Warwickshire Shadow Health and Wellbeing Board

Agenda

13th November 2012

A meeting of the Warwickshire Shadow Health and Wellbeing Board will take place at **Committee Room 2, Shire Hall, Warwick on Tuesday 13th November 2012 at 13.30.**

The agenda will be:-

1. (13.30 – 13.35) General

(1) Apologies for Absence

(2) Members' Declarations of Personal and Prejudicial Interests

Members of the Board are reminded that they should declare the existence and nature of their personal interests at the commencement of the item (or as soon as the interest becomes apparent). If that interest is a prejudicial interest the Member must withdraw from the room unless one of the exceptions applies.

Membership of a district or borough council is classed as a personal interest under the Code of Conduct. A Member does not need to declare this interest unless the Member chooses to speak on a matter relating to their membership. If the Member does not wish to speak on the matter, the Member may still vote on the matter without making a declaration.

(3) Minutes of the Meeting on 24th September 2012 and Matters Arising

Draft minutes are attached for approval.

2. (13.35 – 13.45) Green Sleeve – Palliative Care in North Warwickshire

Introduced by Kiran Singh and Andrea Green – Warwickshire North CCG

3. (13.45 – 14.10) George Eliot Hospital

i) Progress towards Foundation Status

Introduced by Kevin McGee – George Eliot Hospital

ii) Mortality Rates in North Warwickshire

Introduced by Kevin McGee – George Eliot Hospital and Andrea Green – Warwickshire North CCG

Report and data to follow

Input from John Linnane on SHMI and Dr Foster.

4. (14.10 – 14.25) Warwickshire North CCG – Progress towards Authorisation

Introduced by Andrea Green, Warwickshire North CCG

5. (14.25 – 14.40) Priority Families

Introduced by Nick Gower-Johnson, Warwickshire County Council

6. (14.40 – 14.55) Warwickshire Safeguarding Children Annual Report

Introduced by Vic Tuck, Warwickshire County Council

7. (14.55 – 15.10) Director of Public Health Annual Report 2012 1 in 3: The Picture of Ill Health in Warwickshire

Introduced by John Linnane, Director of Public Health

8. (15.10 – 15.30) Health and Wellbeing Board Strategy – Sign off

Latest draft to follow

Introduced by Bryan Stoten, Chair

9. Any other Business (considered urgent by the Chair)

Bryan Stoten
Chair

November 2012

Future meetings

24th January 2013	13.30 – 15.30	Committee Room 2, Shire Hall
19th March 2013	13.30 – 15.30	Committee Room 2, Shire Hall

Shadow Health and Wellbeing Board Membership

Chair: Bryan Stoten

Warwickshire County Councillors: Councillor Alan Farnell, Councillor Heather Timms; Councillor Isobel Seccombe; Councillor Bob Stevens

GP Consortia: Dr Inayat Ullah/Dr Ram Paul Batra, Dr Charlotte Gath, Dr Kiran Singh, Dr Heather Gorringe, Dr David Spraggett, Dr Richard Lambert

Warwickshire County Council Officer: Wendy Fabbro Strategic Director, People Group

Warwickshire NHS: John Linnane-Director of Public Health; Stephen Jones - Chief Executive (Arden Cluster)

Warwickshire LINKS: Councillor Jerry Roodhouse

Borough/District Councillors: Councillor Neil Phillips, Councillor Claire Watson, Councillor Michael Coker

Warwickshire County Council Advisor to the Board: Monica Fogarty – Strategic Director, Communities Group

General Enquiries: Please contact Paul Williams on 01926 418196
E-mail: paulwilliamscl@warwickshire.gov.uk

Minutes of the Meeting of the Shadow Warwickshire Health and Wellbeing Board held on 24 September 2012

Present:-

Chair

Bryan Stoten

Warwickshire County Councillors

Councillor Alan Farnell
Councillor Izzi Seccombe
Councillor Bob Stevens

Clinical Commissioning Groups

Dr Jeff Cotterill – Coventry and Rugby CCG
Dr Kiran Singh – Warwickshire North CCG
Andrea Green – Warwickshire North CCG
Dr Charlotte Gath – Coventry and Rugby CCG
Gill Entwistle – South Warwickshire CCG

Warwickshire County Council Officers

Monica Fogarty – Strategic Director, Communities Group
Wendy Fabbro – Strategic Director, People Group

Borough/District Councillors

Councillor Michael Coker – Warwick District Council
Councillor Neil Phillips – Nuneaton and Bedworth Borough Council
Councillor Derek Pickard – North Warwickshire Borough Council

Warwickshire LINk

Deb Saunders

1. (1) Apologies for Absence

Councillor Heather Timms – Warwickshire County Council
Dr David Spraggett – South Warwickshire CCG
Stephen Jones – Chief Executive Arden Cluster
John Linnane - Director of Public Health (WCC/NHS Warwickshire)
Councillor Claire Watson (Rugby Borough Council)
Councillor Jerry Roodhouse (Warwickshire LINk)

(2) Members' Declarations of Pecuniary and Non-Pecuniary Interests

None

(3) Minutes of the meeting held on 17 July 2012 and matters arising

Referring to page 2 of the minutes the Chair commented on the continuing high mortality rates at the George Eliot Hospital in Nuneaton. The Summary Hospital Mortality Indicator (SHMI) figures were 121 in January 2012, 123 in April and 122.6 in July. Councillor Seccombe observed that whilst the Board had previously been advised that these figures were partly due to a lack of palliative care in North Warwickshire she had recently learned of the provision by Myton Hospice of such facilities on the Coventry/North Warwickshire border. She had been informed of reported instances of relatives being unaware of this facility. The Chair reported that in a recent survey 40% of staff at the George Eliot had stated that they would recommend the hospital to a relative. The mortality rate at Warwick hospital was reported as 109, a figure which Glen Burley, Chief Executive of the South Warwickshire NHS Foundation Trust stated to be in the "as expected" range. Glen added that it is something that is being closely monitored.

It was agreed that mortality rates should be revisited at the Board's meeting in November.

Referring to item 5 of the July 17th agenda it was confirmed that the deadline for the transfer of NHS capital was 1st April 2013.

Referring to item 7 of the July 17th agenda it was agreed that the minutes should be amended to reflect the Coventry and Warwickshire Partnership Trust's on-going commitment to service improvement. Wendy Fabbro, Strategic Director, People Group, observed that the work of the Partnership Trust had been subject of reports to the Adult Social Care and Health Overview and Scrutiny Committee. It was agreed that the relevant reports should be forwarded to board members.

2. Draft Joint Health and Wellbeing Strategy for Warwickshire

The Chair introduced this item explaining that the response to the draft strategy had been generally positive. However, some commentators had questioned the apparent lack of substance to the strategy whilst others had suggested that some of the stated aspirations were, in their opinion, unrealistic. The inclusion of health determinants such as housing and transport were welcomed whilst the lack of reference to the role of the voluntary and community sector was raised as a concern.

The ability to “make every contact count” had been questioned by certain district and borough councils. However, it is Department of Health policy to encourage all public agencies to deliver advice on health.

The ability to limit the number of fast food outlets had been questioned by respondents but the Chair observed that there is a precedent for this in the north of the country. The Chair suggested that there are three major themes that have now emerged from the exercise.

1) The role of the community and voluntary sector
2) The need for continuity of care on a 24/7 basis which would help avoid inappropriate admissions to hospital.
3) The need to avoid telling those in education, social care, transport etc what they should be doing to improve health. Rather they should be encouraged to engage.

The meeting was informed that the Director of Public Health is reviewing the strategy and will take it to the November Board meeting for final sign off. Councillor Bob Stevens observed that it should be considered and agreed by the County Council Cabinet. The Chair agreed with this point adding that the County Council is in a powerful position to influence health across Warwickshire. Monica Fogarty stressed that the board is in a position to add real value through its collaborative work.

Jerry Hutchinson, the Chief Executive of North Warwickshire Borough Council agreed to look into the area of the licensing of take aways adding that district councils do concern themselves with smoking, obesity and other health issues.

Councillor Izzi Seccombe stressed the need for early intervention, supporting vulnerable people in avoiding dependency.

3. Clinical Commissioning Groups - Commissioning Intentions

Jeff Cotterill informed the meeting that by the end of October the Coventry and Rugby CCG will have a fully functioning board. Charlotte Gath introduced the paper previously circulated. She highlighted the fact that the current priorities have little reference to children and young people adding that this will be addressed. It was agreed that a more comprehensive statement of the Coventry and Rugby CCG intentions will be taken to the Board meeting in November.

Phillip Bushill-Matthews, Coventry and Warwickshire Partnership Trust informed the meeting of a body called “38 Degrees” that has organised a petition to stop the perceived over-privatisation of the health service. No one else at the meeting had heard of this but Jeff Cotterill stated that there is concern that private providers could cherry pick cases preferring to take on the simple ones and ignoring complex ones. It was acknowledged that the question of privatisation is a political one.

Returning to the Coventry and Rugby CCG paper the Chair highlighted the need to prioritise obesity, smoking cessation and teenage conception whilst Wendy Fabbro stressed the importance of discharge to assess.

Councillor Seccombe observed that as well as undertaking patient health checks it is important to remember the health of carers.

Andrea Green from Warwickshire North CCG informed the meeting that the election process for that area has been completed and that a workshop is planned to consider priorities. She agreed to prepare a paper for the board that will detail the key emerging themes. Andrea and Kiran Singh summarised what these are, namely,

1. The need to make the best of what is already available.
2. Emergency out of hours care.
3. End of life care.
4. The quality of nursing home care.
5. Addressing chronic disease and frailty.

In terms of end of life care it was observed that patients are not being identified early enough. With regards to chronic disease there is a need to revive initiatives such as “exercise on prescription” and there is a need to identify cancers earlier. (At present 25% cancers are being identified at A&E).

Gill Entwistle, South Warwickshire CCG, reminded the Board that Dave Spraggett had briefed it on emerging commissioning intentions in July. She agreed to circulate the final draft of the agreed submission to Board members.

In reply to a question from the Chair, Wendy Fabbro reminded the Board that she had presented a paper in December 2011 on the Children’s Trust. It was agreed that there needs to be a clearer link between the Board and the Children’s Trust. Regarding the commissioning of paediatric services it was acknowledged that acute paediatric services will be commissioned by the CCG whilst specialist services will be commissioned by the Specialist Commissioning Group. The Chair suggested that as paediatric services are so important it will be necessary for the Board to consider further how the right links can be made and sustained.

Les Yeates, Warwickshire LPC observed that the role of local pharmacies was also acknowledged with the Healthy Living Pharmacy Programme operating to address smoking cessation, sexual health and alcohol-related problems.

4. Arden Commission Support Unit

The Chair welcomed Rachel Pearce to the meeting. Rachel explained the role of the CSU and how it along with the others across the country will serve to support the CCGs. It is expected that this support will cover day to day issues as well as developing expertise with the CCGs. The Arden CSU will cost £20m a year to run and will employ 270 staff. The CSUs are not statutory

bodies and it is expected that by 2016 they will have been externalised from the NHS. The Chair noted that the original aspiration for the reformed NHS was that it would have a flat structure adding that the result has been far from it.

5. Arden Cluster Health Protection Committee

With reference to paragraph 3.1 of the report Monica Fogarty suggested that where the committee has any concerns these should in appropriate circumstances be escalated to the Local Resilience Forum and County Council Cabinet. Wendy Fabbro drew attention to the reference to Environmental Health in the report and suggested that the Health and Wellbeing Board should consider its relationship with this function. Richard Hall, Warwick District Council, informed the meeting that a joint workshop will be held in October between Public Health and Environmental Health to consider future work. It was agreed that the outcomes from that workshop should be circulated to the Board.

6. Children's Services Structures and Commissioning – Proposal for Workshop

Wendy Fabbro asked for the Board's approval to arrange a workshop to look at how health service commissioning and children's services will complement each other. She asked for volunteers to help with the session and Charlotte Gath was (in her absence) proposed.

7. Green Sleeve

Deferred

8. Any Other Business

None

The meeting rose at 15.00

……..Chair

Item 3(IIa)

Warwickshire Shadow Health and Wellbeing Board

13 November 2012

George Eliot Hospital - Mortality Report

Recommendation

The Shadow Health and Well-Being Board is requested to comment on this report.

1. Introduction

1.1 George Eliot Hospital has been identified as an outlier against mortality ratings over the years with a higher than expected HMSR. Last October we were identified as having a higher than expected SHMI, being the highest in England. It is expected that the Dr Foster figures of HSMR for the year until March 2012 will continue to show high ratings for this parameter, although both SHMI and HSMR show an improving position.

2.0 External Reviews

2.1 As a direct and immediate response to the increase in HSMR in September 2011 and prior to the October SHMI being released, the Trust put actions in place to undertake a wholesale review of organisational systems and processes.

2.2 **Mott MacDonald**;

2.3 The Trust commissioned an external review, undertaken by Mott MacDonald, who explored potential contributors to mortality statistics and identified four key areas for improvement;

- Continuity of care: Particularly in relation to patient moves between wards and change of responsible consultant
- Patient flow: Need for better pathways for patients to and from primary/community care and the hospital.
- Information management: Need to improve information management systems to support clinical and managerial decision-making and to improve the recording of patient information which can impact the way mortality rates are calculated.
- Impact of external factors on GEH mortality figures: Specifically for end-of-life care in the community and to improve healthy living,

health outcomes and reduce health inequalities within the local community.

2.4 These improvements would be delivered through a number of recommendations and subsequent actions which formed the basis of the Trust's plan, some of which have been implemented immediately, whilst others required continuing work or investigation.

2.5 The report also noted that George Eliot had higher deaths in hospital and at home than the national average, with lower numbers of deaths in hospice and nursing homes. Significantly the report also found that there was no single cause of high HSMR / SHMI i.e. any specific patient group, specialty or diagnosis group.

2.6 **The Royal College and the Association of Surgeons of Great Britain and Ireland**

2.7 The Royal College undertook a service review of colorectal services at the George Eliot Hospital in February 2012, from which we received a positive outcome- concluding that that there were no significant immediate causes for concern with regard to the clinical outcomes of the colorectal surgical service at the George Eliot Hospital.

2.8 **Inpatient census (commissioned by the Clinical Commissioning Group)**

2.9 This work highlighted patient records to be an area of concern and a Task and Finish Group chaired by the Medical Director has been established to improve the quality of recording in the notes and the quality of composition of the medical records.

2.10 **In depth Coding Review**

2.11 This work has just recently concluded and the report is awaited later this month.

3.0 Action Plans

3.1 A detailed action and implementation plan was put in place in response to findings from the above reviews and amalgamated with other actions underway. The detailed action plan is reviewed and updated monthly.

3.2 Actions completed or in train include:

- All inpatient deaths are coded by the consultant responsible for the care in the final illness with subsequent review of the coding by the Medical Director, the Associate Medical Director and members of the coding team.

- Mortality Reviews are carried out on 20 medical deaths per month and all surgical deaths. The reviews are carried out by a buddy consultant and presented to the consultant responsible for the care. Any issues of concern are discussed at a mortality review meeting with the Medical Director and Associate Medical Director.
- Patient moves have been seen to be a key component of diminished care and the number of moves is being monitored and has reduced.
- The management of end of life is being addressed and a Task Group established to improve this process. The Trust intends to join the Route to Success Pilot Programme for End of Life Care and education of staff.
- A sepsis care bundle has been introduced and is being audited regularly to address compliance.
- Investigation of a number of Dr Foster alerts over a period of time have demonstrated inaccuracies of coding and have not demonstrated sub-standard care.
- To facilitate 7 day services, business plans have been approved in cardiology and radiology, an additional cardiologist has been appointed and the interviews for an additional radiologist will be held in November. Work is underway in pharmacy.
- The Trust Board receives detailed information regarding HSMR and SHMI and are fully appraised of the actions and progress on a regular basis, including monthly reports utilising the Dr Foster data.
- Medical and Nursing Directors of both the Trust and Arden Cluster continue to meet monthly to review the action plan. The Chair of the CCG has recently joined this meeting.

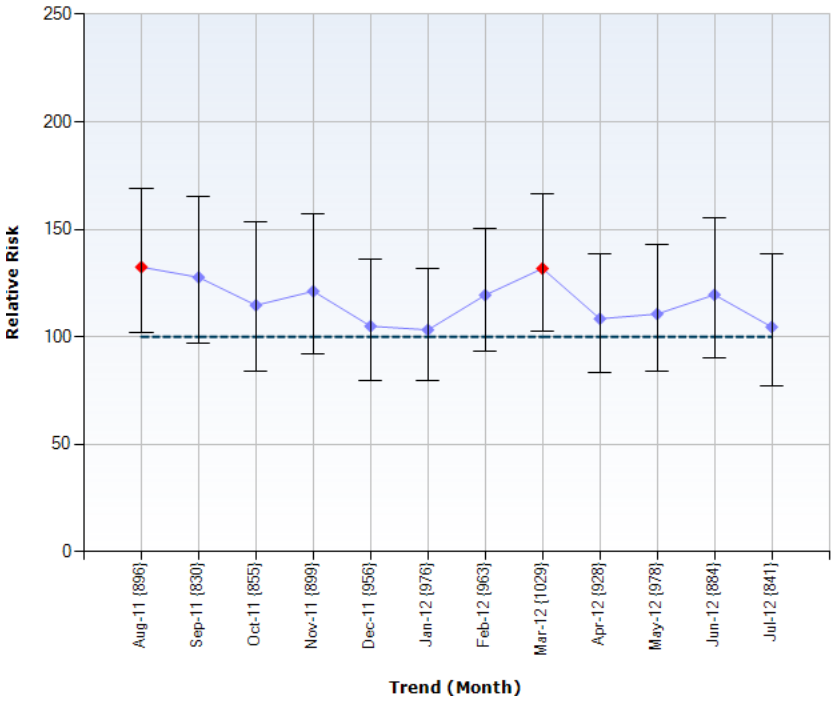
3.3 A summary action plan has been developed as an overview document which identifies the major work streams that are key to the on-going delivery of a reduction in mortality rates at the George Eliot (Appendix 1).

3.4 Underlying all of these actions has been the organisational change resulting in devolved decision making in the organisation. The revision and re launch of the organisations vision, core value pledges and strategic objectives, alongside the introduction of a new divisional structure reinforces this.

4. Progress

4.1 Mortality Rates

4.2 From a starting mortality rate of 117.3 last September, there has been a general improvement in the mortality figures and since March 2012 HSMR has been on a downward trend, but still remains above the benchmark. It is important to note that the current benchmark year is 2011/12 after being rebased in August 2012.



4.3 The current HSMR for August 2011 to July 2012 is 116.0; July 2012's HSMR is 104.5, which is very pleasing although the Trust is not complacent and will need to show month on month improvement. Likewise the recently published SHIMI for 2011/2012 shows that the Trust's figure has reduced from 1.23 to 1.16, again a significant improvement and one that the Trust now needs to build from. However, both the recent HSMR and SHIMI results shows that the work detailed within this report is starting to work and take traction both within the Trust and across the wider Health System.

MORTALITY SUMMARY ACTION PLAN OCTOBER 2012

Area for review	Sub area	Expected Outcomes	Completion /Review	RAG Rating	Comment/ Evidence
1.Clinical	a)Sepsis Bundle:	Implement Sepsis Care Bundle	June 12		Completed. Identified as issue in nursing mortality review, linked to CQUIN 8c delivery in year.
		Completion of baseline audit against sepsis six compliance	July 12		Completed.
		Multidisciplinary launch of Sepsis campaign	Sept 12		Completed
		Improve compliance with sepsis bundle- to include improvements to numbers receiving antibiotics and reduction in time from medical review to antibiotic delivery	Oct 12		Trajectory to be agreed via CQR.
	b)Fluid Balance	Review and change to timings of fluid balance charts with a change to timing of analysis and completion	June 12		Completed. Focus on fluid balance identified through patient safety leaders' work.
		Workshops for nursing home staff planned to highlight nutrition and dehydration management	Nov 12		Internal clinical mortality highlighted issues with admissions from nursing homes.

	c) Escalation & Intervention	Internal in depth clinical review	April 12		Completed
		Track and Trigger system procurement	August 12		Procurement delayed due to challenge from unsuccessful bidder.
		Reduction in trigger point scale for senior review within 60 minutes. Monitor via outreach audit.	Nov 12		Further detail of trajectory/ timeframe to be provided.
		ISOBAR handover tool- Increase interventions, with improved communication, monitor via audit.	May 12		Ongoing review of all areas to ensure core information and implementation maintained. Part of Matron Audit.
		Completion of escalation and intervention "vital" module	Mid October 12		5% remain outstanding. Clear plan in place to reduce over next two weeks. Ongoing for all new starters.
2. Documentation	Medical records	Increase capacity of ward clerks and work to standardised practice	Dec 12 (R)		Reviewing current workforce and redeployment of Band 2 staff as part of capacity changes
		Clear Backlog of filing, splitting of oversized notes and replacement programme	Dec 12 (R)		Led by Task & finish group- chaired by Medical Director (Mott Mc review)
	Record keeping	Compliance with Royal College of Physicians standards	Monthly Audit		Led by Task & finish group- chaired by Medical Director (Mott Mc review)
		Weekly audit of PAS updates	Weekly		Have improved but need to sustain this. Introduction of Track and Trigger system

			review		will resolve issues.
		Nurse sensitive indicators – compliance above 90%	Monthly review		Measured and reported monthly in quality report to Quality Assurance Committee. Tolerance to be increased to 95%.
		Raise awareness of record standards	Sept 12		Led by Task & finish group- chaired by Medical Director (Mott Mc review)
		Establish patient documentation performance measure, add to performance dashboard	Nov 12		Audit tool to be implemented as part of NSI programme monthly.
	Coding	Implementation of outcomes of full coding review when known	Oct 12		Report due later this month.
3. Culture	Nursing/ medical relationships	Roll out of Excel- Trust vision, core values and strategic objectives	Nov 12		Good practice highlighted at Back to Basics and Healthcare Operational Board meetings. Embedded within divisional objectives.
		Ward round project to improve discharge rates and delays in patient flow	Nov 12		Baseline work completed and reported to Execs end of Sept.
	Changes in nursing/ medical practice	Reduction in patient ward moves- based on agreed % trajectory	Oct 12		Linked to CQUIN 8a. To be reviewed Oct 12 by CQRG
		Increase in (all) Incident reporting by 10%.	Jan 13		Red risk as low starting point as reported in NRLS data Sept. Monthly review by governance team. Reporting to Quality

					Assurance Committee.
		Pressure area care- maintenance of PUPs campaign	Monthly review		Reports to Quality Assurance Committee
		WHO Surgical checklist- 100% compliance	Monthly review		Reports to Quality Assurance Committee
		Mortality Reviews of all inpatient deaths by medical and nursing staff- based on agreed review process, audit methodology and assurance mechanisms.	Oct 12		Linked to CQUIN 8d
4. Whole Health Economy	Palliative Care/ End of Life	Increase number of end of life patients on Liverpool Care pathway based on agreed % trajectory as agreed at CQRG	Oct 12		Linked to CQUIN 8b. To be reviewed Oct 12 by CQRG
		Implement outcomes of pilot of RIPPLE	Nov 12		Pathway and documentation developed. Patient testing of process to commence, with review to follow.
		Delivery of Route to Success	Oct 12		OBC to partnership Board, Exec in Oct for sign off at Healthcare Operational Board in November.
	Introduction of 7 day working	Acute: Phased implementation plan with business case for capacity, medical teams, pharmacy, radiology, physiotherapy, occupational therapy and pathology	Dec 12		Further detail of whole health economy involvement to be included.

Item 3(IIb)

Warwickshire Shadow Health and Wellbeing Board

13 November 2012

Mortality Rates in North Warwickshire

Recommendation

The Shadow Health and Well-Being Board is requested to comment on this report.

1.0 Introduction and Background

1.1 Warwickshire North CCG were asked to provide a Commissioner update of progress with the Hospital Mortality Rate at the George Eliot Hospital . The nationally agreed measure of mortality is the Summary Hospital Level Mortality Index (SHMI). The Trust have been reporting a higher than expected SHMI rate over the last year, and as such been the subject of scrutiny by the SHA, Arden PCT Cluster and Warwickshire Health Scrutiny Committee.

1.2 Warwickshire North CCG will take over the commissioner responsibility from November 2012, as the PCT Cluster agreed delegated authority for managing the contract for services with George Eliot at the end of October 2012.

2.0 The Commissioner Role, in respect of quality and other issues

2.1 The commissioner role in this situation is one of lead NHS contractor, performance manager and guardian of high quality care for the population of North Warwickshire, Nuneaton and Bedworth and patients from other areas who use the services at the George Eliot Hospital. The Cluster Medical Director and Director of Nursing, Quality and Engagement from the Cluster have been leading the work to monitor the mortality figures and actions being taken to address the issues, to sustain safe and effective care for patients.

2.2 The Warwickshire North CCG Chair (designate) and Accountable Officer (designate) participated in the mortality review led by the PCT in September 2012. Prior to this the Trust had been transparent in sharing the plans and actions to address the issues, with the CCG Chair at internal Trust Mortality meetings, and with the CCG and other health economy clinical leads, at the Partnership Board meeting.

2.3 The Arden Cluster Board received a full report on trends in hospital mortality and actions being taken to address safety of patients on 12 September 2012. This was derived from an account provided to the NHS Coventry and NHS Warwickshire Quality, Safety and Governance Committee on 31 July 2012.

2.4 The action plan agreed, focused on action to address four areas for improvement;

1. Quality of care
2. Culture
3. Data/Information
4. External factors.

3.0 Moving Forward

3.1 Moving forward the CCG will have the role as commissioner, performance manager and guardian of high quality care for the local population, aiming to improve health outcomes. In readiness for this the Accountable Officer (designate) chaired the contract clinical quality review meeting with support of the GP Clinical Lead for Commissioning with the Trust in October 2012. At this meeting, the Trust Medical Director provided a full report on the latest actions to address the poor mortality indicators under the four headings above.

3.2 From this review the CCG can confirm that the Medical Director gave assurance that the Trust Board have an appropriate focus on monitoring and making improvements on this critical matter. The Trust have taken a systematic approach to addressing each of the areas of concern across the organisation, this is led by the Medical Director. The Trust have put new structures in place to ensure fast identification of any problems going forward, this includes learning from complaints, incidents, monitoring and reporting key governance metrics at divisional level.

3.3 The CCG also received information on broader quality indicators, namely progress on workforce appraisal rates, being transparent about areas of risk. The Medical Director also provided assurance that the revalidation of acute doctors will be delivered on time.

4.0 CCG soft intelligence

4.1 The CCG Accountable Officer (designate) led engagement events with the public during August and October 2012. The CCG met with the Practice Patient Group Chairs in August and October, and 4 public engagement events have been held in Nuneaton, Bedworth and 2 in Atherstone, to secure public views of the CCGs plans and priorities moving forward. No member of the public or PPG lead raised any concerns about quality at the George Eliot Hospital during any of these events.

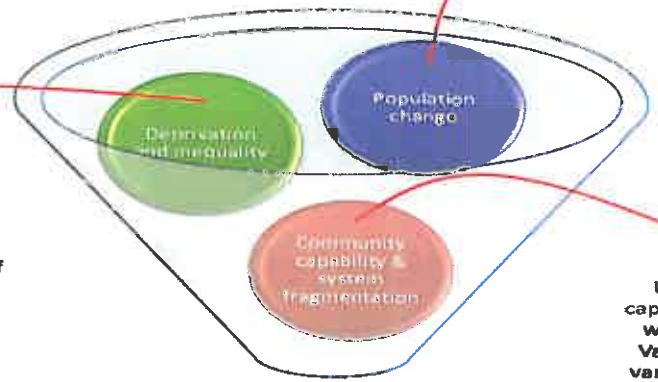
ITEM 4

Warwickshire North CCG
Draft Commissioning Strategy

Our Draft Plan on a Page

1 November 2012

The challenge.....



Unemployment, **income & educational attainment are all factors affecting lifestyle choices, late presentation with disease, costs and outcomes of health and social care**

Growing, ageing population:
- **increasing** demands
- **more people** living **longer with LTCs, more** multiple co-morbidities and complex needs

Under-utilised community capacity but patients in hospital who don't need to be there. Variation in primary **care and variable** capability **in nursing & residential care homes.**

Pressure on health & social care system

Our ambition.....

move from here → to here

Current services are commissioned in "discrete" sectors

Community

Hospital

Mental Health

Needs blending of care sectors to optimise patient pathways and outcomes

Early detection & intervention	Self management	Efficient pathways	Better outcomes
Risk stratification Making Every Contact Count	Simple telehealth Care planning Family nurse partnerships Carer support	Integrated community teams Alternatives to admission Discharge to assess Nursing/residential homes support	Long term conditions Frailty & End of life
Access to memory clinics	Post diagnosis support Alternatives to secondary care: low level prevention Carer support	Access to services Liaison between MH and other sectors e.g. GPs and acute care Optimising & reducing antipsychotic use	Dementia

Our Mission	Continuously improving quality of outcomes and access, meeting the needs of our population " ensure there is respect in all communications – professional to patient; patient to professional ; professional to professional" Involving patients, carers and our population in decisions about their care and the services we commission, demonstrate honesty and transparency in decision making "no excuses, give us reasons for decisions" Providing the best stewardship in the use of our resources Developing our clinicians, our staff and our providers to continuously improve leadership and capability at every level.
Strategic Objective 1: Making better use of the money we already spend over the next 3 years by identifying opportunities to:	Use our contracts and commissioning to improve services where there are inequalities of access and/or outcomes Make sure that all contracts (Public Health, Local Authority; Health) are getting the service we have specified Commissioning jointly to deliver better service co-ordination – care at the right time, in the right place, with the right professional Reduce duplication and waste between existing services by working with partner organisations to improve "hand over" of care between service providers
Measures	Better health outcomes from current contracts; within financial envelope; partners active/positive commissioning best value; improved patient experience; better access and outcomes for those who suffer inequalities
Strategic Objective 2: Building a sustainable system by investing in prevention, early identification and best care for patients	Use evidence base approach to proactively address the gaps and any service duplication to deliver high quality, cost effective services Actively identify those "at risk" and their carers who could potentially have unidentified needs – invest in services to meet those needs Working with public health, partners, care homes and local employers to ensure "health checks" and other tools target 'at risk' groups Working with other commissioners and providers to secure long term system clinical and financial sustainability
Measures	Reduce sickness absence; alcohol and obesity reductions; fewer gaps in key pathways, greater numbers of patients in treatment for CVD and cancer earlier; Better outcomes of care
Strategic Objective 3: Building an excellent CCG over the next 3 years that improves the outcomes for our patients, is a great partner to work with and a great place to work	Actively engaging member practices so that they perceive they have a great CCG Actively engaging, involving and learning from our patients, their carers and the public to drive quality improvements Actively working with partners to break down the barriers to working together and drive integration Effectively and efficiently delivering on our duties as a commissioner Supporting a "common purpose" leadership programme across our whole economy to support innovative ways of addressing population need
Measures	Our member practices, our population, our partners will all see/feel the CCG has improved
Values	Quality and Equality first Valuing everyone Dignity, respect and compassion in the services we commission Working together, improving health and securing sustainable services Benefiting the whole community, as wasted resources are wasted opportunities for others

Item 5

Warwickshire Shadow Health and Wellbeing Board

13 November 2012

Priority Families - Update

Recommendation

The Shadow Health and Well-Being Board is requested to note the progress being made with this initiative

1.0 Overview

1.1 Government, largely in response to the riots, through the Department for Communities and Local Government (DCLG) and the Department for Work and Pensions (DWP), informed all local authorities of the need to 'turn around' the lives of 120,000 families in the UK.

1.2 Based on the Government's calculation from 120,000 nationally, the Government has indicated that there are 805 Troubled Families in Warwickshire.

1.3 At present the Priority Families Programme will seek to integrate and deliver 3 programmes:

1.4 **DCLG:** This programme will address the needs of 5/6 of the 805 families. 671 families will be identified and their needs addressed principally through the allocation of a key worker who will 'grip' the family and make sure that the input of all agencies with that family is coordinated well and that between them the family has the support that it needs. This project will run until March 2015. The programme is being delivered through multi agency arrangements led by the County Council. In terms of resources the Government has calculated that each intervention costs approximately £10,000 per family. Of this amount 60% of resources are to be provided locally from within existing budgets whilst £4000 is being received from Central Government through a combination of an up-front allocation (based on the number of families that will be worked with in any given year) and payment by results (where a portion of the allocation is released upon evidence of demonstrable change).

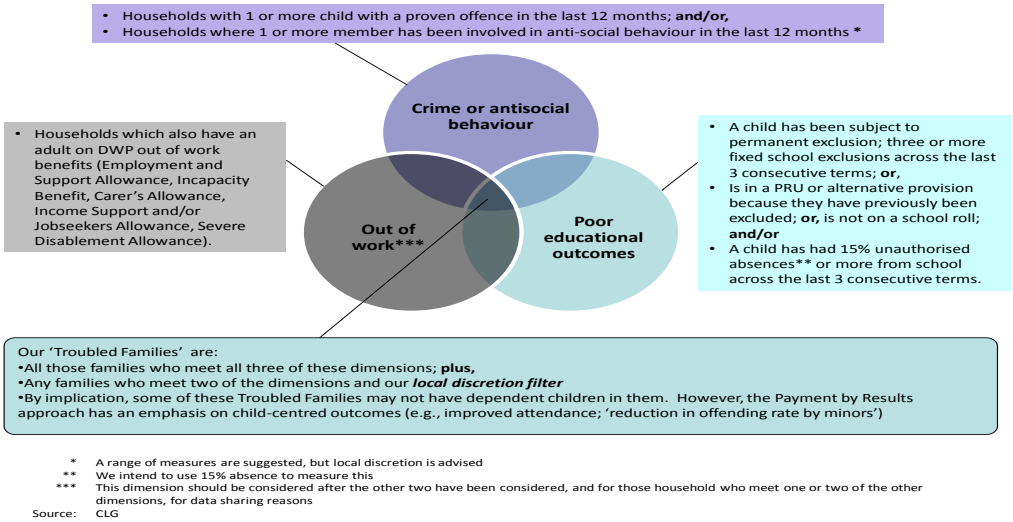
1.5 **Local Family Intervention Projects:** Notwithstanding recent Government initiatives, Board Members may be aware that Warwickshire already has a track record of work in this area. Two Family Intervention teams are currently in operation in the County addressing issues that overlap significantly with the DCLG Programme. The projects are funded (through LPSA 2 monies) to operate to March 2015 by which time 180-200 families will have participated in the programme.

1.6 **DWP-ESF Supporting Families Programme:** 671 families are anticipated through the DCLG programme. The remaining 134 families will be referred to the DWP Programme. This initiative has been developed independently by the DWP who have contracted delivery of the programme to EOS- a Birmingham based Company. The role of the County Council and its partners is to act as a referrer of families who would be eligible for the programme which is essentially removing barriers to sustained employment. In addition to the external dimension of delivery, the project differs from the preceding two in terms of intensity (there is a presumption that families at the lower end of the spectrum of need will be most suitable) and its focus on individuals within families rather than a 'whole family' approach. On this, negotiations with DWP have since clarified that Care Leavers would be eligible for the programme. This programme is scheduled to operate until December 2014.

2.0 Identification

2.1 This diagram shows the 3 DCLG National Criteria :

Figure 2: Government criteria for identifying 'Troubled Families'



* A range of measures are suggested, but local discretion is advised
** We intend to use 15% absence to measure this
*** This dimension should be considered after the other two have been considered, and for those household who meet one or two of the other dimensions, for data sharing reasons
Source: CLG

2.2 If a family meets all three of these criteria then it must be included in our work. Although the Programme is technically voluntary, the likelihood is that the family will be facing a number of sanctions – e.g. through the Courts, or through Social Care, so they may well fell that it is their interests to 'volunteer' for the scheme.

2.3 If a family meets two of these criteria (say Crime / ASB and Education) then the Council can introduce a third 'Local Criterion' to get the family on the programme. In Warwickshire, the Local Criteria have been agreed as:

- Child Protection / Safe Guarding
- Health/ Emotional/ Physical Well Being
- Economic Well Being and Housing
- Reduce Crime & Anti-Social Behaviour / Promote Rehabilitation

2.4 In terms of existing local family intervention projects the DCLG criteria (plus local filters) will ensure that there is congruence between the two.

2.5 In terms of DWP eligibility:

- At the start of the provision at least one member of the family must be on a DWP working age benefit (it is not, however, a requirement that this family member participates in the provision at any point). This family member passports all other eligible family members; and
- Either no one in the family is working, or there is a history of worklessness across generations of the family.
- Where an eligible family includes an individual who is working, or taking part in the Work Programme, that individual will not be eligible for ESF provision. Other eligible family members will still be able to participate.
- Only family members requiring support moving into work should be attached to the provision.

3.0 How can a family benefit from the Programme?

3.1 In short in a number of ways – the needs, difficulties and issues that the family may have faced for years (even for generations) will be identified and a range of support arranged for them. Often the families will be living in chaos, with really serious issued affecting their well-being (e.g. poverty / debt, mental health problems, domestic abuse, drugs and alcohol misuse, housing problems).

3.2 The programme will provide them with the chance to 'turn their lives around' and, most importantly for children and young people in the family the chance to escape from the things that may have stopped their parents from having a decent life – for example think of the benefits to the child of regular school attendance, better access to counselling services and no longer being branded as 'a trouble maker'

4.0 The Role of Health and Wellbeing

4.1 The delivery of the programme is very much dependant on consultation with existing services and interventions in order to build on existing good practice, identify gaps and barriers and thereby ensure that we do not create a silo based service of key workers operating independently of service provision within Warwickshire. What the consultations have revealed is that whilst the national criteria focus on crime, education and worklessness, a large proportion of these families will also have deep rooted health and emotional wellbeing issues. This is supported locally and nationally by statistics that suggest that up to half of these families will have mental health or other emotional wellbeing issues. It also supports the original criteria for the identification of the 120,000 national figure (from which 805 was derived) where 2 of the seven criteria related to mental health and 'at least one parent has a longstanding illness, disability or infirmity'.

4.2 The Health and Well-Being Board thus has an important role in overseeing delivery of the programme. Particular areas of benefit could be:

- **Identification and Referral:** Ensuring that health sector professionals are 'plugged' into the programme and aware of the process for identifying and referring families whom they think may be suitable for the programme.

- **Commissioning and Delivery:** Delivery of the programme will help the Board deliver its aspirations in the Joint Health and Well-Being Strategy. It therefore has an important role to play in ensuring that health dimension is entrenched within work of the Priority Families Programme and that the work around Priority Families is equally evident within the future direction of the services that fall within the Board's remit.

- **Adding Value:** Linked to above, the Board is well placed to identify synergies across the spectrum of health and social care delivery and its suggestions for improvement would enhance the delivery of the programme. This may for example relate to suggestions that the key worker for particular families be a health professional as they are best placed to deal with the entrenched issues.

- **Areas of Exception:** The effectiveness of a partnership body in part should be measured by the extent to which it can resolve those issues which require collective rather than individual consideration. The Board could perform a valuable role in this respect where 'blockages' are being encountered during the delivery of the programme.

- **Progress and Evaluation:** Delivery of Government targets should not detract partners in Warwickshire from the outcomes that we are seeking to achieve and the Board could play an important assurance role.

5.0 Further Information

A Website presence is currently being developed alongside other communications. In the meantime please contact Nick Gower Johnson on 01926 742642 nickgower-johnson@warwickshire.gov.uk

Item 6

Warwickshire Shadow Health and Wellbeing Board

13 November 2012

Warwickshire Safeguarding Children Board Annual Report

Recommendation

The Shadow Health and Well-Being Board is requested to note the Warwickshire Safeguarding Children Board Annual Report 2012-2013.

1 This report introduces the WSCB Annual Report for 2012-2013. The Annual Report has been prepared in accordance with Chapter 3 of *Working Together to Safeguard Children* (HM Government 2010), which sets out detailed requirements for the content of such reports. It also points to the expanded remit of LSCBs recommended by the Munro Review of Child Protection by beginning to include details of "Early Help" provision as well as assessments of local safeguarding children services. The former is a new requirement set out in draft revised child protection guidance published in the summer, including a new version of "Working Together".

2 In accordance with the requirements of this statutory guidance, this report comes before the Warwickshire Shadow Health and Well-Being Board for the first time for its contents to be noted. This will now be a regular feature. The report is also to be presented to the Warwickshire Children's Trust Executive Board, the Chief Executive of Warwickshire County Council, the Leader of the Council, and the Police and Crime Commissioner for Warwickshire once elected. The importance of this document in assisting strategic planning for safeguarding children services in the County is therefore underlined.

3 Accordingly, its content reflects a heavy emphasis on the WSCB Strategic Priorities for 2012-2015 as well as detailing the extensive work of the Board during the last year and its other plans for the year ahead. It also emphasises the trend of year on year increases in child protection activity in Warwickshire, and by implication the heavy demands placed on professionals working to protect children from harm in the County.

	Name	**Contact Information**
Report Author	Dr Vic Tuck	victuck@warwickshire.gov.uk
Head of Service	Phil Sawbridge	philsawbridge@warwickshire.gov.uk
Strategic Director	Wendy Fabbro	wandyfabbro@warwickshire .gov.uk
Portfolio Holder	Councillor Heather Timms	cllrtimms@warwickshire.gov.uk

ANNUAL REPORT
2012 - 2013

"Keeping Children Safe and Healthy"

MISSION STATEMENT OF THE WARWICKSHIRE SAFEGUARDING CHILDREN BOARD (WSCB)

- The Warwickshire Safeguarding Children Board ensures that sound arrangements to protect children are in place in Warwickshire.

- The Board safeguards children by contributing to the prevention of harm and the promotion of the welfare of children in Warwickshire.

- The Board achieves these objectives by promoting inter-agency cooperation, collaboration and challenge.

CONTENTS

1. FOREWORD BY CHRIS HALLETT
Independent Chair of Warwickshire Safeguarding Children Board (WSCB)

A major focus of activity for WSCB over the last year has been consideration of how the Board and its partners will implement the findings and recommendations of the Munro Review of Child Protection and government response published last year. For this reason, the new Strategic Priorities of WSCB for the period 2012-2015 feature prominently in this year's annual report. Identification of these priorities, a task which has involved the full membership of the Board, has enabled us to develop a comprehensive Munro implementation plan. WSCB is well positioned to play its part in taking this work forward having received strong endorsement of its work in Warwickshire in an Ofsted inspection of safeguarding and looked after children services conducted in the County at the end of 2011. Among the points highlighted by the inspectors were:

- WSCB demonstrates its vision and ambition and the implications for service provision very well to the workforce;
- The WSCB Annual Report demonstrates how statutory requirements are being met;
- The Board plays a major part in contributing to sound arrangements for partnership working in the County;
- The *Memorandum of Understanding* between WSCB and Warwickshire Children's Trust precisely defines accountability and communication between the two bodies;
- Priorities for the WSCB are clearly stated within the Board's Action Plan;
- High levels of training are provided by the Board linked to service improvements identified in strategic plans;
- The Board demonstrates strong support for collaborative work with children and young people;
- WSCB contributes to the monitoring of safeguarding performance;
- The Board's subcommittee structure – recently reviewed and updated – enables a diverse mix of professional expertise to be employed to address the Board's safeguarding agenda and achieve its strategic priorities.

What was also pleasing about the inspectors' assessment was their recognition of the important contribution the Board has made to professional practice as well as its strategic influence. The WSCB Case Escalation Process and Warwickshire Risk Assessment Model were cited as effective mechanisms for action. Further details of the Ofsted inspection are included in this report under what is now a standing item, namely inclusion of assessments of the effectiveness of local arrangements to safeguard children (see section 9). In future WSCB annual reports, these assessments will extend to a consideration of the effectiveness of early help provision and plans in Warwickshire in line with the Munro Review and the likely requirements of a new version of *Working Together to Safeguard Children*

due to be published in autumn 2012 (which will herald a new edition of the "Blue Book"). A full report will be received by WSCB before the end of 2012 on this provision to ensure it is compliant with the requirements of the Munro Review and pointing the way forward.

It should be noted that the Ofsted inspection commented on the quality of current early intervention and early help services and these observations are highlighted in section 9. Since this inspection, an Early Intervention Business Unit has been established in Warwickshire County Council and its manager sits on the WSCB. *Family Intervention Projects (FIPs),* originally established in some parts of Warwickshire to support families with multiple needs, have now been rolled out across the whole County, underlining the commitment to and investment in early help commented upon by the Ofsted inspectors. There are plans to develop a "Troubled Family Strategy". These developments, allied to the anticipated report to the Board, auger well for the future.

A further significant area of work for the Board over the last year has been the completion of a Serious Case Review. LSCBs are required to demonstrate how these reviews impact on improvements to services for children and families. Accordingly, a summary of the main findings and actions arising from the Serious Case Review are set out in section 7 of this report. I should like to take this opportunity to thank all those who contributed to the successful completion of this substantial piece of work, which was evaluated very positively by Ofsted.

In my introductions to previous annual reports I have highlighted how the important business of safeguarding children is taking place in a very difficult economic and organisational climate. I have continued to welcome the regular updates provided to the Board at each of its meetings by partner agencies, describing how they are managing these challenges. The on-going nature of these challenges is confirmed in this report by the data relating to child protection activity in Warwickshire over the period April 2011 to March 2012 appearing in section 8. The trends of previous years, in terms of rising numbers of children requiring a child protection plan, has continued with an 11.7% increase on last year's figure. The Board and its partners remain committed to supporting professionals and others in delivering a high quality of response to the needs of these children and their families in challenging conditions, and I am pleased to see the evidence of this in the assessments of safeguarding arrangements included in this report.

In this regard, the observations made by the two lay members of WSCB, Mrs Angela O'Boyle and Mr Keith Drinkwater, in their contribution to this document, are as significant as they were last year. Their continuing contribution to our work and the invaluable scrutiny and challenge they provide are greatly appreciated. I am particularly pleased and grateful that Keith has become the Vice-Chair of WSCB. This can only serve to strengthen the independent aspects of the operation of the Board.

The report, as in previous editions, summarises the activity of the subcommittees - the "engine room" of the Board - and our working groups,

where a huge amount of work continues to take place. A further task and finish group has been launched under the auspices of the Warwickshire Missing Persons Working Group to ensure we are positioned to implement the government's action plan for Children who are Sexually Exploited. The review of the subcommittees of the Board described in last year's report has been completed. The need to have adequate capacity to implement our new strategic priorities in addition to taking forward other tasks described in section 6, confirms the importance of the arrangements on which the Board has agreed.

This year has seen significant changes in the membership of the Board. We have bade fond farewells to Martin Cliff and John Sullivan (both from Warwickshire Children's Services) and Mary Weeks (NHS Warwickshire), all of whom have been stalwarts of WSCB for many years. Our grateful thanks go with them. We also said good-bye to Marion Davis (Strategic Director for Children, Young People and Families in Warwickshire County Council), Richard Desjardins (representing the Voluntary and Community Sector), and Tracey Wrench (Coventry and Warwickshire Partnership Trust - CWPT) and Graeme Pallister (Warwickshire Police). However, it has been my pleasure to welcome to our ranks Wendy Fabbro (Strategic Director for the People Group, Warwickshire County Council), Jackie Channell (Designated Child Protection Nurse), Mel Coombes (CWPT), Adrian Over (Interim Education Safeguarding Manager), Richard Long (Warwickshire Police), and Jodie Green who I am delighted to say is going to maintain our vital links with the Voluntary and Community Sector.

There is another important arrival to mention and this is our WSCB Interagency Training Officer, Mark Simmonds, who arrived earlier this year and has taken up his role with great energy and enthusiasm. I would also like to take this opportunity to thank Pat Convery who undertakes an enormous amount of administrative and support work on behalf of WSCB, and without whom it would not have been possible to complete the Serious Case Review referred to in this report as effectively or smoothly.

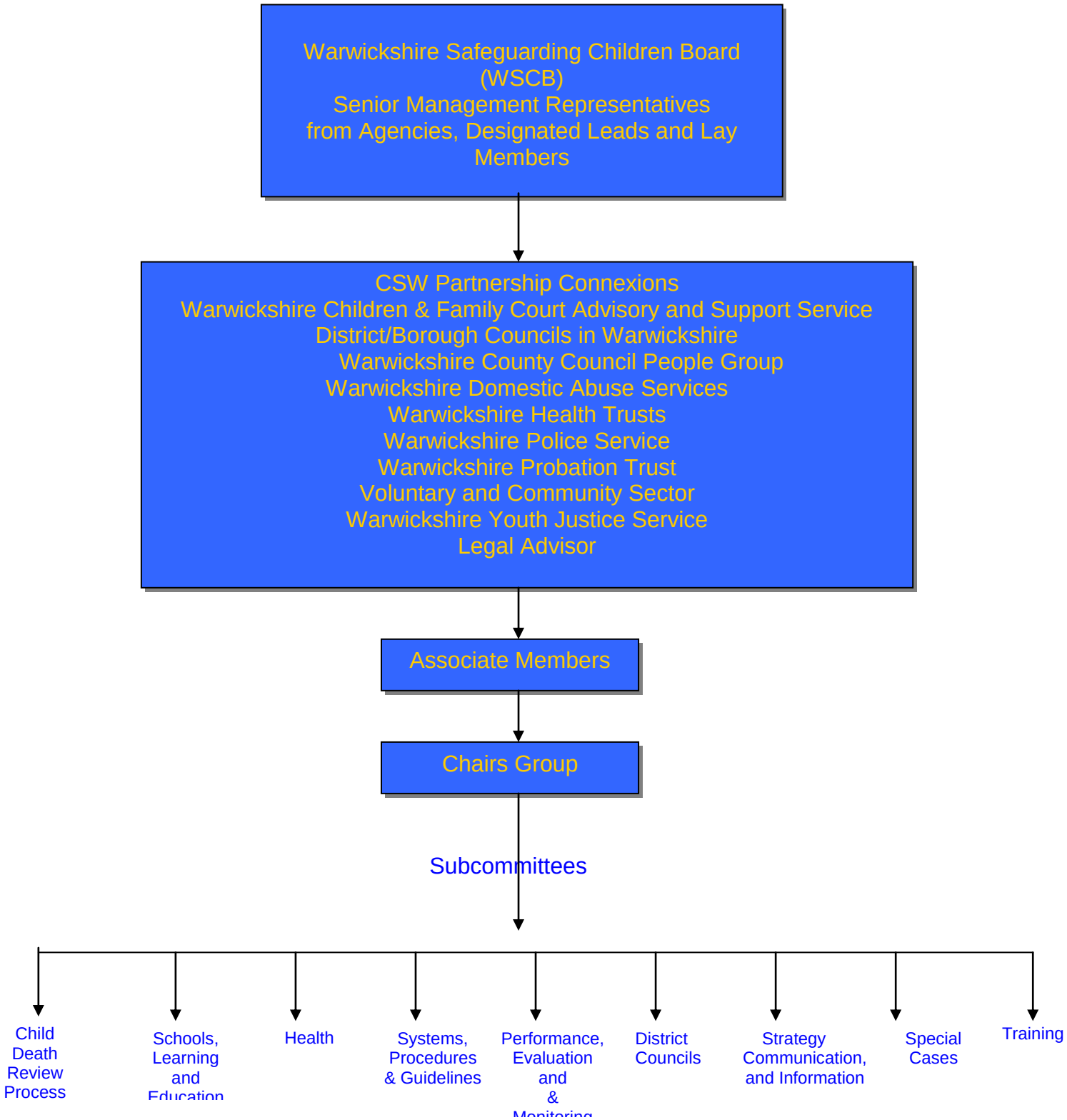
At the end of December we shall be saying a fond farewell to Vic Tuck who is retiring. Vic has been the Development Manager for WSCB for the past twelve years and one can only describe his contribution to the Board and keeping children safe from harm in Warwickshire as awesome. His knowledge, skills and attributes will be sorely missed and at the moment we are in the process of securing a replacement manager. I am sure the whole of WSCB would wish Vic the very best in his retirement. I know Vic wishes to thank members of the Board, past and present, partner agencies and the many other people who have been associated with the work of WSCB over this period, for their unstinting help and support.

As I commented last year, as we contemplate the year ahead, no one should be in any doubt as to the ongoing scale of the task we face in keeping children safe and healthy. The Board continues to value the dedication and skill that professionals across the County demonstrate on a day to day basis in meeting this challenge.

Finally, I would like to thank WSCB Board members, Associate members and members of the various subcommittees and working groups since the progress made by WSCB as documented in this annual report would not have been achieved without their dedication and diligent contribution to the activities within the report. Many thanks to you all.

Chris Hallett
Independent Chair of WSCB

2. STRUCTURE OF THE WARWICKSHIRE SAFEGUARDING CHILDREN BOARD



3. MEMBERSHIP OF WSCB

Fay Baillie
Director of Nursing for the Arden Cluster – NHS Coventry and NHS Warwickshire

Maria Barnes
Service Manager North Safeguarding – People Group, Warwickshire County Council

Jenny Butlin-Moran
Service Manager Child Protection - People Group, Warwickshire County Council

Paul Chapman
Policy Officer – Stratford District Council

Jackie Channell
Designated Nurse Child Protection – NHS Coventry and NHS Warwickshire

Mel Coombes
Executive Director of Quality, Safety and Service User Experience–Coventry and Warwickshire NHS Partnership Trust

Craig Dicken
Communities Officer (Equalities and Cohesion) - Nuneaton and Bedworth Borough Council

Hugh Disley
Head of Service Early Intervention – People Group, Warwickshire C.C.

Keith Drinkwater
Lay Member and Vice Chair

Liz Elgar
Service Manager - Coventry and Warwickshire CAFCASS

Wendy Fabbro
Strategic Director – People Group, Warwickshire County Council

Victoria Gould
Young People's Legal Services Manager, Warwickshire County Council

Jodie Green
Youth Work Officer, NFYF Clubs - Representative of the Warwickshire Voluntary and Community Sector

Chris Hallett (WSCB Independent Chair)

Bill Hunt
Deputy Chief Executive - Warwick District Council

Sue Ingram
Domestic Abuse Manager – Community Safety, Drugs and Alcohol Action Team, Warwickshire County Council

Detective Inspector Nigel Jones
Warwickshire Police

Detective Chief Inspector Richard Long
Warwickshire Police

Angela O'Boyle
Lay Member

Adrian Over
Education Safeguarding Manager –People Group, Warwickshire C.C.

Simon Powell
Assistant Director (Community Development) - North Warwickshire Borough Council

Phil Sawbridge
Head of Service Safeguarding - People Group, Warwickshire County Council

Steven Shanahan
Head of Housing Services - Rugby Borough Council

Dr Peter Sidebotham
Designated Doctor Child Protection – NHS Warwickshire

Steve Stewart
Executive Director - Coventry and Warwickshire Partnership: Connexions

Cllr Mrs Heather Timms
Warwickshire County Council Lead Portfolio Holder for Children - People Group, Warwickshire County Council

Lesley Tregear
Manager - Warwickshire Youth Justice Service

Dr. Vic Tuck
Development Manager - Warwickshire Safeguarding Children Board

Andy Wade
Assistant Chief Probation Officer – Warwickshire Probation Trust

Jenny Wood - Head of Social Care and Support – People Group, Warwickshire County Council

4. STRATEGIC PRIORITIES OF WARWICKSHIRE SAFEGUARDING CHILDREN BOARD 2012-2015

Having achieved its Strategic Priorities for 2008-2011 or reached a point where these could be relinquished to a discrete working group for consolidation and development, Warwickshire Safeguarding Children Board set itself the task of identifying new Key Strategic Priorities for the period 2012-2015. The process commenced at the 8th Annual WSCB Conference in October 2011, ensuring the widest possible involvement and ownership of these new priorities. They have been derived from the findings and recommendations of the Munro Review of Child Protection in England and the Government Response. They are consistent with the Mission Statement of Warwickshire Safeguarding Children Board which appears at the beginning of this annual report.

Subsequently, these priorities were developed and refined by the WSCB Chairs Group on behalf of the Board, and now constitute a comprehensive Munro Review Implementation Plan which is set out below. The actions which flow from each strategic priority have been assigned to the appropriate WSCB Subcommittee with the Chairs Group taking responsibility for their overall implementation as well as spearheading key aspects of each priority:

Strategic Priority 1

Create and Maintain a Learning System which builds on the achievements to date of the WSCB Training Strategy and within which the perspectives of children and young people are at the heart of learning.

Actions:

- Review and update the WSCB Training Strategy and its content in the light of the Munro Review ***(Training Subcommittee)***;
- Strengthen the links already established between WSCB and the Warwickshire Children in Care Council for the purpose of securing continued feedback on the child protection system as experienced by children and young people. Explore other mechanisms by which this might also be achieved ***(Munro Recommendation 3) (Performance, Monitoring and Evaluation Subcommittee)***;
- Embed this feedback within all training programmes delivered by WSCB ***(Training Subcommittee)***;
- WSCB to monitor and evaluate the steps taken within the County to take forward the professional capabilities framework that is being developed nationally, and also work undertaken to ensure social work students are prepared for the challenges of child protection work ***(Munro Recommendations 11 and 12) (Chair's Group on behalf of the Board)***;
- Ensure that findings from Serious Case Reviews continue to be integrated as appropriate into training programmes, and are reflected in interagency and single agency child protection procedures ***(Special***

Cases; Systems, Procedures and Guidelines, and Training Subcommittees);

- Pilot the SCIE systems methodology in Warwickshire to explore the learning potential of this approach and prepare WSCB for its anticipated implementation by the government ***(Munro Recommendation 9) (Special Cases Subcommittee)***.

Strategic Priority 2

Strengthen Accountabilities by continuing to provide leadership and challenge on children's safeguarding issues, holding agencies and other strategic bodies to account for the effectiveness of their safeguarding activity and provision in Warwickshire.

Actions:

- Ensure the local "test of assurance" is satisfactorily completed by Warwickshire County Council in respect of the positions of Director of Children's Services and Lead Member for Children's Services ***(Munro Recommendation 7) (Chair's Group on behalf of the Board)*** ;
- WSCB to satisfy itself that as a result, leadership of children's services in the County remains robust and effective, particularly in relation to children's safeguards and child protection ***(Chair's Group on behalf of the Board)***;
- Ensure that assurances are obtained from the Chair of the new Warwickshire Health and Well-Being Board that safeguarding children will be a priority of the Board, with regular updates received by WSCB on the actions being taken to remodel local services in a manner that is consistent with this priority ***(Munro Recommendation 8) (Chair's Group on behalf of the Board)***;
- Continue to receive regular reports from partner agencies of WSCB on safeguarding provision and in particular how current challenges and changes are impacting on the ability to demonstrate continued compliance with section 11 of the Children Act 2004, and how these challenges are being addressed ***(At WSCB Meetings)***;
- Conduct a further audit of section 11 at the mid-point of the period covered by these strategic priorities ***(Performance, Monitoring and Evaluation Subcommittee)***;
- Warwickshire to contribute to the national consultation exercise on a new national inspection framework ***(Munro Recommendation 2) (Performance, Monitoring and Evaluation Subcommittee)***;
- Consider how WSCB will contribute to the implementation in Warwickshire of a new safeguarding performance data set as envisaged by the government following the Munro Review ***(recommendation 4) (Performance, Monitoring and Evaluation Subcommittee)***;
- WSCB to undertake a "health check" in respect of the questions for LSCBs posed in the Ofsted Report: *Good Practice by Local Safeguarding Children Boards* ***(Strategy, Communication and Information Subcommittee)****;*

- WSCB Annual Reports to be shared in future with the W.C.C Chief Executive and Leader of the Council and subject to the passage of legislation, The Health and Well-Being Board and Police and Crime Commissioner ***(Munro Recommendation 5) (Performance, Monitoring and Evaluation Subcommittee)***;
- The relationship between WSCB and the Warwickshire Children's Trust to be re-considered in the light of these changes and how the current *Memorandum of Understanding* between the two may need to be redrafted as a consequence ***(Chair's Group on behalf of the Board)***;
- The Annual Report to continue to contain as a major feature an assessment of the effectiveness of local safeguarding arrangements ***(Performance, Monitoring and Evaluation Subcommittee)***;
- All WSCB Subcommittees to review and where appropriate update their strategic objective and terms of reference to reflect the actions assigned to them in this document ***(All WSCB Subcommittees)***.

Strategic Priority 3

Promote Effective Practice by continuing to ensure that child protection systems and practices in Warwickshire are rooted in an evidence-based approach where the best available research and knowledge is consistently applied, informed by the perspectives and experiences of children and young people.

Actions:

- New WSCB Interagency Child Protection Procedures produced which fully reflect the findings of the Munro Review, Government Response, subsequent new Government Guidance, and best practice locally and nationally ***(Munro Recommendation 1) (Systems, Procedures and Guidelines Subcommittee)***;
- All single- agency "internal" child protection procedures reviewed to ensure these are also fully compliant with these components ***(Systems, Procedures and Guidelines Subcommittee)***;
- Exploration as to how, in addition to our single and interagency training programmes, relevant research may be best disseminated to practitioners and others across the County in order to further embed evidence-based practice ***(Strategy, Communication and Information Subcommittee)***;
- Current work being undertaken on behalf of Warwickshire Children's Services by the Dartington Social Research Unit to inform the re-design and delivery of services and the further introduction of evidence-based programmes, to be considered by the Board to assess its implications for interagency working. ***(Munro Recommendation 13) (Performance, Monitoring and Evaluation Subcommittee)***;
- WSCB to monitor progress on the implementation of the proposal that a Principal Child and Family Social Worker be established within Warwickshire Children's Services ***(Munro Recommendation 14) (Chair's Group on behalf of the Board).***

Strategic Priority 4

Promotion of Early Help for Children, Young People and Families

Actions:

- Warwickshire Children's Trust to provide WSCB with a report setting out the availability and effectiveness of early help and intervention, and how any gaps identified in this report will be addressed ***(To be sought by the Chair's Group on behalf of the Board)***;
- To enable the progress of early help services to be monitored and evaluated, further reports to be compiled on an annual basis by the Children's Trust ***(To be sought by the Chair's Group on behalf of the Board)***;
- WSCB to establish processes by which it will quality assure the early help plans developed by partner agencies and others ***(Strategy, Communication and Information Subcommittee)***;
- Details of the effectiveness and efficiency of these services to be included in the WSCB Annual Report alongside accounts of the effectiveness of safeguarding arrangements in the County ***(Performance, Monitoring and Evaluation Subcommittee).***

(All relating to Munro Recommendations 6 and 10)

Allocation of Actions by Responsible Body

Warwickshire Safeguarding Children Board:

- Continue to receive regular reports at business meetings from partner agencies on safeguarding provision and in particular how current challenges and changes are impacting on the ability to demonstrate continued compliance with section 11 of the Children Act 2004, and how these challenges are being addressed by partners.

Chairs Group (on behalf of the Board):

- Monitoring of overall implementation of the strategic priorities with progress reports appearing in the WSCB Annual Report;
- Seeking assurances from others where appropriate that actions referred to in the Munro Review and government response are being satisfactorily addressed in Warwickshire;
- Monitoring and evaluation of steps taken within the County to take forward the professional capabilities framework which is being developed nationally, and also work undertaken to ensure social work students are prepared for the challenges of child protection work;

- Ensuring the local “test of assurance” is satisfactorily completed by Warwickshire County Council in respect of the positions of Director of Children’s Services and Lead Member for Children’s Services;
- Enabling WSCB to satisfy itself that as a result, leadership of children’s services in the County remains robust and effective, particularly in relation to children’s safeguards and child protection;
- Ensuring that assurances are obtained from the Chair of the new Warwickshire Health and Well-Being Board that safeguarding children will be a priority of the Board, with regular updates received by WSCB on the actions being taken to remodel local services in a manner that is consistent with this priority;
- Ensuring the relationship between WSCB and the Warwickshire Children’s Trust is re-considered in the light of these changes and how the current *Memorandum of Understanding* between the two may need to be redrafted as a consequence;
- Monitoring progress on the implementation of the Munro recommendation that a Principal Child and Family Social Worker be established within Warwickshire Children’s Services;
- Ensuring that Warwickshire Children’s Trust provide WSCB with a report setting out the availability and effectiveness of early help and intervention, and how any gaps identified in this report will be addressed;
- Enabling the progress of early help services to be monitored and evaluated on an on-going basis by seeking annual reports from the Children’s Trust.

Performance, Monitoring and Evaluation Subcommittee:

- Strengthening the links already established between WSCB and the Warwickshire Children in Care Council for the purpose of securing continued feedback on the child protection system as experienced by children and young people. Exploration of other mechanisms by which this might also be achieved;
- Conducting a further audit of section 11 at the mid-point of the period covered by the strategic priorities for 2012-2015;
- Managing Warwickshire’s contribution to the national consultation exercise on a new national inspection framework;
- Consideration as to how WSCB will contribute to the implementation in Warwickshire of a new safeguarding performance data set as envisaged by the government following the Munro Review;
- Ensuring WSCB Annual Reports are shared in future with the W.C.C Chief Executive and Leader of the Council and subject to the passage of legislation, The Health and Well-Being Board and Police and Crime Commissioner;
- Ensuring the Annual Report continues to contain as a major feature an assessment of the effectiveness of local safeguarding arrangements;

- Assessing the implications for interagency working of the study currently being undertaken on behalf of Warwickshire Children's Services by the Dartington Social Research Unit to inform the re-design and delivery of services and the further introduction of evidence-based programmes;
- Ensuring an assessment of the effectiveness and efficiency of early help services is included in the WSCB Annual Report alongside accounts of the effectiveness of safeguarding arrangements in the County.

Special Cases Subcommittee:

- Ensuring that findings from Serious Case Reviews continue to be integrated as appropriate into training programmes, and are reflected in interagency and single agency child protection procedures (*with Systems, Procedures and Guidelines Subcommittee and Training Subcommittee*);
- Piloting the SCIE systems methodology in Warwickshire to explore the learning potential of this approach and prepare WSCB for its anticipated implementation by the government;

Strategy, Communication and Information Subcommittee:

- Undertaking a "health check" in respect of the questions for LSCBs posed in the Ofsted Report: *Good Practice by Local Safeguarding Children Boards;*
- Exploration as to how, in addition to our single and interagency training programmes, relevant research may be best disseminated to practitioners and others across the County in order to further embed evidence-based practice;
- Establishing processes by which WSCB will quality assure the early help plans developed by partner agencies and others;

Systems, Procedures and Guidelines Subcommittee:

- Ensuring that findings from Serious Case Reviews continue to be integrated as appropriate into training programmes, and are reflected in interagency and single agency child protection procedures (*with Special Cases and Training Subcommittees*);
- Ensuring new WSCB Interagency Child Protection Procedures are produced which fully reflect the findings of the Munro Review, Government Response, subsequent new Government Guidance, and best practice locally and nationally;
- Ensuring all single agency "internal" child protection procedures are reviewed to ensure these are also fully compliant with these components.

Training Subcommittee:

- Reviewing and updating the WSCB Training Strategy and its content in the light of the Munro Review;
- Embedding feedback on the experiences of children and young people of child protection within all training programmes delivered by WSCB;
- Ensuring that findings from Serious Case Reviews continue to be integrated as appropriate into training programmes, and are reflected in interagency and single agency child protection procedures *(With the Special Cases; Systems, Procedures and Guidelines Subcommittees)*.

All Subcommittees:

- Reviewing and where appropriate updating their strategic objective and terms of reference to reflect the actions assigned to them.

5. LAY MEMBERS REPORT – COMPILED BY ANGELA O'BOYLE AND KEITH DRINKWATER.

As lay members it is our remit to promote good governance by ensuring that the Warwickshire Safeguarding Board operates effectively and retains a clear focus on issues relating to the safeguarding and well-being of the County's children and young people. Our experiences have provided reassurance regarding the quality of the work undertaken, and confidence that the Board is effectively discharging its duty to safeguard and protect children.

Substantial reports and Board meetings provide us with details of the safeguarding activities of agencies, and of the work of the Board's specialist sub-committees. Regular presentations to the Board have increased our knowledge and raised awareness of a number of agency developments. They have brought to our attention achievements, innovations, areas for improvement and identified emerging concerns.

Training sessions, conferences, and reports of external inspection bodies provide insight into the complex work and demands made of the safeguarding agencies. Responses to these external reports have shown a willingness to learn lessons from their findings, and have demonstrated the Board's overall commitment to continuous improvement.

The economic crisis has affected the funding of public services. Many agencies have faced severe financial constraints: cuts in funding have led to a reduction in provision and staff redundancies. Limited resources are being used to maintain essential services: however without adequate funding high standards cannot be maintained. An admirable response from the wider community has, to some extent, ameliorated the detrimental impact caused by budget cuts. Voluntary agencies and faith groups have increased their help to children and families, and striven to provide support and to create environments which promote children's safety and healthy development.

The strength of the Safeguarding Board is the commitment of partners to the implementation of the Safeguarding Plan. The diversity, expertise and specialist knowledge of its members enables it to provide well-qualified professional leads for the various sub-committees where detailed work is done. The effectiveness of the contributing agencies is strengthened by adoption of the agreed management framework, a whole system approach which focuses on outcomes. This framework is fundamental to achieving coherence which takes account of local priorities, reflects government requirements and ensures maximum provision for safeguarding. It includes a requirement for agencies to provide details of their safeguarding audits planned for each year and to report their outcomes. It makes safeguarding a shared responsibility and individual agencies accountable for taking the appropriate actions to secure it.

This unifying framework will enhance the good practice already apparent in agencies which contribute to safeguarding in Warwickshire. During the past year considerable achievements provide evidence of good multi-agency work.

These include the very positive Ofsted evaluation and all aspects of the recent Serious Case Review. The successful Family Interventions Scheme has yielded good results and will serve as a sound basis for the incoming government scheme to help troubled families. Warwickshire's commitment to this initiative is welcome as it adopts a holistic approach to families who have difficulties and cause problems. It should help agencies to reduce the risk of harm to children and improve the lives of their families.

These programmes incorporate aspects of the Munroe recommendations which called for a revised approach to safeguarding children. Last year's Annual Conference, 'The Child's Journey: Safeguarding Children in Warwickshire agencies' was a great success and instigated significant progress and activity. The next conference will further amplify the work when it takes as its theme: 'Evidence-Based Programmes in Safeguarding Children: Implementing in Warwickshire what works.'

Despite the pressures on the public sector, the quality of the Safeguarding partnership continues to be of a high standard with evidence of commitment, expertise and professionalism. Safeguarding practice is underpinned by partners' mutual trust, hard work and reliability. As lay members, we cannot overstate the value and importance of this multi-agency work. We are indebted to all those who provide the resources which both prevent harm to children and help those who have been hurt.

It is the duty of the Safeguarding partnership to tackle known causes of abuse and to understand and combat the multitude of social and psychological issues which damage children. To prevent this, risks must be recognised, exposure to damaging experiences prevented, and effective help given. Warwickshire's Safeguarding Children partnership achieves these goals through a well-co-ordinated response and implementation of its mission to protect the county's vulnerable children.

Keith Drinkwater: Vice-Chair of WSCB
Angela O'Boyle

6. PROGRESS REPORTS FROM THE SUBCOMMITTEES OF WARWICKSHIRE SAFEGUARDING CHILDREN BOARD

Last year's report described how Warwickshire Safeguarding Children Board had embarked on a review of its subcommittee structure to identify ways in which this might be streamlined and possible efficiencies achieved. The Chairs Group led this work on behalf of the Board, mindful of the consideration that the current structure had served the Board well in terms of delivering statutory requirements and other responsibilities, and that the structure in place needed to continue to have the capacity to deliver the high volume of work the Board is required to achieve. The second phase of the review focused increasingly on how we could ensure the Board's structures were compliant with the findings of the Munro Review and Government Response and capable of delivering the challenging WSCB Strategic Priorities for 2012-2015 and Implementation Plan described in Section 4 of this report. As a result of this exercise, the functions of some subcommittees were modified and titles amended to reflect new roles and responsibilities, and embrace the spirit of the Munro Review. Work-plans were updated to incorporate any actions assigned to the subcommittee arising from the new strategic priorities of the Board.

The result of this review is that WSCB now has eight sub-committees, comprising representatives from the member agencies of the WSCB, which are tasked to complete work plans and report progress on these plans to the full Board when it meets. The Chairs Group continues to provide a forum where the Independent Chair of WSCB, Vice Chair, all the chairs of the subcommittees and WSCB Development Manager meet to identify issues which the Board may need to consider and advise upon the strategic dimensions that arise.

In compliance with government guidance the ***Warwickshire Child Death Review Process (CDOP)***, is officially classified as a formal subcommittee of the Board making nine in all, but is distinguished from the others by its specific statutory functions rather than acting as a vehicle for driving the business of the Board. Its activities are described in full in the Annual Report of the sub-regional child death review processes encompassing Coventry, Solihull and Warwickshire. This document can be found on the WSCB web-site.

In summary, ensuring that all agencies provide information to the three Child Death Review Panels, which comprise the sub-regional CDOP, in a timely way enabling these panels to complete reviews, has continued to advance significantly over the last year. The development of robust electronic systems has made it possible to conduct CDOP business more efficiently. The system of "fast track" review established last year for cases that can be appropriately managed in this way has gone from strength to strength, making it possible to review a higher volume of cases, including neo-natal deaths.

Progress Reports on the work of the other subcommittees appear below. Details are also provided of the work of two key working groups which reflect

the commitment of WSCB to promote the wider protection of vulnerable children.

District Council Subcommittee

Strategic Objective: *To ensure the safeguarding children agenda is fully embedded in district and borough councils across Warwickshire.*

As part of the review of the Safeguarding Board's Subcommittee structure, members of this subcommittee have given consideration to the most effective means of continuing to advance the safeguarding agenda in district councils. This has led to the retention of the subcommittee, meeting as appropriate to advance its objectives.

The major tasks identified by the subcommittee for progression over the next year are to:

- Ensure that the Housing Services-Children's Services Protocols for households containing vulnerable children, and assessing and managing the accommodation needs of homeless 16 and 17 year olds set in place last year, are actively followed by each district authority;
- Ensure Independent Contractors engaged by district and borough councils operate in accordance with safeguarding requirements and are monitored for compliance;
- Continue to promote the "Safer Employment" agenda in each council;
- Promote the safeguarding agenda with "Registered Providers" operating within Warwickshire.

Health Subcommittee

Strategic Objective: *To provide the key mechanism through which the Warwickshire Safeguarding Children Board can be assured that the appropriate and timely delivery of the Safeguarding Children Agenda is delivered across the Warwickshire Health Economy and Independent Contractors. This includes ensuring that all training, audit and specific work around safeguarding is facilitated, implemented, monitored, evaluated and integrated in the ongoing work of all health professionals.*

Since the last annual report, the Chair of the Health Subcommittee and some members has changed. Membership and Terms of reference have therefore been reviewed and updated accordingly. This development is linked to the major changes that are taking place within the Health Service. Two new Designated Nurses for example, covering the Arden Cluster (NHS Coventry & NHS Warwickshire) have been appointed. Work to involve the new Clinical Commissioning Groups in the work of the subcommittee and more widely in the Safeguarding Board has continued. Actions arising from the WSCB Section 11 audit of 2010 have now been completed.

The subcommittee has focused on the following tasks in its work-plan which will continue to be taken forward in the year ahead:

- Promoting stronger involvement of G.Ps and other independent contractors in safeguarding children, including further opportunities for training in child protection;
- Implementation of the Ofsted/CQC Action Plan as this relates to health services;
- Implementation of health recommendations from the Serious Case Review documented in this annual report;

Performance, Monitoring and Evaluation Subcommittee

Strategic Objective: *To ensure that the Safeguarding Board has in place sound mechanisms for monitoring, evaluating and auditing safeguarding activity by partner agencies, and ensuring that improvements are made to deliver better outcomes for children.*

Among major tasks accomplished by this subcommittee, formerly the Quality and Information Subcommittee, over the last year has been the formulation of a comprehensive Warwickshire Safeguarding Delivery Plan of which our Munro Action Plan and Strategic Priorities are the corner-stone; a review of the WSCB Escalation Process which is to lead to a revised version of this process, and an updated Performance Management Framework for the Board.

In addition, the work arising from the last round of WSCB Interagency District Workshops which took place in response to the death of baby Peter Connolly and which applied a "systems" approach to identifying good practice in localities and areas for development, has been brought to fruition with the local partnerships of the Warwickshire Children's Trust Executive Board ensuring that safeguarding children is embedded in their work. A document seeking to better define thresholds for intervention has also been presented to the Board on behalf of the subcommittee.

As part of the on-going operation of the escalation process, members of the subcommittee continue to identify cases that appear to be drifting and where necessary conduct a case file audit.

Significant activities for the year ahead will be:

- Development of the Board's work on promoting the participation of children and young people assessing the impact of child protection processes;
- Assessing the implications for interagency working of the findings of a project taking place within the county by the Dartington Social Research Unit on promoting evidence-based programmes;
- Preparing for a fresh WSCB Section 11 Audit to be undertaken in 2013;
- Advising the Board on its budgetary position and how its financial viability may be maintained.

Schools, Learning and Education Subcommittee

Strategic Objective: *To ensure that specific issues relating to the Education Service are addressed and brought to the attention of the full board and or other sub-committees as appropriate.*

A major piece of work for the subcommittee has been consideration of the implications of the Serious Case Review completed by North Somerset LSCB which examined the abuse of children at an independent school in the West Country. A series of actions were identified to ensure that the prospect of such a situation occurring in Warwickshire was minimised. The subcommittee has also acted on the findings of the Serious Case Review completed in Warwickshire in 2012, which identified some areas for improvement, including consideration of fresh guidance for education providers on the subject of "parental responsibility". Other significant areas of activity and achievement for the subcommittee have been:

- Ensuring that schools in Warwickshire are represented on WSCB in line with the complex requirements of government guidance;
- Ensuring model policies are updated annually;
- Making safeguarding advice and guidance available across the education sector;
- Developing and sharing good practice;
- Encouraging schools and early year settings to prioritise safeguarding children within their improvement plans;
- Providing training specific to the education sector;
- Scrutinising some of the special risks that affect the most vulnerable children (children and young people with Special Education Needs and disabilities);
- Contributing to government consultation papers as appropriate.

Key challenges in the year ahead include:

- Taking steps to improve still further communication between education providers and the subcommittee including provision of information and support for designated persons in schools;
- Explore the implications for safeguarding of the government's agenda for schools and disseminate information and good practice accordingly;
- Receive regular reports from the E-Safety Task Group established under the auspices of WSCB to take forward the agreed strategy;
- Inspections of Safeguarding in Schools

The Subcommittee will continue to monitor the specific judgements on the effectiveness of the safeguarding provision in schools arising from Ofsted inspections, and share good practice across Warwickshire.

Special Cases Subcommittee

Strategic Objective: *To ensure that sound processes for conducting Serious Case Reviews are in place in Warwickshire and lessons arising from these and other reviews are disseminated, as appropriate, across the multi-agency network.*

The subcommittee was responsible for completing a Serious Case Review in 2012. This was a major piece of work for members of the subcommittee and colleagues who were co-opted to assist in the process. In line with government guidance the impact of this review on improving services and reducing possible harm to children are included in this report. The review was assessed very positively by Ofsted which was testimony to the skill and commitment of everyone who contributed.

Other pieces of work undertaken by the subcommittee which will continue into the coming year are:

- Ensuring that the learning and improvement processes of Warwickshire Safeguarding Children Board, and attendant procedures relating to Serious Case Reviews and other reviews conducting by the Board and its partners, are compliant with the new version of *Working Together to Safeguard Children;*
- Completion of an exercise to pilot the "systems" methodology for Serious Case Reviews pioneered by the *Social Care Institute for Excellence (SCIE);*
- Ensuring the implementation of the recommendations of the Serious Case Review completed this year and draw to the attention of WSCB lessons arising from the review process which will have bearing on any future serious case review;
- Consideration of reviews conducted in other parts of the country which may have learning implications for Warwickshire.

Strategy, Communication and Information Subcommittee

Strategic Objective: *To facilitate and advise on the development of co-ordinated approaches across WSCB partner agencies to implement major initiatives and achieve consistent practice improvements.*

This subcommittee, formerly the Strategy and Communication Subcommittee, has continued the task of ensuring that the Board is on a sound strategic footing and that key areas of practice development are advanced. It is to assume an important role in ensuring that that new strategic priorities of WSCB and associated actions are implemented, particularly in ensuring that that Board's new duty to scrutinise the quality of early help and early help plans in Warwickshire is realised.

Areas of significant activity and achievement over the last year have been:

- Taking forward the implementation of a new, comprehensive Communications Strategy the aim of which is to promote awareness in the Warwickshire media and public at large that safeguarding children is everybody's responsibility. To this end, a highly successful media event took place resulting in wide and encouraging publicity for the Board and professionals involved in safeguarding work;
- Delivery of the 8th WSCB Annual Conference which considered the major developments of 2011-2012 including the completion of the Munro Review of Child Protection in England and the government's response – from this conference emerged the WSCB Strategic Priorities for 2012-2015;
- In respect of children who are trafficked – one of the most vulnerable groups – the subcommittee enabled WSCB to build on its participation in a regional project funded by the European Union, making it possible, in collaboration with the Training Subcommittee and Warwickshire County Council Learning and Development and partner agencies, to train staff on the subject.
- Planning of the 9th Annual WSCB Conference which will explore the implementation of evidence-based programmes in the county to strengthen the provision of early help services and effective safeguarding. Key-note speakers will be provided by the Dartington Social Research Unit which is leading on this development in Warwickshire.
- Further editions of the WSCB News Bulletin were produced.
- Continued expansion of links with Faith Groups and the Voluntary and Community Sectors in Warwickshire with a highly successful dedicated safeguarding event for these groups delivered in May 2012 (See report below);
- Linked with the task and finish group established to take forward in Warwickshire the government action plan on children who are sexually exploited.

Systems, Procedures and Guidelines Subcommittee

Strategic Objective: *To take major responsibility for preparing and updating WSCB Inter-agency Child Protection Procedures and advise on and monitor the development of guidelines and procedures by WSCB partner agencies to safeguard children.*

In line with this strategic objective, this subcommittee, formerly the Procedures and Guidelines Subcommittee, takes the lead in discharging the function of the Board (as defined in government guidance for LSCBs) to assess its child protection and safeguarding systems and procedures, those of partner agencies and others to ensure these are effective in keeping children safe. It is currently working on the implications for the *WSCB Interagency Child Protection Procedures* of the revised version of *Working Together to Safeguard Children 2012*.

Following the final publication of this government guidance, a new "Blue Book" will be published and the focus of the subcommittee's work-plan will shift to arranging for the production, launch, publicising and implementation of our new interagency procedures. Partner agencies will then be expected to amend their internal child protection procedures in accordance with changes made to the *WSCB Interagency Child Protection Procedures,* and the progress of this work will be monitored by the subcommittee.

Training Subcommittee

Strategic Objective: *To ensure there is effective multi-agency training in place in Warwickshire that promotes a shared understanding of the tasks, processes, principles, roles and responsibilities outlined in national guidance and local arrangements for safeguarding children and promoting their welfare, in order to achieve better outcomes for children and young people in Warwickshire.*

The Training Subcommittee has welcomed Mark Simmonds, the new WSCB Interagency Training Officer, to its ranks. The subcommittee has continued to deliver its training strategy during 2011-2012 and the coming year will see the next phase of this, buttressed by an extensive updating of the content of training and the materials used, while retaining the traditional strengths of these events. A highly significant development during the previous year was the delivery of two events on safeguarding disabled children, led by colleagues in the Warwickshire Integrated Disability Service. The success of these new programmes has encouraged the subcommittee to commission further events and they are likely to become a permanent feature of the training strategy.

WSCB training programmes have continued to be well subscribed and the upward trend in the number of staff being trained is expected to continue. However, the subcommittee will carefully monitor the levels of nomination and attendance to ensure that the challenging financial and organisational climate does not deter agencies from supporting staff to attend training.

The WSCB Training Pools have continued to operate effectively despite the operational demands on its members, ensuring that the capacity of the Board to deliver child protection training can be sustained. It is an enduring strength that the Board is able to draw upon the skill, knowledge and commitment of colleagues in the county to deliver high quality single and interagency training. Recruitment to the pools will be kept under review and appropriate steps taken should the need arise.

Coventry and Warwickshire Safeguarding Children in Faith Groups Forum

An important area of work of the Board, led by the Strategy, Communication and Information Subcommittee, has been the establishment, in collaboration with Coventry LSCB, of this forum, designed to promote and embed the safeguarding children agenda within faith groups. WSCB has traditionally

enjoyed a positive working relationship with child protection leads in religious organisations – the Coventry Diocese, Birmingham Archdiocese and Methodist Churches - and the forum has helped to consolidate this work while making it possible to develop a relationship with inter-faith groups representing a wider range of faiths, based in Coventry, Warwick and the West Midlands. These organisations are provided with places at the WSCB Annual Conference and have been featured in our news bulletin.

The forum has made it possible for individuals involved in the work of the two LSCBs to share details of important developments in the safeguarding agenda with our colleagues in faith groups, and for these colleagues to raise issues of interest and concern to them.

During the last year key developments have been the formation of a link with the *Churches Child Protection Advisory Service (CCPAS),* which seeks to provide training and support to a range of faith groups and organisations. The forum has also expanded to include a representative from *Safe Network,* an organisation that aims to train and support staff working in the voluntary and community sectors on safeguarding issues. The manager of *Warwickshire Community and Voluntary Youth Services,* Vic Jones, has energetically supported this expansion, and thanks to Vic, Rebecca Edwards from Safe Network and Claudia Bell from CCPAS, it was possible to hold a highly successful event for colleagues from faith groups and the voluntary and community sectors in 2012. This has enabled us to consolidate and widen the previous events mounted by the forum, extending the links we have with faith groups and now crucially the voluntary and community sectors. Plans are to be made to expand this work still further in the year ahead. *Full details of the forum; its work, and terms of reference can be found on the WSCB Website.*

Forced Marriage and Honour Based Violence (FM and HBV) Working Group

Work on this important aspect of safeguarding both adults and children has been undertaken in Warwickshire over the last few years by a number of agencies. However, 2012 has continue to see the significant progress of previous years consolidated with the interagency group established in 2010 by both Warwickshire Safeguarding Adults Board, WSCB and partner agencies continuing to take forward this work. Training for professionals with a specialist role in identifying and investigating FM and HBV was delivered as planned and a further event will take place. Participants have included the Police and Social Workers from both adult and children's safeguarding teams. The successful awareness raising package set in place in 2010 continues to be delivered throughout the interagency network with the materials now updated by the WSCB Interagency Training Officer. A county-wide conference which featured this issue (and also included consideration of the plight of trafficked children) was held in late 2011, again as planned. Audits submitted by the working group to a government backed agency, confirm that sound progress is being made in taking forward this issue in Warwickshire.

7. SERIOUS CASE REVIEW

Local Safeguarding Children Boards are required by the government to give details in their annual reports on the impact of Serious Case Reviews on improving services to children and families. It was necessary for WSCB to complete one Serious Case Review in 2011-2012 concerning the death of a child. An independent overview report author and independent review panel chair-person were appointed to manage the process. An interagency review panel was formed. The completed review was submitted within the required time-scale and was subsequently positively evaluated by Ofsted.

Key Findings of the Review:

- The death of the child could not have been predicted or prevented;
- While Serious Case Reviews often identify unhappy, dangerous and tragic circumstances that persistently impact upon the safety and welfare of the child concerned, this was not such a case;
- All the available evidence indicated that the child was a much loved child and the parenting received was good;
- Agencies acted appropriately in response to the information available to them;
- There were never any grounds for compulsory intervention under child protection procedures and the history indicates it is doubtful if the parent caring for the child would have given consent to social work involvement.
- In the absence of clear distress signals from the parent, other family members could have done nothing more to help.

Areas for Development:

In addition to these findings, the Serious Case Review identified six aspects where services could be improved:

- Review of child protection training for staff working in Minor Injuries Units and other unscheduled Care Units to ensure they have the necessary skills and knowledge to detect possible harm to children.
- Ensuring midwives are able to discuss with a mental health professional situations where a pregnant woman has a history of current and/or enduring mental health problems.
- Strengthening child protection training for GPs in Warwickshire.
- Ensuring the suicide prevention strategy in place in Warwickshire makes provision for appropriate risk assessment of lone parents and adolescents.
- Ensuring that local drug services provide information for young people about the potential link between cannabis use and psychotic illness in later life.

- The importance of professionals including in assessments of families information relating to the role of the father and male partners. In respect of this, professionals need to understand fully the composition of families, including the presence or otherwise of fathers and partners in the household and record information relating to this accurately in case records.

Actions Plans to implement these improvements in services have been implemented by WSCB and partner agencies.

8

Warwickshire Safeguarding Statistics 2011/12
Summary of Key Issues

- There were 606 children subject to an Initial Child Protection Conference held during 2011/12. This represents a 13% increase on last year when 536 children were conferenced.

- There has been a significant increase in the number of children who were made subject to a Child Protection Plan with 520 plans initiated during 2011/12 in comparison to the 459 initiated in 2010/11. Interestingly more plans were initiated than closed this year which is in contrast to last year when more plans were closed than initiated.

- As at 31 March 2012, 534 children were subject to a Child Protection Plan in Warwickshire. This is an 11.7% increase on the 478 children subject to a plan as at 31st March 2011

- As at 31 March 2012, the largest group of children who were subject to a Child Protection Plan were those aged 1-4 years. This was the same at the end of the previous year.

- Out of the five Child Protection Plan categories, children subject to a plan under "Multiple" categories has seen the greatest increase this year, up by 1.6% to 39.9% this year.

- The proportion of children subject to a CP Plan whose ethnicity was Black/Minority Ethnic has increased, up from 7.3% last year to 11.8% at 31st March 2012. In comparison White British children subject to a Plan saw a decrease, down from 89.5% to 85.1%.

- Warwickshire's performance under the former National Indicators (NIs) in relation to child protection during 2011/12 is as follows:

  Child Protection Plans lasting 2 years or more (Previously National Indicator 64)
  Performance for NI64 is 10.8%, which is a slight increase on last year's figure of 8.4%.

  NI65 - Percentage of children becoming subject to a child protection plan for a second or subsequent time
  During 2011/12, 16.5% of child protection plans initiated were the second or subsequent plan for a child. This is higher than the previous year (14.4%) and therefore a reduction in performance.

  Timeliness of child protection reviews (Previously National Indicator NI67)
  Performance for NI67 is 100%. This is an improvement on last year when 99.2% was achieved.

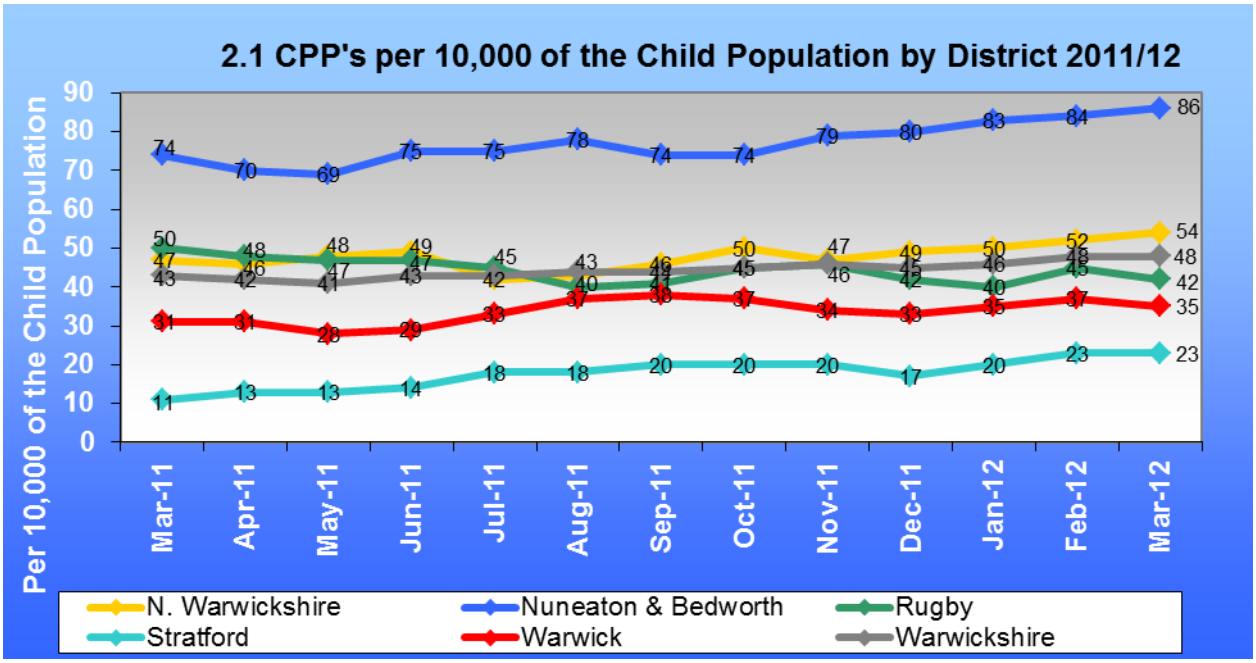
1. INTRODUCTION

1.1 This report summarises child protection activity in Warwickshire between 1 April 2011 and 31 March 2012.

1.2 Warwickshire Safeguarding Children Board has agreed the dataset on which this report is based.

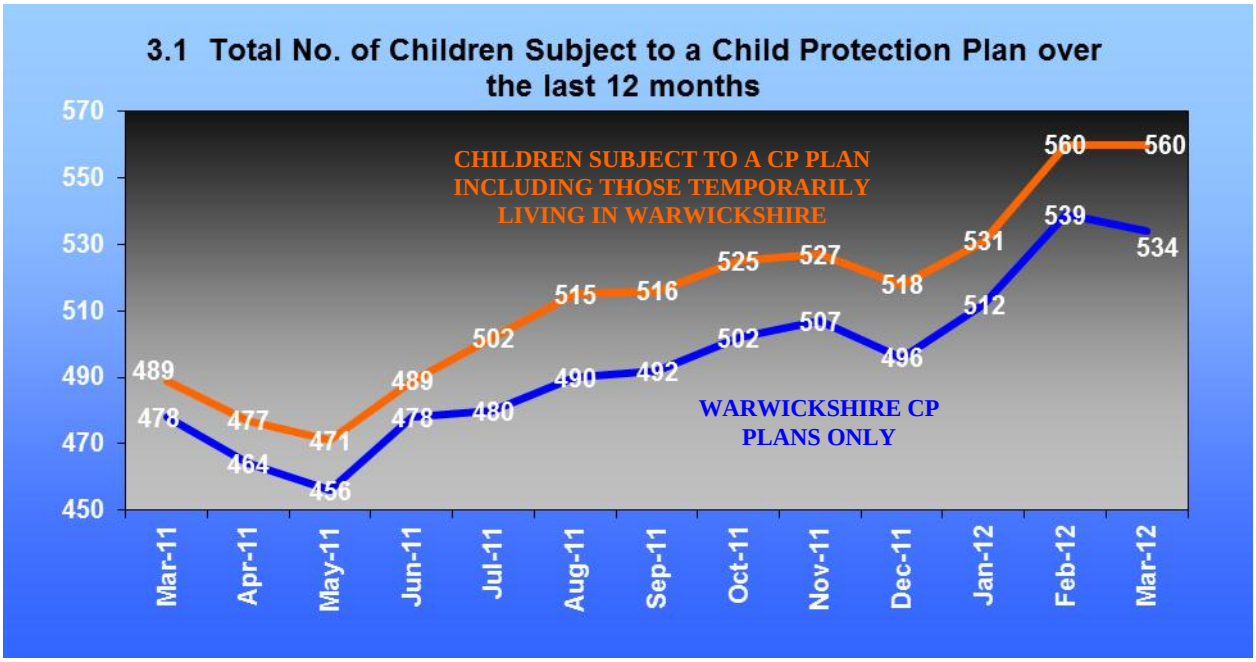
2. NUMBER OF CHILDREN SUBJECT TO A CHILD PROTECTION PLAN PER 10,000 OF 0-17 POPULATION

2.1 The county rate per 10,000 has increased from 43 at 31 March 2011 to 48 at 31 March 2012. The majority of districts have seen a rise in their Child Protection cases per 10,000 when compared to the same point last year with the exception of Rugby where there has been a reduction. The chart below shows the district breakdown of children subject to a Child Protection Plan per 10,000 of Warwickshire's 0-17 population over the last 12 months.



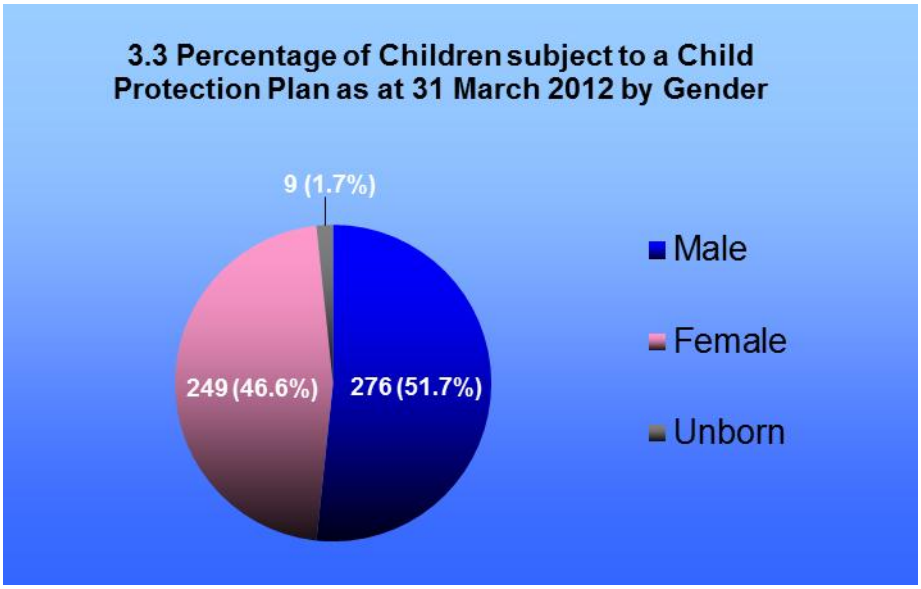
3. CHILDREN SUBJECT TO A CHILD PROTECTION PLAN AS AT 31st MARCH 2012

3.1 As at 31 March 2012, 534 children were subject to a Child Protection Plan in Warwickshire. This is an 11.7% increase on the 478 children subject to a plan as at 31st March 2011. Chart 3.1 shows how this number has progressed over the past year.

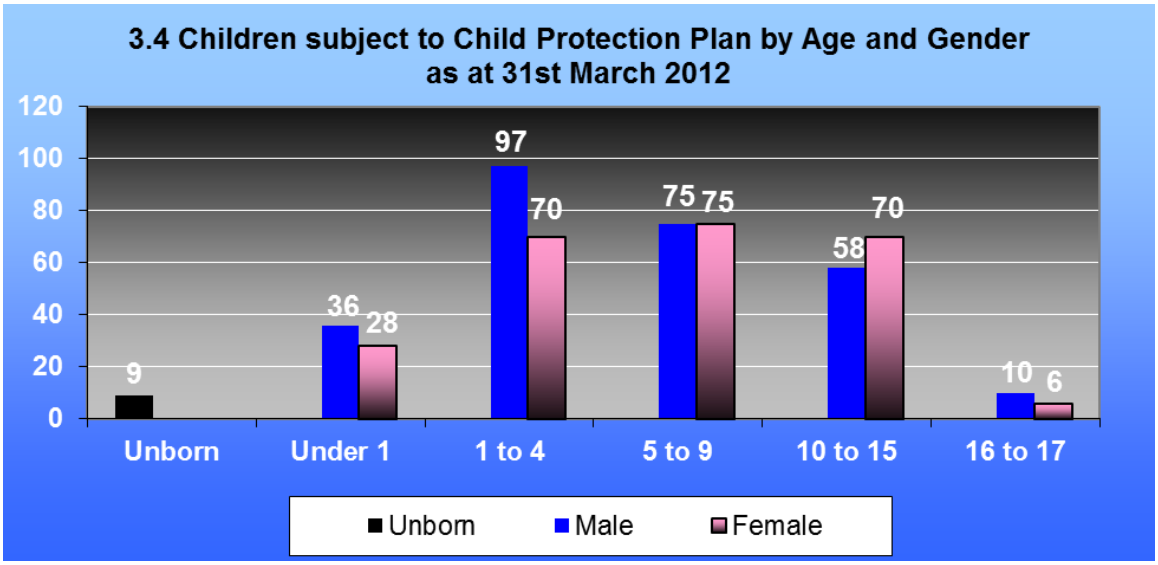


3.2 As at 31st March 2012 there were 26 children subject to a Child Protection Plan, who were temporarily living in Warwickshire. This is an increase of 15 children when compared to the 11 children subject to a CP Plan who were temporarily living in the area at 31 March 2011.

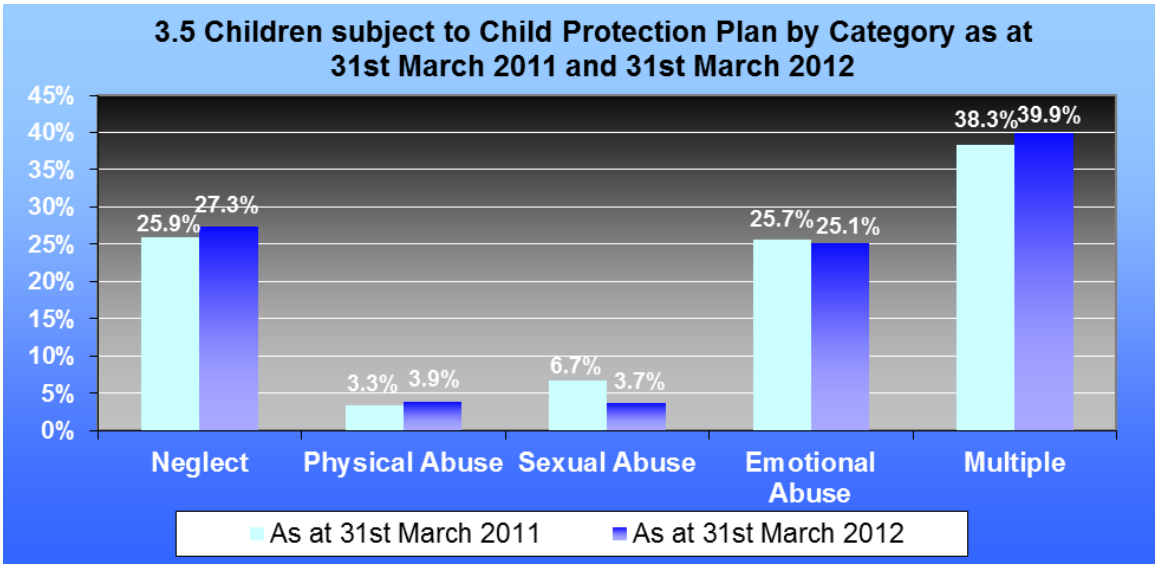
3.3 The gender breakdown of children subject to a Child Protection Plan as at 31st March 2012 is detailed in chart 3.3. 51.7% (276) of children subject to a Child Protection Plan were male as at 31 March 2012 which is an increase on last year's figure of 50.8% (243). However, although the number of females who were subject to a Child Protection Plan increased, up from 224 at 31 March 2011 to 249 at 31 March 2012, proportionately they saw a decrease, down from 47.1% to 46.6%.



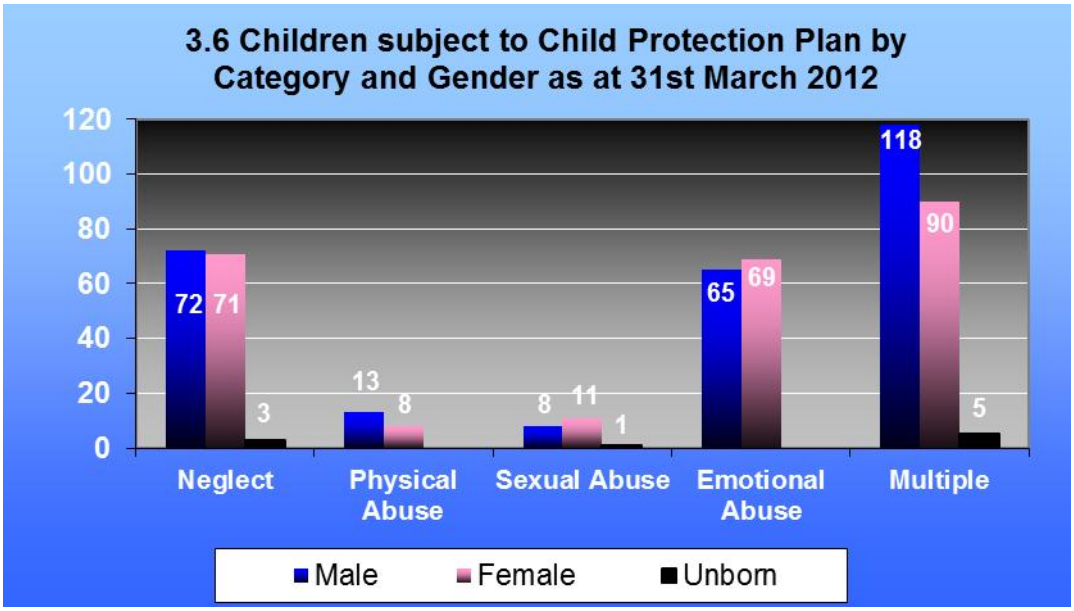
3.4 The proportion of children subject to a Child Protection Plan who are under the age of five (including unborn children) has decreased slightly to 44.9% (240) this year from 47.9% (229) last year. Therefore as at 31 March 2012 there has been an increase in children subject to a Child Protection Plan aged 5 or over, representing 55.1% of the child protection population. There were 9 unborn children subject to a Child Protection Plan as at 31st March 2012 compared to 12 unborn children at the same point last year.



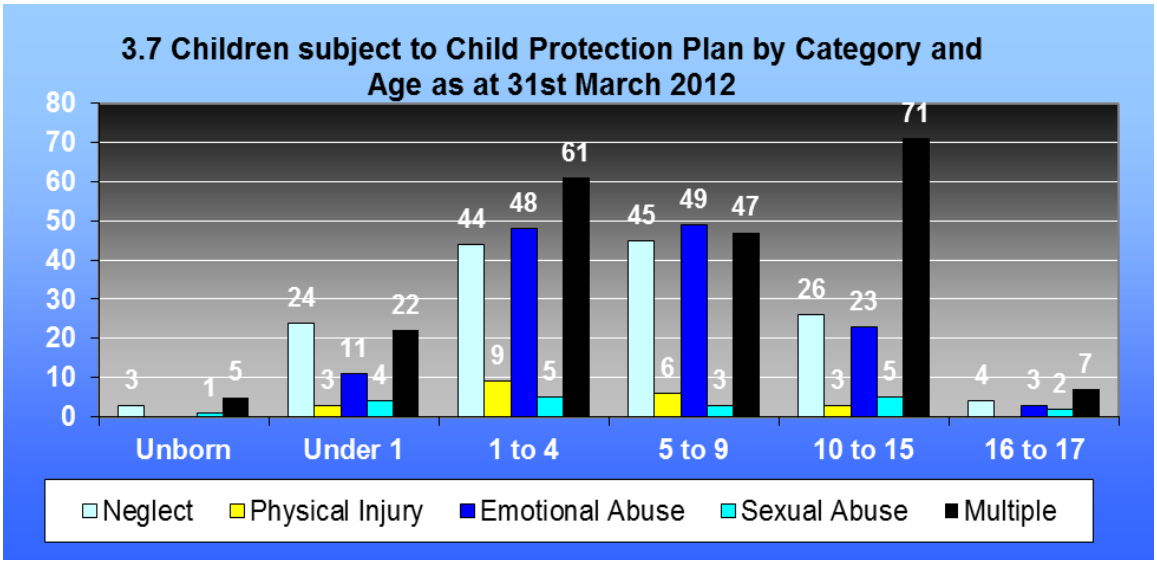
3.5 Chart 3.5 shows the categories under which children were subject to a Child Protection Plan as at 31st March 2012 with the previous year's figure shown for comparison. Increases were seen this year in children under the category of 'Neglect' (up 1.4% to 27.3%), 'Physical Injury' (up 0.6% to 3.9%) and 'Multiple' categories, up 1.6% to 39.9%. However, decreases were seen in children subject to Child Protection plans under 'Emotional Abuse' (down 0.6% to 25.1%) and 'Sexual Abuse' (down 3% to 3.7%)



3.6 Chart 3.6 shows the children subject to a plan at 31 March 2012 by Category and Gender. More females were subject to a Child Protection Plan under the categories of 'sexual abuse' and 'emotional abuse' than males. Whereas, more males were made subject to a Child Protection Plan under the categories of 'Neglect', 'Physical Abuse' and 'Multiple' categories than females.



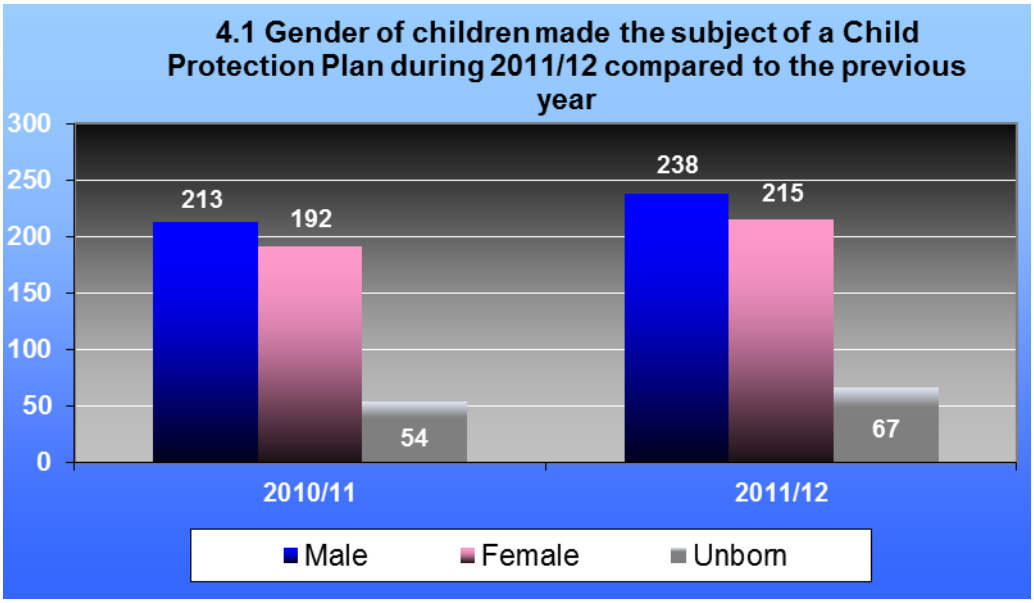
3.7 Chart 3.7 shows children by category and age range. As at 31 March 2012, the largest number of children subject to a Child Protection Plan were those aged 10 to 15 who had 'multiple' categories. The largest number of children under a single category though were those aged 5 to 9 for 'emotional abuse'.



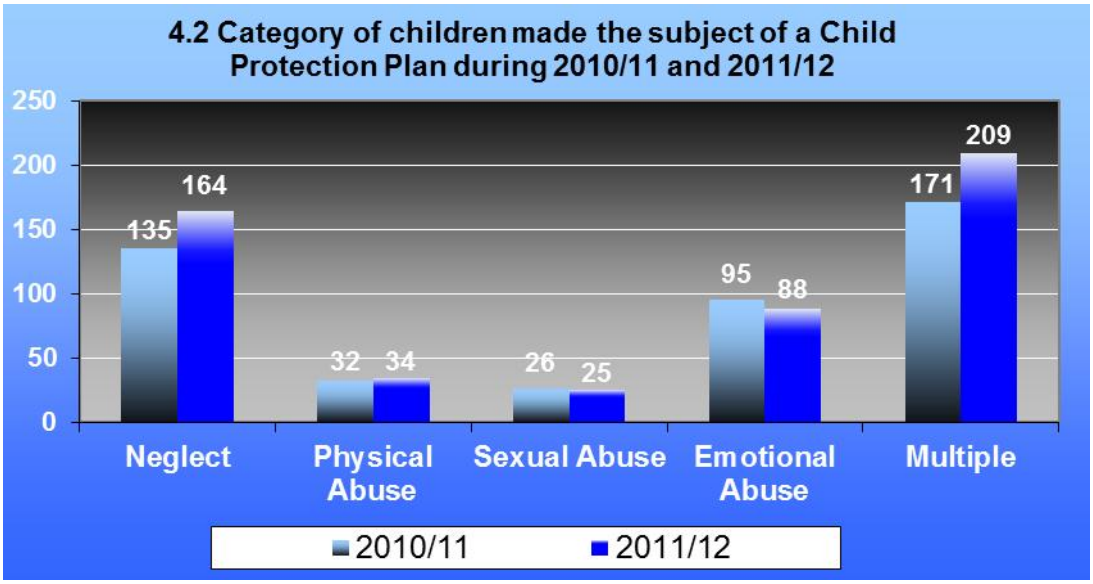
3.8 Excluding the 9 unborn children subject to a Child Protection Plan at 31 March 2012, 85.1% were of White British ethnic origin. This is a decrease on last year when the comparable figure was 89.5%. This year, there were 62 children (11.8%) whose ethnicity was black/minority ethnic which is a 4.5% increase on last year when there were 34 children (7.3%) black/minority ethnic children subject to a Child Protection Plan as at 31 March 2011.

4. CHILD PROTECTION PLANS INITIATED DURING THE YEAR

4.1 520 children became subject to a Child Protection Plan during 2011/12, compared to 459 during 2010/11. Of those 520 children, 238 (45.7%) were male, 215 (41.3%) were female and 67 were unborn. The chart below shows the largest number of children becoming subject to a Child Protection Plan during 2011/12 were males which is the same as the previous year.

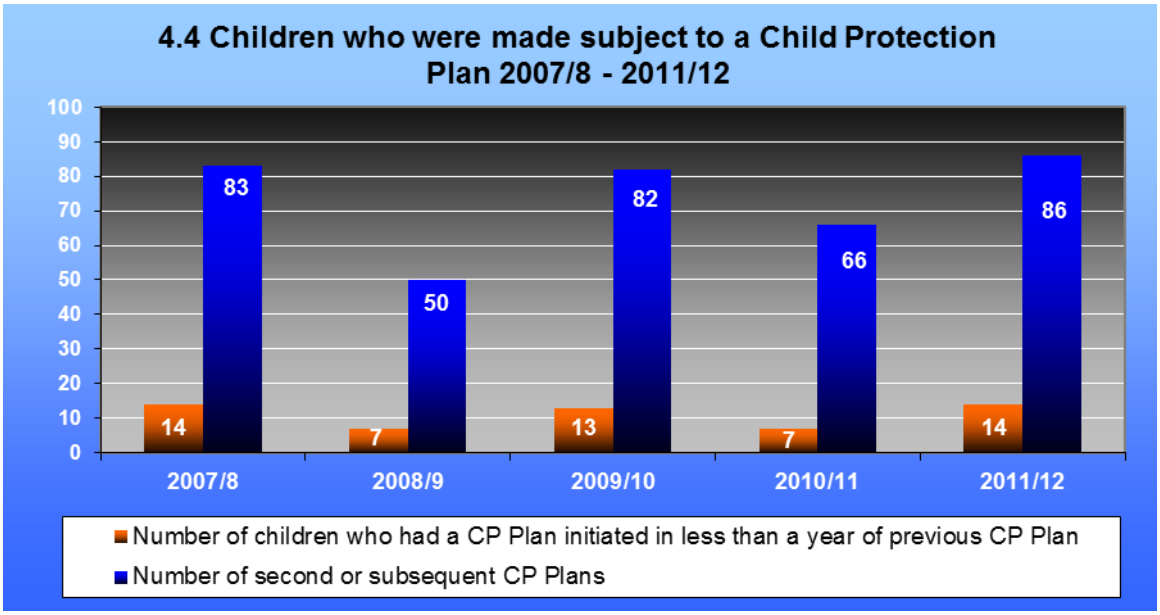


4.2 The majority of the 520 children made subject to a Child Protection Plan during 2011/12 were given the category of 'Multiple'. This was followed by the categories of Neglect and Emotional Abuse. The category that has seen the biggest increase compared to last year was for those with 'multiple' categories whilst the biggest decrease was seen in those who had a plan initiated under the category of 'emotional abuse'. (See Chart 4.2 overleaf).



4.3 Of the 520 children who became subject to a Child Protection Plan during the year ending 31st March 2012, 434 (83.5%) of these became subject of a Child Protection Plan for the first time compared to 393 (85.6%) last year. A further 86 (16.5%) children became subject to a Child Protection Plan for a second or subsequent time. This is an increase on last year when 66 (14.4%) of the total number (459) of children became subject to a Child Protection Plan for a second or subsequent time.

4.4 Chart 4.4 shows the number of children who became the subject of a child protection plan for a second or subsequent time over the last five years. This chart also identifies those who became subject to a child protection plan for a second or subsequent time within less than a year of their previous plan.

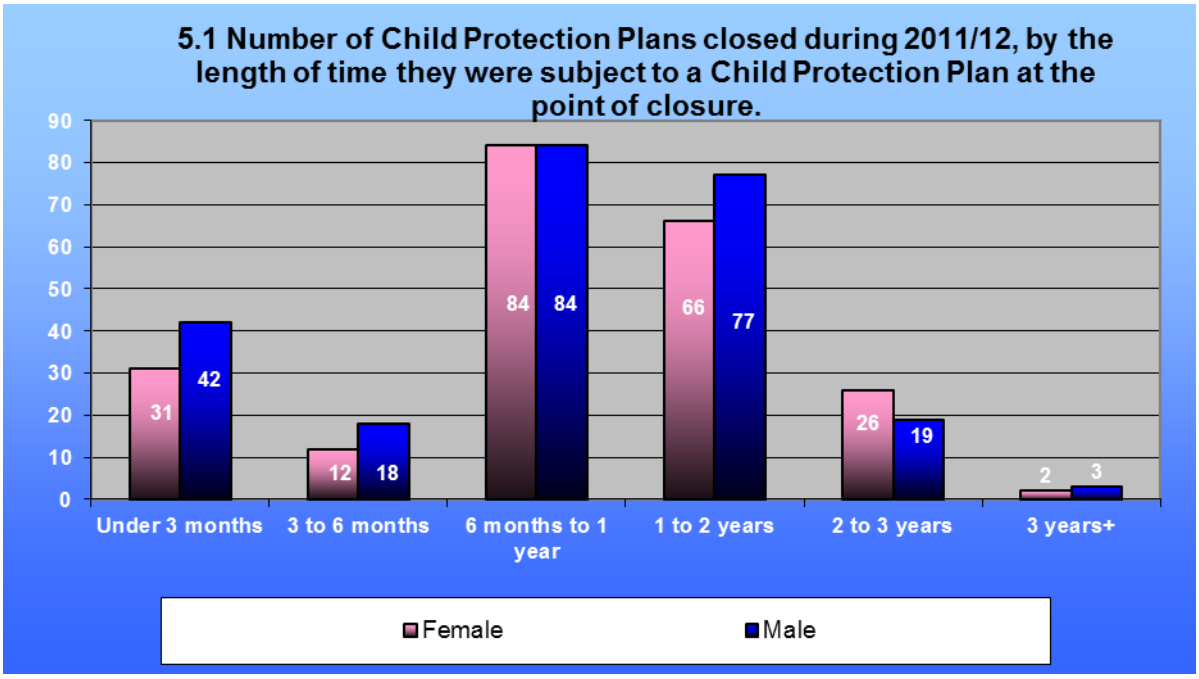


The number of children who became subject to a plan for a second or subsequent time has increased from 66 last year to 86 this year. The number for whom a second or subsequent plan was initiated within a year of their previous plan had doubled, up from 7 in 2010/11 to 14 in 2011/12.

In 2011/12, Warwickshire reported a figure of 16.5% against former national indicator NI65 (Percentage of children becoming subject to a child protection plan for a second or subsequent time). This is higher than the previous year (14.4%) and therefore a reduction in performance.

5. DURATION OF CHILD PROTECTION PLANS

5.1 464 children had their plans closed during the year ending 31st March 2012. This is a decrease of 22 (4.5%) when compared with the 486 discontinued during the previous year. Chart 5.1 shows the number of children who had their Child Protection Plans closed during 2011/12, by the length of time they were subject to a Child Protection Plan at the point of closure.



5.2 Chart 5.1 shows that for both genders, the majority of plans were closed between 6 months and 1 year and between 1 year and two years which is the same as last year. The numbers of children that fall into the "2 to 3 Years" category increased compared to the previous year whilst the number closed after "3 Years +" saw a slight reduction this year.

5.3 Table 5.3 shows this year's discontinued plans by the length of time the child was subject to a Plan and compares this with the previous two year's figures.

5.3 Duration of Child Protection Plans Prior to Discontinuation			
	2009/10	**2010/11**	**2011/12**
Under 3 months	13.6%	14.4%	15.7%
3 months but under 6 months	11.8%	5.8%	6.5%
6 months but under 1 year	38.5%	37.0%	36.2%
1 year but under 2 years	28.7%	34.4%	30.8%
2 years but under 3 years	6.5%	7.0%	9.7%
3 years and over	1.2%	1.4%	1.1%

5.4 Performance for Child Protection Plans lasting 2 years or more (previously national indicator NI64) was 10.8%, which is an increase on last year's figure of 8.4%.

6. INITIAL CHILD PROTECTION CONFERENCES HELD DURING THE YEAR

6.1 During the year ending 31st March 2012 there were 606 children subject to Child Protection Conferences. This represents a 13% increase on last year when 536 Children were subject to a Child Protection Conference. Of the 606 Children subject to a conference held during 2011/12, 520 (85.8%) resulted in the initiation of Child Protection Plans.

7. REVIEWS OF CHILD PROTECTION CASES

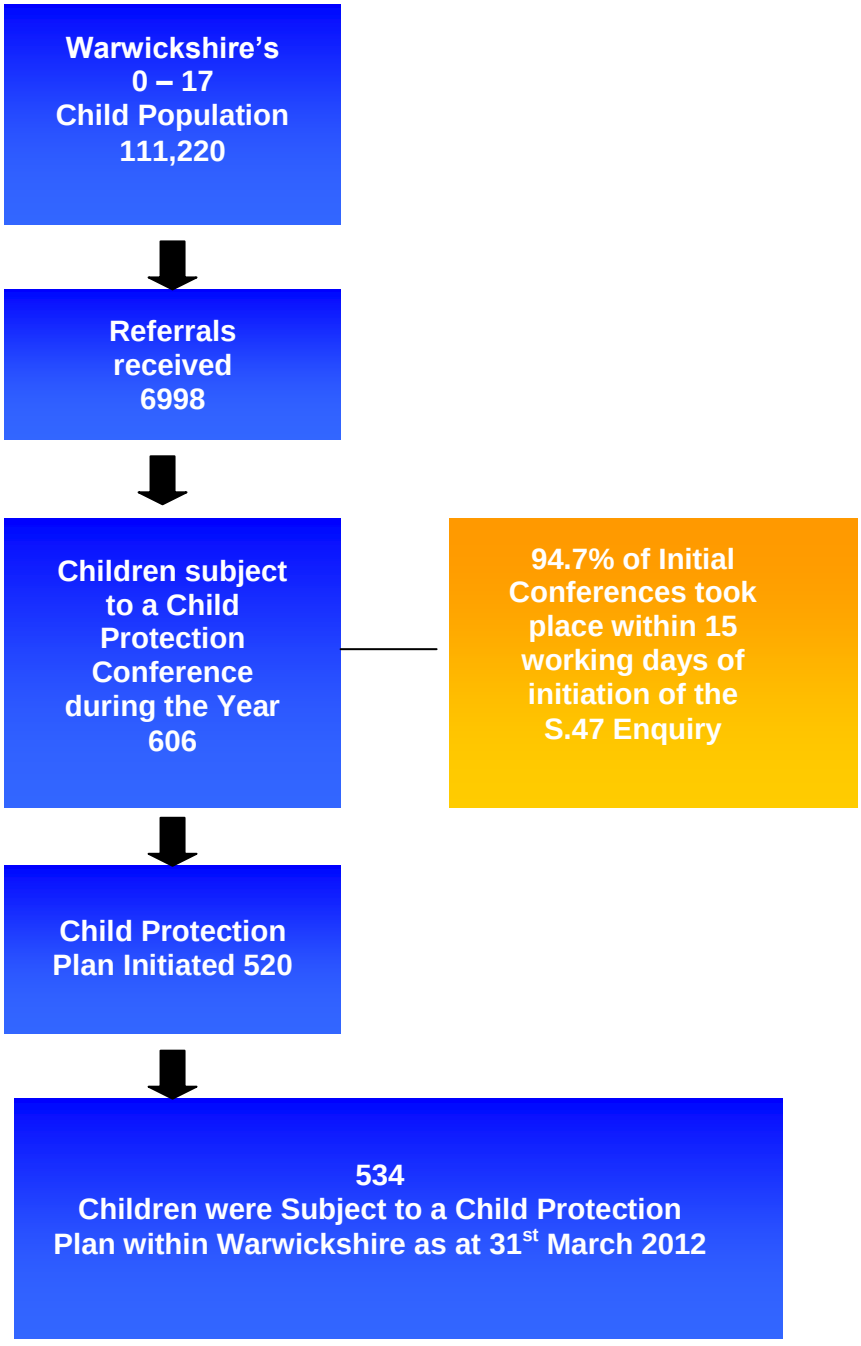
7.1 During the year ending 31st March 2012, 409 children had been subject to a plan continuously for at least three months. Of that 409, all 409 (100%) had been reviewed within timescales. This is an improvement on last year when 99.2% was achieved. This means that our performance under former national indicator NI67 (Timeliness of reviews) would have increased to the top banding under this indicator.

8. POLICE PROTECTION AND EMERGENCY PROTECTION ORDERS

8.1 As at 31st March 2012 there were no children accommodated under either Police Protection or Emergency Protection Order. However, during 2011/12 there were a total of 18 children placed on Emergency Protection Orders and 11 subject to Police Protection.

9. SUMMARY OF CHILD PROTECTION ACTIVITY

9.1 Chart 9.1 below summarises some of the activity detailed in Sections 1-8.



10. NUMBER OF PRIVATE FOSTERING ARRANGEMENTS

10.1 A privately fostered child is defined as a child under the age of 16 (18 if disabled) that is cared for by someone other than a close relative (i.e. a grandparent, brother, sister, uncle, aunt, or step-parent). A child is not privately fostered if the person caring for him or her has done so for fewer than 28 days and does not intend to do so for longer than that. Privately fostered children are not "looked after" children in the terms of section 22 of the Children Act 1989. However, Local Authorities have a responsibility to ensure that the welfare of privately fostered children is promoted, as identified in Part IX of the Children Act 1989, amended by section 44 of the Children Act 2004.

Warwickshire now have to make a statutory return on the number of children privately fostered across the county during the year. Below outlines some of the key data submitted to the DfE for 2011/12.

Number of children under private fostering arrangements as at 31 March 2011	7
The number of notifications of new private fostering arrangements received during 2011/12	9
Number of new arrangements that began during 2011/12	8
Number of private fostering arrangements that ended during 2011/12	10
Number of children under private fostering arrangements as at 31 March 2012	**5**

11. LEGAL ACTIVITY TO SAFEGUARD CHILDREN

The following data confirms the significant upward trend in child protection activity in Warwickshire, this time viewed through the issuing of care proceedings evident over the last four years. Again, this reflects a national trend.

In the year July 2008 – July 2009, 60 new cases were issued

In the year July 2009 - July 2010, 82 new cases were issued.

In the year July 2010 – July 2011, 90 new cases were issued.

In the year July 2011 – July 2012, 118 new cases were issued.

W.C.C Children's Legal Services are currently holding 120 issued cases in public law care proceedings (not including appeals, discharge of care order and contact applications) compared with 115 last year and 107 in July 2010.

9. FURTHER ASSESSMENTS OF THE EFFECTIVENESS OF SAFEGUARDING ACTIVITY IN WARWICKSHIRE

This Annual Report has already presented information on the variety of ways in which WSCB, through its strategic priorities, subcommittee structure and work-plans, the completion of Serious Case Reviews when necessary, audits and other initiatives, assesses and contributes to the effectiveness of safeguarding activity in Warwickshire. Our annual data set has provided insight into the *levels* of this activity and how our systems have worked to keep pace with significant year on year increases in demand for child protection services. In addition to this important information, there has been, as was the case last year, regulatory activity that has contributed to the building of a comprehensive picture of safeguarding activity in the County and its quality. Details are presented in this section of the report. (Points made by inspectors in relation to early help and intervention services have been highlighted as indicated in the introduction to this annual report by the WSCB Independent Chair. These aspects will feature more prominently in next year's annual report).

Inspection of safeguarding and looked after children services (Warwickshire)

Conducted in October and November 2011 this inspection evaluated a range of evidence which included discussions with 65 children and young people receiving services, 33 parents and carers, front line staff and managers, senior officers, including the Strategic Director of the Warwickshire County Council People Group, the Independent Chair of WSCB, elected members and a range of staff and managers from Health Organisations and other partner agencies, including Warwickshire Police, the Voluntary and Community sector.

A review of 40 case files for children and young people with a range of need was conducted by the inspectors. This provided a view of services provided over time and the quality of reporting, recording and decision-making undertaken. The outcomes of the most recent annual unannounced inspection of local authority contact, referral and assessment services undertaken in June 2011 and documented in last year's WSCB Annual Report was used in the assessment.

Following this detailed survey, the inspectors concluded that ***the overall effectiveness*** of the county council and its partners in safeguarding and promoting the welfare of children in Warwickshire is ***good***. Among the conclusions reached by inspectors were:

- Strong leadership of elected members and senior managers has contributed to improved safeguarding outcomes for children and young people enabling children's social care services to be protected during a period of severe financial pressure and cuts to other services;
- Strong and effective leadership is provided by the Children's Trust at both county and district levels and by WSCB. The strategic priorities of WSCB link well to those of the Children and Young People's Plan;
- The consideration of the challenges arising from restructuring of services has been thorough and risks appropriately identified;
- A culture of learning through performance management permeates all agencies;
- Children most at risk of harm are appropriately protected and prioritised with robust arrangements between partners to manage and monitor cases;
- *Early intervention is appropriately prioritised and well-resourced with good examples of effective and innovative practice;*

- Workforce development is effective in helping to retain competent and experienced staff. Staff are well supported including those who are newly qualified and have access to good quality training;
- *Improvements to practice are supported through Warwickshire being an early implementer for "Action for Health Visiting";*
- Service users in council run services are actively involved in individual case planning and increasingly consulted about service planning.

In terms of ***capacity for improvement,*** inspectors assessed this as ***good,*** noting the reconfiguration of children's services as having been well managed but too early to judge the effectiveness of the new structures. In addition:

- *The strong investment by the council in early intervention services is underpinned by well- articulated business planning and research evidence, helping to achieve a long term reduction in the need for costly statutory intervention;*
- *Early intervention services are yielding good outcomes and parents are very positive about the services they receive;*
- *Evaluation of the current raft of services and work carried out with the Dartington Social Research Unit is helping to determine where future investment of resources will have most impact;*
- The council has successfully dealt with most areas for development identified during the unannounced inspection of contact, referral and assessment services carried out in June 2010. Some action is still required on some issues such as the variable quality of initial assessments;
- *The council, health services and partners are providing appropriate challenge for each other and this is helping to ensure the next Joint Strategic Needs Assessment enables deficits in services to be addressed;*
- The WSCB demonstrate its vision and ambition and the implications for service provision very well to the workforce and its business plan clearly shows how regulatory requirements are being met in including the implications of the Munro Review of Child Protection.

In order to improve the quality of provision for safeguarding children and young people in Warwickshire, Ofsted Inspectors stated that the local authority and its partners should take the following action:

- Ensure that health agencies, including GPs, are promptly notified of child protection strategy meetings and conferences to which they are being invited;
- Ensure that notifications of attendance of children from unscheduled care and accident and emergency units are of good quality so that concerns can be followed up effectively;
- Improve the robustness of children's social care case file audits;
- Ensure that all child protection plans are specific and measurable and have clear time-scales;
- Warwickshire County Council and NHS Warwickshire should ensure that referral thresholds for safeguarding are applied consistently across the county;
- NHS Warwickshire should ensure there are robust systems in place to collect safeguarding training information; assess the impact of training on improving safeguarding health services within each contracted service and ensure this training is sufficient to meet the needs of staff;
- Improve management oversight of the councils' HR recruitment processes;

- NHS Warwickshire should review the different approaches to identifying domestic violence in respect of pregnant women.

In response to these identified actions a ***Warwickshire Integrated Action Plan*** was devised by Warwickshire County Council and NHS Warwickshire which was shared with the Warwickshire Safeguarding Children Board in January 2012. WSCB has received progress reports on the implementation of this action plan allowing it the opportunity to scrutinise this progress.

For further information regarding this Annual Report and other aspects of the work of the Warwickshire Safeguarding Children Board please contact:

www.warwickshire.gov.uk/wscb

Item No 7

Warwickshire Shadow Health and Wellbeing Board

13 November 2012

Director of Public Health Annual Report 2012
1 in 3: The Picture of Ill Health in Warwickshire

Recommendation

That the Warwickshire Shadow Health and Wellbeing Board notes the recommendations in the Director of Public Health's Annual Report 2012

1. Last year's report focused on the lifestyle priorities for Warwickshire's people. This report begins to look at the effects lifestyle has on our health and wellbeing.

2. Chronic ill health can affect people at all ages but is predominately within an older age group and a major contributor to frailty. We are all living longer related to our increasing affluence through not always into a healthy old age.

3. Long term conditions are increasing, partly as a consequence of the aging population and unhealthy lifestyle choices. Nationally, around 1 in 3 people, aged over 16, live with at least one long term condition An estimated 1 in 3 people in Warwickshire, aged over 16, are living with one or more long-term conditions, this equates to 147,000 people.

4. A long term or a chronic condition cannot, at present, be cured but is controlled by medication and/or other treatment/therapies. Assessing and understanding the needs of these people is key to the planning and provision of public services locally. This is particularly so for NHS emergency services as well as access to Adult Social Care Services.

5. The report looks at some of the challenges and solutions through **Primary Care** in the management of chronic diseases. It highlights the issue of **multi-morbidity** where an individual is suffering from more than just one condition. This is important because it is the norm rather than the exception for many people. It considers the **implications for the wider workforce** and the role that it has to play in identification and prevention through **Making Every Contact Count**. Finally it looks at the opportunities presented by influencing the **wider determinants** of health with a focus on the role and potential of the **health impact assessment** process.

	Name	**Contact Information**
Report Author	John Linnane	John.linanne@warwickshire.nhs.uk
Head of Service	John Linnane	john.linnane@warwickshire.nhs.uk
Strategic Director	Monica Fogarty	monicafogarty@warwickshire.gov.uk
Portfolio Holder	Cllr Bob Stevens	cllrstevens@warwickshire.gov.uk

Joint Director of Public Health

Annual Report **2012**

1 in 3: The picture of **ill health** in Warwickshire

Every third person in Warwickshire has a chronic health condition.

Why is that and what can we do to prevent it...?

Warwickshire County Council

Warwickshire Joint Strategic Needs Assessment

NHS Warwickshire

Joint Director of Public Health

Annual Report **2012**

Contents:

This report will be published locally to partners through a variety of media, to disseminate messages and implement the findings.

"Progress will be monitored in future reports and your comments and feedback are always welcome. Please direct any comments to: publichealthintelligence@warwickshire.nhs.uk I look forward to hearing your views."

Acknowledgements: I am grateful to my many colleagues for their help in the production of this report:

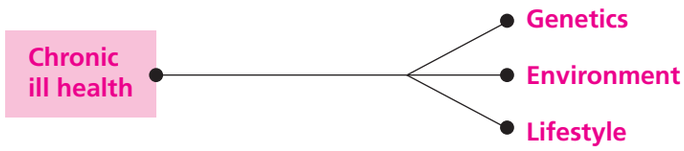
Editorial Team: Mike Caley, Rachel Robinson, Gareth Wrench.
Contributors: Ali Boffin, Mark Chapman, Emmie Fulton, Paul Kingswell, Kathryn Millard, Emily Smith, Caron Williams, Warwickshire Observatory.
Design: Communications, NHS Warwickshire
Telephone: 01926 413775 Fax: 01926 410130.
This report is also available on www.warwickshire.gov.uk/publichealth and www.warwickshireobservatory.org

LARGE TEXT VERSION AVAILABLE ON REQUEST THROUGH PUBLIC HEALTH

Welcome to my Annual Report for 2012

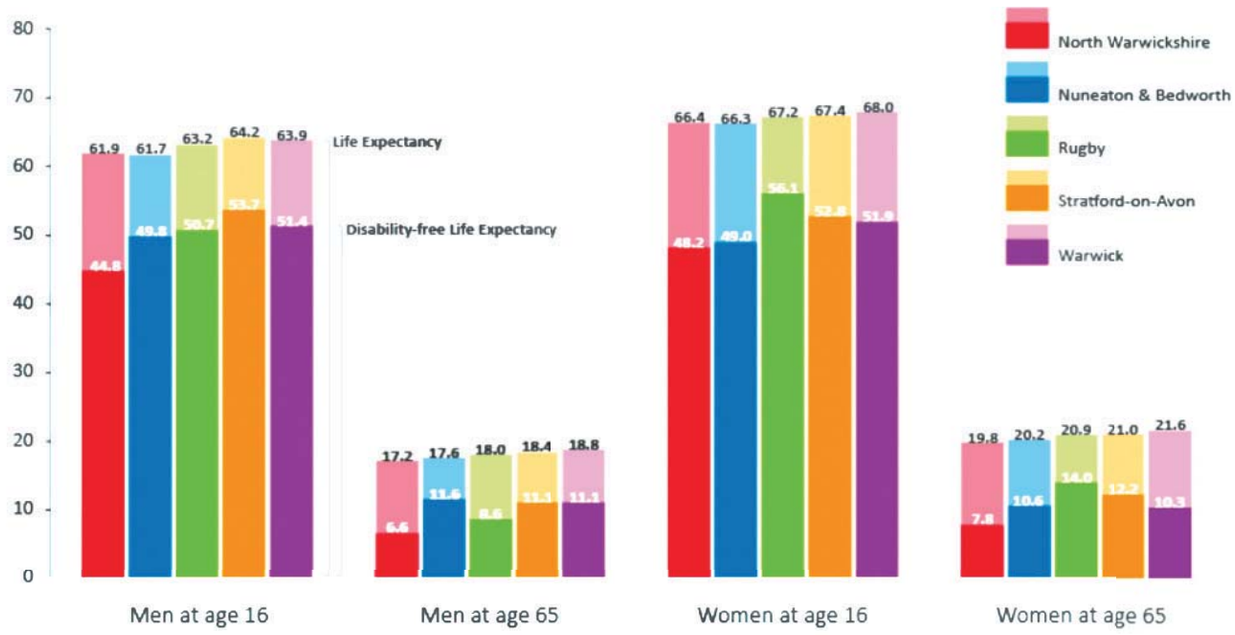
My last report focused on the lifestyle of Warwickshire people and this report begins to look at the effects lifestyle has on our health and wellbeing.

Chronic ill health can affect people at all ages, but predominately exists within older age groups, and can be a major contributor to frailty. We are all living longer, related to our increasing affluence, though not usually into a healthy old age.



Dr John Linnane,
Joint Director of Public Health
john.linnane@warwickshire.nhs.uk

Figure 1: Comparing disability-free life expectancy and life expectancy, 2007-09



Source: Office for National Statistics: http://bit.ly/P24Rwx

Disability free life expectency (DFLE) estimates the average number of years a person could live without a long term condition, assuming that there is no change to future death rates and health status rates in the population.

Section One: Welcome and Introduction

Why Focus on Long Term Conditions?

A long term condition (LTC) or a chronic condition, is a condition that cannot, at present, be cured but is controlled by medication and/or other treatment or therapies.

Examples of long term conditions, in Warwickshire, include high blood pressure, diabetes, asthma, arthritis, heart disease and chronic obstructive pulmonary disease. People live with these conditions for many years, often decades, which can impact on their quality of life.

People with long term conditions continue to see variation in care and services across the county. They are intensive users of health and social care services, including community services, urgent and emergency care, and acute services.

The 2009 General Lifestyle Survey showed that, nationally, 15 million people are living with long term conditions which account for:

- 50% of all GP appointments.
- 60% of outpatient appointments.
- 70% of all inpatient bed days.
- Around 70% of the total health and care spend in England (£7 out of every £10) is attributed to caring for people with LTCs. This means that 30% of the population account for 70% of the spend.

Firstly, we look at long term conditions, particularly some of the challenges and solutions, through Primary Care, in the management of these diseases. The next section, highlights the issue of multi-morbidity where an individual is suffering from more than just one long term condition. This is important because it is the norm rather than the exception for many people. It illustrates why care needs to be focused on considering the person and not the services. The third section considers the implications for the wider workforce and the role that it has to play in identification and prevention through the Making Every Contact Count (MECC) agenda. The final section looks at the opportunities presented by influencing the wider determinants of health, with a focus on the role and potential of the health impact assessment process.

The scale of the problem

Long-term conditions have been identified as a priority in the 2011 Annual Review of Warwickshire's Joint Strategic Needs Assessment (JSNA). The purpose of the JSNA is to analyse and examine the current and future health and wellbeing needs of the local population, to inform and guide the commissioning of health, wellbeing and social care services.

The JSNA highlights:

- Around 1 in 3 people, aged over 16, live with at least one long term condition.
- People with long term conditions are more likely to see their GP, be admitted to hospital, stay in hospital longer, and need more help to look after themselves than people without long term conditions. They are also increasingly involved in manageing their own conditions with the support of a health care team.
- High quality management of long term conditions helps to keep people healthier and independent for longer.
- People with long term conditions need to be helped to understand their condition in order to manage it as well as possible, but in Warwickshire we have very few services that can help people learn about their condition, or have the right rehabilitation to improve the management of their condition.
- Warwickshire GPs usually work with people to manage their long term conditions and for the most part this care is very good, but we know that there are some patients who are not getting the treatments that they need, for example:
  - 20% of people with high blood pressure do not achieve the recommended level of control.
  - 11% of people with diabetes have dangerously poor levels of blood sugar control.
  - 10% of people with heart failure are not taking the recommended treatment.
  - 6% of people who have coronary heart disease are not taking blood thinning medication that has been proven to reduce the chance of a heart attack and death.

Figure 2 draws together information from a range of sources to help illustrate and enable us to understand the scale of the problem in terms of need, unmet need and demand. It aims to quantify and provide an overview of the gaps between those who have been diagnosed, with a long-term condition, and those who have not. The prevalence rates used for the population as a whole are all taken from the best sources available.

The health needs of a population derive from the prevalence of diseases, that is the numbers of people suffering from different types of illness. Looking only at the numbers of patients currently being treated for a disease does not show the true prevalence and impact on the population's health. At any given time, there are many people who have a disease but are not aware of it because they have not yet been diagnosed.

The numbers of patients recorded on general practice disease registers in Warwickshire, when compared with the expected numbers of people with specific conditions calculated from prevalence rates, shows that there are potentially large numbers of undiagnosed or unrecorded cases This is especially the case for coronary heart disease, hypertension, diabetes, chronic obstructive pulmonary disease, asthma and chronic kidney disease. For example, in relation to hypertension, it is estimated that there are over 60,000 undiagnosed or unrecorded cases in Warwickshire.

An estimated 16% of total hospital admissions have a primary diagnosis which could be categorised as a long term condition. In some cases patients may have a long term condition, but this may not be the primary cause of admission and therefore would not be recorded as such.

- An estimated 1 in 3 people in Warwickshire, aged over 16, are living with one or more long-term conditions. This equates to 147,000 people. The chronic conditions in the table below account for approximately 21,000 hospital admissions and around 3,000 deaths, on average, each year.
- Hypertension is the most common long-term condition in Warwickshire, in terms of both estimated and actual prevalence.
- The highest average number of hospital admissions and average deaths, per year, are for various types of cancer.

Figure 2: The Burden of Long-Term Conditions in Warwickshire and England, 2010/11

Condition	National Figures (England)	Warwickshire			
	Estimated Number & Prevalence (%)	Estimated Number & Prevalence (%)	GP Practice Disease Registers	Hospital Admissions[17]	Deaths[18]
				Average per year	Average per year
All Conditions				130,000	4,900
All Long Term Conditions	14,187,000 (33%)	147,000 (33% of the adult population)		20,000	2,800
Coronary Heart Disease (CHD)	2,493,000 (5.8%)[1]	25,400 (5.7%)[1]	17,790 (3.2%)[7]	1,500	650
Stroke & Transient Ischaemic Attacks (TIA)	1,075,000 (2.5%)[1]	11,100 (2.5%)[1]	9,464 (1.7%)[8]	1,000	400
Hypertension	13,155,000 (30.6%)[1]	148,000 (33.2%)[1]	80,277 (14.6%)[9]	350	50
Diabetes	3,267,000 (7.6%)[1]	34,800 (7.8%)[5]	23,406 (5.2%)[10]	450	60
Chronic Obstructive Pulmonary Disorder (COPD)	1,548,000 (3.6%)[1]	13,400 (3.0%)[1]	8,106 (1.5%)[11]	850	200
Asthma	4,493,000 people (1 in every 12 adults & 1 in every 11 children)[2]	46,000 (37,100 adults & 8,900 children)[2]	34,209 (6.2%)[12]	500	15
Epilepsy	408,000 people (1 in 130 people)[3]	4,200	3,408 (0.8%)[13]	350	15
Cancer	260,000 cases per year[4]	2,500 cases per year (incidence)[4]	9,379 (1.7%)[14]	15,000	1,400
Hypothyroidism	352,000 (15 in every 1,000 women, 1 in 1,000 men)[3]	3,600 (15 in every 1,000 women, 1 in 1,000 men)[3]	18,479 (3.4%)[15]	12	5
Renal Disease/CKD	3,783,000 (8.8%)[1]	41,900 (9.4%)[6]	21,013 (4.8%)[16]	400	20

Sources: Full details are given in Appendix 2. **Note:** Patients may be present on more than one disease register. Numbers relate to Adults aged 16+ unless stated. Prevelence data is based on the most up to date evidence based

With a growing and ageing population, Warwickshire is predicted to see a significant increase in numbers of long-term conditions. My 2009/10 Annual Report showed almost an estimated 90% increase over 20 years in older people with dementia. In addition, conditions such as diabetes and depression will see more than a 50% increase. This will place an increased burden on future health and social care resources.

In addition, we need to consider people living with multiple conditions, which is the norm rather than the exception. Multi-morbidity is associated with poorer quality of life, higher hospital admissions and mortality. This is explored in more detail in Section 5 on **Multi-morbidity and maintaining independence**.

Section Two: Executive Summary and Recommendations

1. Long Term Conditions (LTCs)

The Challenge: LTCs cannot, at present, be cured but are controlled by medication and/or other treatment/ therapies.

- Nationally, around 1 in 3 people (33% of the population), aged over 16, live with at least one long term condition. In Warwickshire, this equates to an estimated 147,000 people. However, more recent research suggests the rate may be as high as 42%.
- LTCs are increasing, partly a result of the ageing population and unhealthy lifestyle choices.
- The NHS overall helps people maintain a good level of control, however there is variation.
- People with LTCs are 2-3 times more likely to experience mental health issues than those without.

The Opportunities:

- **Early intervention** - It is important that we test people to ensure we diagnose early.
- **Giving people the best treatment** – Good management can reduce complications from long term conditions and help to keep people healthier and independent for longer.
- **Helping people adjust and recover** - Taking the time to teach people about their condition makes big differences to how well people can control their condition.
- **Good mental health** – Is as important as good physical health and influences our physical wellbeing.

Recommendations:

- Roll out NHS Health Checks across the whole of Warwickshire.
- Improve the clinical indicators and outcomes for people with LTCs and reduce the variation in outcomes between GP practices, ensuring the treatments given to patients with LTCs are at recommended levels for all practices.
- Increase the availability of 'expert patient' and rehabilitation programmes.
- Improve the coordination of services for people with more than one condition.
- Increase the availability of services to help with mental wellbeing in people with LTCs.

2. Multimorbidity and Maintaining Independence

The Challenge: Co-morbidity or multimorbidity is the presence of two or more LTCs.

- The latest research suggests that more than 42% of the population could have one or more LTCs, and that more people (23%) have two or more LTCs than have only one.
- As people develop more than one chronic condition, their care becomes more complex and difficult for them and/or the health and social care system to manage.
- Multimorbidity is associated with poorer quality of life, more hospital admissions and higher mortality. This in turn leads to an increase in costs for care.
- Services, particularly health services, are largely organised to provide care for single diseases.

The Opportunities:

- **Risk profiling** - Using risk profiling to ensure that commissioners understand the needs of their population and manage those at risk (e.g. the risk stratification tool).
- **Neighbourhood care teams** - The creation of integrated health and social care teams based around a locality to provide joined up and personalised services.
- **Self care / shared decision making** - There needs to be a transfer of knowledge and power to patients to empower them to maximise self-management and choice.

Recommendations:

- Seek to improve data collection on co-morbidities and analyse data across all long term conditions including capturing hypertension and mental health.
- Adopting an integrated pathway, rather than an organisational response, is key to delivering high quality services that meet the needs of patients/clients.
- Shifting the emphasis of self care towards community and network centered approaches. This may also prove appropriate to engage people in socially and economically deprived contexts.

3. A Health Promoting Workforce: Making Every Contact Count (MECC)

The Challenge:

- More than 50% of premature deaths in western countries are attributable to lifestyle.
- A few minutes of personalised feedback can be as effective as longer interventions.

The Opportunities:

- Brief opportunistic advice usually lasts up to 5 minutes. It involves raising a lifestyle issue with an individual, where appropriate, and signposting them to further information. This can be used by anyone engageing with members of the public alongside their everyday work.

Recommendations:

- All agencies/partners are aware of and adopt the MECC philosophy.
- To maintain a consistent approach to delivery that meets the competency framework and to ensure all MECC work is captured; we recommend that all MECC activity is co-ordinated through the Warwickshire MECC Implementation Group and via this group to the Arden Strategic Group.
- That all organisations within and outside of the NHS, have a Board level commitment to the delivery of MECC and that this is implemented through a local action plan overseen by the implementation lead.
- The use of contractual arrangements to ensure that organisations sign up and deliver the MECC.
- As a basic requirement to be considered competent, as an individual and organisation to deliver MECC, staff should undergo Level 1 NHS Local (e-learning) training.
- Development and securing of additional resources to support the implementation of MECC, through local pilots and match funding commissioning for training where appropriate.

4. The Wider Determinants of Health: Health Impact Assessments

The Challenge:

- Poor health and wellbeing is a result of a variety of factors that people experience throughout their life. Many of these factors are related to people's surroundings and their communities. It is important that the health impacts of such factors are considered when making decisions about care needs.

The Opportunities:

- One way to ensure that health and wellbeing are explicitly considered when making these decisions is for organisations to carry out "Health Impact Assessments".
- Health Impact Assessments (HIAs) consider any proposed change. This could be anything from a new housing development or new policy, and assess what the likely positive and negative consequences for health and wellbeing will be. Recommendations are then made on how to enhance the positive consequences and reduce the negatives.
- Types of developments or changes that may warrant an HIA include: large housing development, major commercial or industrial development, significant changes to the way public services are delivered and significant changes to public infrastructure.
- The six steps of Health Impact Assessment are screening, scoping, assessment, recommend, communicate, evaluate.

Recommendations:

- All public sector organisations, in Warwickshire, commit to carrying out Health Impact Assessments of all new major plans and policies to ensure that the maximum health gain is achieved.
- Health and wellbeing should be included, as core considerations, in every planning and transport policy in Warwickshire and as part of the District and Borough Council's Core Strategies and Neighbourhood Plans.
- Some funding from Community Infrastructure Levies on new developments is used to address local health and wellbeing issues and where necessary carry out more in depth HIAs.
- The Warwickshire Health and Wellbeing Board champions the use of HIAs as a way of addressing the social determinants of health and reducing health inequalities.

Section Three: Annual Review and Health Profile for Warwickshire

"While there are still significant health concerns within Warwickshire as highlighted in the updated Health Profile (Figure 3), major achievements have been made in core areas of public health during the last 12 months."

Health Protection:

- 76,995 people aged 65 and over were immunised against seasonal flu.
- 5,996 one year old babies were fully immunised against serious infection.
- 2,319 girls have been fully immunised against HPV, the virus that causes cervical cancer.
- Well over 95% of all children are fully immunised against serious infection, some of best results in the West Midlands.
- With the Health Protection Agency and Environmental Health colleagues, we managed 78 separate communicable disease outbreaks and environmental incidents.
- We carried out 10,124 NHS Health Checks and found 1,341 people with an undiagnosed chronic health condition.
- We screened 6,024 newborn children for serious genetic disorders.
- We screened over 18,000 people for bowel cancer and detected 261 cancers early.
- We screened 18,208 diabetics for eye disease.
- We launched a new screening programme to detect abdominal aortic aneurysms, in men aged 65, and have screened more than 630 men to date.
- We treated 23,941 people in sexual health services.
- We reduced teenage pregnancies by 6% compared to the previous year.
- We led the work to agree the building of a sexual assault referral centre at George Eliot Hospital.

Health Improvement:

- We helped 3,646 people quit smoking.
- We treated 2,015 people for alcohol and drug misuse.
- We jointly, with district colleagues, funded £40,000 worth of grants to community groups to improve health in Warwick and Stratford.
- We were awarded £70,000 to develop a mobile phone app to help young people access services and improve their sexual health.
- We successfully bid for £68,000 from the Department of Health to reduce fuel poverty.
- "Sorted!" our programme to improve the mental health of young people won the Innovation in Public Health category at the West Midland Public Health Conference.
- We weighed and measured over 11,000 children as part of the National Child Measurement Programme.
- A total of 635 referrals have been made to the Exercise Referral programme since May 2011.
- A total of 532 families, of primary school age children, took up the family Change4life service (around weight management).

Wider Determinants and Population Health

- We launched the updated Warwickshire Joint Strategic Needs Assessment (JSNA) www.warwickshire.gov.uk/jsna.
- We helped establish the Warwickshire Health and Wellbeing Board and launched the Warwickshire Health and Wellbeing Strategy consultation.
- We worked with Warwickshire Road Safety Partnership and GPs to develop an 'in car safety' pack around child car seats. It will be distributed to 7,000 Warwickshire new parents.
- We liaise with other Responsible Authorities, across the County, to understand partners positions on licensing decisions, making representations against license applications where appropriate.
- Public Health are working with District and Borough partners on agreeing Supplementary Planning Guidance around healthy urban and rural planning.
- Together with Warwickshire Country Parks we are exploring the development of 'trim trails'.
- Warwickshire's 'Books on Prescription' scheme is being developed to include books for people with dementia and their carers. These texts will be available from Autumn 2012.
- We are working with partners in the Districts/Boroughs to encourage them to include measured miles and Green Gyms as part of their planning process.
- We continue to advise the three emerging Warwickshire Clinical Commissioning Groups on Public Health issues and work closely with the five District and Borough Councils.
- Public Health Warwickshire has successfully moved offices from NHS Warwickshire to Warwickshire County Council.

Figure 3: Health Profile for Warwickshire

Domain	Indicator	Warwickshire 2012	England 2012	Trend	Variation across Districts	Data
Communities	Deprivation	5.6	19.8	→	0.0-18.4	% living in deprivation
	Children in poverty	15.0	21.9	↑	10.7-20.9	%
	Statutory homelessness	1.6	2.0	↑	0.8-2.1	Rate per 1,000 households
	GCSE achieved (5A*-C inc Eng & Maths)	60.5	58.4	↑	49.1-70.0	%
	Violent crime	10.0	14.8	↓	7-14.5	Rate per 1,000
	Long term unemployment	3.3	5.7	n/a	1.7-5.1	Rate per 1,000
Children's and young people	Smoking in pregnancy	16.7	13.7	↑	n/a	%
	Breast feeding initiation	71.6	74.5	↓	n/a	%
	Obese children (Year 6)	16.2	19.0	↑	13.9-19.5	%
	Alcohol-specific hospital stays (under 18)	63.9	61.8	n/a	44.1-82.1	Rate per 100,000
	Teenage pregnancy (under 18)	36.0	38.1	→	23.7-48.8	Rate per 1,000
Adult's health and lifestyle	Adults smoking	19.3	20.7		15.5-22.4	%
	Increasing & higher risk drinking	23.3	22.3	n/a	22.1-24.0	%
	Healthy eating adults	28.2	28.7	→	22.6-32.6	%
	Physically active adults	10.6	11.2	↓	9.5-13.3	%
	Obese adults	25.5	24.2	→	21.4-29.8	%
Disease and poor health	Incidence of malignant melanoma	13.1	13.6	→	6.7-17.0	Rate per 100,000
	Hospital stays for self-harm	189.3	212.0	n/a	120.1-257.2	Rate per 100,000
	Hospital stays for alcohol related harm	1,693	1,895	↑	1519-1935	Rate per 100,000
	Drug misuse	6.0	8.9	n/a	3.2-8.4	Rate per 1,000
	People diagnosed with diabetes	5.2	5.5	↑	4.6-6.3	%
	New cases of tuberculosis	9.7	15.3	→	3.4-18.2	Rate per 100,000
	Acute sexually transmitted infections	664	775	n/a	445-862	Rate per 100,000
	Hip fracture in over-65s	465	452	→	413-555	Rate per 100,000
Life expectancy and causes of death	Excess winter deaths	17.9	18.7	→	14.2-24.5	Ratio
	Life expectancy – male	79.1	78.6	↑	77.5-80.4	Years at birth
	Life expectancy – female	83.0	82.6	↑	81.9-84.3	Years at birth
	Infant deaths	5.0	4.6	↑	2.8-6.4	Rate per 1,000
	Smoking related deaths	178	211	→	146-226	Rate per 100,000
	Early deaths: heart disease & stroke	57.5	67.3	↓	41.9-75.5	Rate per 100,000
	Early deaths: cancer	101.6	110.1	→	95.2-111.5	Rate per 100,000
	Road injuries and deaths	59.6	44.3	↓	39.9-89.4	Rate per 100,000
Health Protection	Chlamydia	218.8	351.4	↓	139.5-298.7	Rate per 100,000
	Gonorrhoea	27.6	39.1	↑	7.6-60.5	Rate per 100,000
	Syphilis	3.3	5.4	→	0.8-5.3	Rate per 100,000
	Herpes	61.5	58.1	↑	41.2-73.7	Rate per 100,000
	Warts	134.1	141.8	↓	98.6-159.6	Rate per 100,000
	Flu vaccinations in over 65s	74.6	n/a	↑	59.6-89.9	%

Source: APHO Health Profiles and Health Protection Agency
More detailed indicator notes see references and key documents

Finances

Many of the achievements, of the last 12 months, have been made possible through services directly commissioned from the public health budget.

The overall Public Health budget for 2012/13 is £37 million. In April 2013, almost £20 million of this money will move with Public Health to Warwickshire County Council. Other Public Health budgets will transfer to the NHS Commissioning Board (NHSCB), Public Health England (PHE) and Clinical Commissioning Groups (CCGs).

The estimated spends by CCGs based on 2012/13 allocations are:

Figure 4: Public Health Spending 2012/13, Budget Breakdown by CCG

	Warwickshire North	Coventry & Rugby (excluding Coventry)	South Warwickshire
Total Spend	£7,012,258	£3,485,556	£9,451,944
Estimated spend per head of pop	£37.44	£34.82	£36.85

Source: Public Health and PCT Finance 2012

Figure 5 shows the priority investment of £4.7 million from a health improvement perspective.
The programmes will be funded over a number of years in order to ensure improvements in longer term health outcomes. All of these programmes are being delivered with partners and are available in local communities across Warwickshire.

Figure 5: Priority Investment for Public Health across Warwickshire as at 2012/13

Investment Area	Funding 2012/13
Smoking cessation; Smoking in pregnancy	£105,000
Reinstating growth programme including (MECC)	£150,000
Improving/tracking data and patient impact	£20,000
Contingency for over performance	£25,000
Tobacco Control	£75,000
DAAT allocation for 2013	£2,970,000
Sexual Assault Referral Centre	£50,000
Affordable Warmth	£60,000
Health checks	£320,500
Weight Management	£445,000
Health visitors/ Family Nurse Partnership	£495,000
Total	**£4,715,500**

Source: Public Health and PCT Finance 2012

The spend for health improvement programmes reflects the inequalities across the county, for example we will spend more in areas where there are greater needs for services than in other areas. Some programmes will focus on specific areas of the county such as the Health Check Programme which has screened over 10,000 otherwise healthy people, and found for example 688 people with high blood pressure. Other programmes such as Smoking Cessation is a universal service across Warwickshire. Figure 6 illustrates how much we spend annually on helping people to give up smoking, which remains our number one cause of mortality.

Figure 6: Warwickshire Smoking Cessation Services, Budget Breakdown by District

	North Warwickshire	Nuneaton & Bedworth	Rugby	Stratford	Warwick	TOTAL
Total Spend	£82,950.00	£193,520.00	£131,991.00	£147,010.00	£155,015.00	£710,486.00
Estimated spend per head of population (2010/11)	£1.34	£1.54	£1.32	£1.22	£1.14	£1.31

Source: Warwickshire Smoking Cessation Service, 2012 Notes: Figures given for the Central Service and Stop Smoking in Pregnancy Service are estimates Payments to Service Providers are by case

Section Four: Long Term Conditions

Long term conditions are medical conditions that cannot, at present, be cured but can be controlled by medication and other treatments.

Examples of common long term conditions in Warwickshire include high blood pressure, diabetes, asthma, heart disease and chronic obstructive pulmonary disease. People live with these conditions for many years, often decades, and they can impact on their quality of life by causing disability, loss of independence and early death.

Why are Long Term Conditions Important?

In Warwickshire we estimate that about 1 in 3 people, aged over 16, live with a long term condition, an estimated 147,000 people.

People with long term conditions are more likely to see their GP, be admitted to hospital, stay in hospital longer, and need more help to look after themselves than people without long term conditions. Some people have more than one long term condition which increases the impact on their overall quality of life (Section 5). However, we know that giving people the best care and helping them to take control and manage their own condition, with the help of health services, we can improve people's quality of life, reduce their need for health services and reduce the number who die early as a result of their condition.

Early Intervention

People can have long term conditions, such as high blood pressure or diabetes, for many years and not have any symptoms. This means that whilst they think they are healthy, the condition is not being treated and causing damage. For these conditions, it is important that we take appropriate opportunities to test people, ensuring that we diagnose them.

Case Study: NHS Health Checks

People, between the ages of 40 and 74, are invited every five years to have their blood pressure, cholesterol, blood sugar and kidney function checked. People are also asked about smoking, alcohol use and exercise.

Health checks are only available, at the moment, in North Warwickshire and Nuneaton. We want to be able to roll this out to everyone in Warwickshire. This year through NHS Health Checks:

- 10,124 otherwise healthy people were screened
- 668 had high blood pressure
- 213 people were found to have diabetes
- 114 people had chronic kidney disease
- 51 people had heart disease
- 31 people had an abnormal heart rhythm

Figure 7 shows the ratio of reported to expected prevalence for a number of long-terms conditions for each of the Clinical Commissioning Groups (CCGs) across Warwickshire. A more detailed breakdown is given in Appendix 3.

Ratios are lower for conditions including heart failure, chronic kidney disease, hypertension and chronic obstructive pulmonary disorder. Where ratios are lower, it could be interpreted that there is a lower than expected underlying risk, ineffective case finding, effective prevention of incidence or coding issues.

Conversely, if the ratio is high, it could be interpreted that there is a higher than expected underlying risk, effective case finding, ineffective prevention of incidence or coding issues. Ratios in Warwickshire are highest for epilepsy and stroke.

There is some variation in terms of the ratios across Warwickshire's CCGs for each of the long-term conditions but this is particularly pronounced in terms of diabetes.

Figure 7: Ratio of Reported to Expected Prevalence by Clinical Commissioning Group (CCG)

Long-Term Condition	Rugby (excluding Coventry) CCG	South Warwickshire CCG	Warwickshire North CCG	Warwickshire	West Midlands Region	England
Coronary Heart Disease	0.78	0.81	0.74	0.78	0.74	0.80
Stoke & TIA	0.86	0.93	0.80	0.87	0.82	0.85
Hypertension	0.58	0.58	0.59	0.58	0.57	0.55
Diabetes (Aged >=17)	0.81	0.68	0.92	0.78	0.95	0.88
Chronic Obstructive Pulmonary Disorder	0.61	0.57	0.67	0.61	0.47	0.52
Epilepsy (Aged >=18)	0.98	0.80	0.93	0.87	0.95	0.87
Asthma	0.71	0.71	0.67	0.70	0.67	0.64
Heart Failure	0.47	0.47	0.55	0.50	0.54	0.51
Chronic Kidney Disease (Aged >=18)	0.42	0.44	0.50	0.46	0.48	0.47

Source: NHS Comparators (more detail in Appendix 3)

N.B. A ratio of less than 1 indicates that the expected count is higher than the reported count and a ratio of more than 1 indicates that the reported count is higher than the expected count.

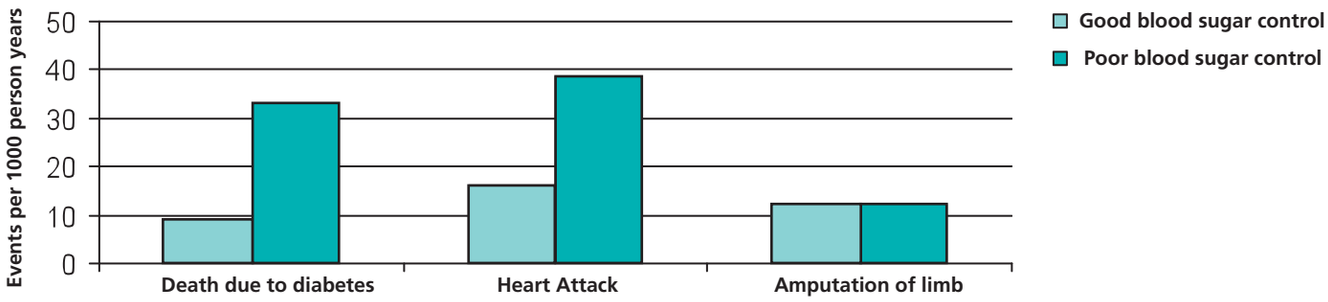
Giving People the Best Treatment

We know that excellent management can reduce the complications from long term conditions and help to keep people healthier and independent for longer.

Good control and treatment, over many years, can make real differences to people's health and wellbeing. For example, we know that people with diabetes who have very good blood sugar control are at less than half the risk of having a heart attack compared to people with poor blood sugar control (Figure 8).

In Warwickshire:
- 1 in 6 adults are diagnosed with high blood pressure.
- 1 in 19 adults have a diabetes diagnosis.
- 1 in 23 adults are recognised as having heart disease.

Figure 8: Comparison of Good and Poor Blood Sugar Control of events per 1,000 person years



Source: http://www.bmj.com/content/321/7258/405.pdf%2Bhtml

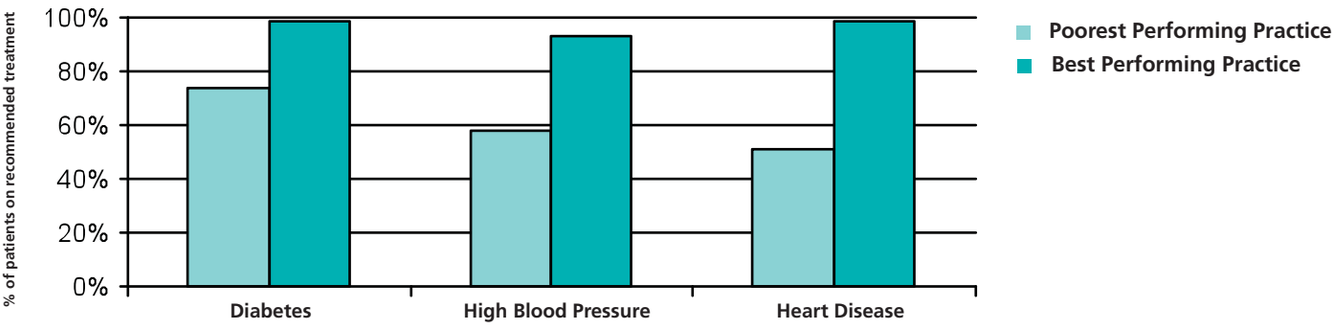
The NHS can, and overall does, help people maintain a good level of control of their conditions. Many people have excellent control; however, care differs depending on where people are looked after. For example, there is a large variation between the outcomes for patients at different GP surgeries across Warwickshire. Some surgeries manage to treat almost all their patients to the recommended level for certain long term conditions. However, some surgeries struggle to achieve this high level of performance. Overall, in Warwickshire, we have thousands of people with common long term conditions who are not receiving the recommended treatment. In some cases, this can be because patients are not following the prescribed treatments or the condition is difficult to control, but sometimes it may be because the NHS needs to do more to help people manage their condition better.

Figure 9: Patients with Long Term Conditions in Warwickshire by recommended treatment level

	People with Condition in Warwickshire	People not treated to recommended level	% not treated to recommended level
High Blood Pressure	79,297	16,422	21%
Diabetes	22,190	3,157	14%
CHD on beta blocker	17,993	5,667	31%

Source: Quality & Outcomes Framework (QOF) 2010/11

Figure 10: Variation in the percentage of patients on recommended treatment for three long term conditions by best and poorest performing practice in Warwickshire



Source: QOF 2010/11

Helping People Adjust and Recover

Being diagnosed with a long term condition can be daunting to deal with. The evidence shows, that taking the time to teach people about their condition makes big differences to how well people can control their condition. For example, people that take part in "expert patient programmes" to teach them about their condition are more likely to be able to manage their condition better and have better outcomes.

Case Study:

DESMOND (Diabetes Education and Self Management for Ongoing and Diagnosed) Programme

People with diabetes that attend the DESMOND education programme:

- Have lower blood sugar levels.
- Lose more weight.
- Better understand their condition and how to manage it.
- Have lower blood pressure.
- Are less likely to need medication.

Helping people recover after a period of illness or injury can also dramatically improve their recovery, reduce the likelihood of getting ill again and improve their ability to look after themselves. For example, after a heart attack having a period of cardiac rehabilitation can reduce death rates by more than a quarter compared to people that do not take part in rehabilitation programme. In Warwickshire, we currently have only a small number of rehabilitation programmes:

Recommendations

- Roll out NHS Health Checks out across the whole of Warwickshire.
- Improve the clinical indicators and outcomes for people with long term conditions and reduce the variation in outcomes between GP practices.
- Ensure that the treatments, being given to patients with long term conditions, are as good as recommended levels for all general practices in Warwickshire.
- Increase the availability of expert patient and rehabilitation programmes.
- Improve the coordination of services for people with several different long term conditions.
- Increase the availability of services to help with mental wellbeing in people with long term conditions.

Living with multiple conditions is the norm rather than the exception for many people.

Multi-morbidity is associated with poorer quality of life, higher hospital admissions and mortality. Health services in particular, are largely organised to provide care for single diseases.

As people get older they are more likely to develop a long term condition and to experience multi-morbidity, the numbers therefore are expected to increase significantly over the next two decades. Many people with long term physical health conditions also have mental health problems.

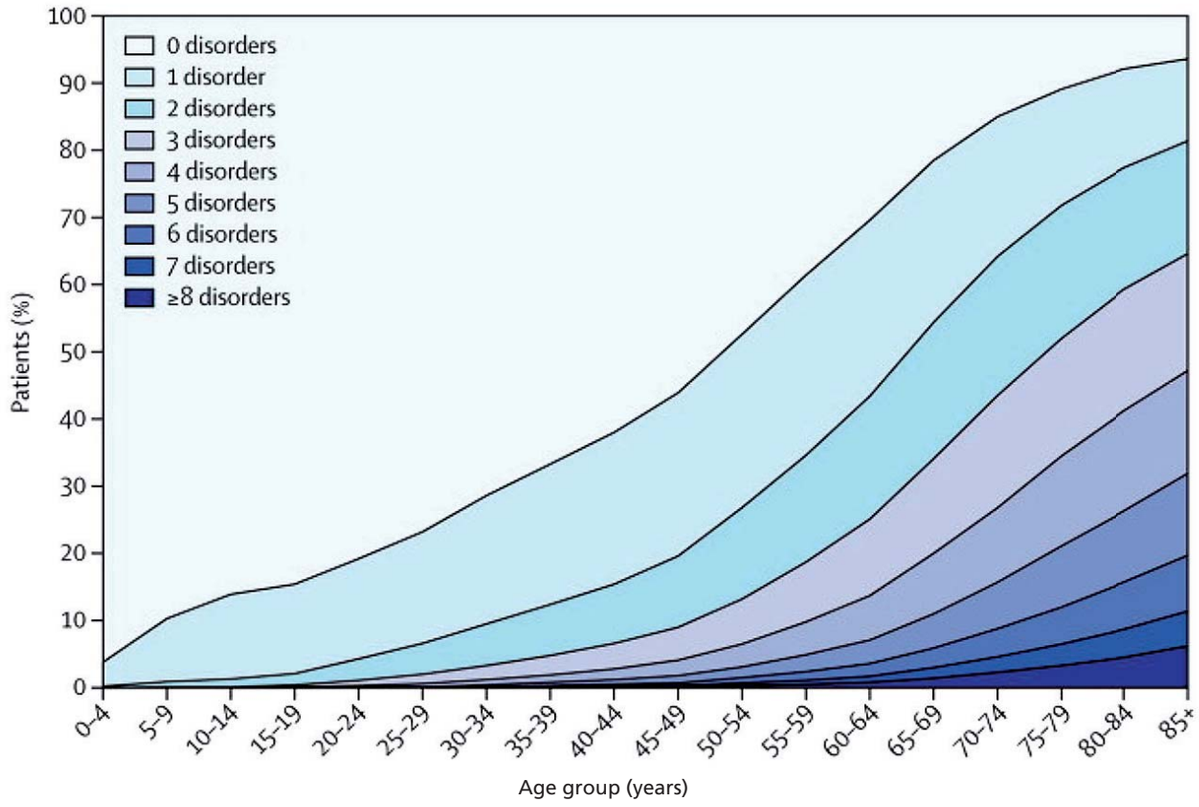
Co-morbidity or multi-morbidity is the presence of two or more long term conditions.

Management of the increasing prevalence of long term conditions is a major challenge for health and social care systems. As people develop more than one chronic condition, their care becomes disproportionately more complex and difficult for them and/or the health and social care system to manage. Multi-morbidity is associated with poorer quality of life, more hospital admissions and higher mortality. This in turn leads to an increase in costs for care. Services and particularly health services, are largely organised to provide care for single diseases. An integrated pathway rather than an organisational response is key to delivering high quality services that meet the needs of patients/clients.

The invisible epidemic?

Multi-morbidity is important because it is the norm rather than the exception. Some of the most recent research suggests that over 42% of the population have one or more long term condition and that more people (23%) have two or more than have only one (Figure 11). This is higher than previously thought (1 in 3).

Figure 11: Number of Chronic Disorders by Age Group, Scotland



Source: The Scottish School of Primary Care, Multi-morbidity in Scotland, Barnett et: http://press.thelancet.com/morbidity.pdf

Case Study: Warwickshire Risk Stratification Tool Analysis

In Warwickshire, while data is available on both predicted and actual prevalence of individual disease groups (Appendices 2 and 3), data is not available on multi-morbidities across all long term conditions. Data is, however, available through the risk stratification tool, on five of the most common long term conditions (diabetes, COPD, CHD, Chronic Heart Failure and Asthma). Data is currently extracted from 59 practices across Warwickshire to identify patients at risk from admission to hospital. This data, is limited and is currently being updated. However, it illustrates some of the patterns in multi-morbidity across the County and many of the trends and patterns identified in the Scottish research are also reflected in Warwickshire.

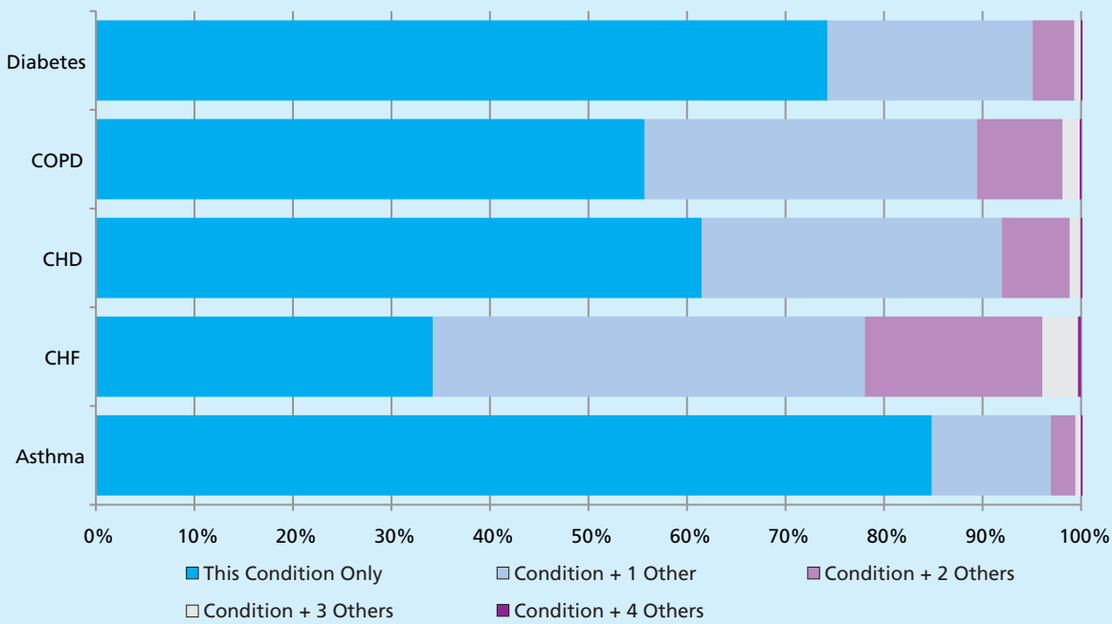
Warwickshire data collated on five of the most common long term conditions from the 59 out of the 76 practices shows there are 58,429 people in Warwickshire diagnosed with one or more of the following long-term conditions; asthma, chronic obstructive pulmonary disorder, coronary heart disease, chronic heart failure and diabetes. 49,362 people (84.5%) are diagnosed with a single condition, with 9,067 (15.5%) having two or more long-term conditions. The data calculates 2.4% of patients, aged over 16, in Warwickshire have two or more conditions. Patients with Chronic Heart Failure are more likely to have two or more conditions, although in absolute numbers there are more patients with CHD and diabetes who have multi-morbidities.

The most commonly diagnosed long-term condition in Warwickshire is asthma. Asthma patients were the least likely to be diagnosed with an additional disease – only 15% also had a further long-term condition. This is in contrast to heart failure patients, where nearly two thirds were living with an additional long-term condition, and over 20% had two or more further conditions.

Figure 12: Long-Term Conditions in Warwickshire, March 2012

Number of Long-Term Conditions	Number of Patients	Proportion of Total Patients
1	49,362	84.5%
2	7,673	13.1%
3	1,222	2.1%
4	162	0.3%
5	10	0.0%
Total	58,429	100.0%

Figure 13: Proportion of patients with one or more long term condition, by condition, Warwickshire, March 2012



Note: Risk Stratification Tool includes the following Long-Term Conditions only: Asthma, Chronic Obstructive Pulmonary Disorder, Coronary Heart Disease, Chronic Heart Failure and Diabetes.

Source: Risk Stratification Tool, NHS Warwickshire Intelligence Department

Section Five: Multi-morbidity and Maintaining Independence

The number of people in Warwickshire living with one or more long term condition is increasing. One of the main reasons for this is the changing demographics of the population. People are now living longer and over the next 20 years the numbers of people over 75 years of age will more than double. The prevalence of multi-morbidity increases with age. As people get older they are more likely to develop a long term condition or to experience multi-morbidities. In Warwickshire over 75% of the multi-morbidities from the risk stratification data were in people over 65. As a result, their need for health and social care interventions increases significantly and this has implications for the delivery of health and social care. [6,7]

The evidence shows that people living in deprived areas are likely to develop multi-morbidity 10 years before those living in the most affluent areas.

There is a strong relationship between the number of physical conditions that people have and mental health problems, particularly in deprived areas.[10]

Good Mental Health

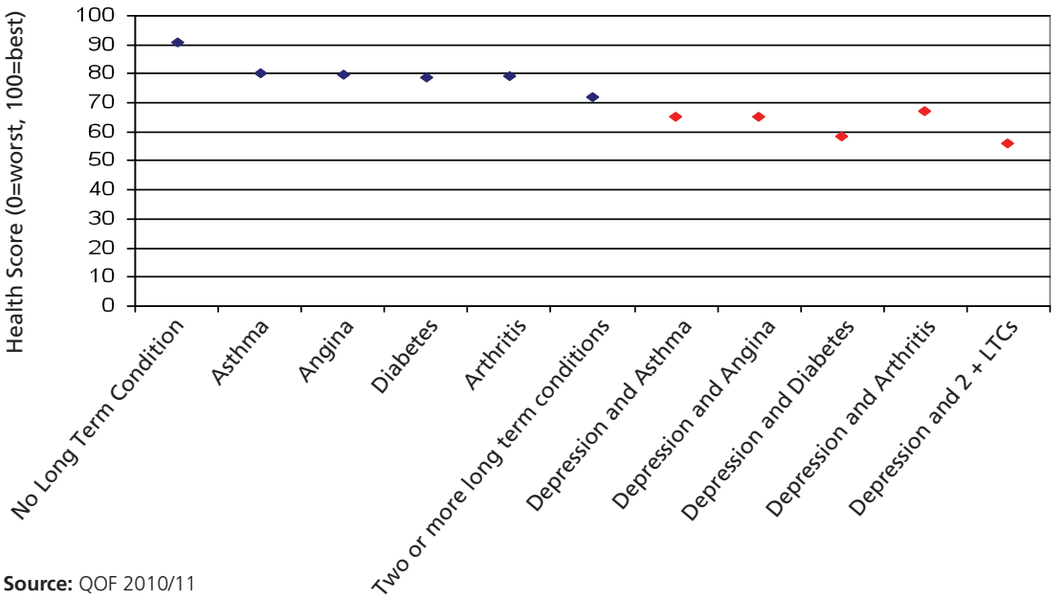
As well as making sure that people with long term conditions get the best treatment and support for their physical health we must also remember the importance of being mentally healthy. Having a long term condition can have serious impacts on people's health, their ability to do things and look after themselves and have unpleasant symptoms that they find distressing. Many long term conditions can lead to the prospect of an early death. These issues can make people feel anxious, stressed or depressed which can severely affect their quality of life.

Case Study: The Improving Access to Psychological Therapy (IAPT)

The IAPT Service, in Warwickshire, is delivered jointly by Coventry and Warwickshire Partnership Trust and Coventry and Warwickshire MIND, and is funded by NHS Warwickshire. Clients are supported to develop their skills to self-manage their condition, and to enhance their psychological resilience. The service provides assessment and access to two levels of intervention. Lower intensity treatments include: computer based Cognitive Behavioural Therapy, stress control courses, low mood groups, telephone and face to face therapy. Higher Intensity Workers provide access to more intensive therapy, including up to 20 sessions of Cognitive Behavioural Therapy. Over 11,000 people have been referred since 2010/11.

People with long-term conditions are two to three times more likely to experience mental health problems than the general population. These are usually conditions such as depression and anxiety. However, because long term conditions are more common in older people, dementia is also common. Mental health problems are particularly common in people with cardiovascular diseases, diabetes, chronic obstructive pulmonary disease (COPD) and musculoskeletal disorders. Cardiovascular patients with depression experience 50% more acute exacerbations per year and have higher mortality rates. Patients with chronic heart failure are eight times more likely to die within 30 months if they have depression. Katon et al (2004) reported that people with diabetes and co-morbid depression have a 36% to 38% increased risk of all-cause mortality over a two-year follow-up period. Co-morbid mental health problems are associated with poorer glycaemic control, more diabetic complications and lower medication adherence.

Figure 14: Management of mental health problems in long term conditions



Source: QOF 2010/11

Poor Co-ordination of Care and Higher Admissions

International evidence shows that people with multi-morbidity experience more problems with the co-ordination of their care and more medical errors.[12]

People with more than one condition are more likely to have emergency and potentially preventable admissions. People in hospitals and institutional care have an increased risk of their condition worsening or secondary conditions taking hold. Currently patients with long-term conditions account for 70% of overall healthcare spending. They are disproportionately higher users of health services representing 50% of GP appointments, 60% of outpatient and A&E attendances and 70% of inpatient bed days. By placing people in hospital we increase the risk of the need for greater intervention from health and social care services following discharge.[14,15]

The LTC Quality, Innovation, Productivity and Prevention (QIPP) workstream seeks to improve clinical outcomes and experience for patients with long term conditions in England.[14] A reference panel agreed a model of care for LTCs based on the following 3 key principles, which are the fundamental features of all best practice LTC care programmes both here and abroad:

- **Risk profiling** - Using risk profiling to ensure that commissioners understand the needs of their population and manage those at risk. This will assist in preventing disease progression and will allow for interventions to be targeted and prioritised (e.g. the risk stratification tool).

- **Neighbourhood care teams** - The creation of integrated health and social care teams based around a locality (or neighbourhood) to provide joined up and personalised services. These generic teams pull in specialist services when necessary, but treat a patient holistically, regardless of their condition(s). This is not to say that in the integrated teams, there will not be a specialist nurse; rather they will be embedded in the team that possess the skills best suited to manageing what will be a majority of their patients; people with multiple conditions. Each patient has a key worker within the team who co-ordinates their care and acts as the point of contact. The benefits are particularly strong where jointly delivered rapid and flexible response services are in place, targeted at older people with mental health needs.[15]

- **Self care / shared decision making** - There needs to be a systematic transfer of knowledge to patients to empower them to maximise self-management and choice. This includes ensuring; that patients engage in shared decision making in order to co-produce a care plan, that both patients and their carers have access to the appropriate information about how to manage their condition and that there is 'no decision about me without me' and that patients are active participants in all decisions about their care. For example, many long-term conditions can be self-managed, particularly through the use of technology, for example, through developing our approach to telecare and telehealth.

Section Five: Multi-morbidity and Maintaining Independence

An element of self management highlighted in several documents including the Scottish Self Management Strategy for Long Term Conditions is the role of improving social capital, particularly through involving the voluntary sector. This view is supported in subsequent research including work by Vassilev et al around social networks, social capital and chronic illness self management, which indicated that social networks play an important part in the management of long term conditions.[17]

Case Study: The joint benefits of physical health and mental health

A client started with the Brunswick Gets Physical programme in October 2010, who had a number of chronic conditions including issues around low self esteem and highly significant confidence challenges. The client attended numerous classes, with one to one emotional support provided, to prompt further development in confidence. He/she has intergrated into group activities well and taken a huge step in participating in a gym on a solo basis. Other positive changes noted are the client's drop of excessive weight, their blood sugar is in a healthy & manageable level (previously at double figures and now stabilised at 6.4) and has become instrumental in the promotion of physical activity to other members in our community.

Integrated Discharge Pathways in Warwickshire

In Warwickshire, work is currently underway to align and integrate appropriate services for all adults who require a supported discharge from hospital. This meets the requirements of the Kings Fund and the Quality, Innovation, Productivity and Prevention (QIPP) Programme.

The programme will establish three pathways of care based on risk and complexity. These pathways will be established to meet the needs of low to moderate complexity, median to high complexity and very complex cases. They will include people who can recuperate/rehabilitate at home or who have night needs and require a different setting, to manage their care, and people who might be subject to continuing healthcare needs if they are not given a full opportunity to recover prior to assessment.

The model for social care has changed emphasis to focus more on prevention, reablement and recovery. Through this approach it is envisaged that there are likely to be fewer older people accessing social care support and for shorter periods. A further key change will be the roll out of personal budgets across the county, initially for new service users. More integrated intermediate care and re-ablement services are planned through joint work on Cutting the Cost of Frailty.

The pathways will combine the health and social care contributions (some examples are given in the case studies on page 17) and will provide the basis of the offer contained within the discharge to assess process.

Case Study: Examples of good practice to support independent living in the community and not a hospital setting

Telehealth/Telecare

There is an increasing demand for care close to home and for it to be case managed in new and innovative ways. The evidence around telehealth is growing. Its success varies depending on a number of factors including the intervention, context, the patients involved and the disease.[18]

Telehealth is the remote monitoring of a patient's medical condition. With modern technology, patients can be monitored in their own homes without having to visit their GP surgery or local hospital. Telecare relates to the combination of equipment, monitoring and response that is needed to make a home a place of safety. It can help individuals maintain independence, increase safety and confidence and support carers alongside traditional healthcare, social care and housing initiatives.

Virtual Wards

The Virtual Ward provides a community-based service using systems, processes and staffing similar to a hospital ward but without the physical building. The average length of stay for a patient on the Virtual Ward is twelve weeks. The Virtual Ward is staffed by a team of nurses who work closely with a patient's own GP and a range of health and social care professionals to improve the quality of life, reduce unplanned hospital admissions, facilitate patients to self-care and provide appropriate end of life care and support personalised self-management plans.

Self Directed Support and Personal Budgets

Self-directed support allows you to have more flexibility and choice in arranging the services you need, for example, who provides them and when they are provided. Warwickshire County Council (WCC) recognise that you are in the best position to know what kind of support will enable you to live as independently as possible. It's your care... and your choice.

Case Study: BoroughCare 24 hour Community Alarm Service

Being able to live independently at home and feeling safe is important for everyone, whether you are an older person, frail, disabled or isolated. This service is for any person living in North Warwickshire and paying Council Tax to North Warwickshire Borough Council (private/rented/owner occupier) who feels vulnerable or at risk.

It is an emergency alarm unit and personal trigger that connects to an existing telephone, linking to the Council's Central Control. Fully trained staff guarantee a rapid response. BoroughCare are on call 24 hours a day, 365 days a year to offer help and advice. Control Centre staff can contact a nominated key holder, call emergency services, send staff to visit or offer other types of assistance. The service is free to those who are 62 or over and there is a modest charge for those younger if they do not qualify for a subsidy due to low income.

For more information contact: 01827 711560 - 24 hours or **communitysupport@northwarks.gov.uk**

Recommendations

- Seek to improve data collection on co-morbidities and analyse data across all long term conditions including capturing hypertension and mental health.
- Adopting an integrated pathway rather than an organisational response is key to delivering high quality services that meet the needs of patients/clients.
- Shifting the emphasis of self-care towards community and network centred approaches, this may also prove appropriate to engage people in socially and economically deprived contexts.[17]

Section Six: A Health Promoting Workforce: Making Every Contact Count

More than 50% of premature deaths in western countries are attributable to lifestyle. Every day there are thousands of contacts between the public sector, business and voluntary sector staff and individuals in Warwickshire.

We need to use these opportunities, where appropriate, to support individuals to consider the possible impact of their lifestyle on their health and be given the opportunity to change.

Making Every Contact Count is a long term strategy that aims to help us create a healthier population and reduce costs.

A few minutes of personalised feedback can be as effective as longer interventions. This is a new way of working but it will make a real difference to the health and wellbeing of the people of Warwickshire.

The 2011 Director of Public Health Annual Report identified 'Making Every Contact Count' (MECC) as a priority for all public health staff, agencies and partners in Warwickshire. MECC is a solid investment that will improve health outcomes and save money in the long term. The report states that "all agencies/partners shall be aware of and adopt the 'Making Every Contact Counts' philosophy where every opportunity to reinforce advice about healthy lifestyles and/or signpost to the relevant services is exercised". This aspiration was restated in the 2012 Warwickshire Public Health Transition Plan.

"This is the Public Health Core offer: that we can improve the health of our population, increasing life expectancy and reducing inequalities by working together, investing in prevention and making every contact count."

The Making Every Contact Counts ambition is focused on ensuring that the promotion of health and wellbeing is embedded in service design and organisational culture. The current expectation is that all NHS organisations will commit to training their front-line staff in delivery of brief opportunistic healthy lifestyle advice – so that every contact has the potential to promote health. In Warwickshire, we have extended our vision beyond the NHS to partner organisations and their staff.

Brief opportunistic advice usually lasts up to 5 minutes. It involves raising a lifestyle issue with an individual, where appropriate, and signposting to further information. This can be used by anyone engageing with members of the public alongside their everyday work. It is an opportunity to dispel myths and give accurate advice.

Size of the problem – What could we achieve through MECC?

Unhealthy lifestyle behaviours create a financial and resource burden on the NHS and society as a whole and generates inequalities in health outcomes.

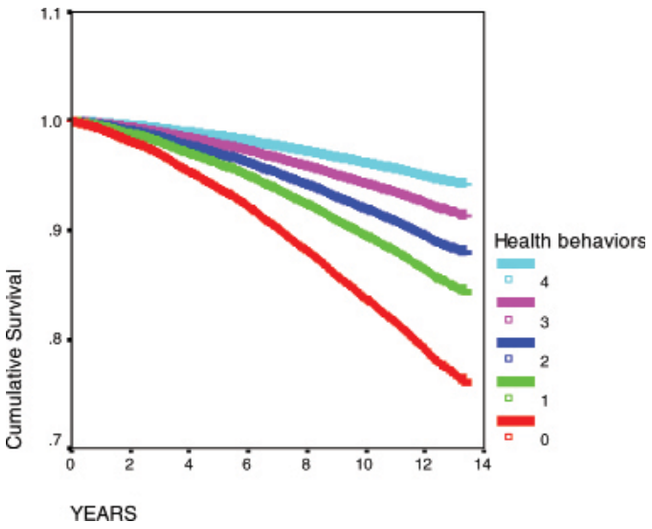
Within Warwickshire:

- **Smoking** – 19% of our population smoke.
- **Alcohol** – 22% are drinking at increasing risk or high risk levels.
- **Obesity** – 26% of adults are obese.
- **Physical Activity** – Only 11% of adults achieve recommended levels of physical activity.
- **Diet** – 28% of adults eat healthily.
- **Mental Health** – An estimated 25% of people will have a mental illness during their lifetime.
- **By District/Borough** – Life expectancy ranges from 77 to 84 years.

Source: Health Profiles 2012

Research by Khaw et al (2008) shows that people who are non-smokers, drink less than 14 units a week, are active and have 5 servings of fruit and vegetables daily, live 14 years longer on average than those who follow none of these healthy behaviours (Figure 15).

Figure 15: Survival in 20,244 healthy adults aged 40-79 by health behaviours



Health Behaviours:
1 Non smoker
2 Alcohol <14 units/wk
3 Not inactive
4 Blood vitamin C >50 mmol/l
(5 servings fruit and veg daily)

Overall impact:
14 year difference in life expectancy

Source: Khaw et al. PLoS Medicine 2008 Jan 8: 5 (1), http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.0050012

Across the NHS, public services and voluntary sectors in Warwickshire, there are over 33,000 staff who collectively have millions of contacts with the public every year.

- If each staff member delivers MECC just 10 times a year, there would be a third of a million opportunities to change behaviour each year.
- If even 1 in 20 of these goes on to make a positive change to their behaviour a total of 16,500 people would be improving their health and wellbeing.
- It is not just service users who could benefit; MECC has the potential to influence staff's own health and wellbeing.

Strong evidence base

- Recommended in national guidance.
- Lord Darzi's work highlighted the need to put prevention first.
- The Marmot Review has an objective to strengthen the role and impact of ill health prevention.
- Healthy Lives, Healthy People: Public Health White Paper emphasises the need for personalised preventive services that are focused on delivering the best health outcomes.
- Liberating the NHS - White Paper emphasising the importance of giving patients access to information which enables them to make their own healthy choices.
- QIPP Framework (2010) recognises the need for transformational change and emphasises quality, innovation, productivity and prevention within the NHS today.

There is a great deal of research which tells us that working in this way makes a difference. The evidence largely relates to specific lifestyle behaviours being delivered by defined clinical staff, in defined clinical circumstances, specifically:

- Smoking
- Physical activity
- Alcohol use
- Sexual health

Evaluating behaviour change is very complex, as it is very difficult to prove that a certain type of strategy was the only influence that helped an individual change their behaviour. However, it has been recognised that a supportive conversation from a frontline worker given consistently and respectfully will encourage reflection and change in up to 20% of patients/clients.[24]

Benefits of MECC - MECC has the potential to deliver better quality at lower cost.

- Patient/service user benefits - Better health and longer, healthier lives for the people of Warwickshire. By providing advice and support for behaviour change, we reduce the causes of cancers and coronary heart disease. These diseases are the biggest killers and are also the cause of years of disability for many people.
- Quality benefits - One of the main principles of the MECC framework is to work with individuals and communities from their perspective. This requires being understanding, responsive and offering advice tailored to circumstances. This is both more effective and will make advice and support services more accessible, and community and patient focused.
- Efficiency benefits - This approach uses the everyday contacts patients have with a range of services. This workforce transformation will be a big step in moving Warwickshire towards the 'fully engaged' scenario described in the Wanless Report as the best way to deliver productivity as well as better health.

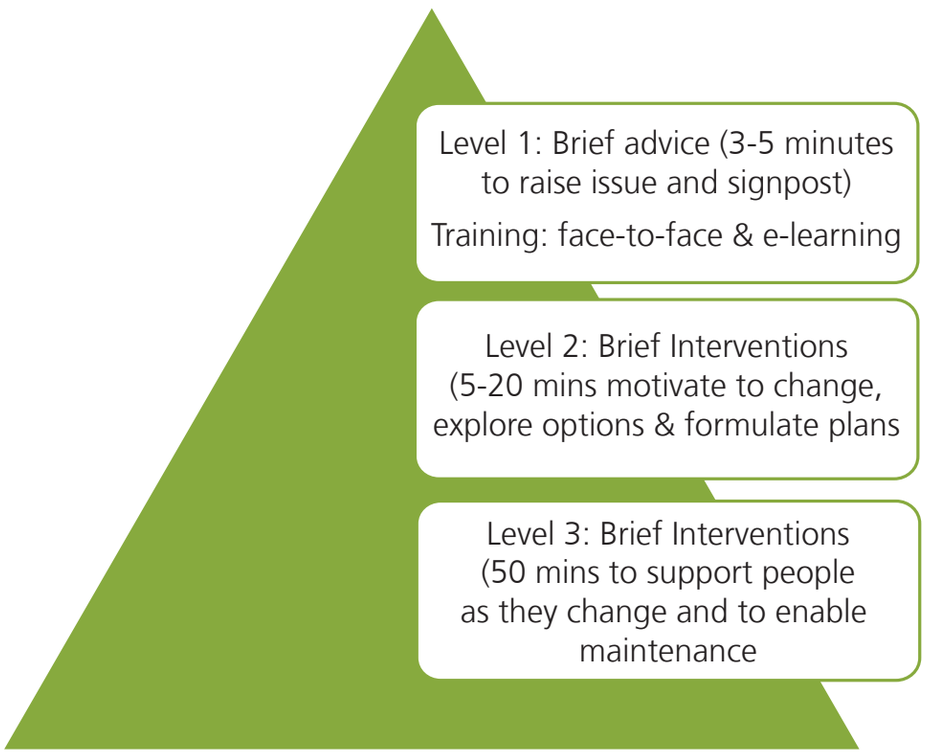
Implementing MECC in Warwickshire

There are four recognised levels of MECC, which are commonly mapped against 4 competency/training levels illustrated in Figure 16.

At its centre, MECC is about all organisations having a health promoting role as part of their core culture. This applies to their staff as well as customers/clients and patients

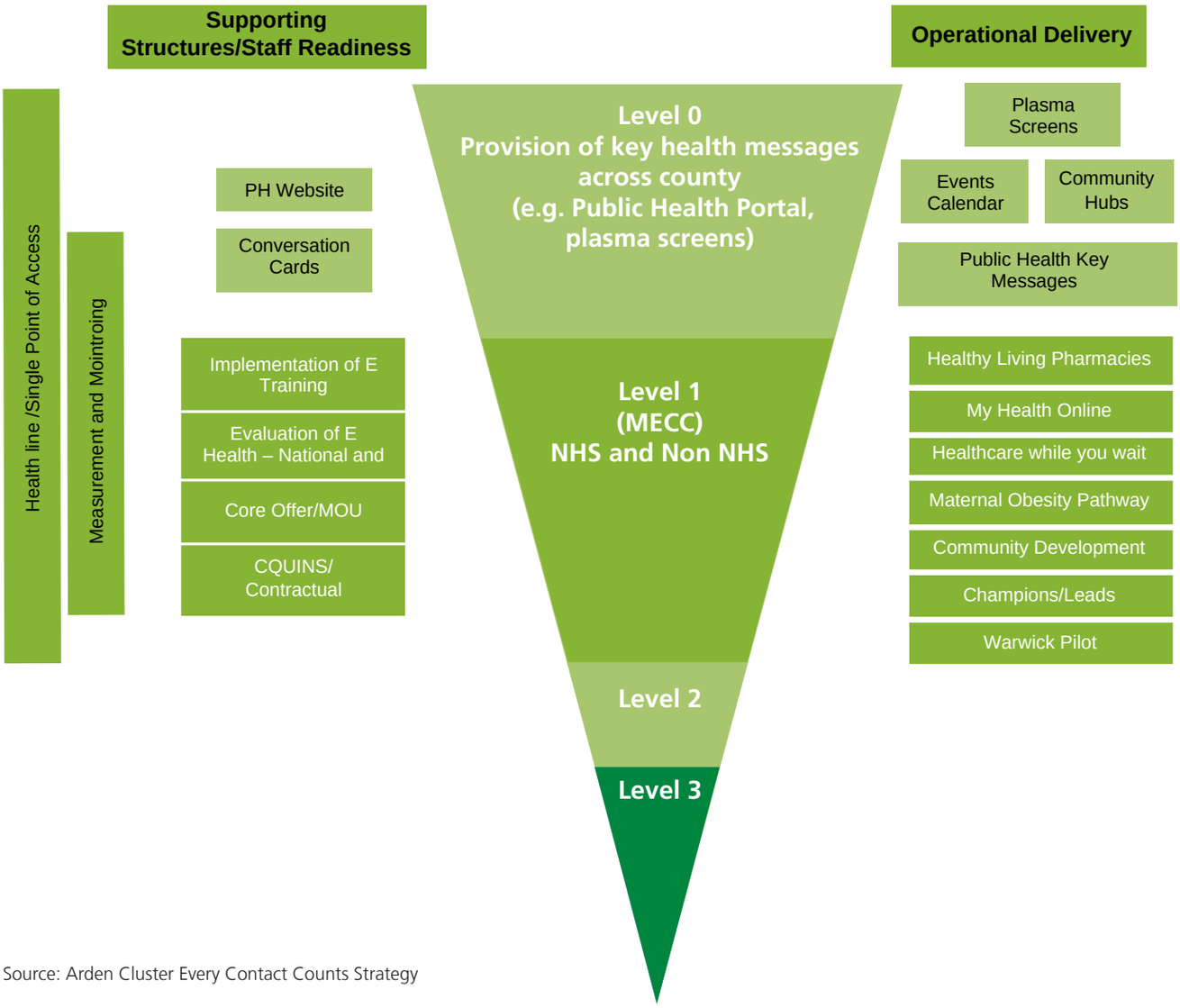
Figure 16: Proposed training levels based on competency

In Warwickshire, we have added Level 0 which is around opportunities which are not face to face, including using technology such as websites, plasma screens and tablets as well as the more traditional leaflets and posters. At this stage, in Warwickshire, we are focusing on implementing Level 0 and Level 1 MECC, and developing the supporting tools required to ensure that this can be achieved. A summary is provided in Figure 17 and the full plan is available in the Arden Strategy and Warwickshire Implementation Plan.



Source: SHA Midlands and East

Figure 17: Delivery of MECC in Warwickshire mapped against competency levels



Source: Arden Cluster Every Contact Counts Strategy

Frontline Workers Role

- Identify lifestyle cues and permission to raise issues.
- Provide opportunistic information (see Key Messages).
- To be enthusiastic about the benefits of change.
- Consider their readiness to change.
- Respond accordingly.
- Signposting to www.warwickshire.gov.uk/publichealth or Warwickshire HealthLine 0300 247 111.

Not your Role

- To approach people directly.
- To give detailed specialist knowledge or prescribe.
- To assist them through a programme or monitor outcomes.
- To act as counsellor / or advise.
- To tell them what to do and set goals for them.
- To talk about your own previous issues.

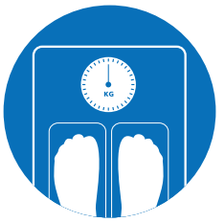
Use the 3 A's to help you:

- Ask
- Assess
- Advise

Key Messages:

Stopping smoking

The single most important thing you can do to improve your health.
You are up to 4 times more likely to quit if you get help from the NHS Stop Smoking Service. To find your local service call 0800 085 2917 or text LIFE to 80800.



Maintain a healthy weight

Maintain, or aim for, a healthy weight (BMI 20-25). Eating a healthy diet - Eat at least 5 portions of fruit & vegetables each day and cut down on fat, salt and added sugar is the most effective way to loose weight if you are overweight or obese.

Being physically active

Adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more, one way to approach this is to do 30 minutes on at least 5 days a week. Exercise is important for everyone in staying healthy and maintaining a healthy weight.

If you drink, keep within sensible limits

If you drink alcohol, have no more than 2-3 units a day (women) or 3-4 units a day (men), with at least 2 alcohol free days per week. You can use this website to calculate your units and keep track of your drinking: http://www.nhs.uk/Livewell/alcohol/Pages/Alcoholtracker.aspx

Look after your sexual health

This means enjoying the sexual activity you want, without causing yourself or anyone else any suffering, or physical or mental harm. Sexual health is not just about avoiding unwanted pregnancy or sexually transmitted infections - but using a condom will help with both.

Mental Health

Manage your stress levels. Talking things through, relaxation and physical activity can help. Have a good work/life balance. Developing interests outside of work can help reduce stress and improve productivity.

Taken from the 12 key Public Health Messages, for full list see pull out poster

Case study: Healthy Living Pharmacies in Warwickshire

The public recognise the pharmacy as a place that provides general advice on leading a healthier lifestyle and take a holistic approach in improving general health and wellbeing. In Warwickshire, we are currently in the first stages of our Healthy Living Pharmacies (HLP) programme and have embedded MECC training into the HLP development framework. The response from staff and patients so far has been extremely positive.

Staff involved in the Warwickshire Healthy Living Pharmacy scheme are required to complete Module 1 Brief Opportunistic Advice MECC Training (www.education.nhslocal.nhs.uk) in order to reach Level 1 accreditation. Public health issues relevant to Level 1 accreditation are smoking cessation, emergency hormonal contraception and chlamydia testing.

"Having completed the every contact counts training I have changed my opinion on the role of pharmacists and the part they play in delivering public health messages. I have always felt uncomfortable discussing intimate lifestyle choices such as eating habits, smoking or sexual health. However having completed this short piece of training I feel equipped with the skills to raise these difficult topics with the patient groups where Brief Opportunistic Advice could make a difference. This is particularly useful for pharmacists delivering medicine use reviews and the new medicine service. I believe that every member of the pharmacy team has a part to play in voicing these important messages"
Warwickshire Pharmacist

Pharmacies from across the county have signed up to participate in the Healthy Living Pharmacy scheme which has been rolled out across Warwickshire since May 2012.

Case Study: Warwick District Housing Pilot

A half day training in Making Every Contact Count was piloted with 16 housing officers in Warwick. The aim of the training was to build on what is offered in the NHS local e-learning tool. This would include giving staff an opportunity to role play before putting the learning into practice. The session also aimed to engage and problem solve around how MECC can be adapted and embedded in the roles of non-NHS staff.

The training included:

- Background to MECC and its importance.
- Why we need to work together on this agenda.
- Practicing raising the issue about healthy lifestyle change.
- Ways to embed MECC in individual job roles.

Feedback from the training was positive and it acted as a useful forum for the generation of ideas that will be used to inform the MECC Implementation Plan and signposting resources. Evaluation questionnaire scores showed improvements in understanding about MECC, confidence to raise the issue and embed MECC; and knowledge about signposting.

Section Six: A Health Promoting Workforce: Making Every Contact Count

Recommendations: All agencies/partners are aware of and adopt the MECC philosophy

Every opportunity and contact with healthcare professionals and other frontline staff, is seen as an opportunity to reinforce advice about healthy lifestyles and/or signpost to the relevant services. It should be part of all routine services.

This includes staff in:

- Primary and Secondary Care
- Primary Care Commissioning (Clinical Commissioning Groups)
- County Council
- District and Borough Councils
- Public Health Professionals
- Schools and Colleges
- Business
- Voluntary Organisations

- That all organisations within and outside of the NHS, have a Board level commitment to delivery of MECC and this is implemented through a local action plan overseen by the implementation lead.

- The use of contractual arrangements to ensure that organisations sign up and deliver the MECC ambition.

- As a basic requirement to be considered competent as an individual and organisation to deliver MECC, staff should undergo Level 1 NHS Local training (Brief Opportunistic Advice). All frontline staff across Warwickshire to be trained in MECC over the next 5 years.

- Include MECC training in induction and mandatory training and in the undergraduate curriculum.

- Develop and secure additional resources to support the implementation of MECC, through local pilots and match funding commissioning for training where appropriate.

- Develop clear pathways into services that provide a holistic response and single point of access.

MECC will help public and voluntary service staff adjust the way we work, to engage and encourage people to make positive changes in their lives. The people of Warwickshire will then have consistent messages, information and support to make positive changes to their lives, whichever service they are in touch with.

Section Seven: The Wider Determinants of Health: Health Impact Assessments

Poor health and wellbeing is a result of a variety of factors that people experience over the course of their life.

Many of these factors are related to people's surroundings and their communities. Factors such as housing, our built environment, transport, education, employment and community cohesion are some of the most important "social determinants of health" (Figure 18).

Healthcare services only contribute about a quarter of the health benefit when compared to some of these other factors (Figure 19). This is why it is important that the health impacts of the factors are considered when making decisions.

People who suffer more negative impacts on their life are often those we think of as more deprived. Deprivation means that people often have fewer life chances and fewer opportunities to lead a flourishing life. They also have worse health. The two are linked: the less favoured people are, socially and economically, the poorer their health. This link between social conditions and health is not a footnote to what some consider the "real" concerns with health, health care and unhealthy behaviours, it should become the main focus. In Warwickshire, the impact of social factors largely contributes to people living 13 years less in some wards in the county than in others (see Figure 20).

Figure 18: The Wider Determinants of Health

These socioeconomic factors are often the responsibilities of local authorities, schools, employers, community and voluntary sector organisations and communities. These factors can have a much greater impact on health and wellbeing than health services do.

Source: Dahlgren and Whitehouse

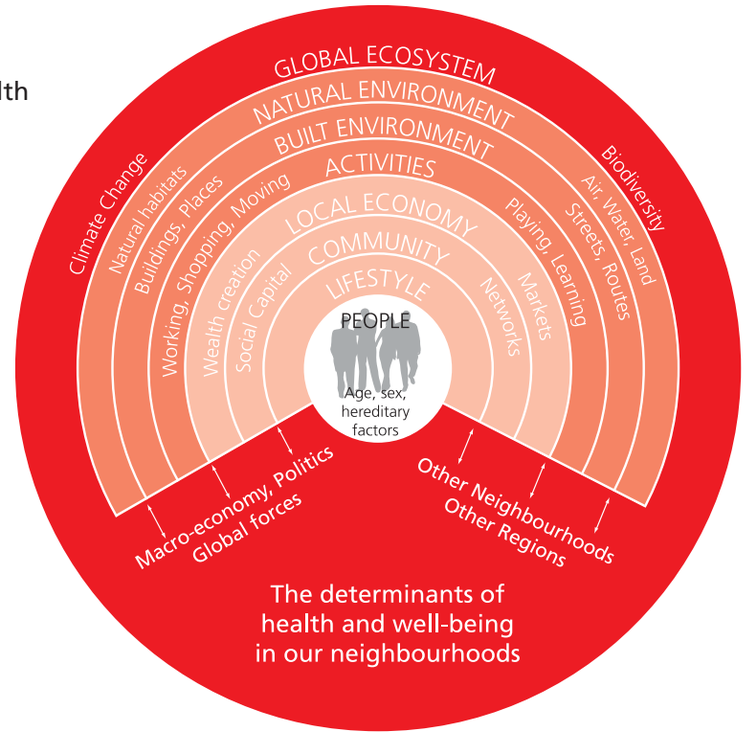
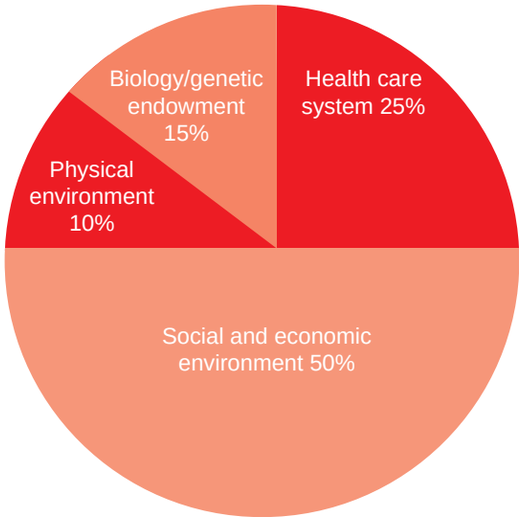
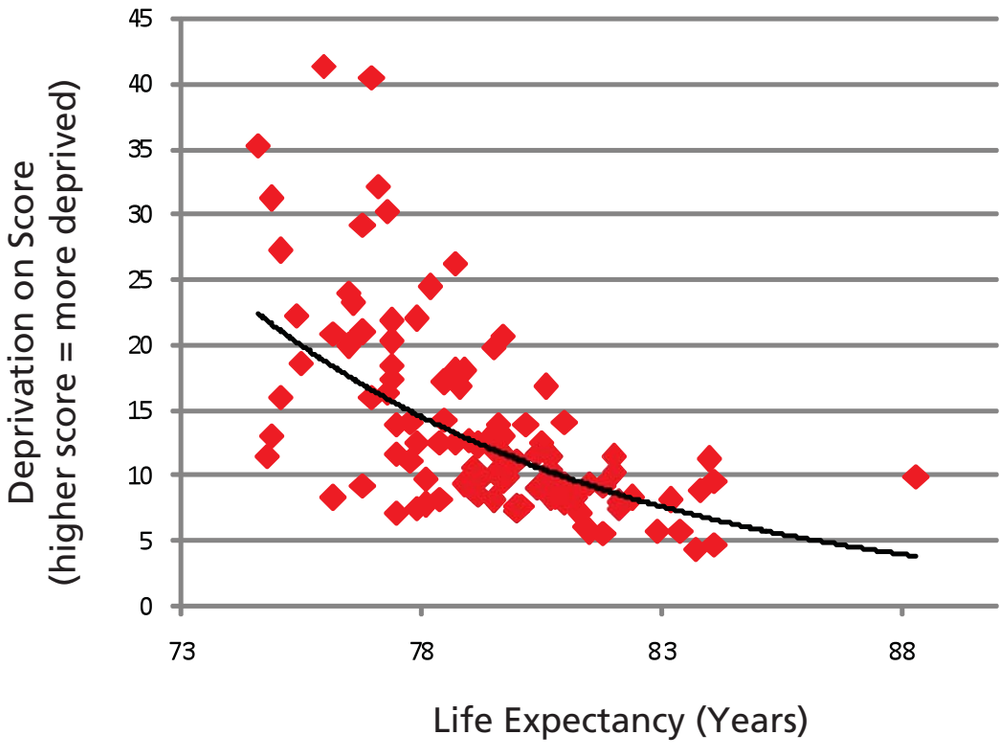


Figure 19: Contributory Factors to Health Benefit



Source: Canadian Institute for Advanced Research, Health Canade, Population and Public Health Branch AB/NWT 2002

Figure 20: Relationships between deprivation and life expectancy in Warwickshire, by Ward



Source: Public Health Warwickshire
Please note each diamond represents a ward

This means that when these factors, which could be public services, buildings, communities and infrastructures, are being planned or changed it is vital their impact on health and wellbeing is fully considered. Ensuring that health and wellbeing are central to decision making within our public organisations is important. They make important decisions about the places we live, how we get from place to place, the environment in which our children are taught and the businesses that prosper.

Community Infrastructure Levy

The Levy allows local authorities in England and Wales to raise funds from developers undertaking new building projects in their area. The money can be used to fund a wide range of infrastructure that is needed as a result of development. This includes new or safer road schemes, flood defences, schools, hospitals and other health and social care facilities, park improvements, green spaces and leisure centres.

Green Spaces

The Marmot Review[20] refers to evidence that well-designed green and open spaces can benefit communities – increasing social contact and social integration, particularly in underprivileged neighbourhoods. People are more likely to be physically active if they live in neighbourhoods with many destinations and where they have a number of reasons for walking including walking to work, for recreation and for other tasks. Prevalence rates for diseases such as diabetes, cancer and depression are lower where there is more green space, and mental health may be particularly affected by the amount of green space.

Case study: Green Therapy

In Warwickshire, 'Measured Miles' have been developed across the county. Outdoor activities are a natural, free and accessible treatment that boosts mental wellbeing – either horticultural and allotment programmes or simple walks in the park:

- Within Nuneaton and Bedworth, 4 way-marked measured miles routes have been commissioned with the aim to train volunteer walk leaders to run 4-5 led walks per week for each locality:
  - Riversley Park
  - Middlemarch
  - George Eliot Hospital
  - Bedworth Miners Park
- North Warwickshire has a measured mile in place in Hurley.
- Warwick District have two measured miles:
  - Victoria Park, Leamington
  - St Nicholas Park, Warwick
- Stratford-on-Avon is planning a measured mile around the recreation ground in Stratford and in Alcester in conjunction with development of a new hospital/health centre.
- Rugby have plans to develop a measured mile in Caldecott Park.

Additionally, Green Gyms are also being planned:
- Stratford-on-Avon – have one green gym in the district and are planning one more.
- Nuneaton and Bedworth have three green gyms in the borough.

Walking for health walks are also available in each district/borough and through Age Uk.
You can find them at www.exercisereferral.org.uk/exercisereferral.

One way to ensure that health and wellbeing are explicitly considered when making these decisions is for organisations to carry out "Health Impact Assessments".

Health Impact Assessments (HIAs) consider the proposed change, this could be anything from a new housing development or new policies, and assesss what the likely positive and negative consequences for health and wellbeing will be. Recommendations are then made on how to enhance the positive consequences and reduce the negatives.

Types of developments or changes that may warrant a Health Impact Assessment include:
- Large housing developments.
- Major commercial or industrial developments.
- Significant changes to the way public services are delivered.
- Significant changes to public infrastructure.
- Changes to local policies where there is a link to the social determinants of health.

The six steps of Health Impact Assessment:

1 Screening: Decide whether a proposal requires assessment by HIA.
2 Scoping: Clarify the questions to be answered by the HIA and how the assessment will be carried out.
3 Assessment: Decide what the health impacts will be and how big by considering each pathway by which the proposal could impact on health.
4 Recommend: For each option make recommendations as to how good health consequences could be enhanced, how bad health consequences could be avoided or minimised, and how health inequities could be reduced.
5 Communicate: Communicate the findings of the HIA to the decision makers.
6 Evaluate: Evaluate the quality of the HIA highlighting lessons for future HIAs. Monitor which proposals and if possible assess whether any predictions made were correct.

Section Seven: The Wider Determinants of Health: Health Impact Assessments

The Public Health Warwickshire Department would encourage and support a requirement for Health Impact Assessments on all major planning proposals and policies. HIAs do not have to take a long time and making changes to plans early on can reap rewards later. The changes to maximise the gain for health and wellbeing often do not cost anything when made at this early stage and can create benefits for years or decades.

In Warwickshire, we think we can start to improve health and wellbeing by addressing specific social inequalities:

- Good quality housing for all.
- Freedom from poverty.
- Smoke free environment.
- Healthy and sustainable communities and places.
- Safer communities.
- High quality schools and education.

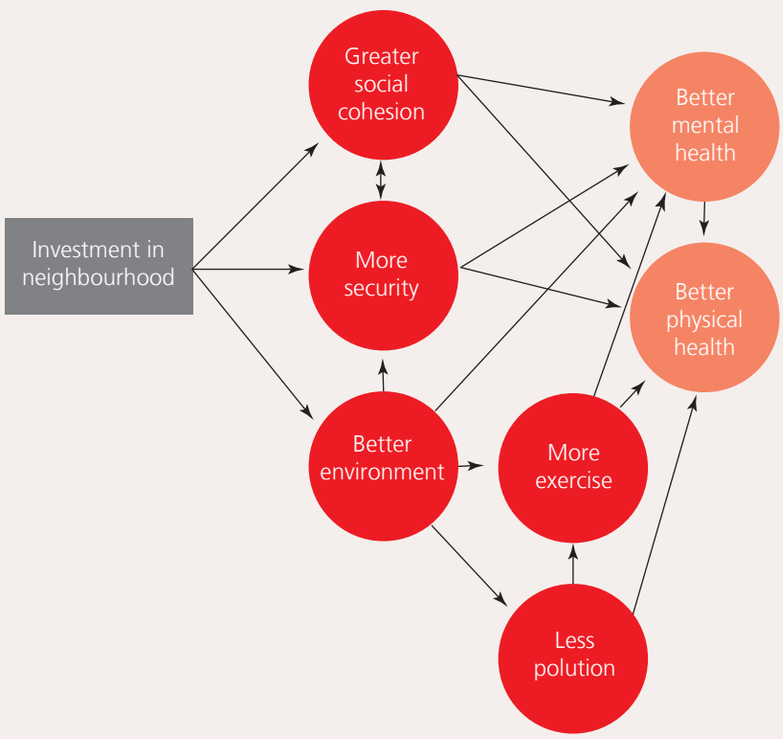
These issues are specifically targeted in the Health and Wellbeing Strategy.

Local Government Assets which influence Health and Wellbeing (both County and District/Borough)

- Environmental Health Powers
- Transport Policy and Regulation
- Housing Stock and Services
- Leisure Services
- Planning Powers
- Environmental Services
- Locally Elected Councillors

Figure 21: Causal Pathways in Health and Wellbeing

Health Impact Assessments draw the links between the causes and effects of factors on health and wellbeing. By doing this we can think about how to improve the root causes of health and wellbeing.



Recommendations

- All public sector organisations in Warwickshire commit to carrying out Health Impact Assessments on all new major plans and policies to ensure that the maximum health gain is achieved including Core Strategies and Neighbourhood Plans.
- Health and wellbeing should be included as core considerations in every planning and transport policy in Warwickshire and as part of the District and Borough Council's Core Strategies and Neighbourhood Plans as part of becoming a health improving local authority.
- Some funding from Community Infrastructure Levies on new developments are used to address local health and wellbeing issues and where necessary carry out more in depth Health Impact Assessments.
- Organisations contact the Warwickshire Public Health department to discuss how to take forward a Health Impact Assessment.
- The Warwickshire Health and Wellbeing Board champions the use of Health Impact Assessments as a way of addressing the social determinants of health and reducing health inequalities.

Appendices

Appendix 1: Full Details of Sources for Figure 2

[1] Modelled estimates of prevalence (%) Association of Public Health Observatories (APHO) applied to 2011 Census resident population estimates.
[2] NHS Direct, Asthma UK.
[3] NHS Direct.
[4] NCHOD.
[5] Diabetes Prevalence Model, (persons aged 16+), 2012 estimates, APHO.
[6] NEOERICA Study Estimates (persons aged 18+ years.
[7] Coronary Heart Disease Register, QOF 2010/11.
[8] Stroke or Transient Ischemic Attacks (TIA) Register, Quality and Outcomes Framework (QOF) 2010/11.
[9] Hypertension Register, QOF 2010/11.
[10] Diabetes Mellitus (Diabetes) Register (ages 17+), QOF 2010/11.
[11] Chronic Obstructive Pulmonary Disease Register, QOF 2010/11.
[12] Asthma Register, QOF 2010/11.
[13] Epilepsy Register (ages 18+), QOF 2010/11.
[14] Cancer Register.
[15] Hypothyroidism Register.
[16] Chronic Kidney Disease Register (ages 18+), QOF 2010/11.
[17] Evolve, NHS Warwickshire.
[18] Public Health Mortality Files, Office for National Statistics.

Appendix 2: Disease Prevalence - Actual v Estimated

Warwickshire PCT Actual vs. Expected Disease Prevalence			
Condition	**Actual Count**	**Expected Count**	**Difference**
Coronary Heart Disease	18,033	23,067	-5,034
Stroke and Transient Ischemic Attack	9,071	10,402	-1,331
Hypertension	77,721	133,791	-56,070
Diabetes (ages 17+)	21,033	26,903	-5,870
Chronic Obstructive Pulmonary Disease	7,527	12,308	-4,781
Epilepsy (ages 18+)	3,344	3,841	-497
Hypothyroidism	17,301	11,217	6,084
Cancer	7,235	4,398	2,837
Asthma	34,752	49,904	-15,152
Heart Failure	4,182	8,444	-4,262
Palliative care	366	5,685	-5,319
Dementia	2,489	6,386	-3,897
Chronic Kidney Disease (ages 18+)	18,194	39,938	-21,744
Obesity (ages 16+)	38,471	103,497	-65,026
Depression (ages 18+)	40,675	36,478	4,197

Source: NHS Comparators

N.B. Actual Counts have been taken from the Quality and Outcomes Framework (QOF) Disease Registers. Expected prevalence data for 2008/09 are derived using expected prevalence rates provided by the Eastern Region Public Health Observatory (ERPHO) which take account of age, sex, ethnicity, smoking status and deprivation score at practice level. Modelled estimates are published on the Association of Public Health Observatories (APHO) website. http://www.apho.org.uk/resource/item.aspx?RID=77180

Practice Level data is provided on the website www.warwickshire.gov.uk/publichealth and on www.warwickshire.gov.uk/jsna.

Appendix 3: Disease Prevalence - Actual v Estimated by Clinical Commissioning Group (CCG)
Actual vs. Expected Disease Prevalence by Clinical Commissioning Group (CCG), 2008/09

Long-Term Condition		Rugby (excluding Coventry) CCG	South Warwickshire CCG	Warwickshire North CCG	Warwickshire	West Midlands Region	England
Coronary Heart Disease	Reported Count	2,989	8,828	6,216	18,033	203,504	1,886,406
	Expected Count	3,821	10,867	8,381	23,069	273,586	2,367,043
	Difference	-832	-2,039	-2,165	-5,036	-70,082	-480,637
	Ratio	**0.78**	**0.81**	**0.74**	**0.78**	**0.74**	**0.80**
Stoke & TIA	Reported Count	1,485	4,721	2,865	9,071	98,675	901,323
	Expected Count	1,726	5,089	3,587	10,402	120,718	1,063,855
	Difference	-241	-368	-722	-1,331	-22,043	-162,532
	Ratio	**0.86**	**0.93**	**0.80**	**0.87**	**0.82**	**0.85**
Hyperten-sion	Reported Count	13,381	37,285	27,055	77,721	812,836	7,132,856
	Expected Count	23,032	64,806	45,957	133,795	1,415,855	13,079,549
	Difference	-9,651	-27,521	-18,902	-56,074	-603,019	-5,946,693
	Ratio	**0.58**	**0.58**	**0.59**	**0.58**	**0.57**	**0.55**
Diabetes	Reported Count >=17	3,654	9,294	8,085	21,033	255,405	2,213,138
	Expected Count >=17	4,533	13,569	8,808	26,910	268,532	2,505,033
	Difference	-879	-4,275	-723	-5,877	-13,127	-291,895
	Ratio	**0.81**	**0.68**	**0.92**	**0.78**	**0.95**	**0.88**
Chronic Obstructive Pulmonary Disorder	Reported Count	1,242	3,188	3,097	7,527	86,902	834,312
	Expected Count	2,049	5,624	4,635	12,308	183,115	1,604,715
	Difference	-807	-2,436	-1,538	-4,781	-96,213	-770,403
	Ratio	**0.61**	**0.57**	**0.67**	**0.61**	**0.47**	**0.52**
Epilepsy	Reported Count >=18	651	1,521	1,172	3,344	37,310	326,841
	Expected Count >=18	664	1,909	1,267	3,840	39,442	373,621
	Difference	-13	-388	-95	-496	-2,132	-46,780
	Ratio	**0.98**	**0.80**	**0.93**	**0.87**	**0.95**	**0.87**
Asthma	Reported Count	6,253	17,407	11,092	34,752	351,333	3,197,726
	Expected Count	8,773	24,459	16,671	49,903	527,976	4,958,717
	Difference	-2,520	-7,052	-5,579	-15,151	-176,643	-1,760,991
	Ratio	**0.71**	**0.71**	**0.67**	**0.70**	**0.67**	**0.64**
Heart Failure	Reported Count	656	2,067	1,459	4,182	45,577	397,040
	Expected Count	1,406	4,362	2,673	8,441	84,395	776,263
	Difference	-750	-2,295	-1,214	-4,259	-38,818	-379,223
	Ratio	**0.47**	**0.47**	**0.55**	**0.50**	**0.54**	**0.51**
Chronic Kidney Disease	Reported Count >=18	2,802	8,984	6,408	18,194	191,987	1,739,443
	Expected Count >=18	6,640	20,433	12,865	39,938	397,315	3,670,504
	Difference	-3,838	-11,449	-6,457	-21,744	-205,328	-1,931,061
	Ratio	**0.42**	**0.44**	**0.50**	**0.46**	**0.48**	**0.47**

Source: NHS Comparators

N.B. A ratio of less than 1 indicates that the expected count is higher than the reported count and a ratio of more than 1 indicates that the reported count is higher than the expected count.
Reported Count data: Count of patients recorded by practice as having condition as reported in QOF data.
Expected Count data: Expected count of patients by practice on the disease register.
Expected prevalence data for 2008/09 are derived using expected prevalence rates provided by the Eastern Region Public Health Observatory (ERPHO) which take account of age, sex, ethnicity, smoking status and deprivation score at practice level. Modelled estimates are published on the Association of Public Health Observatories (APHO) website. http://www.apho.org.uk/resource/item.aspx?RID=77180

References

[1] Stratton IM, Adler AI, Neil HA, Matthews DR, Manley SE, Cull CA, Hadden D, Turner RC, Holman RR Association of glycaemia with macrovascular and microvascular complications of Type 2 diabetes: prospective observational study.. British Medical Journal 2000;321:405-412.

[2] Deakin T, McShane CE, Cade JE, Williams RD. Group based training for self-management strategies in people with type 2 diabetes mellitus. . Cochrane Database Systematic Review 2005 Apr 18;(2):CD003417.

[3] Sign Guidance, 57; Cardiac Rehabilitation, 2002. www.sign.ac.uk/guidelines/fulltext/57/index.

[4] The Lancet http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)60240-2/fulltext
The Scottish School of Primary Care; Mutimorbidity in Scotland.

[5] Director of PH Annual Report 2009/10.

[6] KingsFund http://www.kingsfund.org.uk/topics/longterm_conditions/index.html

[7] Director of Public Health Annual Report 2009/2010.

[8] Kings Fund, Long term conditions and mental health, 2012.

[9] Whooley et al JAMA 2008, 300 (20); 2379-2388 Depressive symptoms, Health Behaviours and Risk of Cardiovascular Events in Patients with CHD.

[10] Katon WJ (2003). 'Clinical and health services relationships between major depression, depressive symptoms, and general medical illness'. Biological Psychiatry, vol 54, no 3, pp 216–26.

[11] Junger J, Schellberg D, Muller-Tasch T, Raupp G, Zugck C, Haunstetter A, Zipfela S, Herzog W, Haass M (2005). 'De pression increasingly predicts mortality in the course of congestive heart failure'. European Journal of Heart Failure, vol 7, no 2, pp 261–7.

[12] Katon JW, Von Korff M, Lin EHB, Simon G, Ludman E, Russo J, Ciehanowski P, Walker E, Bush T (2004). 'The Pathways Study – A randomised trial of collaborative care in patients with diabetes and depression'. Archives of General Psy chiatry, vol 61, no 10, pp 1042–9.

[13] Das-Munshi J, Stewart R, Ismail K, Bebbington PE, Jenkins R, Prince MJ (2007). 'Diabetes, common mental disorders, and disability: Findings from the UK National Psychiatric Morbidity Survey'. Psychosomatic Medicine, vol 69, no 6, pp 543–50.

[14] Department of Health, Long Term Condtions.dh.gov.uk.

[15] Warwickshire Adult Social Care & Health, Supporting Independence (prevention) Strategy, 2011 – 2014 http://www.swft.nhs.uk/our-services/virtual-wards.aspx (virtual Ward ref).

[16] The Scottish Government and Long term Conditions Alliance Scotland, The Self Management Strategy for Long Term Conditions in Scotland, 2008.

[17] Vassilev et al, Social Networks, Social Capital and chronic illness self management: a realist review, Chronic Illness, 2011.

[18] Joint Director of Public Health (2011) 'Reaching Higher: Healthy Lives, Healthy People, Healthy Warwickshire'.

[19] Lord Darzi. High Quality Care for All: NHS Next Stage Review, 2008.

[20] Marmot M, Allen J, Goldblatt P et al. Fair society, healthy lives: the Marmot review – Strategic review of health inequalityes post – 2010. University College London, 2010.

[21] HM Government (2010) Healthy Lives, Health People: our strategy for public health in England. London: TSO.

[22] DH (2010). Equity and Excellence: Liberating the NHS White Paper. London: TSO.

[23] DH (2010). The NHS Quality, Innovation, Productivity and Prevention Challenge: an introduction for Clinicians. London: TSO.

[24] Moyer A, Finney JW, Swearingen CE, Vergun P. Centre for Health Care Evaluation, 2002. Brief interventions for alcohol problems: a meta-analytic review of controlled investigations in treatment-seeking and non-treatment-seeking populations.

[25] NHS Yorkshire and the Humber. Delivering Healthy Ambitions Better for Less: Making Every Contact Count http://www.healthyambitions.co.uk/Uploads/BetterForLess/08%20BETTER%20FOR%20LESS%20every%20contact%20counts.pdf

Joint Director of Public Health

Annual Report **2012**

PO Box 43 - Shire Hall
Public Health Department
Barrack Street
Warwick
CV34 4SX

Telephone: 01926 413 775
Fax: 01926 410 130