Warwickshire Shadow Health and Wellbeing Board

Agenda

19th March 2013

A meeting of the Warwickshire Shadow Health and Wellbeing Board will take place at **Committee Room 2, Shire Hall, Warwick on Tuesday 19th March 2013 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 January 2013 and Matters Arising

Draft minutes are attached for approval.

2. (13.35– 14.05) George Eliot Hospital – Initial Response to the Francis Report

Kevin McGee – Chief Executive of the George Eliot Hospital NHS Trust

3. (14.05 – 14.30) NHS Coventry and Rugby Clinical Commissioning Group Identification of Local Priorities: 'Everyone Counts' planning requirements

Adrian Canale-Parola - NHS Coventry & Rugby CCG

4. (14.30 – 14.50) South Warwickshire CCG – Plan on a Page

David Spraggett – South Warwickshire CCG

5. (14.50 – 15.05) Warwickshire Information Sharing Charter

Andy Morrall – Corporate Information Manager, Warwickshire County Council

6. (15.05 – 15.20) Health and Wellbeing Strategy

Bryan Stoten – Chair of the Warwickshire Shadow Health and Wellbeing Board

7. (15.20 – 15.30) Plans for Commissioning Children's Services

Chris Lewington - Head of Strategic Commissioning

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

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 Kiran Singh, Andrea Green, Dr David Spraggett, Dr Richard Lambert, Dr Adrian Canele-Parola, Dr Jeff Cotterill

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, Councillor Derek Pickard

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

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Minutes of the Meeting of the Shadow Warwickshire Health and Wellbeing Board held on 24 January 2013.

Present:-

Chair

Bryan Stoten

Warwickshire County Councillors

Councillor Alan Farnell
Councillor Izzi Seccombe
Councillor Bob Stevens
Councillor Heather Timms

Clinical Commissioning Groups

Dr Kiran Singh – Warwickshire North CCG
Andrea Green – Warwickshire North CCG
Gill Entwistle – South Warwickshire CCG
Steve Allen – Coventry and Rugby CCG

Warwickshire County Council Officers

Monica Fogarty – Strategic Director, Communities Group
John Linnane – Director of Public Health (WCC/NHS)

Borough/District Councillors

Councillor Michael Coker – Warwick District Council
Councillor Neil Philips (Nuneaton and Bedworth Borough Council)

Warwickshire LINk

Councillor Jerry Roodhouse

Other people present are listed at the end of these minutes.

1. (1) Apologies for Absence

Councillor Claire Watson (Rugby Borough Council)
Wendy Fabbro – Strategic Director, People Group
Dave Spraggett – South Warwickshire CCG
Adrian Canale-Parola – Coventry and Rugby CCG

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

None

(3) Minutes of the meeting held on 13 November 2012 and matters arising

The minutes were agreed as a true record of the meeting. There were no matters arising.

The Chair welcomed various guests and substitutes to the meeting.

(4) Correspondence

The Chair referred to an email from Paul Lankester, Chief Executive of Stratford on Avon District Council. The email contains a reference to the desirability of increasing district/borough council representation to five members (one for each council). The meeting agreed that this was a good idea and that it should be introduced when the Board moves out of shadow status in April 2013. The Chair agreed to write to Paul Lankester relaying to him the outcome of the Board's discussion.

2. Health and Wellbeing Board Strategy

The Chair introduced this item reminding the Board that it was agreed in November 2012 that amendments to the draft would be provided to authors in early December.

Monica Fogarty informed the meeting that the drafting process had resulted in a number of versions of the document. This in turn had led to a degree of confusion. She suggested that the key to progress is to retain the integrity of the consultation process and a sense of ownership amongst partners. The challenge is to be able to articulate the changes required. Officers of the County Council will work on the document with a view to completing a further draft by early February. The key is to have a strategy in place before 1st April 2013. This will be circulated to the Board to obtain its agreement before consideration by the Council's Cabinet in March.

The Board was informed that it is necessary for the CCGs to be able to demonstrate the link between their commissioning plans and the strategy.

Councillor Roodhouse, representing Warwickshire LINk agreed that the strategy needs more work and called for a rapid turnaround of the revised strategy.

Having agreed that John Linnane and Chris Lewington (Head of Strategic Commissioning, People Group) will work together on the necessary revisions the Chair suggested that as a new strategy will be required for 2014 at the end of July any revisions for the current plan should take account of this and ensuring that it contains the elements the CCGs will require for their new commissioning plans to be developed in August.

3. Dementia in Warwickshire – The Warwickshire Dementia Strategy, National Dementia Declaration, Dementia Care and Support Compact

Chris Lewington introduced this item providing the background to the strategy and calling on the Board to sign up to the National Dementia Declaration and action plan. The meeting was informed of the partnership work currently being conducted by Coventry City Council, Warwickshire County Council and others. The number of people with dementia is increasing as is the number being diagnosed. The theme of diagnosis was picked up by the Board. John Linnane stated that early diagnosis is important as it allows for early intervention. “Exercise on Prescription” will soon be available for dementia sufferers and carers. This initiative is being promoted on the basis of evidence that exercise reduces the progress of dementia.

Councillor Izzi Seccombe expressed her support for the strategy and declaration adding that it is most important that people receive the right attention. She stressed that it is necessary to ensure that the workforce is well trained and highlighted the recognition the Coventry/Warwickshire Dementia Portal has received. She concluded by noting that dementia should feature strongly in the Health and Wellbeing Board Strategy.

Councillor Roodhouse highlighted the value of the “Locksmiths Scheme” which seeks to help dementia sufferers by revisiting their past and identifying coping strategies. He noted the challenges the ambulance service faces when care homes call on it for assistance. When a person is dying it is often preferable for them to do so in their home or care home. In the past the general practice when an ambulance was called was for the patient to be taken straight to a hospital. Increasingly however paramedics will negotiate with care homes to ensure that the patient is in the best place to meet their needs.

The meeting was informed that dual diagnoses often feature. This is where a person may be suffering from dementia but also from physical conditions as well. The two are often related.

The Chair welcomed Maureen Hirsch from Older People in Action. Maureen explained that many people have a fear of diagnosis. She stressed the value of advanced care planning, care education and training for care home staff. The role of nutrition and exercise in wellbeing was stressed.

Martin Lee from the NHS Commissioning Board noted that the CCGs now commission the ambulance service. They will therefore have a role in ensuring that paramedics operate appropriately. He added that NHS111 will have an opportunity to include information about people requiring special consideration.

Les Yeates of the Warwickshire Local Pharmaceutical Committee (LPC) informed the meeting that his organisation will sign the declaration next week. He added that the LPC also supports “books on subscription”.

Philip Bushill-Matthews, Coventry and Warwickshire Partnership Trust expressed support for the idea of a dementia conference in the summer. This theme was picked up by Councillor Seccombe who stated that such a conference could be very powerful.

Resolved:

That the Warwickshire Shadow Health and Wellbeing Board agrees to:

1. Sign up to the National Dementia Declaration and action plan.
2. Lead the implementation of the actions associated with the Prime Minister's 'Challenge on Dementia' as defined within the letter to the chair from the Care and Support national sub group.
3. Make Dementia a priority.
4. Support the organisation of a conference on Dementia scheduled for the Summer of 2013.

4. Warwickshire Alcohol Implementation Plan 2012 -2014

Paul Hooper, Group Manager, Community Safety & Substance Misuse, introduced his report noting that 30% of incidents of domestic abuse are related to alcohol. Nationally it costs around £300 million a year to tackle the consequences of alcohol. There are three elements to the plan namely challenge and enforcement, treatment and recovery and education and prevention. It is possible to measure the outputs from the plan but the aim is to be able to measure its success ie the outcomes. Government is consulting on the impact of multipack sales and on minimum pricing for alcohol whilst breweries are starting to produce lower alcohol beer.

John Linnane, Director of Public Health, noted that in his annual report he highlighted the increase in binge drinking amongst young people as well as increased drinking amongst older people. He welcomed the Government's consultation and Paul Hooper's plan.

Councillor Alan Farnell noted that a view has emerged that minimum pricing may lead to an increase in illegal drinks production and consumption. The meeting was informed that in some instances it is cheaper to buy alcoholic drinks than water in supermarkets. In addition some pubs charge as much for soft drinks as alcoholic ones.

Councillor Seccombe observed that there is a need to link the alcohol strategy to drug. This was acknowledged by Paul Hooper who said the joint strategy will be addressed in 2013.

5. Future Work with the Coventry and Warwickshire Partnership Trust

The Chair explained that despite the fact that mental health is the largest single financial commitment of the NHS it has always been something of a "Cinderella Service". There is a clear relationship between physical and mental health issues. For example one third of all adolescents will experience mental health issues. Martin Gower, Chair of Coventry and Warwickshire Partnership Trust, informed the meeting that the Trust expects to gain foundation status on 1st May 2013. Once this status has been achieved the Trust will have more freedom to invest and develop services. There is a drive for more engagement with key stakeholders one of which is the Health and Wellbeing Board. It was proposed that a meeting be held at St Michael's Hospital Warwick. This venue was proposed because along with the Caludon Centre in Coventry it will be a centre of excellence for mental health services in the sub-region. The status of Brooklands was questioned and the meeting was informed that this centre focuses principally but not exclusively on learning disabilities. Further meetings with other stakeholders will also be held. Councillor Roodhouse welcomed the idea of a meeting but expressed reservations regarding any possible outcome from it.

Martin Gower stated that the Partnership Trust has a dementia strategy and is setting up an integrated practice unit.

Councillor Les Caborn informed the meeting that progress had been made with the relationship between the Partnership Trust and the Council's Adult Social Care and Health Overview and Scrutiny Committee. Reporting to the committee has improved and a report on performance is expected in March. He noted that there had been a narrow focus on waiting times for children and adolescent mental health services and suggested that it is now necessary to look at wider service provision. In addition the balance between services for Coventry and for Warwickshire will need to be monitored.

Work will be required on an outcomes framework. This will be a challenge as identifying and monitoring mental health outcomes can be difficult.

Councillor Seccombe suggested that work is required to establish who the customers of the Trust are. The relationship between those customers and the CCGs also needs to be clarified. It would also be useful to agree definitions eg is "dementia" an illness or a mental health issue? The idea of a conference to look at these and other issues in the summer of 2013 was supported.

John Linnane reiterated the relationship between mental and physical health. He said that this has been ignored and that the focus in the future should be more around wellbeing. It will be important to work with the Trust on prevention of conditions such as anxiety and to ensure a clear link with the Health and Wellbeing Strategy.

Paul Tolley (CAVA) welcomed the strategic approach being adopted but noted that this now requires transition to the operational level. He expressed concern that there remain capacity issues on the ground and particularly highlighted the challenge to service delivery that reductions in transport provision will impose.

The meeting was informed that the releasing of offenders with mental health problems into the community will present new challenges for the Trust.

Martin Gower concluded by reminding the Board that the Coventry and Warwickshire Partnership Trust will deliver the services it is commissioned to deliver. There will always be more demand for services than can be provide. The "Increased Access to Psychiatry Therapies" (IAPT) service is delivered successfully across the sub-region and it would be good to do more if the money was available. It was suggested that the key to success is early intervention.

6. George Eliot Hospital – (i) Brief Update on Mortality Rates and (ii) Progress towards Foundation Status

Andrea Green updated the Board on the latest performance figures for the George Eliot. These are 112.6 (annual rolling figure) and 96.4 in September. There has been a gradual downward trend but the challenge is to maintain this. The SHMI (which has a 6 month time lag) is currently 1.12. This figure takes the George Eliot out of the group of hospitals with higher than expected mortality rates.

Kevin McGee expressed a degree of cautious optimism and reminded the Board that the hospital had engaged on a long term programme that would take time to fully realise. Clinical practices have been changed to improve overall performance and increase operation to 24/7. In addition there has been investment in nursing staff and doctors.

The target figure is 103. This is realistic based on demographics and factors beyond the control of the hospital. Councillor Pickard welcomed the improved results and recognised the contribution that quality accounts and improved partnership working was making to this. This view was echoed by Councillor Roodhouse.

The Chair welcomed the improved performance but reminded the meeting that it was not long since the mortality rate was 143. He added that the Mid Staffordshire Report (Francis Report) is expected soon and suggested that people will cite the low mortality rates seen at that hospital in Staffordshire before the crisis broke. Kevin McGee stated that there is no link between the George Eliot Hospital and Mid Staffordshire. Mortality should not be regarded in isolation. It is the result of a number of different factors. The CQC made an unannounced visit to the hospital in December and reported very favourably on what it found.

Martin Lee of the NHS Commissioning Board stressed the need to look beyond mortality figures and consider causes of mortality eg heart disease and stroke. Performance in these areas can improve but they are subject to community influences and not just to what happens in hospital.

Turning to the George Eliot Hospital's move to foundation status Kevin McGee reminded the Board that his is a relatively small district general hospital. It needs to have the financial and clinical support of a partner to remain robust. The hospital wishes to avoid the position where an outside agency comes in and takes control. NHS mergers and acquisitions are rarely successful so the George Eliot is looking to enter into a partnership based on a set of locally agreed criteria. The George Eliot is not in financial difficulties. It is looking to go out to the market and ask potential partners how they would work in the hospital in going forward. The whole process to find a partner is likely to take 15 months.

The Chair called for a Warwickshire based solution to the matter. In response the meeting was told that if local providers wish to be part of the hospital's future they must present a good solution. If a franchise arrangement is developed the George Eliot will remain a legal entity in its own right. Merger and acquisition would present more of a challenge. This requires a memorandum of understanding and the agreement of commissioners and stakeholders to ensure that nobody can renege on the deal. This approach is more about the system holding parties to account.

The meeting was told that to date there has been a lot of consultation with communities and partners. The hospital has been working with the press and is now working through a detailed communication and engagement process. The County Council is a major stakeholder.

7. Progress Report on the Health Check Programme in Warwickshire

The meeting was informed of the background to the Heath Check initiative. It is a mandated service which from April 2013 will become the responsibility of the County Council. The Board will be responsible for overseeing the spend of the budget. The contract lies with GP practices who call in relevant people to check their health and if necessary treat them.

The Board was asked whether given the shortage of funds health checks should be rolled out to the south of Warwickshire. The matter has been discussed with the South Warwickshire CCG and it has agreed to look at options.

The Chair noted that rural areas appear to be missing out under current funding arrangements. He asked whether health checks have to be undertaken by GPs. This has been explored although the conclusion is that whichever party undertakes the checks the patient will eventually be referred back to the GP. Some of the programme is undertaken by pharmacies. They

undertake screening and also provide advice. In addition some pharmacies have been administering flu injections.

Returning to the question of whether the health checks should be introduced in the south of the County the Chair expressed some reluctance to see a blanket exclusion of part of the county. Councillor Seccombe suggested that if the health checks were to be rolled out county wide then it would be important to know what other services cannot be provided. To gain this understanding a business case is required. Kiran Singh observed that there is no evidence that a blanket roll out is effective suggesting that a more focused approach would be preferable. Councillor Timms added that the work in the north of the county has now resulted in a reduction in health inequality. John Linnane question Dr Singh's assertion of the need for a focused approach.

The Chair concluded by calling on Public Health to develop a business case that would provide a clearer indication of the impact of a county-wide roll out on finances and other services.

8. Future Arrangements for the Health and Wellbeing Board

The Chair explained that the March 2013 meeting of the Board will be his last as Chair. Overall governance arrangements will need reviewing with an item on the next meeting's agenda.

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

Concern was raised over the paucity of information and engagement around NHS111. The chair called for a brief update on this matter for the Board

Chris Lewington announced that a briefing session will be arranged for Board members on Winterbourne View.

The meeting rose at 15.50

……..Chair

Other attendees.

C Goody	South Warwickshire CCG
C Lewington	Warwickshire County Council
J Ives	South Warwickshire Foundation Trust
N Wright	Warwickshire County Council
Kate Wooley	Warwickshire County Council
Paul Tolley	Warwickshire CAVA
Cllr Caborn	Warwickshire County Council
Philip Bushill- Matthews	Cov. & Warks. Partnership Trust
Cllr Gill Roache	Stratford on Avon District Council
Kathryn Carpenter	Care Farming West Midlands
Cllr Derek Pickard	North Warwickshire Borough Council
Maureen Hirsch	Older People in Action
Les Yeates	Warwickshire Local Pharmacy
Nathan Chapman	Glaxo Smith Kline
Richard Hall	Warwick District Council
Esther Peapell	Coventry and Rugby CCG
Simon Tidd	Warwickshire County Council
Steve Allen	Coventry and Rugby CCG
Martin Lee	NHS Commissioning Board
Anne Deas	Guidepost Trust
Jill O'Hagan	Coventry and Rugby CCG
Jeff Hunt	
Richard Grimes	

Item 2

Warwickshire Shadow Health and Wellbeing Board

19 March 2013

George Eliot Hospital – Initial Response to the Francis Report

1.0 Introduction

1.1 Care at Mid Staffordshire NHS Foundation Trust between 2005- 2008 has been the subject of a previous inquiry which aimed to give a voice to those who had suffered as a result of poor care and consider how this had occurred. This second Inquiry focussed on the involvement of the wider health system- commissioning, supervisory and regulatory authorities- their actions and roles, and identify lessons that could be learnt to ensure failing and potentially failing hospitals or their services are identified as soon as is practicable.

1.2 Robert Francis QC delivered his report, with a very clear message that improvement should be driven by cultural change by putting patients first.

2.0 Key Recommendations from the report

2.1 The report emphasises the need to avoid further structural change and does not seek to scapegoat individuals. It makes a total of 290 recommendations along the following four themes.

2.2 A structure of fundamental standards and measures of compliance:

- A list of clear fundamental standards, which any patient is entitled to expect which identify the basic standards of care which should be in place to permit any hospital service to continue.
- These standards should be defined in genuine partnership with patients, the public and healthcare professionals and enshrined as duties, with which healthcare providers must comply.
- Non compliance should not be tolerated and any organisation not able to consistently comply should be prevented from continuing a service which exposes a patient to risk.
- To cause death or serious harm to a patient by non-compliance without reasonable excuse of the fundamental standards should be a criminal offence.
- Standard procedures and guidance to enable organisation and individuals to comply with these fundamental standards should be produced by the National Institute for Clinical Excellence with the help of professional and patient organisations.

- These fundamental standards should be policed by the Care Quality Commission (CQC)

2.3 Openness, transparency and candour throughout the system underpinned by statute. Including:

- A statutory duty to be truthful to patients where harm has been caused; The obligations embraced in the duty of candour as set out at Recommendation 181 include:
    - Full disclosure of the circumstances and provision of support where a patient is injured by the organisation.
    - Full and truthful answers to any reasonable question by a patient.
    - A requirement to disclose knowledge of unacceptable practice within the provider organisation.
- Staff to be obliged by statute to make their employers aware of incidents in which harm has been or may have been caused to a patient
- Trusts have to be open and honest in their quality accounts describing their faults as well as their successes
- The deliberate obstruction of the performance of these duties and the deliberate deception of patients and the public should be a criminal offence
- It should be a criminal offence for the directors of Trusts to give deliberately misleading information to the public and the regulators
- The CQC should be responsible for policing these obligations

2.4 Improved support for compassionate, caring and committed nursing

- Entrants to the nursing profession should be assessed for their aptitude to deliver and lead proper care, and their ability to commit themselves to the welfare of patients
- Training standards need to be created to ensure that qualified nurses are competent to deliver compassionate care to a consistent standard
- Nurses need a stronger voice, including representation in organisational leadership and the encouragement of nursing leadership at ward level
- Healthcare workers should be regulated by a registration scheme, preventing those who should not be entrusted with the care of patients from being employed to do so.

2.5 Stronger healthcare leadership

- The establishment of an NHS leadership college, offering all potential and current leaders the chance to share in a common form of training to exemplify and implement a common culture, code of ethics and conduct
- It should be possible to disqualify those guilty of serious breaches of the code of conduct or otherwise found unfit from eligibility for leadership posts
- A registration scheme and a requirement need to be established that only fit and proper persons are eligible to be directors of NHS organisations.

2.6 A number of these recommendations require actions from a number of other organisations, including the Government, to make necessary changes to process, structures and statute as appropriate. These changes will take time to implement.

2.7 In the interim the George Eliot Hospital Trust Directors have commenced a review of the recommendations to identify which areas could be implemented ahead of those requiring external input.

3.0 Actions

3.1 It is envisaged that these recommendations will cut across all areas of the Trusts work and therefore the engagement of all Trust staff is imperative to success.
Immediate actions undertaken to date:

- All Directors have reviewed the report and its recommendations
- Meeting held Tuesday 12 February focussed on the report and its recommendations. Led by CEO, with invites extended to Directors, Associate Medical Directors, General Managers and Heads of Nursing.
- Agreed co-ordination of GEH response by Associate Director of Governance & Transition.
- Programme of staff communications delivered pre and post report publication via email and team brief. A continuing staff communication and engagement plan in development.
- Additional risk of Non- delivery of the recommendations of the Mid Staffordshire NHS Foundation Trust Public Inquiry added to the Board Assurance Framework.
- Proposal for unannounced attendance by CEO and other Directors at key governance and risk meetings to increase transparency and openness within the organisation and assure Directors that robust governance processes are embedded in the organisation.
- Board away day planned to review recommendations and actions in detail.

3.2 The development of full and detailed action plan is now underway. Progress, implementation and timescales will be reported via the Board and Quality Assurance Committee on a monthly basis.

4.0 Review into the Quality of Care and treatment provided by 14 Hospital Trusts in England

4.1 The Trust has received confirmation from the Department of Health that it is one of 14 Trust's across the country that will be subject to a review of mortality rates. This review will be led by Department of Health medical director, Professor Sir Bruce Keogh.

4.2 Although the George Eliot has made significant reductions in mortality rates over the last couple of years, the Trust has been selected because of historically high mortality rates.

4.3 The Trust is working closely with stakeholders in preparation for this review that will take place before the summer.

4.4 The Trust very much welcomes this opportunity to demonstrate improvements and progress made at the George Eliot to the mortality rates to both Professor Keogh's team and the wider public. This review will also provide an opportunity to identify any further improvements that can be made and take on board best practice in order to reduce our mortality rate further.

KEVIN MCGEE
CHIEF EXECUTIVE

Item 3

Warwickshire Shadow Health and Wellbeing Board

19 March 2013

NHS Coventry and Rugby Clinical Commissioning Group identification of local priorities: 'Everyone Counts' planning requirements

Recommendation

The Warwickshire Shadow Health and Wellbeing Board is asked to note this report and indicate its support for the 3 selected local priorities.

1.0 Key Issues

- The 'Everyone Counts' Planning Framework guidance for 2013-14 was published in late December.
- NHS Coventry and Rugby CCG was required to make a formal submission to the NHS Commissioning board on a number of areas, including its 'plan on a page' and 3 locally determined priorities
- The planning guidance required the 3 local priorities to be aligned to local health and wellbeing strategies, and to have Health and Wellbeing Board support
- Discussions with public health colleagues in both Coventry City Council and Warwickshire County Council allowed for the selection of 3 local priorities, drawn from the findings of the JSNA and health and wellbeing strategies
- The achievement of locally determined priorities will influence payments made to the CCG under the Quality Premium.

2.0 Background

2.1 On 18 December 2012, the NHS Commissioning Board published its planning framework guidance 'Everyone Counts' for the year 2013-14 with further supporting guidance for CCGs on 21 December.

2.2 Key messages from the guidance are:

- Rather than impose targets, the NHS Commissioning Board expects CCGs to develop their own local priorities through their input into the joint health and wellbeing strategies.
- With assumed liberty comes public responsibility, hence CCGs should set out real ambition in the selection of its 3 local priorities, and focus on maximising health gain for the population

- Achievement of local priorities will be taken into account in determining if CCGs should be rewarded through the Quality Premium
- The approach aims to strike a balance between local determination of priorities and the NHSCB responsibility for oversight to ensure that statutory requirements around improving quality and financial duties are being met.
- Through discussion and agreement, the CCGs and LATs will be jointly satisfied that the statutory duties to deliver the mandate and make sufficient contribution to quality improvement within allocated resources are being delivered, and that the best possible outcomes for patients are achieved within available resources.
- The assurance process for CCG plans will build on the authorisation process, which requires CCG to develop clear and credible plans.

2.3 This guidance required CCGs to make formal submissions of its plans to NHS Commissioning Board Local Area Teams (LATs) by 25 January, comprising:

- a simple summary of its commissioning plans and priorities through a 'Plan on a Page'
- a commitment to deliver on the NHS Mandate and NHS Constitution, to tackle Health Care Acquired Infections and to ensure provider CIPs are safe
- trajectories for:
  - 2 national priorities (dementia and IAPT services)
  - 3 locally determined priorities which resonate with local health and wellbeing strategies and JSNA findings
  - Activity for 4 key measures: elective FFCEs, non-elective FFCEs first outpatient attendances and A&E attendances

2.4 A representative from the LAT visited the CCG on 4 February and has signed-off the chosen local priorities and related trajectories.

3.0 'Plan on a page' and review of 2013-14 CCG commissioning plans

3.1 The CCG draft commissioning plan for 2013-14 (dating from October 2012) indicated that a refresh would take place in February 2013. A desktop review has taken place comprising:

- Comparison with commissioning plans for first wave authorised CCGs
- Gap analysis against the NHS Outcomes Framework, NHS Mandate, NHS Constitution, Everyone Counts and Quality Premium planning guidance
- Progress against the Equality Impact Assessment action plan resulting from the commissioning plan

3.2 One of the main findings of the review was that there were insufficient outcomes articulated, and that the CCG needed to develop an operating plan for 2013-14 (heavily based on 3 locality delivery plans) to ensure delivery

against the strategic aims, in order to achieve the desired outcomes. Work has already commenced to address these findings.

3.3 This review also identified the high priority areas to be included in the 'Plan on a page'.

3.4 The purpose/benefits of a 'plan on a page' are:

- Clearly and succinctly articulates the top priorities for the CCG – the 'what' needs to happen and some key outcomes/measures for success
- Can be used to communicate with key stakeholders internally and externally and to demonstrate accountability
- Encourages the CCG to prioritise its objectives in the context of its vision, values, strategic aims and key challenges

3.5 Appendix 1 shows NHS Coventry and Rugby CCG's plan on a page which has been accepted by the NHS Commissioning Board Local Area Team.

3.6 During the spring, it is intended to revisit the commissioning plan again with full stakeholder input, to understand how these priorities and plans could be shaped into a 3 year commissioning strategy, with a shorter list of high priority strategic aims, so that the CCG can remain focused on key deliverables.

3.7 It is acknowledged that once the commissioning plan refresh and further prioritisation work has been completed, the 'plan on a page' will need to be updated accordingly. In line with national policy, the plan on the page will need to emphasise more the outcomes that are anticipated.

4.0 Selection of local priorities and trajectories

4.1 To identify meaningful local priorities across the Coventry and Rugby CCG area, public health colleagues from Coventry and Warwickshire were asked to advise on which of the CCG outcome indicators (where the CCG's benchmarked position was less favourable) aligned well with the local health and wellbeing strategies and JSNA findings. An initial shortlist was prepared, taken from the CCG Outcomes benchmarking support packs (showing the CCG's performance relative to other CCGs against the NHS Outcomes Indicators).

4.2 Given the tight timescales for this piece of work, it was impossible to present proposals to formal health and wellbeing board meetings. Instead, it was agreed with public health colleagues that as long as the local priorities aligned with health and wellbeing strategies (which were developed through robust consultation with and input from key stakeholders) this would be a proxy for engagement with the Health and Wellbeing Boards. However, public health colleagues were asked to ensure that health and wellbeing board members were sighted on this work through virtual communication, and it was agreed that formal reporting and discussion at the forthcoming Health and Wellbeing board meetings would take place.

4.3 From these informal discussions, the shortlist was reviewed and 3 priority areas agreed upon across Coventry and Warwickshire. Further joint discussions then took place between public health specialists information analysts, contracting managers and clinical leads regarding historical performance, the feasibility for improvement, the likely health benefit, the ability to monitor progress, and the likely impact for the population. There was some further refinement after discussions with the LAT regarding the limitations of the UNIFY (on-line reporting tool).

4.4 Appendices 2 and 3 show the indicators selected and proposed trajectories – along with accompanying narrative.

5.0 Next steps: Operationalising the Improvements in Order to Meet the Trajectories

5.1 The CCG is currently developing its operating plan for 2013-14 which will detail the action (who/what/when) and expected outcomes, in relation to its various strategic priorities, including these 3 local priorities.

5.2 Discussions are taking place with public health and local authority commissioning colleagues within the Local Authorities about the respective contribution of the LAs and CCG in helping deliver on these targets for the benefit of the wider population.

5.3 A meeting to map data flows to allow monitoring and reporting arrangements across the CCG, Coventry City Council and Warwickshire County Council took place on 6 February.

6.0 Timescales

6.1 The CCG operating plan is due to be completed by 31.3.13 and will be approved and progress will be monitored by the CCG governing body.

7.0 Background Papers/further information

Further information on Everyone Counts Planning guidance, can be found at:
http://www.commissioningboard.nhs.uk/everyonecounts/

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Plan on a Page

NHS Coventry and Rugby Clinical Commissioning Group

One CCG with 3 separate and strong localities, but variations in the quality of primary care
450,000 population, CCG Budget of £553m, 2013/14 QIPP challenge of £18.6m

Strategic Context	Local Purpose and Vision		Strategic priority area	NHS Outcomes Framework domains	Strategic priority initiatives	Delivery Priorities			QIPP and Transformational Change 13/14	2014/15 Future vision
Significant deprived communities Increasing no. of patients with LTC Increasing no. over 75s req. support Large variation in LIfe	**Improve the health and wellbeing of our community**	**"Working together to improve the NHS"**	Primary care quality and safety	2, 3, 4	Peer support, with focus on LTC; targeted support Ongoing development of integrated teams and promotion of telehealth	Delivery of NHS Constitution / NHS Mandate / Everybody Counts	Effective planning and delivery of Joint strategic priorities with health and wellbeing boards	Effective Delivery of Quality, Innovation, Prevention and Productivity across the Local Health Economy Delivery of performance improvement for A&E waits, ambulance turn around times, Delayed Transfers of Care and CAMHS waiting times	LTC urgent care planned care EOL mental health community services referral ma nagement medicines use prescribing	Patients confidence that information about themselves is shared between clinicians accurately and in a timely manner
			Frail (older) people	2, 3, 4	Integrated end of life services Reduce Fractured Neck of Femurs/access to appropriate rehab Consider specialist integrated gerontology assessment service					Greater integration of health and social care- positive impact for frail elderly
			Wellbeing in mental health	1, 2, 3, 4	Promote shared care models. CPN interface with integrated teams Reduce waiting times for CAMHS assessment and treatment Improve access to IAPT services Improve physical health/wellbeing of people with long term mental health conditions Improve mental health and wellbeing of LTC patients					Reduction in health inequalities People with long term conditions managed more effectively and able to self manage
High rate of hip Rapid increased in birth rate in most	**Provide the best possible patient experience**		Best practice in acute hospital care	2, 3, 4, 5	Timely and effective discharge and post-discharge support Enhanced Recovery pathways implemented Streamline patient pathways (using new technologies) Ensure choice within maternity services/reduce still and low weight births Implement recommendations of the WM stroke care review Embedding patient quality/safety tools					Improvements in life chance for children and young people
High level of alcohol related admissions Lower cancer screening uptake high level of infectious dieases	**Ensure choice, value for money and high quality care**		Healthy Living and Lifestyle Choices (LA lead)	1	Encourage GP promotion of healthy living initatives incl MECC and health checks Ensure good uptake of training by practice staff Infectious Diseases service review				Confirm new QIPP initiatives Sustainable specialities programme Frail older people's transformation	NHS Trusts suppored to improve quality and efficiency Culture of excellence in relation to patient experience

Specific Targets to be met from NHS Constitution and NHS Mandate

RTT Admitted 90% within 18 weeks
RTT Non-admitted 95% within 18 weeks
RTT Open Pathways 92% within 18 weeks
No over 52 week patients on open pathways
Diagnostic tests 99% within 6 weeks

A&E Patients 95% dealt with seen within 4 Hours
No waits from decision to admit to admission in A&E over 12 hours

Cancer 93% of urgent referrals seen within 2 weeks
Cancer 96% patients have first treatment from diagnosis within 31 days
Cancer 85% patients have first treatment from GP referral within 62 days

Ambulance 75% of Category A calls arriving within 8 minutes
All handovers between ambulance and A & E must take place within 15 minutes

Zero Mixed Sex Accommodation Breaches

Cancelled operations on the day, to be offered another binding date within 28 days
No urgent operation to be cancelled for a 2nd time

Mental Health (CPA) 95% of patient followed up within 7 days of discharge

3.2% reduction in potential of years life lost from amenable mortality
No growth in emergency admissions year on year
Health acquired infections to show year on year improvement
Improvement in patient experience as reported in the Family and Friends Test

Appendix 2

NHS Coventry and Rugby CCG

'Everyone Counts' Local priorities

Indicator	Justification	CCG existing investment and further actions to be taken	Risk of non delivery and level of risk
COMBINED Hospital admissions wholly attributable to alcohol and admissions due to alcohol-related liver disease MAPS TO DOMAIN 1 OF NHS OUTCOMES FRAMEWORK WAS INCLUDED IN ORIGINAL PUBLIC HEALTH OUTCOMES FRAMEWORK	<u>Health needs/strategic fit</u> Included in the Health and Wellbeing strategies for Coventry and Warwickshire. Public health colleagues agreed this is a key local priority. Potential for health gain for CCG population, and contribution to QIPP delivery. Decision not to look solely at emergency admissions for alcohol related liver disease (as detailed on the NHS outcomes indicator set) – limited potential for health gain, and small number of patients. Equality Impact Assessment identified unacceptably high numbers of young people being admissions for alcohol related harm. Therefore Rugby locality has selected this as a particular priority to focus on. Joint strategic priorities listed in the CCG commissioning plan include: • Reduce the number of Alcohol related hospital admissions • Reduction in the number of Alcohol 'frequent flyers' attending A&E JSNA for Coventry shows excessive consumption of alcohol is causing a high level of harm: • Hospital admissions & deaths linked to alcohol were significantly worse in Coventry than for England. • Among 16-24 year old males, 27% of all deaths were estimated to be attributable to alcohol consumption <u>Performance concerns</u>	The main elements of work which should reduce alcohol admissions (and which aren't being delivered now, or aren't being delivered effectively/completely) are: (1) alcohol IBA (2) the hospital alcohol liaison nurse team (3) multiple attender service (4) Integrated Acute Liaison. 3 x alcohol liaison nurses in A&E funded by CCG Specialist treatment already commissioned by LA, so cost neutral. CWPT commissioning intentions for 13-14 identify an intention to explore multi-agency strategies and pathways to reduce the number of alcohol related admissions Additional identified investment (circa £50k) for Coventry City Council for city-centre alcohol triage. Making Every Contact Count included as requirement in all contracts. Primary care key role in identifying and	Coding fluctuations – LOW

Indicator	Justification	CCG existing investment and further actions to be taken	Risk of non delivery and level of risk
	Significantly higher hospital admissions compared to national/WM average Upward trend in hospital admissions over last 4 years <u>Alignment with QIPP</u> Enables more upstream prevention work – with QIPP benefit. QIPP plans 13-14 identify alcohol as priority The historical data indicates around 4,000 admissions wholly attributable to alcohol. The number of admissions was stable between 2010/11 and 11/12; but it is forecast that it will increase by around 12% between 11/12 and 12/13. It is unclear for the increase, but it seems to have happened fairly evenly across primary and secondary diagnoses (could be linked to coding. The are 4 strands of work that will be undertaken in 13/14 which should reduce alcohol admissions (and which are not currently being delivered, or are not being delivered effectively/completely) . The CCG will also be using contractual levers and additional investment (already identified).	referring alcohol-dependent clients to specialist treatment – raise awareness around evidence base/encourage referrals. Review/promote Coventry LES for IBA. Consider IBA LES for Rugby. Liaise with LAT re. alcohol DES and health checks monitoring	
Cervical screening rates MAPS TO DOMAIN 1 OF NHS OUTCOMES FRAMEWORK	Lower screening uptake in Coventry than national. Recommend choice of cervical screening rates due to the contribution that general practice can make to this. National target for cervical screening is 80%. Baseline data shows CCG average in last 5 years is 77.23% with 10 practices achieving below 70% Improvements in cancer screening rates would contribute to the improvement of under 75 cancer mortality rate i.e. it is in effect a proxy measure – which can be monitored in-year (as opposed to change in the under 75s cancer mortality rate which cannot be measured in e timely manner or over a 12 month period.	Bespoke support to individual practices – to achieve on average an additional 17 patients per practice. Further publicity campaigns.	Need to undertake EIA on approach due to correlation between practices with low uptake and their ethnic minority populations. LOW
Maternal	Smoking in pregnancy can have serious health implications for	UHCW CQUIN on CO monitoring on booking	SATOD data relies on

Indicator	Justification	CCG existing investment and further actions to be taken	Risk of non delivery and level of risk
smoking at time of delivery (SATOD) MAPs TO DOMAIN 1 OF THE NHS OUTCOMES FRAMEWORK	both mother and child. The adverse effects of smoking during pregnancy can result in the increased risk of miscarriage, preterm birth, low birth weight and stillbirth. It is associated with sudden infant death syndrome, childhood respiratory illnesses etc. SATOD is included within the Public Health Outcomes Framework. Aligns with Coventry's Joint Health and Wellbeing Strategy priorities relating to giving every child the best start in life and reducing smoking rates in Coventy. Smoking is the major factor behind the health inequalities that exist in the city's poorest and more affluent wards. Aligns to Warwickshire's JSNA and annual public health report. Rapid increase in birth rate in most deprived communities identified in EIA of commissioning plan. Flagged on corporate performance report	in 2012-13 Ensure this is embedded within the KPIs (incl. sanctions) for 13-14. Making Every Contact Count included within commissioning intentions for 2013-14. Work with GP practices on pre-conceptual advice regarding smoking	accurate reporting by patient. Smoking at booking data is currently CO monitored. There is quarterly variation in SATOD rates which may be affected by % of women booking in as smokers. If smoking at booking rates increase, this may have an effect on smoking at delivery. Impact of stop smoking in pregnancy team on quit rates during pregnancy. Accuracy of coding MEDIUM

Appendix 3

Local priorities – supporting analysis

Indicator description	Baseline	Trajectory end 13/14	Supporting analysis	Numerator/ Denominator	Monitoring arrangements
Hospital admissions wholly attributable to alcohol (including alcoholic liver disease)	12/13 forecast 4,292  	4,017 Reduction of 275 hospital admissions	The historical data indicates around 4,000 admissions wholly attributable to alcohol. The number of admissions was stable between 2010/11 and 11/12; but it is forecast that it will increase by around 12% between 11/12 and 12/13. It is unclear for the increase, but it seems to have happened fairly evenly across primary and secondary diagnoses (could be linked to coding). Unable to access historical data per 2010/11 as dataset was unvalidated and from different database – therefore long-term historical view unavailable. Longer term view is available for former NI39 indicator (alcohol-related hospital admissions) and shows year on year increases and rates, particularly for Coventry patients, higher than regional averages and comparable areas <u>Actions to reduce hospital admissions - assumptions for the impact:</u> 1. If the various IBA schemes in primary and secondary care are delivered appropriately, it should result in around 200 fewer admissions per annum across Coventry and Rugby. 2. As well as delivering IBA, the alcohol liaison nurse team at UH will help manage around 30	tbc	Need to include on corporate performance dashboard

Indicator description	Baseline	Trajectory end 13/14	Supporting analysis	Numerator/ Denominator	Monitoring arrangements
			patients per month drinking at higher risk levels. Some of these will require hospital admissions (but for shorter periods) and some will be counted among those receiving specialist treatment. However, the improved targeting and greater level of intervention may account for 50 fewer admissions per annum. 3. The multiple attender service will have a small caseload (probably not more than 15 throughout the year). Assuming each will be admitted 2-3 times per annum (plus numerous attendances), and a 70% reduction in admissions, this service will result in around 25 fewer admissions. 4. The impact of Integrated Acute Liaison is not really known. It will certainly facilitate improved pathways to specialist services and the alcohol liaison nurse team. Hence, overall these services should lead to <u>at least 275 fewer admissions</u> (this ignores the impact of the RAID service). There are other interventions which may increase this reduction, such as Making Every Contact Count and the development of IBA within the hospital (as part of the ALN service), which could increase this reduction further. Specialist alcohol services are provided by the Recovery Partnership and have been recommissioned, partly to increase capacity.		

Indicator description	Baseline	Trajectory end 13/14	Supporting analysis	Numerator/ Denominator	Monitoring arrangements
Maternal Smoking at Time of Delivery SATOD	**Data analysis incomplete regarding reduction in smoking rates between booking at delivery** <u>Smoking at time of delivery</u> Rugby data is only available for 11/12 and 12/13, hence not possible to use a 3-year average for the whole CCG. Coventry 3-year average for 2009-2012 is 14.1% 13/14 YTD CCG position	Tbc <u>Smoking at time of delivery</u> 13.4% proposed reduction of 0.1% from YTD position of 13.5%	Rugby smoking at time of delivery figures are higher than for Coventry consistently. The overall CRCCG figure is running at 13.5%, but we only have 2 year's data (since the introduction of CO monitoring in UHCW) so the trajectory should reflect this. The West Midlands figures over the last 3 years have not changed significantly and are running at over 15%, so it would be unrealistic to set a trajectory significantly below that figure and to expect any large reduction in one year for CRCCG. However, important to note that the % smoking at time of delivery is closely linked to % smoking at booking, and reflects the particular cohort. It is possible to have a high prevalence of smoking at booking which could mean the % at delivery is also high – not necessarily reflecting the impact of interventions by stop smoking teams, during a woman's pregnancy. It would be preferable to set a trajectory based on a % reduction between the time of booking and at delivery, rather than a downward trajectory between different cohorts at time of delivery. Further data analysis is being requested on this and if available, will be used for a trajectory rather than a downward trajectory in smoking at time of delivery rates. However, the NHS Outcomes Indicator Set suggests the smoking at time of delivery. Hence, this trajectory	<u>Smoking at time of delivery</u> 847 mothers smoking at delivery out of a forecast number of 6318 births in 2013-4.	Already included on corporate performance dashboard.

Indicator description	Baseline	Trajectory end 13/14	Supporting analysis	Numerator/ Denominator	Monitoring arrangements
	is 13.5%.  Y:\PrimaryCare\ Coventry and Rugby		has been developed and we will need to negotiate with the LAT (this should be a second choice however).		
Cervical screening coverage rates	Coverage over last 5 years for CCG is 77.23% (baseline data April 2011 – March 2012)  Y:\PrimaryCare\ Coventry and Rugby	78.5% coverage	Equates to an additional 17 patients per practice, or an additional 25 patients per practice to those practices with coverage rates of less than 70%	80,974 numerator 103,151 denominator	Commissioning responsibility with LAT, however, need to include on CCG corporate performance dashboard

NHS
South Warwickshire Clinical Commissioning Group

BETTER HEALTHCARE FOR EVERYONE

Vision: To build relationships with patients and our communities to improve health, transform care and make the best use of resources

Values: Committed | Listening | Innovative | Empowering | Responsive | Collaborative | Equitable

- South Warwickshire CCG has a registered popuklation of 273,000, 36 practices and a budget of £285 million
- The health of our population is better than average; life expectancy is higher than national average
- We are expecting a high rate of population growth, particularly in the over 65's. In addition we have the highest dependency ratio in Warwickshire. This means that the frail and elderly need to be the focus of our attention
- We have good quality primary care but we need to reduce variation and strive for excellence in the management of Long Term Conditions. We want to keep people well and out of the dependent category for as long as possible
- Our Non-Elective admission rate is in line with our peer group but it is growing. Our services for the frail elderly are not delivering optimum results for patients. We need more co-ordinated services that are planned around the needs of the patient. This will improve quality and patient experience
- In order to achieve this we need to release resource by striving for top quartile performance in elective care and prescribing
- Innovation in service delivery will be driven through improved engagement with our stakeholders and community. Our service delivery options for the future will need to be more creative and build on the social capital available in our communities

Aims	Objectives	QIPP 2013/14	QIPP 2014/15	QIPP 2015/16	Outcomes that will be achieved by 2016	National Outcome Framework	JSNA	JHW Strategy
To build relationships with patients and our communities	Improve communication between organisations and professionals	*	*	*	Number of complaints from our member practices regarding transfer of clinical information reduced by 50%	4		
	Co-ordinated services for dementia patients and their carers		*	*	100% of Dementia patients and their Carers have access to a Dementia Navigator	2	*	*
	Prevention of admission for the frail elderly through integrated Health and Social Care	*	*	*	The number of over 75year olds admitted to Hospital reduced by 10% and their LOS will be comparible to top-quartile performance	2	*	*
	Support individuals to die in their place of choice	*	*	*	80% of our population who are on an EOL Pathway will have their preference for place of death recorded We will have improved our identification of those in their last 12 months of life and given our demographics we will have 0.8% of our population on the EOL pathway at anyone time	2		*
	Develop a thriving engagement network	*	*	*	Through our engagement activities with local communities, especially those hard to reach groups we will have reduced paediatric admissions to hospital by 10%	2	*	
To improve health and reduce health inequalities	Improve the management of Long Term Conditions	*	*	*	Reduce the number of Hospital admissions for ambulatory sensitive conditions to top quartile performance	2	*	*
	Improve the choices made by pregnant women			*	100% of pregnant women will be offered an assessment for smoking, alcohol use and obesity and helped to adopt a healthy lifestyle	1	*	*
	Stop the trend of Increasing alcohol related admissions	*	*	*	Stabalisation of the growth we are experiencing for alcohol related admission rates	1	*	*
	Improve the physical health of vulnerable adults and children			*	Increase the number of people with Learning Disabilities and Mental Illness accessing Health Checks	1	*	*
	Reduce the unplanned variation in Primary Care quality and prescribing	*	*	*	Reduced variation between our practices in referrals and prescribing spend to achieve top 5% performance All GPs and Practice Nurses trained in Safeguarding by the end of 2013/14	4 5		*
To improve the quality of care and transform services	Improve the access to Mental Health Services through improved communication between professionals		*	*	The satisfaction of patient accessing MH services will improve by 2% All of the South Warwickshire population will have appropriate access to Early Intervention Mental Health Services (IAPT)	4 2	*	*
	Reduce avoidable harm	*	*	*	Avoidable pressure sores will be eradicated and the number of HCAI will reduce year on year	5		*
	Improved patient experience	*	*	*	Acute Hospital patient satisfaction will increase by 5% Patients will have access to information relating to clinical outcomes in order to make informed choices (NHS Choices)	4		
	Reduced variation in clinical outcomes			*	Our Providers will perform at national average or better for Clinical Outcomes that are measured nationally	4		*
	Improve the quality of care of Nursing Home residents	*	*	*	Number of patients admitted to Hospital from Nursing and Residential Homes will have reduced by 30%	2	*	*
To make best use of our resources	Providers will have reduced unnecessary steps in their processes	*	*	*	Length of Stay will be in line with top quartile performance	4		
	Adherence to NICE and other evidence based guidance	*	*	*	We will have mechanisms to ensure that high cost drugs are clinically indicated	5		*
	Optimise Continuing Health Care spending	*	*	*	High cost Out of Area Packages of Care will be regularly reviewed The number of patients accessing CHC will be in line with peer group average and we will be assurred we are getting value for money from CHC providers	2 2		*
	Commission services within our resource envelope	*	*	*	We will achieve our financial control target each year			*

better healthcare for everyone


SWCCG has 36 practices and serves a popultaion of 270,000
The health of our population is better than average, life expectancy is higher than national average and better than our ONS peer group
We are expecting high rates of population growth particularly in the over 65's. This alongside having the highest dependency ratio in warwickshire means that the frail and elderly our the focus of our attention
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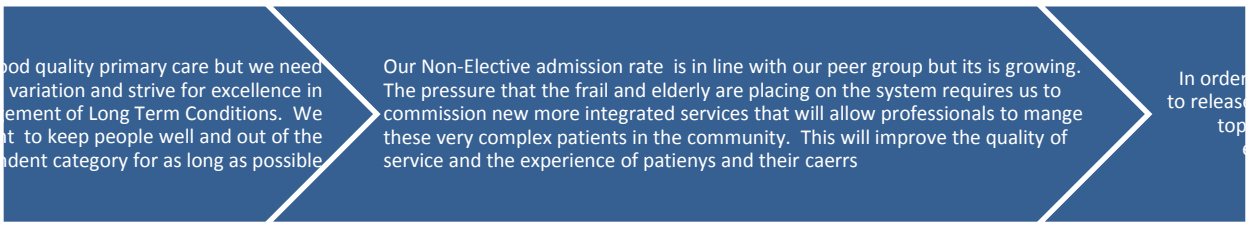
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Our Non-Elective admission rate is in line with our peer group but its is growing. The pressure that the frail and elderly are placing on the system requires us to commission new more integrated services that will allow professionals to mange these very complex patients in the community. This will improve the quality of service and the experience of patienys and their caerrs
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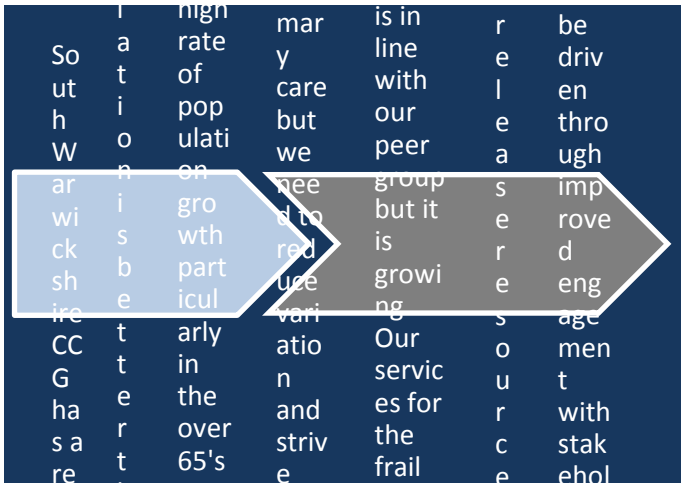
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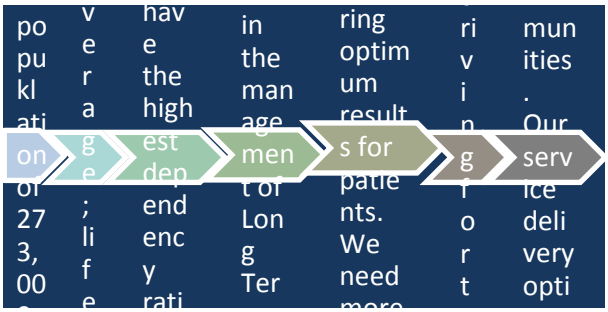
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Item 5

Warwickshire Shadow Health & Wellbeing Board

19 March 2013

Warwickshire Information Sharing Charter

Recommendations

1. Agree to the principles and commitments in the current Warwickshire Information Sharing Charter.

2. Corporate Information Manager is tasked to review the 2008 Charter with partner organisations and it is then taken forward to the relevant Board/partner organisations for revised signatories.

1.0 Key Issues

1.1 The Warwickshire Information Sharing Charter and the associated framework underpins the secure and confidential sharing of information between organisations involved in delivering public services in Warwickshire, in accordance with national and local policy and legislative requirements. The Charter is also intended to inform members of the community why information about them may need to be shared and how this sharing will be managed.

1.2 The framework still requires purpose-specific data sharing protocols and agency-specific agreements to be in place and a register of these should be maintained and published.

1.3 The Charter was agreed by the Public Service Board in 2008 by a wide range of organisations. The PSB is no longer in existence and other organisations have changed or are changing.

1.4 The Charter does not cover all purposes for which data is shared across the multi-agency partnerships in Warwickshire, specifically the general health and wellbeing programmes and Public Health.

1.5 With the transition of NHS Warwickshire from April 2013, Arden Cluster and the three CCGs in Warwickshire require separate signup.

1.6 The NHS Trusts providing services in Warwickshire are not included. The Priority Families programme also has a wider partnership and the organisations need to be included.

2.0 Options and Proposal

2.1 Review and update the current 2008 Warwickshire Charter with partner organisations to update: a) the general purposes to include the wider health and wellbeing areas; (b) ensure compliance with the Information Commissioner's Data Sharing statutory code of practice, and is then taken forward to the relevant Board/partner organisations for revised signatories.

2.2 Establish information governance contacts in partner organisations in the medium-term to coordinate the framework.

3.0 Timescales associated with the decision/Next steps

3.1 Agreement to take forward.

Background Papers

None

Supporting Papers

1. **Warwickshire Information Sharing Charter (2008) available at http://www.warwickshire.gov.uk/sharinginformation**
2. **Information Commissioner's Data Sharing Code of Practice available at http://www.ico.gov.uk/for_organisations/data_protection/topic_guides/data_sharing.aspx**

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Strategic Director	David Carter	

WARWICKSHIRE INFORMATION SHARING CHARTER

Why do we need a Charter to share information?

Organisations already share a great deal of information, much of which is general, strategic or financial in nature, and some of which is personal information relating to individual citizens. With statutory agencies, organisations, the voluntary and the private sector working more closely together, there is often a public concern that some of that information exchange may be taking place without their knowledge or in such as way as to threaten confidentiality. At the same time, sharing information about an individual within and between partner agencies is vital to the provision of co-ordinated services.

Both public and private organisations in the community must demonstrate a commitment to share information responsibly, appropriately, and securely. They must establish procedures and agreements that manage the exchange of information, and make sure that those processes are open, transparent, and accountable, while keeping personal information protected throughout.

The Charter and the associated framework will underpin the secure and confidential sharing of information between organisations involved in delivering public services in Warwickshire, in accordance with national and local policy and legislative requirements. The framework will encompass purpose-specific protocols and agency-specific agreements. The Charter is also intended to inform members of the community why information about them may need to be shared and how this sharing will be managed.

The Information Sharing Charter

This Charter recognises that sharing of information should be done fairly and lawfully and should strike a balance between the specific rights of individuals and the public interest. The following are the principles to be applied whenever personal information is shared or exchanged. The organisations signed up to this Charter are fully committed to ensuring that these standards and principles are adhered to at all times.

The principles established by this Charter are:

- **Information about individuals will only be shared when and where it is needed.**
- **Information will be shared in accordance with statutory duties, underpinned by specific protocols where appropriate.**
- **Information that is provided in confidence will be treated as confidential.**
- **Information will only be used for the purposes for which it was collected and shared.**
- **Individuals will be properly informed about the way their personal information is used and shared.**
- **Consent to share personal information will be sought wherever appropriate.**
- **Considerations of confidentiality and privacy will not automatically cease on death.**

- **The information rights of individuals will be respected and observed.**

- **Organisations collecting personal information will publish service-specific privacy statements**

The principles are explained in Appendix 2.

General purposes for which information will be shared

Each signatory to this Charter is responsible for the safe keeping of the information that they hold and is responsible for their own decisions as to when sharing information will be fair and lawful but wherever possible the signatories will work to agree common approaches to the sharing of specific items of information.

Each of the signatory agencies, their staff and representatives, agree to share information between them, to the extent that is fair and lawful, for the purposes of:

- Contributing to the delivery of the Local Area Agreement including the delivery of the agreed outcomes under the 6 theme blocks:
    - Safer Communities
    - Stronger Communities
    - Children and Young People
    - Healthier Communities and Older People
    - Economic Development and Enterprise
    - Climate Change and the Environment
- Delivering or commissioning integrated public services;
- Protecting communities and individuals from risk and harm;
- Promoting community cohesion and wellbeing;
- Planning for future services, learning lessons and sharing good practice.

Specific areas where information about individuals may need to be shared include:

- Initiatives to address the prevention of crime and disorder, where details of offenders, victims of crime, and potential perpetrators may need to be exchanged between the police and other partners addressing community safety issues.
- Initiatives to support and protect young people at risk of social exclusion, which require that information about those young people be shared between relevant agencies.
- Developments in services to vulnerable people, older people, those with disabilities or health needs, supported by doctors, hospitals, and social care services - along with providers in the private sector – that require the exchange of information about patients and service users.
- Initiatives to reduce social exclusion, enhance community cohesion, promote lifelong learning and develop sustainable communities.

Specific protocols will be developed to support these purposes where appropriate.

Commitments in support of the Charter

Signatories to this Charter are committed to the implementation of an appropriate level of information governance throughout their organisation, in accordance with recognised national standards. They will:

1. Adhere to the standards and principles of this Charter whenever exchanging personal information, whether with a co-signatory or other agency/organisation.

2. Share statistical and depersonalised data wherever possible, eliminating the use of personal information except where reasonably necessary.

3. Ensure that all staff (including temporary employees, contractors and volunteers) are aware of and comply with their responsibilities arising from both the Charter and relevant legislation, and receive adequate training in order to do so.

4. Implement their own policies on confidentiality, data protection information security and information management which are appropriate to their organisation and comply with recognised good practice.

5. Establish efficient and effective procedures for:
   - Obtaining written, informed consent to collect, share and process personal information wherever reasonably practicable;
   - Informing citizens what information they collect and share about them;
   - Sharing of personal information identified as part of a detailed agreement;
   - Addressing complaints arising from the misuse or inappropriate disclosure of personal information;
   - Enabling access to records of individuals by those individuals on request;
   - Amending records where they have been shown to be inaccurate;
   - Sharing information without consent when necessary, recording the reasons for that disclosure and the person responsible for making the decision;
   - Making information-sharing an obligation on staff and allocating senior staff responsibility for making complex disclosure decisions;
   - Ensuring that personal information is reasonably protected at all times, through the use of appropriate security measures.

6. Work towards reducing duplicated requests for information where several agencies are dealing with a single individual.

7. Develop and work to detailed, specific information sharing protocols that support identified purposes

8. Ensure that future developments in technology reflect the requirements of the Charter and any detailed protocols that support it.

9. Maintain information that is accurate and up to date, hold information securely for a reasonable period of time, and review and destroy information in accordance with good records management practice;

10. Adopt a suitable procedure for resolving complaints from customers about information-sharing decisions;

11. Share information between each other free of charge unless special charging arrangements have been agreed;

12. Seek legal advice where appropriate;

13. Ensure their registration as Data Controllers under the Data Protection Act is adequate for the purposes for which they may need to process and share information with one another.

14. Support the principles of equality and diversity within the community and ensure that whenever information is provided to the public it will be supplied in appropriate formats and languages as appropriate.

Implementation, Monitoring and Review

The Charter has been developed in consultation with stakeholders within Warwickshire. The Charter is owned by all of its signatories. The intention has been to develop an over-arching code of behaviour for all information-sharing applications. This will be supplemented by protocols for specific purposes which will adopt the principles and standards in the Charter as their base line and identify any additional service specific requirements.

Work to develop individual protocols will be pursued through the partnership of Warwickshire agencies and stakeholders. The Warwickshire Public Service Board will be advised as detailed protocols are developed, ensuring consistency in the development process and enabling priority areas to be identified.

Warwickshire County Council will undertake to document the framework in a consistent fashion, and publish the relevant documents on a publicly accessible website.

The Charter will be reviewed annually and will be updated to account for any changes in legislation and developments in national guidance. Issues arising from breaches of the Charter, changes in legislation, or recommendations arising from review will be presented to the Warwickshire Public Service Board for consideration. Issues, incidents and complaints resulting from failures in the specific agreements will be fed into the review processes for the individual protocols.

The Warwickshire Information Sharing Charter was agreed by the Public Service Board on 10th July 2008

The Partners below have agreed to abide by the terms of this Charter, its schedules and any variations to the Charter or its Schedules:

Coventry and Warwickshire Chamber of Commerce

Coventry and Warwickshire Infrastructure Consortium

Coventry and Warwickshire Learning and Skills Council

Coventry Diocese

Coventry Solihull Warwickshire Partnership Limited

Government of the West Midlands

Job Centre Plus

National Probation Service - Warwickshire

North Warwickshire Borough Council

Nuneaton and Bedworth Borough Council

Rugby Borough Council

Stratford-on-Avon District Council

University of Warwick

Warwick District Council

Warwickshire and West Midlands Association of Local Councils

Warwickshire County Council

Warwickshire Primary Care Trust

Warwickshire Police Authority

Warwickshire Police Service

Warwickshire Race Equality Partnership

Warwickshire Rural Communities Council

APPENDIX 1
GENERAL LEGAL FRAMEWORK AND GUIDANCE

General legal framework

The general legal framework surrounding the sharing of information includes:

- the law that governs the actions of public bodies (administrative law);
- the Human Rights Act 1998 and the European Convention on Human Rights;
- the common law duty of confidence;
- the Data Protection Act 1998; the Freedom of Information Act 2000; and
- legislation that covers specific aspects of public service delivery (eg crime and disorder prevention, social care, child protection, patient records)

Overall the law strikes a balance between the rights of individuals and the interests of society. The law is not a barrier to sharing information where there is an overriding public interest in doing so (such as where it is necessary to do so to protect life or prevent crime or harm) provided it is done fairly and lawfully.

Often personal information can be shared simply by informing people from the outset what purposes their information will be used for and then sharing only for those agreed purposes. There are however special legal considerations around sharing information that is personally sensitive or confidential, because this could have serious consequences for individuals. In deciding whether the law allows personal information to be shared, the following four steps should be considered (as recommended by the Department of Constitutional Affairs);

1. Establish whether there is a legal basis for sharing the information (ie whether the reason for sharing the information has a statutory basis – eg the prevention of crime) or whether there are any restrictions (statutory or otherwise) to sharing the information.

2. Decide whether the sharing of the information would interfere with human rights under the European Convention on Human Rights.

3. Decide whether the sharing of the information would breach any common law obligations of confidence.

4. Decide whether the sharing of the information would be in accordance with the Data Protection Act 1998, in particular the Data Protection Principles, which are that personal information must be:
    - Fairly and lawfully processed
    - Processed for limited purposes
    - Adequate, relevant and not excessive
    - Accurate and up to date
    - Not kept for longer than is necessary
    - Processed in line with individuals' rights
    - Secure
    - Not transferred to other countries without adequate protection

Further detailed guidance on using personal and sensitive personal information fairly in accordance with the Data Protection Act is set out in ***Appendix 2.*** In addition, the Freedom of Information Act gives anyone (an individual or an organisation) a right to request access to information from a public body. Where an exemption applies (eg it is third party personal information or commercially sensitive information), disclosure may be refused.

Categories of Information

This Charter applies to all the categories of information listed below;

Category of Information	Comments
Aggregate/statistical information	Information which does not contain personal information about individuals and is often used for planning service delivery and monitoring performance. It is not subject to the Data Protection Act nor should it be subject to any other restrictions on disclosure. Usually the sort of information that is publicly available or disclosable under the FoI Act
Depersonalised/anonymised information	Information which has had any personal information relating to living individuals removed. As this information does not contain personal information about individuals, it is not subject to the Data Protection Act nor should it be subject to any restrictions on disclosure (unless it contains some commercially confidential information- see below).
Personal information and sensitive personal information	Information that identifies a living individual and can affect their privacy. Deciding whether information is "personal" and subject to the protection of the Data Protection Act often depends on the context. The Act also defines a particular class of information - "sensitive personal information" - to which greater protection must be given.
Confidential information	Information provided in confidence by another person – this creates a duty of confidence not to disclose further. Confidential information may be personal or non personal information. Confidential information should not be disclosed without the consent of the person to whom the duty of confidence is owed, unless there are overriding public interest reasons for disclosing it without consent. The fact that a document is marked "confidential" does not automatically mean that it is subject to a duty of confidence. The important characteristic is that it has been provided by a person in the expectation that it will not be further disclosed without the consent of that person, and it is information that has some "quality of confidence" about it (eg it is not trivial, and it is the type of information an emergency court injunction could be obtained to protect). The Government's protective marking scheme gives clear guidance on the circumstances in which "confidential" should be used to mark documents. NHS and Social Care organisations which are party to this Charter are committed to the Caldicott principles when considering whether confidential information should be shared. These are: • Justify the purpose(s) for using confidential information • Only use when absolutely necessary • Use the minimum that is required • Access should be on a strict need to know basis • Everyone must understand his or her responsibilities • Understand and comply with the law

APPENDIX 2
SHARING PERSONAL INFORMATION

This Appendix gives more information on the principles established by the Charter, in the context of information about individuals which is sensitive and personal.

Information about individuals will only be shared when and where it is needed.	Personal information will only be disclosed where necessary and it will always be dealt with in a sensitive and non-discriminatory manner. For all other purposes, information about individual cases will be anonymised. Agencies will exchange statistics and aggregated information wherever possible, reducing the need for individuals to be identified. Where it is agreed that it is necessary for personal information to be shared, information will be shared on a "need to know" basis only. Agreements will be made between agencies defining exactly what information they need for any given purpose, how it will be shared, and who will have access to it.
Information will be shared in accordance with statutory duties.	Organisations will put in place procedures which ensure that the principles of the Data Protection Act 1998 are adhered to. In particular, they recognise the special considerations needed when sharing information defined as "sensitive personal data" in Section 2 of the DPA, that is, information relating to: • a person's racial or ethnic origin • his political opinions • his religious or other similar beliefs • his trade union membership • his physical and mental health • his sexual life • the commission or alleged commission by him of any offence • any proceedings for any offence committed or alleged to have been committed by him, the disposal of such proceedings or the sentence of any court in such proceedings. Organisations which have directly obtained this type of information about an individual will usually seek to obtain the explicit consent of that person to disclose that information to another organisation. If consent is not given, because the person is either unable or unwilling to give that consent, or it is not sought due to issues of risk, then the information will only be released if there are statutory grounds for doing so and one of the remaining conditions in Schedule 3 of the DPA can be satisfied. Where consent is required before information can be disclosed, an individual will be made fully aware of what information is to be shared and the purposes for which it will be used.
Information that is provided in confidence will be treated as confidential	Much of the information provided by service users will be considered by them to be confidential in nature. All organisations that are party to this Charter accept this duty of confidentiality and will not disclose such information without the consent of the

	person concerned, unless there are statutory grounds and an overriding justification for so doing. In responding to information requests from partner agencies, staff in all organisations will respect this responsibility and not seek to override the procedures that each organisation has in place to ensure that information is not disclosed illegally or inappropriately.
Information will only be used for the purposes for which it was collected and shared.	Organisations will not re-use or abuse information that has been disclosed to them for specific purposes identified in an agreed protocol. Information shared with another organisation for a specific purpose will only be used for that purpose and not be regarded by that organisation as being generally available for their use. Where further purposes are identified, they must be in the sharing agreement, and steps taken so that the individual concerned is aware.
Individuals will be properly informed about the way their personal information is used and shared.	Individuals in contact with organisations will be properly informed about information that is recorded about them. If an organisation has statutory grounds for restricting an individual's access to information relating to them, then the individual will be told that such information is held and on what grounds it is restricted. Other than this, they will be given every opportunity to gain access to information held about them and to correct any factual errors that may have been made. Similarly, where opinion about them has been recorded and the service user feels this opinion is based in incorrect factual information, they will be given every opportunity to correct the factual error and record their disagreement with the recorded opinion. When disclosing information about an individual, practitioners will clearly identify whether the information being supplied is fact, opinion, or a combination of the two. Wherever professionals request that information supplied by them be kept confidential from the individual concerned, the outcome of this request and the reasons for taking the decision will be recorded. Such decisions will only be taken on statutory grounds. Some agencies may maintain electronic indexes of service users in order to ensure that they are consistently identified across a range of services. These indexes may also be used to ensure that information can be shared securely and enable relevant changes (eg the updating of an address) to be made from a single request or contact. Agencies using these kind of indexes will ensure that the individuals concerned are aware that information they provide will be used to update or create indexed records, and will inform them which other systems the indexes are linked to.
Consent to share information will be sought wherever appropriate.	In the majority of cases, consent to share will be sought from the individual concerned. Where this is not feasible, consent will be sought from a parent or legally registered guardian. Incapacity to consent will be judged on an individual basis, ensuring that young children, individuals subject to mental illnesses, or those who are confused due to age or other conditions, can still exercise their

	rights to confidentiality whenever they can demonstrate an understanding of them. If a parent or guardian withholds consent and there are no concerns regarding significant harm to the individual, this will be considered to be the same as an individual refusing consent and information will not be shared unless there is a statutory requirement to do so. Whilst the signatories to this Charter have a commitment to seeking consent before sharing detailed personal information, there will be occasions when the law allows sharing to take place without consent. This will generally take place only where there is a clear and identified risk in not sharing the information, where there is potential harm to an individual, or there is need to take action for the prevention of crime. The decision to share in these cases will be based on appropriate professional judgement and actioned within the requirements of the law. Such decisions must be made at an appropriate level within the agency supplying the information, and the reasons for not obtaining consent must be recorded. Each agency must identify who has been given authority to take this kind of decision, and in what circumstances the exercise of that authority is allowed.
Considerations of confidentiality and privacy will not automatically cease on death.	While the requirements of Data Protection Act are specifically related to living individuals, signatories to this Charter recognise that there may be occasions when information relating to deceased individuals is shared. Where possible, agencies will attempt to identify the wishes of individuals concerning the use of their personal information after death, and to comply with those wishes in line with the duty of confidentiality. Consideration will also be given to any potential impact on the privacy of relatives of deceased individuals when considering how and with whom information about those individuals may be shared. Legal advice will be sought on individual cases.
The information rights of individuals will be respected and observed.	In order to observe the requirements of the Data Protection Act (1998), signatories will also work to ensure that the following principles apply in handling personal information: • where there is a choice as to whether the information can be shared or not, it will be made as easy as possible for an individual to exercise that choice; • information will only be processed without an individual's knowledge where this is necessary for purposes such as national security, public safety, statistical analysis, the protection of the economy, the prevention of crime or disorder, the protection of health or morals, or the protection of the rights and freedoms of others; • only information which is actually needed will be collected and processed; - personal information will only be seen by staff who need it to do their jobs; • any information which is no longer needed will be deleted;

	• decisions affecting an individual will only be made on the basis of reliable and up to date information; • personal information will be protected from unauthorised or accidental disclosure; • subject to any statutory exemptions, a copy of any information held will normally be provided on request; • any inaccurate or misleading information will be checked and corrected as soon as it is identified; • proper procedures will be in place for dealing promptly with any complaints that are made; and • personal information will be stored securely and for no longer than is necessary. The principles apply to personal information which is held both on computer and in some paper records (including all papers records previously covered by the Access to Personal Files Act 1987).
Organisations collecting personal information will publish service-specific privacy statements where appropriate.	In order to comply with the requirements of the Data Protection Act it is good practice to publish privacy statements which set out who will see the information collected, why it is needed, what will be done with it and how long it will be retained for. It will also state how that personal information is safeguarded, how an individual can check and correct the information that is being held, how to pursue a query or complaint; and where to get more information.

Item 6

The Warwickshire Shadow Health and Wellbeing Board

Interim Strategy

[Inside Cover]

Health is something that we collectively share not individually consume. Inequalities in health arise because of inequalities in society – in the conditions in which people are born, grow, live, work, and age. So close is the link between particular social and economic features of society and the distribution of health among the population, that the magnitude of health inequalities is a good marker of progress towards creating a fairer society. Taking action to reduce inequalities in health does not require a separate health agenda, but action across the whole of society.

Professor Sir Michael Marmot

Marmot's key enablers of equity:

1. Giving every child the best start in life

2. Enabling all children, young people and adults to maximise their capabilities and have control over their lives

3. Creating fair employment and good work for all

4. Ensuring a healthy standard of living for all

5. Creating and developing healthy and sustainable places and communities

6. Strengthening the role and impact of ill-health prevention

Contents

The Purpose of our strategy

The Health and Wellbeing Board (HWBB) is a body tasked with the improvement of the health and wellbeing of the population. It is required by Government to produce a formal strategy outlining how it will achieve these improvements. The Board will be guided by the intelligence and information contained within Warwickshire's Joint Strategic Needs Assessments (JSNAs) which can be found at www.warwickshire.gov.uk/jsna and the Joint Director of Public Health's Annual Reports which can be found at www.warwickshire.gov.uk/publichealth .

Using the JSNA tools, data and intelligence, and the Joint Director of Public Health's Annual Report 2012, all partners and statutory agencies can inform and influence their decisions and policies to impact positively on the health and wellbeing of the population. It is a fundamental principle of the Health and Wellbeing Strategy that all organisations will work together to target agreed investment and efforts to where they are needed most and proven to have the greatest effect.

The strategy will continue to be informed by extensive engagement with not only our key stakeholders (public representatives, clinicians and service providers, local authority professionals and emergency services staff), but also by the public at large through a variety of approaches – community forum discussions, special interest groups, engagement with parent – teacher associations, Foundation Trust Governors and patient groups.

This Strategy offers a way of using our current health and social care services to best effect and puts forward evidence-based measures that all Warwickshire's major statutory and independent sector bodies can adopt in order to improve the wellbeing of our residents.

Resourcing health and wellbeing

It is important to acknowledge that the wide range of organisations and services that support the health and wellbeing agenda are in a period of significant financial challenge. District and County Council budgets have been reducing under the current spending review period and will continue to reduce under the next one. Health budgets are not falling in cash terms but demographic pressures are not being funded and are therefore driving the need to continue to find significant savings and productivity improvements. It is not clear if or when any of the key financial recommendations from the Dilnot review will be implemented to help to manage the financial position locally. In the private and voluntary sector many traditional sources of income are reducing, and the outlook for the economy and the business to be won from public services is far from certain.

However, improvements in the use of public funds to promote health and wellbeing and to provide care and support for those who need it are still achievable. This strategy should change where spending is focussed as services are reshaped, resulting in new costs and new savings. This strategy does not quantify the potential financial impact of the priorities proposed but key organisations and stakeholders will need to ensure appropriate business cases and plans are in place for particular initiatives before they are implemented. Crucially

this strategy is seeking to find ways to promote and champion early intervention and prevention that by its very nature will achieve savings and improved outcomes for individuals.

We need to use our current health and social care services to best effect and put forward evidence-based measures that all Warwickshire's major statutory and independent sector bodies can adopt in order to improve the wellbeing of Warwickshire residents. We feel the partnership approach to formulating and delivering this strategy will help avoid duplication of effort and allow us to support and challenge each other in our delivery. We will always consider how to deliver our services from a value for money perspective, making the most of community assets and encouraging and stimulating change and innovation where possible.

Introduction and Context

Our aspiration is that:
"In Warwickshire people will live longer, in better health and be supported to be independent for as long as possible. We will see the people of Warwickshire free from poverty, have a decent standard of living and no child will start their lives at a disadvantage or be left behind."

This strategy identifies both the challenges we in Warwickshire face in achieving the very best health for ourselves and the opportunities now available to us to dramatically improve our health and wellbeing.

Warwickshire has an ageing population, in part because we are living longer, in part because older people choose to retire here. Both trends are to be welcomed. Living longer and well, must be a key goal for any compassionate society.

However, this county still demonstrates unacceptable differences in life expectancy between the north and south, between those on low incomes and those who are comfortably off. In addition, despite being a relatively prosperous county, Warwickshire is ranked 128th out of 142 local authority areas when it comes to 'happiness'. Worryingly, Warwickshire's Observatory Quality of Life report shows that one in five people spend at least ten percent of their income on fuel bills and a quarter of children do not eat breakfast. A rural county poses particular problems in accessing health and social care, whilst older people are more limited in their own personal mobility and transport options.

This strategy is not a reference document to all key services. It highlights the highest priorities, that if addressed would make the most significant difference to reducing our health deficit. Many services are working extremely well in Warwickshire and provide high quality care and support. These services are not the focus of this strategy, though they will in due course express their own strategic ambitions.

We have attempted to chart a path forward to a better, healthier and more independent life for all Warwickshire residents. This is our *'Life Course approach',* and there are three aspects of that path to improved health and wellbeing:

- Mobilising communities
- Improving access to services including 24/7 access to care
- Public agencies - working together

As Sir Derek Wanless pointed out, without the "full engagement" of all our citizens the health and social care we seek will become unaffordable by the 2020s. The demand for care by an ageing population will be unsustainable if we do not improve our health in old age by sensible preventative measures and offer more care and support closer to people's homes and neighbourhoods where informal support can also be offered. That in turn will require greater attention being paid to supporting carers and community infrastructure.

We also recognise that we have constructed a health and social care system that for many of our residents appears to disappear at six o'clock on a Friday evening only to reopen at

eight o'clock the following Monday, unless it is a bank holiday! That experience is rare in all other aspects of our society where supermarkets may be open 24/7, and the rest of the service sectors work through the weekend.

Some of our Primary Care services are already looking to address this problem. Larger practices are planning an integration of medical, nursing and social care with pharmacy and even short stay care. The use of tele-health, e-medicine, remote alarm screening and the development of nurse practitioners will make round the clock care sustainable and will prevent the hospital admission that often leads not to cure but increasing dependence. Some commentators now suggest that up to a third of current hospital admissions could be avoided with such developments. That in turn will radically change the way our hospitals are used.

We have created environments in which healthy lifestyles are ever harder to maintain. And the very fact that there are identifiable groups exhibiting health compromising behaviours demonstrates that they do not result from random irresponsibility.

The evidence of the ban on smoking in workplaces and enclosed public places demonstrates how individual changes in healthy lifestyles can be supported by collective action. The Police with zero tolerance of domestic violence, bearing down on speeding drivers and addressing anti-social behaviour are as engaged in improving our health and wellbeing as our immunisation and vaccination service. We are committed to the Department of Health's policy of "Making Every Contact Count" whereby all public services – with brief advice and encouragement - can encourage healthier behaviours whether by ignoring the lift, giving up smoking or walking along the "measured mile" marked routes appearing across the county.

Warwickshire can improve our health and wellbeing as long as individuals, local neighbourhoods' public and commercial services, serving the county together, all embrace the message that "health and wellbeing is for the taking". Our interim Health and Wellbeing Strategy outlines how this can be achieved.

Professor Bryan Stoten
Chair of the Warwickshire Health and Wellbeing Board

Our priorities explained

Warwickshire has a health deficit. It is an affluent county but has only little better than average health outcomes compared to the rest of England. We need to do much better.

1. Mobilising communities to develop and sustain their independence, health and wellbeing

We want to concentrate our efforts on encouraging communities to set up support networks which will help individuals to improve their lifestyle choices and which will significantly reduce Warwickshire's health deficit. In line with the localism agenda, this includes:

- Mobilising community and neighbourhood support ensuring full engagement of local communities, motivating an interest in social responsibility and the independence of vulnerable people
- Building a healthier, more productive and fairer society in which we recognise difference, build resilience, promote mental health and wellbeing and challenge stigma and discrimination
- Working with local community and voluntary sector organisations to build the social infrastructure of community facilities.

By mobilising communities, we are aiming to:

- Reduce the social acceptability and so the levels of smoking in the north of the county compared to that in the south
- Reduce carbon monoxide (CO) levels in pregnant women through getting compliance with CO monitoring at first booking
- Support independent living and enable all Warwickshire residents to enjoy the best possible mental health, have a good quality of life and a greater ability to manage their own lives in community settings
- Reduce the weight of schoolchildren by engaging local communities in creating opportunities for physical activity
- Develop personalised, tailored and bespoke health prescriptions for wellbeing to counteract poor lifestyle choices targeting diet, exercise and addictive behaviours
- Improve the monitoring of weight, blood pressure and cholesterol levels into old age by the vulnerable, and where necessary, their carers

2. Improving access to services

We need to improve access to our public services. We will do this by:

- Ensuring that primary, community and social care facilities are of high quality across the county with health and care pathways being easily accessible to all communities
- Developing the co-ordinated delivery of out of hours access that includes pharmacy, general medical, general dental, mental health and wellbeing services, health visiting and district nursing care
- Developing alternative models for out of hours services which better meet the needs of the population and fit with models of independence and wellbeing that we see as the basis for a sustainable health care system
- Ensuring that children and young people have timely access to support and service to reach their full potential and make their right decision for themselves

- Investing in the development of tele-health and tele-care services

3. Public Services – Working Together

Demand for services is growing at a time when all services are under increased pressures. In order to meet these challenges we need to find new ways to work together to share resources and improve the quality of services whilst delivering them more effectively.

We need to address the sustainability of services faced by increasing demands from an ageing population and take account of the changing socio-demographic profiles for wellness and ill health. We also need to work together to ensure children and young people are able to reach their full potential to help ensure that health and wellbeing inequalities such as differential levels of educational attainment are minimised.

Managing demographic pressures, the increases in long term conditions and complex diseases such as dementia alongside the need to reduce costs creates an on-going challenge. National policy such as Think Local Act Personal and the Care and Support White Paper are re-stating the need to ensure that low level, early intervention services and support are available to people at the earliest possible stage to prevent them needing to rely on more costly health and care services at a later stage.

Housing plays a core and central role in maintaining and improving health and wellbeing. Joint approaches should be developed to ensure that there is recognition of the role that good housing has on people's health and wellbeing. We need to work together to ensure that Warwickshire residents have access to an adequate standard of housing as this has an impact on the extent to which someone experiences good health and wellbeing.

We will work together to promote health and wellbeing by:

- Agreeing and, where possible, aligning our strategic commissioning intentions and financial plans to achieve value for money across all public sector services. For example jointly scoping the development of a co-ordinated primary, community and social care delivery model that will help make the best use of scarce resources and result in the best outcomes for patients, customers and the wider public
- Creating opportunities for joint commissioning – working with partners towards shared objectives and outcomes, reducing duplication and making the best use of resources
- Ensuring frontline services support the delivery of preventative as well as treatment strategies across all public services
- Identifying opportunities to address the impacts of the wider determinants of health and wellbeing such as poverty, homelessness and obesity
- Supporting young people to aspire and achieve to their educational potential to close the outcomes gap between vulnerable groups and their peers
- Promoting the message of *Making Every Contact Count (MECC)* in frontline customer and public interactions
- Integrating community and secondary care delivery. The management of community health services by South Warwickshire NHS Foundation Trust offers such an approach. This is where early discharge from hospital is enabled following planned surgery e.g. a hip replacement, by providing outreach nursing and physiotherapy. It

helps ensure that people are enabled to recover in the best place for them with efficient community support around them to help support a safe recovery

- Improving the public knowledge, awareness of and access to early intervention services
- Jointly recognising the role that good quality housing has on people's health and wellbeing and prioritise joint approaches to securing decent housing for all
- All agencies adopting the principles of early help and support, e.g. public sector, voluntary organisations, community organisations, businesses, schools, colleges, GP surgeries, housing services, clinical commissioning groups, etc.
- All public services working together in keeping people safe from harm.

By doing all of the above we will harness a strong joint sense of achievement by all agencies, acknowledging their contributions and valuing the inter-dependency needed to meet agreed outcomes.

Our Vision

'We will be a healthy county, where all our partners are committed to supporting jointly agreed priorities for action, embedding behaviours and approaches that will make a tangible difference to the economic and lifestyle prospects of all Warwickshire residents enabling all to live well.'

How healthy will Warwickshire be:

- Warwickshire will be in the best 20% in the UK for all major health and social care indicators.
- The educational attainment of children in Warwickshire will be consistently improved in our most deprived areas – no school will demonstrate more than 20% variance from the best in examination outcomes (GCSEs etc).
- All our local councils will be 'Healthy Councils' which champion health and wellbeing in its widest sense with a focus on Marmot's top six objectives (shown on the inside of the covering page) and our local priorities.
- All our partners will actively role model health and wellbeing.
- Adults and children will have early access to high standard mental health and wellbeing services that are community based and close to home.
- Our investment in preventative health and social care will be prioritised and underpin our commissioning strategies.
- Statutory services will be much more integrated with, in particular, innovative joint primary, secondary and social care teams that work together in the interests of the public's health rather than the interests of the organisations who employ them.

What working together for Warwickshire means for all public services?

It is our intention that Warwickshire residents should be able to maintain a healthy lifestyle, in an environment that is supportive of their health and wellbeing, with access to the highest quality health and social care at the most local level possible within the resources available. This can be achieved most efficiently by the collaborative work of the NHS, Local Authorities and the Voluntary and Independent Sector together with the fullest possible engagement of the population at large in behaviours which are evidenced to improve their health and wellbeing.

In our collaborative work and joint commissioning we will be guided by the following principles:

1. **We will enable people to remain independent and well for as long as possible, wherever possible and in a place of their choosing.**

2. **We will encourage more people in Warwickshire to have a greater say in how local services are provided.**

3. **Every public service will be involved in improving the health and wellbeing of Warwickshire residents.**

4. **We will invest in preventative approaches to keep people well and identify where we can act early to prevent ill health.**

5. **We will look for all public services to work together towards the same aims and improve the quality of people's lives.**

6. **We will endeavour that people get the right care in the right place at the right time.**

What needs to be done in Warwickshire?

This strategy asks every statutory agency in Warwickshire to articulate their commitments to the strategy using the life course approach and demonstrate this in organisational policies and plans as well as local area and joint partnership plans.

Our Life Course approach

Our approach is based on Marmot's Life Course Approach. **Thinking about the life course should enable all statutory agencies to plan for the health and wellbeing of the population they serve.**

In November 2008, Professor Sir Michael Marmot chaired an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010. *Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England*. He looked at ways in which each stage in the populations' lives could be enhanced by appropriate interventions.

When Marmot commenced the review it was feared that he would make financially unsustainable recommendations. The review, however, looked at the cost of doing nothing. Doing nothing is simply not an economic option. The human cost is enormous – 2.5 million years of life potentially lost resulting from health inequalities alone.

There are important differences in the north and the south of Warwickshire – the health deficit in Warwickshire overall is 13.7 years. A man in Nuneaton and Bedworth would live on average 15.4 years less and a Rugby woman nearly 14.7 years less than people in the least deprived areas of Warwickshire. The least deprived ward in all cases is Leek Wootton (ONS data).

Broader factors have a far greater impact on health and wellbeing than NHS and social care services do alone.

In Warwickshire:
39% of children in Warwickshire leave school with less than five good GCSEs
14% of children in Warwickshire grow up in poverty
20% of people in Warwickshire still smoke
25% of people in Warwickshire are obese
1 in 6 adults suffer from some form of mental illness
1 in 3 adults over the age of 16 live with a long term condition (147,000 people)

Wider determinants of health and wellbeing

Care and support at home

Housing has a central role in improving health and wellbeing. We know that most older people and people with physical and learning disabilities want to stay in their own home wherever possible and not have to go into residential or nursing care. In Warwickshire, more than 30% of people with a severe disability are looked after in residential care whilst in other parts of the UK this is 10%. Similarly, between one third and a half of people in hospital could be cared for just as well in their own home. Secure, warm and non-overcrowded housing conditions mean people are less likely to suffer from physical or mental illness, and children in similar settings are likely to do better at school.

Freedom from poverty

14.3% or 16,160 children in Warwickshire are growing up in poverty, an increase from 13.2% in 2008. In some neighbourhoods over half of our children are living in poverty. Since 2008 the number of looked after children in our county has increased by 20%. Providing the best start in life for children includes living in a home that offers healthy food, warmth and opportunities. Protecting children in their early years from poverty has been shown to be one of the most beneficial long term interventions to support their health and wellbeing.

Poverty in adults can lead to serious physical and mental health conditions. Such adults are more likely to drink harmful amounts of alcohol and smoke. Much poverty arises from a lack of employment as a result of ill health or disability, or lack of educational skills. However, low-income working families with children remain the single largest group of people living in poverty. Part of the 'Going for Growth' initiative within the County Council has been to offer more apprenticeships to enable improved employment and life chances.

Smoke free Warwickshire

Over half of the health inequalities between the north and the south of the county result from differential smoking behaviours. Three quarters of smokers begin smoking before it is legal to buy a cigarette. Our Trading Standards colleagues are crucial in addressing this shameful statistic.

Smoking has serious consequences for people's health with one in two life-long smokers dying from their addiction. The effect of second hand smoke on us all, but especially unborn babies and young children is harmful. In Warwickshire around 20% of people still smoke, as do 15% of pregnant women. At least 20% of our children live in a house where people smoke. Children of smokers are almost twice as likely to be admitted to hospital with breathing difficulties as those that live in a smoke free home. Community attitudes to smoking are probably the most powerful factor in shaping smokers preparedness to quit or continue with their addiction. Our work with Warwickshire Fire and Rescue Services will be important in both engaging in the ***Make Every Contact Count*** *(MECC)* programme and undertaking home safety visits to vulnerable people known to partners. Tobacco control is the responsibility of all of us.

Stopping smoking even in later life can make big differences to people's health and to how long they live. Quitting on retirement will increase life expectancy by an average of three years.

Hundreds of frontline public sector staff go into thousands of people's homes and see thousands more. This presents opportunities to MECC.

We must support people who work with children in their own homes such as social workers, health visitors and midwives to spend more time and be more confident in encouraging parents to keep their homes and cars smoke free.

Living in Warwickshire

The environment where we live is crucial for our health and wellbeing. Well maintained areas have low levels of crime and when people feel safe there is a greater feeling of community cohesion which in turn leads to people taking greater responsibility for themselves and their local community.

We have however created an environment that minimises the expenditure of effort. As a society we must consciously build a "non-obesogenic" environment which encourages walking, physical effort and minimises car use, sedentary game playing and recourse to convenience foods and "grazing". The school meal as a communal experience needs to re-enter the school setting to support the development of desirable nutritional behaviours from the earliest age.

Safe and green spaces encourage play and physical exercise. Maintaining the number and quality of community spaces is especially important when considering new housing developments. Local plans can encourage walking, cycling or the use of public transport instead of car use. Similarly, statutory agencies need to determine how our health and social care systems will cope with a growth in new residencies. Equally, good quality leisure facilities that are especially accessible to those living in more deprived areas are important where people may be unable to pay for alternative leisure pursuits.

We need to plan our public sector buildings in a more co-ordinated way, so that we can base several services in one place. 'Community hubs' are developing across the country where local people can access a range of public services such as GPs, social services, housing, dentistry, pharmacists, optometrists, libraries and community healthcare. Often these hub developments have been catalysts to shape and increase the level of joint community and voluntary sector involvement.

Safer Communities

Crime

Being a victim of crime or being afraid of crime has a major impact on people's confidence, mental health and wellbeing. Anti-social behaviour is a major factor in promoting this fear. Complex family problems often include domestic abuse, alcohol or drug misuse and non-attendance at school.

Drugs, alcohol and illicit substances

In Warwickshire, we estimate that drug misuse is a factor in 21% of crimes; alcohol in 43% of crimes and half the prison population has some form of mental health condition.

"Well-mannered" alcohol consumption is killing too many of our citizens. Warwickshire had 164 alcohol related deaths in 2011 compared to the West Midlands average of 131. We need a "wake up" call now. Alcohol admissions are increasing in prevalence nationally and locally. Harmful and dependent lifestyle choices are limiting people's ability to both improve their life chances and their health and wellbeing. This is an area for significant concern and needs continued investment and attention.

Offender health

Improving the health outcomes for offenders can contribute to reducing re-offending rates which in turn will bring wider benefits to the community. Warwickshire Probabtion Trust supervises approximately 2000 offenders in the community each year of which 29% experience drug problems, 51% have alcohol problems and 31% report emotional wellbeing concerns. Without access to good healthcare this group will continue to place disproportionate demands on health services. We will work with Warwickshire Probation Trust, Warwickshire Police and the Prison Service on reaching offenders who have the greatest need to improve their health and wellbeing.

Schools and Education

Education is an independent determinant of life expectancy. Together with its impact on employment potential and earnings, educational attainment has a direct effect on people's health and wellbeing over their entire lifetime. The gap in achievement between our schools is too great and we must demonstrate much greater equity in outcome.

39% of children in Warwickshire leave school without five good GCSEs. This means - for many – poor employment opportunities, low income and resultant poor health. Warwickshire's aspiration for educational attainment needs to increase significantly. We are performing below the standard to be expected given our levels of affluence and cannot be satisfied with 39% of our children leaving school without good qualifications. We expect the variation in attainment to reduce to no more than 20% by 2018.

Schools are important settings where children spend a lot of their life. Schools can significantly influence the positive social and lifestyle behaviours we take into later life. Children need to be encouraged to live their lives to their full potential. Healthy children who stay safe, achieve economic wellbeing and make a positive contribution are key indicators of success for this strategy.

We can show that school performance varies significantly depending on the culture and leadership within the school. The experience of those with a proven track record of success should be drawn upon by less successful neighbours to improve the attainment of all our children. As schools such as Ash Green have shown dramatic improvement in school performance is possible with the right authoritative leadership.

We believe the school meal is a vital component of social interaction and an excellent means of supporting children to develop mature social skills and behaviours. The School Food Trust found that healthier school food has a positive impact on pupils' academic achievement and therefore on earnings through the course of an individual's life. *(School Food Trust (2009) 'Healthy School Meals and Educational Outcomes', Institute for Social and Economic Research, Paper 2009-1)*

We believe breakfast clubs can also make a positive contribution to children, particularly those from low income and/ or priority families, achieving increased performance at school.

Re-shaping the delivery of care

Warwickshire's ageing population will force changes in the way that we deliver both health and social care. We expect to see a major increase in the over 75-year-old population in the county in the next decade, and more than half of unplanned or emergency hospital admissions are from this age group.

For too long the debate about hospital care has centred around waiting times, waiting lists, patient choice in hospital referrals, and the "tariff" to be paid for such episodes of care. In fact such referrals constitute no more than 11% of NHS activity. This pre-occupation has resulted in insufficient attention being given to the management of emergency admissions, the long term conditions of diabetes management, chronic obstructive pulmonary disease (COPD), heart failure, Parkinson's disease and cancers which increasingly require longer term management as a chronic rather than acute condition. As a result there has been a public demand to protect existing services rather than reconfigure them to meet the new and increasingly complex care needs of patients, facilitate new techniques and technologies and maximise the best care and patient safety. Evidence shows that this comes from high volumes and short bed stays. The fear of hospital closures has led to maintaining suboptimal services in the wrong place for too long. Increasingly, we need to support unpaid carers in their caring role and their life apart from caring. Their involvement in developments affecting them and the people they care for will be valuable in reshaping services.

This strategy looks to build on the strengths of our hospitals rather than their weaknesses and continue to offer more care choices and greater independence for those living with Long Term Conditions (LTC), supporting them to develop their own care plans that include end of life preferences, and for those who are frail or ill. We want to see specialist and major surgical interventions concentrated where such patients can be treated in high volume by clinicians with the greatest experience of such procedures. The evidence shows that outcomes for patients of all ages are safer and better as a result.

We want our local hospitals to offer increasing levels of day surgery, outpatient attendances, imaging and diagnostic facilities. Rapid hospital discharge is shown to be safer and we know of remarkable achievements in this area by hospitals in Warwickshire. Integrated care pathways can significantly reduce the cost of emergency admissions and at a time of great change across health and social care we must ensure that our joint working can be maintained and enhanced.

People at the end of their lives are often unnecessarily admitted to hospitals when they and their families could be more sensitively cared for at home. Hospice at home is vital in supporting this aspiration. Our joint responses can ensure that we increase people's ability to live well with terminal illness and die where they prefer.

That will require changes in Primary Care, too. We know that there is clinical enthusiasm for closer working between GPs, community and practice nurses, social care providers and therapists – physiotherapists, chiropodists, podiatrists, community pharmacists and key voluntary sector organisations.

Leading successful improvements

We know there are radical changes required to improve the health and wellbeing of Warwickshire residents. We will need to gain their support and confidence. The Health and Wellbeing Board, Overview and Scrutiny mechanisms and existing local area joint partnership will all be important in delivering tangible improvements for this strategy.

The demise of the Primary Care Trust with its monthly publication of key performance indicators must be replaced. We propose to publish outcome information from our hospitals and GP practices on the JSNA website, so that residents can compare, and hold to account, those serving their health and social care needs.

We expect to see in the plans of Clinical Commissioning Groups measures designed to bring about changes in the way and the place where patients are treated and cared for, together with an outline of the changes required in existing infrastructure.

There are four key outcomes frameworks that will drive the improvements in this strategy and in core services. Department of Health performance frameworks guide delivery for health overall, children's' services and adult social care services and are the key documents that will indicate an improvement or deterioration in any given service area. These frameworks are also referenced in, and integral to, the Health and Wellbeing Board review mechanisms:

- Adult Social Care Outcomes Framework 2012-13
- Every Child Matters Outcomes Framework
- NHS Outcomes Framework 2012-13
- Public Health Outcomes Framework for England 2013-16

The performance frameworks including at a glance summaries are on the JSNA website and we will use additional indicator sets from these frameworks to assess overall progress. These are cited at http://jsna.warwickshire.gov.uk/supporting-documents/government-guidance/

Evaluating collective views on our health and wellbeing

Local Healthwatch will play a key role in ensuring patients' and public voice is represented on the Board. 'Healthwatch Warwickshire' will be the local consumer champion for health and social care. It will build up a local picture of community needs, aspirations and experiences. It will do this by engaging with local communities, including local voluntary organisations, networks, people who use services and the wider population.

Health and wellbeing – building success

Aligned to the Joint Strategic Needs Assessment, that underpins this strategy, we will use the following outcomes and outputs to measure progress against our three priorities. These will be further developed through an action plan and aligned to the outcomes frameworks relevant to each organisation.

Children and young people

- Pupils are ready for school, attend and enjoy school with key indicators measuring attendance, exclusion and attainment.
- Children and young people achieve personal and social development and enjoy recreation.
- There are positive outcomes and destinations for pupils post 16 years.
- Transitions between settings and from children to adult services are well managed.
- 95% of children receive their vaccinations and immunisation.
- The variance in the percentage of children, in particular those looked after, attaining 5 or more GCSEs across Warwickshire schools will be no more than 20%.
- We will narrow the gap in outcomes for looked after children and young people as compared with that of the general population.
- Children and young people will sustain improved health and emotional wellbeing and have opportunities to develop resilience and skills to prepare themselves for change, independence and adulthood.

Healthy lifestyles

- There is a reduction in the number of people who start smoking coupled with an increase in the number of people who are supported to quit.
- Pregnant woman will be offered the opportunity to be assessed for smoking, alcohol use and obesity and helped to adopt a healthy lifestyle.
- All relevant partner organisations will support the delivery of *'Making Every Contact Count'.*
- Children and adults will be encouraged to eat more healthily.
- At least three "measured mile" walks will be available within every district and borough council.
- Warwickshire services will work with retailers to publicise the calorific content of alcoholic drinks and to encourage fast food outlets to promote healthier and informed choices.
- Supermarkets will be canvassed to promote healthy food and we will develop a "healthy hearts" award for local retailers in association with the British Heart Foundation.
- We will continue to reduce the number of under 18s' conception rates.
- More Warwickshire will reduce their alcohol consumption through good advice and the number of alcohol related admissions also be reduced.

Reducing health and wellbeing inequalities

- We will reduce poverty and increase educational attainment and skills to improve jobs prospects for those most in need.
- We will embed the reduction of health inequalities in the decision making process of all public agencies and partners.
- We will improve equity of access to services, especially health and care services.
- We will continue to promote mental health and wellbeing as a foundation stone to good health across the population, building on the notion of 'No Health without Mental Health'.
- We will increase the promotion of positive sexual health with a focus and promotion on HIV prevention.

Ill health

- We will improve clinical outcomes for people with long term conditions.
- There will be a greater use of assistive technology including, tele-health, aids and adaptations.
- We will imrpove rehabilitation services for people with long term conditions.
- Pregnant women and new mothers will all be offered assessment for post natal depression and other needs in order to prevent, detect and treat early mental health and wellbeing issues.
- People are supported to manage their condition themselves with improved access to personal learning opportunities and services such as psychological therapies and "Books on Prescription".
- Greater use of risk stratification tools will identify people who are at high risk of being admitted to hospital and will be proactively supported to prevent deterioration.
- We will reduce hospital admissions and improve discharges.
- All at risk patients will receive an annual health check.
- Warwickshire children and young people will have improved and timely access to early intervention mental health services.

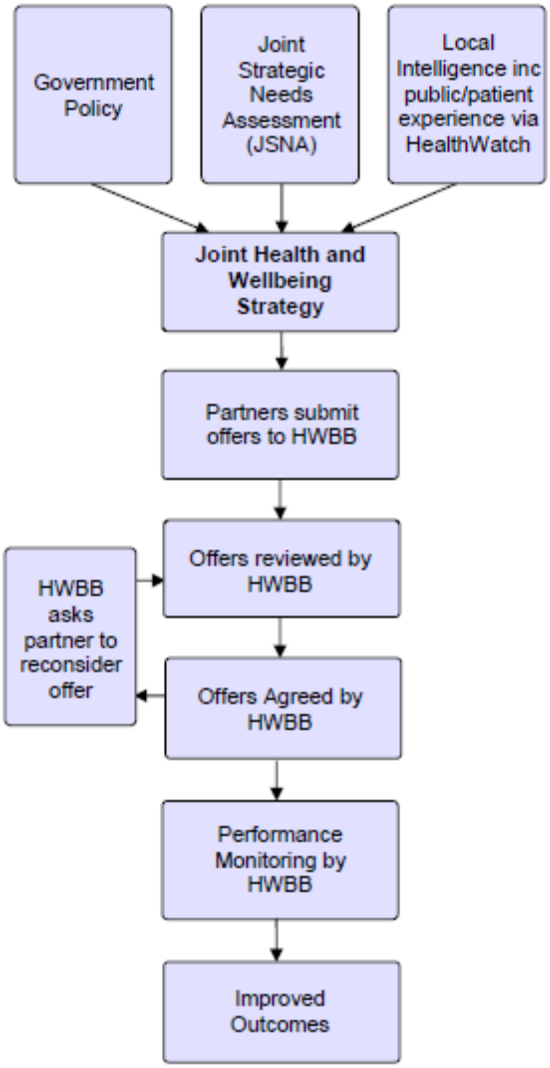
Older people's needs

- Universally older people will be offered appropriate and timely advice to support them to maintain their independence and remain at home for as long as they choose including good advice about housing and related support such as keeping warm and well.
- We will work to reduce the risk of falls and fractures in older people.
- We will work to decrease social isolation, in particular in rural areas, through improved community inclusion and activities.
- We will promote and encourage the benefits of healthy living in old age, including health eating and exercise.

- We will make sure at the end of life people die well and in a place of their choosing with dignity and respect and their loved ones are supported.
- We will aspire to decrease winter deaths by 10% up to 2016 (baselined against 2013 population figures and environmental factors).
- We will develop a more extensive “trusted traders” scheme.
- Carers of older people will have access to information, advice and support services that is timely and specific to their own needs and the needs of the person they care for.
- We will improve the rates of diagnosis and support for people with dementia and their carers.
- We will have created at least one integrated care hub that will enable more people to be cared for closer to home and in more local community settings without recourse to being admitted to hospital.

Turning the strategy into action

The Health and Wellbeing Strategy covers a wide area of responsibilities and crosses the remits of many different organisations. In order to turn this strategy into action each organisation will make a formal response, or offer, to deliver parts of the strategy that they think they can influence. For some organisations, such as the NHS Clinical Commissioning Groups, these responses may form part of their annual commissioning plans that describe the services that they will commission to care for their population.



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Partnerships

Unipart which employs over 2600 people in Warwickshire and Leicestershire has embarked on a programme of health and wellbeing initiatives in partnership with Public Health Warwickshire. Emma Dempsey, a Director at UTL said: "We are delighted to work in partnership with Public Health Warwickshire across a range of initiatives and hope that by participating in the programme our people become increasingly aware of the benefits of healthy living, which means UTL will benefit from healthier, happier people working in the business."

Integrated care

The local community of Shipston on Stour and its health providers are proposing full integration of primary community and social services around a health and social care hub. One of the aims of this initiative is to keep people out of hospital, maintaining their independence wherever possible for as long as possible and minimise lengths of stay when admissions to hospital are unavoidable.

Increasing physical activity in the North

For a small investment, we are targeting people with a CVD risk factor, who live in one of five of the most deprived wards. The aim of the project is to get people more active, addressing diet and healthy eating at the same time, thereby reducing health inequalities. Of 73 people seen, 17 have now completed the programme losing 145 kg in total and an average 7.5% e body fat. Several cases show significant reductions in health-threatening blood pressure and cholesterol levels. This has been a joint venture between Public Health and the Nuneaton and Bedworth Local Leisure Trust. In addition, a recently agreed pilot study in North Warwickshire will build on the healthcheck screening programme and identify people who are at risk of developing diabetes. Blood tests will target patients who have abnormally high blood sugars and are pre-diabetic. They will be referred to exercise schemes and healthy living education to encourage preventative behaviours thereby preventing them from becoming diabetic.

Healthy eating programmes for Children - NOSH

Public Health and the Mancetter Children's Centre enhanced the original Baby and Toddler NOSH Porgramme developed by the Centre and tailored it for families. Children's Centre Staff have been trained by health advisors to deliver 4-6 week projects. Each project develops parent/carer skills and knowledge on healthy eating, menu planning, hygiene and cooking skills. All information given to parents/carers, aligns with national Start4life,

Change4life and The Healthy Child programme recommendations. Early indications are that as a result of this programme, the families are carrying out on a budget, more healthy eating at home and cooking with their children. The impact of each project assesses changes in parents' knowledge and attitude to healthy lifestyle behaviours.

Smoking in pregnancy

Together with the Tobacco Control Collaborating Centre (TCCC) we have been working to improve the way we collect data around smoking at the time of delivery in pregnant women. A new screening method is being piloted at the labour wards of Warwickshire hospitals which tests Cotinine levels within the saliva of women due to deliver on the test day. The saliva test is accompanied by a simple questionnaire. The new tests hope to improve on the reliability and accuracy of the previous technique which involved monitoring carbon monoxide levels. Tests results will encourage women to stop smoking with support from the smoking cessation team.

Supporting independent living and re-ablement

A recently funded joint programme between Public Health and Stratford District Council is supporting people with learning disabilities to learn how to cook and support their independent living. A ten week programme guides the candidates through basic cookery skills and provides them with a basic food hygiene safety certificate. On a weekly basis they hold a luncheon club at the Buzz community café in Stratford town for people with Parkinson's disease. The people coming for lunch purchase the meal at a nominal charge and get a copy of the menu and a recipe card to encourage them to eat more healthily at home. This is a sustainable solution for promoting healthy eating and social inclusion. We are seeking to expand this initiative to meet a range of needs.

Reducing harmful drinking

Warwickshire Police is supporting the Warwickshire Drug and Alcohol Action Team to implement the Alcohol Diversion Scheme, targeting people who commit minor disorder offences. The scheme allows people subject to a fixed penalty notice to attend a course where alcohol abuse and health related consequences are presented – much like the speed awareness courses, and where the attendance results in the level of fine being reduced or removed.

Linking offenders to appropriate treatment and interventions:

Warwickshire has designated treatment for offenders requiring treatment and interventions for substance misuse which is provided through the recovery partnership and the Criminal Justice Mental Health Liaison service. This initiative attempts to connect offenders with required mental health services from the point of arrest onwards. This service has recently attracted favourable attention from the Government. This is an important service that will need to be strengthened as needs continue to grow.

A new Sexual Assault Referral Centre

A new Sexual Assault Referral Centre for Coventry and Warwickshire is being built at George Eliot Hospital and will open in November 2012. The centre will enable those who have been sexually assaulted to be supported and treated in a specialist environment. The Centre will include support for children of sexual abuse and is a combined approach by Warwickshire Police, NHS Arden, Coventry and Warwickshire Councils and the voluntary sector.

Eliminating Child Sexual Exploitation

A new Child Sexual Exploitation (CSE) Task and Finish Group has been established with partners from Safeguarding, Education, Police and the Respect Yourself Campaign. The group are seeking to Prevent, Protect and Prosecute, particularly supporting the prevention aspects by:

- *Advising that consultation commences with young people regarding the definition of CSE*

- *Young people's forum to advise and influence CSE activity*
- *Including CSE as a core aspect of www.respectyourself.info within the safer relationships aspects and increasing awareness*
- *Embedding CSE training within the RYC training brochure and framework*

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If you would like this document in another format or in large print, please contact us.

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Appendix 1. Our Baseline Performance and Key Performance Indicators

Indicator	Definition	Source	Time Period	Current Performance/Baseline	Comparator
Preventative					
Breast screening	Coverage of women aged 53-70 by Primary Care Organisation – Number of women screened as a proportion of the eligible population.	NHS Information Centre	31st March 2011	To be inserted	To be inserted
Excess winter deaths	Excess Winter Deaths Index (EWD Index) is the excess of deaths in winter compared with an expected number of deaths based on non-winter months, expressed as a percentage. The year runs from August to July. Winter months are December to March; Non-Winter months are August to November and April to July.	Annual Public Health Mortality File provided by ONS.	2007-2010	Average yearly excess winter deaths – 276 EWD Index = 17.9%	England = 18.7% West Midlands = 19.8%
Immunisation and childhood vaccinations to achieve herd immunity (95%)	Proportion of children vaccinated by age 1 year of age: Diphtheria, Tetanus, Pertussis, Polio, Haemophilus Influenza type b (Hib) vaccinations, Pneumococcal vaccination, Meningitis C vaccine 2 years of age: Haemophilus Influenza type b (Hib) vaccinations, Meningitis C vaccine, Pneumococcal vaccination, Measles, Mumps and Rubella vaccination. 5 years of age: Diphtheria, Tetanus, Pertussis and Polio	Inform, Department of Health	To be inserted	At 12 months of age: 97.6% At 24 months of age: 95.6% At 5 years of age: 96.6%	To be inserted

	vaccinations, Measles, Mumps and Rubella vaccination				
Early Intervention					
NHS Health Check Uptake	Number of patients who have received a health check as a proportion of those offered in total	NHS Warwickshire Informatics	2012	9,934 Health Checks offered 6,896 Health Checks delivered 69.4%	
Childhood Obesity	Estimate of prevalence of obesity in children in Reception and Year 6. Children are classified as obese if their BMI is on or above the 95th centile of the British 1990 growth reference (UK90) according to age and sex. This definition is commonly used in England for population monitoring.	National Child Measurement Programme (NCMP)	2010/11	7.8% obesity prevalence in Reception children 16.2% obesity prevalence in Year 6 children	England - 9.4% obesity prevalence in Reception children England - 19.0% obesity prevalence in Year 6 children West Midlands Region – 10.1% obesity prevalence in Reception children West Midlands Region Reception children 20.5% obesity prevalence in Year 6 children
Treatment and management					
Falls and fall injuries in the over 65s	Age-sex standardised rate of emergency hospital admissions for falls or falls injuries in persons aged 65 and over	Hospital Episode Statistics (HES) via NHS Information Centre for Health and Social Care (IC).	2010/11	To be inserted	To be inserted
Hospital stays for alcohol related harm	Number of admissions for alcohol-attributable conditions, directly age and sex standardised rates, all ages, admissions per 100,000 European	Hospital Episode Statistics (HES) via NHS Information Centre for Health	2010/11	11,493 admissions, 1,693 admissions per 100,000 European Standard Population	England - 1,895 admissions per 100,000 European Standard Population

	Standard Population	and Social Care (IC).			West Midlands Region – 1,910 admissions per 100,000 European Standard Population
Patients diagnosed with Diabetes	Total Patients on GPs Diabetes Mellitus (Diabetes) Register (ages 17+) as a proportion of total GP Practice list size	Quality & Outcomes Framework (QOF), NHS Information Centre	2011/12 data as at end of July 2012	24,572(5.4%)	West Midlands – England –
Patients diagnosed with COPD (Chronic Obstructive Pulmonary Disorder)	Total Patients on GPs Chronic Obstructive Pulmonary Disease Register as a proportion of total GP Practice list size	Quality & Outcomes Framework (QOF), NHS Information Centre	2011/12 data as at end of July 2012	7,527	West Midlands – England –
Patients diagnosed with Depression	Total Patients on GPs Depression Register (ages 18+) as a proportion of total GP Practice list size	Quality & Outcomes Framework (QOF), NHS Information Centre	2011/12 data as at end of July 2012	47,286 (10.6%)	West Midlands – England –
Recovery and Reablement					
Readmission rates within 28 days	To be inserted	To be inserted	To be inserted	GEH SWFT UHCW	To be inserted