mental wellbeing throughout life
- ☐ Support people who misuse drugs and alcohol, or who smoke
- ☐ Support and protect those with multiple complex vulnerabilities
- ☐ Every child has the best start in life
- ☐ Improve education outcomes for disadvantaged children and young people
- ☐ Ensure there is good work for everyone
- ☐ Increase access to healthy and sustainable food and physical activity
- ☐ Protect the natural environment and reduce our carbon footprint
- ☐ Improve housing and reduce homelessness
- ☐ Reduce loneliness and social isolation across all ages
- ☐ Support people to age well
- ☐ Improve access to local services

Q13a Please can you tell us why you have chosen these as your top three priorities?

Q14 Please tell us about any other health and wellbeing priorities that are not covered above and which you think should be addressed in the strategy?

Q15 Is there anything else you would like to add?

Section 2 - About You

Q16 Are you answering the questions today on behalf of yourself or on behalf of a group or organisation?

○ Myself ○ A group or organisation

Q16a Please tell us the name of your group or organisation.

The following questions are about you. You do not have to answer these questions but if you do it will help us to better understand how views may vary between different groups of people and areas of the county.

Q17 What is your age band?

○ 16 to 24 ○ 25 to 44 ○ 45 to 64 ○ 65 to 74 ○ 75 or over ○ Prefer not to say

Q18 What is your gender?

○ Male ○ Female ○ Other ○ Prefer not to say

Q19 How would you describe your ethnic group?

○ White British/English/Welsh/Scottish/Northern Irish
○ Other White (please specify below)
○ Any other ethnic group (please specify below)
○ Prefer not to say

Q19a Your ethnic group:

Q20 Do you have a disability, long-term illness or health problem (12 months or more) which limits daily activities or the work you can do?

○ Yes ○ No ○ Prefer not to say

Q21 Please tell us your postcode (this information will be treated as strictly confidential and will not be shared with any third parties).

Thank you for taking the time to give us your views, please click on the SUBMIT button below to send us your response.

Herefordshire Council

Title of report: Thematic Review: Premature Deaths

Meeting: Health and Wellbeing Board

Meeting date: 13 March 2023

Report by: Herefordshire Safeguarding Adults Board

Classification
Open

Decision type
This is not an executive decision

Wards affected

(All Wards);

Purpose:

- For the Board to receive and comment on the Herefordshire Safeguarding Adults Board Thematic Review: Premature Deaths

Recommendation(s)

- That the Board considers and comments on the Thematic Review.

Alternative options

1: The Board could choose not to consider this report. This is not recommended as the HWBB will provide its opinion, as appropriate, to Herefordshire Council, the Integrated Care Board or NHS England, as to whether they are discharging their duty to have regard to any assessment of relevant needs prepared by the Council, the ICB or NHS England in the exercise of their functions.

Key considerations

- Herefordshire County Council referred six deaths of individuals, their deaths occurring between January 2019 and August 2020. The information received from partners indicated a high level of substance abuse and physical and mental health issues. All were known to the police as victims and offenders. Concerns surrounded some of the individuals relating to self-harm, homelessness, self-neglect and suicidal ideation.

- Four were accommodated at the time of their death in accommodation for single homeless people with support needs. No inquest was held with respect to the deaths of three individuals, their deaths being either expected or from natural causes. An open verdict was recorded in one case. Cause of death was given as pneumonia in one instance, liver failure in a second and as substance-related in a third.

- The referral was prompted by the pattern of deaths over a two-year period. Similarities had been observed, namely individuals presenting with complex needs including substance misuse, offending, mental health, underlying physical health issues, and challenging behaviours. Herefordshire Safeguarding Adults Board (HSAB) accepted that the criteria for a discretionary safeguarding adult review (SAR) were met[1].

- This report was commissioned to consider learning from the individual cases within scope of the review, with an additional focus on repetitive learning across the cases that would indicate system-wide concerns and challenges.

- The focus of this report is on the issues professionals encountered in working with the six individuals. Examples of good practice have been included alongside analysis of gaps in provision and shortfalls in practice. Throughout there has been a clear commitment from practitioners, operational managers and strategic managers to appraise current service provision and to identify priorities for service improvement and enhancement.

- Appendix 1 HSAB-Thematic-review-Premature-Deaths-Adults
- Appendix 2 Thematic review exc videos

Community Impact

In accordance with the adopted code of corporate governance, Herefordshire Council achieves its intended outcomes by providing a mixture of legal, regulatory and practical interventions. Determining the right mix of these is an important strategic choice to make sure outcomes are achieved. The council needs robust decision-making mechanisms to ensure its outcomes can be achieved in a way that provides the best use of resources whilst still enabling efficient and effective operations and recognises that a culture and structure for scrutiny are key elements for accountable decision making, policy development and review

Environmental Impact

There are no general implications for the environment arising from this report.

Equality duty

- Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:

A public authority must, in the exercise of its functions, have due regard to the need to –

a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
c) Facilitate good relations between persons who share a relevant protected characteristic and persons who do not share it.

- The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services.

Resource implications

- There are no resource implications associated with this report. However, the resource implications of any recommendations made by the HWB will need to be considered by the responsible party in response to those recommendations or subsequent decisions

Legal implications

- Health and wellbeing boards are responsible for encouraging integrated working between health and social care commissioners, including partnership arrangements such as pooled budgets, lead commissioning and integrated provision.
- Their purpose is to establish collaborative decision making, planning and commissioning across councils and the NHS, informed by the views of patients, people who use services and other partners.
- The functions of the Health and Wellbeing Board are set out in paragraph 3.5.24 of the constitution.

Risk management

There are no risk implications identified emerging from the recommendations in this report

Consultees

Matt Pearce (Director of Public Health), Hilary Hall (Corporate Director Community Wellbeing), Ivan Powell (Independent Chair – Herefordshire Safeguarding Adults Board).

Appendices

Appendix 1 – HSAB-Thematic-review-Premature-Deaths-Adults

Appendix 2 - Thematic review exc videos

Background papers

None

THEMATIC REVIEW: PREMATURE DEATHS

Report for Herefordshire Safeguarding Adults Board

March 2022

Professor Michael Preston-Shoot and Mike Ward

Contents

1. Introduction

1.1. Herefordshire County Council referred six deaths of individuals, their deaths occurring between January 2019 and August 2020. The information received from partners indicated a high level of substance abuse and physical and mental health issues. All were known to the police as victims and offenders. Concerns surrounded some of the individuals relating to self-harm, homelessness, self-neglect and suicidal ideation.

1.2. Four were accommodated at the time of their death in accommodation for single homeless people with support needs. No inquest was held with respect to the deaths of three individuals, their deaths being either expected or from natural causes. An open verdict was recorded in one case. Cause of death was given as pneumonia in one instance, liver failure in a second and as substance-related in a third.

1.3. The referral was prompted by the pattern of deaths over a two-year period. Similarities had been observed, namely individuals presenting with complex needs including substance misuse, offending, mental health, underlying physical health issues, and challenging behaviours. Herefordshire Safeguarding Adults Board (HSAB) accepted that the criteria for a discretionary safeguarding adult review (SAR) were met[1].

1.4. This report was commissioned to consider learning from the individual cases within scope of the review, with an additional focus on repetitive learning across the cases that would indicate system-wide concerns and challenges.

1.5. The focus of this report is on the issues professionals encountered in working with the six individuals. Examples of good practice have been included alongside analysis of gaps in provision and shortfalls in practice. Throughout there has been a clear commitment from practitioners, operational managers and strategic managers to appraise current service provision and to identify priorities for service improvement and enhancement.

[1] Section 44 (4) Care Act 2014.

2. Safeguarding Adults Reviews

2.1. HSAB has a mandatory statutory duty[2] to arrange a SAR where:

- An adult with care and support needs has died and the SAB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive and the SAB knows or suspects that they have experienced serious abuse or neglect, and
- There is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.

2.2. HSAB has discretion to commission reviews in circumstances where there is learning to be derived from how agencies worked together with respect to an adult with care and support needs, but where it is inconclusive as to whether an individual's death was the result of abuse or neglect[3]. Abuse and neglect includes self-neglect. HSAB commissioned this thematic review using that discretion.

2.3. It is important to emphasise the distinction between the mandatory and the discretionary criteria because this is not always understood. Under current law (Care Act 2014), for the mandatory criteria to be met, a SAB must have reasonable reason to believe that the adult whose case has been referred has/had care and support needs, has/had experienced abuse or neglect, including self-neglect, and there is/was reasonable cause for concern about how agencies have worked together in that case.

2.4. Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons in the future[4]. The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.

2.5. SARs provide a rich seam of evidence, alongside research and the voices of people with lived experience. This enables the construction of an evidence-base for positive practice. That evidence-base has been used in this report to inform the analysis.

[2] Sections 44(1)-(3), Care Act 2014
[3] Section 44(4), Care Act 2014.
[4] Section 44(5), Care Act 2014

3. Review Process

3.1 Focus

3.1.1. HSAB commissioned this thematic review having identified a pattern of deaths amongst a cohort of adults with complex needs arising from substance use, mental health, offending and/or behaviour needs. Often these deaths seemed to be the consequence of long term lifestyle, behaviour and underlying health needs. Seeing the circumstances surrounding these deaths as a humanitarian issue, HSAB believed that there should be some form of review process to investigate the factors leading to these deaths, and learn any lessons to improve the support and services available to others with similar reliance upon drugs and alcohol, and with complex and risk taking behaviours. Thus, its purpose was to examine the events and circumstances that led to the deaths of this group of people, explore what if anything could have been done to prevent or avert this outcome, and capture learning as to what might be done to improve the effectiveness of services in Herefordshire that support people experiencing multiple and complex needs, including mainstream services.

3.1.2. The review would also consider recent and ongoing strategic initiatives focused on people with multiple physical and mental health needs, some of whom are experiencing or have experienced homelessness, and designed to address the increase in substance-related deaths. Thus, the thematic review would look at the range of existing and developing provision, including statutory services, outreach work and third sector organisations in order to gain a better overview of whether learning from the six cases regarding systemic issues was being addressed and to identify what further actions agencies can take to address any gaps.

3.1.3. A wide range of organisations were involved with some or all of the six individuals at one time or another. Representation was therefore sought from:

3.1.3.1. Organisations that work exclusively with people experiencing homelessness and/or substance misuse including local drug and alcohol services, and accommodation providers;

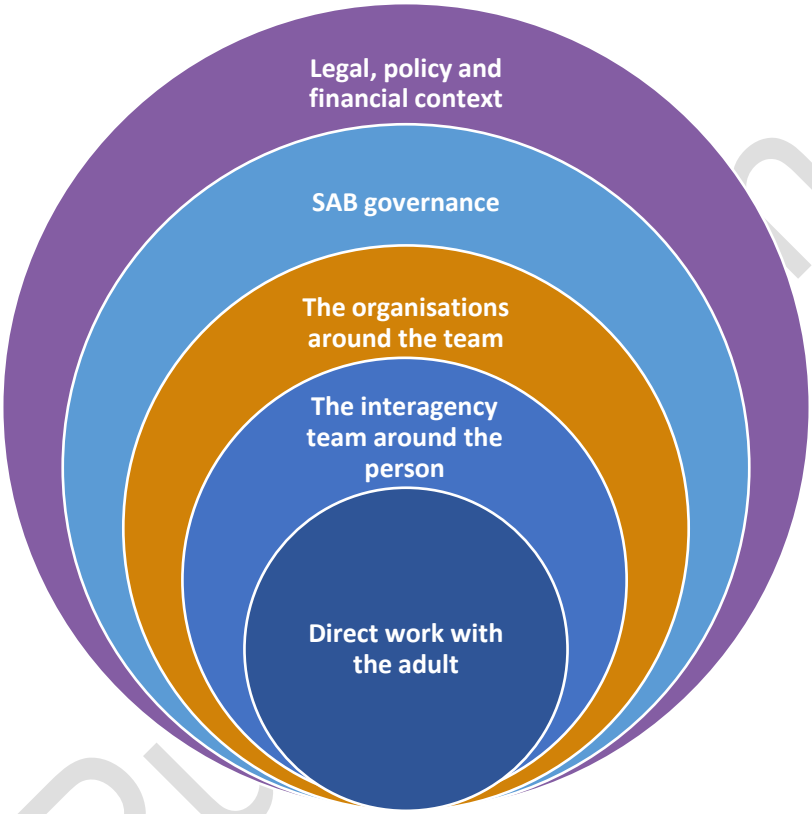
3.1.3.2. Organisations that provide services to the wider population, namely Herefordshire Council, West Mercia Police, Herefordshire and Worcestershire Health Care Trust, Wye Valley NHS Trust, Herefordshire and Worcestershire CCG, GP Practices, National Probation Service, Community Rehabilitation Company and West Midlands Ambulance Service.

3.1.4. The review also brought together commissioners/senior managers who have responsibility for the commissioning/management of these services. The purpose of their involvement was to identify strategic and commissioning level learning.

3.1.5. The review focused on the period from January 2018 to April 2020, during which time the deaths occurred.

3.1.6. The six individual cases are summarised below. However, rather than a traditional review that concentrates on a detailed chronology of a single case, this thematic review looks across all six cases for learning from recurring themes that indicate systemic issues to be addressed.

3.1.7. The review has adopted a whole system focus. What enables and what obstructs best practice may reside in one or more of several domains, as captured in the diagram. Moreover, the different domains may be aligned or misaligned, meaning that part of the focus must fall on whether what might enable best practice in one domain is undermined by the components of another domain.



3.2. Methodology

3.2.1. Combined chronologies were compiled regarding the six people who died from information supplied by partner agencies. From the combined chronologies it proved possible to identify themes for further exploration.

3.2.2. The review followed a blended approach incorporating elements of traditional case review methodology and appreciative inquiry (AI), primarily through a facilitated workshop reflection event and discussions with the panel of senior leaders who supported the independent reviewers. This combined approach is rooted in action research and organisational development, and is a strengths-based, collaborative approach for creating learning change while providing assurance of a thorough investigative process. The approach was underpinned by use of the evidence base now

available for working with people who self-neglect[5], with complex and change resistant substance misusers[6] and with people experiencing multiple exclusion homelessness[7].

3.2.3. The reflective learning event with practitioners and managers discussed learning from the six cases and the degree to which the challenges and concerns highlighted by these cases represented systemic issues in Herefordshire. The reflective learning event offered an opportunity for those involved in commissioning, in working with people with complex needs, and with adult safeguarding more generally to comment on what they believed was working effectively in Herefordshire and on where they felt that improvements were required. Contributions during the reflective learning event have been woven into the analysis that follows.

3.2.4. Interviews were also held with service users who were accessing accommodation and support provision. Their contributions have been woven into the analysis that follows.

3.2.5. Relevant policy documents have also been accessed, most especially relating to Project Brave and complex adult risk management (CARM) guidance. Reference is made to these and other initiatives in the following analysis.

3.2.6. Terms of reference were set by HSAB, namely:

3.2.6.1. To seek to understand the multi-agency responses in respect of the individuals who are the subject of this review and identify how services might be better equipped to help prevent future deaths of adults with similarly complex needs related to lifestyle, behaviours and substance use, whether or not they had eligible needs under the Care Act 2014.

3.2.6.2. To consider the impact of physical or mental impairment or illness, including dual diagnosis, on the risks experienced by adults who have substance use problems, including the service response to those issues.

3.2.6.3. To identify any other specific themes in the experience of those who are the subject of this review, such as experience of debt, family support issues, homelessness or similar, which might have an impact on learning from this thematic review overall.

3.2.6.4. To reflect on learning about any relationship between the safeguarding and assessment duties of the Care Act 2014 and safeguarding good practice such as Making Safeguarding Personal (MSP).

3.2.6.5. To consider other relevant legislation (for example, the Mental Health Act 1983 as amended and the Mental Capacity Act 2005) in relation to the experience of people with complex substance use and lifestyle issues.

3.2.6.6. To consider self-neglect as a Care Act 2014 category of abuse linked to issues around substance misuse.

3.2.6.7. To detail any learning that may be used to improve system support arrangements as well as highlighting any areas of good practice.

[5] Braye, S., Orr, D. and Preston-Shoot, M. (2014) *Self-Neglect Policy and Practice: Building an Evidence Base for Adult Social Care*. London: Social Care Institute for Excellence. Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234.

[6] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[7] Preston-Shoot, M. (2020) Adult Safeguarding and Homelessness. A Briefing on Positive Practice. London: LGA and ADASS.

3.3. Family Involvement

3.3.1. Where relatives could be identified from agency records, a letter was sent informing them of the thematic review and inviting their participation. Responses were received from relatives on behalf of WILL, DAWN and JOBY, all of whom shared their memories and perspectives with one of the independent reviewers. Their contributions have been woven into the analysis that follows.

3.3.2. Relatives of DAWN, JOBY, WILL and JUSTIN have given permission for their first names or nicknames to be used.

3.3.3. The names AIDEN and PASCAL are pseudonyms.

4. Case Narratives of Six People

4.1. Initials have been used for the six individuals.

4.2. Person One: AIDEN

AIDEN was a White British man who died at the age of 39 years. His childhood included experiencing and/or witnessing domestic, physical and alcohol abuse. He had a close relationship with his mother. Case information records he used drugs and alcohol, usage increasing in the months before his death. He had been sentenced for offences of theft and shoplifting, actual bodily harm and grievous bodily harm. A 12-month community order, including an unpaid work requirement and a restraining order, was in place at the beginning of the timeframe in scope for this review. He had police 'markers' for anxiety, depression, personality disorder and alcohol use, and had police contact as both victim and offender. He was the subject of 2 police 'Adult protection incidents'. Prior to accepting supported accommodation in a placement for single homeless people with support needs, he had spent considerable time living on the streets. AIDEN was in receipt of a local authority funded care package. Before his death he was trying to gain custody of his young son, with whom he had lost contact, following concerns about the care being provided by his son's mother. At an inquest, cause of death was recorded as substance-related.

4.3. Person Two: DAWN

DAWN was a White British woman who died at the age of 42 years. Case information records she had alcohol dependence syndrome and depression. She had police 'markers' for self-harm, alcohol use, heroin use, suicidal ideation, and had police contact as both victim and offender. She was the subject of 4 police 'Adult protection investigations'. DAWN had a history of rough sleeping and had also spent several months in a refuge. She had recorded contact with the local authority welfare team, often associated with the provision of benefits advice. She had not been the subject of a care and support assessment. She is recorded as having experienced adverse childhood experiences, having contact with her mother whilst being brought up by her grandparents, and as struggling with the loss of contact with her child and with the death of her father, himself alcohol-dependent, with whom she did not enjoy a close relationship. She is reported as finding this more difficult when sober.

4.4. Person Three: JUSTIN

JUSTIN was a White British man who died at the age of 45 years. He experienced the loss of mother and grandfather to cancer and was greatly affected by the death of his grandmother. Due to his lifestyle he was estranged from the rest of his family especially his brother whose property he destroyed in a drunken episode in 2016. He first experienced problems with his mental health in 1996 and had taken many overdoses and spent time as an inpatient. The last time a mental health assessment had been requested was in 2018 and he had not needed secondary care interventions at that stage. Case information records he used drugs and alcohol. He had police 'markers' for suicidal ideation, depression, epilepsy and anxiety. He also experienced heart arrhythmia, chronic obstructive pulmonary disease (COPD), oesophageal varices, stomach ulcers and liver problems. He had suffered a drug induced cardiac arrest that had required cardiopulmonary resuscitation (CPR). He had police contact

as both victim and offender and had been the subject of an alcohol treatment requirement. He was recorded as having a long history of failed housing placements. He was referred to a project providing accommodation for single homeless people with support needs through the Housing Solutions Team. He was very vulnerable due to many physical health issues, periods of poor mental health, and substance misuse. He had become homeless when his relationship with his brother who inherited the tenancy from his grandmother broke down and he flipped between street homelessness and hostels. He was the subject of 6 police 'Vulnerable adult incidents'. JUSTIN had not been the subject of a care and support assessment. He died of natural causes and no inquest was held.

4.5. Person Four: PASCAL

PASCAL was a White British man who died at the age of 54 years. Case information records a history of physical ailments, anxiety and depression. A community order sentence for theft was in place during the timeframe in scope for this review. He had police 'markers' for drugs and heroin. He had police contact as both victim and offender. He was the subject of 3 police 'Vulnerable adult incidents'. He was homeless at the time of his death. He had recorded contact with the local authority welfare team, which is most often associated with the provision of benefits advice. PASCAL had not been the subject of a care and support assessment. Cause of death was pneumonia.

4.6. Person Five: WILL

Will Pen Picture
(This picture has been provided by Wills parents)

Will was born on 5th September 1995. In his early years his development was normal and untroubled. He developed very well in his early years in terms of his ability to speak at an early age and read. There were no issues. During Will's early childhood 3 separate foster children were welcomed into the family home. The first two of which were teenagers but presented no major issues outside what you normally expect of adolescents. The third child however was clearly troubled, Will by this time was aged 3 to 4 years. Although we have no way of proving this it is possible that the presence of this child in the household had some impact on Will. Will started in a local primary school and in the first couple of years things went along normally. However as Will got to about age 7 or 8 there started to be one or two concerns about things that were happening. Towards the end of Will's time at Primary school he was having liaison with the LA pupil support officer. Home life was generally normal and as you would expect for a child of Will's age, as was his social and wider family life. When Will then joined secondary school it was not long before things started to go downhill with his general behaviour and lack of interest in obtaining a good education. We believe the school's attitude towards Will and their actions did not help the situation but only made it worse.

Continues over

Will generally suffered with low self-esteem and lack of confidence, which again was not helped by several things that happened, including losing a circle of close friends due to the school's response to an incident. However when Will was around 13/14 the PE teacher at his school spotted a talent for Rugby in Will and nurtured this. This seemed to perk Will up and he became a key part of the school's Rugby team. As his father I then sought a local Rugby team for him to play for and he joined Ledbury, again becoming a key part of the team and enjoyed playing for them and meeting a new circle of friends. This lasted for maybe a year and a half. However, outside of school and his Rugby the friends he started to spend time with gradually became less positive characters. Eventually at about age 15 Will lost interest in Rugby and his behaviour at school also deteriorated to the point at which he was expelled and referred to a PRU.

Throughout this time, as his parents we tried to help and support Will through difficult teenage years and tried to engage the support of local services without much success. Will did not take to attendance at the PRU and was not a regular attendee. During this time we began to notice that Will was abusing certain substances (mcat and alcohol primarily) and he would often go missing for several days. This led to a real strain in the parent/child relationship. As his father I had numerous one to one conversations with Will about the direction his life was going and he would often get upset and declare that he wanted to change and wanted to succeed but could not seem to pull himself up. We used to report this to the police on each occasion but often had an indifferent response or they would track him down to a place but say as he was safe they couldn't do anything (bearing in mind he was still a juvenile at the time). Will drifted without much motivation to sort himself or do anything. Due to his natural inclination to be good at sport we encouraged him to consider attendance at Hartpury Sports College and we managed to secure a residential place for him. This started OK! However unfortunately Will's behaviour meant he was not allowed to consider residing on campus but was allowed to continue as a day student. This did not last long as Will could not commit to this.

Again Will drifted in life and had no real motivation or inspiration to pursue a job or career in any path, even though as his parents we tried many, many times to help him. Will's behaviour continued to deteriorate and he started to get into some trouble with the authorities, generally low level stuff. Eventually, Will started a relationship with a local girl and moved in with her. The relationship was quite tempestuous, however they eventually had a child together, who Will loved dearly. However, the relationship was not stable and they eventually parted. Unfortunately, the ex-partner was difficult and would flit between Will and us as grandparents being able to see his child and then not. Will found this extremely difficult and upsetting. Will had developed a dependence on alcohol and also became a regular cannabis user. He had the odd job that lasted for a while but unfortunately could not sustain this on a long term basis.

It was clear that his mental health had deteriorated and we tried to continue to support him but occasionally his behaviour was such that we was sometimes excluded from the family home, although we would continue to have contact and try to support him. Occasionally, in trying to help Will and get to the bottom of his issues he would disclose that something had happened to him to cause him to be the way he was. However, we could never get to the bottom of what that was.

At one point when Will was excluded from the family home he presented himself at the Stonebow unit, literally begging for help for his mental health. The unit phoned me as his father. I advised them that he was excluded from the family home and that he was there because he needs help. However, we woke the following morning to find out that he had been dropped off on the family drive early in the morning with a blanket and bottle of water. Fortunately, his mother's car was open so he was able to sleep in it. Will flitted in and out of the family home then and continued to abuse alcohol and cannabis, although he would go through periods where he would abstain. Eventually we tried to help William to source alternative accommodation and we eventually managed to secure a place at Pomona where we thought he might get the support and help he needed, however this was where Will unfortunately spent his last couple of months.

Underneath his problems Will was at heart a kind person. As a child he would want to give money to people he saw homeless on the street. He was very intelligent and had the potential to succeed in whatever field he may have chosen. He was extremely funny and all his friends said he would light up the room when he came in and make everyone laugh. Unfortunately, this sometimes attracted negative attention from some males who would get jealous of Will's popularity and bully him. His death was a great loss to us as his parents, his friends and most of all his daughter, who he loved dearly and who loved him.

WILL was a White British man who died at the age of 24 years. Prior to accepting accommodation for single homeless people with support needs, he had been either sofa surfing or living in the family home with his parents. Case information records anxiety and depression, dating back to his childhood. He had police 'markers' for self-harm and drugs. He had police contact as both victim and offender. He had been the subject of an alcohol treatment requirement. He had several convictions relating to alcohol misuse, including violence. He had not been the subject of a care and support assessment. He had a child, with whom he had not had contact for some time. This had a negative impact on his mental wellbeing. He received regular support from his parents. He experienced several relationship breakdowns which he reported also had a negative impact on his mental wellbeing. An open verdict was recorded at an inquest.

4.7. Person Six: JOBY

JOBY was a White British man who died at the age of 44 years. As a child, he experienced and witnessed domestic abuse. He was supported by an aunt until his

behaviour was impacting negatively on her own children. His relationship with his sister broke down because of events within the family although she stepped in as his next of kin shortly before his death. Case information records alcohol and 'related ailments', and mental and behavioural disorder, anxiety and depression. There are references to him having several children, none of whom were living with him. He had police 'markers' for diabetes, asthma, seizures, respiratory problems, pancreatitis, sleep apnoea, cirrhosis of the liver, previous strokes (TIA's), alcohol-dependence, nerve damage to his legs, suicidal ideation, drugs and a blood borne virus. He had police contact as both victim and offender. He had a long history of violent, acquisitive and drug related offending. He was the subject of 7 police Vulnerable adult or adult protection investigations. JOBY had become homeless when he was evicted from his private rented accommodation due to antisocial behaviour. When he moved into accommodation provided by a project for single homeless people with support needs, he was drinking very heavily. Despite the support on offer he continued substance misuse. He developed oesophageal thrush and became severely restricted in his mobility. JOBY was in receipt of a local authority funded care package. He had a girlfriend who was initially believed to be supportive but before his death the police were investigating whether he was being financially abused by her. His death was anticipated and the Coroner was not advised. His health had been deteriorating rapidly but he was very reluctant to have any medical intervention that involved going to hospital. He lied repeatedly about whether he had attended appointments and when his girlfriend was his carer, she also backed up him up. He was supported to have a care package put in place, was visited twice daily and had an alert alarm fitted (pendant) due to risk of falls. Shortly before his death he had an assessment for Hospice at Home which he found very upsetting.

4.8. Premature mortality is evident in all six cases. In five of the cases the individuals died before or about the average age of deaths for men (44) and women (42) who have experienced homelessness alongside mental and physical ill-health, and drug and/or alcohol misuse[8].

4.9. Drawing on the combined chronologies:

4.9.1. there is evidence of substance misuse in all six cases;
4.9.2. there is evidence of physical health concerns in all six cases;
4.9.3. four individuals had been diagnosed with Hepatitis C (AIDEN, DAWN, JUSTIN and PASCAL);
4.9.4. three individuals had experienced falls (AIDEN, JUSTIN and PASCAL) and head injury is explicitly referenced in two instances (AIDEN and JUSTIN); JUSTIN also had fits which could lead to cognitive damage;
4.9.5. concerns for mental health are referred to in all six cases;
4.9.6. adverse experiences in childhood can include abuse and neglect, domestic abuse, poverty and parental mental illness or substance misuse[9]. Adverse childhood experiences can be identified for four individuals (AIDEN, DAWN, JUSTIN and JOBY) from information supplied by the services involved;

[8] ONS Deaths of homeless people in England & Wales 2013-2017
https://www.ons.gov.uk/peoplepopulationanDawnommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2013to2017#deaths-of-homeless-people-have-increased-by-24-over-five-years

[9] Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping)*. London: Public Health England.

4.9.7. four individuals had lost contact with their own children (AIDEN, DAWN, WILL and JOBY);
4.9.8. there is evidence of domestic abuse, both as victims (DAWN and JOBY) and perpetrators (WILL and JOBY);
4.9.9. five individuals appear to have been victims of assault (AIDEN, DAWN, JUSTIN, WILL and JOBY) and two to have perpetrated violence (PASCAL and WILL);
4.9.10. in four cases individuals were able to access supported accommodation (AIDEN, JUSTIN, WILL, JOBY).
4.9.11. all six individuals appear to have committed offences.

4.10. Only two individuals were in receipt of care packages through Adult Social Care. Given the presence of substance misuse in all six cases, alongside physical and mental health concerns, one key line of enquiry explores whether or not the other individuals were referred and assessed[10] given the statutory definition of care and support needs.

4.11. Section 9 Care Act 2014 enables local authorities to assess a person who appears to have needs for care and support, regardless of the level of need. Where the authority is satisfied on the basis of a needs assessment that a person has needs for care and support, it must determine whether any of the needs meet the eligibility criteria (section 13). The eligibility criteria are set out in the Care and Support (Eligibility Criteria) Regulations 2015. An adult's needs meet the eligibility criteria if (a) the adult's needs arise from or are related to a physical or mental impairment; (b) as a result of the adult's needs the adult is unable to achieve two or more of certain specified outcomes; and (c) as a consequence there is, or there is likely to be, a significant impact on the adult's well-being. Thus, such needs may arise from physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury. The specified outcomes include being appropriately clothed, being able to maintain a habitable home environment, and being able to use facilities and services in the community. These are needs that many people experiencing multiple exclusion homelessness have and outcomes which they may not be able to achieve. If the needs are urgent, care and support can be provided before an assessment is completed (section 19(3)).[11] Besides a duty to meet eligible needs, local authorities also have a power to meet other care and support needs, again for adults ordinarily resident in their area or present and of no settled residence (section 19 (1), Annex H – Statutory Guidance[12]).

[10] Section 9 Care Act 2014.
[11] Braye, S. and Preston-Shoot, M. (2016) Practising Social Work Law (4th ed). London: Palgrave Macmillan.
[12] Department of Health and Social Care (2018) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office.

5. The Evidence-Base for Best Practice

5.1. Reference was made earlier to research and findings from SARs[13] that enable a model of good practice to be constructed in relation to adults who self-neglect. The model comprises four domains. In line with Making Safeguarding Personal, the first domain focuses on practice with the individual. The second domain then focuses on how practitioners worked together. The third domain considers best practice in terms of how practitioners were supported by their employing organisations. The final domain summarises the contribution that Safeguarding Adults Boards can make to the development of effective practice with adults who self-neglect. The domains are summarised here.

5.2. For the purposes of this thematic review, evidence has been integrated into these domains regarding best practice drawn from research and SARs featuring homelessness and substance misuse.

5.3. It is recommended that direct practice with the adult is characterised by the following:

5.3.1. A person-centred approach that comprises proactive rather than reactive engagement, and a detailed exploration of the person's wishes, feelings, views, experiences, needs and desired outcomes; work to build motivation with a focus on a person's fluctuating and conflicting hopes, fears and beliefs, and the barriers to change[14];

5.3.2. A combination of concerned and authoritative curiosity appears helpful, characterised by gentle persistence, skilled questioning, conveyed empathy and relationship-building skills; early and sustained intervention includes supporting people to engage with services, assertive outreach and maximising the opportunities that encounter brings[15];

5.3.3. When faced with service refusal, there should be a full exploration of what may appear a lifestyle choice, with detailed discussion of what might lie behind a person's refusal to engage; failing to explore "choices" prevents deeper analysis;[16]

5.3.4. It is helpful to build up a picture of the person's history, and to address this "backstory"[17], which may include recognition of and work to address issues of loss

[13] Braye, S., Orr, D. and Preston-Shoot, M. (2014) *Self-Neglect Policy and Practice: Building an Evidence Base for Adult Social Care*. London: Social Care Institute for Excellence. Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234.

[14] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern. NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

[15] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK. Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping).* London: PHE. Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[16] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK.

[17] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK. NICE (2018) *People's Experience in Adult Social Care*

and trauma in a person's life experience that can underlie refusals to engage or manifest themselves in repetitive patterns;

5.3.5. Contact should be maintained rather than the case closed so that trust can be built up;

5.3.6. Comprehensive single and multi-agency risk assessments are advised, especially in situations of service refusal and/or non-engagement, using recognised indicators to focus work on prevention and mitigation[18];

5.3.7. Where possible involvement of family and friends in assessments and care planning[19] but also, where appropriate, exploration of family dynamics, including the cared-for and care-giver relationship;

5.3.8. Thorough mental health and mental capacity assessments, which include consideration of executive capacity; assumptions should not be made about people's capacity to be in control of their own care and support[20]; all five statutory principles in the Mental Capacity Act 2005 should be accurately understood and considered together;

5.3.9. Careful preparation at the point of transition, for example hospital discharge, prison discharge, end of probation orders and placement commissioning;

5.3.10. Use of advocacy where this might assist a person to engage with assessments, service provision and treatment;

5.3.11. Thorough housing, health and social care assessments, care plans and regular reviews, comprehensive enquiries into a person's rehabilitation, resettlement and support needs[21]; taking into account the negative effect of social isolation and housing status on wellbeing[22].

5.4. It is recommended that the work of the team around the adult should comprise:

5.4.1. Inter-agency communication and collaboration, working together[23], coordinated by a lead agency and key worker in the community[24] to act as the continuity and coordinator of contact, with named people to whom referrals can be made[25]; the

Services: Improving the Experience of Care and Support for People Using Adult Social Care Services. London: National Institute for Health and Clinical Excellence.

[18] Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25. Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[19] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[20] NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

[21] Ministry of Justice (2018) *Guidance: The Homelessness Reduction Act 2017 Duty to Refer*. London: MoJ.

[22] NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

[23] Parry, I. (2014) 'Adult serious case reviews: lessons for housing providers.' *Journal of Social Welfare and Family Law*, 36 (2), 168-189. Ministry of Justice (2018) *Guidance: The Homelessness Reduction Act 2017 Duty to Refer*. London: MoJ.

[24] Whiteford, M. and Simpson, G. (2015) 'Who is left standing when the tide retreats? Negotiating hospital discharge and pathways of care for homeless people.' *Housing, Care and Support*, 18 (3/4), 125-135. NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

[25] Parry, I (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25.

emphasis is on integrated, whole system working, linking services to meet people's complex needs[26];

5.4.2. A comprehensive approach to information-sharing, so that all agencies involved possess the full rather than a partial picture;

5.4.3. Detailed referrals where one agency is requesting the assistance of another in order to meet a person's needs;

5.4.4. Multi-agency meetings that pool information and assessments of risk, mental health and mental capacity, agree a risk management plan, consider legal options and subsequently implement planning and review outcomes[27];

5.4.5. Use of policies and procedures for working with adults who self-neglect and/or demonstrate complex needs, with specific pathways for coordinating services to address such risks and needs as suitable accommodation on discharge from prison or hospital[28];

5.4.6. Use of the duty to enquire (section 42, Care Act 2014) where this would assist in coordinating the multi-agency effort, sometimes referred to as safeguarding literacy;

5.4.7. Evaluation of the relevance of diverse legal options to assist with case management, sometimes referred to as legal literacy;

5.4.8. Clear, up-to-date[29] and thorough recording of assessments, reviews and decision-making; recording should include details of unmet needs[30].

5.5. It is recommended that the organisations around the team provide:

5.5.1. Supervision and support that promote reflection and critical analysis of the approach being taken to the case, especially when working with people who are hard to engage, resistant and sometimes hostile;

5.5.2. Access to specialist legal, mental capacity, mental health and safeguarding advice;

5.5.3. Case oversight, including comprehensive commissioning and contract monitoring of service providers;

5.5.4. Agree indicators of risk that are formulated into a risk assessment template that will guide assessments and planning;

5.5.5. Attention to workforce development[31] and workplace issues, such as staffing levels, organisational cultures and thresholds.

5.6. SABs:

[26] Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping).* London: PHE. Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern. The MEAM Approach (2019) *Making Every Adult Matter*. London: Homeless Link and Mind.

[27] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[28] Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping).* London: PHE.

[29] Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25.

[30] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[31] Whiteford, M. and Simpson, G. (2015) 'Who is left standing when the tide retreats? Negotiating hospital discharge and pathways of care for homeless people.' *Housing, Care and Support*, 18 (3/4), 125-135. The MEAM Approach (2019) *Making Every Adult Matter*. London: Homeless Link and Mind.

5.6.1. Ensure that multi-agency agreements are concluded and then implemented with respect to working with high risk individuals; this will include the operation of MAPPA, MARAC, MASH[32] and other complex case or multi-agency panel arrangements, responding to anti-social behaviour, domestic abuse, offending (community safety) and vulnerability[33]; strategic agreements and leadership are necessary for the cultural and service changes required[34];

5.6.2. Develop, disseminate and audit the impact of policies and procedures regarding self-neglect;

5.6.3. Review the interface between housing/homelessness and adult social care, mental health, and adult safeguarding, and include housing in multi-agency policies and procedures[35];

5.6.4. Establish a system to review the deaths of homeless people and/or as a result of alcohol/drug misuse;

5.6.5. Work with Community Safety Partnerships, Health and Wellbeing Boards and partnership arrangements for safeguarding children and young people, to coordinate governance, namely oversight of the development and review of policies, procedures and practice;

5.6.6. Provide or arrange for the provision of workshops on practice and the management of practice with adults who self-neglect.

5.7. This model enables exploration of what facilitates good practice and where barriers to good practice reside. The thematic analysis that follows draws on information contained within the chronologies and discussions during the learning event. Where relevant, it also draws on available research. It follows the whole system framework for analysis presented above, beginning with the components of direct work with individuals and moving outwards to the legal, policy and financial context within which adult safeguarding and work with people with multiple and complex needs are situated.

[32] Multi-Agency Public Protection Arrangements (MAPPA), Multi- Agency Risk Assessment Conferences (MARAC), Multi-Agency Safeguarding Hub (MASH)

[33] Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25.

[34] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[35] Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25.

6. Thematic Analysis – Direct Work with Individuals

6.1. Using the evidence-base as a framework for analysis, themes arising from the chronologies are analysed here.

6.2. Person-centred approach and responses to repeating patterns. Research has identified that staff can become inured to or normalise risk when what is being presented is repetitive[36]. Within all six chronologies there is evidence of repeating patterns of attendance at Emergency Departments and/or self-discharge and/or non-engagement or disengagement and/or non-attendance at arranged appointments. There does not appear to have been a plan to address the repeating pattern of not waiting to see a clinician and of self-discharge (AIDEN, JUSTIN, PASCAL, JOBY). Follow-up when individuals did not attend appointments or declined (drug and alcohol) support was inconsistent (AIDEN, JUSTIN, PASCAL, WILL, JOBY). Occasionally, the lack of assertive follow-up of (multiple) missed medical and key worker reviews by the substance misuse service provider was reported as being out with agency policy (JUSTIN and JOBY).

6.2.1. In response there were examples of cases being closed (DAWN, JUSTIN and WILL), resulting in needs being unmet, including for accommodation when facing the prospect of homelessness. When individuals are facing significant challenges and do not attend appointments, careful single and multi-agency consideration should be given before cases are closed. There are also instances of renewed attempts to maintain contact by offering "more of the same", namely appointments at designated times and places. This is unlikely to prove effective. AIDEN, for example, declined appointments for cognitive behavioural therapy because he felt unable to keep them. WILL was reported to experience difficulty attending appointments but outreach to assist him appears to have been limited. JUSTIN repeatedly failed to attend appointments with the substance misuse service and there is reflection in the notes that *"The local policy should have perhaps included different actions where complexities are present."*

6.2.2. There were, however, examples of wrap-around support that included outreach (PASCAL and JUSTIN), home visits (AIDEN, PASCAL, JUSTIN and DAWN) and support to attend medical reviews, outpatient appointments and other meetings (AIDEN, PASCAL, WILL). This was good practice. Thus, an outreach worker engaged with PASCAL to assist with welfare benefit applications and to appeal against DWP decisions. His offender manager, together with an outreach worker and practitioners working for the drug and alcohol misuse service, constructed a plan to address his need for accommodation. This included taking him to appointments to ensure he had money and the offer of temporary accommodation, and supplying him with a mobile phone so that he could remain in contact. Similar work was undertaken with JUSTIN to secure him accommodation.

[36] Braye, S., Orr, D. and Preston-Shoot, M. (2014) *Self-Neglect Policy and Practice: Building an Evidence Base for Adult Social Care*. London: Social Care Institute for Excellence. Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234.

6.2.3. DAWN was seen without an appointment in an overflow clinic in order to respond to her need for healthcare. This was good practice. The importance of providing wrap-around support and outreach healthcare practitioners is clearly indicated in DAWN's case as the chronology contains several comments to the effect that she often did not attend GP, outpatient and key worker appointments when not supported to do so. She could find engagement difficult at times, perhaps because of the extent of her substance misuse and the significantly deleterious effects this had on her physical and mental health. When support was provided to enable her to keep appointments, this was good practice.

6.2.4. Advice to contact services and signposting to services as single strategies are unlikely to be effective with people who self-neglect. That was the case here with several individuals (WILL, AIDEN, PASCAL, JOBY). Assertive outreach, including proactively introducing individuals to recommended services, is more likely to be effective. Practitioners commenting on recent service developments, especially Project Brave, spoke of progress that key workers had been able to make to secure people's access to provision and to coordinate a joint holistic approach to meeting their needs and mitigating risk.

6.2.5. There are instances when chronologies explicitly question practitioner attitudes (possible unconscious bias), as in the absence of professional curiosity and making safeguarding personal. Instances include the approach to assessment by ASC (AIDEN), the police omitting to explore alleged harassment (PASCAL), and the police not attending repetitive incidents of drunkenness (DAWN). The chronology for the last of these episodes also observes inappropriate comments recorded in the police log.

6.2.6. Both DAWN's relative and JOBY's relative drew attention to what they perceived as negative attitudes towards people who misuse alcohol and other drugs. They felt that practitioners could be judgmental and "not see the person". They emphasised that practitioners and services needed "to look for the person behind the substance misuse", "to go below the surface and consider causes" in order to attempt to provide "person-specific support and individualised care." WILL's family members referred to an absence of support and to a condescending response from some practitioners when they were approach for help.

6.2.7. Lack of understanding of behaviours. At the reflection learning event some participants felt that individuals could be deterred from engaging because of the number of services involved and having to repeat their stories multiple times. It was recognised that prior experiences of involvement with services, coupled with a feeling of having been let down, could act as a deterrent, and that professional curiosity and time to build up relationships of trust were essential. Third sector agencies could be helpful in this respect.

6.2.8. However, it was evident from the chronologies that some practitioners did not consistently appear to consider why people disengage or are unable to engage with treatment, and not seeing repeated patterns of such behaviours as information to address. There appears to be a need for a better understanding of how to work with people who do not prioritise their own

needs, in other words who self-neglect. Best practice considers the 'history' and the meaning of the pattern of events rather than seeing just a single isolated incident.

6.2.9. For example, AIDEN was very unwell, could barely walk and had little short-term memory. As was observed in his chronology, his poor health and mobility likely explained his infrequent engagement with his drug and alcohol key worker. PASCAL missed some health appointments and did not always cooperate with medical advice and recommendations. A pattern of self-neglect and his disinterest in practitioners trying to assist him continued. The chronology does not indicate whether practitioners expressed curiosity about this, or how PASCAL responded if they did. WILL's chronology observes that he had not been engaged with services other than a drug and alcohol misuse provider. It does not indicate what work was done to address this other than signposting him to agencies that could offer support for his mental health issues, namely paranoia, agitated depression, low mood and anxiety. The substance misuse service understood that JUSTIN was Hepatitis C positive. This is known to lead to fatigue and what those with the disease call "brain fog". However, this is not factored into their understanding of his pattern of poor engagement.

6.2.10. Although outreach services were available, a sense was conveyed that outpatient and substance misuse services still operated on an appointment basis and that greater flexibility was needed. Similarly, whilst support to meet people's needs and to manage risk was available, responses to "did not attend" were still not good-enough and that practitioners needed to understand what got in the way of attendance and to coordinate support to facilitate engagement.

6.2.11. Service users who shared their experiences for the purposes of this report acknowledged that changes of providers of substance misuse services, and changes of support workers, with the subsequent necessity of having to repeat their stories, made engagement more difficult. Continuity was an important part of recovery. Some acknowledged feeling ashamed about their use of drugs and/or alcohol, leading them to hide rather than disclose their dependence. It took time to build up trust and courage to disclose what had happened in their lives and the impact of such experiences.

6.2.12. Staff working with services users also emphasised the need to reflect on the language used about non-engagement or dis-engagement, when it could be that the way services were organised erected barriers. Equally, they reminded the independent reviewers of the importance of individuals feeling listened to.

6.2.13. DAWN and JOBY's relatives also focused on the theme of engagement. Drawing on their experience they questioned how accessible practitioners had proven to be. They were critical of "long waiting lists." JOBY's relative felt that he had not been prioritised because of his history of non-engagement, as a result of which he had lost motivation to address his substance misuse.

6.2.14. Throughout this and subsequent sections of the report reference is made to the importance of wrap-around support. This was clearly acknowledged at the reflection learning event. Use of drugs and alcohol can be a coping mechanism for some individuals, to nullify the pain of adverse experiences. Attempting to take this away without support will prove counter-productive.

6.2.15. DAWN's relative spoke of the importance of "knowing the full history", drawing attention to the impact on DAWN of her father's alcohol problems and to "demons" arising from her childhood, including bereavements of adults caring for her. JOBY's relative also referred to "demons" arising from adverse experiences.

6.2.16. Indeed, one service user now engaged with accommodation, mental health and substance misuse services described their use of drugs as "my safety shield" against the impact of adverse experiences. The death of a friend had proved a turning point. Similarly, practitioners recognised that individuals with whom they were working were using drugs and/or alcohol for a reason that needed to be understood. Simply expecting individuals to be clean and/or sober before offering help was unrealistic. WILL's family members reinforced this knowledge, believing that he might have been using substances to cope with adverse experiences that he was unable to talk about.

6.3. Risk assessment. Risk assessment and risk management are crucial, with plans preferably co-designed with service users/patients and shared across partners. There were examples when risk assessments were completed. In AIDEN's case, the risk to his mother was assessed when she was visiting him as there was a restraining order in place and he had been convicted of theft from her. When AIDEN assaulted another resident (JOBY) in the accommodation where they were both residents, a risk assessment was submitted to the Adult Referral Team by the police. However, the incident was seen as a single agency issue and therefore was not shared with other services supporting the individual. There is no record of work with staff supporting residents to maintain their flats on the ongoing risk to AIDEN and JOBY.

6.3.1. Other SARs[37] have remarked that hostels and supported accommodation can be experienced as unsafe by residents who therefore prefer to return to street-based living. There were several incidents where AIDEN attacked other residents and his chronology refers to drug dealing amongst residents.

6.3.2. Risk assessments were completed on JUSTIN by the substance misuse service but these do not appear to have influenced or informed the way the service was provided to him.

6.3.3. PASCAL disliked using the night shelter and preferred to sleep in a camp. A risk assessment for PASCAL included his propensity to refuse accommodation, even in extreme weather. Risks were clearly discussed with him, for example surrounding use of needles and the danger of bleeding to death because of injecting. The chronology in one instance records that PASCAL understood the risks. However, sustained drug and alcohol misuse raises the possibility of impulse control disorder[38], which should indicate a detailed mental capacity assessment of decisional capacity and executive functioning.

[37] For example, Manchester SAB (2020) Thematic Review – Homelessness.
[38] Isle of Wight SAB (2018) SAR – Howard.

6.3.4. DAWN's GP clearly discussed risks associated with decreasing her alcohol intake too quickly and sleeping rough. WILL's chronology records an occasion when the police openly discussed risks with him to his life, and another when suicidal ideation was risk assessed following an arrest for shoplifting. His association with drug dealers and his involvement in supplying drugs was known to the police but there is less sense of a coordinated risk management plan involving NPS and the drug and alcohol misuse service provider.

6.3.5. The police completed risk assessments when JOBY assaulted his partner, concluding that the risk was high. His partner would not file a complaint and/or denied being assaulted. It is not clear from the chronology whether undue influence or coercive and controlling behaviour was recognised as impacting on her decision-making. Nor is it clear from the chronology whether there was a risk management plan in place that would seek to safeguard her and her son. He was non-compliant with medication and advice on structured reduction of his alcohol intake, and continued to misuse alcohol and drugs.

6.3.6. There were occasions when reading the chronologies that a risk assessment and mitigation plan would have been expected. For instance, there was information that AIDEN was buying illegal drugs off the internet but this intelligence was not acted upon. He was non-compliant with medication to control his epilepsy and his physical health was deteriorating because of his injecting. Similarly, JOBY's chronology contains references to a history of alcohol withdrawal symptoms, non-compliance with advice and with medications, continued misuse of alcohol and drugs, about which he was not always honest. Yet, there is no evidence of a coordinated risk assessment and mitigation plan being updated and implemented.

6.3.7. It may be that practitioners would be assisted by having risk assessment templates from which to draw. HSAB should engage with partner agencies on the subject of risk assessment and mitigation planning, as well as exploring how practitioners and managers understand and respond to situations of self-neglect, self-harm and risks arising from persistent and at times escalating concerns regarding physical health, mental health, and substance misuse.

6.4. Mental capacity assessment. There were very few references to mental capacity assessment in the chronologies, which is perhaps surprising given that the Code of Practice[39] refers to symptoms of alcohol or drug use in the context of disorders of mind or brain. There were examples in the individual narratives of where mental capacity assessments should have been undertaken. For example, there were occasions when AIDEN was found incoherent, confused and in a state reminiscent of self-neglect. His medical diagnoses included peripheral neuropathy, encephalitis caused by drug misuse, resulting in long-term damage to his brain that meant that he had little short-term memory. That should have raised doubt about his mental capacity. However, there is no reference to assessment of his decisional capacity and executive functioning, other than one mention of an outstanding mental capacity test in the chronology for the month he died.

[39] Department of Constitutional Affairs (2007) *Mental Capacity Act 2005: Code of Practice* (London: The Stationery Office.

6.4.1. There is only one explicit reference to mental capacity in the DAWN chronology, when she refused hospital admission in the month before she died. There is reference elsewhere to her understanding the need to keep appointments. However, from the recorded episodes it is clear that she was unable to prioritise self-care by attending appointments. She was unable to sustain reductions in her use of alcohol and drugs. She had been diagnosed with Hepatitis C, which can impair brain functioning. She had been prescribed anti-depressant medication. In that context, it is possible that her executive functioning and decision-making were impaired. The chronology also records that she had no understanding of the connection between substance misuse and low mood.

6.4.2. In May 2018 WILL's chronology references that he was assessed to have decisional capacity with respect to his use of drugs and alcohol, accommodation, and engagement with mental health services. He was given blankets and food, and signposted to services. The chronology observes that this was a missed opportunity to engage with him fully regarding his safety. WILL's family members described one such incident, seeing this as an example of "indifference" and a failure to provide "proper support."

6.4.3. In January 2019 the liaison psychiatrist in the hospital wrote to JUSTIN's GP that use of the MCA/DOLS should be considered with JUSTIN because he lacked the capacity to make decisions about his medical care. One week later he was in hospital and refusing a brain scan, yet the MCA does not appear to have been considered. Nor is it considered at any subsequent point.

6.4.4. Despite evidence of JOBY's increasing anxiety and depression, and episodes of intoxication and prolonged misuse of alcohol and drugs, with an impact on his memory and physical health, a cognitive assessment does not appear to have been completed, despite a recommendation in February 2018. No concerns have been recorded about his mental capacity, notwithstanding that in April 2018 the chronology refers to mental and behavioural disorders as a result of harmful use of alcohol and opiate-dependence syndrome. In December 2019 the chronology records that there were no indications that he lacked capacity regarding treatment decisions, at a time when he was known to be using a range of drugs together with alcohol, with impact on his physical wellbeing. Into 2020 he declined to accept treatment, partly related to his reluctance about admission to hospital, which he linked to anxiety. His declining physical health included jaundice, oedema and chronic liver disease, abdominal pain and vomiting.

6.4.5. At the reflection learning event participants were acutely conscious of the responsibility involved in assessing mental capacity, especially in situations where individuals might be assumed to be making lifestyle choices and/or where they present well verbally but where there were doubts about their executive functioning. There appeared to be some uncertainty as to which practitioner might be the ultimate decision-maker when several agencies were involved[40].

[40] This question is addressed explicitly in *SAR-MS*, published by City of London and Hackney SAB (2021).The answer depends on what the type of decision to be made, the context, and the professional expertise required.

6.4.6. JOBY's relative recounted an experience when she took him to hospital. She believed that he was experiencing "delirium" and was "confused", his capacity fluctuating as a result of sepsis and not having eaten for a week. Her experience was that practitioners lacked an understanding of capacity. She felt that perceptions needed to change, highlighting that addiction is an illness.

6.4.7. Three questions arise that HSAB should raise with partner agencies as part of its statutory mandate to seek assurance that services across Herefordshire are working effectively in preventing abuse and neglect, including self-neglect.

6.4.8. Firstly, is there an understanding of executive capacity? Especially where there are repetitive patterns, it is essential to assess executive capacity as part of mental capacity assessment. Guidance has commented that it can be difficult to assess capacity in people with executive dysfunction. It recommends that assessment should include real world observation of a person's functioning and decision-making ability[41], with subsequent discussion to assess whether someone can use and weigh information.

6.4.9. Secondly, is sufficient recognition given to the impact of trauma and adverse childhood experiences?

6.4.10. Thirdly, is drug and/or alcohol abuse seen as a lifestyle choice and unwise decision-making or possibly invoking considerations of mental capacity and self-neglect?

6.4.11. The absence in the chronologies of explicit reference to self-neglect and to following agreed multi-agency procedures is a concern. To varying degrees all three questions were engaged when individuals were known to have experienced trauma, were revealing that they were drinking to control anxiety, were wanting to control their substance misuse but could not carry this through and/or were depressed and unable to implement their stated intentions.

6.4.12. The independent reviewers, and the representatives of the services who contributed to this thematic review, all recognise that concerns about the implementation of the Mental Capacity Act 2005 extend nationally. Any revision to the code of practice that accompanies the Act needs to address the nuances and complexities that practitioners encounter, especially those captured in the aforementioned three questions.

6.5. Domestic abuse. DAWN's chronology records domestic abuse by her partner, who allegedly also stole her bank card. A risk assessment was not completed because she did not keep appointments. As her relative pointed out, however, this may have been because of the multiple issues with which DAWN was having to cope; supportive outreach might have enabled completion of the risk assessment.

[41] NICE (2018) *Decision Making and Mental Capacity*. London: National Institute for Health and Clinical Excellence.

6.5.1. WILL's chronology contains a record of domestic assaults on his former partner which on one occasion, because of apparently weak evidence of harassment, resulted in no further action by the police. A second incident is recorded as related to a custody dispute and resulted in a harassment warning. The chronology also observes that this episode did not result in a review of risk by his offender manager as would have been expected according to CRC public protection policy.

6.5.2. JOBY's chronology records allegations of him being assaulted by a former partner and of domestic abuse of his current partner. As children appear to have witnessed the assaults, the police made appropriate referrals to Children's Social Care. His partner repetitively withdrew complaints. The police completed risk assessments and placed warning markers on their recording system but there is no reference to the episodes being considered by a MARAC. It is not clear from the chronology how Children's Social Care or Adult Social Care responded to the notifications of risk submitted by the police.

6.6. Care and support assessment. The absence of requests for an Adult Social Care assessment for care and support in the majority of cases in the sample is noticeable. Adult Social Care assessment is an essential part of any plan that seeks to address a person's accommodation, and mental and physical health needs, as part of wrap-around support. Outreach social work is a possible helpful future development[42], alongside other practitioners, reaching out and assessing the person in their locations. Research elsewhere[43] has found that agencies can be deterred from making referrals to Adult Social Care because of potential volumes and/or that Adult Social Care is operating a higher threshold for care and support assessments than Section 9 (Care Act 2014) permits. HSAB needs to be assured that these factors are not present in Herefordshire.

6.6.1. Within the narratives of the six cases were instances of individuals who potentially had care and support needs, but were not referred for an Adult Social Care assessment of their needs and therefore did not receive an assessment.

6.6.2. AIDEN was referred to ASC for care and support assessments. On one occasion it appears that he might have declined assessment, in which case, given his presenting physical and mental health problems and substance misuse history, it is unclear why an assessment was not undertaken anyway, using the powers in section 11 Care Act 2014. The chronology also refers to a probation officer appealing against ASC decision-making and recording the assessment process as a negative experience. Once AIDEN was assessed as having care and support needs, there were then difficulties in commissioning a provider because of the risks associated with substantial substance misuse.

6.6.3. PASCAL became homeless following his mother's death. He was physically disabled, had been diagnosed with depression and anxiety, was addicted to

[42] Preston-Shoot, M. (2020) Adult Safeguarding and Homelessness. A Briefing on Positive Practice. London: LGA and ADASS.

[43] Mason, K., Cornes, M., Dobson, R., Meakin, A., Ornelas, B. and Whiteford, M. (2017/18) 'Multiple exclusion homelessness and adult social care in England: exploring the challenges through a researcher-practitioner partnership.' *Research, Policy and Planning*, 33 (1), 3-14.

heroin and also alcohol-dependent. He was not referred to ASC for assessment. He was observed to be "unkempt."

6.6.4. DAWN was not referred to ASC despite evidence of physical illness, mental distress and substance misuse, and references to self-neglect. DAWN's relative questioned why this was, suggesting it was a shortcoming. Nor did WILL have an assessment of his care and support needs.

6.6.5. JOBY was referred to ASC. Initially, after two referrals, he did not respond to efforts made to contact him. Incidents involving other residents in the accommodation setting were seen as a matter for the police. He did receive an assessment by an occupational therapist that resulted in the provision of equipment. He is reported as having found this helpful.

6.6.6. In early 2019, JUSTIN was the subject of several safeguarding referrals and adult social care referrals following a series of incidents associated with bizarre behaviour. Assessment was undertaken but following a hospital admission he was now sober and refusing care, as a result of which the case was closed. This approach is problematic with a chronic relapsing condition such as substance misuse, where it is quite predictable that, as happened, JUSTIN quickly returned to substance use and former patterns of behaviour. A longer process of assessment and monitoring is required to understand the needs of this client group.

6.6.7. At the reflection learning event, the focus fell especially on individuals at the edge of eligibility, namely where they might not meet the eligibility criteria that would trigger a duty on ASC to respond but where there were significant risks, for example of self-neglect. Agencies needed to refer and to be clear what was being requested (a care and support assessment (section 9 Care Act 2014) and/or adult safeguarding enquiry (section 42).

6.6.8. Previous experiences of referral to ASC were reported as having been "hit and miss." Some practitioners had experienced referrals being bounced back without apparent consideration of the power available to ASC to meet any social care need (section 19). Other services needed to highlight the urgency of a situation, with the CARM procedure now providing an escalation pathway.

6.7. Responses to substance misuse and mental distress. Individuals in the grip of substance misuse do not find change easy to achieve and this realisation should be factored into how services are set up to provide support. This reinforces the commentary on executive decision-making and mental capacity assessment above. This links also to later sections on commissioning and on workforce development.

6.7.1. There were missed opportunities to consider the interface between mental health and substance misuse. AIDEN experienced anxiety, for which medication had been prescribed. Records indicate that he may have had a personality disorder and there are references in the chronology to depression. Despite this, and addiction being evidence of impulse control disorder, there was no referral to mental health services. The last contact with mental health services was in 2017 in Accident and Emergency.

6.7.2. AIDEN had been allocated a key worker as a response to his substance misuse from March 2016. His GP is recorded as being unsure how to respond to his continued substance misuse other than to provide advice about wound management and about what medications were contraindicated because of his alcohol-dependence. There were regular discussions in the GP surgery, including with a mental health practitioner[44] and safeguarding lead, which is good practice. There is reference in the chronology to detox whilst in hospital but also to his unsuitability for a drug rehabilitation requirement when he was sentenced to a community order. However, despite the support outlined above, his misuse of drugs and alcohol continued until his death.

6.7.3. PASCAL may at one point have been allocated a clinical psychologist but there is no detail in the chronology of their involvement and this practitioner was not with the secondary NHS mental health provider. His GP discussed with PASCAL his anxiety and depression on several occasions. However, the chronology reflects that there is "no evidence of referral to appropriate services for mental health concerns" or of further discussions when "not fit for work" notes were issued. Nonetheless, conversations between PASCAL and his GP did include candid focus on risks.

6.7.4. DAWN had been drinking heavily for twenty years and had been diagnosed with alcoholic cirrhosis and depression. She was also using heroin. Her GP refused to prescribe addictive medication, which was good practice, and referred her to an adult mental health provider, which requested further information. She underwent one detox in hospital shortly before she died.

6.7.5. WILL had a history of alcohol-dependence, anxiety and depression. The GP prescribed medication but the combined chronology records that he did not find medication helpful. Less evident is how his mental wellbeing was considered and addressed alongside his substance misuse. Following one opiate overdose in April 2018 he was seen by the Mental Health Liaison Team in hospital. The overdose appears to have been assessed as accidental, no suicidal ideation was identified, and the problems were framed as homelessness and addiction, based on the extensive discussion with WILL. He was at risk of accidental harm when under the influence of substances. He was discharged back to the care of his GP. He presented to the crisis team in May 2018 and was assessed and given blankets with a follow up appointment the next day which he did not attend. Otherwise there does not seem to have been any mental health involvement with WILL before his death although requests were made. The chronology records that there was a lack of professional curiosity by this team. He had mobility issues so his non-attendance was not surprising. There was no follow-up with his offender manager, whom he was seeing weekly, or with Housing Solutions. There was no multi-agency meeting at this point. The problem was clinically assessed as primarily alcohol-related, even when subsequently WILL described his mental health as "not good" and even though there is an association in the chronology between WILL not drinking and an increase in his anxiety, and between binge drinking as a coping mechanism for paranoia and anxiety.

[44] This may have been a practice based lead and not part of secondary mental health services.

6.7.6. WILL's relatives were critical that "nothing came of mental health referrals from his GP" and that there was "no real support" or "plan to help him" with his substance misuse and mental health. They were critical of what they felt was an absence of "therapeutic input." They described a young man who "needed to be guided", who "felt ashamed and a failure" and who "would not share things, saying he was okay when he was not."

6.7.7. JOBY was known to experience anxiety and depression, especially when alone. He had a history of attempted suicide. There does not appear to have been, at least in the timeframe under review, any involvement by secondary mental health services[45]. To his substance misuse key worker and in medical reviews completed by that provider, he would often report no mental health issues. Occasionally he reported low mood and one medical review concluded that he had "mental and behavioural disorders due to harmful use of alcohol and opiate dependence syndrome."

6.7.8. Allegations that he was selling his methadone and opiate medication do not appear from the chronology to have been followed up[46]. There was a standard response to his missed clinical reviews and key worker appointments. When he was seen, detox was sometimes discussed alongside advice regarding his physical health but without assertive outreach it proved difficult to sustain any intervention. There does not appear to have been a coherent plan that was followed through.

6.7.9. JUSTIN had a long history of substance misuse and his death was almost certainly the result of the damage done by dependent drinking. However, a problem in managing substance misuse was that assessment could be very difficult because he was very poor at reporting his patterns of use. This made it challenging to determine the best course of action and the intensity of intervention required. This highlights the benefits of a multi-agency perspective that can give a much more three dimensional picture of his drinking, by comparing his reports with information from, for example, the police or housing services. This also indicates the importance of all agencies adopting a consistent alcohol screening tool (AUDIT[47] is the preferred choice) and using it consistently with all clients.

6.7.10. JUSTIN's care also raises concern about advice around detoxification. In March 2018, his medical notes state that he was advised to abstain from drinking by his GP but without any advice on the possible risks. Addaction[48] also put him on an alcohol reduction regime. JUSTIN had a significant history of fits and it is unsurprising that he was unable to complete these regimes.

[45] For JOBY, and the other individuals with ongoing mental health concerns, a question to be considered relates to what monitoring of mental health GPs are expected and enabled to undertake, and what involvement of, or oversight by secondary mental health services is indicated.

[46] The allegation was made anonymously to a drug and alcohol service provider in October 2018. A similar allegation was made to police regarding WILL in May 2018. The chronology states that this information was passed to a safer neighbourhood team but the chronology does not record any subsequent prevention or disruption activity.

[47] Alcohol use disorders identification test (AUDIT) AUDIT is a comprehensive 10 question alcohol harm screening tool.

[48] Drug and alcohol misuse service.

6.7.11. JUSTIN's mental health problems were known to his GP, secondary mental health and substance misuse services, police and probation. Medication was prescribed by his GP. The chronology references JUSTIN's self-report on occasion that his mental health had improved and discussion with practitioners about his mental wellbeing. There were occasions when secondary mental health services were assessed as not indicated because there was no evidence of acute mental illness when he had presented at emergency departments, with advice given to access substance misuse services and to re-refer if there were concerns about psychosis or confusion following alcohol detox.

6.7.12. Service users reported mixed experiences of mental health provision. On the one hand, crisis, early help and therapeutic responses had assisted them to manage their mental distress and to begin to address the adverse experiences that had, for instance, led to depression and anxiety. However, waiting lists and consequent delays in accessing support impacted on their ability to move on. Cancelled appointments and limitations on the number of sessions were also experienced as unhelpful.[49] The Covid-19 pandemic had also had an impact, with telephone appointments being experienced as less helpful even though the reason for them was acknowledged.

6.7.13. Practitioners observed that a dual diagnosis pathway was needed, building on the recognition in Project Brave that substance misuse often arises as a response to the impact of trauma. A both/and approach to accessing community-based mental health support when substance misuse is "chaotic", in other words collaborative arrangements, is best practice[50].

6.7.14. DAWN's relative had formed an impression that after-care, following overdoses, self-harm and attempted suicide, had been poor, which had resulted in descending spirals, use of harder drugs and loss of her accommodation and training course. She recounted that DAWN had stated that support workers were not helping her. JOBY's relative also emphasised that practitioners and services needed to understand "what deterioration looks like." They were critical of how healthcare practitioners managed his aggression when he was intoxicated, resulting in him self-discharging.

6.8. Responses to physical ill-health. Good practice is evident in response to physical health needs. Both by a GP and secondary healthcare practitioners, there were attempts to manage AIDEN's deteriorating physical health. He had CT head scans following falls, which proved unremarkable, and was referred to a seizure clinic. The GP followed-up his deep vein thrombosis and monitored his use of medications, sometimes declining to prescribe or to release prescriptions early. This was good practice.

[49] The independent reviewers have been told that therapeutic modalities have an evidence-base for the number of sessions to be provided. Cancelled appointments by the service user may indicate difficulties with engagement and a need for pre-clinical work.

[50] National guidance is available, namely: Public Health England (2017) *Better Care for People with Co-Occurring Mental Health and Alcohol/Drug Use Conditions. A Guide for Commissioners and Service Providers.* NICE (2016) *Coexisting Severe Mental Illness and Substance Misuse: Community Health and Social Care Services*. NICE (2011) *Coexisting Severe Mental Illness (Psychosis) and Substance Misuse: Assessment and Management in Healthcare Settings*.

6.8.1. There were similar attempts by GPs and secondary healthcare providers to address PASCAL's physical ill-health, including follow-up of deep vein thrombosis and confirmation that he had Hepatitis C, not always successfully when he did not attend appointments or could not be contacted. This offers an instance where outreach health provision might have been useful.

6.8.2. Significant concern is evident regarding DAWN's physical wellbeing. She experienced seizures, a bloated abdomen, vomiting, stomach ulcers, dental abscesses and liver cirrhosis. She was appropriately referred by her GP and her physical health and alcohol use were reviewed by her substance misuse key worker and the GP. The police, when requested as a result of concerns for her safety, searched for and usually located her. On occasions she refused to be taken to hospital by ambulance, which raises a question as to her decisional capacity.

6.8.3. WILL's GP tried to keep in contact with him, which was good practice, questioned some of his requests for medication, declined to prescribe without a face-to-face appointment, and prescribed medication for depression, anxiety and panic attacks according to NICE guidelines. It appears that WILL may have been using increasingly high doses of diazepam to maintain its effect on his anxiety.

6.8.4. JOBY's physical health was monitored by both his GP and staff working for the substance misuse service, although he did not always attend appointments, including outpatient clinics to which he had been referred. Over time he was tested for Hepatitis B and Hepatitis C, which do not appear to have been detected. He had a CT scan, which was normal, after one of several falls, which may have been the result of intoxication. He explained his reluctance to be admitted and/or to remain in hospital as due to anxiety. Between early May and December 2018 the GP surgery did not see him although it did receive letters about his attendance at A&E departments. This meant that there was no follow-through on whether he had followed advice on medication and to contact Addaction. He was seen quickly in January 2019 when he requested an appointment. Responses to missed key worker appointments and clinical reviews by staff in the substance misuse service were always the same, namely sending written communications with further appointments. Persistent non-attendance did not trigger a change of approach. The approach to his physical ill-health thereby appears somewhat incoherent, the more so as his physical health declined during 2019 as a result ongoing significant substance misuse.

6.8.5. JUSTIN was, by the last few months of his life, very seriously ill. He had a range of problems including Hepatitis C, advanced alcoholic liver disease, breathing problems, seizures, incontinence, and a decreased platelet count that could lead to inter-cranial bleeds. He appears to have received good medical care generally. However, this was interrupted by his non-attendance and non-compliance with his Hepatitis treatment.

6.8.6. JOBY's relative was critical of what they saw as inaction in response to his poor mobility, not eating and swollen stomach.

6.9. An additional feature of the evidence-base is "think family." The independent reviewers have been told that accommodation and support providers often feature think family in their work with individuals. However, there is little sense in the chronologies of the history of family relationships featuring in assessments and planning. Support was offered to AIDEN with respect to his son who was in foster care and awaiting adoption. There was concern regarding risks to his mother when she visited him. She also alerted services when she felt he was taking too much medication.

6.9.1. An aunt sometimes provided WILL with somewhere to stay when his parents could not have him home, because they were looking after his child and he was not allowed to be there[51], and raised concerns about his mental health with his GP. His mother accompanied him to GP appointments and probation and the GP liaised with his family. This was good practice. His chronology refers to agencies being aware of difficulties for some years. Missing, though, is any work with the family to explore what support they might be willing to provide. Family members have referred to a lack of support, to being "left on our own", including on one occasion WILL being dropped off outside his parents' home when he was in crisis. He did not have contact with his child but the chronology provides no insight as to the impact this had on him.

6.9.2. JOBY was often accompanied to appointments by his partner. A carer assessment was apparently discussed in April 2018 but there is no record of this having been completed. There were occasions when their relationship broke down but she does appear from agency records to have been supportive and may have helped him to engage with appointments. It does not appear from the chronology, however, that their relationship was a focus for any work, including when there were concerns that she might have been exploiting him. This would have included how she could safeguard her child when JOBY was intoxicated. Indeed, in September 2018 the chronology refers to the house in which they were living, when he was not in the accommodation with independent living staff support, as "cluttered" and a "tip". It is not clear which service submitted a "vulnerable adult" incident notice, nor is it clear what action may have resulted, included in relation to the child who was living there. It is noteworthy, in that context, that earlier in 2018 JOBY had expressed concern about the implications of his substance-dependence for his partner and her son, who had separate contact with social workers.

6.9.3. JOBY's relative was especially critical of what they regarded as a failure to explore whether his partner was financially and physically abusing him. They wondered whether this had been because he was often intoxicated. They acknowledged that both JOBY and his partner had "dependencies" but believed that insufficient protective action had been taken when he was exploited, for example when his methadone was taken from him. JOBY's relative was also critical of what they saw as a lack of information-sharing both before and after his death

6.10. Another component of the evidence-base refers to transitions. In the context of this review, transition refers to the point at which people transfer from one service to another.

[51] The chronology refers to the involvement of CAFCASS and court orders.

It is a point of movement between, for example, hospital and community services or between community and supported living provision.

6.10.1. Prison discharge and hospital discharge are key points of transition. Looking at the six cases, some of the individuals did not appear to have the skills, resilience and capability, at least not without wrap-around support, to successfully manage transitions, for example into supported accommodation. What is being highlighted here was the need to consider what wrap-around support was necessary in order to support those who were trying to recover from the impact of trauma and adverse experiences and trying to manage their emotional responses. Project Brave has sought to address this resource gap.

6.10.2. When AIDEN was discharged from hospital in February 2020, the accommodation provider was called for an update post discharge. This was good practice.

6.10.3. In one instance (JOBY) a hospital discharge generated explicit concern. The accommodation provider indicated in late June 2020 that he could not return until there was a treatment plan. The provider discussed their concerns with a safeguarding professional at the GP Practice, who suggested that a multi-agency meeting would be appropriate prior to discharge. This was good practice. Nonetheless he was discharged from hospital without a multi-agency meeting being held. There does not appear to have been any escalation of concern about this discharge. He was readmitted in early July 2020 but discharged the same day without a package of care. The chronology records this episode as a failure in discharge planning. A similar pattern repeated in August 2020, after which his GP referred him for hospice care, which JOBY declined as he did further hospital admission. He had previously been recorded as being afraid of dying alone in hospital.

6.10.4. There is NICE guidance about the transition between inpatient mental health or general hospital settings and community settings. For people with serious mental health issues who have recently been homeless or are at risk of homelessness, the guidance[52] recommends intensive structural support to assist with finding and retention of accommodation. This support should begin prior to discharge and continue for as long as necessary. Housing and mental health services should work together to jointly problem solve. The chronology for JOBY refers to mental and behavioural disorder due to harmful alcohol use, and to anxiety and depression. Similar guidance for people in inpatient general hospital settings[53] recommends on admission that a person's housing status is established and that, prior to discharge, if a person is likely to be homeless, liaison occurs with the local authority's Housing Options service to ensure that advice and help is offered. Homelessness and safeguarding issues should be addressed by agencies working together to ensure a safe and timely discharge. Those at risk of readmission should be

[52] NICE (2016) *Transition between Inpatient Mental Health Settings and Community or Care Home Settings*. London: National Institute for Health and Clinical Excellence.

[53] NICE (2015) *Transition between Inpatient Hospital Settings and Community or Care Home Settings for Adults with Social Care Needs*. London: National Institute for Health and Clinical Excellence.

referred to community practitioners prior to discharge for health and social care support.

6.10.5. DAWN's relative was critical of the lack of transition planning or follow-up when she was discharged after rehabilitation (detoxification), particularly the absence of support to address her mental distress.

6.10.6. PASCAL was discharged from prison before implementation of the Homelessness Reduction Act 2017. He appears to have been discharged to no fixed abode although the independent reviewers have been informed that, at the time, there was a hospital discharge homelessness worker. Moreover, provisions for homeless people in the Housing Act 1996 should have been explicitly considered.

6.10.7. Another transition is when someone moves off the streets and into some form of accommodation. PASCAL moved into a flat in May 2018 with the assistance of an outreach worker but the landlord was soon complaining about who else was accessing the accommodation. This would have been one occasion when a multi-agency meeting was indicated to determine how best to meet his diverse needs, including a review of legal options pertaining to housing, community safety, adult social care and adult safeguarding. The move coincided with ongoing attempts with DWP to reinstate his entitlement to employment and support allowance. Individuals must be provided with the basic necessities for such a move. He also alleged being bullied and threatened, which highlights that accommodation can feel unsafe because of being surrounded by and/or engaging with a high level of drug and/or alcohol abuse. The chronology contains an observation that PASCAL was staying away from his accommodation because of drug-related issues. He was eventually issued with a notice to quit by his landlord because of anti-social behaviour and he surrendered his tenancy, thereafter using a night shelter.

6.10.8. DAWN did move into a flat but found it difficult to mobilise and walk anywhere and so preferred to live on the streets. Her chronology also records that she felt unsafe in her flat, with the locks having been changed because other people had acquired the keys. DAWN's relative observed that continuity of a support worker would have been helpful at this point, to build on DAWN's ability to keep herself safe. This is another illustration of the importance of providing wrap-around support to enable a person to sustain a tenancy and address their social care and healthcare needs. It is a service now available in Herefordshire.

6.10.9. DAWN's relative recounted occasions when they had been told, or had heard her being taunted by other women in a refuge, or abused by other residents in a safe house. DAWN had told of other residents in a block of flats engaging in substance misuse. Her relative felt that she was vulnerable and had not been protected.

6.10.10. WILL was offered a flat with an accommodation provider offering support in November 2019. The chronology observes that his offender manager had persisted with efforts to find him accommodation, the initial approach to Housing Solutions having been made in March 2018. He did not maintain a

reduction in his use of alcohol or engagement with support staff. He was using cannabis (again) in breach of his tenancy agreement. At this time he was also withdrawing from engagement with his offender manager and practitioners at the drug and alcohol provider. WILL's family members have questioned the adequacy of the level of support and oversight on offer when he was provided with accommodation.

6.10.11. There were several incidents over the months when JOBY threatened or reported being bullied, assaulted and harassed by another resident (AIDEN) living in the same accommodation setting[54]. The police responded but the incidents highlight the importance of a whole system response to ensure that accommodation provision is experienced as safe and does not break down. Indeed, the chronology records JOBY as remarking in January 2019 that peer pressure in the supported living accommodation was unhelpful.

6.10.12. One service user interviewed for this report detailed an experience of having been discharged from mental health detention onto the street (October 2018) without their welfare benefits having been sorted and with no apparent discharge plan or meeting. Provisions in the Homelessness Reduction Act 2017 would be relevant here.

6.10.13. Another example of transition is when young people known to children's social care approach and reach the age of 18. WILL was known to children's services but apparently disengaged from the 16+ team on reaching his eighteenth birthday. The independent reviewers understand that a project has been launched focused on an all-age strategy on transition. Briefings are available that offer guidance on transitional safeguarding[55].

6.11. A further element that emerged from the evidence was provision or lack of provision of advocacy, and Appropriate Adult support for those involved with the criminal justice system. Neither appeared in the chronologies. Advocacy may be indicated, for example, when health systems are based on self-reporting and attendance at appointments at specified times and places. Not everyone can easily engage with such a system, at least not without outreach support. If this is not provided, cases may be closed when individuals do not engage and/or are unable to readily explore what lies behind their presenting problems.

6.11.1. At the reflection learning event mention was made of the use of peer supporters, through the Hepatitis C Trust, participating in the Hepatitis C service, mobile clinic and point of care testing in care homes. Peer support and mentoring may be one option where individuals do not have a statutory entitlement to advocacy, such as with housing and/or clinical health services.

[54] Incidents are recorded during 2018 and 2019. He would not always make a complaint.

[55] Holmes, D. and Smale, E. (2018) *Mind the Gap: Transitional Safeguarding – Adolescence to Adulthood*. Dartington: Research in Practice. Holmes, D. (2021) *Bridging the Gap: Transitional Safeguarding and the Role of Social Work with Adults*. London: DHSC.

7. Thematic Analysis – Team around the Person

7.1. From a reading of the combined chronologies, and mindful of the evidence-base, the following themes were identified for exploration at the learning event and are analysed here.

7.2. Working together. From the chronologies it is possible to discern examples of close liaison between practitioners in different services, for example variously between a probation officer, key worker from the substance misuse provider, hospital healthcare practitioners and staff from an accommodation provider (AIDEN). There were examples of partnership working between GPs and substance misuse practitioners, pharmacists or offender managers regarding prescribing and attempts to address an individual's drug use (AIDEN, WILL, JOBY). The National Probation Service (NPS) worked with welfare rights advisers to ensure individuals received their benefits (PASCAL), and with substance misuse practitioners and outreach workers to secure accommodation and maintain tenancies (PASCAL). Housing providers and outreach updated the substance misuse service on client welfare. (JUSTIN) There were instances where practitioners from different services saw individuals together (DAWN, WILL).

7.2.1. In the chronologies there were also instances where joined-up planning would have been helpful. When AIDEN dropped out of contact following a change of offender manager, breach proceedings were initiated. At this point there is no evidence of contact being made with other agencies when a more proactive approach would have been appropriate.

7.2.2. When in May 2018 WILL presented at an Emergency Department dishevelled and dirty (self-neglect), with his parents unable to accommodate him, there was no liaison with his offender manager, ASC, or a homelessness worker to explore options for emergency accommodation.

7.2.3. At the reflection learning event an impression was conveyed that multi-agency working had improved, including information-sharing about service user/patient outcomes. Sometimes this was linked with the commissioning of Turning Point as the provider of substance misuse services, both by senior leaders who were interviewed and by practitioners who attended the reflection event. Similarly there was acknowledgement of a transformation programme within secondary mental health provision, including joint work with MIND and with Turning Point, including attendance of the latter provider at multi-disciplinary team meetings (MDTs). There was, though, recognition that there remained a need to enhance working together with other services.

7.2.4. Similarly accommodation providers recognised that practitioners from other agencies were visiting accommodation sites and positive views were expressed about a recent innovation, namely high and critical risk review meetings. Another very recent positive innovation was reported by staff involved with alcohol-dependent individuals in a secondary health care setting. MDT planning meetings had been instituted that involved practitioners from the Mental Health provider and from Turning Point.

7.2.5. Similarly, there were positive reflections at the learning event concerning outreach involving the secondary health care provider and Turning Point, with point of care testing available and collaborative working designed to tackle obstacles preventing access and/or admission to hospital. Emphasis was being placed on responding quickly to referrals, with increasing use of mobile clinics where practitioners from across providers and with a range of knowledge and skills would be present.

7.2.6. Nonetheless, notes of caution were expressed. Silo working was still a feature of local practice. Cases were described where communication between services and the use of multi-agency meetings had prevented an individual's death but it was felt that this practice had been possible because of individual practitioner relationships rather than as a result of expectations of a multi-agency system. A view was also expressed concerning the need to improve working together, including the use of MDTs, at the beginning of a person's journey. Practitioners also referred to the benefits of co-location and thought that this approach could be developed further.

7.2.7. The approach with individuals with dual diagnosis or co-occurring diagnoses remained difficult. There were positive reflections about joint working within an assertive outreach team but within a context where it was felt that care could be better coordinated in line with NICE guidance[56].

7.3. Information-sharing. There were missed opportunities to share information about adults at risk (AIDEN, JOBY, WILL). For example, when AIDEN was not compliant with medical advice, this information was not shared by the GP with his substance misuse key worker. Probation does not appear to have updated the police when AIDEN's mother was visiting him despite a restraining order being in place. It is not clear that the reasons why PASCAL would not utilise the night shelter were known to all the services working with him. The police do not appear to have shared the information that PASCAL had been reported for summons for begging.

7.3.1. WILL's GP knew that he had difficulty attending appointments on account of his mental health and mobility difficulties, and heavy alcohol use, but this information was not shared with the result that Housing Solutions closed down their involvement when he failed to keep an appointment to complete a personal housing plan. This may have been because the GP was unaware of Housing Solutions' involvement.

7.3.2. There were positive examples of information-sharing, for example when the police shared details with ASC of PASCAL's anti-social behaviour, and when they exchanged information with hospital staff when he self-discharged shortly before he died. The National Probation Service exchanged information with other services, particularly his key worker in a drug and alcohol service and the police, as part of keeping a risk management plan updated, for example when appointments were not kept (WILL). The police shared information about domestic abuse incidents and allegations with new offender managers and/or accommodation providers (WILL, JOBY). GPs, the independent living accommodation provider and substance misuse key

[56] NICE (2016) *Coexisting Severe Mental Illness and Substance Misuse: Community Health and Social Care Services*. London: National Institute for Health and Care Excellence.

workers exchanged information (JOBY). JUSTIN's outreach worker and housing provider consistently shared information with the substance misuse service about his current whereabouts or health status.

7.3.3. At the reflection learning event some participants recounted that the General Data Protection Regulations (GDPR) had prevented information-sharing. The independent reviewers were told that an information-sharing protocol was being developed under the auspices of Project Brave.

7.3.4. The Data Protection Act 2018, which incorporates GDPR into UK law, permits the sharing of information to safeguard a child or an adult at risk, and to assist with the prevention, detection and prosecution of crime. Information-sharing remains a challenge.

7.4. Referrals. The chronologies contain examples of appropriate referrals. For example, a probation officer referred AIDEN to ASC for assessment of his care and support needs and, moreover, challenged the "no further action" outcome of a previous assessment. On two occasions the probation officer followed up their challenge, as well as escalating concern within their own service. PASCAL was referred by his GP to a vascular surgeon. After an A&E attendance in May 2018, JUSTIN was appropriately referred to a range of agencies including mental health, outreach and an accommodation provider for ongoing support.

7.4.1. The police appropriately referred domestic assaults on (former) partners to children's social care (WILL, JOBY). However, there were no referrals to ASC for care and support assessments for WILL, for example when he was offered and given a place in an independent living setting with staff support on site. Chronologies do not routinely detail the safeguarding responses by Children's Social Care, although on one occasion information was exchanged with the substance misuse provider (JOBY).

7.4.2. There are also examples of missed opportunities to make referrals. PASCAL's mental health was managed in primary care. For PASCAL, but also for WILL and JOBY who were similarly observed to experience ongoing anxiety and depression, locating lead responsibility for managing mental health may well be appropriately located in primary care. However, further consideration about access to psychological therapies also appears indicated. Nor was PASCAL referred to ASC until the month of his death. ASC's response to the referral was to send a letter to his flat even though the police had stated that he was not living there. No alternative options for attempting to make contact with PASCAL appear to have been considered.

7.4.3. DAWN was not referred to ASC, for example by her GP or by the police, despite appearing to have care and support needs, arising from physical and mental ill-health, and substance misuse, including needs relating to sustaining accommodation and maintaining a habitable environment. She was referred appropriately for outpatient appointments by her GP.

7.4.4. JOBY was referred to ASC in April 2018, with some liaison between the department and the substance misuse provider. However, the referral did not result in a focus on his care and support needs, or the needs as a carer of his

partner. The situation appears to have been seen as one of harassment between residents within the accommodation provider setting and therefore a matter for the police. JOBY's GP did refer him to hepatology for clarity about the degree of his liver cirrhosis. In July 2020 safeguarding practitioners at a GP Practice raised concerns with ASC that current arrangements to support JOBY were inadequate.

7.5. Multi-agency meetings. Across the chronologies there is limited evidence of the use of multi-agency meetings to agree an approach to mitigating risks and meeting need. For example, a case conference or multi-agency risk management meeting should have been considered when an offender manager visited AIDEN at his place of residence and found him physically very unwell, with loss of short-term memory and slurred speech, and again when AIDEN appeared to be declining a care and support assessment, with possible confusion about what different agencies could offer and with the probation officer concerned about his unmet needs. A third missed opportunity to bring services together occurred when AIDEN was only engaging intermittently with his substance misuse key worker, when he was minimising and appeared unconcerned about his use of drugs and when his mother, his only family support, had been diagnosed with cancer.

7.5.1. In AIDEN's case a multi-agency meeting was convened in November 2019 at the request of his accommodation provider. There were concerns about his ability to mobilise and to self-care. A care package was approved but care staff would not visit because of the risks arising from used needles. Despite repetitive concerns about his inability to self-care or manage his medications, and refusals of some medical assistance, a further multi-agency meeting was not convened until early February 2020.

7.5.2. In PASCAL's case, there is evidence of liaison between practitioners across different services but no whole system meeting was convened to coordinate wrap-around support or to address his substance misuse and deteriorating health and wellbeing.

7.5.3. In DAWN's case, her agreement to professionals meeting to agree a care plan appears to have been obtained around a month before she died. This was too late, given her deteriorating physical health, the challenges she encountered trying to live in her flat and also to sustain engagement with services, and her substance misuse. No meeting appears to have been held before she died. Moreover, her consent was not formally required for such a meeting.

7.5.4. In WILL's case, a multi-agency meeting was convened in October 2018. It is not clear from the chronology who attended and what the outcomes were. It appears to have focused in part on his compliance with court orders.

7.5.5. In JOBY's case entries on the chronology emphasise that a multi-agency meeting would have been prudent, for instance after repeat domestic abuse incidents and the submission again of risk assessments by the police to ASC and Children's Social Care, or in response to non-attendance at clinical reviews in a context of increasing concerns about physical health, mental wellbeing and substance misuse. When a multi-agency meeting was suggested, this was just two months before his death and no meeting was

held despite concerns about discharge from hospital to the independent living accommodation setting without a care and support package in a context of deteriorating health and wellbeing.

7.5.6. In JUSTIN's case there were no multi-agency meetings about his needs. This would undoubtedly have benefited the provision of care by providing a fuller picture of his substance misuse and physical and mental health.

7.5.7. In cases where incidents of domestic abuse featured, the chronologies do not indicate that episodes were discussed in MARAC meetings subsequent to police submission of risk assessments.

7.5.8. At the reflection learning event participants conveyed uncertainty about how agencies could initiate a multi-agency meeting, using the complex adult risk management (CARM) procedure. Although some good results had been obtained as a result of the use of multi-agency meeting procedures, a sense was conveyed that CARM is still being embedded, and that greater and more effective use could be made of case conferencing.

7.6. Use of policies and procedures. The evidence from the chronologies appears to be that self-neglect was mentioned but policy or procedures were not being used by all staff across all agencies as a framework within which to locate their approach (AIDEN).

7.6.1. There are also occasions when individuals do not appear to have been seen as "vulnerable" or at risk, such as when drunk, disorientated and lost (DAWN).

7.6.2. The discharge policy adopted by the substance misuse service does not appear to have been used with flexibility by staff faced with a client who was clearly having problems engaging (JUSTIN), which predates the current provider and remodeling of the service. On the other hand, his housing provider altered their missing person's procedure with regard to JUSTIN to ensure there were more regular checks on his wellbeing.

7.7. Safeguarding literacy. A recurrent theme was the lack of recognition of safeguarding needs, although all six people had histories of misusing substances, physical and/or mental health problems and several had been subject to assault, abuse, and/or self-neglect. This links to issues raised earlier regarding the lack of referrals for a Care Act assessment.

7.7.1. There were missed opportunities to refer adult safeguarding concerns for individuals appearing to have care and support needs, experiencing abuse and neglect, including self-neglect, and unable to protect themselves because of their care and support needs[57]. Examples include individuals being found incoherent, confused and/or intoxicated in a public place, sometimes being taken to an Emergency Department (AIDEN, PASCAL, DAWN, JUSTIN, WILL), and individuals sleeping rough with increasing concern for their physical health (PASCAL) or being at risk from exploitation, County Lines and risk-taking behaviour (DAWN, WILL). Services should refer adult safeguarding concerns rather than expect other agencies to do so.

[57] Section 42(1) Care Act 2014.

7.7.2. When safeguarding concerns were referred to ASC, there were missed opportunities to convene a multi-agency meeting or complete an enquiry as a response to repetitive episodes, for example of individuals appearing unsafe and at risk to the police in public spaces (AIDEN, DAWN). When the police did submit details of adult protection incidents, the chronology is sometimes silent on any outcome (DAWN, JOBY, JUSTIN); at other times, the decision appears to have been that incidents were a police rather than ASC matter despite a repeating pattern and evidence of care and support needs.

7.7.3. Children were clearly involved in some situations, witnessing substance misuse and/or domestic abuse (WILL, JOBY). Chronologies indicate that children were not allowed to have contact when individuals were intoxicated and/or alone but, without ongoing involvement from Children's Social Care, it was unclear how services could be assured that children were being adequately safeguarded.

7.7.4. Both DAWN's and JOBY's relatives were concerned about some of the responses to referred adult safeguarding concerns (section 42, Care Act 2014), either the lack of timeliness or a care management rather than a safeguarding response.

7.8. Legal literacy. In one instance the Homelessness Reduction Act 2017 does not appear to have been considered by an Emergency Department when an individual was ready for discharge but homeless (WILL).

7.8.1. In one case the police made appropriate referrals of domestic abuse, sometimes witnessed by a child, but could also have considered use of civil orders through Domestic Violence Protection Notices and Domestic Violence Protection Orders.

7.8.2. Practitioners reflected that there was a need for better understanding of the Mental Health Act 1983 and Mental Capacity Act 2005 across all agencies.

7.8.3. Representatives of the services involved in this thematic review, and the independent reviewers, are agreed that a broad view of legal literacy should be taken by SABs and partner agencies. Focus needs to be maintained not just on understanding and application of the Care Act 2014 but also of housing, mental health, mental capacity, anti-social behaviour, criminal justice and public health legislation. This reflects the system-wide, multi-agency response that is required.

7.9 Recording. The chronologies contain examples of incomplete recording. For example, it is unclear what action the police took when DAWN was found intoxicated and unable to find her way to her flat. Records are also incomplete on the outcomes of police referral for domestic abuse following reported theft of DAWN's bank card by her partner.

7.9.1. In other cases too, judging by entries on chronologies, there were shortcomings in recording of what referrals were sent, to whom, and with what outcomes (WILL). There were also shortcomings in recording when individuals did or did not attend

appointments, or what prescriptions were issued and why by GPs (WILL), or what had been discussed in supervision and management oversight meetings (JOBY).

7.9.2. Family relationships were clearly under strain in several cases but again records could be limited. Thus, in one case (WILL) it is not clear from agency records why family members would not offer accommodation. Feedback from family members, however, included descriptions of going missing, drinking, stealing and aggressive outbursts when at home with his parents.

7.9.3. There were some references to clear and precise case notes, for example recorded by an occupational therapist after an assessment (JOBY), and recording by a GP of alcohol use (JOBY).

8. Organisations around the Team

8.1. Supervision and management oversight are core components of the evidence-base for best practice. The chronologies provide occasional examples of each, for instance when offender managers in NPS discussed cases with senior probation officers (AIDEN, PASCAL, WILL) and when a substance misuse key worker had a case discussion with their manager (JOBY). In the JOBY case, a GP discussed their concerns with a safeguarding lead GP. The GP also sought advice from an on-call medical consultant about treatment options.

8.1.1. At the reflection learning event an accommodation provider acknowledged that clinical supervision was now being provided for staff to assist them with responding to the needs and risks presented by residents. Staff too have acknowledged the importance and benefits of reflective practice spaces and sessions focusing on coping strategies given the increasingly complex situations that they are having to manage. Otherwise the feeling of futility that the work can generate, especially when individuals die, can prove overwhelming.

8.2. The evidence-base also refers to commissioning. HSAB has a statutory mandate to seek assurance that, in order to prevent and to safeguard people from abuse and neglect, commissioners are responding effectively to people who present with complex needs including substance misuse, offending, mental health, underlying physical health issues, and/or homelessness. Research[58] strongly recommends new commissioning approaches that deliver integrated provision and a greater number of specialist multi-disciplinary services.

8.2.1. The chronologies identify occasions when there were difficulties finding a provider that would take on a care package when there were risks arising from substance misuse (AIDEN). The chronologies also identify shortfalls in the supply of temporary accommodation, including hostel places (PASCAL), demand exceeding availability.

8.2.2. JOBY's relative expressed some unease about the response to provider concerns, namely whether action was taken and feedback given in response to issues that had been raised about delivery of care and support.

8.2.3. At the reflection learning event Turning Point referred to the provision of a female only space and to a forthcoming pathway for LGBTQ+ individuals. Other practitioners argued for more joint commissioning of pathways to treatment, including mental health and addiction, pathways to support to assist individuals to sustain their accommodation, and pathways to support effective hospital discharge.

8.2.4. Dual diagnosis remained a challenging area for those at the reflection learning event. The independent reviewers have been told of concerns about gaps in

[58] Cream, J., Fenney, D., Williams, E., Baylis, A., Dahir, S. and Wyatt, H. (2020) *Delivering Health and Care for People who Sleep Rough: Going Above and Beyond*. London: King's Fund. Weal, R. (2020) *Knocked Back: How a Failure to Support people Sleeping Rough with Drug and Alcohol Problems is Costing Lives*. London: St Mungo's.

provision for people with co-occurring diagnoses, pointing particularly to lack of local treatment provision for particular issues, such as post-traumatic stress disorder. It has been suggested that service capacity has impacted on individuals' mental health and addiction recovery, including caseload size. Short-term funding represents an additional complication, meaning that newly commissioned services might raise hope and expectations but not prove sustainable in the longer-term. In relation to outreach homelessness support, the government's response to the pandemic brought significant increases in funding, unlocking new pathway approaches. However, this funding is fundamentally short-term.

8.2.5. There was considerable support for the principles and motivations underpinning Project Brave, with its emphasis on co-production, single assessment, and shared leadership. It was attempting to view service provision from the perspective of service users, to hear their voices and to embed their feedback into multi-agency working together. A sense was conveyed of progress towards a more holistic understanding of people's complex needs, thorough risk assessments and structured provision, and enhancement of partnership working and planning both strategically and operationally. It was seen as an opportunity for improving keyworker support and responses to mental distress, substance misuse and homelessness. Some concerns were expressed about whether Project Brave would continue.

8.2.6. What was universally supported was the need to integrate accommodation and wrap-around support, as exemplified by Housing First, so that individuals were provided with safe spaces where they could begin to address the origins of their complex needs through the presence of key relationships.

8.2.7. Several services cross local authority boundaries, particularly with Worcestershire. This includes the Clinical Commissioning Group (CCG), mental health provider and the police. However, different commissioning arrangements for provision, such as drug and alcohol services and mental health services, it was reported, can complicate joint working.

8.3. Workforce and workplace development are other components of this part of the evidence-base. When key workers changed, as a result of staff moving on, there were examples of good handover arrangements (AIDEN) and when reallocation was necessary and in line with service requirements, because of level of risk and the presence of particular types of abuse and neglect (domestic violence) (WILL). However, such changes, sometimes multiple times, could also disrupt relationship-based practice (AIDEN, WILL, JOBY) and did result in difficulties in renewing engagement with service users.

8.3.1. There were occasions when the police could not deploy, for example when AIDEN was reported by hospital staff to be disruptive, with also the probability that a girlfriend was bringing heroin onto the ward.

8.3.2. In WILL's case, when he could not see the GP with whom he usually engaged, that may have led to different prescribing practice in response to his medication requests.

8.3.3. At the reflection learning event, availability of staffing was reported as an issue in discussion concerning work with individuals with co-occurring diagnoses.

8.3.4. Some services have begun initiatives relating to early help responses with adverse childhood experiences and with developing a trauma-informed approach. The latter development may progress further once the new integrated care system has been fully developed and agreed.

8.3.5. The challenges of assessing mental capacity were noted at the reflection learning event, with some practitioners advising of the need for further training, for example in respect of assessing executive functioning, and some also indicating the need for access to specialists to advise on complex cases.

8.3.6. Service users accessing accommodation with support recognised that there had been system change, with policies revamped and the quality of staffing enhanced. This had resulted in fewer "blue light" occurrences, less substance misuse on site and a greater sense of stability, security, support and confidentiality.

8.3.7. Both DAWN's and JOBY's relatives thought that more training was necessary, especially for practitioners, especially those working in supported accommodation settings, so that they understood mental capacity and dependence on alcohol and other drugs, and pathways for accessing help.

9. Governance

9.1. Getting the governance right is important. Clearly, HSAB holds the statutory mandate for governance of adult safeguarding. However, there is no one forum for where governance of services for people who present with complex needs including substance misuse, offending, mental health, underlying physical health issues might reside – the SAB, Health and Wellbeing Board, Community Safety Partnership or Homelessness Reduction Board may all be appropriate choices for 'holding the ring', for providing strategic leadership and holding partners to account. What works may vary depending on local government structures. Thus, a governance conversation is recommended, inclusive of elected members, partnership and board chairs and strategic leaders, where agreement is reached on a common and shared vision, alongside roles and responsibilities for assuring the quality of policies, procedures and practice. Whatever governance arrangements are agreed locally, they must be able to hold relevant organisations and system leaders to account for delivering strategic objectives and service improvement[59]. The HSAB should consider whether to initiate that governance conversation.

9.2. The independent reviewers were told of the Homelessness Forum that provides a connection between local communities, small agencies and larger service providers. The potential contribution that Talk Community hubs could offer towards prevention was noted. Given ongoing concern regarding premature deaths, it might be timely for an appraisal of the engagement between statutory and third sector agencies, and local communities.

9.3. This thematic review has been commissioned by HSAB using its mandate in Section 44 Care Act 2014. HSAB with its partner agencies should now consider its approach to reviews of and learning from cases where neither the criteria for a mandatory or discretionary review are met, principally because the individuals concerned did not have care and support needs. Some SABs have supported the development of homelessness fatality reviews[60] and drug and alcohol fatality reviews, using the model of learning disability mortality reviews as the basis. As with SARs the focus is on implementing learning, for example on making safeguarding pathways and high risk panels more accessible, and providing staff development opportunities on safeguarding and relevant law. As with SARs, fatality reviews remind managers and practitioners of the importance of relationships in people's lives and also of the impact on staff of fatalities, whether or not they were directly involved in the case. This would be one response to the call[61] for a review of every death of an individual with complex needs while sleeping rough or in emergency accommodation.

[59] Preston-Shoot, M. (2020) Adult Safeguarding and Homelessness. A Briefing on Positive Practice. London: LGA and ADASS.
[60] Presentation by Gill Taylor (2019) Homelessness Fatality Review. Reported in Preston-Shoot, M. (2020) Adult Safeguarding and Homelessness. A Briefing on Positive Practice. London: LGA and ADASS.
[61] Weal, R. (2020) *Knocked Back: How a Failure to Support people Sleeping Rough with Drug and Alcohol Problems is Costing Lives*. London: St Mungo's.

10. Revisiting the Terms of Reference

10.1. Whilst this SAR was being prepared, two national inquiries have reported that have direct applicability to reinforcing the learning from this thematic review. The Dame Carol Black report[62] concludes that public provision with respect to substance misuse is not fit for purpose. Amongst its findings and recommendations, it urges government to reverse its disinvestment in treatment and recovery services, and provide the resources and whole system approach that provides people with somewhere to live and something meaningful to do. It recognises that addiction is a chronic health condition requiring long-term follow-up, and emphasises the importance of greater coordination at national and local levels. It observes that prevention is ultimately more cost effective and that trauma and/or mental ill-health are drivers of much addiction, with the consequence that commissioners of substance misuse and secondary mental health services must ensure that individuals do not fall through the cracks.

10.2. The interim report of the Kerslake Commission[63] also recognises that ultimately investment in prevention is a more cost effective approach. It recommends a combination of government support and collaboration across and between key service providers to build on the lessons learned from the Everyone In initiative. It notes that this response to the COVID-19 pandemic saved lives and enabled many people who had been experiencing homelessness to move on into longer-term accommodation. This report also recommends a whole system approach, recognising that seeing homelessness as a public health rather than simply a housing issue led to better partnership working, understanding and treatment. The report observes the importance of good quality accommodation, food and in-reach multi-agency services but criticises short-term funding. It recommends that government leads on provision of affordable housing, pathways beyond hostels, and welfare support. It too recommends reversal of disinvestment in substance misuse services and retention of welfare changes and the derogation of rules on priority need, local connection and no recourse to public funds.

10.3. The final report of the Kerslake Commission[64] makes recommendations to both central government and local authorities. Recommendations for central government include extending the duty to refer (Homelessness Reduction Act 2017) to incorporate a duty on services to collaborate, building on the Everyone-In programme and retaining the welfare changes introduced at the outset of the pandemic, and reviewing law and policy concerning people with no recourse to public funds. Among the recommendations for local authorities and their partners are the development of integrated homelessness and health strategies, long-term strategic planning for managing winter peaks, the development of professional accreditation for staff working in the homelessness sector, and ensuring that new

[62] Black, C. (2021) *Review of Drugs, Part 2, Prevention, Treatment and Recovery*. London: The Stationery Office.
[63] McCulloch, L. with Cookson, E, Currie, H., Kulkarni, D., Orchard, B and Piggott, H. (2021) *The Kerslake Commission on Homelessness and Rough Sleeping: When We Work Together – Learning the Lessons. Interim Report*. London: St Mungo's.
[64] Kerslake Commission on Homelessness and Rough Sleeping (2021) *A New Way of Working: Ending Rough Sleeping Together.*

ICS arrangements tackle health inequalities and provide trauma and psychologically-informed services.

10.4. One senior leader noted the impact of the national context on available local services, explicitly referencing financial austerity.

10.5. The independent reviewers have been told that there have been deaths of individuals in similar circumstances to those that form the basis of this SAR. That underscores the importance of pulling together findings with respect to the key lines of enquiry for this thematic review. These are now summarised below.

10.5.1. Multi-agency responses to individuals with multiple complex needs. The implementation of Project Brave was regarded as having achieved positive outcomes for some individuals with multiple complex needs that stand in contrast to how services worked with the six individuals whose experiences were the impetus for this review. The use of CARM procedures has also achieved positive outcomes. A frequent attenders at A&E multi-disciplinary team meeting has secured good cross-agency support and been enabled to link individuals into appropriate services with risk management plans. Panel members who supported the independent reviewers have pointed to improved communication and working together between services. However, multi-agency working together does not yet appear to have been fully embedded.

10.5.2. Service responses to the impact of physical and mental impairment or illness, including dual diagnosis. The police now participate in monthly multi-agency meetings, including mental health practitioners, to coordinate the approach with high intensity service users, with onward referral to CARM where this is indicated. The recent change of substance misuse service provider does appear to have generated some positive change but a dual diagnosis pathway remains a gap. Project Brave in terms of outreach provision, key worker allocation and wrap-around support has enabled some individuals to move on positively. Weekly multi-disciplinary meetings are now held between hospital and community services, including substance misuse services, to coordinate hospital discharge. These developments need to become embedded as standard practice, with primary care, secondary health care providers and substance misuse providers strategically and operationally committed to learning from this review and from the outcomes of Project Brave.

10.5.3. Use of Care Act 2014. There were missed opportunities to refer and to enquire into adult safeguarding concerns (section 42(1) and 42(2), Care Act 2014). There were missed opportunities to refer adults with care and support needs for assessment (section 9, Care Act 2014).

10.5.4. Use of Mental Health Act 1983 and Mental Capacity Act 2005. There were missed opportunities to consider the impact on mental capacity of addiction. There is a need to develop awareness of the potential impact on physical

health and on cognition when individuals change their primary drug from heroin to alcohol. There were missed opportunities to seek to help individuals address the origins of their mental distress. Pathways into mental health treatment and support have been recognised in Project Brave but concerns have been expressed about their sustainability and accessibility.

10.5.5. Understanding of self-neglect. The independent reviewers understand that HSAB is completing a scheduled review of its self-neglect policy. Self-neglect was not explicitly identified in the six cases but it is one of the types of abuse and neglect now included in adult safeguarding by the Care Act 2014 and there is an established evidence-base, as this report has identified, against which SABs can audit service responses.

10.5.6. Impact of homelessness, poverty and family relationships. All six individuals had, at some point, experienced homelessness and Project Brave explicitly includes a focus on homelessness when responding to individuals with multiple complex needs. Project Brave has enabled some individuals to move away from street-based lives with accommodation and wrap-around support. In some of the cases reviewed, there were complex family relationships, some of which included children, necessitating a "think family" approach and close working together between Children's Social Care and ASC. That approach was not evident in the chronologies available to the independent reviewers.

10.5.7. Learning for the health, housing and social care system. The analysis of the information provided by agencies with respect to the six cases and the information offered by practitioners and managers provide signposts to how services have been developing, perceived gaps or vulnerabilities in current arrangements and clear endorsement for a whole system response strategically and operationally to individuals presenting with multiple complex needs. The strategic and operational architecture exists. For example, five surgeries have become a super surgery and have appointed a safeguarding coordinator. The other three surgeries left in the city centre have recently employed a care coordinator. It is reported that these roles have made a huge difference for the safeguarding of adults and children and the ability for GP information-sharing at meetings. However, a sense has been conveyed that positive developments need reinforcement to be sustained. The independent reviewers have been told frequently that, in order to design, commission, deliver and sustain effective services for people with multiple complex needs, additional resources are required. The independent reviewers understand that attempts to secure these resources for Herefordshire have been unsuccessful to date. The funds available for commissioning a wide range of services have greatly decreased over the last decade.

10.5.8. Both DAWN's and JOBY's relatives, when talking about the brother or sister that they remembered, referred to early sporting, artistic and/or career aspirations but how these had begun to unravel as a result of exploitation,

vulnerabilities and/or relationships. Both described episodes of recovery from substance misuse, which were not sustained. Their contributions are reminders of the importance of early intervention as well as later support. As DAWN's relative observed when describing the problems she faced in her later years: "how could it get that far?"

10.5.9. The picture given by WILL's family members is similar. They described someone who was intelligent and who excelled at sport. However, he had fragile and often low self-esteem, and fractured relationships. He became drawn into a way of life and was unable to sustain periods when he would abstain from using alcohol and other drugs. According to family members, "inside he was tortured."

10.5.10. Although there have been, as already noted, deaths of individuals in similar circumstances whilst this thematic review has been underway, cases have also been shared with the independent reviewers where positive change has been achieved. In one case the CARM created an opportunity for services to agree a multi-agency action plan designed to manage risk and provide support. This action plan involved a GP carrying out specialist tests, continued mental health allocation/monitoring, ASC offering community broker options and West Mercia Police facilitating a fast track approach to decision making. Since this intervention the level of risk to the individual has reduced and she is considered more stable within her presentation.

10.5.11. A second case involved complex dynamics between mental health intervention, alcohol use and mental capacity, with services experiencing difficulties in providing a consistent risk management plan to reduce the extreme risk. CARM enabled discussion that concluded with a creative outcome to reduce the risk. This involved action by primary care, mental health and the police to ensure a consistent approach rather than the individual "bouncing" from service to service.

10.5.12. A third case concerned an individual with a long history of homelessness, temporary accommodation, disengagement, physical and mental health concerns, and self-neglect. Detailed assessments, which considered his ongoing health and social care needs, and decisional capacity, were undertaken when he was ready for discharge from an acute mental health ward. This resulted in a recommendation, which was accepted, that he be placed in a residential placement, where he is now doing well.

11. Recommendations

11.1. Arising from the analysis undertaken within this review, the independent reviewers recommend:

11.1.1. HSAB should consider how to take forward locally the recommendations in the Black and Kerslake reports.

11.1.2. HSAB should consider using available briefings to review current approaches to transitional safeguarding and service responses to young people/young adults at risk of abuse, neglect and exploitation.

11.1.3. HSAB should consider whether further work is required to reach agreement on how the SAB, Health and Wellbeing Board, Community Safety Partnership and Homelessness Forum provide strategic leadership and hold partners to account for the care of adults with multiple complex vulnerabilities including change resistant substance misusers.

11.1.4. HSAB should seek assurance from partner organisations regarding the development and use of a local dual diagnosis pathway and whether that clarifies how services will work together in accordance with NICE and Public Health England guidance. In particular, HSAB should seek assurance about the procedure for resolving different clinical opinions about the best way to approach an individual's needs.

11.1.5. HSAB should consider whether to seek assurance from services about their responses to individuals who appear to be disengaging, with particular emphasis on assertive outreach, follow-up and flexibility of times and locations of appointments. HSAB should also consider whether further procedures are necessary to guide practitioners on how to respond to safeguarding individuals whose engagement fluctuates.

11.1.6. HSAB should consider audits of practice to be assured that the specific needs of people with multiple complex vulnerabilities are identified in care and support, risk and mental health assessments, with resulting wrap-around and where appropriate multi-agency plans.

11.1.7. HSAB should ensure that all frontline practitioners and their managers are trained in best practice in working with individuals experiencing multiple complex vulnerabilities, including the need for professional curiosity, the application of the safeguarding provisions of the Care Act (including self-neglect) and the quality of Mental Capacity Act assessments (including executive capacity).

11.1.8. HSAB should consider the need for training and awareness raising on the impact of brain injury on the behaviour and mental capacity of people who are dependent on alcohol and drugs, and the impact of Hepatitis C on the cognitive functioning and mood of clients.

11.1.9. HSAB should consider further awareness raising of the procedures for complex adult risk management (CARM) and should consider audits of the use and outcomes of this guidance.

11.1.10. HSAB should consider further awareness raising of the components of Project Brave and subsequently how it may support and seek assurance about the outcomes of the transformational change underpinning Project Brave.

11.1.11. HSAB should consider sharing this thematic review with Worcestershire Safeguarding Adults Board and Worcestershire Children Safeguarding Partnership.

11.1.12. HSAB should consider sharing this thematic review within the region, firstly to seek usable examples of effective solutions elsewhere, and secondly to establish whether there are commonly held concerns, especially regarding available resources, that should be escalated to the Department of Health and Social Care through the escalation pathway now established via the national network of SAB chairs.

Premature deaths – thematic review

Ivan Powell
Independent Chair – Herefordshire Safeguarding Adults Board

Referred cohort

- Six individuals;
- Five men and one woman
- Died between the ages of 24 and 54

Multiple Complex Vulnerabilities

Exploited Adults

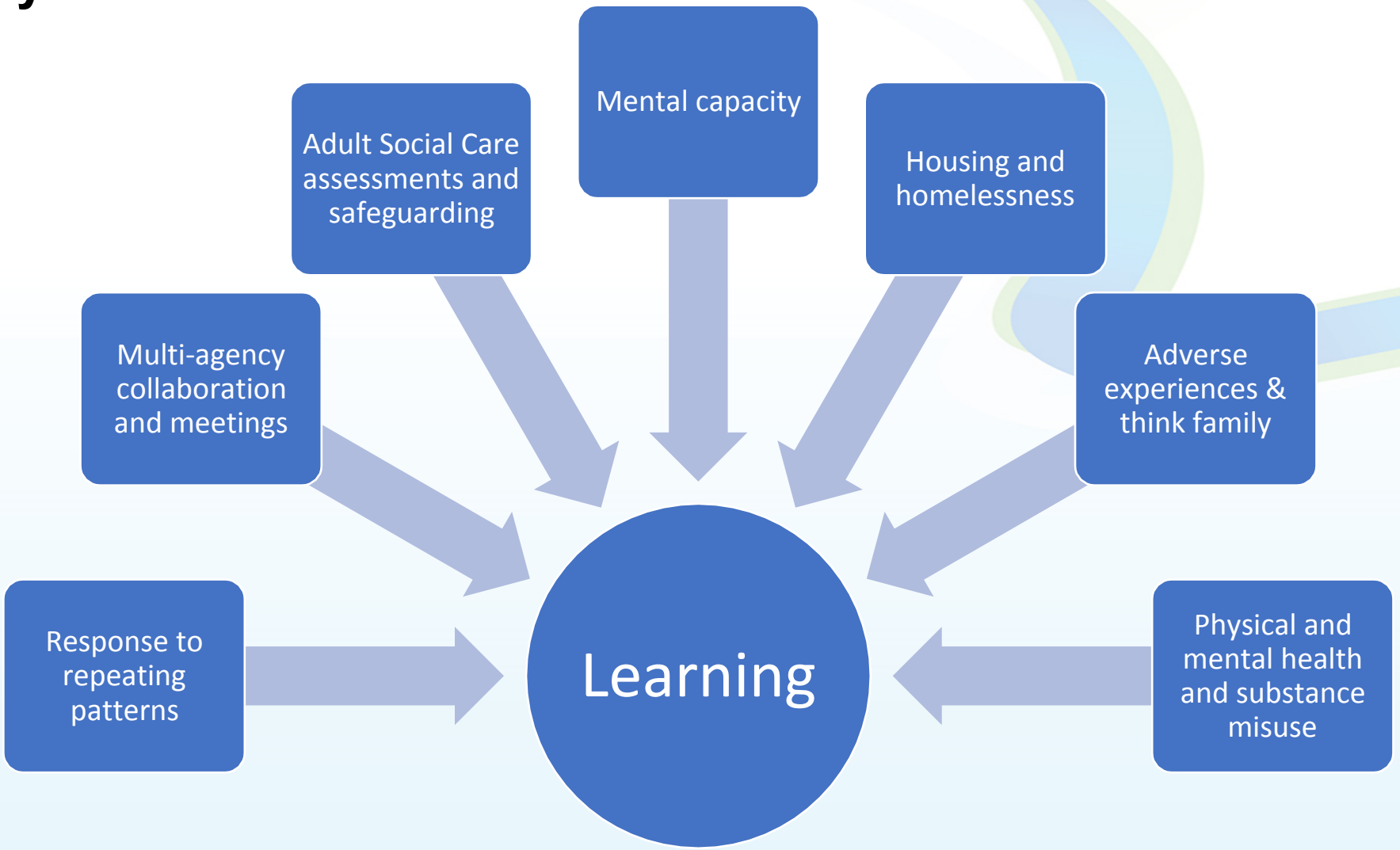
Substance Use

Homelessness

Criminal Justice

Poor Mental Health

Key themes


Mental capacity
Adult Social Care assessments and safeguarding
Housing and homelessness
Multi-agency collaboration and meetings
Adverse experiences & think family
Response to repeating patterns
Learning
Physical and mental health and substance misuse

Responses to repeating patterns

- No apparent coordinated response to frequent A&E attendance
- No apparent change of approach to repeated “did not attend”, non-engagement and/or dis-engagement?
- Insufficient outreach and in-reach to facilitate engagement and completion of assessments and work plans?
- Very few multi-agency meetings.
- No apparent pathway into multi-agency meetings when there is a risk of significant harm that requires a multi-agency response?

Multi-agency collaboration and meetings

Complex adult risk management pathway.
Project Brave for those with multiple and complex needs.

Is a system now embedded of coordinated assessments and interventions, with appointment of a lead agency and key worker?

Across the system

- Care and support assessments or safeguarding?
- Drug and/or alcohol abuse seen as a lifestyle choice and unwise decision-making
- Considerations of mental capacity?
- Sufficient provision of wrap-around support
- Trauma and adverse childhood experiences?
- Sufficient focus on the background?

Mental health and substance use

- Mental health challenges vs enduring mental illness?
- GPs role in monitoring and responding to individuals' mental distress.
- Are professionals routinely identifying substance misuse in their clients?
- Joint working when there are multiple complex needs and risks related to substance misuse?
- Dual diagnosis?
- How well do mental health and substance misuse providers work together?

Physical health

- How well do primary and secondary health care practitioners and services work together?
- How do providers work together when there are multiple complex health care needs and risks?
- Are agencies addressing poor engagement with health care services?
- Is a system change required to help individuals who leave hospital with treatment incomplete?
- What positive differences are super surgeries making?

Working with individuals

- ***Engagement*** – recognise that people may be wary of services; appreciate that individuals may feel alone, fearful, helpless, confused, excluded, suicidal and depressed. Reach out.
- ***Professional curiosity*** – There is always more to know. Experiences (traumas) had a "lasting effect on me." "Appreciate the journey."
- ***Partnership*** – "work with me, involve me, and support me." "Keep in touch so that we know what is going on." Help with practicalities. Build rapport. Go at their pace and in their time.
- ***Person-centred*** – see the person; challenge misconceptions and evidence of assumptions (unconscious bias); there are multiple reasons behind why a person may become homeless.
- ***Assessment*** – what does this individual need? Do not assume or stereotype. Be thorough.
- ***Wrap-around support*** - not just accommodation. See transitions as opportunities
- ***Language*** – be careful and respectful about the language we use; words and phrases can betray assumptions. For example, who is not engaging? What does substance misuse imply?

Recommendations

Direct practice and team around the person

- Assessment & support for people with complex needs
- Focus on transitional safeguarding
- Outreach & engagement
- Embed CARM

Organisational support and governance

- Dual diagnosis pathway
- Project Brave
- Use of Black and Kerslake reports
- Location of strategic leadership
- Training

To read the full review go to: HSAB Thematic Review - Premature Deaths Adults Reviews - Herefordshire Safeguarding Boards and Partnerships

Herefordshire Council

Title of report: Project Brave Strategic Approach

Meeting: Health and Wellbeing Board

Meeting date: 13 March 2023

Report by: Community Wellbeing Directorate

Classification
Open

Decision type
This is not an executive decision

Wards affected

(All Wards);

Purpose:

- For the Board to receive and comment on the Herefordshire Project Brave Strategic Approach

Recommendation(s)

- That the Board considers and comments on the Project Brave Strategy.

Alternative options

:

1: The Board could choose not to consider this report. This is not recommended as the HWBB will provide its opinion, as appropriate, to Herefordshire Council, the Integrated Care Board or NHS England, as to whether they are discharging their duty to have regard to any assessment of relevant needs prepared by the Council, the ICB or NHS England in the exercise of their functions.

Key considerations

- Project Brave is a multi-agency partnership initiative enabling and finding solutions for very vulnerable people, at risk from; homelessness, substance use, mental health, criminal experience and exploitation.

- It is about new homes and changing lives for vulnerable people in communities. It is a creative and joined up approach by the council and its partners to fulfilling their public duties to those who are most vulnerable.

- Project Brave was instigated as an early response to the Covid19 pandemic, focusing on people who were very vulnerable but are not eligible for or fall between various statutory services. Initially, the Project delivered rapid and very effective response to the Government's "Everyone In" initiative. It then evolved into an ambitious but earnest intent to eradicate high risk homelessness in Herefordshire. It recognises that homeless people need homes and sets out to find those homes and support people to live in them.

- Project Brave is also about multiple complex vulnerability, connecting with and embracing the lived experience of people for whom services and systems have persistently failed. Agencies challenge themselves and each other to work in a joined up and personalised way to enable people to be safer and achieve better outcomes.

- The project began rapidly and naturally during a national emergency and has evolved pragmatically and within available resources. Following award of MEAM network membership, progress review and stakeholder engagement in late 2022, approval is now sought for this strategic approach, guiding the onward development of Project Brave.

Community Impact

In accordance with the adopted code of corporate governance, Herefordshire Council achieves its intended outcomes by providing a mixture of legal, regulatory and practical interventions. Determining the right mix of these is an important strategic choice to make sure outcomes are achieved. The council needs robust decision-making mechanisms to ensure its outcomes can be achieved in a way that provides the best use of resources whilst still enabling efficient and effective operations and recognises that a culture and structure for scrutiny are key elements for accountable decision making, policy development and review

Environmental Impact

There are no general implications for the environment arising from this report.

Equality duty

- Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:

A public authority must, in the exercise of its functions, have due regard to the need to –

a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
c) Facilitate good relations between persons who share a relevant protected characteristic and persons who do not share it.

- The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services.

Resource implications

- There are no resource implications associated with this report.
- The new services and activity involved has been largely funded by very significant revenue grant aid, attracted from DLUHC. These have been under a number of grant schemes, including RSI programmes 2 to 5 and RSAP. The Total grant awarded to the council so far for Project Brave for the period 2020 to 2025 is as follows;

- £4,183,912 in revenue funding
- £824,000 in capital funding

Legal implications

- Health and wellbeing boards are responsible for encouraging integrated working between health and social care commissioners, including partnership arrangements such as pooled budgets, lead commissioning and integrated provision.
- Their purpose is to establish collaborative decision making, planning and commissioning across councils and the NHS, informed by the views of patients, people who use services and other partners.
- The functions of the Health and Wellbeing Board are set out in paragraph 3.5.24 of the constitution.

Risk management

There are no risk implications identified emerging from the recommendations in this report

Consultees

Matt Pearce (Director of Public Health), Hilary Hall (Corporate Director Community Wellbeing), Ewen Archibald (Head of Community Commissioning and Resources).

Appendices

Appendix 1 - Project Brave Strategic Approach
Appendix 2 - Project brave strategic approach slides

Background papers

- Housing Act 1996 Part VII 1
- Homelessness Reduction Act 2017 (now part of the Housing Act 1996, as amended
- Care Act 2014, including s42
- Mental Health Act 1983, as amended
- Mental Capacity Act 2005, as amended
- Equality Act 2010
- Human Rights Act 1998 and European Convention on Human Rights
- From Harm to Hope; a Ten Year Drugs Plan to cut crime and save lives
  The Rough Sleeping Initiative (RSI)

Herefordshire Council

January 2023

Community Wellbeing Directorate

Project Brave Strategic Approach

DRAFT 2

1. Overview

Project Brave is a multi-agency partnership initiative enabling and finding solutions for very vulnerable people, at risk from;

Homelessness Substance use Mental Health Criminal experience Exploitation

It is about new homes and changing lives for vulnerable people in communities. It is a creative and joined up approach by the council and its partners to fulfilling their public duties to those who are most vulnerable.

Project Brave was instigated as an early response to the Covid19 pandemic, focusing on people who were very vulnerable but are not eligible for or fall between various statutory services. Initially, the Project delivered rapid and very effective response to the Government's "Everyone In" initiative. It then evolved into an ambitious but earnest intent to eradicate high risk homelessness in Herefordshire. It recognises that homeless people need homes and sets out to find those homes and support people to live in them.

Project Brave is also about multiple complex vulnerability, connecting with and embracing the lived experience of people for whom services and systems have persistently failed. Agencies challenge themselves and each other to work in a joined up and personalised way to enable people to be safer and achieve better outcomes.

The project began rapidly and naturally during a national emergency and has evolved pragmatically and within available resources. Following award of MEAM network membership, progress review and stakeholder engagement in late 2022, approval is now sought for this strategic approach, guiding the onward development of Project Brave.

2. Overall Aims

- Greatly improving outcomes for vulnerable individuals
- New homes and sustainable support models for homeless people
- Empowering people with multiple complex vulnerability to direct their own lives
- Reducing avoidable demands on health, housing, social care and police systems
- Making high risk homelessness largely a thing of the past
- Promoting safe, healthy, independent living and community participation and preventing the next generation of people with multiple complex disadvantages
- Developing and galvanising accommodation assets

3. Building Blocks of Project Brave and Specific Objectives

3.1 Homes for Homeless People
Objectives;

- Ensuring sustained provision of emergency and transitional accommodation, in Hereford City and other locations.
- Ensuring appropriate accommodation and support during extreme weather and winter
- Delivering a continuing pipeline of long term homes for homeless people, utilising capital grants and linked to appropriate support
- Enabling homeless people to move into social housing tenancies through a continuing partnership with registered housing providers.

3.2 Support which is joined up and personalised
Specific Objectives;

- Ensuring all people rough sleeping and in emergency and transitional accommodation have a named link worker through outreach or homelessness hub teams.
- Ensuring an effective, reliable and well promoted out of hours emergency response to homeless people in crisis, with access to temporary or emergency accommodation.
- Ensuring that everyone who needs it has a personal housing plan.
- Ensuring that all new housing schemes for homeless people have dedicated link workers or support teams, including transitional accommodation.
- Enabling a “team around the person” approach via link workers, giving access to professionals in health, housing, social care, communities and criminal justice.
- Sustaining a “deal” with registered housing providers which ensures support for homeless people given tenancies, linked to a homelessness/eviction prevention protocol.
- Ensure trauma informed training for all staff working with homeless people and more widely.

3.3 Multiple Complex Vulnerability
Specific Objectives;

- Multi disciplinary working adopted routinely for all with multiple complex vulnerability and risk of serious harm or death.
- Sustain and review the “breaking the cycle” approach to case review and problem solving.
- Maximise appropriate referrals for assessment and intervention under a Care Adult Risk Management (CARM) processes where adults are vulnerable, linked to multi agency interventions as appropriate.
- Sustain and expand existing Multi-disciplinary Team (MDT) approach in Accident & Emergency A&E attendances amongst people with multiple complex needs, where mental health is the main presenting need.
- Develop and action plan for identifying and managing risks of drug and alcohol deaths in the community, linked to wider strategic and partnership work and MDT approaches.
- Establish a new, workable protocol for supporting and risk assessment for vulnerable people not engaging with services.
- Establish an action plan for optimising access to primary care for people with multiple complex vulnerability, including take up of immunisation and health checks programmes.

3.4 Homelessness Prevention
Specific Objectives;

- Sustaining and promoting use of the Client debt alleviation fund, relieving barriers to tenancies and accommodation
- Ensuring homelessness outreach and duty teams provide holistic support and advice to people homeless or at risk, including home-finding, arrears and financial issues and support planning.
- Optimising take up of specialist mediation services, including for 16-25 year olds, enabling people to maintain their existing housing and support networks.
- Consolidating and maintaining a homelessness and eviction prevention protocol with registered housing providers.

3.5 Talk Community Prevention
Specific Objectives;

- Identify research and models of practice around incidence of Adverse Childhood Experiences (ACEs) in communities and early intervention related to risk of complex vulnerability.
- Development of trauma informed engagement approaches through commissioned community services and training for volunteers and Talk Community Hubs.
- Sustain and promote the network of trained volunteer mental health first aiders as part of Talk Community Hubs.
- Develop and pilot “active community plans” for vulnerable people, promoting participation in communities, including online and other communities of identity/interest.
- Ensure access for vulnerable people to financial and debt advice and healthy lifestyle support through Talk Community Hubs and commissioned services.
- Deliver Training in identifying and engaging with people with multiple vulnerability for volunteers and staff working in signposting roles.
- Ensure community hubs and services promote access to primary care for vulnerable people

3.6 System Working
Specific Objectives

- Commitment from all agencies to multi-disciplinary practice and joint risk management.
- Establishing simple data sharing arrangements between key agencies to support identification of and joined up working with people with multiple complex needs.
- Agreement to joined up approaches to maximising external grant funding for Project Brave, utilising the eligibility, networks and expertise of all partner agencies.
- Agreed, documented and shared protocol/process for use of CARM approach with people with multiple complex vulnerability

4. Selected Outcome Measures

A. To make rough sleeping rare, infrequent and non recurring in Herefordshire.
B. Optimum take up of transitional accommodation, with appropriate lengths of stay and access to support.

C. Significantly more formerly homeless people sustaining long term tenancies, with support where required.
D. Everyone identified within Project Brave has a named link worker
E. Every person identified with multiple complex vulnerability including a mental health or substance use diagnosis has a treatment plan or pathway plan.
F. New long term housing for homeless people is of high quality and well maintained.
G. A reduced rate of deaths among people with multiple complex vulnerability or as part of Project Brave.
H. All people identified as at risk from serious harm or death subject to proactive engagement, MDT working and risk assessment/monitoring.
I. Every homeless person known to Project Brave has a personal housing plan
J. Total provision of newly available transitional and long term housing for homeless people reaches 120 units
K. Fewer blue light emergencies and A&E attendances by people with multiple complex vulnerability.
L. Increased use of CARM processes to identify vulnerability and multi agency responses
M. Continued take up of new tenancies with registered housing providers by Project Brave cohort, with support where required.
N. Increased take up of community services and engagement in volunteering and community activities by people identifying as having mental health needs, substance use needs or experience of exploitation.
O. Growing numbers of volunteers trained in mental health first aid, trauma informed practice and identifying complex vulnerability.

5. Principles of Project Brave

- A whole system collaboration, with multi-disciplinary practice embedded
- Knowing who everyone is, not relying on referrals
- The team around the Person
- Listening to and led by lived experience
- Strengths based and promoting independence
- Real Homes for Homeless People
- Participation in communities aids prevention
- Joint approaches to training and information sharing
- Robust project and performance management

6. Impact of Project Brave

Project Brave has had a significant impact so far on the lives of individuals and on the scale and incidence of high risk homelessness in particular. Since March 2020,

- 252 households have been accommodated in total
- 157 households moved into transitional or long term housing
- More than 70 people helped initially by Project Brave have found their own solutions, by finding accommodation or relocating outside Herefordshire.
- 62 units of new housing have been created for homeless people so far through Project Brave, including long term homes and transitional housing, with support.
- Approximately 20 homeless people have been supported into tenancies with registered housing providers in existing social housing stock
- In January 2023, the Rough Sleeper Outreach Team continued to work with 98 people at risk of rough sleeping, including 16 current rough sleepers.

The pattern of outcomes being achieved for individuals is complex and not regular, with people's journeys progressing and then reversing or stalling. Some people can find resolutions very quickly and for others it takes a long time. It may be that 10 people move into settled housing in one week, but this could be the culmination of many months of work and different steps.

The following case examples illustrated a typical range of experiences and how Project Brave has had real impact on people's lives;

A 54 year old man rough sleeping, with a history of evictions, rent arrears and substance use, had faced various barriers to finding housing. He was moved quickly into temporary accommodation and with the building of trust was supported around his debts and to apply on Home Point. He was successfully matched to a social rented home and has remained there for 18 months, with support from the outreach service.

A 34 year old man has a complex range of needs as an ex-offender, including substance use, domestic abuse and a diagnosed serious mental health need. He had been rough sleeping intermittently for years, punctuated by periods of family life, hospital admissions and relationship breakdown. These patterns led to significant risk of serious harm or death. He was encouraged to move into the Whitecross Homelessness Hub in 2022 and engaged with professional intervention for his mental health and substance use. Having made significant progress ,he has now taken a social housing tenancy, with continuing light touch support from council teams.

A 34 year old man has a history of offending and substance use. He was accommodated under the Everyone In scheme at Hedley Lodge. Following a period of support from Vennture and the Outreach Team, he secured a home via Home Point in March 2021, where he continues to live.

A 26 year old man was sofa-surfing, with a recent history of offending, relationship breakdown and anger management issues. Previous accommodation in supported housing had broken down. Early in the Covid pandemic he was accommodated under Everyone-In and engaged with support through Project Brave. He began bidding on Home Point and gained a social housing tenancy in March 2021. He continues to live there successfully, with light touch outreach support.

A young couple returning to Herefordshire after living elsewhere, experienced a series of problems in maintaining housing, despite managing to find jobs, first in Hereford and then in Leominster. They were supported in temporary accommodation through mental ill health, and relationship breakdown and eventually in November 2020, moved into private rented housing secured by the outreach team. They remain there, living successfully together.

A 31 year old man who had been trying to manage his own mental health and alcohol use, was evicted in January 2021 for economic reasons. This led to an escalation of his health needs, against a backdrop of past domestic abuse and relationship breakdown. He was supported into temporary accommodation and continued to try to manage his own needs. In view of these needs, he moved into supported housing at the Whitecross Hub and was enabled to make progress in various aspects of his life, including having an autism diagnosis. Council teams have continued to support him as he has made two further moves and now has a social housing tenancy. He is volunteering with a local health provider and receiving training, building upon his lived experience.

7. Making Every Adult Matter (MEAM)

MEAM – Making Every Adult Matter – working for people affected by multiple disadvantage. MEAM have a network of 42 local authorities across England who subscribe to the seven key principles of the MEAM approach. (see below)

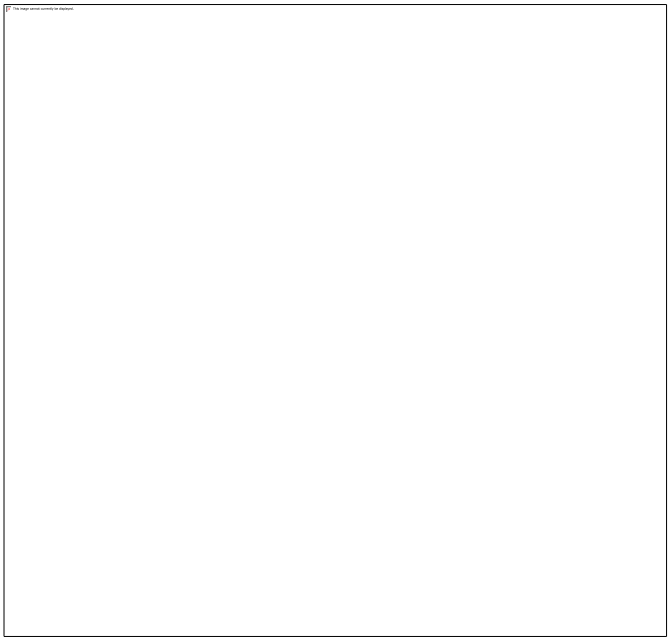
In June 2022, MEAM opened up the network in order to recruit 10 new local authority areas to it. Herefordshire's multi agency / cross sector partnership, Project BRAVE, who work collaboratively as part of our response to Homelessness and rough sleeping, submitted an application and secured an interview to become one of these new Local Authority areas. In August the multi-agency / sector partnership, were successful at interview and became one of the 42 Local Authorities that now make up the MEAM Network.

MEAM defines multiple disadvantage as including, homelessness, substance misuse, mental ill health and contact with the criminal justice system. Where services in a local area do not work in partnership with each other, the combination of these multiple disadvantages can lead to people not being able to engage with local services. This in turn can lead to additional disadvantages such as poverty, ill-health, homelessness, relationship breakdown, loss of employment, amongst others.

Herefordshire's Project BRAVE approach to homelessness and rough sleeping has helped a range of statutory agencies and Community, Faith and Voluntary groups to work more collaboratively, to reduce the risks of becoming homeless in Herefordshire and is working towards the goal of making homelessness rare, brief and non-recurring.

Herefordshire is now working with a dedicated MEAM project delivery officer, in order to focus our work to ensure that our collective efforts reduce the opportunities for multiple disadvantages to occur in Herefordshire and when they do people and communities are supported to overcome them.

<u>The MEAM Approach</u>



8. Policy and Legislative Context

Project Brave starts from a recognition that people can be very vulnerable despite not being eligible for certain statutory services or not being able to engage with those services. Nonetheless, the initiative takes place in the context of a wide range of legislation and national policy. This includes;

Housing Act 1996 Part VII 1
Homelessness Reduction Act 2017 (now part of the Housing Act 1996, as amended

Care Act 2014, including s42
Mental Health Act 1983, as amended
Mental Capacity Act 2005, as amended
Equality Act 2010
Human Rights Act 1998 and European Convention on Human Rights
From Harm to Hope; a Ten Year Drugs Plan to cut crime and save lives
The Rough Sleeping Initiative (RSI)

9. Stakeholder Engagement

There are many local stakeholders in Project Brave and its various streams of work. The most important stakeholders are people with lived experience of homelessness and /or

multiple complex vulnerability .The council is seeking to maintain direct, credible and sustainable ways of engaging with and learning from that experience.

Key public sector and voluntary or community stakeholders in Project Brave include;

Herefordshire Primary Care Networks and Taurus GP Federation
Wye Valley Trust
Herefordshire and Worcestershire Health and Care Trust
Herefordshire and Worcestershire ICB
West Mercia Police
West Midlands Probation Service
Herefordshire Homelessness Forum
Herefordshire Community Safety Partnership
The Diocese of Hereford
Vennture,
Ethos
Connecting Communities and People
Turning Point
Connexus Housing
Stonewater Housing Group
Citizen Housing
Platform Housing
Herefordshire Community Partnership
Talk Community Hubs
Hereford BID
Herefordshire MIND

In Autumn 2022, Herefordshire Council embarked upon stakeholder engagement for the purpose of consolidating review of Project Brave, preparatory to its relaunch. Three workshops were held in November and December with agencies and professionals and a fourth with experts by experience. In the workshops for professionals, which were well attended, there was considerable interest and positive engagement in the ideas and practice involved with Project Brave. This was accompanied by a clear commitment from multiple agencies to continue working together in advancing this initiative.

The themes emerging from the professionals workshops included;

- The need for wider and more consistent joint working between agencies
- The necessity of effective multi-disciplinary practice in assessment and intervention to support people to achieve the best outcomes.
- Support for more strategic focus and direct work on longer range prevention
- The importance of recognising and taking proper account of Adverse Childhood Experiences (ACEs).
- A commitment to appropriate yet pragmatic sharing of information in order to ensure joined up working and risk management.
- Tapping into the networks within Talk Community and opportunities they present for vulnerable people and prevention.

The experts by experience who participated in engagement in December, drew mainly on their experience of homelessness. Some themes from their input include;

- The need for help earlier in people's lives.

- Recognising and tackling the different causes of homelessness and the different routes people take.
- Recognising that some homeless people move between areas and in and out of Herefordshire.
- Need to accept that people may only be able to seek help and move towards improved outcomes when they are ready and services need to be agile enough to respond when that happens.
- Some frustration around council decisions relating to homelessness duty to individuals and how that is communicated.

Continuing engagement

The project management and internal governance arrangements for Project Brave will provide an opportunity for continuing engagement, particularly amongst professionals. These arrangements include the two operational groups and the regular liaison with the Homelessness Forum

It is proposed to establish a standing/continuing expert experience forum comprising experts by experience to support and advise the onward development of Brave. This will follow good practice identified elsewhere or through research. The group will be developed through the cohorts of people identified and support though Brave. Once this is established, the most effective means by which it and its membership can be heard within the wider management and development of Brave.

10. Resources

9.1 Staffing

The implementation of Project Brave so far has called very substantially on the staff time and resources of the council's Housing Solutions service, including the rapid development and expansion of the Rough Sleeping Homelessness Outreach function. This now includes a team of workers based at the Homelessness Hub and supporting vulnerable homeless people in a variety of locations. New staff and services have also been developed at times by Vennture in particular and the initiative has placed broader demands on teams and services in other agencies.

This Project Brave staffing has been largely dependent on funding from the Department of Levelling up, Housing and Communities (DLUHC). Continued staffing of this kind will remain essential to sustaining and building upon Project Brave. Therefore continued external funding is essential to the continuation of Brave.

Grant Funding to date

The new services and activity involved has been largely funded by very significant revenue grant aid, attracted from DLUHC. These have been under a number of grant schemes, including RSI programmes 2 to 5 and RSAP. The Total grant awarded to the council so far for Project Brave for the period 2020 to 2025 is as follows;

£4,183,912 in revenue funding
£ 824,000 in capital funding

This level of grant aid reflects both the scale of the work within Brave and DLUHC's recognition of and confidence in what Herefordshire is delivering and achieving. There is close working relationship between the council and DLUHC's homelessness and regional teams, who have made a number of visits to the county to view Project Brave in practice. The capital grant funding is overseen and assured by Homes England, with whom Herefordshire Council is now an Investment Partner.

The capital grant has supported acquisitions and conversions or improvement of properties to bring them into use as transitional accommodation or long term homes. The council has also deployed capital spending of around £1.05m to Brave properties over the period.

In total, £1.824M in capital has been spent on delivering 44 units of housing under Project Brave.

Further Funding Opportunities

Current RSI5 revenue funding already allocated to Herefordshire will continue until 2025. DLUHC has now announced a further funding scheme, Supported Housing Accommodation Programme (SHAP), which is available over the next three years, incorporating both revenue and capital grants. This is incremental and complementary to the existing RSI regime and provide opportunities for councils to develop more specialist, targeted provision for certain groups. For Herefordshire, DLUHC will consider funding accommodation and support for 16 to 25 year olds at risk of homelessness.

There are also external funding opportunities available to voluntary and community organisations for which the council is not eligible. These can potentially complement the resources available to the public sector and Vennture in particular has successful attracted funding, notably around Winter homelessness services.

11. Risks and Challenges

The following risks and challenges have been identified in the sustaining and onward development of Project Brave;

- Insufficient engagement or commitment from partner agencies to sustain the joined up and multidisciplinary approaches essential to Project Brave.

  Many organisations have maintained their commitment to the Brave partnership over time. The recent engagement has underlined that commitment at various levels in a number of key partners. There is a continuing challenge around consistent engagement from primary Care Networks and GPs given, the many demand on their resources, but there has been valuable contributions to some issues.

- Dwindling resources with which to fund the sustained outreach and support staffing required.

Government has recognised the importance of sustained staffing to deliver this work and so has made an extended funding commitment to Herefordshire to 2025 and is now introducing further funding programmes as well.

- Lack of engagement or offers of accommodation from registered housing providers.

  All major stockholding providers in the county have committed to working with project Brave to provide housing with tenancies for previously homeless people. This is based on the council's commitment to providing support for all Brave tenants for as long as needed.

- Barriers to a funding continuing pipeline of accommodation through properties acquired or converted by the council.

  There appear to be continuing sources of capital grant funding to support the pipeline. The council's own commitment of capital, including when matching government grant will be kept under review, with significant spending so far delivering housing at a good return on investment. There are robust assurances and processes involved in the council's capital programme to manage any risks.

- Rising prices in the local housing market restricting acquisition and wider options.

  Whilst prices have risen significantly since 2020, they are thought now to be stabilising somewhat in Herefordshire. Pricing is not for the time being rising so far ahead of grant and other resources to present a major barrier.

- Services and agencies practice retreating to non collaborative working or narrow statutory approaches to eligibility.

  This would be a significant risk to the Brave approach but is not being seen generally or currently. The partnership working through Operational Groups and multi disciplinary practice substantially mitigates this risk, given the commitment made at senior level by most agencies.

- Challenges to effective progress in prevention of homelessness and complex vulnerability.

  The council has dedicated resources for homelessness prevention and reduction, in the context of clear statutory obligations. A variety of schemes and offers and expert knowledge mean the council is well placed to achieve progress over time.

  Prevention of complex vulnerability is itself a complicated proposition and one which in most cases can be achieved only on a generational basis. Behaviours and patterns of substance use are established for many reasons and over a long time and often with very significant impact on people's physical and mental health. There is a commitment within Project Brave to planning for this long range prevention approach, working through Talk Community, health partners and others.

- Risks from non engagement with essential support services.

  This is a common factor in multiple complex vulnerability and homelessness and can be associated with high risk of harm for individuals. The Brave model of named link workers and teams around the individual are design in part to address this. Existing training including around trauma can help tackle the issues and more focused training is being considered.

- The potential for poor outcomes for people, despite interventions and support.

  The journey to safe, independent health living for many people in the Brave cohort is a complex one, with frequent reverses and detours. This is inherent in complexity of people's needs, lifestyles and personal histories. The Brave approach is designed as far as possible to embrace and tackle that complexity and risk, but positive or linear outcomes cannot be guaranteed in every case.

12. Partnerships and Governance

Formal Governance

- Cabinet is asked to approve the strategic approach to Project Brave in February 2023. Subsequently, other partner agencies are invited to formalise their commitment to the project through their various governance arrangements.

- An annual report on Project Brave to Health and Wellbeing Board is proposed, along with periodical reporting to and review by cabinet members for housing and Health and wellbeing.

- Periodical updates on Project Brave developments will also be provided to the Community Safety Partnership (CSP) Board.

- The work and resources supporting Project Brave will also be reviewed as appropriate by various internal governance boards within Herefordshire council.

Project Governance

- The partnership approach to Project Brave has emerged naturally and rapidly during Covid19 and has persisted to the present day. Somewhat revised internal governance is proposed for the initiative going forward, as follows.

- A strategic project board, chaired by the council and with senior manager representation from Police, NHS agencies and representatives from housing and voluntary and community sectors, complemented by experts by experience, where available. It will oversee the development and delivery for the project overall, its performance and delivery of the action plan.

- An operational Board focused on homelessness, featuring operational managers and other key professionals and experts by experience. To include the council, police, major stockholding housing providers, Herefordshire Homelessness Forum, commissioned accommodation providers and other voluntary organisations.

- An operational Board focusing on multiple complex vulnerability and prevention, featuring operational managers and key professionals, along with experts by experience. Organisations involved will include the council, health agencies, specialist voluntary organisations, adult social care and others.

- Attendance at these boards by experts by experience is expected to be achieved over time and supported through the development of the proposed expert's focus group.

13. Action Plan and Timelines

In order to implement this strategic approach to Project Brave, an action plan will be prepared with clear achievable actions and accountability, based upon the building block areas, objectives and outcomes set out in the document. The action plan will be in place from April 2023, will be monitored by the Strategic Project Board and progress will be reported using Verto and to Health and Wellbeing Board and Cabinet Members.

Clear Timelines will be set out for each action in the plan and monitored trough the project governance.

Project Brave
Strategic Approach

January 2023

Project Brave
Strategic Approach to Homelessness and Vulnerability

- An early response to Covid19, now seeking to end rough sleeping & high risk homelessness
- Significantly advancing priorities in the Homelessness Prevention Strategy

  Minimising rough sleeping - New tenancies & support - Improved health/wellbeing – Focus on complex needs
- A focus on multiple complex vulnerability, improving outcomes for people at risk in communities
- A Partnership approach with engagement from all sectors and with people with lived experience
- Clear principles, targeting support & housing in a personalised and effective way
- Continued support for people in accommodation, giving assurance to landlords and partners
- Membership of MEAM network, promoting best practice in partnership
- New transitional housing & long term homes for homeless people
- Working through Talk Community to prevent future complex vulnerability and homelessness
- Optimising use of grant funding to deliver Project Brave

Project BraveNew homes - Changing lives

Identifying and enabling new homes and solutions for vulnerable people in communities;

At risk arising from;

Homelessness

Substance Use

Mental Health Needs

Criminal Justice Experience

Exploitation or Abuse

Working with Communities to prevent vulnerability

Overall Aims of Project Brave

- Greatly improving outcomes for individuals
- New homes and support models for homeless people
- Reducing avoidable demands on health, housing, social care and police systems
- Making homelessness largely a thing of the past
- Establishing sustainable models of delivery/support
- Enabling safe participation in communities
- Promoting safe, healthy, independent living and preventing the next generation of people with multiple complex disadvantages
- Developing and galvanising accommodation assets

Review of Homelessness Prevention & Rough Sleeping Strategy 2020-2025

1. Focusing operational structures & work on prevention evolved gradually during Covid19 but a full review taking place in early 2023.
2. Project Brave has delivered a Housing First approach to homes for homeless people, with new self contained homes being created and people also being supported into social housing.
3. Working through MEAM with housing & system partners, Brave is driving the promised eradication of rough sleeping & high risk homelessness, to make them a thing of the past.
4. The promise to reduce reliance on B&B emergency accommodation as challenged by Covid19 and the Everyone In policy, with current demand growing nationally.
5. However, use of B&B will now be managed through a framework, according with best practice
6. Brave has brought forward new forms of emergency accommodation including Hedley Lodge and Whitecross Homelessness Hub, significantly helping response to demand.
7. MEAM will help ensure accommodation & support are people focused and manage risk in an holistic, person-centred way.

MEAM (Making Every Adult Matter)

- National programme led by Homeless Link, sponsored by DLUHC
- Herefordshire accepted following competitive, multi-agency process
- Does not bring funding (but may assist future access to funding)
- Practice development, training, mentoring and networking
- Significant focus on homelessness
- Also encompasses multiple complex vulnerability
- Based around partnership and multi-disciplinary working
- Seven core objectives of MEAM

Core Principles of Project Brave align with the Objectives of MEAM

• Partnership & Co-production;	A whole system collaboration
• Consistent Cohort	Knowing who everyone is
• Co-ordination for people/services	A Team around the Person
• Flexible responses from services	Strengths based, Promoting Independence
• Sustainability & System change	Whole system collaboration & solutions
• Service Improvement & staffing	Training and data sharing
• Measurement of success	Project & performance management

Homes for Homeless People

- 120 plus homes sought as temporary and permanent accommodation
- A pipeline of property development, acquisitions and existing accommodation with partnering registered housing providers and private landlords
- 45 units secured for transitional accommodation at Hope Scott House, The Whitecross Hub & Hedley Lodge
- 29 units secured for long term homes at Blackfriars Street, Newtown Road & Hereford City
- The potential for a further 28 units of accommodation in the city, in the pipeline

Multiple Complex Vulnerability

Focus on high intensity users of emergency services

Reducing deaths

Mental Health MDT; high intensity users

High risk Alcohol, substance misuse and acute pathway,

Vaccination & population health work

Personalised and strengths based practice

Access to primary care

MDT models and team around the person

(MEAM) Research and evidence based

Talk Community and Preventing Vulnerability

- Focus on ACES and long term prevention of complex vulnerability
- Trauma informed approaches
- Talk Community Hubs
- Mental Health First Aid and wider training for volunteers
- Identifying individual's journeys and links to communities of interest/identify
- Promoting active participation in Communities
- Digital access and participation
- Access to primary care and promoting self care

Project Brave Engagement

Four engagement workshops were held with local stakeholders and/or people with lived experience during November and December 2022

Key themes emerging from the engagement;

- More joined up working including multi disciplinary meetings/practice
- A greater focus on prevention of vulnerability and effective early intervention
- Recognising impact of Adverse Childhood Experiences (ACEs) and work with children's services
- Need to tackle diverse causes of vulnerability/homelessness including employment, addiction
- Mental health needs are widespread and often go undiagnosed
- Need to understand an work with the mobility of some homeless/vulnerable people

There is commitment to continued engagement with people with lived experience, including focus groups

Delivered under Project Brave

- Since the inception of Project Brave, the council has accommodated **252** households at risk of homelessness or rough sleeping. Almost overwhelmingly these have been single people.

  - and successfully moved **157** households into transitional or long-term accommodation.

- Only **2** households remain accommodated within the emergency accommodation linked to Project Brave - each will move into more permanent accommodation before the end of the month.
- Over **70** people who accessed the service, later then moved away for a variety of reasons – including moving out of area or finding their own accommodation
- The Council's Outreach team remain actively working with **98** individuals (as at 18 January) who remain known to be at risk of rough sleeping. **16** of these have been rough sleeping and have been accommodated recently under the winter response and the Severe Weather Emergency Protocol (SWEP)
- 62 units of new accommodation secured, with a pipeline of further properties
- £4.2m revenue funding and £824k capital funding secured from external grants since 2020

Project Brave Potential Performance Indicators

Numbers rough sleeping, using B&B and presenting as homeless

People engaging with services, feeling trusted and listened to

People taking up and maintaining tenancies with support

Time spent in emergency, temporary and transitional accommodation

People at high risk of harm or death, with or without personal plan and MDT

CARM processes, MDTs and assessments completed

Transitional and long term accommodation; capacity and pipeline

People supported through link workers and team around person

People with MCV with MH/substance diagnosis and treatment plan

Attendances at A&E by people with MCV

Project Brave: Governance

- Strategic approach to be approved by Cabinet
- Aligns with review of Homelessness Prevention and Rough Sleeping Strategy
- Reporting to HWbB and annual reporting to HSAB and CSP Board
- Strategic Multi-agency Partnership Group
- Two Operational Groups; Homelessness and Multiple Complex Vulnerability
- Project plan and PMO support, recording on Verto
- Potential review of the name and “branding” of Brave, in 2023

Herefordshire Council

Title of report: Herefordshire Inequalities Strategy 2023-2026

Meeting: Health and Wellbeing Board

Meeting date: 13 March 2023

Report by: Director of Strategy and Planning

Classification
Open

Decision type
This is not an executive decision

Wards affected

(All Wards);

Purpose:

- For the Board to receive and comment on the Herefordshire Inequalities Strategy 2023-2026
- The purpose of this Inequalities Strategy is to shape the direction and the objectives of work over the next three years to reduce inequalities across the county.

Recommendation(s)

- That the Board considers and comments on the Inequalities Strategy.

Alternative options

1: The Board could choose not to consider this report. This is not recommended as the HWBB will provide its opinion, as appropriate, to Herefordshire Council, the Integrated Care Board or NHS England, as to whether they are discharging their duty to have regard to any assessment of relevant needs prepared by the Council, the ICB or NHS England in the exercise of their functions.

Key considerations

- Harms caused by inequalities are largely preventable; the aim of the Inequalities Strategy is to take action to reduce inequalities and to reduce or prevent poor health and well-being to make Herefordshire a happier, healthier, and safer place to live and work in.

- Creating a more equal society, in which it is easier and fairer for all people to sustain or return to good health and well-being, will require co-production with a range of organisations and bodies over a significant period of time. Meeting the challenge requires a renewed emphasis on inequalities and prevention across all organisations with action in the long term to address the wider influences on health and well-being.

- Appendix 1 contains the Herefordshire Inequalities Strategy 2023-2026

Community Impact

In accordance with the adopted code of corporate governance, Herefordshire Council achieves its intended outcomes by providing a mixture of legal, regulatory and practical interventions. Determining the right mix of these is an important strategic choice to make sure outcomes are achieved. The council needs robust decision-making mechanisms to ensure its outcomes can be achieved in a way that provides the best use of resources whilst still enabling efficient and effective operations and recognises that a culture and structure for scrutiny are key elements for accountable decision making, policy development and review

Environmental Impact

There are no general implications for the environment arising from this report.

Equality duty

- Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:

A public authority must, in the exercise of its functions, have due regard to the need to –

a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
c) Facilitate good relations between persons who share a relevant protected characteristic and persons who do not share it.

- The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services.

Resource implications

- There are no resource implications associated with this report. However, the resource implications of any recommendations made by the HWB will need to be considered by the responsible party in response to those recommendations or subsequent decisions

Legal implications

- Health and wellbeing boards are responsible for encouraging integrated working between health and social care commissioners, including partnership arrangements such as pooled budgets, lead commissioning and integrated provision.
- Their purpose is to establish collaborative decision making, planning and commissioning across councils and the NHS, informed by the views of patients, people who use services and other partners.
- The functions of the Health and Wellbeing Board are set out in paragraph 3.5.24 of the constitution.
- The production of a Joint Local Health and Wellbeing strategy is a statutory requirement and therefore its endorsement and support is required.

Risk management

There are no risk implications identified emerging from the recommendations in this report

Consultees

Matt Pearce (Director of Public Health), Hilary Hall (Corporate Director Community Wellbeing), Alan Dawson (Director of Strategy and Planning).

Appendices

Appendix 1 – Herefordshire Inequalities Strategy 2023-2026

Background papers

Core20PLUS5
NHS England » Core20PLUS5 – An approach to reducing health inequalities

Equality Act 2010
Equality Act 2010: guidance - GOV.UK (www.gov.uk)

Herefordshire Council Joint Strategic Needs Assessment (JSNA)
Herefordshire's Joint Strategic Needs Assessment

Indices of Deprivation
English indices of deprivation 2019 - GOV.UK (www.gov.uk)

The Marmot Review, 2010
Fair Society, Healthy Lives,

NHS Long Term Plan

NHS Long Term Plan

Office for National Statistics, 2022
Health state life expectancies by national deprivation deciles

Public Health England, 2017
Chapter 6: social determinants of health

Public Health England, 2018
National Dental Epidemiology Programme for England: oral health survey of five-year-old children 2017

Public Health England, 2020
Health Equity Assessment Tool: practice example. Health and Wellbeing Team, West Midlands (publishing.service.gov.uk)

Public Sector Equality Duty
Equality Act 2010 (legislation.gov.uk)

Tudor Hart, 1971. The Inverse Care Law.
THE INVERSE CARE LAW - The Lancet

The role of digital exclusion in social exclusion, Martin, C., Hope, S. and Zubairi, S., Ipsos MORI Scotland, 2016.

Government Digital Inclusion Strategy, Cabinet Office, 2014.

Internet Users - Table 6b, ONS, 2019.

Using Telecare and technology survey, Herefordshire Council, 2019.

Active Herefordshire & Worcestershire - Birmingham 2022: Active HW receives £60k to support community sport & physical activity projects

Active Herefordshire & Worcestershire - £105,000 invested into Tackling Inequalities across Herefordshire (activehw.co.uk)

Community Diagnostic Hubs (CDHs) in London (england.nhs.uk)

Introducing CAMBUS – Association for Dementia Studies Blog (wordpress.com)

Community Partnership - Healthwatch Herefordshire

Herefordshire Council

Herefordshire

Health and Well-being Board

Inequalities Strategy

2023-2026

Plan on a Page

Vision;	Herefordshire residents are resilient; lead fulfilling lives; are emotionally and physically healthy and feel safe and secure.		
The Challenge	Requires inequalities in health outcomes between different groups of people to be reduced. This necessitates a mix of short, medium and long term action including upon the wider determinants.		
We will focus on;	Reducing health inequalities across the population, particularly within:		
	Rurally dispersed	**Travelling Community**	**Unregistered individuals**
To do this we will;	Work in partnership to develop local solutions, using national frameworks and best practice, which encourage and empower people of all ages and abilities to reduce inequalities and improve health and wellbeing; focusing on;		
1.	**Engaging healthcare professionals to improve digital and health literacy**		
2.	**Empower and support workforces to understand and deliver equitable services that reduce inequalities and address workforce inequality and training needs**		
3.	**Reaching communities to work in partnership to reduce inequalities**		

Context

1. Since the last strategy, the Herefordshire Health and Well-being Board agreed that its vision is that; **Herefordshire residents are resilient; lead fulfilling lives; are emotionally and physically healthy and feel safe and secure.**

2. A new Herefordshire Health and Well-being Board Strategy is currently under development, with tackling inequalities identified as a key area of focus during 2022/23. The new strategy will be available from April 2023.

3. The purpose of this Inequalities Strategy is to shape the direction and the objectives of work over the next three years to reduce inequalities across the county.

4. Harms caused by inequalities are largely preventable; the aim of the Inequalities Strategy is to take action to reduce inequalities and to reduce or prevent poor health and well-being to make Herefordshire a happier, healthier, and safer place to live and work in.

5. Creating a more equal society, in which it is easier and fairer for all people to sustain or return to good health and well-being, will require co-production with a range of organisations and bodies over a significant period of time. Meeting the challenge requires a renewed emphasis on inequalities and prevention across all organisations with action in the long term to address the wider influences on health and well-being.

Health Inequalities

6. Health inequalities are defined as the **'unfair** and **avoidable** differences in health across the population and between different groups within society'. They 'arise because of the conditions in which we are born, grow, live, work and age'. This can include, although is not limited to, differences in health status, access to care and wider determinants of health such as housing and education.

7. The Equality Act 2010 identified nine protected characteristics:

    - Age;
    - Disability;
    - Race including ethnicity and national identity;
    - Sex;
    - Gender re-assignment;
    - Marriage and civil partnership;
    - Pregnancy and maternity;
    - Religion or belief, including lack of belief;
    - Sexual orientation

8. Whilst equality aims to provide individuals with the same opportunities or resources, health equity is realised when each individual has a fair opportunity to achieve their full health potential. This emphasises a non-uniform approach to facilitate the same level of health outcome and reinforces the NHS commitment that everyone should receive services according to individual need. We recognise that need and the capacity to benefit from services is shaped by the factors listed in paragraph 9 below.

9. The Health Equity Assessment Tool (HEAT) uses four overlapping dimensions to describe where health inequalities exist:

    - Protected characteristics
    - Inclusion health and vulnerable groups e.g., homeless individuals, people who leave prison, travelling community
    - Socio-economic groups and Deprivation e.g. deprived areas
    - Geography e.g., rural and urban

10. Health inequalities are known to exist across some of the protected characteristics (such as age, sex and ethnicity) but data is less clear for others. In addition, there are some important dimensions of health inequalities, such as deprivation, employment, income and educational attainment that are not protected characteristics under the Equality Act 2010.

11. The interplay between these factors and the wider determinants of health is complex and often requires a life course perspective. This may include targeting lifestyle factors – such as smoking and diet, as well as education, housing and employment/income.

12. A factor frequently associated with health inequalities is deprivation. This is measured using the Index of Multiple Deprivation 2019 (IMD2019) that summarises the overall deprivation experienced in each Lower Super Output Area (LSOA), fixed statistical geographies of about 1,500 people designed by the Office for National Statistics (ONS), in England. It is made up of seven weighted domains of deprivation: income; employment; education; health deprivation and disability; crime; barriers to housing & services; and living environment. The health deprivation and disability domain consists of the following indicators:

    - Years of potential life lost: an age and sex standardised measure of premature death
    - Comparative illness and disability ratio: an age and sex standardised morbidity/disability ratio
    - Acute morbidity: an age and sex standardised rate of emergency admission to hospital
    - Mood and anxiety disorders: a composite based on the rate of adults suffering from mood and anxiety disorders, hospital episodes data, suicide mortality data and health benefits data

13. The coronavirus (COVID-19) pandemic has highlighted and exacerbated the widening health inequalities that occur nationally with a disproportionate impact on certain, often disadvantaged, populations such as the most deprived populations.

14. Health inequalities are, by definition, preventable. Evidence has shown that reducing health inequalities within a population helps to improve life expectancy and reduce disability throughout the social gradient. This requires a multifaceted, cross-sector collaborative approach across all social determinants of health.

What is the national picture?

15. Health inequalities exist nationally. The 'social gradient' of health' describes the relationship between deprivation and health outcomes, including life expectancy, within England (Public Health England, 2017). Individuals from a lower socioeconomic position are more likely to have poorer health outcomes and a lower life expectancy than those of higher income.

16. Healthy life expectancy is another important indicator of health inequalities. This accounts for an individual's quality of life as well as the length – encompassing morbidity as well as mortality. In England, people living in the least deprived areas of the country live around 20 years longer in good health than people in the most deprived areas.

17. The ONS 2018-20 data (2022) showed that males who live in the least deprived decile of England had over 18 years more of good health compared to the highest deprived decile.

18. As well as health outcomes, access to healthcare services is associated with health inequality. Tudor Hart's 'inverse care law', proposed in 1971, remains relevant today. This describes how the 'availability of good medical care tends to vary inversely with the need for it in the population served'. Communities with higher deprivation, rural dispersion and the travelling community tend to face more barriers in accessing services despite, on average, greater health needs.

19. The financial implications of health inequalities were estimated by the Marmot Review (2010) at over £30 billion in lost productivity, with further costs for NHS healthcare use and welfare payments.

20. Digital exclusion has the potential to exacerbate social exclusion and inequalities. This is likely to become increasingly important as it is forecast that 90% of all jobs will soon require some form of digital capability. However, the Government's digital inclusion strategy (2014) has identified key groups that are at risk of digital exclusion including social housing tenants, those with registered disabilities and those aged over 65. Ensuring these groups have equal future opportunities and prospects is imperative.

21. Common causes of digital exclusion include lacking digital skills and the confidence to use them; poor access to infrastructure, fast broadband and local amenities, which can be worse in rural areas; and costs including devices, broadband subscription or monthly fees for mobile data.

What is the scale of the problem in Herefordshire?

22. Overall, Herefordshire's residents are in good health. When compared to other areas of England, Herefordshire has, on average, lower levels of overall, multiple deprivation and there is a relatively low proportion of children living in income deprived households. However, Herefordshire is more deprived than its geographical neighbours Shropshire, Worcestershire and Gloucestershire.

23. Nine of Herefordshire's LSOAs are within the 25% most deprived in England in terms of the IMD2019's 'health and disability' domain.

24. Almost two thirds of all Herefordshire LSOAs (72 of the 116) are among the 25% most deprived in England with respect to IMD2019's 'geographical barriers to services' domain, with 53 being in the most deprived 10% across England. Of these deprived 72 LSOAs three quarters are in rural areas, with living costs estimated as 10-20% higher for rural households and deprivation related to housing and physical access to services.

25. Herefordshire is the fourth lowest population density county within England with 95% of the land classified as 'rural' which is home to over 50% of its population. Transport links are an issue in the county, with more than half of it being classified as amongst the worst in England in terms of geographical access to services. This is highlighted by the poor scores for Herefordshire in the Office for National Statistics Health Index 2020 that relate to access to services and it re-iterates the need to consider the effects of rural dispersion throughout the inequalities strategy and subsequent action plan. It is known that rural dispersion brings higher service costs as well as issues of access to services.

26. People born in the most deprived 10% of areas in Herefordshire have a shorter life expectancy at birth than those living in the least deprived 10% by an average of 4.2 years for males and an average of 3.0 years for females. Those living in the most deprived areas are 36% more likely to die prematurely of cancer; 22% more likely to die prematurely of cardiovascular disease; 18% more likely to die from respiratory disease; and approximately a third more likely to die as a result of suicide. All of these causes of death are sensitive to early, preventive, action.

27. 4,450 under 16s are living in absolute poverty. There are persistent gaps in educational attainment for disadvantaged children, and for those with Education and Health Care Plans (EHCP)/ Special Educational Needs and Disability (SEND). Furthermore, inequalities in health outcomes between socioeconomic groups can already be prevalent in childhood. For example, a Public Health England report (2018) found that there is a 20.1% difference in the prevalence of dental decay

between 5 year olds in the most deprived and least deprived communities in England (33.7% and 13.6% respectively).

28. Herefordshire is flagged as a ‘cold spot’ by the government’s social mobility index, amongst the lowest 20% of local authorities in England in terms of the chances that disadvantaged children will do well at school, get a good job and secure housing. They key driver of this is low wages, with 31% of county jobs paying less than the living wage of £8.75 an hour and an average residents’ salary of just over £350 per week – amongst the lowest 10% in England.

29. Digital exclusion is also a concern within Herefordshire and the County performed poorly for ‘internet access’ in the Office for National Statistics Health Index 2020. An estimated 7% of people aged 16 and over in Herefordshire last used the internet over three months ago, or have never used the internet. Over 75s, people who are economically inactive, people in housing association rented accommodation are significantly less likely to use the internet regularly. A recent survey of Telecare service users in Herefordshire (of whom there are over 1,500) found that 52% of those who responded to the survey do not use the internet.

30. COVID-19 has further widened inequalities, with 28% of the poorest fifth of Herefordshire residents furloughed and experiencing a loss of income compared to 17% of the richest fifth. Access to health services for people with pre-existing conditions was 20% lower during the peak of COVID, while in April 2020 63% of people with long term health conditions requiring treatment did not receive it. Vaccination uptake was also lower amongst the 30% most deprived areas.

Tackling the Problem - National Policy

31. The Health and Social Care Act 2012 reported the rising demand on the NHS with increasing treatment costs. It noted the need for improvement in certain clinical areas such as cancer survival rates. ‘Tackling inequalities in healthcare’, both access and health outcomes, was considered a ‘cross-cutting theme of the act’.

32. Subsequently, The Health and Care Act 2022 outlined significant changes to the structure of the NHS within England. This included the formation of integrated care systems that encouraged the collaboration between NHS and other organisations such as local authorities. This is essential for successful action on health inequalities that targets the integral wider determinants of health.

33. The NHS Long Term Plan identified health inequalities and ill-health prevention as priorities in improving the healthcare of the nation. This plan’s approach included distributing a higher share of funding to areas that experience high health inequalities and investing more money into meeting the needs of certain groups, such as rough sleepers. However, this initiative recognises that the NHS must work in collaboration with other organisations such as local governments.

34. To help in the approach to reducing health inequalities, national frameworks and tools exist. For example, Core20PLUS5 is a new NHS England and NHS

improvement approach to health inequalities. This aims to provide a framework from which local authorities can base their health inequality strategy. This acronym can be broken down into three components:

- Core20 – encompassing 20% of the national population who live in the most deprived quintile as per the Index Multiple Deprivation
- PLUS – additional population groups that have been identified locally as being at risk of health inequalities
- 5 – five key clinical areas that have been prioritised within the NHS long term plan: continuity of maternity care, annual health checks for severe mental illness, vaccination uptake for individuals with chronic respiratory disease, early cancer diagnosis and hypertension case-finding and management.

35. The Equality Act 2010 legally protects people from discrimination in the workplace and in wider society, replacing several previous pieces of legislation into one single Act that:

- protects and enables action against discrimination, harassment and victimisation related to protected characteristics and increase equality of opportunity
- requires decision makers to consider and aim to reduce socio-economic inequalities in policy making and public procurement
- requires public bodies demonstrate compliance with the Act and advance equality of opportunity and foster good relations between people who share a protected characteristic and those who do not, formally known as the Public Sector Equality Duty

36. The Health Equity Assessment Tool (HEAT) of UK Health Security Agency, previously Public Health England, was designed to support professionals within the public health system in their aims to identify and reduce health inequalities. This tool has been used by the West Midlands' Health and Wellbeing Team to 'drive forward work on health inequalities' (Public Health England, 2020).

37. NICE guideline 44 [NG44] focusses on community engagement to improve health and wellbeing whilst reducing health inequalities. This guideline recommends working collaboratively between multiple organisations as well as the local community. They advise that strategies should consider how to facilitate communities to engage in the initiatives including those who may have additional barriers to engagement, such as non-English speakers and those with additional needs.

38. NICE also recommends taking the 'Making Every Contact Count' (MECC) approach. This is an evidence-based initiative that aims to deliver opportunistic brief interventions during routine appointments and contacts. These may take the form of conversation, encouragement or referrals to help behaviour change such as reducing alcohol intake or smoking cessation. This will be particularly beneficial

for those who do not attend healthcare services frequently and/or have less uptake in health promotion and preventative services.

39. The role of anchor institutions in promoting social mobility and value to a local population is highlighted by the 'Health Anchors Learning Network'. This describes anchor institutions as 'large public sector organisations which are rooted in place and connected to their communities, such as universities, local authorities, and hospitals. Anchors have significant assets and spending power and can consciously use these resources to benefit communities.' Examples of positive actions that these institutions can make include:

    - Engaging with other organisations that have high value of social benefit to the local population such as the opportunity of apprenticeships
    - Increasing the access to available spaces for community use such as provision for the voluntary sector
    - Reducing their environmental impact with the production of a sustainability strategy

40. Whilst these national policies are essential in ensuring all areas of England are aiming to reduce health inequalities, these must be tailored and applied to local populations.

What is Herefordshire doing now?

41. The emerging 'Health and Wellbeing Strategy' for Herefordshire is currently out for consultation to determine the priorities but there will be a strong theme of narrowing health inequalities throughout.

42. At Integrated Care System level for Herefordshire and Worcestershire, tackling inequalities is one of four 'strategic purpose' areas. Within the 'ICS health inequalities, prevention and personalisation strategic intent', empowerment of staff, working collaboratively and improvement of health literacy are identified as ways to do this. Milestones that have been set include a waiting list dashboard through a health inequalities lens by 2022/23 and targeted engagement with the Core20PLUS5 groups in 2023/24. Subsequent intended outcomes include a reduced variation in healthy life expectancy by ethnicity, deprivation and rurality.

43. Recent Council initiatives to directly minimise inequalities included: the development and implementation of a COVID vaccine inequalities programme; support for more than 11,000 bill payers through the council tax reduction scheme; and support for over 200 individuals via debt, financial and fuel poverty service available in all market towns.

44. Talk Community is a Herefordshire-based initiative that aims to make Herefordshire a 'better place to live and work'. There is an on-line and an in-person offer. The online service offers an extensive range of information covering

everything from health and wellbeing, housing, carers support and transport to legal and financial advice, bereavement support and home adaptations, and signposts to local services, groups, events and activities across the county.

45. There are also 65 volunteer-led ‘Talk Community Hubs’ based in existing community buildings, such as churches and village halls, across the county where local people can access information and activities to support their wellbeing and independence and that bring together and connect people to each other, their communities and local areas. They have also established the Talk Community kitchen that provides healthy meals to the local community.

46. The Herefordshire Community Partnership brings public, voluntary and community stakeholders together with statutory partners to work towards the common goal of a commitment to producing and designing health, wellbeing and care solutions together. They have identified four key topics that the community want to prioritise for their work on reducing health inequalities in Herefordshire, formed cross-sector project groups interested in each topic, secured funding for each work stream to facilitate collaborative working, and have had initial meetings of each work stream to confirm membership, identify leads and begin scoping and planning. These topics are:

    - Rurality, transport and access
    - Health and managing preventative actions
    - Managing mental health loneliness and isolation
    - Deprivation, food and fuel poverty

47. Fastershire is a partnership between Herefordshire Council and Gloucestershire County Council to bring faster broadband to the two counties and promote digital inclusion. They have worked with suppliers to reach 93.7% of premises with superfast and full fibre broadband and introduced a new community broadband scheme to connect some of the hardest to reach premises.

48. With the aim of improving the health and wellbeing of children, the Council has: provided free gym and swimming lessons for children; created 14 enhanced play areas supported by the COVID recovery grant; introduced new Universal Public Health nursing visits for 4-6 month olds; introduced an on-line oral health training package reaching 177 professionals and parents; and launched a new campaign to improve young children’s oral health based on ‘Brush, Book, Bed’ with packs from libraries and supervised tooth brushing in children’s settings.

49. Active Herefordshire and Worcestershire (Active HW) were provided with 'Tackling Inequalities’ and Herefordshire Council COVID-19 recovery plan funding to help reduce the negative impact of COVID-19 and to tackle the widening of the inequalities in sport, physical activity and exercise by supporting local communities to become and remain active following the pandemic. Through the Birmingham

2022 Commonwealth Games, they were able to fund community sport and physical activity projects that supported residents who needed it most or were from underrepresented groups.

50. The Council has also worked with partners to increase the skills and workforce in the county by: establishing contracts with two Community Renewal Fund projects; backing the Kickstart scheme launched to support young people into work / apprenticeships; and using COVID-19 recovery funding to support 28 young people most at risk of not being in education, employment and/or training.

51. The creation of a joint Community Integrated Response Hub with Wye Valley NHS Trust to facilitate patients receiving care at home by providing access to a range of community responses that routinely meets need on the day.

52. The recently launched Coffee and Memory Bus (CAMBUS) scheme comprises of two minibuses/vans that travel around Herefordshire and Worcestershire reaching out to people in their community and providing a safe and friendly space for people to enjoy a tea or coffee, have a chat, find out useful information and access support services. In Herefordshire, the CAMBUS 'Molly' is operated by Dementia Matters Here, which supports people affected by dementia and memory issues, their carers and families across Herefordshire to live well.

53. The Advancing Mental Health Equality (AMHE) Collaborative is a Royal College of Psychiatrists initiative that Herefordshire and Worcestershire Health and Care NHS Trust have signed up to. It is a quality improvement and co-production informed three year structured programme designed to support providers identify and address aspects of inequality in the services they provide; specifically inequalities in access, experience and outcome. It includes access to equality resources; an 'improvement community'; a network of experts (clinicians, academics, service users/carers) including a QI coach assigned to the trust; support around co-production, data collection and evaluation; and shared learning from other participating organisations (there are 21 in total across the UK). The AMHE toolkit provides a framework for identifying inequalities, designing services differently to address these, delivering a measurable strategy and evaluating the impact of changes/interventions introduced. The Trust have identified three key cohorts to focus activity on within this framework; our local farming & agricultural communities; transgender people; and children and young people. The farming and agricultural work stream is already well established; the work is being overseen by a sub-group consisting of a broad range of stake holders including the local council, public health, Healthwatch and a broad range of VCSE providers already working in this area.

54. Community Diagnostic Centres (CDCs) are an NHS initiative aimed at building capacity for more diagnostic testing in England, thereby relieving pressure on hospitals. They are to be multi-diagnostic facilities, separate from acute hospitals

and placed in local communities. Among the primary aims of CDCs are to reduce health inequalities by improving access to diagnostics for people in health inequalities groups and to deliver a better patient experience by providing coordinated tests in the community and in as few visits as possible. Wye Valley NHS Trust are currently at an advanced stage of planning for a Hereford City CDC, supported by the ICB.

55. Each Primary care network has been tasked to use available data to identify a focus area based on priority patient populations within the PCN experiencing inequality in health provision and/or outcomes (see section 60).

The Inequalities Strategy

56. There are a range of national policies that aim to reduce health inequalities but with a lack of clear, consistent methodology at local level.

57. Herefordshire's Health Inequalities Group plan to develop a shared-system wide understanding of inequalities. The empowerment of others in the system will enable effective collaborative work.

58. The Core20PLUS5 approach sets out a national NHS framework for action to narrow health inequalities in order to ensure delivery of the NHS Long Term Plan commitment on health inequalities. It defines a target population for local action. This is made up of three elements: the most deprived 20% of the national population; five clinical areas with identified tasks for accelerated improvement; and a third locally defined target population. It recommends incorporating their lived experiences with evidence-based approaches to utilise pre-existing services, such as community hubs, as well as developing new initiatives that can provide data to ensure the objectives are fulfilled.

59. Evaluation and impact assessment of change is imperative but there is an expectation that some outcomes will be long-term and the use of intermediate goals may be required.

Our Target Groups

60. Using the Core20PLUS5 framework, as noted in paragraph 57, Herefordshire's target groups include:
    - Core20 – 9 out of 116 LSOA's within Herefordshire were within England's most deprived quintile in 2019 (with one LSOA in the 10% most deprived). These most deprived communities are identified in the JSNA Herefordshire's Joint Strategic Needs Assessment - Understanding Herefordshire and are targeted across the public sector

- PLUS – these have been agreed as: people who are not registered with a general practice, the most rurally dispersed population, and Gypsy Roma and traveller community (see paragraph 60)
- 5 – For these five key clinical areas identified nationally, Herefordshire have pre-existing initiatives that include:
    i. Maternity care – within Herefordshire, data is collected for the BAME population for both antenatal and postnatal continuity of care. However, continuity of care does not include care during birth. It is estimated by the service that all BAME women receive continuity of care during the antenatal and postnatal periods.
    ii. Severe mental illness – the mental health collaborative of the ICS have agreed a transformation plan with the uptake of annual health checks in individuals with serious mental illness being a priority.
    iii. Chronic respiratory disease – Herefordshire have a vaccination programme that has been built upon learning from the COVID vaccination scheme and includes outreach services such as a vaccination bus. The Respiratory Pathway is a priority scheme for 1HP and service improvement work is underway.
    iv. Early cancer diagnosis - the development of a community based diagnostic hub aims to improve the proportion of cancer diagnoses that are made at an early stage. Furthermore, initiatives for this clinical area have been identified as a priority at PCN level (see table on paragraph 62).
    v. Hypertension case-finding and management – the county are currently reviewing their health checks offer for the 40-74 year old and a population health management approach to individuals who have had a single high reading in clinic.

61. The three ‘PLUS’ population groups identified below demonstrate our approach of meeting the most deprived population and have been chosen as priorities for this inequalities strategy:

People who are not registered with a general practice: By definition, accurately quantifying the number of unregistered individuals within Herefordshire is difficult. Unregistered individuals are at risk of being ‘unseen’ and ‘unheard’ within health services, increasing health inequalities. This is a priority group that has been identified at Integrated Care System (ICS) level.

Rurally Dispersed: Given Herefordshire’s low population density, there is a large proportion of inhabitants who face significant geographical barriers to accessing healthcare. 53% of inhabitants live in areas defined as ‘rural’, with the majority of these in the most rural ‘village and dispersed’ areas nationally. The vast majority of those working in farming and agriculture also live in rurally dispersed areas. Just under a third of the population lives in Hereford city, and just under a fifth in one of the three largest market towns of Leominster, Ross and Ledbury.

Gypsy Roma and Traveller community: This population is often under-recorded in census data. The Gypsy traveller team in Herefordshire Council estimate they account for approximately 3% of the Herefordshire population. The UK Government previously stated that 'Gypsies, Travellers and Roma are among the most disadvantaged people in the country, and have poor outcomes in key areas like health and education'.

Objectives

62. There are three over-arching objectives for this Inequalities Strategy which run above and through the priorities discussed above. These are;

Digital and health literacy - Engage healthcare professionals to help improve digital and health literacy skills among rural residents to reduce isolation and poorer health outcomes. This refers to both improving these residents' literacy as well as ensuring the professionals are able to identify those with lower literacy skills and suitable adapt their consultations.
Empowering workforces - Empower workforces to deliver equitable services to reduce inequalities: what workforce/practitioners/providers need to do differently to reduce inequalities whilst understanding and addressing workforce inequality and need for staff training to consider their work through an inequality or inequity lens
Reaching our communities - Explore use of link or community development workers in practice to reduce inequalities; Improving uptake of services and help seeking through community building approaches

63. Examples of actions to be undertaken against each of the three objectives is outlined in the table below. These actions will be reviewed on a quarterly basis to monitor progress and to respond to challenges, remain appropriate and proportionate to the needs of the county. Where applicable, new actions will be agreed for the following year(s);

Herefordshire Council

Improving digital and health literacy			
AIM	**ACTION**	**OUTCOME**	**LEAD AGENCY**
Improve digital access in communities at risk of exclusion	Increasing awareness of digital training that is available in libraries	Greater use of digital resources by wider communities	Herefordshire Council and NHS
	Provide free public Wi-Fi access in priority sites	Reducing barriers of accessibility to digital resources	Herefordshire Council / Talk Community
	Ensure the provision of devices that are freely available to use in community settings such as libraries and Talk Community hubs	Enhanced use of digital resources by wider communities	Herefordshire council / Talk Community /PCNs / Public Health
Ensure accessibility of other formats of health information	Encourage the availability of hard-copy information in both easy-read and non-English versions. This will start with a county-wide focus on early signs and symptoms of cancer throughout 2023/24 using the above formats and tailoring ways of reaching target populations	Improved access to health information	All agencies including healthy pharmacies
	Ensuring those at risk of the poorest outcomes receive tailored information and signposting following a cancer diagnosis	Improved education and service uptake for those diagnosed with cancer	S&W PCN
	Develop information for patients who have declined bowel and/or cancer screening	Increased uptake of screening	S&W PCN and Public Health

Empowering workforces that work collaboratively			
AIM	**ACTION**	**OUTCOME**	**LEAD AGENCY**
System staff training in narrowing health inequalities and developing evidence-based improvement plans	Promote e-learning that is available for staff such as e-LFH	Practitioners to have better awareness of health inequalities and their impact	All agencies
Empower system staff to communicate well with people at risk of poor health outcome	System staff training in health literacy	Improved communication skills	Public Health
Embed asset-based models in practice delivery to enable wide understanding of community led service design and co-production.	System staff training on asset-based practice	Understanding of community development and support	Public Health
Support Primary Care Networks (PCNs) to deliver inequalities reduction schemes tailored to their communities	Using social prescribing links to reduce obesity in individuals with BMI>30, depression and no Covid-19 vaccination.	Reduced obesity prevalence	East PCN/Public Health
Create population health management approaches to tackling health inequalities	Identify patients affected by adverse childhood experiences & understand how this cohort can be better supported. Improve system staff awareness and trauma informed care training and working with partner organisations, VCSE and service users	Improved health outcomes for people who have experiences ACEs	Herefordshire Medical Group PCN/Public Health

	Identify patients BMI >30 with depression and no COVID vaccination	Improved COVID vaccination rates	S&W PCN
	Patients who have declined bowel and/or cancer screening	Increased uptake of screening	S&W PCN
	BMI>35 who have used GP services 4 or more times in 2 months – offer dietician group consultations and HWbC	Reduced obesity prevalence	S&W PCN
	Group approach for BMI >30, fibromyalgia, loneliness & isolation identifying and tailoring the offer to those at risk of experiencing health inequalities	Reduced obesity prevalence	N&W PCN
	Group approach BMI >30, pre-diabetes and anxiety identifying and tailoring the offer to those at risk of experiencing health inequalities	Reduced obesity prevalence	N&W PCN
Utilise the power of anchor institutions in promoting social mobility	First step: initial anchor institution meeting led through 1HP – to review the 'Health Anchors Learning Network' 6 strategic areas and Purpose Coalition Impact Report to identify local existing activity and where there are gaps. Continuation of applying an Equalities Impact Assessment for all specifications/service change, Procurement Initiation Documents and business case proposals.	Development of a 1HP anchor mission that includes a commitment to use assets and resources in partnership with the community and other anchors to benefit the local population. Improved social mobility of local population	1HP and constituent organisations, Public Health

Use of co-design to inform our work and address the currently fragmented approach.	Complete an options appraisal on co-design capacity to be discussed at 1HP	Robust way to deliver initiatives that incorporates the use of co-design	1HP partners
Ensure that changes to existing services and new services do not worsen health inequalities	Use of the Health Equity Assessment Tool (HEAT) and local impact assessments for all major service developments in order to demonstrate impact on health inequalities	Service redesign and new service implementation reduces health inequalities rather than worsens them.	1HP partners

Reaching Communities			
AIM	**ACTION**	**OUTCOME**	**LEAD AGENCY**
Undertake a pilot of a community survey to explore the perspectives and lived experiences of the local population	1HP Health Inequalities Group to Lead	Inequalities initiatives that are tailored to local population needs	1HP partners
Find new ways to reach harder to reach populations	Marquee at Belmont Community Centre on Fridays to coincide with a visiting food van	Increased uptake of health assessment services Raised awareness about health screening opportunities through conversations with the health and wellbeing team Identify challenges and highlight opportunities to improve trust, engagement and relationships	Hereford City WBC PCN
Use learning from COVID-19 vaccinations to determine methods to engage typically 'hard to reach' groups	Increase uptake of annual health checks and other screening programmes among hard to reach groups	Uptake of annual NHS health checks and other screening programmes	All PCNs and Public Health
Ensure that those living in areas of deprivation are not facing bias when accessing emergency, urgent and planned care	Undertake an analysis of patient waiting lists by index of multiple deprivation	Understanding and removing barriers to accessing healthcare	Wye Valley NHS Trust

64. Progress and implementation of the Inequalities Action Plan will be reported to the One Herefordshire Partnership, ICS Health Inequalities Collaborative and Herefordshire Health and Well-being Board.

Evidence, Strategies and Guidance

Core20PLUS5
NHS England » Core20PLUS5 – An approach to reducing health inequalities

Equality Act 2010
Equality Act 2010: guidance - GOV.UK (www.gov.uk)

Herefordshire Council Joint Strategic Needs Assessment (JSNA)
Herefordshire's Joint Strategic Needs Assessment

Indices of Deprivation
English indices of deprivation 2019 - GOV.UK (www.gov.uk)

The Marmot Review, 2010
Fair Society, Healthy Lives,

NHS Long Term Plan
NHS Long Term Plan

Office for National Statistics, 2022
Health state life expectancies by national deprivation deciles

Public Health England, 2017
Chapter 6: social determinants of health

Public Health England, 2018
National Dental Epidemiology Programme for England: oral health survey of five-year-old children 2017

Public Health England, 2020
Health Equity Assessment Tool: practice example. Health and Wellbeing Team, West Midlands (publishing.service.gov.uk)

Public Sector Equality Duty

Equality Act 2010 (legislation.gov.uk)

Tudor Hart, 1971. The Inverse Care Law.
THE INVERSE CARE LAW - The Lancet

The role of digital exclusion in social exclusion, Martin, C., Hope, S. and Zubairi, S., Ipsos MORI Scotland, 2016.

Government Digital Inclusion Strategy, Cabinet Office, 2014.

Internet Users - Table 6b, ONS, 2019.

Using Telecare and technology survey, Herefordshire Council, 2019.

Active Herefordshire & Worcestershire - Birmingham 2022: Active HW receives £60k to support community sport & physical activity projects

Active Herefordshire & Worcestershire - £105,000 invested into Tackling Inequalities across Herefordshire (activehw.co.uk)

Community Diagnostic Hubs (CDHs) in London (england.nhs.uk)

Introducing CAMBUS – Association for Dementia Studies Blog (wordpress.com)

Community Partnership - Healthwatch Herefordshire

Herefordshire Council

Title of report: Herefordshire and Worcestershire Child Death Overview Panel Annual Report 2021-22

Meeting: Health and Wellbeing Board

Meeting date: 13 March 2023

Report by: Director of Public Health

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards);

Purpose:

- For the Board to receive and comment on the Herefordshire and Worcestershire Child Death Overview Panel Annual Report 2021-22

Recommendation(s)

- That the Board consider and note the report.

Alternative options

1: The Board could choose not to consider this report. This is not recommended as the HWBB will provide its opinion, as appropriate, to Herefordshire Council, the Integrated Care Board or NHS England, as to whether they are discharging their duty to have regard to any assessment of relevant needs prepared by the Council, the ICB or NHS England in the exercise of their functions.

Key considerations

- The death of a child is always tragic. It is essential that in seeking to identify factors that, if modified, might have prevented a child's death or might prevent future deaths, sight is never lost of that or the life-changing impact of losing a child on parents, siblings, extended families and friends.

- The number of deaths reviewed was relatively low, modifiable factors were identified in 57% of deaths reviewed. That is significant for two reasons:

    - The identification of those factors underlines the importance of CDOP's work.

    - Thorough analysis of 43% of the deaths reviewed led to a conclusion that nothing whatsoever could have been done to prevent the deaths of those children. In looking for lessons, themes and trends, there is a need to recognise that the deaths of some children are utterly unpreventable but no less tragic for that.

- Appendix 1 contains the Herefordshire and Worcestershire Child Death Overview Panel Annual Report 2021-22

Community Impact

In accordance with the adopted code of corporate governance, Herefordshire Council achieves its intended outcomes by providing a mixture of legal, regulatory and practical interventions. Determining the right mix of these is an important strategic choice to make sure outcomes are achieved. The council needs robust decision-making mechanisms to ensure its outcomes can be achieved in a way that provides the best use of resources whilst still enabling efficient and effective operations and recognises that a culture and structure for scrutiny are key elements for accountable decision making, policy development and review

Environmental Impact

There are no general implications for the environment arising from this report.

Equality duty

- Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:

A public authority must, in the exercise of its functions, have due regard to the need to –

a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
c) Facilitate good relations between persons who share a relevant protected characteristic and persons who do not share it.

- The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services.

Resource implications

- There are no resource implications associated with this report. However, the resource implications of any recommendations made by the HWB will need to be considered by the responsible party in response to those recommendations or subsequent decisions

Legal implications

- Health and wellbeing boards are responsible for encouraging integrated working between health and social care commissioners, including partnership arrangements such as pooled budgets, lead commissioning and integrated provision.
- Their purpose is to establish collaborative decision making, planning and commissioning across councils and the NHS, informed by the views of patients, people who use services and other partners.
- The functions of the Health and Wellbeing Board are set out in paragraph 3.5.24 of the constitution.

Risk management

There are no risk implications identified emerging from the recommendations in this report

Consultees

Matt Pearce (Director of Public Health), Hilary Hall (Corporate Director Community Wellbeing), Elizabeth Altay (Interim Director of Public Health, Worcestershire).

Appendices

Appendix 1 – Herefordshire and Worcestershire Child Death Overview Panel Annual Report 2021-22

Background papers

None identified

Herefordshire and Worcestershire Child Death Overview Panel

Annual Report

1st April 2021 to 31st March 2022

worcestershire county council

Contents

1. Foreword

I am very pleased to introduce the annual report for the joint H&W CDOP for the period 1st April 2021 to 31st March 2022.

Last year's report reflected themes and developments in both counties leading up to and following the establishment of the new joint panel in late 2019. This is therefore the first report that specifically focuses on completed activity in the review of children's deaths for a single year and provides information for Child Death Review (CDR) partners on local patterns and trends in the deaths of children, lessons learned and modifiable actions identified.

In reflecting on my foreword to last year's report, some of my comments then - when the world was in the midst of the COVID-19 pandemic - are just as pertinent now:

- The death of a child is always tragic. It is essential that in seeking to identify factors that, if modified, might have prevented a child's death or might prevent future deaths, we never lose sight of that or the life-changing impact of losing a child on parents, siblings, extended families and friends.
- Working remotely seems to have become routine and I am still to meet many of my CDOP colleagues in person. Nonetheless, an excellent group of professionals from across the CDR partnership demonstrate a high level of ongoing commitment to meeting remotely and ensuring that a thorough analysis of the CDR process is undertaken in respect of the death of every child normally resident in Herefordshire or Worcestershire.

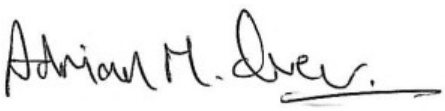
The findings of the report speak for themselves. Although the number of deaths reviewed is relatively low, modifiable factors were identified in 57% of deaths reviewed. That is significant for two reasons:

- The identification of those factors underlines the importance of CDOP's work
- Thorough analysis of 43% of the deaths reviewed led to a conclusion that nothing whatsoever could have been done to prevent the deaths of those children. In looking for lessons, themes and trends, we have to recognise that the deaths of some children are utterly unpreventable but no less tragic for that.

I should like to thank all members of the wider CDR process for their hard work and commitment in notifying CDOP when a child dies; convening and attending child death review meetings; and completing and submitting analysis forms. Huge thanks also to all members of CDOP for their diligent attendance and participation in panel meetings. Analysing the deaths of children is an emotionally as well as intellectually demanding task, which should never be underestimated.

In thanking everybody, I feel as chair that it is particularly important to acknowledge the wonderful contribution of our designated doctors in preparing and presenting case information for analysis. CDOP benefits enormously from their dedication, diligence and expertise.

Finally, my special thanks to CDOP Co-ordinator Polly Lowe for her tireless efforts in co-ordinating the panel's work, standardising the CDR process across the two counties and chasing up information and responses to identified actions; to Jayne Williams for her patient and consistent work in providing administrative support to the panel; and to Hayley Durnall and Polly for all their work in writing this report.



Adrian Over

Herefordshire and Worcestershire Child Death Overview Panel Independent Chair

2. Introduction

The death of a child is a devastating loss that profoundly affects the bereaved parents as well as extended family, friends and professionals who were involved in caring for the child.

Herefordshire & Worcestershire Child Death Overview Panel (H&W CDOP) operates as a combined CDOP. In the counties of Herefordshire and Worcestershire (H&W) the current child death review (CDR) partners are:

- Herefordshire Council (Public Health)
- Worcestershire County Council (Public Health)
- NHS Herefordshire and Worcestershire

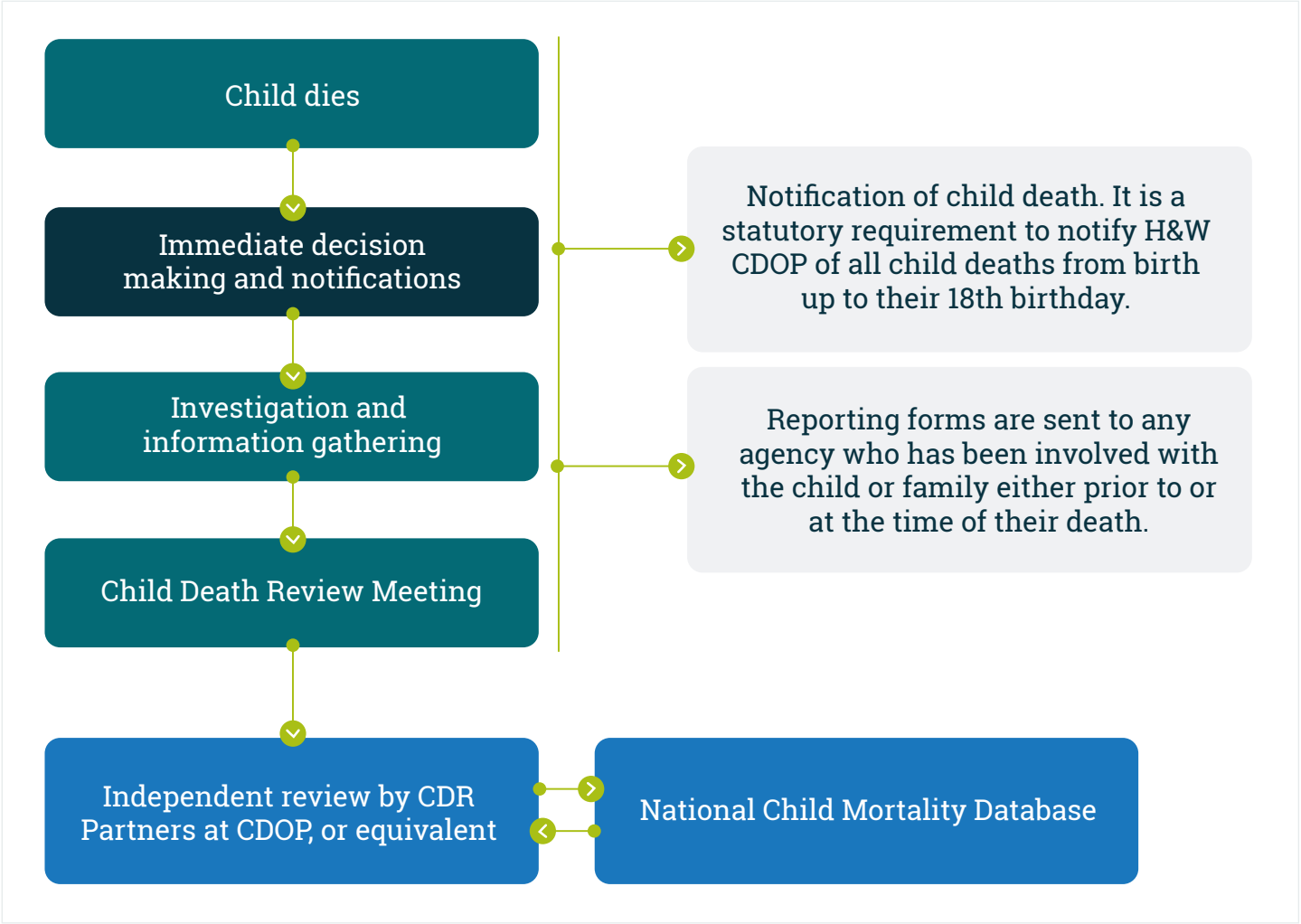
H&W CDOP is an independent multi-agency panel whose role is to carry out an anonymised secondary review of each child's death to learn lessons and share any findings for the prevention of future deaths. One of the responsibilities of H&W CDOP is to produce an annual report on behalf of the statutory partners, which is reported to both Herefordshire and Worcestershire's Health and Wellbeing Boards and the Integrated Care Board. The report may also be shared, as appropriate, with other key strategic partnerships. The report provides an overview of all completed child death reviews, highlighting the most frequent modifiable factors. Analysing the data by varying categories often results in very small numbers. Therefore, data has been summarised in proportions throughout this report to prevent an individual child being able to be identified from the analysis.

Overview of CDOP Process

There is a statutory obligation to notify a child death to Child Death Overview Panel (CDOP) However, CDOP reviews are not always completed in the same year as the notification of death. Some child deaths may involve a coronial investigation, post-mortem, Child Safeguarding Practice Review, Healthcare Safety Investigation Branch investigation, Serious Incident investigation or Police investigation which all have varying timescales for completion. Most cases are reviewed in the years following the child's death. The timescale for secondary review at CDOP relies on the collection and analysis of information requested from professionals.

Before the death of a child can be reveiwed at CDOP it must be reviewed by the Child Death Review Meeting (CDRM) process. The Child Death Review Meeting CDRM is a multi-professional meeting where all matters relating to an individual child's death are discussed. A Joint Agency Response is triggered if a child dies unexpectedly and is reviewed using SUDIC (Sudden Unexpected Death in Infants and Children) guidelines. These guidelines ensure that all unexpected child deaths are reviewed in detail to identify any learning or actions that should be taken to improve the safety or welfare of children or the child death review process. An initial CDRM is usually held within 14 days of the child's death to ensure that the correct information surrounding the circumstances of the death is collected and that family members and others who were close to the child are being appropriately supported. A final CDRM will be held once any investigations have concluded and any reports from key agencies and professionals have been received.

There is a statutory requirement that all child deaths are independently reviewed so following the CDRM each case will then be taken to H&W CDOP. The Panel will make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths or promote the health, safety and wellbeing of children.



About Herefordshire and Worcestershire

Herefordshire and Worcestershire are two separate counties located in the West Midlands in the heart of England towards the south and southwest of the West Midlands Region. The two counties border Shropshire, Staffordshire, the West Midlands Metropolitan Area, Warwickshire, Gloucestershire and Wales to the west. The two main administrative cities are Worcester City in Worcestershire and Hereford in Herefordshire. Worcestershire consists of 6 districts, namely Bromsgrove, Malvern Hills, Redditch, Worcester City, Wychavon and Wyre Forest

In terms of population, almost 791,000 people live across the two counties. Worcestershire had approximately 604,000 people resident and Herefordshire had a little over 187,000 as at the 2021 census. The overall population in Worcestershire has increased by 6.6% since 2011 which is a similar rate to England. However, Herefordshire has had a slower rate of growth at only 2%.

By area, both counties are largely rural with almost 85% of Worcestershire and 95% of Herefordshire classified as rural areas. However, almost three quarters of the population of Worcestershire and almost half of the population of Herefordshire is defined as living in urban areas.

Despite being seen as relatively affluent counties, 5% of Worcestershire and 1% of Herefordshire's population live in areas which are amongst the 10% most deprived in England. Approximately 9% of children aged under 18 years in Herefordshire and nearly 17% in Worcestershire are living in income deprived households in areas which are classed as amongst the poorest 20% in England.

The 0-4 population in the two counties has decreased since 2011, by 5% in Worcestershire and 13% in Herefordshire. Comparatively, the figure was a 7% decrease in England as a whole. At a district level Redditch has a notably higher proportion of children than is seen nationally.

3. Data Analysis

Child Death Notifications

It is a statutory requirement to notify the relevant CDOP of all child deaths from birth up to their 18th birthday. H&W CDOP now use the below link for notifications of child deaths:
www.ecdop.co.uk/WestMercia/Live/public

3.1 Child Death Notifications in Herefordshire and Worcestershire 2021-2022

- Between 1st April 2021 and 31st March 2022, a total of **43 child death notifications** were received for Herefordshire and Worcestershire resident children.
- **49%** of notifications were male and **51%** were female.
- **67%** of the deaths were expected and **33%** were unexpected

3.2 Child Death Notifications in Herefordshire 2021-2022

- Between 1st April 2021 and 31st March 2022, a total of **9 child death notifications** were received for Herefordshire resident children.
- **67%** of notifications were male and **33%** were female.
- **56%** of the deaths were expected and **44%** were unexpected.

3.3 Child Death Notifications in Worcestershire 2021-2022

- Between 1st April 2021 and 31st March 2022, a total of **34 child death notifications** were received for Worcestershire resident children.
- **45%** of notifications were male and **56%** were female.
- **71%** of the deaths were expected and **29% were** unexpected.

Figure 1. Number of child death notifications received by year of notification and area of residence
Data source H&W CDOP 2021-2022

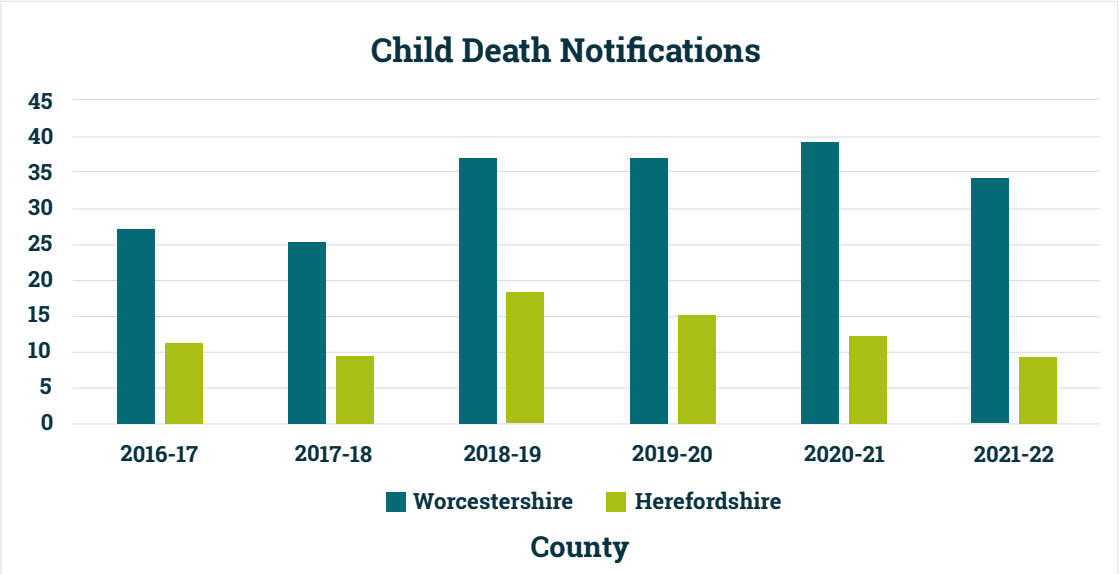
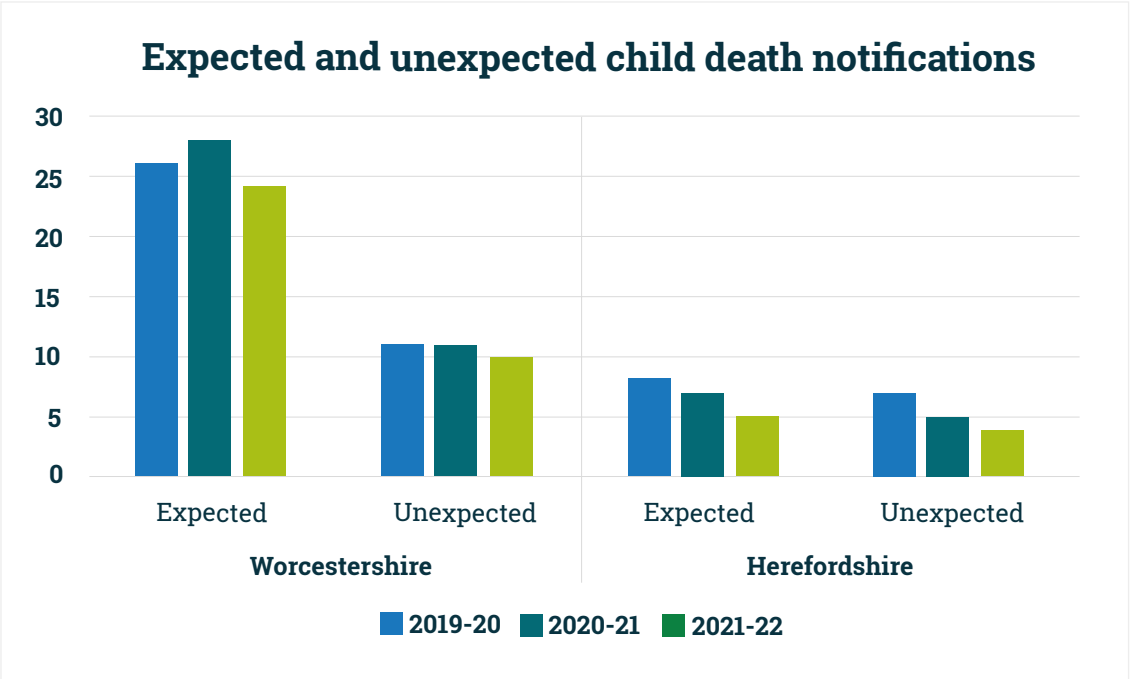


Figure 2. Number of child death notifications received by expected and unexpected death by year of notification and area of residence. Data source H&W CDOP 2021-2022



An unexpected death involves cases in which there is death (or collapse leading to death) of a child, which would not have been reasonably expected to occur 24 hours previously and in whom no pre-existing medical cause of death is apparent. There is a requirement to perform further investigations for children who die where the cause is unknown. This process is referred to as a Joint Agency Response (JAR). Due to the small numbers of unexpected and expected deaths from each county it is difficult to comment on trends. However, both counties show a small reduction in expected and unexpected deaths in 2021-22.

3.4 Cases Reviewed by Herefordshire and Worcestershire Child Death Overview Panel

- Between 1st April 2021 and 31st March 2022, a total of **28** cases were reviewed by H&W CDOP.
- **57%** of cases reviewed were expected and **43%** were unexpected.
- **44%** of expected deaths were female and **56%** male.
- **58%** of unexpected deaths were female and **42%** male.

Figure 3. Number of child death reviews by area of residence.
Data source H&W CDOP 2021-2022

Figure 3 demostrates that of the 28 cases reviewed at H&W CDOP the majority during 2021-2022 were deaths of children from the Worcestershire area.

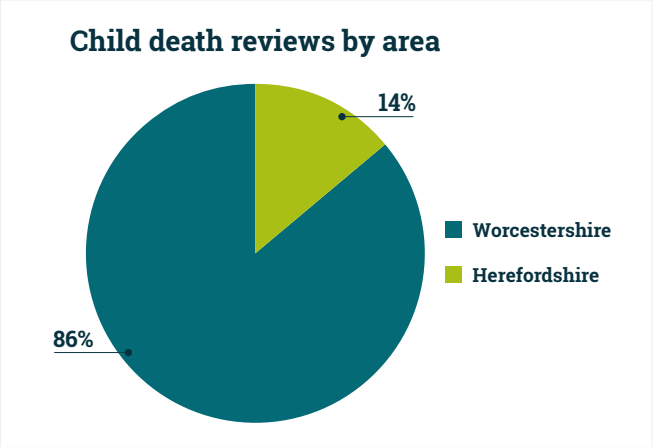


Table 1. Average number of months between CDRM and CDOP by expected and unexpected death
Data source: H&W CDOP 2021-2022

Average number of months between Child Death Review Meeting and H&W CDOP	All deaths reviewed	Expected	Unexpected
<3 months	50%	68%	25%
3-6 months	25%	13%	42%
6-12 months	21%	19%	25%
>12 months	4%	0%	8%

Table 1 shows that the majority of deaths are reviewed at CDOP within 3 months of the final CDRM. However, a larger proportion of expected deaths than unexpected deaths are reviewed within 3 months. The majority of unexpected deaths are reviewed between 3 and 6 months. This data highlights that generally unexpected deaths may take longer to be reviewed at CDOP.

4. Cause of Death

CDOPs are required to assign a category to each death during the review. The classification of categories is hierarchical, where the uppermost selected category will be recorded as the primary category, should more than one category be selected. A description of these categories can be found below. Further details can be found in Appendix A

Category	Name & description of category
1	**Deliberately inflicted injury, abuse or neglect**
2	**Suicide or deliberate self-inflicted harm**
3	**Trauma and other external factors, including medical/surgical complications/error**
4	**Malignancy**
5	**Acute medical or surgical condition**
6	**Chronic medical condition**
7	**Chromosomal, genetic and congenital anomalies**
8 (i) (ii) (iii) (iv)	**Perinatal/neonatal event** Immaturity/Prematurity related Perinatal Asphyxia (HIE and/or multi-organ failure) Perinatally acquired infection Other (please specify)
9	**Infection**
10	**Sudden unexpected, unexplained death**

- **39%** of cases reviewed had a primary category of perinatal/neonatal event.
- **21%** of cases reviewed had a primary category of chromosomal, genetic and congenital anomalies
- **11%** of cases reviewed had a primary category of acute medical or surgical condition
- **11%** of cases reviewed had a primary category of suicide or deliberate self-inflicted harm
- **7%** of cases reviewed had a primary category of sudden unexpected, unexplained death.
- All deaths in categories 2-5 were above the age of 1 year.
- All deaths in categories 7, 8 and 10 were under 1 year.

In England a primary category of Perinatal / Neonatal event was recorded for the largest proportion of deaths (34%). 23% recorded a primary category of Chromosomal, genetic and congenital anomalies and (7%) of deaths reviewed were categorised as Sudden unexpected and unexplained.

Data source: NCMD 1st April 2021 to 31st March 2022

The proportions of death by cause are broadly similar in Herefordshire and Worcestershire to those of England. Although, perinatal/neonatal events are higher, it must be considered that the number of deaths is very small. The 39% represents 11 cases reviewed by H&W CDOP. 10 of these cases were immaturity/prematurity related. Hence, the focus on prematurity in this report's priorities.

Gender

- **50%** of cases reviewed were male and **50%** female.
- There is no significant difference between males and female deaths or for 15-17 age group. However, the number of deaths is very small.

In England the death rate for males remained higher than that of females across all age groups. The largest difference in death rate between males and females can be seen in the 15-17 years age group.

Data source: NCMD 1st April 2021 to 31st March 2022

Age

- **35%** of the deaths reviewed were under 1 day old.
- **61%** of the deaths reviewed were under 1 month old.
- **68%** of the deaths reviewed were under 1 year old.
- There were no deaths reviewed for children between 1-4 years old.
- **7%** of the deaths reviewed were between 5-9 years old.
- **4%** of the deaths reviewed were between 10-14 years old.
- **21%** of the deaths reviewed were between 15-17 years old.

A large proportion of deaths reviewed were in the first month of life. 11% of the cases reviewed were assigned a category of suicide and these involved older teenagers between the age of 15 and 17 years.

In England, suicides were more common in older groups. The proportion of deaths due to suicide is higher in children between the ages of 15 and 17 compared to children aged 14 and below.

The NCMD has continued to monitor suicides of children and young people throughout the pandemic using a real-time surveillance system and has found no consistent evidence that suicide deaths in children and young people increased during the COVID-19 pandemic overall. While there were initial concerns that rates may have increased during the first UK lockdown, this was not statistically significant and baseline numbers remained low.

Childhood suicide is not limited to certain groups; rates of suicide were similar across all areas, and regions in England, including urban and rural environments, and across deprived and affluent neighbourhoods.

Data source: NCMD Suicide in Children and Young People 1st April 2019 to 31st March 2020

Ethnicity

- **82%** of the deaths reviewed were White British
- **10%** of the deaths reviewed were White Mixed
- **4%** of the deaths reviewed were White Other
- **4%** of the deaths reviewed were Pakistani

This reflects that Herefordshire and Worcestershire have a lower proportion of ethnic minority populations compared to England.

In England, where ethnicity was recorded, 64% were of children from a White ethnic group, 18% were from an Asian or Asian British background, 8% were from a Black or Black British background, 7% were from a Mixed background and 3% were from any other ethnic group.

Data source: NCMD 1st April 2021 to 31st March 2022

5. Health inequality

Birth rate

Birth rate has **decreased** in recent years, both nationally and in Herefordshire and Worcestershire.

Smoking in Pregnancy

Herefordshire and Worcestershire has a **higher** percentage than England but it has **decreased** in recent years. There is an association between deprivation smoking in pregnancy.

Maternal Obesity

Mothers living in the most deprived quintile are **more likely** to be obese than mothers living in the least deprived quintile.

Teenage Conceptions

In both counties the rate has been consistently **falling** and is **lower** than England.

Breast Feeding

Percentage of mothers initiating has **increased** over the last 18 months, with a similar percentage to England continuing to breastfeed at 6-8 weeks.

Premature Birth Rate

Premature Birth rate in Herefordshire & Worcestershire is significantly **higher** than that of England.

Infant Mortality

Infant Mortality Rate has **increased** in 2020 in both counties.

Low Birthweight

High percentage of low birthweight births in both counties due to preterm births.

The Index of Multiple Deprivation (IMD) was used to identify the IMD quintile of a particular postcode. IMD is based on a set of factors that includes levels of income, employment, education and local levels of crime. Lower socio-economic groups, for example, tend to have a higher prevalence of risky health behaviours, worse access to care and less opportunity to lead healthy lives. IMD quintile 1 is the most deprived. Postcode information was not available for one of the cases reviewed therefore an IMD quintile could not be identified.

- Due to the small number of deaths reviewed by H&W CDOP in 2021-22, the data does not reflect a linear relationship with deprivation.
- The most deprived quintile of the population had the highest number of deaths overall and the highest number of expected deaths.
- No reviewed deaths in children under 1 were from the least deprived quintile.
- Although small numbers make it difficult to draw conclusions from the deprivation data, 90% of reviewed deaths due to prematurity are from quintiles 1-3.

The child death rate of children resident in the most deprived neighbourhoods in England was more than twice that of children resident in the least deprived neighbourhoods.

Data source: NCMD 1st April 2021 to 31st March 2022

6. Modifiable Factors

Modifiable factors are defined as one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths.

- H&W CDOP identified modifiable factors in 57% of the cases reviewed.
- The category of death where the highest proportion of deaths identified modifiable factors was sudden unexpected, unexplained death, followed by perinatal/neonatal event.
- The most commonly identified modifiable factors were smoking, which was identified in 8 of the 28 cases reviewed, and quality of neonatal care, which was identified in 7 of the 28 cases reviewed.
- Despite the number of modifiable factors in deaths due to suicide or deliberate self-inflicted harm being high, there were no common themes in modifiable factors between the deaths.
- Although prematurity is not considered a modifiable factor it was identified as a factor in 36% of reviewed cases.

Table 2. Percentage of cases reviewed where modifiable factors were identified by category of death.

Data source: H&W CDOP 2021-2022

Primary Category of Death	Proportion of all reviewed cases (%)	Proportion of cases by category of death where modifiable factors were identified (%)
Perinatal/neonatal event	39%	82%
Chromosomal, genetic and congenital anomalies	21%	33%
Acute medical or surgical condition	11%	67%
Suicide or deliberate self-inflicted harm	11%	67%
Sudden unexpected, unexplained death	7%	100%

In England deaths categorised as perinatal/neonatal have the highest number of reviews that identified modifiable factors.

Data source: NCMD 1st April 2021 to 31st March 2022

7. Achievements

The previous H&W CDOP Annual Report made a number of recommendations to itself and various Partnerships/Boards and systems across Herefordshire and Worcestershire. All of the recommendations have been implemented. Achievements are highlighted in the table below:

Recommendation		Responsibility for action	Agency Update
1	CDOP review the number of cases discussed at each Panel meeting.	Herefordshire and Worcestershire Child Death Overview Panel	In order to maximise the number of cases that can be reviewed at Child Death Overview Panels, H&W CDOP have extended the time allowed for each panel and have, when necessary, included additional panels to review additional cases.
2	Herefordshire and Worcestershire Safeguarding Children Partnerships implement the refreshed safe sleeping guidance and delivery of the 'Keep Me Safe' strategy to all relevant agencies.	Safeguarding Partnership	■ The 'Keep Me Safe when I'm Sleeping' guidance has now been completed. This provides consistent advice and messaging for all practitioners working with families with babies using references primarily from the Lullaby Trust. It covers all key risk factors such as sleeping position, bed sharing, smoking and when living arrangements change. It also provides guidance to support practitioners on how to approach discussing each of these areas with parents and carers. ■ This is available on the partnership website and has also been circulated across the partnership agencies. ■ The response of the Herefordshire Safeguarding Children Partnership (HSCP) and Worcestershire Safeguarding Children Partnership (WSCP) to H&W CDOP recommendations has also been guided by two National Child Safeguarding Practice Review Panel reports covering the similar areas as identified in the local recommendations. A 'Keep Me Safe' Strategy, has been developed, supported by the Child Safeguarding Practice Review Group of the WSCP. The Strategy incorporates learning from both the National Panel Review published in July 2020 entitled "Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm", and the later national report entitled 'The Myth of Invisible Men: Safeguarding children under 1 from non-accidental injury caused by male carers' (September 2021). ■ This work has been undertaken jointly with the Herefordshire Safeguarding Children Partnership and has been led by the Deputy Designated Nurse for Safeguarding, NHS Herefordshire and Worcestershire in collaboration with multi-agency partners from across Herefordshire and Worcestershire. The 'Keep Me Safe' Strategy outlines the agreed priorities, aims and objectives for the period 2022-2025. The first two themes to be addressed within this strategy are 'Keep Me Safe when I'm Sleeping' and 'Keep Me Safe when I'm Crying'.
3	There is a renewed focus on reducing smoking during pregnancy and ensuring smoke free homes to support mothers postnatally.	Herefordshire and Worcestershire Local Maternity and Neonatal System	■ A H&W wide deep dive into the smoking in pregnancy pathway and wider system was completed in Spring 2022 ■ This led onto the development of a H&W wide Smoking in Pregnancy action plan. A H&W wide multiagency Task and Finish group has been set up to deliver against this action plan. This meets every 6 weeks. ■ Within the action plan there is a focus on increasing awareness and access of smoking cessation support for families of infants admitted to the Neonatal Unit ■ Worcestershire has recently initiated a postnatal smoking service, delivered through the Starting Well service, focussing on a whole family approach. ■ A specific smoking in pregnancy dashboard, collating data across maternity care and smoking cessation service delivery, is nearing completion. Once set up this will monitor the progress and outcomes of the SIP task and finish group. ■ Key aims of the action plan include: » Increasing CO screening » Increasing referrals to cessation services » Improving service outcomes » Reviewing and ensuring equity of access and outcomes » Reducing rates of smoking at time of delivery. » Nicotine replacement therapy available whilst in hospital (links to the wider H&W initiatives)

Recommendation		Responsibility for action	Agency Update
4	Tackling maternal obesity becomes a key priority.	Public Health across Herefordshire and Worcestershire and the Herefordshire and Worcestershire Local Maternity and Neonatal System	■ A H&W wide multiagency task and finish group has been set up to identify key issues within service delivery and support and take action to reduce maternal obesity rates. ■ A systemwide deep dive was completed into pathways of care regarding maternal obesity- from preconception through to postnatal care. ■ Key aims of this group include: » Reviewing and strengthening referral and support pathways for women with a BMI over 30 at booking » Reviewing and strengthening the lifestyle service offer for pregnant women » Increasing training and support for midwives and health visitors to improve their confidence and skills to engage in conversations with pregnant women about their weight
5	Strengthening and expansion of programmes and interventions in educational settings for children and young people and staff to support emotional health & wellbeing	Herefordshire Children and Young People's Emotional Wellbeing & Mental Health Partnership Board Worcestershire Children and Young People's Emotional Wellbeing & Mental Health Partnership Board	■ Through the DMHL network meetings the whole school approach (Anna Freud Centre, Mentally Healthy Schools) has been recommended to settings. This is supported by services working in schools e.g. EPS, WEST. ■ Emotional Literacy Support Assistants (evidence-based programme to develop capacity in schools to deliver evidence-based interventions to support emotional health and wellbeing) is being offered to all settings (at a cost). ■ Schools are using DfE funding to access the Senior Mental Health Lead training. ■ Public Health is exploring preventative programmes ■ Thrive approach being used in some settings in Worcestershire. ■ WEST team in schools and due to expand in further Waves. ■ CAMHS CAST available for all settings. ■ Trauma Informed training available free to all settings. Over 50% have accessed this.
6	Improve the information and advice available to parents/carers, primary care and community services about identifying the early warning signs of vulnerability and support for children and young people. Including how to identify networks of trusted adults at home, in school and in the community who they might talk to in the event of concerns about themselves or any of their peers	Herefordshire Children and Young People's Emotional Wellbeing & Mental Health Partnership Board Worcestershire Children and Young People's Emotional Wellbeing & Mental Health Partnership Board	■ Bereavement training forms part of the ELSA training for practitioners in schools. ■ Website being developed includes signposting to services that support with bereavement and loss as well as where to go for further support if concerned about CYP. ■ Guidance shared with headteachers about development of suicide safer policy as recommended by Public Health (Papyrus resource). ■ Anna Freud Centre Whole School approach shared with schools includes support to identify and respond to mental health and wellbeing concerns in settings.

Recommendation		Responsibility for action	Agency Update
7	An audit of educational providers on provision of mental health training and how this informs their awareness.	Herefordshire Children and Young People's Emotional Wellbeing & Mental Health Partnership Board Worcestershire Children and Young People's Emotional Wellbeing & Mental Health Partnership Board	■ Public Health tracking training provided to schools. ■ WASH surveyed about DfE training attended. ■ Anna Freud mentally health schools audit has been shared with settings through DMHL network. ■ CPD attendance monitored by Worcestershire Children First and audit kept.
8	Improved promotion of mental health crisis services and how to access them for children, young people, parents/carers and frontline practitioners working with them.	Herefordshire Children and Young People's Emotional Wellbeing & Mental Health Partnership Board Worcestershire Children and Young People's Emotional Wellbeing & Mental Health Partnership Board	■ Services shared with DMHLs and headteachers through briefings and network events.
9	Training for frontline practitioners so they are supported to initiate difficult conversations with parents or carers.	Safeguarding Partnerships	Worcestershire ■ In support of practitioners who on occasions need to have difficult conversations with parents and carers on this subject and explore other areas of their life and relationships, often linked to a challenging family environment, in September 2022 WSCP published its updated guidance on 'professional curiosity' (WSCP - JTAI – Multi-Agency Inspection Briefing for Partners (safeguardingworcestershire.org.uk). Herefordshire ■ The Herefordshire Safeguarding Children Partnership (HSCP) is supporting frontline professionals to identify complex family issues and have difficult conversations with parents or carers through its training programme and guidance. The HSCP has embedded guidance on professional curiosity within its tools and training programme. HSCP courses also offer guidance on motivational interviewing, strengths-based approaches, and managing disclosures. Guidance on professional curiosity has been presented at Practitioner Forums, to a varied audience of multi-agency professionals, and in the virtual learning event about the murders of Arthur Labinjo-Hughes and Star Hobson (July 2022). A learning briefing for practitioners on professional curiosity has also been developed and will be published in 2023.

8. Priorities

As described in this report, a total of 28 deaths were reviewed during 2021-2022 by H&W CDOP. Due to the small number of deaths reviewed it is difficult to draw out commonalities between the deaths that can result in clear recommendations, as each tragic child death has its own distinct set of circumstances. After each panel meeting, recommendations will have been made to the relevant professionals. Also, because deaths usually occur in the years preceding their review at panel, organisations will look to learn and improve from a death immediately. Therefore, many of the issues seen at CDOP are already being prioritised by the relevant organisation. However, there were factors that presented more frequently than others during child death reviews. These themes are named below as system priorities for Herefordshire and Worcestershire for 2022-23.

Prematurity- The definition of prematurity is a baby that is born prior to 37 weeks gestation. Babies who are born prematurely are known to have poorer outcomes than babies born at term. Of the 28 deaths reviewed by CDOP, 10 cases were children who were born prematurely. This finding, in addition to the higher than England rates of prematurity in both Herefordshire and Worcestershire, re-enforce the need for prematurity to remain a priority of the Herefordshire ad Worcestershire Local Maternity and Neonatal System (LMNS). Both in clinical management of women who are at higher risk of preterm delivery and in the reduction of modifiable factors that are known to be linked to prematurity, including smoking in pregnancy.

Smoking- Smoking in pregnancy is widely understood to be linked to prematurity and poorer outcomes for babies. However, babies exposed to smoking postnatally are at higher risk of Sudden Infant Death Syndrome (SIDS) and increased risk of respiratory conditions such as asthma. Smoking was a modifiable factor noted in 7 deaths that were reviewed by CDOP. Although there was a mixture of smoking in pregnancy and household members that smoked, it was reported that some mothers had been offered smoking cessation during pregnancy and had refused. This finding, coupled with the levels of smoking in pregnancy being higher than England in both Herefordshire and Worcestershire allows the CDOP annual report to conclude that reducing smoking in pregnancy and supporting families to have smoke free homes should remain a priority for Herefordshire and Worcestershire, driven by system partners such as Public Health in Herefordshire and Worcestershire Councils, Public Health Nursing and the LMNS.

Neonatal Care- Neonatal care is often required to support babies who are born prematurely or are acutely unwell at or soon after birth. Quality of neonatal care was identified as a modifiable factor in 5 of the deaths reviewed at CDOP. Neonatal care is complex and the individual issues with quality of care identified were not homogeneous. However, due to the number of deaths where this factor was identified CDOP endorses the continued prioritisation of high-quality, safe neonatal care by the LMNS, including Worcestershire Acute Hospitals Trust and Wye Valley Trust and the work with the West Midlands Neonatal Network. The most common factors within neonatal care identified were medicine management, including the timely administration of antibiotics and thermoregulation on admission to the neonatal unit.

Complexity- Complex social factors were identified in 8 deaths and domestic abuse was in a number of these cases. When explored in further detail there were not any common themes between the circumstances. However, this is a reminder that families are complex and may experience a wide range of difficulties such as poor housing, economic difficulties, substance misuse and domestic abuse. Therefore, organisations that provide front line services should give their staff the tools to identify and support families as appropriate. Training and awareness of issues that families experience are important to front line staff and CDOP supports the continuation of a local focus on professional curiosity.

9. Appendices

Appendix A: HEREFORDSHIRE AND WORCESTERSHIRE CHILD DEATH OVERVIEW PANEL MEMBERSHIP

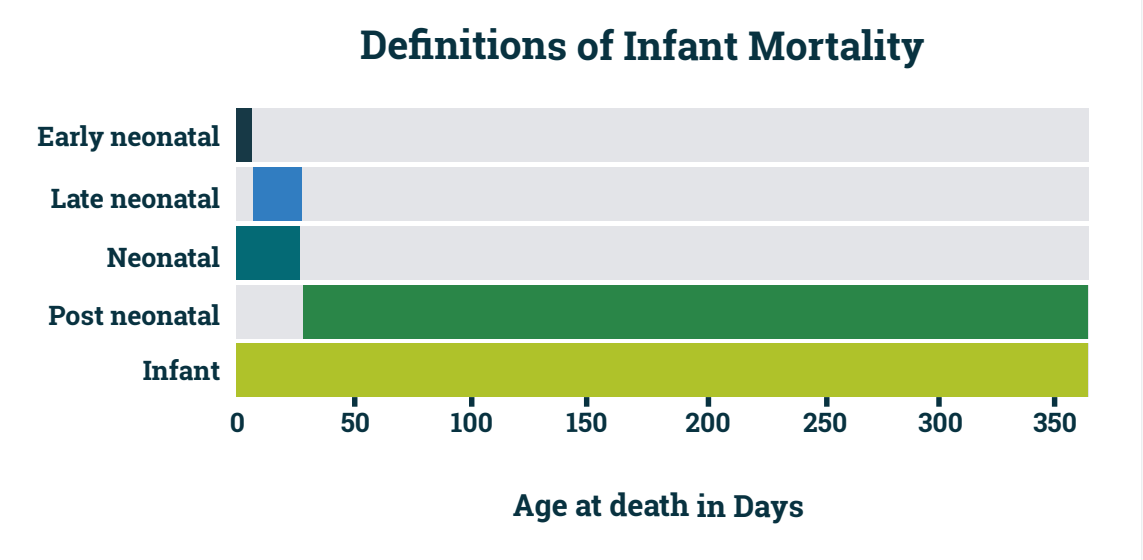
NAME	AGENCY / Contact Info
Liz Altay	Public Health Consultant, Worcestershire
Adrian Over	Independent Chair
Polly Lowe	H&W CDOP Co-ordinator
Jenny Edmunds	Designated Doctor for Child Death, Worcestershire
Julia Greer	SUDIC Coordinator, Worcestershire (Until December 2021)
Donna Steward	SUDIC Coordinator, Worcestershire
Prakash Kalambettu	Consultant Paediatrician, Worcestershire
Tamar Thompson	CCG's LAY Representative
Julia Taylor	Detective Inspector, Herefordshire
Justin Taylor	Detective Inspector, North Worcestershire
Gareth Lougher	Detective Inspector, South Worcestershire
Simon Meyrick	Designated Doctor for Child Death, Herefordshire
Hayley Doyle	Area Safeguarding Officer, Children's Services, Worcestershire
Denyse Ratcliff	MASH Head of Service, Children's Services, Herefordshire
Sue Rogers	Head of Service, Herefordshire Children's Services
Sharon Woodcock	Service Manager, Herefordshire Children's Services
Susan Smith	Quality Governance Manager (Midwifery), Worcestershire
Jez Newell	Deputy Designated Nurse, Adult Safeguarding Lead, NHS Herefordshire and Worcestershire
Heather Manning	Deputy Designated Safeguarding Nurse, NHS Herefordshire and Worcestershire
Sarah Dempsey	Deputy Designated Safeguarding Nurse, NHS Herefordshire and Worcestershire
Rebecca Pickup	Public Health Consultant, Herefordshire
Maria White	Assistant Director, Children's Services, Worcestershire
Jen Rogers	Case Progression Officer, Children's Services, Worcestershire

Appendix B: ANALYSIS PROFOMA CATEGORISATION OF DEATH

Category	Name & description of category
1	**Deliberately inflicted injury, abuse or neglect** This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death.
2	**Suicide or deliberate self-inflicted harm** This includes hanging, shooting, self-poisoning with paracetamol, death by self asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children.
3	**Trauma and other external factors, including medical/surgical complications/error** This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. Also includes proven medical and surgical complications or errors as the primary cause of death.
4	**Malignancy** Solid tumours, leukaemia's & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.
5	**Acute medical or surgical condition** For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.
6	**Chronic medical condition** For example, Crohn's disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. Includes cerebral palsy with clear post-perinatal cause.
7	**Chromosomal, genetic and congenital anomalies** Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis, and other congenital anomalies including cardiac.
8	**Perinatal/neonatal event** Death ultimately related to perinatal events, e.g. sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, necrotising enterocolitis, post-haemorrhagic hydrocephalus, irrespective of age at death. It includes cerebral palsy without evidence of cause and includes congenital or early-onset bacterial infection (onset in the first postnatal week).
(i) (ii) (iii) (iv)	**Immaturity/Prematurity related** Perinatal Asphyxia (HIE and/or multi-organ failure) Perinatally acquired infection Other (please specify)
9	**Infection** Any primary infection (i.e. not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.
10	**Sudden unexpected, unexplained death** Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. Excludes Sudden Unexpected Death in Epilepsy (category 5).

Appendix C: GLOSSARY

BMI	Body Mass Index
CAMHS	Child and Adolescent Mental Health Service
CAMHS CAST	Child and Adolescent Mental Health Service, Consultation Advice Supervision and Training
CO	Carbon Monoxide
CDOP	Child Death Overview Panel
CDRM	Child Death Review Meeting
CDR Partners	Child Death Review Partners
CPD	Continuing Professional Development
CYP	Children and Young People
DMHL	Designated Mental Health Lead
DfE	Department of Education
ELSA	Emotional Literacy Support Assistant
HSCP	Herefordshire Safeguarding Children Partnership
H&W	Herefordshire and Worcestershire
JAR	Joint Agency Response
JTAI	Joint Targeted Area Inspection
NCMD	National Child Mortality Database
SUDI/SUDC	Sudden Unexpected Death in Infancy/Childhood)
WSCP	Worcestershire Safeguarding Children Partnership



Acknowledgements

Thank you to the team who wrote and produced this report.

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Public Health Practitioner - Intelligence

Herefordshire Council

Title of report: Community Paradigm

Meeting: Health and Wellbeing Board

Meeting date: 13 March 2023

Report by: Community Wellbeing Directorate

Classification
Open

Decision type
This is not an executive decision

Wards affected

(All Wards);

Purpose:

- For the Board to receive and comment on the Community Paradigm Presentation.

Recommendation(s)

- That the Board considers and comments on the Community Paradigm Presentation.

Alternative options

1: The Board could choose not to consider this report. This is not recommended as the HWBB will provide its opinion, as appropriate, to Herefordshire Council, the Integrated Care Board or NHS England, as to whether they are discharging their duty to have regard to any assessment of relevant needs prepared by the Council, the ICB or NHS England in the exercise of their functions.

Key considerations

- The Community Paradigm, how public services might need a radical change. It describes a different understanding of power. It recognises that when your overarching goal is to prevent illness, crime, or personal crisis arising in the first place, then power needs to be ‘shared’ with individuals and communities.

- Prevention can ultimately only be successful when those at risk of illness, crime or crisis take the necessary steps to prevent it themselves, with the supportive influence of communities and networks around them.

- This is harder to achieve when power and resources are 'locked up' in the institutions of public services overwhelmingly concerned with acute response, rather than prevention.

Community Impact

In accordance with the adopted code of corporate governance, Herefordshire Council achieves its intended outcomes by providing a mixture of legal, regulatory and practical interventions. Determining the right mix of these is an important strategic choice to make sure outcomes are achieved. The council needs robust decision-making mechanisms to ensure its outcomes can be achieved in a way that provides the best use of resources whilst still enabling efficient and effective operations and recognises that a culture and structure for scrutiny are key elements for accountable decision making, policy development and review

Environmental Impact

There are no general implications for the environment arising from this report.

Equality duty

- Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:

A public authority must, in the exercise of its functions, have due regard to the need to –

a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
c) Facilitate good relations between persons who share a relevant protected characteristic and persons who do not share it.

- The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services.

Resource implications

- There are no resource implications associated with this report.

Legal implications

- Health and wellbeing boards are responsible for encouraging integrated working between health and social care commissioners, including partnership arrangements such as pooled budgets, lead commissioning and integrated provision.
- Their purpose is to establish collaborative decision making, planning and commissioning across councils and the NHS, informed by the views of patients, people who use services and other partners.
- The functions of the Health and Wellbeing Board are set out in paragraph 3.5.24 of the constitution.

Risk management

There are no risk implications identified emerging from the recommendations in this report

Consultees

Matt Pearce (Director of Public Health), Hilary Hall (Corporate Director Community Wellbeing), Amy Pitt (Service Director Communities).

Appendices

Appendix 1 – Community Paradigm Presentation

Background papers

None

Community Paradigm

What is Community Paradigm?

The Community Paradigm, how public services might need a radical change. It describes a different understanding of power. It recognises that when your overarching goal is to prevent illness, crime, or personal crisis arising in the first place, then power needs to be ‘shared’ with individuals and communities.

Prevention can ultimately only be **successful** when those at risk of illness, crime or crisis take the necessary steps to **prevent it themselves**, with the **supportive influence of communities** and networks around them.

This is harder to achieve when power and resources are ‘locked up’ in the institutions of public services overwhelmingly concerned with acute response, rather than prevention.

Why consider the community paradigm shift?

1. Communities' should be respected to source and deliver support
2. Public services would be stronger – and sustainable
3. Empowered communities flourish more and are happier and healthier
4. Community Power is key to greater equality
5. Community Power builds resilience to the environmental and other crises
6. Co-development of community-led, locality-based services is guided by the principle that local families and communities have the knowledge, skills and assets to know how best to respond to challenges and to thrive.

What is a community?

“any network of individuals collaborating more or less formally to achieve a shared socially beneficial goal”.

- Such a community can operate geographically (for example across a neighbourhood) or around a specific interest or need (such as supporting victims of crime) or both. As an approach, community power needs to take account of the very diverse variety of size, goals and working styles of different communities in different areas. Defining the notion of ‘community’ too precisely would disempower many communities and make it harder for them to improve their lives.

Steps to community paradigm shift

- Embedding within Early Help and Prevention approach
- System and council-wide engagement and development – funding shift
- Allowing communities to have much greater say over the decision that affect their lives
- Actively working with communities to support those in need of help or care and to address local challenges
- Shifting the culture of organisations away from the top-down, ‘we know best’ mindset to one that recognises the best solutions are to be found in communities not institutions

Vehicle to deliver the shift

The concept that underpins the **Talk Community approach** in Herefordshire model are the principles of a community paradigm approach. There is potential to build on the current offer to widen the breadth and scope of the focus.

There is scope to take a truly preventative approach by investing heavily in the voluntary, community and faith sectors linked to universal services, who can work together to support children and families at the very earliest opportunities before problems become too complex and embedded.

The opportunity to build the ‘local offer’ without the constraints of public service bureaucratic processes and rigid procurement and accountability frameworks should allow for the many social capital/community assets to thrive through local flexible, delivery and ownership

Next steps

- How does this approach align with the H&WB strategy?
- Adopting this as a system approach, what does this mean for Herefordshire? And how we work as a system?
- What would we need to change to make this a reality?

Health and Wellbeing Board Forward Plan 2023/24

AGENDA ITEM	REPORT FROM	FREQUENCY	PURPOSE	ACTIONS
12 December 2022 – Public Board				
Joint Strategic Needs Annual Update	Charlotte Worthy	Ad-hoc	Information	
Mental Health and Suicide Update	Darryl Freeman/Matt Pearce	Ad-hoc	Information	
Joint Health and Wellbeing Strategy Update	ICS	Ad-hoc	Information	
Winter Plan/BCF	Ewen Archibald	Ad-hoc	Information	
Health Inequalities Plan	Frances Howie/Alan Dawson	Ad-hoc	Information	
Integrated Care Strategy Update	David Mehaffey	Ad-hoc	Information	
11 January 2023 - Private Development Session				
Herefordshire Health and wellbeing strategy	Lucky Beckett/Matt Pearce	Ad-hoc	Information	
Adult Safeguarding Thematic Review	Ivan Powell/Anne Bonney	Ad-hoc	Information	
Project Brave	Ewen Archibald/Lucy Beckett	Ad-hoc	Information	
13 March 2023 - Public Board				
Joint Health and Wellbeing Strategy (Draft)	Matt Pearce	Ad-hoc	Information	
Health Inequalities Plan	Alan Dawson	Ad-hoc	Decision	
Health Protection Assurance Group	Rob Davies	Ad-hoc	Information	
Adult Safeguarding Thematic Review / Project Brave	Ivan Powell	Ad-hoc	Information	
Child Death Overview Annual Report	TBC	Ad-hoc	Information	
Community Paradigm	Amy Pitt	Ad-hoc	Information	
27 April 2023- Public Board				
DPH Annual Report	Matt Pearce	Annually	Information	
Joint Health and Wellbeing Strategy (Sign-off)	Matt Pearce	Ad-hoc	Decision	
Sexual Violence Strategy	TBC	Ad-hoc	Decision	
Integrated Care Strategy (Sign Off)	David Mehaffey	Ad-hoc	Decision	
May 2023 - Private Development Session				
TBC				
June 2023 – Public Board				
Children Improvement Plan	Darryl Freeman	Ad-hoc	Information	
Health and Wellbeing Board Delivery Plans	Matt Pearce	Quarterly	Information	
Mental Health Strategy/ Mental Health Collaborative	ICS	Annually	Decision	

One Herefordshire Update	WVT	Annually	Information	
Community Safety Partnership Update	TBC	Ad-hoc	Information	
Carers Strategy	TBC	Ad-hoc	Information	
Domestic Abuse Strategy 2021-24	Ewen Archibald/ Kayte Thompson-Dixon	Ad-hoc	Information	
Sept 2023- Public Board				
Health and Wellbeing Board Report	Public Health	Quarterly	Information	
Better Care Fund	Hayley Doyle	Annually	Information	
Dec 2023				
Health and Wellbeing Board Report	Public Health	Quarterly	Information	