Warwickshire Health and Wellbeing Board

Agenda

11th June 2013

A meeting of the Warwickshire Health and Wellbeing Board will take place in **Committee Room 2, Shire Hall, Warwick on Tuesday 11th June 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 Final Meeting of the Warwickshire Shadow Health and Wellbeing Board on 19th March 2013 and Matters Arising

Draft minutes are attached for approval.

2. (13.35– 14.00) Overview and Future Ways of Working (No Report)

Councillor Izzi Seccombe – Chair of the Warwickshire Health and Wellbeing Board

3. (14.00 – 14.20) The Police and Crime Commissioner and Collaborative Work with the Health and Wellbeing Board (No Report)

Ron Ball – Warwickshire Police and Crime Commissioner

4. (14.20 – 15.00) i) South Warwickshire NHS Foundation Trust – Key Priorities and Challenges (No Report) ii) Integrated Long Term Conditions – Pioneer Site Application (No Report)

Glen Burley – Chief Executive, SWFT
Ian Philp – Medical Director, SWFT

5. (15.00 – 15.20) Health and Wellbeing Board – Work Programme

John Linnane – Director of Public Health, WCC

6. (15.20 – 15.30) JSNA Update

John Linnane – Director of Public Health, WCC

7. (15.30 – 15.40) Health Protection Strategy

Nicola Wright - Locum Consultant in Public Health WCC

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

Shadow Health and Wellbeing Board Membership (17)

Chair: Councillor Izzi Seccombe (Warwickshire County Council)

Warwickshire County Councillors: Councillor Ann McLauchlan, Councillor Bob Stevens, Councillor Heather Timms

GP Consortia: Andrea Green (Warwickshire North), David Spraggett (South Warwickshire), Jill O'Hagan (Coventry and Rugby)

Warwickshire County Council Officer: Wendy Fabbro - Strategic Director, People Group, Monica Fogarty - Strategic Director, Communities, John Linnane - Director of Public Health

NHS Martin Lee, NHS England

Warwickshire Healthwatch: Deb Saunders

Borough/District Councillors: Councillor Roma Taylor (NBBC), Councillor Claire Watson (RBC), Councillor Michael Coker (WDC) , Councillor Derek Pickard (NWBC), Councillor Gillian Roache (SDC)

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Minutes of the Meeting of the Shadow Warwickshire Health and Wellbeing Board held on 19 March 2013.

Present:-

Chair

Bryan Stoten

Warwickshire County Councillors

Councillor Alan Farnell
Councillor Izzi Seccombe
Councillor Bob Stevens

Clinical Commissioning Groups

Adrian Canale-Parola – Coventry and Rugby CCG
Andrea Green – Warwickshire North CCG
Gill Entwistle – South Warwickshire CCG
Dave Spraggett – South Warwickshire 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)
Councillor Derek Pickard (North Warwickshire Borough Council)
Councillor Claire Watson (Rugby Borough Council)

Warwickshire LINk

Councillor Jerry Roodhouse

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

1. (1) Apologies for Absence

Wendy Fabbro – Strategic Director, People Group

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

None

(3) Minutes of the meeting held on 24 January 2013 and matters arising

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

2. George Eliot Hospital – Initial Response to the Francis Report

Kevin McGee, Chief Executive of the George Eliot Hospital NHS Trust explained that the hospital is one of 14 with elevated mortality rates that will be subject to independent review. The key question, it was suggested, is what are the implications for district general hospitals of the Francis Report?

The meeting was informed that the George Eliot has already done much work around the quality of its services. It did have a period around 18 months ago when mortality rates and other pressures were very high but this has now passed. The culture of an organisation is fundamental and it has been necessary to work to raise the morale of staff. Only by doing this can the quality of care be improved. In other areas the ratio of qualified to unqualified nursing staff has increased, there has been a move towards seven day care and a new paediatric care model has been introduced.

Mortality rates are down. Over the last five quarters the Summary Hospital-level Indicator (SHMI) has decreased from 124 to 112. It is anticipated that this will continue over the next two quarters. There is, however, a limit to the improvements a hospital alone can do. The hospital is increasingly working with outside partners especially in the acute sector.

The acute sector has over the last four to six weeks been under great pressure. It is not only the number of patients that is an issue but also the acuity of their conditions. It is expected that this situation will become increasingly common and this gives greater urgency to the need to work with colleagues to address the underlying causes of ill health.

Kevin McGee informed the meeting that he welcomed the upcoming review noting that it would give the hospital an opportunity to undertake a whole system analysis.

In response to a question from Councillor Jerry Roodhouse, Kevin McGee stated that within the last few days the Trust had met with the local CCG and other clinicians to discuss what action is needed. The emerging Systems Board may offer a partial solution although the fact that it meets infrequently may be a problem.

Dr John Linnane, Director of Public Health, asked how the Health and Wellbeing Board can assist the hospital during its review. Kevin McGee suggested that the Board should be given the opportunity to comment on the hospital's eventual response to the independent review.

In response to a statement from Councillor Bob Stevens, the meeting was informed that the hospital does not have a publicity department. This makes it difficult to broadcast good news to local residents.

Turning to the George Eliot Hospital's application for Foundation status, Kevin McGee explained that he is waiting for permission to move onto the next stage. The key, whilst this process is running, is to keep on providing good services to patients.

Monica Fogarty, Strategic Director for Communities, proposed that members of the Board meet to agree an approach to support the George Eliot. This theme was taken up by Councillor Roodhouse who suggested that this should be undertaken on a formal basis through a sub-committee of the Board. This was agreed.

The Chair welcomed the improvements in performance made by the George Eliot Hospital. He observed that acute services have experienced pressures for years and whilst not presenting insurmountable problems these do little to enhance the patient experience. He reminded the Board of the 2008 Acute Services Review pointing out that there remain some recommendations from that to be implemented. The key is to prevent people from becoming ill thus reducing demand on services.

3. NHS Coventry and Rugby Clinical Commissioning Group Identification of Local Priorities: 'Everyone Counts' planning requirements

Dr Adrian Canale-Parola informed the meeting that the CCG he represents differs from the other two in Warwickshire in that it works closely with the Coventry Health and Wellbeing Board and Coventry Public Health. He introduced the CCG's plan on a page and explained the differing components of it. The three locally determined priorities relate to alcohol consumption, cervical cancer screening and smoking in pregnancy. John Linnane commended the CCG on these priorities stating that they reflect the Director of Public Health's Annual Report and the Joint Strategic Needs Assessment. Charles Goodey questioned why targets were not 100%. The Chair suggested that a figure of 90% is a minimum expectation whilst Adrian Canale-Parola stated that if targets are set too high they can become demotivating.

Councillor Izzi Seccombe welcomed that the references to alcohol were not confined to liver disease. She did however ask that greater emphasis be placed on cancer screening for men. In response, the meeting was told that there remains no easy screening for men. There is bowel cancer screening and this is for men and women. Health checks have been introduced in the north of Warwickshire and these are due for rollout elsewhere. Adrian Canale-Parola assured the meeting that despite pressures on resources they will be able to provide a good level of care.

4. South Warwickshire CCG and Warwickshire North CCG – Plan on a Page

Dr David Spraggett outlined the key components of the South Warwickshire CCG plan. The plan was welcomed by the Chair who noted the clear link between the plan and the Health and Wellbeing Strategy. Councillor Stevens observed that the plan contains little reference to children or obesity. It was acknowledged that there had been little engagement with the Children's Trust and this would need addressing in the future.

Monica Fogarty questioned why, when considering end of life the target stopped short of ensuring that whenever possible people die where they choose. David Spraggett responded that at this stage it is a challenge simply to record patients' preferences on this issue.

Gill Entwistle pointed out that the plan is a summary and that behind it lies a great deal of detail. John Linnane welcomed the focus of the plan on health inequalities, smoking in pregnancy and alcohol consumption but suggested that a reduction in levels of consumption would be better than stabilisation. Chris Lewington, Head of Strategic Commissioning, observed that there is no explicit reference to dementia in two of the three plans. She was asked by the Chair to bring forward the dementia workshop that has been discussed previously.

Andrea Green introduced the Warwickshire North CCG's plan. She chose to highlight the importance of end of life registers adding that so far the take up rate has been low. In addition there is a need to reduce non-elective hospital admissions.

Councillor Alan Farnell commended the work of the three CCGs but asked that in future efforts be made to present the plans in a similar format.

The Chair highlighted the difference in life expectancy between the north and south of the County. It was acknowledged that if smoking could be significantly reduced in the north then there would be less of a differential between the north and the south. In addition the Chair suggested that there should be a "plan on a page" for the National Commissioning Board. It was agreed that a letter should be sent to the National Commissioning Board with this idea.

Paul Tolley asked that future plans use fewer abbreviations. This was agreed.

5. Warwickshire Information Sharing Charter

Andy Morrall, the Warwickshire County Council Corporate Information Manager introduced his report explaining that the current Charter is now out of date having been approved in 2008. John Linnane stated that the transfer of Public Health to the County Council had placed a number of barriers in the way in terms of gaining intelligence from the NHS. This, however, is being looked into by Public Health England.

The meeting was informed that acute trusts are not included in the current charter nor are organisations that did not exist five years ago. Glen Burley, Chief Executive of South Warwickshire NHS Foundation Trust expressed his willingness to get involved in the preparation of the new charter.

Charles Goodey welcomed the development of the new strategy but noted that whilst sharing of information is a realistic aspiration integration of information is a long way off.

6. Health and Wellbeing Strategy

The Chair introduced this item outlining the core elements of the Strategy.

Councillor Bob Stevens proposed the adoption of the Strategy whilst Councillor Izzi Seccombe seconded it. In doing so Councillor Seccombe made a plea for 24/7 social care providing wrap around support. Paul Tolley welcomed the way the Strategy links to the JSNA. He did, however, express concern over threats to volunteer transport. The meeting was informed of the value of this service not only to its clients but also to the health economy in terms of reducing the number of missed appointments. In response, John Linnane stated that he was due to meet with representatives of volunteer transport providers.

7. Plans for Commissioning Children's Services

Chris Lewington gave a powerpoint presentation. Chris highlighted the current position with the commissioning of services being divided between a number of bodies, inconsistencies in the quality of services and the need to work with a number of newly formed agencies and posts.

The target is to develop fully integrated provision through close partner engagement and the development of mutual aims and objectives. The future role of the Health and Wellbeing Board and the Children's Trust was identified.

Councillor Jerry Roodhouse raised the need for engagement with Healthwatch and raised some concerns that the Children's Trust could end up reporting to many bodies. Adrian Canale-Parola stated that it is important to remember the quality of the customer experience and not just focus on hard targets and outputs.

The Chair asked that Children's Trust Board minutes be made available to the Health and Wellbeing Board.

Some concerns were raised over the profile of the Children's Trust. Members were unclear of its role and how it relates to other partner bodies. It was suggested that a report on the Children's Trust be brought to a subsequent meeting of the Board. This was agreed.

8. Any other Business

The Chair outlined a number of outputs from a recent planning meeting. These were,

- Increased involvement by district and borough councils.
- The future Chair of the Board will be the Leader of Warwickshire County Council.
- The meeting of 11th June 2013 will be the first meeting of the Board outside of shadow form.
- The Police and Crime Commissioner and CAVA will have a standing invitation to the Board.
- Sub- committees will be established only as required.
- The Chair of the Adult Social Care and Health Overview and Scrutiny Committee shall be invited to attend Board meetings.
- A communications strategy will be developed.

The meeting rose at 15.30

……..Chair

Item 5

Warwickshire Health and Wellbeing Board

11 June 2013

Health and Wellbeing Board Work Programme 2013-14

Recommendations

That the Warwickshire Health and Wellbeing Board:

1. Considers and approves the draft Work Programme 2013-14 and the draft Board's structures proposal.

2. Encourages partners to review and/ or contribute specific key activities to the Board's draft Work Programme 2013-14.

1.0 Introduction

1.1 During a business planning session on 8 March 2013, the Warwickshire's Shadow Health and Wellbeing Board discussed and agreed a number of key work priorities and key relationships it needs to further develop in 2013-14. These are laid out in the attached draft Work Programme 2013-14 and a draft proposal for the Board's relationships with other partnership bodies and groups.

2.0 Key issues

2.1 It is envisaged that the Board's Work Programme will be reviewed and updated regularly and will incorporate any current or urgent priorities, or changes to existing actions above the ongoing planned activities, as agreed by the Board.

2.2 It is recognised that successful implementation of the Board's Work Programme and Strategy will require effective relationships, partnerships and other support, as specified in the draft proposal. Partnerships with other committees and groups which do not directly relate to the activity of the Health and Wellbeing Board will be explored and established, as may be required.

2.3 The Board's Structures draft document proposes to ensure a coordinated organic approach to a set of arrangements which currently support the Health and Wellbeing Board in its role to lead and assure delivery of agreed local priorities and outcomes for health and wellbeing across the partnership.

2.4 Specific task and finish groups which purpose will be to deliver on specific projects arising from the Board's activity will be established as may be required.

3.0 Conclusions

3.1 Warwickshire's Health and Wellbeing Board's key priorities and activities planned in 2013-14 have been incorporated into a draft Work Programme which will be updated as required. It is also recognised that in order to deliver the Work Programme, the Board requires a coordinated approach to relationships with partners and other support. It is requested that the Board agrees these recommendations.

4.0 Background Papers

None

	Name	**Contact Information**
Report Author	Monika Rozanski John Linnane	monikarozanski@warwickshire.gov.uk johnlinnane@warwickshire.gov.uk
Head of Service	John Linnane	johnlinnane@warwickshire.gov.uk
Strategic Director	Monica Fogarty	monicafogarty@warwickshire.gov.uk

Warwickshire Health and Wellbeing Board Draft Work Programme 2013-14 (1.0)

Governance

Priority/ Item	Lead officer(s)	Timescales	Committee date	Outcomes
Agree chairmanship and membership post elections	Paul Williams	May 2013	11.06.13	Chair and portfolio holder members confirmed
Review and agree Terms of Reference	Paul Williams	June 2013	11.06.13	Revised ToR
Agree connections with other committees and sub-committees with their roles and reporting mechanisms	John Linnane	June 2013	11.06.13	Connections and sub-structures agreed with clear roles and reporting mechanisms
Review and approve JSNA	John Linnane/ Wendy Fabbro	June 2013	11.06.13	JSNA updated and in place
Review Warwickshire Health & Wellbeing Strategy	Nicola Wright/ Monika Rozanski	July 2013	17.07.13	Strategy reviewed and approved
Discuss and approve partners' offers to deliver Warwickshire Health & Wellbeing Strategy	Nicola Wright/ Monika Rozanski	September 2013	25.09.13	Partners' offers/ action plans approved and being delivered
Annual report on the Board's activity and performance	Nicola Wright/ Monika Rozanski	March 2014	26.03.14	Report submitted and published
Annual report on Warwickshire's Health Economy	Nicola Wright/ John Linnane	March 2014	26.03.14	Report submitted and published

Engagement and Relationships

Priority/ Item	Lead officer(s)	Timescales	Committee date	Outcomes
Discuss and approve WHWBB Communications & Engagement Strategy/ Approach	Monika Rozanski/ Comms officer	July 2013	17.07.13	Strategy in place and being delivered
Agree the Board's expectations of key commissioners	Nicola Wright/ John Linnane	July 2013	Workshop	Principles of working together agreed
Discuss and agree a relationship with	John Linnane/	July 2013		Basic principles/ approval systems

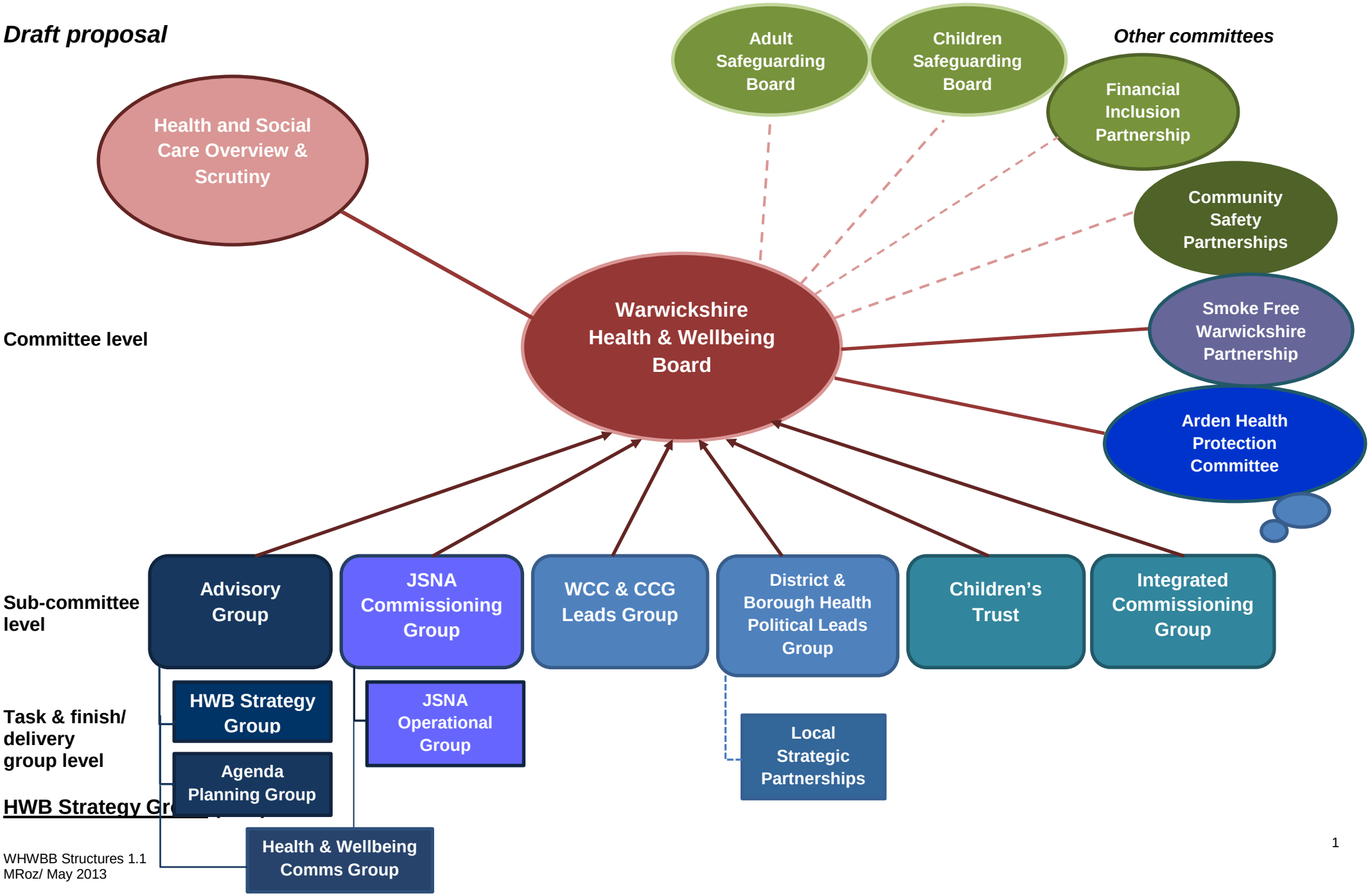
Cabinet	Monica Fogarty			agreed
Discuss and agree a relationship with Overview & Scrutiny	John Linnane/ Monika Rozanski	September 2013	Workshop	Basic principles of working together agreed
Discuss and agree a relationship with Healthwatch Warwickshire	Monika Rozanski	September 2013	Meeting/ workshop	Basic principles of working together agreed
Engagement with voluntary sector	Nicola Wright/ Monika Rozanski	October 2013	Workshop	Principles of working together agreed
Engagement with Providers	Nicola Wright/ Monika Rozanski	October 2013	Workshop	Principles of working together agreed
Engagement with the Police & Crime Commissioner/ Police	Nicola Wright/ Monika Rozanski	October 2013	Meeting/ workshop	Principles of working together agreed
Engagement with NHS England (Area Team)	Nicola Wright/ John Linnane	September 2013	Meeting	Basic principles of working together agreed
Engagement with the Coventry & Warwickshire Partnership Trust	John Linnane		Board to Board meeting	
Health Priorities *(to be further specified)*				
Priority/ Item	**Lead officer(s)**	**Timescales**	**Committee date**	**Outcomes**
Discuss/ approve the Health Protection Strategy		June 2013	11.06.13	Strategy approved and being delivered
Monitor hospital mortality rates		Ongoing		Reduction in mortality rates
Monitor progress and outcomes of the George Eliot Hospital Inquiry and approve strategies for improvement		Ongoing		Strategies for improvement approved and being delivered/ reduction in mortality rates
Discuss, approve and monitor progress of CCG plans		Ongoing		CCG plans linked to the Health & Wellbeing Strategy and JSNA; CCG plans approved and being delivered
Monitor progress towards Foundation status of local trusts		Ongoing		Progress reports considered and approved
Approve strategies and monitor progress on smoking cessation	Jacquie Ashdown/ Paul	Ongoing		Strategies approved and being delivered; increase in number of non-

(including smoking in pregnancy) and its wider determinants	Hooper			smoking population; reduction in smoking in pregnancy
Discuss and approve strategies and monitor progress on managing pressures and patient safety in A&E departments		Ongoing		Strategies approved and being delivered; reduction in inappropriate A&E visits
Discuss and approve strategies and monitor progress of out of hours services		Ongoing		Strategies approved and being delivered; out of hours services in place
Discuss, approve and monitor delivery progress of partnership strategies to reduce health inequalities in Warwickshire		Ongoing		Strategies approved and being delivered
Discuss and agree strategies to improve mental health and wellbeing of the local population	Charlotte Gath/			Strategies agreed and being delivered
Wellbeing Priorities *(to be further specified)*				
Priority/ Item	**Lead officer**	**Timescales**	**Committee date**	**Outcomes**
Consider the "Living in Warwickshire" survey proposal	Gareth Wrench	July 2013	17.07.13	
Monitor progress of the discharge project	Wendy Fabbro	Ongoing		
Consider impact of the Winterbourne View and approve learning disability strategies	Wendy Fabbro			
Discuss impact of Dilnot review and approve social care funding strategies	Wendy Fabbro			
Consider impact of the Youth Justice Report and monitor local	Wendy Fabbro	Ongoing		

improvements				
Discuss and agree strategies around social housing to improve health and wellbeing of local population	Nicola Wright/ DCs + BCs			
Discuss and agree strategies for educational attainment with its impact on health and wellbeing	Wendy Fabbro/ Nicola Wright			
Discuss and approve early intervention strategy for children in care	Wendy Fabbro			
Discuss and approve early intervention strategy for adults	Wendy Fabbro			
Discuss and agree strategies around employment to improve health and wellbeing of the local population	Nicola Wright/ Louise Wall			
Discuss and agree strategies around mobilising communities to improve their health and wellbeing	Nicola Wright/ Dan Green			
Consider Director of Public Health Annual Report	John Linnane	September 2013		

Warwickshire Health & Wellbeing Board structures

Draft proposal



Membership:

- Director of Public Health
- Public Health Consultant of Wider Determinants of Health
- 1 Communities Group representative *(optional)*
- 2 People Group's representatives
- 3 CCG representatives
- 5 District & Borough representatives

Serviced by: HWB Projects Coordinator, Public Health

Role:

- Provide specific contributions to the HWB Strategy which are evidence based and linked to the JSNA
- Lead on the development and submit action plans which will support the implementation of the HWB Strategy
- Monitor, review, update and report on the Strategy's action plans
- Review and update the content of the Warwickshire's Health & Wellbeing Strategy as it may be required
- Develop suitable metrics so that progress in the implementation of the strategy can be suitably measured

Agenda Planning Group (existing)

Membership:

- Chair of HWBB
- Director of Public Health
- Strategic Director for Communities
- Strategic Director for People
- HWB Projects Coordinator

Serviced by: Democratic Services Team Leader

Role:

- Discuss, assess and approve items for agendas of the HWBB meetings
- Suggest and agree items for agendas of the HWBB meetings
- Advise on the frequency of and additional meetings of the HWBB if required

JSNA Commissioning Group (existing)

Membership:

- CCGs
- People Group
- Public Health
- Localities & Partnerships Team representative
- Warwickshire Observatory
- WCAVA

Serviced by:

Role:

- preparation and delivery of Warwickshire's Joint Strategic Needs Assessment (JSNA) and its components

WCC & CCG Leads Group (existing)

Membership:

- Director of Public Health
- Strategic Director for Communities
- Strategic Director for People
- CCG Accountable Officers
- CCG Chairs
- Portfolio Holder for Health

Serviced by: HWB Projects Coordinator, Public Health

Role:

- Provide updates on priorities and challenges
- Discuss and agree HWBB Strategy implementation plans (to be approved by the Board)
- Discuss commissioning plans and explore opportunities for joint commissioning
- Ensure the delivery of the HWBB Strategy
- Contribute to the Board's meeting agendas

District & Borough Health Political Leads Group (existing)

Membership:

- District and Borough political leads for health and wellbeing
- Director for Public Health

Serviced by: Stratford upon Avon District Council CEO

Role:

- Provide updates and discuss current priorities and challenges around health and wellbeing within Districts and Boroughs
- Discuss, comment and provide feedback on current plans and strategies in relation to health and wellbeing

Children's Trust (existing)

Membership:

- Portfolio Holder, WCC, Children, Young People & Families.
- Strategic Director, WCC People Group
- Chair – Children's Safeguarding Board
- Public Health – Lead Officer for CYPF
- Police – Lead Officer for CYPF
- 3 x Chairs CT Area Partnerships
- CCG representatives
- Early Years representative
- Headteacher's Children Services policy group Chair / Vice-Chair
- CAVA / WCVYS representative
- Training / College representative
- Chamber of Commerce representative

Serviced by: People Group's representative

Role:

- Advise and provide regular reports on priorities and challenges around matters concerning children, young People and families
- Ensure that the needs and issues for children, young people and families are addressed in the JSNA
- Act as a liaison between the Health & Wellbeing Board and the Children's Safeguarding Board, youth Justice Board, Schools and other relevant partnership bodies
- Consult with children, young people and families county wide representative groups on behalf of the Warwickshire's Health & Wellbeing Board

Integrated Commissioning Group (existing)

Membership:

- People Group representatives
- Public Health representatives
- CCG representatives
- CSU representatives

Serviced by: Strategic Commissioning Team, People Group

Role:

- Assess, share and discuss commissioning intentions, building on the JSNA and in line with the HWB Strategy
- Agree shared priorities around commissioning health and care services
- Align resources across commissioning partners
- Develop and implement a joint integrated commissioning strategy
- Monitor and report on the progress in the implementation of joint integrated commissioning plans and strategies
- Advise on commissioning connections between various services and organisations

Health & Wellbeing Communications Group

Membership:

- Communications Team representative
- HWB Projects Coordinator

- JSNA Coordinators
- Public Health Knowledge Officer

Facilitated by: Communications Team representative

Role:

- Support the development of the HWBB's communications and engagement strategy
- Ensure the delivery of JSNA and HWBB communication action plans
- Ensure effective and coherent communication of JSNA, Healthwatch and HWBB developments and activities

HWB Projects Coordinator's role in relation to HWBB:

- Plan, organise and facilitate the Board's business planning and development activities
- Coordinate information from and/ or activity of the Board's sub-committees
- Service some of the Board's sub-committees
- Act as the first point of contact for any enquiries relating to the Board and its activity
- Plan, organise and facilitate the Board's engagement with other stakeholders (Police & Crime Commissioner/ Police, providers, 3rd sector and the NHS England Area Team)
- Follow regional and national developments which relate to the activity of Health & Wellbeing Boards and filter relevant information to the Board and its sub-committees
- Organise and service the Board's planning and engagement events
- Draft the Board's work programmes and HWB strategies
- Coordinate projects arising from Board's business
- Develop and oversee the content of the Health and Wellbeing Board webpage and blog
- Draft the Board's communications and engagement strategy and ensure its implementation
- Prepare reports on the Board's activity and performance

Democratic Service Team Leader's role in relation to HWBB:

- Provide secretarial support to HWBB and its members
- Plan and coordinate agendas for the HWBB meetings
- Plan and coordinate agenda planning group meetings and activities
- Advise on decision making and reporting processes in relation to WHWBB
- Facilitate Board's engagement with the Health and Social Care Overview & Scrutiny functions

Item 6

Warwickshire Health and Wellbeing Board

11 June 2013

Joint Strategic Needs Assessment Annual Update

Recommendations

That the Warwickshire Health and Wellbeing Board (HWB):

1. **Approve the 2013 Joint Strategic Needs Assessment (JSNA) Annual update and the proposal to publish it in June 2013.**

In addition:

2. Approve or amend the current plan to conduct a similar Annual Update in 2014.
3. Approve or amend the current plan to conduct a Review of Warwickshire's JSNA and its themes and topics in 2015.

1.0 Key Issues

1.1 Much of the work for the JSNA is timed to fit the cycles of commissioning that it aims to inform. Thus, individual pieces of work or needs assessments will be completed on an ad-hoc basis, in line with commissioners' requirements. However, currently the JSNA produces a Review on every third year and an Annual Update published in May or June on the intervening two years.

1.2 Only one Review has been completed to date, in 2011-12. This set the themes and topics reflected in the structure of the proposed Annual Update and the JSNA website, as well as informed Warwickshire's interim Health and Wellbeing Strategy (JHWS)[1]. The proposed document is the first Annual Update since the 2011-12 JSNA Review and is the first of two proposed Annual Updates before a second Review is carried out in 2014-15.

2.0 Options and Proposal

2.1 The HWB's Options are to:

1. Approve the 2013 Joint Strategic Needs Assessment (JSNA) Annual update and the proposal to publish it in June 2013.
2. Reject or ask for amendment(s) to the Annual Update.

[1] The Interim JHWS can be found here: Interim JHWS.

2.2 In addition the HWB can:

1. Approve the current plan to produce another Annual Update in May/June of 2014 and a Review in 2015.
2. Reject or ask for amendment(s) to the current production plan.

3.0 Timescales associated with the decision/Next steps

3.1 The Annual update is due to be published in June 2013. Thus, the decision to publish or amend it should happen in order to allow that. The next steps would be the publication of the document on the Warwickshire JSNA Website and distribution to partner organisations.

3.2 Decisions relating to further publications can be made with little time pressure although the more notice given to the JSNA programme team, the better.

4.0 Background Papers

None

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Report Author	Simon Tidd Gareth Wrench	simontidd@warwickshire.gov.uk garethwrench@warwickshire.gov.uk
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Strategic Director	Wendy Fabbro Monica Fogarty	wendyfabbro@warwickshire.gov.uk monicafogarty@warwickshire.gov.uk

Warwickshire JSNA

WARWICKSHIRE JOINT STRATEGIC NEEDS ASSESSMENT: ANNUAL UPDATE 2012/13

FOREWORD

John Linnane & Wendy Fabbro

CONTENTS

1 INTRODUCTION

1.1 PURPOSE

This document is intended to provide commissioners and other parties interested in Warwickshire's health and wellbeing with:

a) A summary of Warwickshire's approach to the Joint Strategic Needs Assessment (JSNA).
b) An update on the latest information coming from Warwickshire's JSNA.
c) Key messages from that information that our target audience should hear.

It is intended to supplement the other products produced as part of Warwickshire's JSNA. These can be found on the Warwickshire JSNA website at: http://jsna.warwickshire.gov.uk and are described further in: Warwickshire's Approach to the JSNA.

1.2 BACKGROUND

Warwickshire's JSNA is currently reviewed on a three year cycle with an *Annual Update* published in May or June on the intervening two years. This document is the first Annual Update since the Warwickshire's 2011 JSNA Review, published in 2012.[1]

The publication of this document also coincides with the formation of Warwickshire's Health and Wellbeing Board[2] (HWB) as a statutory committee of the County Council in June 2013 and the publication of Warwickshire's Interim Joint Health and Wellbeing Strategy (JHWS).[3]

It is currently the intention to publish the next iteration of the Annual Update in May 2014.

1.3 STRUCTURE OF THE UPDATE

This update consists of two elements.

1.3.1 Document

The first is the remainder of this document, composed of the following three sections:

Warwickshire's Approach to the JSNA. This section describes the context and history to the JSNA in Warwickshire as well as the current approach including its governance, products and the timeframes for their delivery. This section may be of interest to

[1] The 2011 Review was published in March 2012 and can be found here: Warwickshire JSNA 2011 Review.
[2] Warwickshire has had a 'Shadow' Health and Wellbeing Board since May 2011.
[3] The Interim JHWS can be found here: Interim JHWS

those unfamiliar with Warwickshire's JSNA or who want to learn more about how it is produced. Commissioners and those readers who just want to know the key messages from the JSNA may wish to go directly to the relevant sections below.

Warwickshire People and Place: Key Messages for All. This section provides the key messages from the JSNA that are applicable to all commissioners and interested parties. They are not specific to individual areas of health or care and are not divided by the themes or topics from the 2011JSNA Review, described later. This section aligns with the menu pages from the JSNA website of the same name.[4]

Key Topic Messages. The final section of this update contains key messages from the JSNA that are organised by the five themes and ten topics from the 2011 Review. The messages are targeted at those commissioners and parties who work or have an interest in particular areas but may be of interest to a wider audience. Each topic contains key messages that we think people need to hear, a summary of what the available data is telling us and quotes or case study findings, which you will see in green boxes. The components of this section align with the menu pages of the JSNA website, named as each of the five themes.

1.3.2 Updated and New Interactive Mapping Reports

The second element of this update consists of new reports hosted on the website and in the Local Information System (LIS).

[4] Warwickshire People and Place

There is a new report for each of the ten 2011 Review topics, which sometimes replace existing LIS reports with new data and improved formatting or, in places, fill a gap for a topic that had no pre-existing report. These reports can all be found via the JSNA website, under their relevant topic and links to them are below:

Children & Young People

Educational Attainment

Looked after Children

Lifestyle

Lifestyle Factors Affecting Health

Vulnerable Communities

Reducing Health Inequalities

Disability

Safeguarding

Ill-Health

Long-Term Conditions

Mental Wellbeing

Old Age

Dementia

Ageing & Frailty.

2 WARWICKSHIRE'S APPROACH TO THE JSNA

2.1 HISTORICAL DEVELOPMENT

2.1.1 Original Production (2007-2009)

The Local Government and Public Involvement in Health Act (2007) placed a duty on upper tier local authorities and PCTs to undertake a JSNA. In Warwickshire, work on the original JSNA started in 2007 and was completed in April 2009. It involved the development of the Warwickshire JSNA Steering Group and produced two reports:

- The first was a detailed technical statistical **Foundation Report** to set the context for health and wellbeing trends in Warwickshire, against a number of key client groups. This work was led and carried out by the Warwickshire Observatory.
- The second report was the **Needs Assessment**, led by external Consultants.[5]

The development of the JSNA culminated in a workshop for key stakeholders to consider the findings from the report and provided the learning for future iterations.

[5] The contract for this element of the work was awarded to Tribal Consulting and was completed in spring 2009.

2.1.2 Learning and Development (2010-2011)

In revising the JSNA process from 2010, consultation activity provided suggestions for areas to include and presentational ideas to help target the JSNA to a wider audience.

During early 2010, Warwickshire was also invited to join a national study carried out with a small number of areas across the country, evaluating the first round of JSNAs and how they had been used by commissioners in decision making.

This identified a number of useful points to help evolve the JSNA further. They included:

- The recommendation for the **development of a Local Information System (LIS)** to provide better access to data and allow users to 'self-serve' themselves information directly.
- Recognition of the need to **ensure that JSNAs were being explicitly used in commissioning and decommissioning decision making** by raising awareness and making them more useful to users

These points were pivotal in the changing nature of Warwickshire's JSNA during its 2011 review. In 2012, Warwickshire released its updated JSNA in a dramatically different format; incorporating the learning from the previous three years.

2.2 THE JSNA FROM 2012

2.2.1 The Local Vision

The purpose of the Warwickshire JSNA is **to provide a consensus view of the current and future health and wellbeing needs and inequalities of the local population**.

By doing so, the Warwickshire JSNA will enable the local commissioning of services to be built around need, outcomes, engagement and consultation.

The JSNA will help to:

- Define achievable improvements in health and wellbeing outcomes for the local community;
- Target services and resources where there is most need;
- Support health and local authority commissioners;
- Deliver better health and wellbeing outcomes for the local community;
- Underpin the choice of local outcomes and targets.

Importantly, the **Warwickshire JSNA is not an end in it itself, rather a framework of tools that are produced to inform commissioning**.

2.2.2 Governance Arrangements

The JSNA is a statutory requirement.[6] In Warwickshire prior to 2012, it had been jointly led by the Director of Public Health and the Strategic Director for People Group within Warwickshire County Council. Today the JSNA is produced in partnership across Health and Social Care in Warwickshire, although the strategic direction currently remains with the Director of Public Health and the Strategic Director for People Group. The organisations involved in Warwickshire's JSNA are outlined below and more detail can be found here: Structure and Local Governance Arrangements.

2.2.2.1 Health & Wellbeing Board (HWB)

The HWB is statutorily responsible for producing the JSNA and developing a JHWS,[7] based on the assessment of need outlined in it. Warwickshire has had a 'shadow' HWB since May 2011 and its 'formal' HWB was formed in April 2013. More information on the HWB can be found here: Warwickshire Health and Wellbeing Blog and records of its meetings here: HWB Meetings.

[6] This statutory requirement was introduced by The Local Government and Public Involvement in Health Act (2007): Section 116 (as amended by The Health and Social Care Act (2012): Section 192) and section 116A (as inserted by The Health and Social Care Act (2012): Section 193).

[7] Warwickshire's Shadow Health & Wellbeing Board has produced an Interim JHWS, which can be found here: Interim JHWS

2.2.2.2 JSNA Strategic Group

The Strategic Group has responsibility for ensuring that the JSNA is embedded in local decision making and approves significant JSNA products, such as this Annual Update. The group consists of the Director of Public Health, the Strategic Director of People Group and the Head of Strategic Commissioning, from People Group in Warwickshire County Council. The group meet on an ad-hoc basis and feed directly into the HWB.

2.2.2.3 JSNA Commissioning Group

The JSNA Commissioning Group is responsible for the delivery of the JSNA and for the setting of current and future editorial priorities. The group provides the link between the Strategic Group and the JSNA Working Group.

This group meet every two months and its members include a wide range of partners, and representatives from health, local authorities and other agencies. Details of the Commissioning Group's meetings can be found here: Commissioning Group Meetings.

2.2.2.4 JSNA Working Group

The JSNA Commissioning Group is supported by the JSNA Working Group. The Working Group leads in the production and of Warwickshire's JSNA and its components.

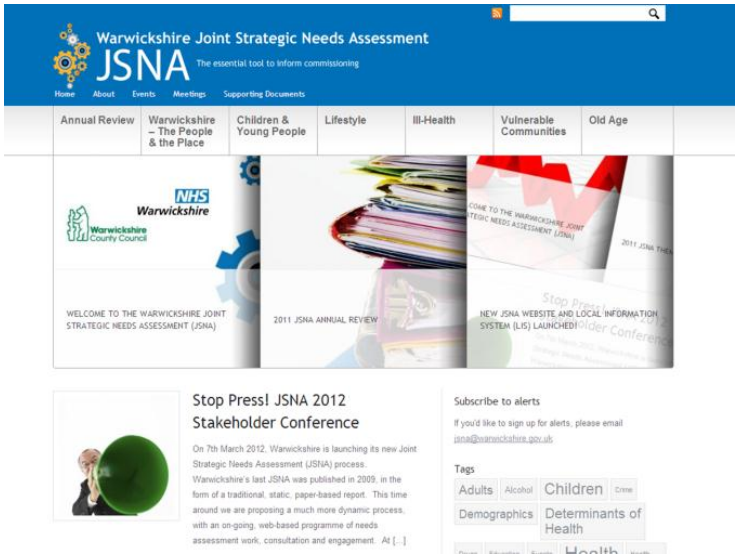
The group meet on a monthly basis and its membership includes research, intelligence, consultation and commissioning representatives covering a wide range of partners as required and subject to commissioning priorities.

2.3 THE STRUCTURE OF WARWICKSHIRE'S JSNA

Warwickshire's JSNA has three key elements:

2.3.1 The Website.

All of the products produced as a part of Warwickshire's JSNA are hosted on the JSNA Website, which can be found at: http://jsna.warwickshire.gov.uk.



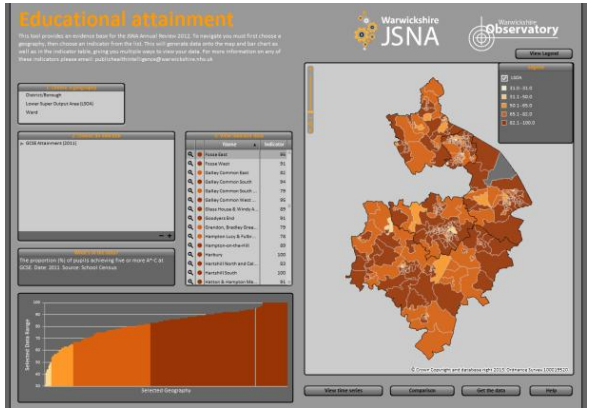
2.3.2 Reports & Specific Needs Assessments.

The JSNA has a programme of work and produces a number of documents or products on an on-going basis; this Annual Update is one such product. These include the Annual Updates, periodic Reviews and specific assessments of need. These assessments of need address prevalence, demand and supply and consider both quantitative and qualitative data[8]. The qualitative data includes finding from formal consultations and findings from surveys and co-production forums, such as the Transformation Assembly.

[8] The data is provided by local experts/specialists, with co-ordination and analysis provided by the JSNA Working Group or specific project teams. The specialists help write and provide the expertise to interpret and interrogate the data to inform users.

2.3.3 Local Information System (LIS)

This is all underpinned by a Local Information System providing access to the library of data and analysis above and the growing and more detailed evidence base[9].

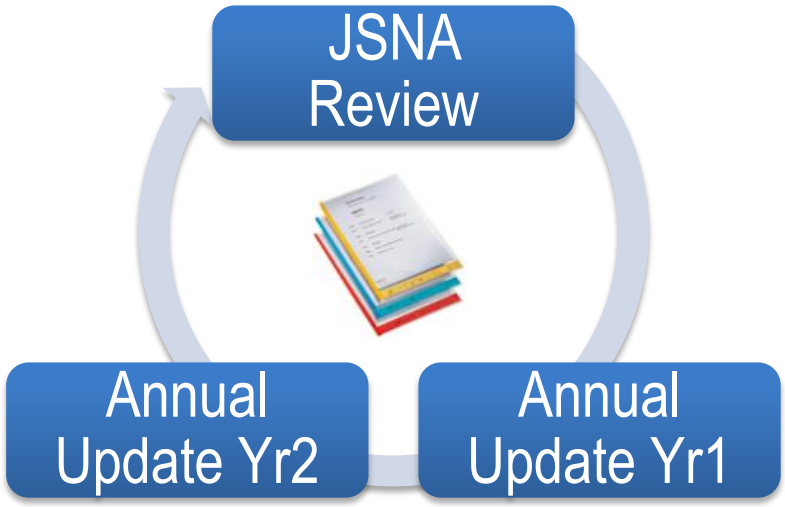


[9] Much of this functionality is still in development; individual LIS reports can be accessed through the JSNA website, by relevant topic.

There is a local element to the LIS but, in addition, there are a number of national reports and data sets which the website will hold and also provide access to.

2.3.4 Timeframes for production

Much of the work for the JSNA is timed to fit the cycles of commissioning that it aims to inform. Thus, individual pieces of work or needs assessments will be completed on an ad-hoc basis, in line with commissioners' requirements.



However, currently the JSNA produces a Review on every third year and an Annual Update in the two intervening years. Only one Review has been completed to date, in 2011-12. This set the themes and topics reflected in the structure of this document and the JSNA website, as well as informed Warwickshire's first, and interim, Health and Wellbeing Strategy (JHWS).[10]

This document is the first of two proposed Annual Updates before a second Review is carried out in 2014-15. All of these timeframes are subject to amendment by the new statutory HWB.

2.4 WORK IN 2012-13

During 2012-13, work for the JSNA has focused on the effective establishment of the structures and governance surrounding the production of the JSNA. All of the groups described above were officially formed in late summer and autumn and much work has gone into trying to raise the profile of, and engagement with, the JSNA with the relevant audiences.

A workshop was held with all stakeholders early last year to launch the new JSNA and since then the team have attended numerous meetings/forums and delivered numerous presentations;[11] most recently, specifically with the Voluntary and Community Sector. Details of the key events and future one can be found here: JSNA Events

[10] The Interim JHWS can be found here: Interim JHWS.
[11] Including: Hosting a needs assessment workshop for colleagues from the voluntary and community sector; the presentations of key findings to the Warwickshire Local Involvement Network (LINk); engagement with housing colleagues; presentations to District/Borough committees, local partnership groups and Community Forum presentations.

Following the launch of the website there has also been continued support and development of this and the LIS that houses much of the data displayed through it.

In addition, The JSNA work approval process and programme management tools have been developed and brought into use to manage the flow of projects and work conducted for Warwickshire's JSNA in the future. These and more information about how Warwickshire's JSNA works can be found here: How Warwickshire's JSNA Works.

Finally, there have also been a number of discrete and specific needs assessments and projects completed in 2012-13, further details of which can be found at the link below:

Warwickshire Drugs & Alcohol Needs Assessment

Warwickshire Adult Mental Health Needs Assessment

Warwickshire DRAFT CAMHS Needs Assessment

2.5 FUTURE INTENTIONS

The year of 2013/14 is a year of significant change for health and social care: The formal introduction of the HWB, the move of Public Health into local authorities, the abolition of the Primary Care Trusts (PCTs) and the formal arrival of the Clinical Commissioning Groups and the introduction of Healthwatch are part of the largest changes in a lifetime. It is anticipated that this will undoubtedly have an impact not only on the JSNA but more importantly, the services the JSNA informs.

Over the past year much work has been done to establish the governance structures and processes that will **ensure the JSNA remains the essential tool to inform commissioning**.

Currently there are several discrete projects underway and more yet to be started. While this past year has been a year of great change, as we move into a more settled period we are keen that we begin to identify Needs Assessment Topics which could be sponsored by the CCGs, perhaps the Districts and Boroughs, the voluntary sector and also NHS Trusts. The key projects in the programme for progress in the current year, and other anticipated work, are listed below and more information can be found here: JSNA Current Work Programme.

- Autism Needs Assessment
- Learning Disabilities Needs Assessment
- Infant Mental Health Needs Assessment Chapter
- Social Care Data Integration Pilot Project
- Drivers of Wellbeing Project
- Impact of Welfare Reforms Project
- Delaying Parenthood in LAC Project
- Carers Needs Assessment

3 WARWICKSHIRE PEOPLE & PLACE: **KEY MESSAGES FOR ALL**

3.1 TURNING POINTS IN LOCAL TRENDS

Over the past decade a number of indicators have followed a relatively predictable trend; crime has fallen year on year, school attainment has consistently improved, and road casualty numbers have reduced without exception. The economic downturn started to impact upon some of our indicators in 2009 and 2010, particularly those relating to worklessness and benefit claimants, but many of the positive trends continued even through the peak of the recession. This year, however, we have seen some evidence of this no longer being the case. **A number of headline indicators have baulked against the trends we are used to seeing**. It is unclear at this early stage whether these may be individual glitches, signs that some indicators have approached a natural plateau or whether the recession is starting to bite.

Our visibility of some indicators affected is delayed and it may be that **we are only now starting to see some of the impacts beyond the immediate economic downturn**. Continued monitoring will help us identify whether some of this year's figures are merely bumps along a general trajectory or whether some more fundamental change is taking place in Warwickshire.

3.2 POPULATION CHANGE AND INCREASING DEPENDENCY

During the last ten years, **there has been an increase of just over 20% in the annual number of births in Warwickshire and a 21% increase in the population aged 65 or over.** At the same time, the working age population has not been increasing at the same rate. **The outcome of this is an increasing dependency ratio;** a shrinking share of the population is economically active and supporting the remaining population. In 2010, there were 1.74 people of working age for every dependent in the county (those aged under 16 or over 64). By 2035, this figure is expected to fall to 1.32. This change brings significant implications, in particular for the local economy, education, health and social care.

We are seeing increasingly different patterns at a local level. The latest data shows that 62% of mothers in Warwick District were aged 30 or above at the time of birth. This is in contrast to Nuneaton & Bedworth Borough where 37% were aged 30 or above. These figures reflect different career paths, financial planning, and perhaps even different aspirations.

Amongst the challenges that a growing and ageing population will bring is an increase in the number of people likely to develop a long-term condition such as high blood pressure, diabetes, arthritis, heart disease and dementia. **Although people are living longer, these extra years may not necessarily be experienced in good health.**

3.3 HOUSING & HOUSEHOLD COMPOSITION

The demand for housing in Warwickshire will continue to grow. At the same time, this will need to be delivered in the context of a changed planning system, the adoption of the district/borough Local Core Strategies reflecting Housing Needs Assessments for the future, and historically low levels of housing completions across Warwickshire since 2008.

Providing services for families will need to change to reflect the shifting make-up of family units and how they choose to live. More older people will live independently at home for longer, people will live with their parents in a family home for longer (in North Warwickshire 38% of 20-34 year olds currently still live with their parents), and the proportion of single person households will continue to grow.

The reforms of the welfare system legislated for in the Welfare Reform Act are likely to have a key impact upon individuals, groups of people, services, and certain geographical areas and communities in Warwickshire. The reforms are likely to have a disproportionate impact upon those areas with higher concentrations of benefit claimants, with subsequent potential knock on effects for local economies and demography. There could also be population movement and migration due to changes in housing affordability. We would benefit by having a greater understanding of the short and longer term impacts of the reforms. A needs assessment has been agreed to get a clearer understanding of the impacts of these changes on users and the wider population and the longer term outcomes for health and social care. This will help us to shape services to meet them or understand where we may fall short and make decisions about what to prioritise.

Housing affordability is likely to remain an issue in Warwickshire. The ratio of lowest quartile house prices have been consistently over six times lowest quartile earnings since 2003 (currently at 6.8) and is unlikely to reduce significantly in the absence of a housing market crash. This means a person earning a low income would need the equivalent of over six years' worth of income to afford just the cheapest housing available.

3.4 THE CHANGING NATURE OF COMMUNITIES

The way that people relate to and identify with their neighbours, localities, communities and social networks is changing. In the future, it is likely that these will be less obviously defined by spatial boundaries, providing a big challenge for organisations used to delivering or commissioning services based on geographic boundaries.

3.5 ECONOMIC AND LABOUR MARKET CHANGE

The number of people claiming Jobseekers Allowance (JSA) in Warwickshire has been falling since February 2010. Despite the fall in unemployment, two specific issues are causing concern:

The number of residents unemployed for more than twelve months has increased from 995 to 1,695 in the last year. **As a**

proportion of all unemployed residents, long term unemployment now makes up 21% of all unemployment, compared to 11% last year[12]. In Nuneaton & Bedworth Borough over one in four unemployed people have been claiming JSA for more than twelve months. Generally speaking, **those who have been out of work for longer periods of time will find it increasingly difficult to get a job**, as well as having a negative impact on their health and wellbeing. This means that when the job market does pick up the long-term unemployed will find it harder to compete with other jobseekers. Despite this worrying finding, long term unemployment in Warwickshire remains below the regional and national average.

The second issue relates to youth unemployment**. The unemployment rate amongst the 18 – 24 age group, although now falling, is more than twice the rate of those aged over 24**. Furthermore, one third of 18 to 24 year olds that are claiming Jobseekers Allowance in Warwickshire have being doing so for more than six months. Long term unemployment is a particular concern with this age group, as many young people will be seeking their first job. The longer it takes to make that first step into the workforce, the more difficult it becomes.

[12] These figures relate to June 2012 and compare year-on-year with June 2011. Long term unemployment in this analysis accounts for those people who have been claiming Job Seekers' Allowance for over 12 months. More information can be found at page 24 of the 2012 Quality of Life report. All unemployment data can be accessed by age and duration from NOMIS which is a service run by the Office for National Statistics providing official labour market statistics.

3.6 MORE YOUNG PEOPLE ENTERING POSITIVE DESTINATIONS

The number of young people aged 16-18 in Warwickshire who are not in employment, education and training (NEET) has reduced. The overall Warwickshire NEET rate stood at 3.6% (660) for 2012[13]. However, the numbers of NEETs are not uniform across the county, with higher numbers and percentages in North Warwickshire 4.1% (82 young people), Nuneaton and Bedworth 4.6% (224 young people) so **the north of the county remains an area of concern.**

Overall NEET figures have decreased in Warwickshire, displaying the lowest volumes and proportions since 2006[14]. However, it remains important that education, skills and training agencies convey the right messages about future careers so that we have a more timely supply of labour skilled in the right areas.

Young people who continue in learning post 16 are more likely to attain higher levels of qualifications and have increased earnings over their lifetime. The **Government's 'Raising the Participation Age' (RPA) strategy raises the age that young people remain in education or training to age 17 by 2013 and up to their 18th birthday from 2015**. Young people will be able

[13] Average of November 2012, December 2012 and January 2013.

[14] Part of this reduction can be explained by an increase in the number of apprenticeships; there has been an increase of nearly two thirds over the two most recent full academic years. There have also been successful ESF funded projects which have impacted on reducing the number of NEETs.

to participate in a way that best suits their needs and aspirations; for instance in full-time education at school or college; on an Apprenticeship or part time if they are also working or volunteering full time[15]. The Council is working closely with key stakeholders to deliver against the strategy to meet the new duties under RPA in particular effective alignment of support mechanisms to ensure all young people have the opportunity to progress and succeed.

3.7 THE HAPPINESS MYSTERY

Despite Warwickshire performing consistently above national averages on many social and economic measures, the results of the inaugural national wellbeing survey suggested that **Warwickshire's residents are notably less happy and satisfied than most other parts of the country.**

For example, when asked "to what extent do you feel the things you do in your life are worthwhile?", responses from **Warwickshire's residents placed us 136th out of 142 local authority areas across Great Britain. In terms of feeling happy, Warwickshire ranked 128th.** These results would not have been predicted, and our analysis illustrates how many counties with similar characteristics to our own have performed much more strongly on the 'happiness' measures.

[15] Promoting effective participation in education or training is a statutory duty of the Local Authority under the Education and Skills Act (2008).

3.8 PERSISTING INEQUALITIES

Our more prosperous neighbourhoods have been best placed to deal with the impacts of the recession and associated trends, and have displayed higher levels of resilience in the face of downturns in the economy over the past year.

However there are examples throughout this report where the inequalities gap has not improved, particularly in the North of the county with most of the inequalities being predominantly associated with the relatively poor health status of residents of Nuneaton & Bedworth.

Some of the most important inequalities are: the considerable differences in life expectancy between areas of Nuneaton and Bedworth when compared with areas in Warwick; the large differences in the rate of smoking between communities; the numbers of looked after children in the North when compared with the South; educational attainment and its impact on people's employment and earnings and the quality of housing and community that they live in.

These examples demonstrate that **inequalities still persist and that the gap in inequalities between the North and the South has continued to increase.**

Inequalities are a multi-faceted issue and require a joined up collaborative approach across key organisations. Further effort is required now and over the longer term to address the growing gap between some of our communities.

3.9 THE RISE OF LONG-TERM CHRONIC HEALTH CONDITIONS[16]

The most recent Director of Public Health Report[17] describes the challenges and opportunities facing the county as a consequence of long term health conditions affecting our residents. **Nationally, around 1 in 3 adults live with at least one Long Term Condition (LTC)**. In Warwickshire, this equates to an estimated 147,000 people. However, more recent research suggests the rate may be as high as 42%. **LTCs are increasing, partly as a result of the ageing population and unhealthy lifestyle choices**.

In 2011, a number of priority public health themes were identified including obesity, alcohol misuse and mental health[18]. We are seeing increases in the prevalence of all three, and the implications go beyond just health services.

[16] LTCs or chronic conditions are those that, at present, cannot be cured. They can be controlled by medication and/or other treatment or therapies. Examples of long term conditions in Warwickshire include high blood pressure, diabetes, asthma, arthritis, heart disease and chronic obstructive pulmonary disease. People live with these conditions for many years, often decades and they can impact on their quality of life by causing disability and early death.

[17] The report can be found here: Warwickshire Director of Public Health Report 2012

[18] People with LTCs are 2-3 times more likely to experience mental health issues than those without.

3.10 THE CHANGING NATURE OF SOCIAL CARE

Budgets for Local Authorities have reduced and will continue to do so. In the short term this is a particular concern in the provision of services to children.

Furthermore, **the number of children entering care in Warwickshire has increased in four of the past five years**.[19] Warwickshire is currently undertaking a project with the Dartington Social Research Unit, looking to commission evidence based programmes designed to safely reduce the numbers of looked after children.

The Dilnott Report recommendations and the changes to the payment for care and support, due for introduction in 2017, will have an impact on the way services are commissioned. The drive towards maintaining independence, the move to more preventative approaches, the duty to promote the integration of care services, and changing inspection guidance and quality assurance, will all challenge the County Council and partners in the way that we view social care in the future, for both adults and children.

[19] At the same time, the unemployment rate has increased. There is a statistically significant relationship between these two variables, which means changes in unemployment, can act as a useful indicator of the likely change in demand for care in the following year.

3.11 THE IMPACT OF TECHNOLOGY ON FUTURE NEED

The pace of technological change is already affecting the way we deliver services. We are interacting with our residents in new ways and increasingly delivering services online. **New technologies can also facilitate change in the way health and wellbeing needs are addressed,** reducing the requirement to travel and speeding up the way tasks can be completed.

In 2010, around 20% of us owned smartphones. At the end of 2012, this figure rose above 50% for the first time[20]. Analysts predict that in two years, 90% of mobile users will have no choice but to own smartphones.

At the same time, we are seeing **improvements in broadband speed and availability**, providing even more opportunities to engage with and deliver services to residents in cost effective ways. Whilst this offers new opportunities, in a county like Warwickshire, **we should be mindful of the differences in the provision of broadband, particularly to rural areas** and the inequalities that could follow.

While actively encouraging residents to self-serve and adopt these new technologies, we understand that not all customers are receptive to this change. There is a distinction between those residents that will or will not adopt these new technologies. **Those that are less likely to consider going online or using social media are also likely to be the most vulnerable members of our communities.** They will be the more intensive users of our services and at the same time least willing or able to interact with us in the most cost efficient ways.

[20] Ipsos Mori Technology Tracker, January 2013 (http://www.ipsos-mori.com/researchpublications/publications/1522/Ipsos-MediaCT-Tech-Tracker.aspx)

4 THEME & TOPIC KEY MESSAGES

Five themes and ten topics were chosen in the 2011 JSNA Review to cover the milestone events in people's lives from preconception to old age. The following section provides an update of the latest picture of need for each topic.

Each topic contains key messages that we think people need to hear, a summary of what the available data is telling us and quotes or case study findings, which you will see in green boxes. The components of this section align with the menu pages of the JSNA website, named as each of the five themes.

4.1 CHILDREN & YOUNG PEOPLE

4.1.1 Educational Attainment

"From secondary to college; the college were good. They arranged an additional visit during the summer holidays & to meet the tutors, which he did, so we were quite lucky really. We used Connexions [now CSWP] from secondary and lots of information was passed over. The college were really good & they recognised that they needed to put in a bit of extra support."[21]

"Just because they [young people] leave school doesn't mean to say they still don't have needs and support that would help them."[22]

[21] Parent of young person in Rugby Borough.
[22] Young person in Nuneaton & Bedworth Borough.

4.1.1.1 What is the headline issue?

Research shows that education is a key determinant of health[23], with the more educated reporting lower morbidity from common acute & chronic diseases, lower anxiety/depression & experiencing a better physical & mental functioning.

Although the percentage of students in Warwickshire achieving 5 A*-C English and mathematics at GCSE level has increased by 2 percentage points from 61 to 63 since 2011, this still means that **one in three of the county's pupils are not attaining what is generally regarded as a minimum level of educational attainment.**

In addition, continued variation in attainment also still persists across different parts of the county and different population groups. Such variation in educational attainment is likely to exacerbate health inequalities in the future.

In addition, **many secondary schools have moved to academy status, which has increased their individual autonomy and changed their relationships with the local authority**. This has the potential to constrain the authority's capacity to understand and influence the quality of teaching and

[23] Equity, social determinants and public health programmes. Editors Erik Blas and Anand Sivasankara Kurup. 2010, World Health Organization: Geneva. Commission on Social Determinants of Health (CSDH), Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health. 2008, World Health Organization: Geneva.

learning generally, and the outcomes for vulnerable groups in particular.

4.1.1.2 What does the data say?

At a District and Borough level, there is an 11 percentage point difference in the proportion of pupils gaining 5 or more GCSEs at grades A*-C, including English and mathematics. Attainment is highest in Warwick District at 69% and lowest in Nuneaton & Bedworth at 58%.

However, even within these areas, considerable differences exist at a very local level. For example, in Warwick District, there is a 35 percentage point difference in the localities with the highest and lowest levels of attainment. Attainment varies from 48% in South Leamington to 83% in both Warwick Rural East and Kenilworth. Also, in Nuneaton & Bedworth Borough, attainment ranges from 46% in Arbury & Stockingford to 71% in Weddington & St. Nicolas; a 25% percentage point difference across a distance of only approximately 3 miles.

Out of the nine localities with the lowest educational attainment levels, six are located in Nuneaton & Bedworth Borough. More detail can be seen in figure 1.

In the localities with the very lowest levels of attainment, only half of pupils are achieving what is commonly regarded as the minimum educational standard. This is the case in four localities distributed across the county – Arbury & Stockingford in Nuneaton, Bede & Poplar in Bedworth, North Warwickshire East and South Leamington.

In addition to geographic variations in educational attainment levels in the county, there are also stark differences on a population group basis. For instance, **the attainment gap between those pupils eligible for Free School Meals (FSM), and those who are not, has increased slightly over the last few years**. In 2012, this reached its widest point in the last 4 years with a 35 percentage point gap in attainment[24].

Interestingly, at a District and Borough level, in 2012, the attainment gap between those pupils eligible for FSMs and those who are not was widest in Stratford-on-Avon District at 41 percentage points.

At a more detailed level, the local authority now has attainment data relating to different socio-economic groups. This shows very wide disparities between the groups. For example, in 2012 the proportion of children gaining five or more GCSE grades A*-C or equivalent including GCSE English and mathematics was 90% for Mosiac Group C, but was only 34% for children from Mosaic Group O[25].

Analysis by socio-economic groups, together with analysis of performance by geographic census super output areas,

[24] Although the attainment levels of those eligible for FSMs have indeed increased slightly, the attainment levels of those not eligible have increased at a faster rate which has resulted in a widening of the gap.
[25] More information on the Mosaic groups can be found here: Mosiac Guide. Group C is: Households classified as "wealthy people living in sought-after areas" and Group O: "Families in low rise social housing with high levels of benefit need".

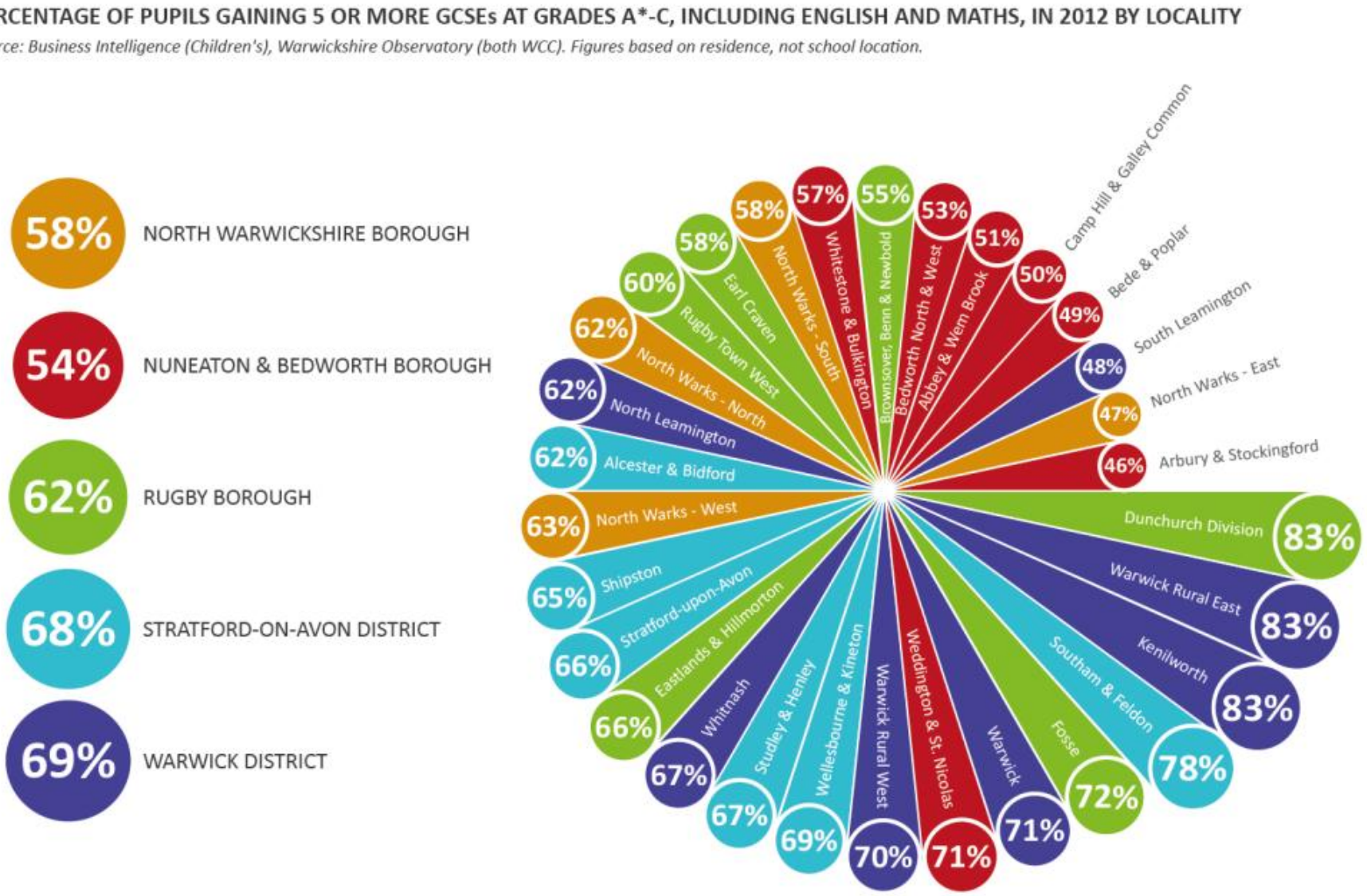
may go a long way towards explaining the differences in outcomes between localities. It may also give insights into how to tackle differences in performance, since a great deal of information is available about the characteristics of the different groups, and how they can be approached.

Even more pronounced disparities in terms of educational attainment exist between those children who have been continuously looked after for at least 12 months and those in the general population. **In each of the last 2 years, attainment levels have been 47 percentage points lower for looked after children in Warwickshire**, in terms of achieving 5+ GCSEs at grades A*-C including English and mathematics, compared to the remainder of the pupil base[26].

The number of Warwickshire's school leavers at 16 entering a positive destination increased from 95.7% in 2011 to 96.6%.

[26] This is similar to the difference at a national level. It is worth noting that the looked after child population in Warwickshire is relatively small but this still represents a significant difference when compared to the wider pupil population.

Figure 1: Warwickshire GCSE attainment in 2012



4.1.2 Looked After Children

"Independence, it's given me independence and financial help whenever I need it…I guess before when I was at home I wouldn't get that. It's given me the confidence to take my driving lessons and pass my test and go to college whereas at home it would be if you don't want to go to college you don't have to go to college, sit down and watch TV all day"[27]

4.1.2.1 What is the headline issue?

The number of Looked After Children (LAC) in Warwickshire has increased from 636 at 31st March 2011 to 681 at 31st March 2012. This represents an increase of 7%. The number of children looked after has seen an increase year on year over the past five years, with a 41.3% increase between 31 March 2008 and 31 March 2012. The district with the largest percentage increase between 2008 and 2012 is Rugby with a 60.2% increase in the number of looked after cases. All districts saw an increase in their looked after population between 2011 and 2012. However, monthly activity data indicates a slowing down in the numbers of LAC in the last 12 months. As at 31 March 2013, Warwickshire's looked after population was 699 and the Dartington Project continues to look as evidence based solutions to reduce this number.

As a consequence of their life experiences, outcomes for looked after children are traditionally poorer than non-looked after children.

Attainment figures for looked after children are significantly lower than those achieved by non-looked after children in the county. Fewer looked after children reach positive destinations post 16 than children who are not looked after.

4.1.2.2 What does the data say?

The rate of LAC per 10,000 population is highest in Nuneaton and Bedworth Borough at 89 and lowest in Stratford-on-Avon District at 36. The largest numbers of LAC are aged between 10 and 15. However, on a proportionate basis, this age group has seen a decrease over the past 5 years, down from 47.9% at 31/03/2008 to 37.2% at 31/03/2012.

The proportion of young people who are looked after at ages 16 to 17 has seen an increase. As at 31/03/2008, it accounted for just 14.3% of the looked after population, whereas at 31/03/2012, it accounted for 24.4%[28].

The majority of LAC have a main need category of 'Abuse and Neglect', which has not changed over the past 5 years, although

[27] Young person Looked After in Warwickshire, now age 20.

[28] This is due in part to the Southwark Judgement, The Southwark Judgement, made by the Law Lords in May 2009, is a piece of case law that obliges children's services to provide accommodation and support to homeless 16- and 17-year-olds.

proportionately it has decreased, down from 68.5% at 31/03/2008 to 58.0% at 31/03/2012.

The number of children with a main need of 'absent parenting' has decreased this year, in line with the overall decrease in the number of unaccompanied asylum seeking young people being supported.

4.2 LIFESTYLE

4.2.1 Factors Affecting Health & Wellbeing

Ronnie and Margaret are in their 80s and say their fitness programme has given them a new lease of life. They are pretty active with Margaret doing regular yoga & swimming & both of them enjoying regular walks.

However, Margaret has arthritis & Ronnie has diabetes & has undergone hip replacement surgery. Their local GP referred them under the new Warwickshire Exercise Referral Scheme, under which health professionals refer patients to one of the Borough Council's leisure centres for a personalised 12 week fitness programme devised by a trained fitness instructor.

The couple say the fitness programme has helped them with their health conditions and plan to continue attending after their 12 weeks are completed.

4.2.1.1 What is the headline issue?

A number of lifestyle factors related to residents' health and wellbeing continue to persist in Warwickshire.

Issues around obesity particularly in children, particularly the large increase between reception and year 6, are likely to result in health problems in later life. **There is a need, supported by the Marmot Report[29], to instil healthy lifestyle choices and behaviour at a young age to reduce risks in later life**.

4.2.1.2 What does the data say?

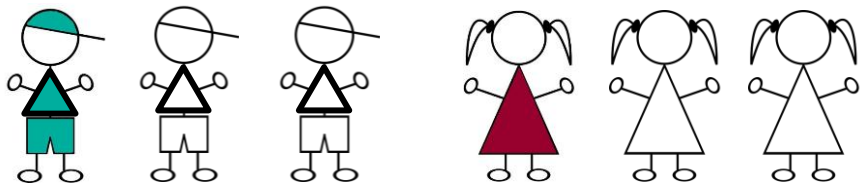
A variety of lifestyle factors can have a major impact on a person's health. These include smoking and alcohol consumption[30], diet and physical exercise [31], sexual behaviour[32], and problems resulting from drug taking. Each of these are addressed below:

4.2.1.2.1 Obesity

Obesity can have a severe impact on people's health, increasing the risk of type 2 diabetes, some cancers, and heart and liver disease. **In Warwickshire, one in four adults is estimated to be obese, with a body mass index of more than 30.** This equates to approximately 110,000 adults and this figure continues to increase**.**

[29] Marmot Review Website
[30] Which account for many coronary heart disease and cancer deaths.
[31] Which contribute to obesity or malnutrition and effect life expectancy.
[32] Which can lead to infection or teenage pregnancy.

Figure 2: One in three children in Year 6 in Warwickshire is overweight or obese (boys 32.2%, girls 31.3%)



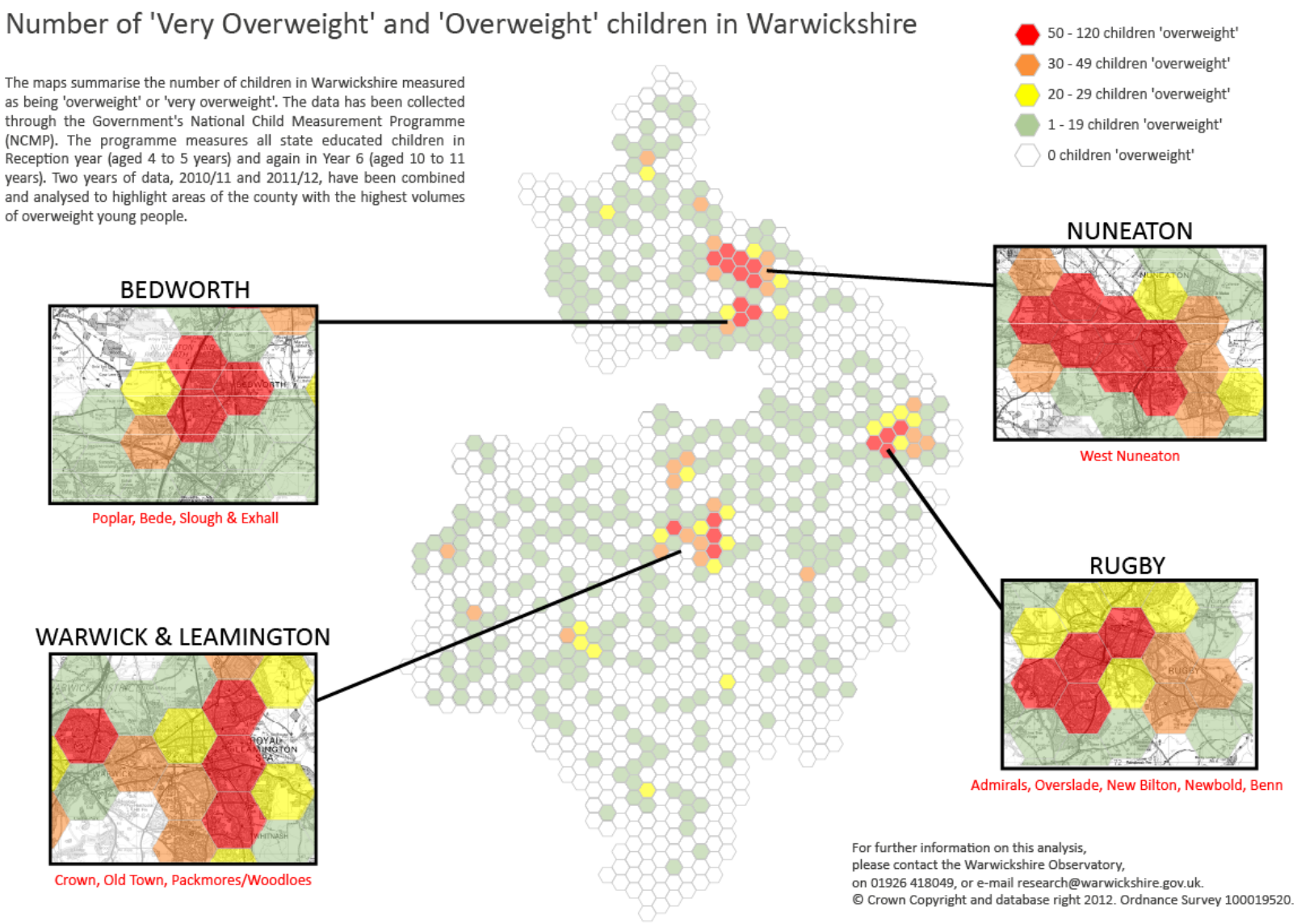
One in five reception age children in Warwickshire are classed as being overweight and obese, but this increases to almost one in three by the time they have reached Year 6 age.[33] However, on a positive note, the reception rate obesity prevalence for 2011/12 shows lowest increase for several years. These figures emphasise the importance of encouraging healthy eating and exercise at the start of school life in order to reduce the risk of obesity in later years.

Figure 3 below shows the distribution of overweight and obese children across Warwickshire and highlights a number of 'hotspots' primarily in the urban areas of Warwick, Leamington Spa, Bedworth, Nuneaton and Rugby.

For the past two years, the prevalence of obesity in Reception aged children has remained the highest in Nuneaton & Bedworth and North Warwickshire. In contrast, the proportions of obese children in all other areas are statistically significantly lower than the Regional & National figures for both Reception and Year 6 age children.

[33] According to the latest 2011/12 data from The National Child Measurement Programme; child overweight (including obesity)/ excess weight: BMI ≥ 85th percentile of the UK,

Figure 3: the distribution of overweight and obese children across Warwickshire



4.2.1.2.2 Physical activity

The Health Impacts of Physical Inactivity (HIPI) tool estimates that **only 20% of the Warwickshire population are currently physically active** and 18% of total premature deaths could be prevented if 100% of the population were physically active.[34] This is equivalent to 388 avoidable deaths in Warwickshire each year. The tool also details that approximately 3,144 cases of diabetes could also be prevented in the county if 100% of the population were active.

4.2.1.2.3 Smoking

Smoking remains the primary cause of preventable mortality and premature death with over 900 deaths a year in Warwickshire and an estimated 80,000 in England. **It is the single biggest preventable cause of health inequalities and increases the risk of cancer** (including lung, oesophagus, bladder, liver, stomach, cervix, myeloid leukaemia, bowel and ovary), heart disease, stroke and chronic respiratory disease.

It is estimated that 19.1%[35] of people aged over 18 in Warwickshire are smokers, which equates to nearly 83,000 adults. There is a clear socio-economic gradient in terms of smoking prevalence and it is estimated that 33.9% of the county's adults employed in routine and manual occupations are smokers.

Prevalence of smoking in pregnancy is high in Warwickshire, with 23% of women smoking at the time of delivery for Quarter 4 2011/12. This equates to nearly 1,000 babies a year who are being born to women who still smoked at the time of delivery and is a **significantly higher rate than the England proportion of 13% for the same period.**[36]

4.2.1.2.4 Alcohol & substance misuse

The 2012 Warwickshire Young People & Substance Misuse Needs Assessment 2012 has recently been published

Data on alcohol use by young people in Warwickshire indicates that **fewer young people are drinking alcohol**, those that do are drinking less frequently, and fewer are attending A&E or being admitted to hospital as a result of alcohol misuse. However, comparisons show that **more young people are drinking every week in Warwickshire (10%) compared to the 2011 national average (6%)**. This is consistent for every age group. Efforts to reduce alcohol misuse therefore, must not be diminished.

[34] The Health Impacts of Physical Inactivity (HIPI) tool uses estimates of local levels of physical activity from the Sport England Active People survey to estimate how many cases of certain diseases could be prevented if the population aged 40-79 were to engage in the recommended amounts of physical activity

[35] Source: Integrated Household Survey, ONS (experimental statistics), 2011/12 data

[36] Due to the data collection limitations, prevalence is believed to be higher and it is suggested that significantly higher numbers of women are likely to be smoking earlier in their pregnancy.

Most young people have never tried illegal drugs (92%). And fewer young people are using illicit drugs in Warwickshire compared with the national average. Research shows that young people who have truanted from school or been excluded, are more likely to have taken drugs in the last year than those who were not vulnerable in this way. Cannabis is the most frequently used substance of those that have tried illegal drugs with 2.8% of young people reported using cannabis in the last four weeks. Efforts to reduce drug misuse therefore, must not be diminished.

4.2.1.2.5 Sexual Health

The rate of under-18 conceptions in Warwickshire for 2011 was 30.9 per 1,000 females aged 15-17, which equates to 299 conceptions. This represents a reduction of 25% from the 1998 baseline rate and a 10% decline on the number of conceptions in 2010. However, **whilst the 2011 rate is in line with the national figure, it represents one of the highest figures in comparison to our statistical neighbours**[37].

Throughout Warwickshire, the rate of chlamydia has been in decline for both the overall population and the aged 16-24 population. **The aged 16-24 population are at higher risk of chlamydia due to higher sexual activity in this age group**, and in 2011 the rate per 1,000 in this age group was 8.12, compared to 1.33 per 1,000 in the general population. There are inequalities in the rate of chlamydia amongst the districts, with consistently (although declining) highest rates across all age groups within Nuneaton and Bedworth and Rugby.

Genital warts are the second most prevalent STI in Warwickshire, and 16-24 years olds are again at increased risk. There is only a small amount of variation in rates throughout the county, and a pattern of slight decline has been seen over the past 3 years.

Although higher in the 16-24 year age group than the general population, the rates of Gonorrhoea, Herpes and Syphilis remain comparatively small and fairly consistent across the county.

4.3 ILL HEALTH

4.3.1 Long Term Conditions[38]

4.3.1.1 What is the headline issue?

The numbers of patients recorded on general practice disease registers, in Warwickshire show that there are potentially large numbers of undiagnosed or unrecorded

[37] Source: Respect Yourself update number 41; ONS teenage conception release

[38] LTCs or chronic conditions are those that, at present, cannot be cured. They can be controlled by medication and/or other treatment or therapies. Examples of long term conditions in Warwickshire include high blood pressure, diabetes, asthma, arthritis, heart disease and chronic obstructive pulmonary disease. People live with these conditions for many years, often decades and they can impact on their quality of life by causing disability and early death.

cases of Long Term Conditions (LTCs), especially for coronary heart disease, hypertension, diabetes, chronic obstructive pulmonary disease, asthma and chronic kidney disease[3940].

An estimated 1 in 3 people in Warwickshire, aged over 16 are living with one or more long-term conditions. This equates to 147,000 people.

With a growing and ageing population, Warwickshire is predicted to see a significant increase in numbers of long-term conditions.

The 2009/10 Joint Director of Public Health Annual Report showed almost an estimated 90% increase over 20 years in older people with dementia. In addition, conditions such as diabetes and depression will see more than a 50% increase. This will place an increased burden on future health and social care resources.

In addition, we need to consider people living with multiple conditions, which will be the norm rather than the exception.

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

Multi-morbidity is associated with poorer quality of life, higher hospital admissions and mortality.

4.3.1.2 What does the data say?

The chronic conditions in the table below account for approximately 21,000 hospital admissions and around 3,000 deaths on average each year:

Table 1: The Burden of LTCs in Warwickshire, 2010/11[41]

Condition	Warwickshire			
	Estimated Number & Prevalence (%)	GP Practice Disease Registers	Hospital Admns	Deaths
			Avg. per year	Avg. per year
All Long Term Conditions	147,000 (33% of the adult population)		20,000	2,800
Coronary Heart Disease (CHD)	25,400 (5.7%)	17,790 (3.2%)	1,500	650
Stroke & Transient Ischaemic Attacks (TIA)	11,100 (2.5%)	9,464 (1.7%)	1,000	400
Hypertension	148,000 (33.2%)	80,277 (14.6%)	350	50
Diabetes	34,800 (7.8%)	23,406 (5.2%)	450	60
Chronic Obstructive Pulmonary Disorder (COPD)	13,400 (3.0%)	8,106 (1.5%)	850	200
Asthma	46,000 (37,100 adults & 8,900 children)	34,209 (6.2%)	500	15

[41] Taken from the Joint Director of Public Health's Annual Report 2012, which can be found here: DPH Annual Report 2012

Condition	Warwickshire			
	Estimated Number & Prevalence (%)	GP Practice Disease Registers	Hospital Admns	Deaths
			Avg. per year	Avg. per year
Epilepsy	4,200	3,408 (0.8%)	350	15
Cancer	2,500 cases per year (incidence)	9,379 (1.7%)	15,000	1,400
Hypo-thyroidism	3,600 (15 in every 1,000 women, 1 in 1,000 men)	18,479 (3.4%)	12	5
Renal Disease/CKD	41,900 (9.4%)	21,013 (4.8%)	400	20

Hypertension is the most common LTC in Warwickshire, in terms of both estimated and actual prevalence. The highest number of hospital admissions and average deaths, per year, are for various types of cancer.

According to the latest 2011 Census data, 26,500 Warwickshire residents self-reported that they were in 'very bad' or 'bad' health; equivalent to the total population of Stratford-upon-Avon.

In Warwickshire, there are 39,743 residents who say that daily activities are limited 'a little' or 'a lot' due to ill health. This is almost equivalent to the entire working population of North Warwickshire. **Nuneaton and Bedworth Borough has the largest number of residents (11,484) experiencing limitations to their daily activities** when compared with the other Districts and Boroughs. However, **the largest increase between 2001 and 2010 occurred in Rugby Borough (+16%).**

4.3.2 Mental Wellbeing

This young person has an eating difficulty, self-harms and has taken a number of over doses, which stems from being abused by her father from a young age. Due to the nature of her mental health she appears to dip in and out of services.

However, she has worked consistently with her Kooth counsellor. She has felt supported to be able to disclose her abuse and realised that there are people out there to help her and she does not have to feel alone.

Her psychiatrist had suspected abuse but she had not opened up about it until she built up trust and rapport with her Kooth counsellor.[42]

"I attended Brunswick Centre on Wednesday Oct 10th and initially as expected I found it stressful, but once inside I was impressed by the amount of help and advice available.

The walk, though only about a mile was a chance to talk, and by the time we arrived back at the centre I felt much more at ease, again help and advice was offered but not forced.

I returned to the centre the following day and took part in another walk, followed by tea and a chat. I intend to use the centre on a regular basis and try to do more events."[43]

4.3.2.1 What is the headline issue?

For people aged between 16 and 74 living in Warwickshire, the rate of common mental health conditions is 121.4 per

[42] Female, aged 22.
[43] New Walker, Leamington.

1,000 population[44]. This means that an estimated 46,000 people aged between 16 and 74 in Warwickshire have a common mental health problem.

4.3.2.2 What does the data say?

The positivity indicator from last year's Quality of Life Survey[45] looks at how positive residents are by analysing data from the Mosaic dataset on whether they agree with the statement 'little can be done to change my life[46].

The worst value across the county is in the Atherstone North (St. Georges & Carlyon) Super Output Area (SOA)[47]. Its index value of 140 suggests that this SOA is 40% more likely than an average community to contain residents that feel that little can be done to change their life. There are eleven SOAs in the county with an index value above 125; seven of these SOAs are in Nuneaton & Bedworth Borough. The figure below presents the SOAs with the lowest and highest index values in the county. It is interesting that SOAs in both Nuneaton & Bedworth and Rugby boroughs feature heavily in the most and least likely to feel that nothing can be done, again highlighting the diversity that exists within these boroughs.

Figure 4: Super Output Areas most and least likely to contain households who feel nothing can be done to change their life.[48]

	SOA Name	District	Index
Most likely to feel nothing can be done to change life	Atherstone North - St Georges & Carlyon	North Warwickshire	140
	Wern Brook East	Nuneaton & Bedworth	133
	Bede East	Nuneaton & Bedworth	131
	Caldecott North West	Rugby	130
	Rugby Town Central	Rugby	130
Least likely to feel nothing can be done to change life	Cawston	Rugby	61
	Brownsover North - East	Rugby	58
	St Nicolas Horeston Grange West	Nuneaton & Bedworth	57
	Galley Common South	Nuneaton & Bedworth	56
	Brownsover North - Campion	Rugby	54

Source: Modelled Mosaic Data 2011

Mental health inpatient data shows that in 2010/11 there were 698 total individual inpatient admissions in Warwickshire. The table below shows that **there has been a significant decrease in mental health inpatient admissions from the previous**

[44] Common mental health conditions include depression, generalised anxiety disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), phobias and social anxiety disorder.
[45] Having a positive outlook on life is an important contributor to someone's quality of life in many ways. It helps to give us a sense of their mental wellbeing. Those that disagree with this statement are more likely to be positive about other aspects of their life, and links have also been made with a reduced risk of various health conditions.
[46] Each Super Output Area[41] has an index score; the higher the index value, the greater propensity the area has to contain households that feel little can be done to change their life, and the lower the index value, the greater the propensity the area has to contain households that do not feel little can be done to change their life. An index value of 100 is the national average.
[47] A Super Output Area (SOA) is a geographic area used for statistical comparison. More information can be found here: Statistical Geography - Super Output Areas. Maps of Warwickshire SOAs can be found in Appendix B.
[48] Taken from the Warwickshire Quality of Life Survey 2012, which can be found here: Warwickshire Quality of Life Survey 2012

year[49]. However, more people are being treated in community settings and admission data is generally a poor indicator of mental illness and mental wellbeing.

Table 2: Total Individual Inpatient Admissions by District/Borough of Residence, 2009/10 – 2010/11[50]

	Year of Admittance		Total	Percentage Change 2009/10 to 2010/11 (%)	Crude Rate per 1,000 Resident Population
	2009/10	2010/11			
North Warwickshire Borough	104	52	156	-100.0	2.5
Nuneaton & Bedworth Borough	224	134	358	-67.2	2.9
Rugby Borough	175	120	295	-45.8	3.1
Stratford-on-Avon District	186	146	332	-27.4	2.8
Warwick District	275	183	458	-50.3	3.3
Warwickshire	964	635	1,599	-51.8	3.0
Null*	71	63	134	-12.7	-
Total	1,035	698	1,733	-48.3	-

**No address data provided.*

Source: Coventry and Warwickshire Partnership Trust Contract Datasets via NHS Intelligence

[49] This is likely to be due to the fact that Mental Health services have been redesigned over the last 18 months and the number of inpatient beds was reduced in early 2010/11, by closing a unit based in Rugby.

[50] Taken from the Adult Mental Health Needs Assessment 2012, which can be found here: AMHNA 2012

4.4 VULNERABLE COMMUNITIES

4.4.1 Reducing Health & Wellbeing Inequalities

4.4.1.1 What is the headline issue?

In Warwickshire, significant disparities exist both on a geographic and population group basis. The health of the most disadvantaged in our society should be our top priority. However, there is a need to ensure that our programmes target people across the inequality profile. In line with the Sir Michael Marmot report on health inequalities**, the highest priority should be given to children from pre-conception through to adolescence**.

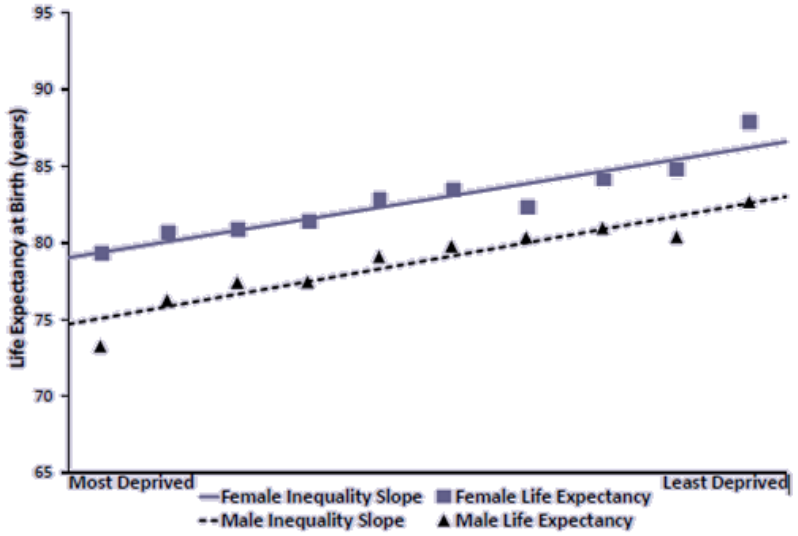
4.4.1.2 What does the data say?

4.4.1.2.1 Life expectancy

Inequalities remain throughout Warwickshire. This is reflected in **differences in average life expectancy** ranging from 77.5 years for males in Nuneaton & Bedworth Borough to 80.4 years in Stratford-on-Avon District and from 81.9 years for females in Nuneaton & Bedworth Borough to 84.3 years in Warwick District and there is an 8.9 year gap in disability-free life expectancy at age 16 between North Warwickshire and Stratford-on-Avon in 2007-09.

Variation in life expectancy is even more pronounced at ward level and ranges from 74.5 years in Abbey, Nuneaton to 88 years in Leek Wootton, Warwick; a difference of 13.5 years.[51]

Figure 5: Warwickshire Slope Index of Inequality[52]



The lines on the chart above represent the Slope Index of Inequality, which is a modelled estimate of the range in life-expectancy at birth across the whole population from most to least deprived. Based on death rates in 2006-2010, this range is 8.3 years for males and 7.6 years for females. There is greater variation in the gradient of the slope at a District and Borough level. For instance, the range for males in Nuneaton & Bedworth Borough is 11 years in life expectancy between the most and least deprived areas.

4.4.1.2.2 Fuel poverty

In 2010, **18.9% of households in Warwickshire lived in fuel poverty compared with a national average of 16.4%**[53]. This equates to 43,000 households and actually represents a fall from 23% in the 2009 data estimates[54].

Fuel poverty was lowest in Warwick District with 16.9% of households. Elsewhere **the proportion of 'fuel poor' households was remarkably similar in North Warwickshire, Nuneaton & Bedworth, Rugby and Stratford-on-Avon**, at just under 20% of households. However, it should be noted that at Lower Super-Output Area level, there are some parts of the county where the estimated proportion of households living in fuel poverty is in excess of 25%.

4.4.1.2.3 Child poverty

The proportion of children in poverty in Warwickshire in 2010 was 13.9% against the England average of 20.6%[55].

[51] A map of Warwickshire Wards during the period is at Appendix A.
[52] The points on this chart show the average life expectancy in each tenth of the population.
[53] 2010 estimates data from the Department of Energy and Climate Change (DECC).
[54] These figures are likely to represent an underestimate of the current picture given the recent prolonged winter and associated above inflation increases in the cost of energy.
[55] Source: HM Revenue & Customs (snapshots as at 31st August 2010).

4.4.1.2.4 Teenage conceptions

There are considerable variations in conception rate at district level. Prior to 2011, North Warwickshire was the only district that had seen an upward trend in rate, although this reversed in 2011 with a reduction from 49.9 conceptions per 1,000 females aged 15-17 in 2010 to 29.5 in 2011. Nuneaton and Bedworth has continued with its decline in rate from 51.6 in 2010 to 43.2 2011, as did Rugby which has seen a new low of 24.3, making it the borough with the lowest rate in the county. Stratford-on-Avon has traditionally seen the lowest teenage conception rates in the county, although the last few years have seen slight increases, which is mirrored in the 2011 figures with a 2% increase from the previous year to 25.4. This trend is reflected in Warwick district, which saw a 15% increase in rate from 2010 to 2011 with 29.6 conceptions per 1,000 females aged 15-17.

There has been a slight decline in the percentage of teenage conceptions leading to abortion across Warwickshire. However, variations persist within the county, with a 13% difference between Nuneaton and Bedworth which has the lowest proportion leading to abortion and Warwick and North Warwickshire which have the highest proportions[56].

[56] Source: Respect Yourself update number 41; ONS teenage conception release

4.4.2 Disability

The Older People's and Physical Disability Team reached the final for the national WOW! Awards which celebrates outstanding service, based purely on nominations from the public. They were shortlisted for the 'You Changed My Life' category for the way they supported a woman with cerebral palsy.

The twenty-five year-old woman felt it was time to move out of home and wanted to live independently. She was allocated a bungalow by a local housing association and, with the assistance of occupational therapists, made sure that the bungalow had all the necessary adaptations to help her live independently. Social workers also supported her to employ a team of personal assistants who help with everyday tasks so she can lead a full and active life.

She said of living in her own home: "It has inspired me to realise just how much I can do for myself. It's enable me to live my life the way I have dream of living. I only wish I had done this sooner."

4.4.2.1 What is the headline issue?

In the future, the ageing population means that the number of residents with physical disabilities and/or sensory impairment will continue to grow. Services will need to be commissioned to target this increasing need[57].

[57] Disabled people are more likely to experience disadvantage in their daily lives. This is evidenced in the fact that they are:

- Less likely to reach their maximum educational potential;
- More likely to be unemployed;

The numbers of children with learning disabilities and complex needs surviving in adulthood are also growing, as are those adults surviving with learning disabilities into old age. In addition, those that do survive into older age can face the loss of their existing support from carers, who are no longer able to look after them.

A recent report by the Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD) in the South West of England found that **43% of the deaths of people with learning disabilities were unexpected**[58]. The most common reasons for deaths assessed as premature were: delays or problems with diagnosis or treatment; and problems with identifying needs and providing appropriate care in response to changing needs. Whether this is borne out locally is not yet known.

The promotion of healthy lifestyles, the provision of information and guidance, and identifying needs at an earlier stage will be required to improve health and wellbeing and increase the numbers of those physically and mentally disabled people living positive and fulfilling lives[59].

- More likely to experience poverty;
- More likely to experience discrimination in relation to housing, employment, transport and leisure services.

These factors can have a significant and lifelong impact on their health and wellbeing.

[58] In the study, a death was considered as premature if, 'without a specific event that formed part of the "pathway" that led to death, it was probable that the person would have continued to live for at least one more year'. The study can be found here: CIPOLD Study.

4.4.2.2 What does the data say?

There are estimated to be 34,664 people aged 18-64 with a moderate or serious physical disability in Warwickshire. Within that figure 26,653 are classed as having a moderate physical disability, with a further 8,011 classed as serious. The total is predicted to rise to 37,397 by 2030 with 28,797 classified as having moderate physical disability and 8,600 as severe.

Countywide there are 2,860 Disability Living Allowance claimants aged under 16 (2.9% of the U16 population)[60]. **Nuneaton & Bedworth has the highest number of Disability Living Allowance claimants (860) and the highest percentage of U16 population (3.6%)**, with Stratford at the second highest (580 & 2.8%). Both the number and percentage of U16 claimants have increased since February 2011, from 2,690 (2.7%).

In 2011/12 645 social care customers with a learning disability were identified as living in their own home or with their family. This represents 54.5% of customers, compared to 57.2% in 2010/11; the national average is 70%. 47% of customers with a learning disability and 44% of customers with a physical disability

[59] See 'Delivering within the Wedge'.

[60] Data on Disability Living Allowance claimants aged under 16 figures from February 2012.

who were living at home had either a personal budget or a direct payment, giving them greater choice and control over their care.

70 social care customers with a learning disability were in paid employment. This represents 5.9% of the social care customers with a learning disability, compared to 6% in 2010/11; the national average is 7.2%.

In the 2012 Adult Social Care Survey, 86% of customers with a learning disability and 68% of customers with a physical disability said they had enough control over their daily life. This compares to 73% for all social care customers. 89% of customers with a learning disability and 48% of customers with a physical disability said their quality of life was either good or better. This compares to 60% for all social care customers[61].

The percentage of pupils with Special Educational Needs (SEN) has remained stable in the last year at around 20%. In 2012 the provisional attainment data show that **there was a gap of 47 percentage points between those without SEN achieving 5 or more GCSEs A*-C** and those with SEN. This is a decrease from 2011's figure of 49%

[61] It should be noted that customers with a learning disability were a lot more likely to have assistance in completing the survey which results in more positive answers compared to those completing their own survey

4.4.3 Safeguarding

"People say, he can't stand up for himself he has a disability, he's an easy target, lot of youths cursing and swearing at you, it makes you feel…you don't feel safe to go out. You should be able to go out in the community and feel part of the community and feel safe and secure."[62]

"I was attacked a year ago by a group of youths for just being me. That's put fear in me and left me really scared; I check behind me when I go into town & I'm just not myself anymore."[63]

"Safe places will help because if you are really scared you can go in and talk and they can put you at ease. There is a sticker on the window and that will let you know that it's a safe place."[64]

"The sticker is in the window; they can come to this café and they will have a safe haven and somebody to help. If the local businesses can all come together, if more people do it, we can help the more vulnerable people."[65]

4.4.3.1 What is the headline issue?

The increase in unemployment rates and the projected rise in population are likely to lead to rises in numbers of children in need, children subject to Child Protection (CP) plans and looked after children[66].

[62] Vulnerable Adult.
[63] Vulnerable Adult.
[64] Vulnerable Adult.
[65] Café owner.
[66] A paper issued by Warwickshire Observatory suggests a time lagged correlation between rising unemployment and children entering care. More

As with the national picture, **over the past three years, referrals to children's social care in Warwickshire have risen steadily** by 18% from 5911 in 2009/10 to 6998 referrals in 2011/12[67]. Figures also show a 33% **rise in the number of children made the subject of Section 47 enquiries**.

This is also reflected by the **significant increase in the number of children who were made subject to a CP Plan** with 520 plans initiated during 2011/12 in comparison to the 459 initiated in 2010/11[68]. **CP activity is the highest in Nuneaton and Bedworth, followed by Rugby**.

Media reporting of high profile cases such as Baby Peter have generated heightened anxiety and increased both public and professional awareness. One of the consequences of heightened awareness has been that professionals have become more cautious and may have lowered their own thresholds for referral onwards to children's social care. Increases in the promotion of safeguarding awareness, training and more coherent multi-agency processes have been implemented over the past few years, as well as campaigns by some leading charities to raise public awareness of child protection[69]. Recommendations from Serious Case Reviews and changes to legislation, have also contributed to the increase in safeguarding activity[70].

4.4.3.2 What does the data say?

534 children were subject to a CP plan in Warwickshire, an 11.7% increase on 478[71] in 2011. More plans were initiated than closed this year which is in contrast to last year when the reverse was true.

The county rate per 10,000 0-17 population has increased from 43 to 48[51]. Most districts saw rises in their CP cases per 10,000 for the same period, except Rugby where there has been a reduction.

The rate of CP per 10,000 population is highest in Nuneaton and Bedworth Borough at 86 and lowest in Stratford-on-Avon District at 23.

The proportion of children subject to a CP plan whose ethnic was Black/Minority increased, from 7.3% last year to 11.8% at 31 March 2012. White British children subject to a plan decreased, from 89.5% to 85.1%.

information can be found here: Examining the link between unemployment and the number of children entering care.

[67] Although data is collected with regard to social care referrals, it is not possible to identify how many referrals move onto an Initial Assessment. Assessments and may lead to no further action, the direct provision of services, and Section 47 enquiries.

[68] The reasons for the increase are complex and are currently being addressed by the Dartington Project.

[69] For example, NSPCC's 'I Stand for Children' Campaign.

[70] e.g. the Southwark Judgement; Caerphilly Judgement (2005); Public Law Outline: Changes to care and other children's proceedings from April 2008.

[71] As at 31 March 2012,

4.5 OLD AGE

4.5.1 Dementia

"'The website is fantastic. Thanks'…'I've learned more this morning using the dementia portal than in 2 years since my father-in-law was diagnosed with dementia."[72]

"It's the only one [book] that was actually written for the person diagnosed with dementia and I felt it was quite optimistic, focussing on the positives of receiving an early diagnosis. I like the inclusion of practical information on a range of topics related to living with dementia. It paints the picture that it's still possible to have a meaningful life with dementia."[73]

4.5.1.1 What is the headline issue?

Dementia is increasingly becoming one of the most important causes of disability in older people[74].

In 2011/12 in Warwickshire, there were 3,169 patients on the GP disease register for dementia[75]. However, **population prevalence data suggests that only 43% of people in Warwickshire with dementia have been formally diagnosed**. This equates to over 4,000 people without a diagnosis[76]. **In line with a growing and ageing population, numbers of people with dementia are set to increase rapidly in the future**.

There are many factors that contribute to low diagnosis rates including levels of awareness and understanding about dementia being low, stigma associated with the diagnosis contributing to people not coming forward to present symptoms or these symptoms being regarded as a normal part of ageing and not investigated. Timely diagnosis' are extremely important for the individual and can help contribute to reduced health and social care costs as the person and their family are more likely to access treatment, support and services that can help support them to stay independent for longer.

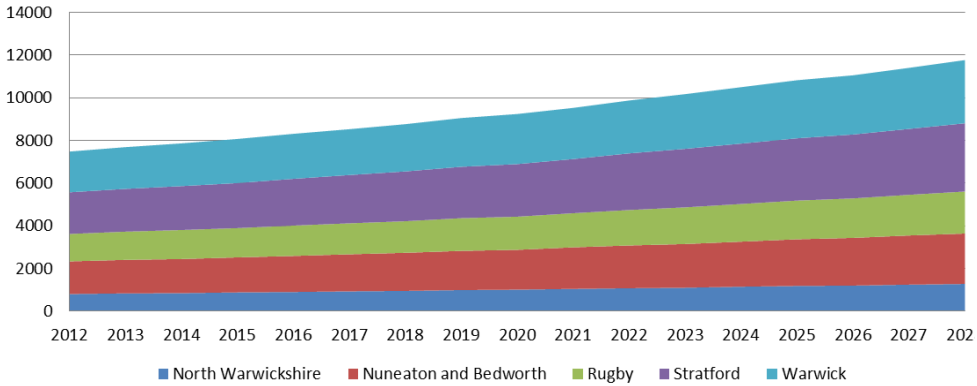
4.5.1.2 What does the data say?

Between 2012 and 2028 the number of people with dementia is projected to increase by 57%[77]. The Alzheimer's Society estimated in 2007 that on average a person with dementia costs £25,472 per year. 41% of this is for accommodation and 36%

[72] Carer talking about the Warwickshire Dementia Portal: www.warwickshire.gov.uk/livingwellwithdementia, following its launch in October 2012.
[73] Rebecca Ledington-Bradshaw, Psychological Wellbeing Practitioner, IAPT, Commenting on *Living your best with early stage dementia* by Lisa Snyder, which has been added to the BOP collection.
[74] The term 'dementia' is used to describe the symptoms that occur when the brain is affected by specific conditions including Alzheimer's disease and stroke.
[75] From the Quality Outcome Framework (QOF), a voluntary return made by GPs to evidence performance.
[76] Source QOF register and Alzheimer's Society 2007 report, via the NHS Dementia Prevalence Calculator: The total number of people estimated to have dementia from the overall prevalence information minus the QOF information.
[77] Figures from Projecting Older People Population Information System (POPPI).

informal care, the remaining 23% is costs to NHS and social services.

Figure 6: Predicted number of people with dementia in Warwickshire 2012 to 2028[78].



In the 2012 Adult Social Care Survey, 65% of customers with dementia said they felt they had enough control over their daily life, this compares to 73% for all social care customers. 76% of customers with dementia said their quality of life was either good or better than good; this compares to 60% for all social care customers[79].

[78] Figures from Projecting Older People Population Information System (POPPI).

[79] National Adult Social Care Survey. A statutory annual return. Of the 483 respondents to the survey, 34 were aged 65+ with mental Health client groups. Thus, the response rate for those with dementia may too low to be significant.

4.5.2 Ageing & Frailty

"I couldn't wash up, I couldn't cook a meal, I couldn't dust the house, I couldn't do anything at all. I had reablement as soon as I came out of hospital.

They taught me how to do lots of exercises, how to get about without too much discomfort, and every day, to do a little more. Each time they came we got a little bit further and by the time the six weeks were up I was able to wash and dress myself.

They were so pleased with me and everything I did. They were thrilled to bits at the end when I could dress myself and it was only through their help. They encouraged me the whole way through.

They can do an awful lot for you but a lot you have to do for yourself. If you have the will to get better then reablement are the people to help you do it."[80]

4.5.2.1 What is the headline issue?

The National End of Life Care Intelligence Network profiles show that the largest underlying causes of death, for the three years from 2008-10, are cancers and cardiovascular diseases each of which account for nearly 30% of all deaths across the county. During the same period, 39% of deaths occurred either at home or in care homes whereas 55% were in hospitals. The profile also includes a **'Total spend on end of life care per death'**

[80] From Age UK Mrs Pile received the Re-ablement service when she was discharged from hospital after a fall down the stairs which injured her back.

figure of £553 for Warwickshire against an England average of £1,096[81].

4.5.2.2 What does the data say?

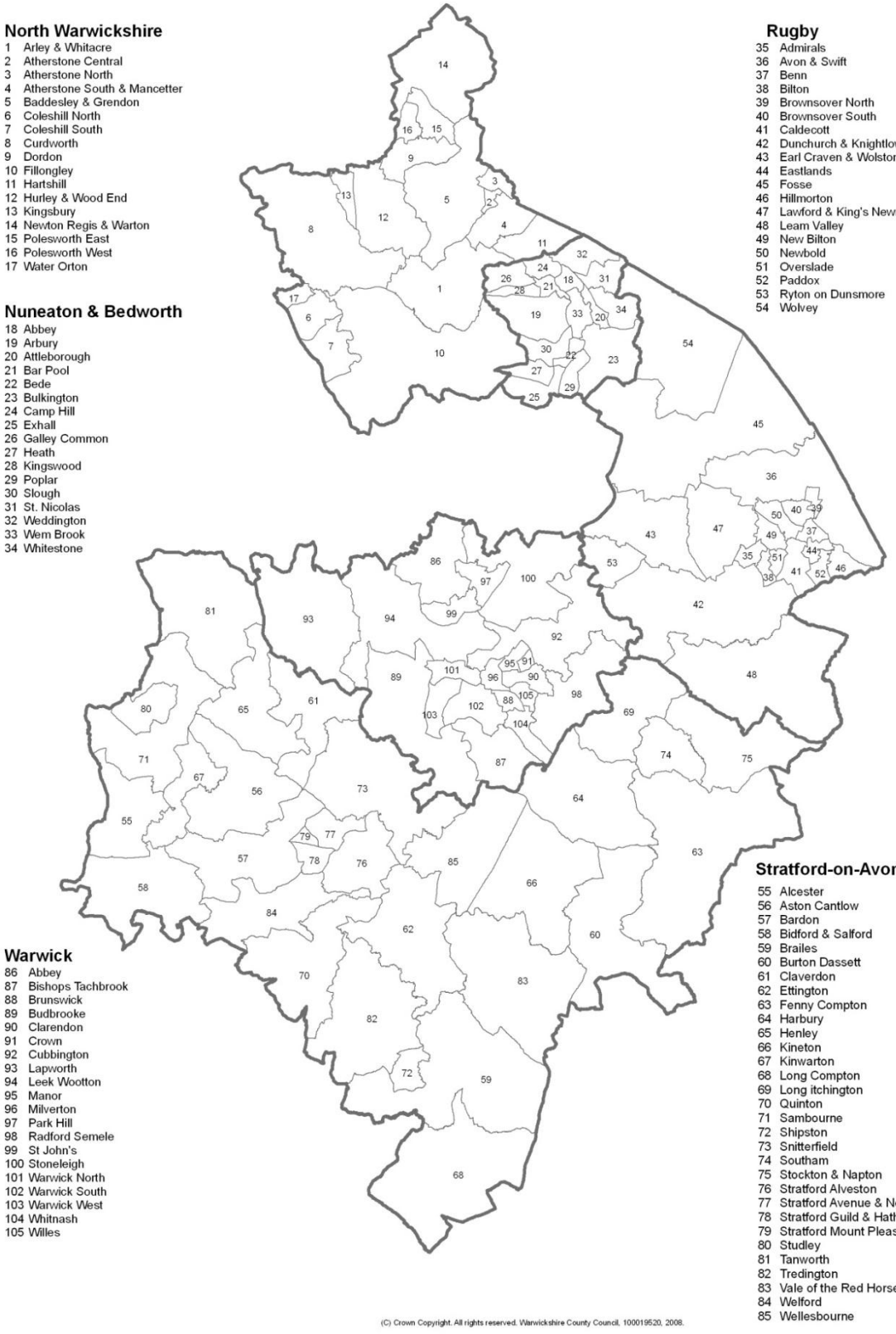
For the first time this year, figures for Excess Winter Mortality (EWM) are available at Local Authority level for 2010/11. Due to small numbers at this level, there are random fluctuations meaning that EWM figures at local authority level are quite variable. As there is no consistent pattern, limited analysis can be performed. However, averaging the five Local Authorities in Warwickshire does reveal a pattern which largely reflects the regional and national trend.

Numbers suggest that there are more fractures in the Warwick & Stratford Districts of the county however no allowance is made for differences in populations. When the crude hip fracture rates are looked at by age groups the differences are striking with those aged 85+ accounting for 47% of all the breakages and those aged 80 and over totalling 68%. The 2011 and 2012 Local Authority Health Profiles both showed that **in Rugby Borough, hip fractures in the over 65s were significantly worse than the England average**.

[81] More information can be found in the Warwickshire National End of Life Care Profile for Primary Care Trusts

APPENDIX A: WARWICKSHIRE DISTRICT/BOROUGH & WARDS

Warwickshire: District/Borough Wards



North Warwickshire
1 Arley & Whitacre
2 Atherstone Central
3 Atherstone North
4 Atherstone South & Mancetter
5 Baddesley & Grendon
6 Coleshill North
7 Coleshill South
8 Curdworth
9 Dordon
10 Fillongley
11 Hartshill
12 Hurley & Wood End
13 Kingsbury
14 Newton Regis & Warton
15 Polesworth East
16 Polesworth West
17 Water Orton

Nuneaton & Bedworth
18 Abbey
19 Arbury
20 Attleborough
21 Bar Pool
22 Bede
23 Bulkington
24 Camp Hill
25 Exhall
26 Galley Common
27 Heath
28 Kingswood
29 Poplar
30 Slough
31 St. Nicolas
32 Weddington
33 Wem Brook
34 Whitestone

Rugby
35 Admirals
36 Avon & Swift
37 Benn
38 Bilton
39 Brownsover North
40 Brownsover South
41 Caldecott
42 Dunchurch & Knightlow
43 Earl Craven & Wolston
44 Eastlands
45 Fosse
46 Hillmorton
47 Lawford & King's Newnham
48 Leam Valley
49 New Bilton
50 Newbold
51 Overslade
52 Paddox
53 Ryton on Dunsmore
54 Wolvey

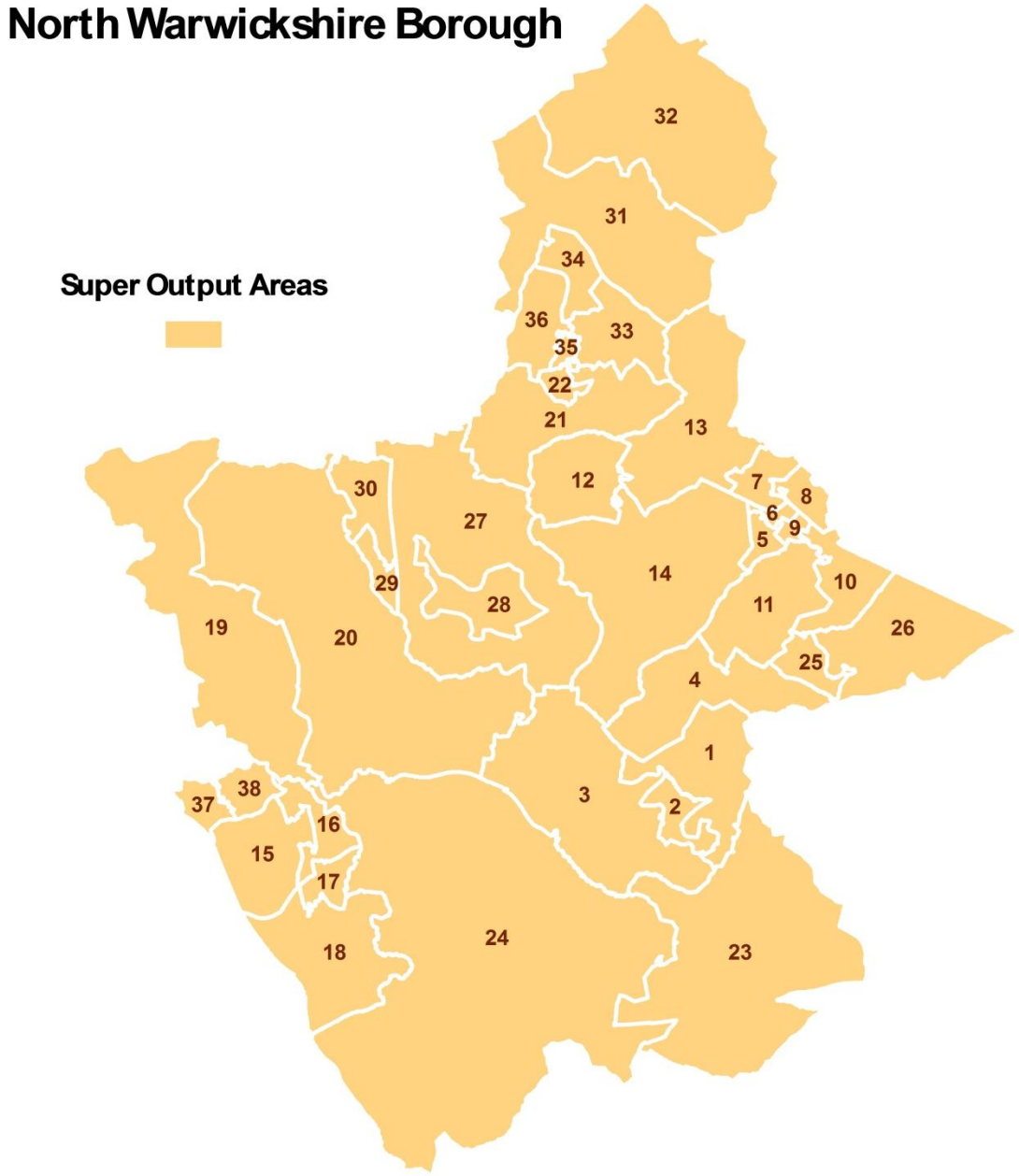
Warwick
86 Abbey
87 Bishops Tachbrook
88 Brunswick
89 Budbrooke
90 Clarendon
91 Crown
92 Cubbington
93 Lapworth
94 Leek Wootton
95 Manor
96 Milverton
97 Park Hill
98 Radford Semele
99 St John's
100 Stoneleigh
101 Warwick North
102 Warwick South
103 Warwick West
104 Whitnash
105 Willes

Stratford-on-Avon
55 Alcester
56 Aston Cantlow
57 Bardon
58 Bidford & Salford
59 Brailes
60 Burton Dassett
61 Claverdon
62 Ettington
63 Fenny Compton
64 Harbury
65 Henley
66 Kineton
67 Kinwarton
68 Long Compton
69 Long itchington
70 Quinton
71 Sambourne
72 Shipston
73 Snitterfield
74 Southam
75 Stockton & Napton
76 Stratford Alveston
77 Stratford Avenue & New Town
78 Stratford Guild & Hathaway
79 Stratford Mount Pleasant
80 Studley
81 Tanworth
82 Tredington
83 Vale of the Red Horse
84 Welford
85 Wellesbourne

N.B. This map show Wards as at

APPENDIX B: WARWICKSHIRE SUPER OUTPUT AREA MAPS

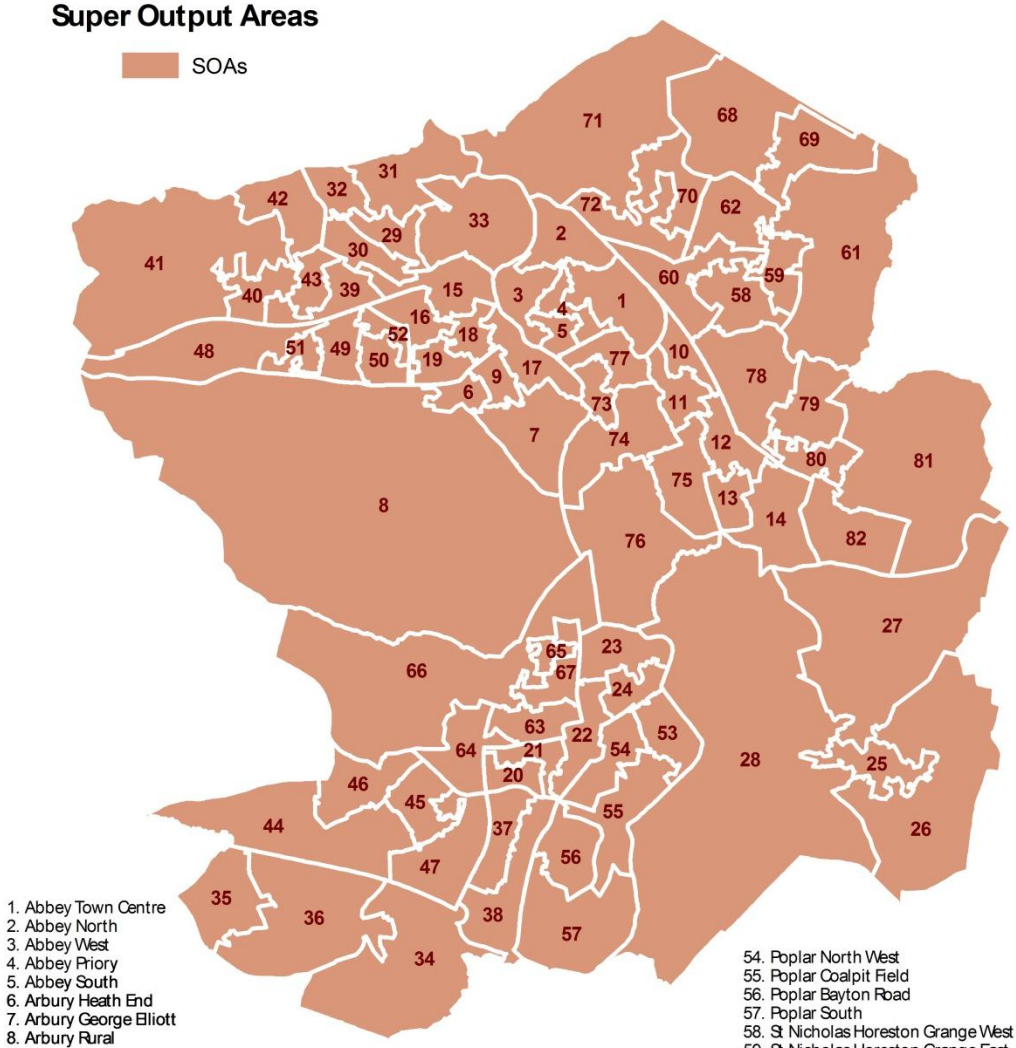
North Warwickshire Borough



1. New Arley East, Hill Top and Ansley
2. New Arley West and Old Arley
3. New Arley South and Over Whitacre
4. Ansley Common and Birchley Heath
5. Atherstone Central - Canal and Outwoods
6. Atherstone Central - Centre
7. Atherstone North - Town Centre North & Alder Mill
8. Atherstone North - St Georges & Carlyon
9. Atherstone South
10. Mancetter North
11. Mancetter South and Ridge Lane
12. Baddesley Ensor West
13. Grendon, Bradley Green and Whittington
14. Baddesley Common, Baxterley and Merevale
15. Coleshill North - Grimstock Hill
16. Coleshill North - Cole End
17. Coleshill South - Centre
18. Coleshill South - Hospital & Southfields
19. Curdworth and Wishaw
20. Marston and Water Park
21. Dordon Rural
22. Dordon Village
23. Corley
24. Fillongley and the Packingtons
25. Hartshill South
26. Hartshill North and Caldecote
27. Piccadilly and Wood End
28. Hurley
29. Kingsbury South
30. Kingsbury North
31. Warton and Shuttington
32. Newton Regis, Austrey and Seckington
33. Polesworth East - St Helena
34. Polesworth East - Station
35. Polesworth West - School
36. Polesworth West - Birchmoor & Pooley Fields
37. Water Orton West
38. Water Orton East

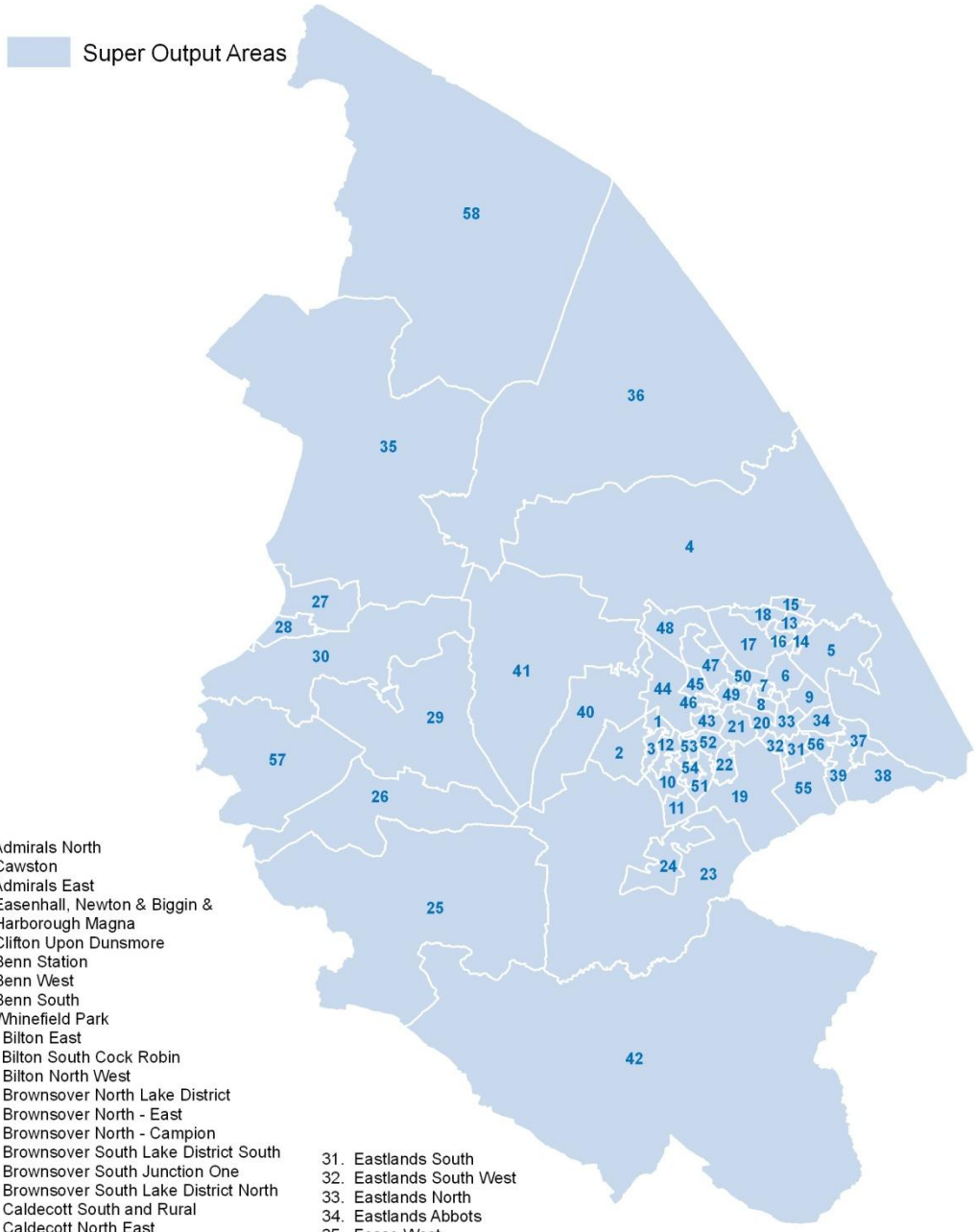
Nuneaton & Bedworth Borough

Super Output Areas



1. Abbey Town Centre
2. Abbey North
3. Abbey West
4. Abbey Priory
5. Abbey South
6. Arbury Heath End
7. Arbury George Elliott
8. Arbury Rural
9. Arbury North
10. Attleborough North East
11. Attleborough North West
12. Attleborough Central
13. Attleborough South West
14. Attleborough South East
15. Bar Pool North & Crescents
16. Bar Pool West & Recreation Ground
17. Bar Pool East & Greenmoor
18. Bar Pool Central
19. Bar Pool South
20. Bede South West
21. Bede Cannons
22. Bede Bedworth Town Centre
23. Bede North
24. Bede East
25. Bulkington Village
26. Bulkington South East
27. Bulkington North
28. Bulkington Arden
29. Camp Hill Village Centre
30. Camp Hill South West & Brook
31. Camp Hill North & Pools
32. Camp Hill North West & Allotments
33. Camp Hill West & Quarry
34. Exhall Grange
35. Keresley North and Newlands
36. Keresley South and Ash Green
37. Exhall West
38. Exhall East
39. Galley Common South East
40. Galley Common South
41. Galley Common West & Rural
42. Chapel End
43. Galley Common East
44. Goodyers End
45. Heath Sports
46. Market End and Newdigate
47. Little Heath
48. Kingswood Grove Farm & Rural
49. Kingswood St Pauls
50. Kingswood Stockingford Schools
51. Kingswood Hills
52. Kingswood North East
53. Poplar Nicholas Chamberlain
54. Poplar North West
55. Poplar Coalpit Field
56. Poplar Bayton Road
57. Poplar South
58. St Nicholas Horeston Grange West
59. St Nicholas Horeston Grange East
60. St Nicholas South West
61. St Nicholas East & The Long Shoot
62. St. Nicholas North & College
63. Slough Mt Pleasant
64. Slough South & Heath
65. Slough Collycroft North
66. Slough West and Rural
67. Slough Collycroft South
68. Weddington St Nicholas West
69. Weddington St Nicholas East
70. Weddington South & Schools
71. Weddington North
72. Wedding South West & River
73. Wem Brook Bridges
74. Middlemarch & Swimming Pool
75. Wem Brook East
76. Hill Top
77. Riversley
78. Whitestone North West & Attleborough Fields
79. Whitestone North
80. Whitestone South
81. Whitestone East & Rural
82. Whitestone South

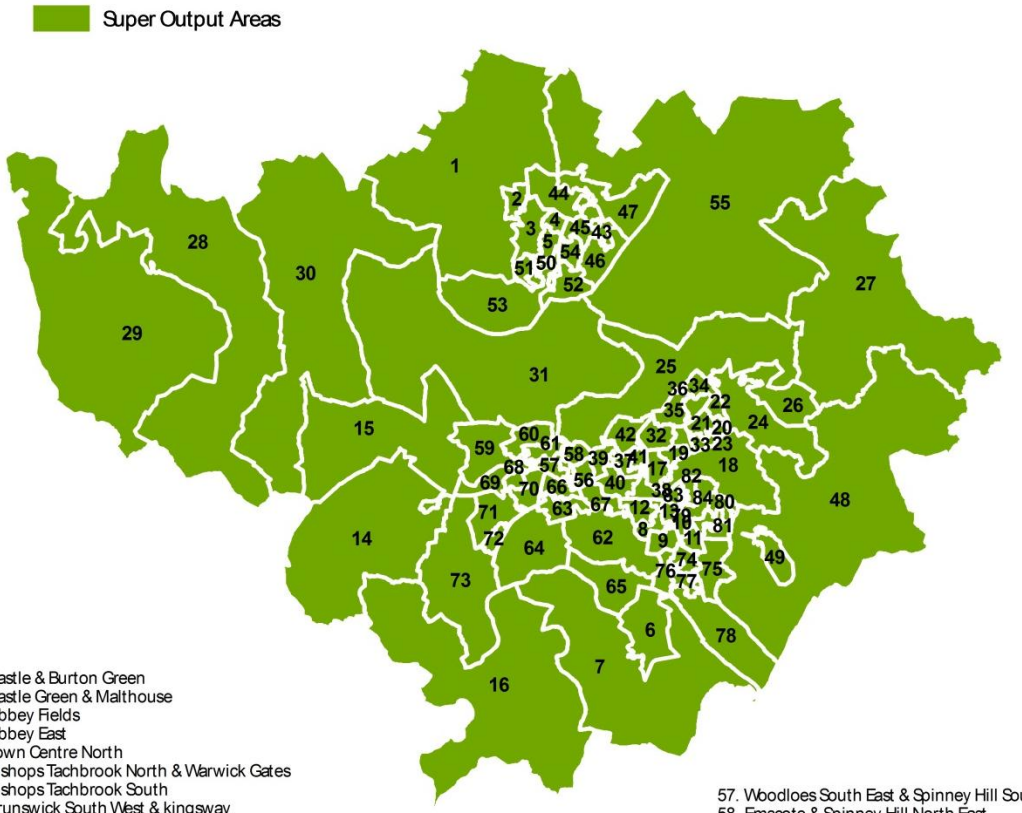
Rugby Borough



1. Admirals North
2. Cawston
3. Admirals East
4. Easenhall, Newton & Biggin & Harborough Magna
5. Clifton Upon Dunsmore
6. Benn Station
7. Benn West
8. Benn South
9. Whinefield Park
10. Bilton East
11. Bilton South Cock Robin
12. Bilton North West
13. Brownsover North Lake District
14. Brownsover North - East
15. Brownsover North - Campion
16. Brownsover South Lake District South
17. Brownsover South Junction One
18. Brownsover South Lake District North
19. Caldecott South and Rural
20. Caldecott North East
21. Caldecott North West
22. Caldecott Rokeby
23. Thurlaston
24. Dunchurch
25. Princethorpe, Marton, Frankton, Bourton & Draycote
26. Stretton on Dunsmore
27. Binley Woods North
28. Binley Woods South
29. Wolston South
30. Brandon & Wolston North
31. Eastlands South
32. Eastlands South West
33. Eastlands North
34. Eastlands Abbots
35. Fosse West
36. Fosse East
37. Hillmorton North and Locks
38. Hillmorton East and Wharf
39. Hillmorton West
40. Long Lawford South
41. Church Lawford, Kings Newnham & Long Lawford North
42. Leam Valley
43. New Bilton South East
44. New Bilton West & Somers Road
45. New Bilton North
46. New Bilton East
47. Newbold Riverside
48. Newbold-on-Avon
49. Town Centre
50. Cattlemarket
51. Overslade South East
52. Overslade North
53. Overslade North West
54. Overslade West
55. Paddox South
56. Paddox North
57. Ryton on Dunsmore
58. Wolvey

Warwick District

Super Output Areas



1. Castle & Burton Green
2. Castle Green & Malthouse
3. Abbey Fields
4. Abbey East
5. Town Centre North
6. Bishops Tachbrook North & Warwick Gates
7. Bishops Tachbrook South
8. Brunswick South West & kingsway
9. Brunswick South & Cemetary
10. Brunswick North East
11. Brunswick South East
12. Brunswick North West & Foundry
13. Old Town West & Railway Bridge
14. Hampton-on-the-Hill
15. Hatton & Hampton Magna
16. Sherbourne, Barford & Wasperton
17. Town Centre
18. Campion Hills & Newbold Comyn
19. Clarendon North
20. Lillington East
21. Lillington West
22. Crown North East
23. Lillington South
24. Cubbington West & New Cubbington
25. New Cubbington, Blackdown & Old Milverton
26. Cubbington East
27. Bubbenhall, Wappenbury, Weston & Eathorpe
28. Lapworth North, Baddesley Clinton & High Cross
29. Lapworth South, Bushwood, Lowsonford & Rowington
30. Wroxhall, Hasely & Honiley
31. Leek Wootton, Guys Cliffe & Beausale
32. Manor South West
33. Manor South & Round Oaks
34. Manor North
35. Manor West
36. Manor East
37. Milverton Cliffe
38. Milverton South East
39. Milverton West
40. Milverton South West
41. Milverton East
42. Milverton North
43. Knowle Hill & Glasshouse
44. Ladyes Hills & Mill End West
45. Whitemoor
46. Glass House & Windy Arbour
47. Mill End East & Crackley
48. Offchurch & Hunningham
49. Radford Semele
50. Town Centre South
51. Borrowell
52. Thickthorn & Castle End
53. St John's Playing Fields
54. Castle End & Windy Arbour
55. Stoneleigh
56. Emscote
57. Woodloes South East & Spinney Hill South
58. Emscote & Spinney Hill North East
59. Wedgenock & Woodloes West
60. Woodloes North
61. Woodloes East
62. Warwick Gates Nth, T. Park & Myton South
63. St Nicholas Park, Myton & Emscote South
64. Bridge End, Castle & Stratford Rd East
65. Warwick Gates
66. Emscote Lawns
67. The Moorings and Myton North
68. Packmores West & The Cape
69. The Cape & Wedgenock
70. Priory Park, Packmores & Hospital
71. Town Centre & Racecourse
72. Warwick West East
73. Kings Meadow & Longbridge
74. Whitnash North
75. Whitnash East & Millponds
76. Whitnash West
77. Whitnash St Margarets
78. Whitnash South
79. Sydenham West
80. Sydenham North
81. Sydenham South & East
82. Old Town North
83. Old Town North West
84. Old Town East & Sydenham Ind. Est.

Stratford District

Super Output Areas

Super Output Areas

1. Alcester South, Arrow & Weethley
2. Abbey, Grammar & Kings Coughton
3. Alcester North & Conway
4. Alcester East & Island
5. Aston Cantlow
6. Bardon
7. Dunnington and Salford Priors
8. Bidford East, Waterloo & Broom
9. Bidford West and Wixford
10. Bidford South, Marlcliff and Barton
11. Brailes
12. Burton Dassett
13. Claverdon
14. Ettington
15. Ladbroke & Priors
16. Fenny Compton, Farnborough & Avon Dassett
17. Deppers Bridge, Chester & Kings
18. Bishops Itchington
19. Harbury
20. Henley West
21. Henley East and Beaudesert
22. Wootton Wawen
23. Kineton, Chadshunt & Compton Verney
24. Kineton Castle, Lt Kineton & Combrook
25. Lighthorne & Lighthorne Heath
26. Kinwarton
27. Long Compton
28. Long Itchington West & Ufton
29. Long Itchington East
30. Quinton
31. Sambourne
32. Shipston South & Furze Hill
33. Shipston North
34. Shipston West and Town Centre
35. Snitterfield & Wolverton
36. Hampton Lucy & Fulbrook
37. Southam East
38. Southam North
39. Southam West
40. Southam South & Town Centre
41. Stockton
42. Napton on the Hill
43. Bridgetown
44. Stratford South East & Alveston Hill
45. Tiddington & Alveston
46. Clopton & Welcombe Hills
47. Town Centre North
48. The Avenue
49. Maybird
50. Shottery South & Racecourse
51. Shottery North & Racecourse
52. Old Town & Town Centre South
53. Old Town
54. Bishopton
55. Stratford Mount Pleasant West
56. Stratford Mount Pleasant East
57. Studley East & Priory
58. Studley North
59. Studley West & Common
60. Studley South
61. Earlswood
62. Tanworth
63. Tredington & Blackwell
64. Newbold-on-Stour, Ilmington East & Whitchurch
65. Vale of the Red Horse
66. Welford
67. Wellesbourne West
68. Wellesbourne East, Walton & Airfield
69. Wellesbourne South
70. Moreton Morrell, Ashorne & Newbold Pacey
71. Wellesbourne North

Item 7

Warwickshire Health and Wellbeing Board

11 June 2013

Arden Health Protection Strategy 2013-15

Recommendation

That the Warwickshire Health and Wellbeing Board considers and approves the Arden Health Protection Strategy 2013-15.

1.0 Introduction

1.1 Under the Health and Social Care Act 2012, Health and Wellbeing Boards have a statutory responsibility for leading and promoting greater integration and partnership in health and social care provision and commissioning.

1.2 The purpose of the Arden Health Protection Strategy 2013-15 is to produce a shared vision and an integrated three year strategy for health protection for the Coventry and Warwickshire population.

1.3 The strategy has been approved by the joint Coventry and Warwickshire's Arden Health Protection Committee on 21 May 2013.

2.0 Health Protection Priorities

2.1 The strategy sets out the priorities agreed by the Arden Health Protection Committee that, if achieved, will bring the biggest benefits to the populations of Coventry and Warwickshire in relation to health protection which include:

- Reduction in avoidable health inequalities and the burden of disease
- Effective planning and provision of high quality services that meet the needs locally
- Effective promotion of health protection information and community engagement

3.0 Partnerships and interdependencies

3.1 It is recognised that successful implementation of this strategy will require effective relationships and partnerships across health and local authorities. Key partners and stakeholders include:

- Local Health and Wellbeing Boards
- Executive teams of City, County, District and Borough Councils
- Local NHS organisations

- Clinical Commissioning Groups
- Voluntary and community sector organisations
- Public Health England

3.2 The strategy is linked to the Joint Strategic Needs Assessments (JSNA) for Coventry and Warwickshire, Coventry's and Warwickshire's Health and Wellbeing Strategies as well as Prevention and Early Intervention Strategies.

4.0 Conclusions

4.1 Arden Health Protection Strategy 2013-15 is key to ensuring that the local populations can benefit from better integrated and improved services which relate to their actual needs.

4.2 Warwickshire Health and Wellbeing Board are recommended to approve this strategy, so that its implementation plans can be developed and progressed.

5.0 Background Papers

None

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ARDEN HEALTH PROTECTION STRATEGY

Coventry and Warwickshire

2013-2015

Contents

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Introduction

Clear and integrated strategies are necessary to protect the health of populations and prevent disease. After publication of the NHS White Paper, Equity and excellence: Liberating the NHS in 2010 the healthcare sector has undergone significant organisational change. It is recognised that successful implementation of this strategy will require effective relationships and partnerships across health and local authorities.

As the structure, functions, roles and relationships are being defined, the key challenge for agencies is to maintain the health of the population through the period of change and in the future.

Both Coventry and Warwickshire have a long history of effective relationships and collaborative approaches to delivery of services for health protection. We are confronted with new challenges to population health, such as the health effects of climate change; emerging epidemics and drug resistance; changing environments and demographics as well as the escalated risks of chemical and biological incidents, it is clear that the continued assessment and application of health protection issues and challenges is necessary.

The purpose of developing this strategy is to produce a shared vision and an integrated three year strategy for health protection for the Coventry and Warwickshire population during a transitional period. The strategy is structured around the remit of the Arden Health Protection Committee (Figure 1).

The strategy sets out the priorities agreed by the Committee in terms of the areas of health protection that, if achieved, will bring the biggest benefits to the populations of Coventry and Warwickshire, and it is the responsibility of the Health Protection Committee to monitor its progress against this strategy and the subsequent action plans from the specialist groups.

The aim is to:

- Reduce avoidable health inequalities and the burden of disease.
- Provide strategic direction for the planning and provision of high quality and evidence-based services that meet the needs locally.
- Guide involvement and education of people from across all sectors and communities, to improve the provision of health protection information and to promote empowerment among communities.
- Regularly review and appropriately modify the strategy to maintain quality and relevance.

Who is the strategy for?

Local Health and Wellbeing Boards, Executive Teams of City, County, District and Borough Councils, local NHS organisations, Clinical Commissioning Groups, voluntary sector partner organisations and Public Health England in the West Midlands.
This strategy has links with other key local strategies such as the Joint Strategic Needs Assessments (JSNA), Health and Wellbeing Strategies and Prevention and Early Intervention Strategies.

Accountability & Governance arrangements

Health Protection arrangements within Coventry and Warwickshire are overseen by the Arden Health Protection Committee. Its role is to:

- Coordinate the transition of health protection functions to partner organisations and to mitigate associated risks
- Quality and risk assure health protection plans on behalf of the local population for Coventry and Warwickshire local authorities
- Provide a forum for professional discussion of health protection plans, risks and opportunities for joint action

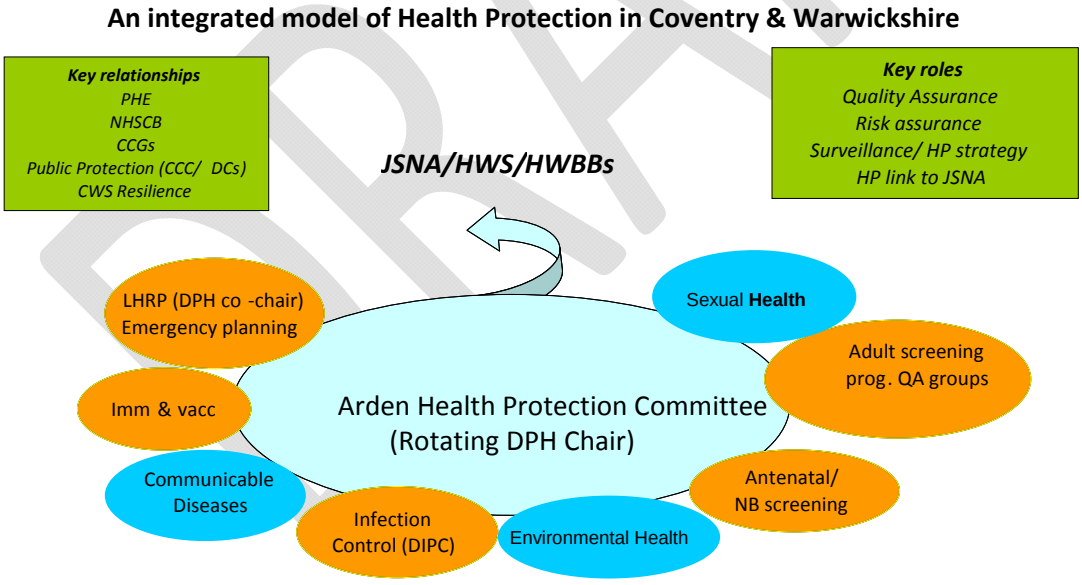
- Provide recommendations (on behalf of local authority Health and Wellbeing Boards and Health Scrutiny) regarding the strategic/operational management of these risks, to complement and feed into current accountability structures of committee member partners
- Escalate concerns where necessary
- Provide oversight of health protection public health outcomes
- Agree local health protection strategy and influence local commissioning through Joint Strategic Needs Assessment process to be approved by Coventry and Warwickshire Health and Wellbeing Boards.

The implementation of the strategy will be carried out by the network and strategy implementation groups where set up already such as Directors of Infection Prevention and Control Group, Sexual Health Implementation Groups, Coventry and Warwickshire Hepatitis Strategic Groups and the Coventry & Warwickshire TB Strategic Group.

The groups will submit the action plans including indicators and progress in achieving the objectives using the agreed indicators to the Health Protection Committee annually.

The transition to new organisations – National Commissioning Board, Public Health England, Clinical Commissioning Groups and Local Authorities - with new areas of responsibility and accountability provides an opportunity for us all to pledge our commitment to review performance, identify ways to improve efficiency and effectiveness of services, prioritise prevention and work in a coordinated and integrated manner.

Figure 1: Structure of the Health Protection Committee



Coventry and Warwickshire Population Profile

Figure 2: Age structure of the local population

	Persons All Ages (thousands)	Persons 0-15 years	Persons 16-64 years	Persons 65 years and over
Coventry	316.9	63.0	207.5	46.5
North Warwickshire	62.1	11.0	39.6	11.5
Nuneaton and Bedworth	125.4	24.0	80.3	21.1
Rugby	100.5	19.4	63.6	17.5
Stratford-on-Avon	120.8	20.4	73.4	27.0
Warwick	137.7	23.6	90.9	23.2

Source: ONS Mid-Year Population estimates 2011

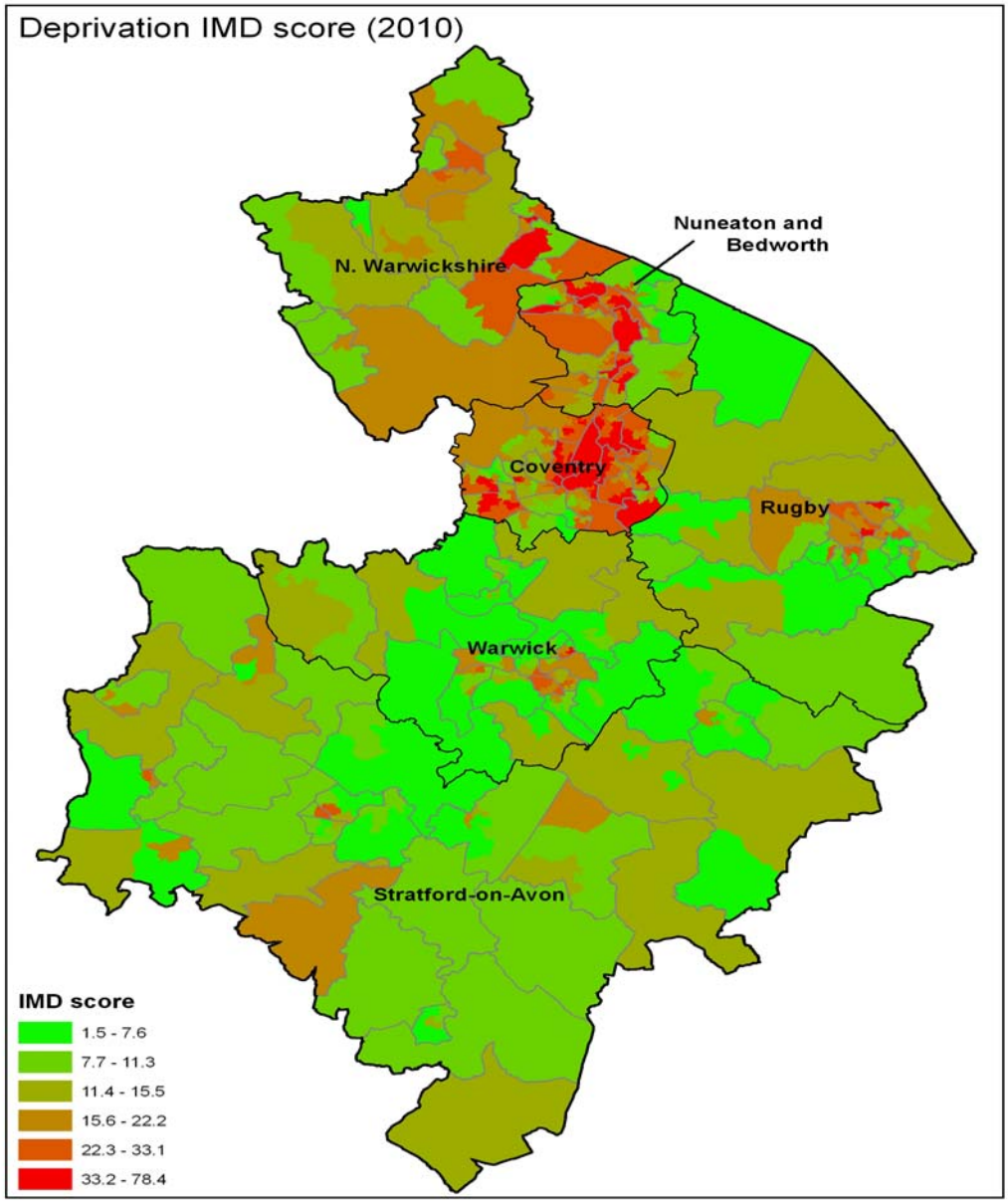
- In 2011 Warwickshire had an estimated population of 546,600 people and Coventry 315,700.
- Coventry's growth rate was faster than the West Midlands regional average and the West Midlands metropolitan average
- The population of Coventry is young which is reflected in higher fertility rates
- Warwickshire population is older in south of county compared to the north.
- Ethnic minorities form a quarter of the Coventry population. Immigrant health is a key issue across the area.

Deprivation

Deprivation disproportionately affects the health outcomes of population – those living in poverty have a shorter life-expectancy and suffer more from chronic conditions than those living in affluent areas.

Deprivation is measured by the Index of Multiple Deprivation (IMD) score. The IMD brings together several indicators which cover specific domains of deprivation such as income, employment, health and disability, education, environment etc. These are weighted and combined to create the overall IMD 2010 scores. Figure 3 demonstrates deprivation scores within Coventry and Warwickshire, the areas of high deprivation are coloured red and low deprivation green.

Figure 3: Deprivation in Coventry and Warwickshire



Communicable Disease Control

Communicable disease control is a key component in protecting the health of the local population. Outbreaks of infectious diseases have a potential to cause severe disease, disruption and even death. The Arden Health Protection Committee has agreed the following to be local priorities for this strategy.

Gastrointestinal (GI) Diseases

Why is this important?
GI diseases impact on local economies through days lost working and put a burden on local health services. In general, for most diarrhoeal diseases people have to stay away from work/ education for a minimum of 48 hours after symptoms have ceased and for some diseases or occupations, exclusions can be for longer periods. This results in loss of working/ study time.

Early recognition and reporting by general practitioners, other clinicians and laboratories are key to prevention and control of outbreaks.

What does the data tell us?
Areas which have a notified incidence rate of over 330 cases per 100,000 population in 2010 are higher than the national average. Both Coventry and Warwickshire are below the national average notification rate.

The two commonest notified causes of gastrointestinal illness are Salmonella and Campylobacter.

Figure 4: Salmonella cases notified in Coventry and Warwickshire 2007-12

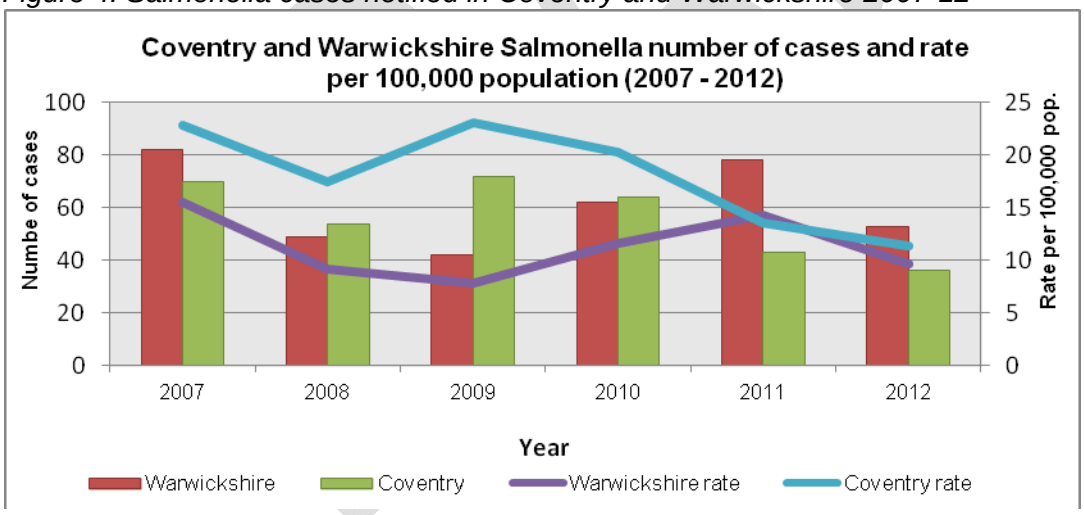
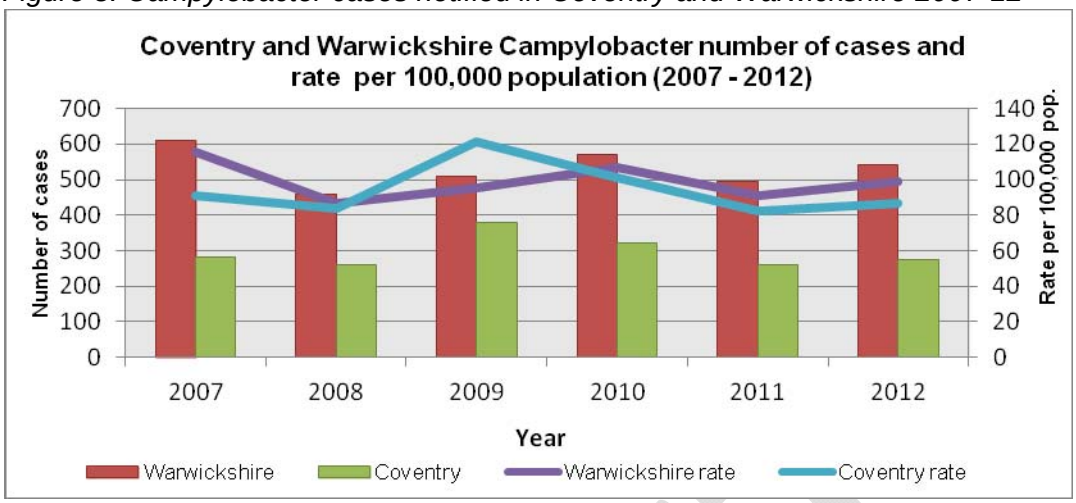


Figure 5: Campylobacter cases notified in Coventry and Warwickshire 2007-12



What should we be doing about this?

Revised guidance to underpin enhanced surveillance has been produced by HPA and recommendations for follow up and exclusion have been revised and include:

- Continue and improve on real time surveillance, to improve on standards of investigation of single cases with timely communication to and from partner agencies. Public Health England (PHE) to be the lead organisation for this.
- Clinicians should notify disease in a timely manner (numbers currently notified are smaller than numbers diagnosed).
- Laboratories are also required to notify and their IT systems should be improved.
- The relevant commissioning leads need to ensure appropriate services are available for supply, storage and administration of prophylaxis, clinical diagnosis (including domiciliary visits if necessary), laboratory diagnosis and logistical arrangements for samples and therapeutics both during and out of working hours.
- Local authority environmental health departments are central to investigation and control of single cases and outbreaks. This requires an urgent response where appropriate or necessary, from appropriately skilled personnel and capacity to provide this response should be ensured in and out of working hours.

What is the local plan?

- Reorganisation is affecting most of the responsible organisations and it would be advisable to safeguard the response capability in each of the organisation so that efficient control of disease can be maintained.
- The Warwickshire and Coventry Food Liaison Group to continue and strengthen their arrangements for collaboration and sharing of good practice.
- Partners should continue to develop public awareness of food hygiene and personal precautions with initiatives targeting children and young persons, food business operators and food handlers etc and increased awareness amongst professionals.
- Proprietors of animal recreational and farming facilities should be aware of the risk of E. coli O157 and ensure they minimise those risks and improve safety on the premises.
- Raising awareness in the general population about consulting the GP or the pharmacist prior to travelling so that timely advice and immunisations can be obtained is crucial to reducing the number of infections.
- Clinicians need to continue to investigate early and notify any suspicion of infectious gastrointestinal disease in a timely manner.

Viral Hepatitis (Hepatitis B and Hepatitis C)

Why is this important?
Hepatitis B virus (HBV) and hepatitis C virus (HCV) are both blood borne viruses which cause liver infection. Both viruses are spread by contact with blood or body fluids from an infected person, with HBV being more infectious than HCV. Many people who carry the viruses are unaware of this and can thus spread the infection. Untreated hepatitis can lead to cirrhosis and liver cancer.

What does the data tell us?
In the UK, the commonest reported risk factor for acute cases of HBV is heterosexual exposure followed by injecting drug use (IDU) and homosexual exposure. In contrast, more than 90% of all newly diagnosed HCV infections for which the source of infection is reported, are acquired via IDU.

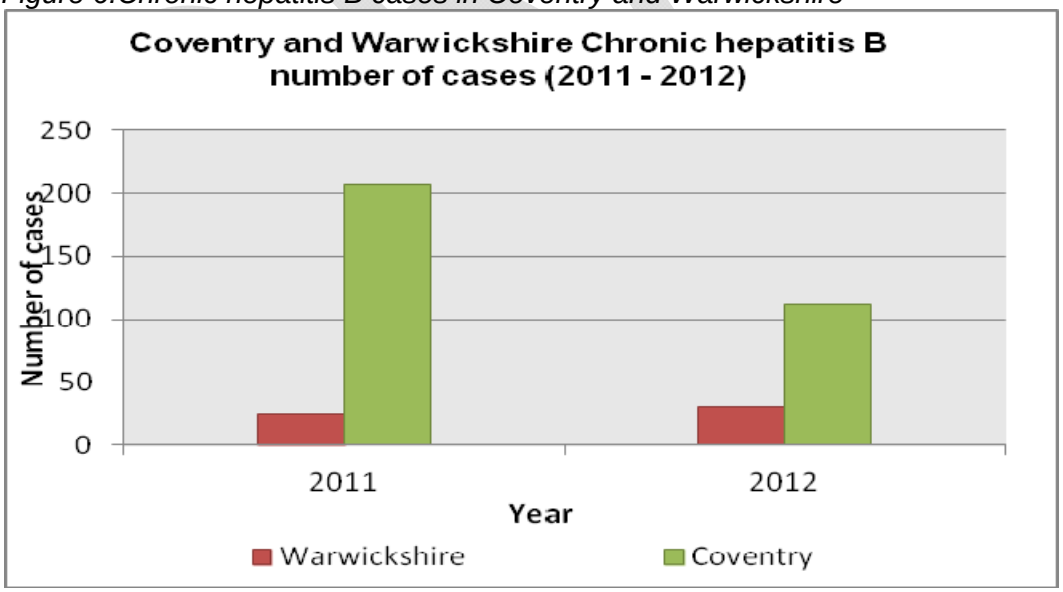
Other groups at increased risk of infection include individuals originating from countries where the prevalence of hepatitis B and C is high (such as South Asia and Africa).

Overall numbers of cases of acute HBV are small in Coventry and Warwickshire (17/year). This represents an incidence of 1.97 cases per 100,000, which is higher than the regional rate 0.7/100,000 population in 2012.

There were a total of 143 laboratory reports of confirmed cases of chronic HBV living in Coventry and Warwickshire reported in 2012 and 230 cases in 2011. The incidence rate of chronic hepatitis B in Coventry was 35/100,000 population in 2012 compared to 65/100,000 population in 2011.

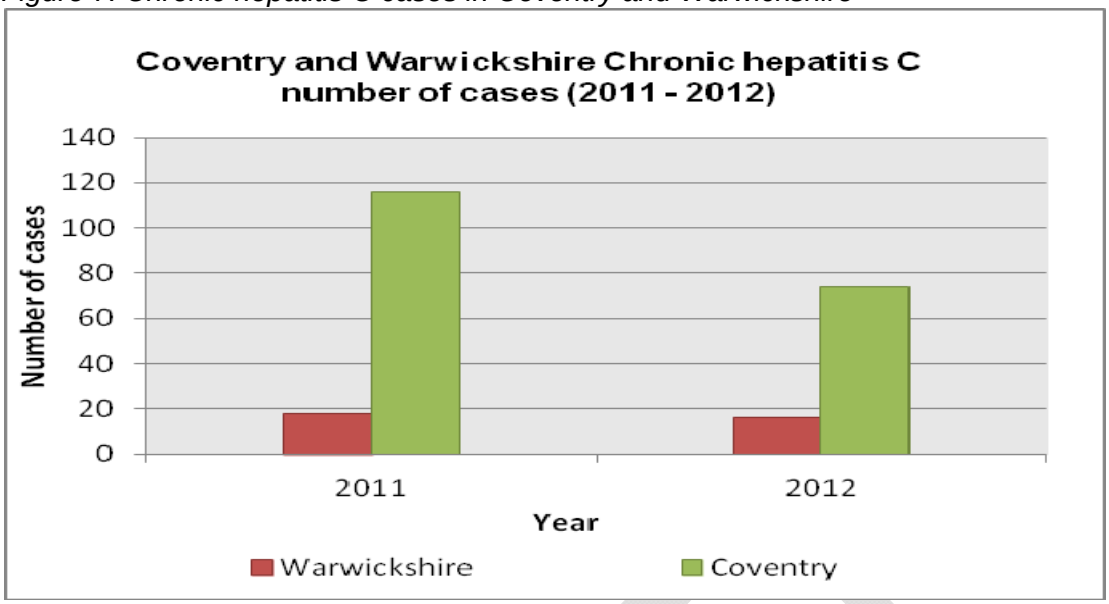
There is a substantial variation in the number of mothers identified with hepatitis B infection in Coventry and in Warwickshire. Consequently the immunisation programmes are different but both aim to completely vaccinate 100% of the babies identified as at risk.

Figure 6:Chronic hepatitis B cases in Coventry and Warwickshire



Coventry has seen a decrease in cases of Hepatitis C which may be a reflection of reduced ascertainment and/or true decrease. Warwickshire cases have remained the same. Most cases of hepatitis C are amongst those aged 30-44 years. Cases are also seen amongst the 15-29 year old and 45-64 year old age groups.

Figure 7: Chronic hepatitis C cases in Coventry and Warwickshire



What should we be doing about this?
The overall aim is to reduce burden of Hepatitis B and C by focusing on reducing the pool of unidentified cases, increasing the number of cases receiving treatment and being monitored, and ending onward transmission. Improve the quality of life for people living with infection.

Post exposure prophylaxis is recommended for babies born to mothers who are chronically infected with hepatitis B virus or who have had acute hepatitis B during pregnancy and for sexual and other household contacts of infected individuals. Babies acquiring infection at this time have a high risk of becoming chronically infected with the virus. The development of the carrier state after perinatal transmission can be prevented in over 90% of cases by appropriate vaccination

What is the local plan?
National best practice recommends coordinated services and managed Hepatitis networks:

- PHE to facilitate the development and strengthening of integrated care pathways and services and ensure coordination between all hepatitis care stakeholders.
- Improve the quality of care for patients including access to testing and high quality laboratory testing and treatment services.
- Partners to promote public awareness about hepatitis B and C infection, particularly in younger age groups and hard to reach groups and professionals including general practice.
- Increase knowledge and skills among health professional and others providing services for people at increased risk of hepatitis and liver disease.
- Increase identification of individuals with hepatitis infection in general practice, GUM clinics and Drug services.
- Commissioners should review needle exchange and harm minimisation services.
- Commissioners, where appropriate, to standardise care between Drug and Alcohol Action Teams (DAAT) in Coventry and Warwickshire.
- Environmental Health Teams and PHE to review skin piercing activities and effective sharing of intelligence to identify and deal with unregistered practitioners.
- The Coventry and Warwickshire Hepatitis B pathway for neonatal vaccination of babies born to Hepatitis B infected women must be fully implemented. This involves the antenatal screening midwives, UHCW virology department, Child Health Information System managers, General Practice, the Coventry Immunisation team and health visiting services.

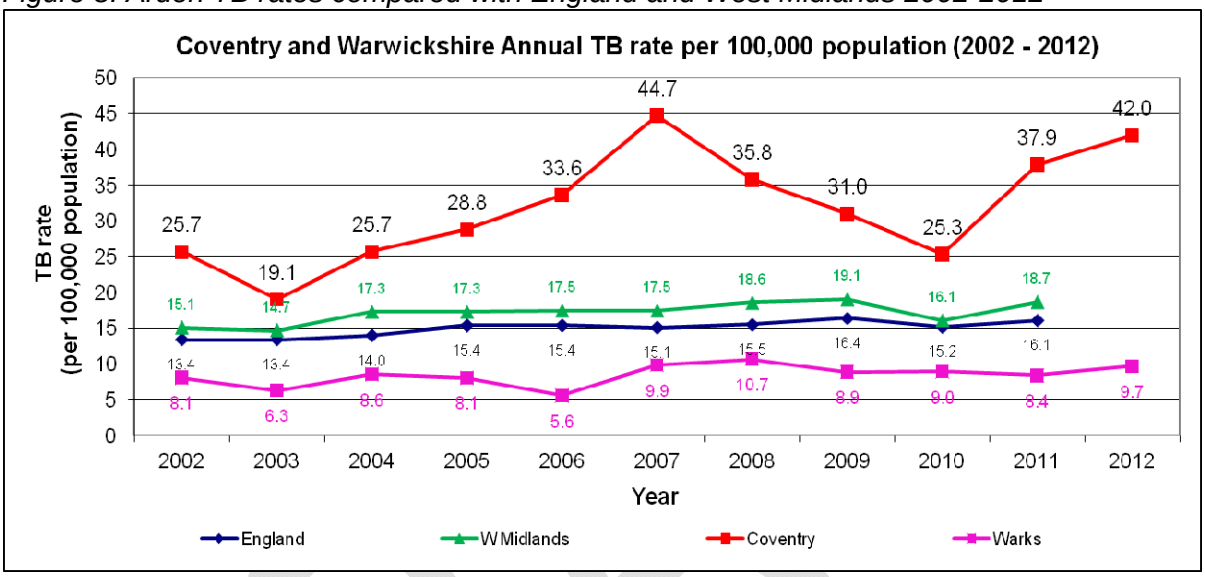
Tuberculosis

Why is this important?

Tuberculosis (TB) is an infectious disease commonly affecting the lungs, but which can involve any part of the body. It is usually spread by the cough of an infected person. Prolonged close contact with a person with TB, for example, living in the same household, is usually necessary for infection to be passed on. It may take many years before someone infected with TB develops the disease.

What does the data tell us?

Figure 8: Arden TB rates compared with England and West Midlands 2002-2012



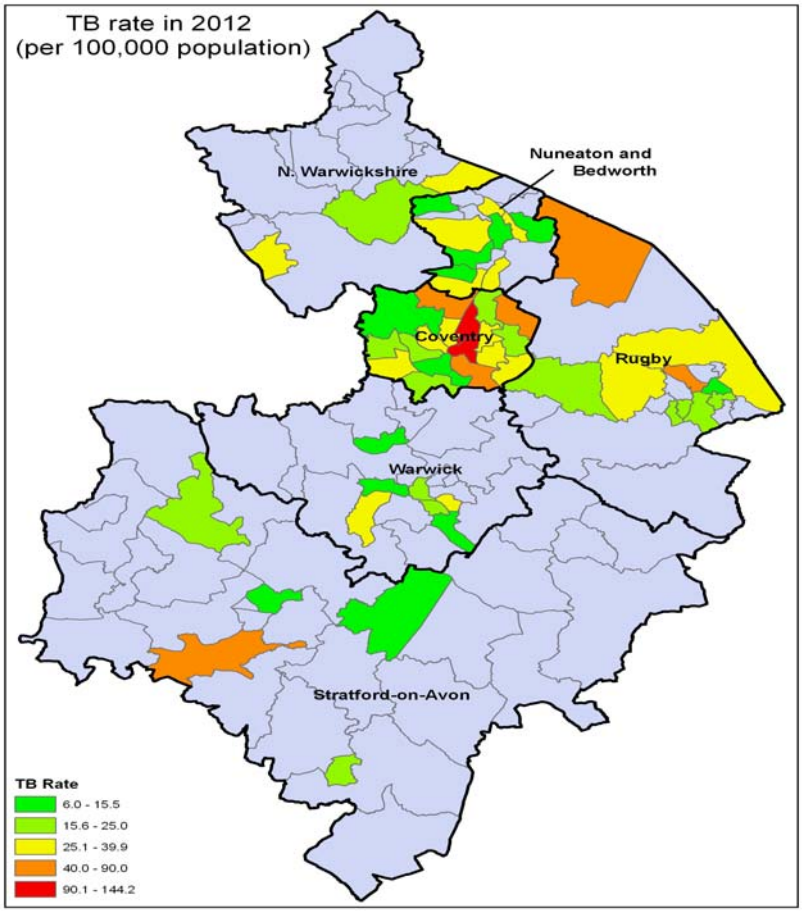
Coventry

- There were more cases of TB in Coventry in 2012 (133 cases) compared to 2011 (120 cases). TB incidence rate in Coventry is 42/100,000 population in 2012. The incidence rate is increasing after a temporary decrease in 2010 and remains well above the regional and national average.
- The number of new cases among South Asians was almost three times higher than those among the White ethnic group. Of the 133 cases in 2012, at least 72% were born overseas. More than one third (37%) of the 133 cases in 2012 were from two electoral wards – St Michael's and Foleshill Wards.

Warwickshire

- There were 53 cases of TB in Warwickshire in 2012, which was similar to the number of cases in 2011 (46 cases). In 2012, TB rates in Warwickshire of 6.7 cases per 100,000 populations continued to be substantially lower than the regional and national rate.
- In 2012 in Warwickshire, white ethnic group contributed to 32% (17 cases) of cases; 60% of the cases were born overseas.
- Other groups at increased risk include those who are homeless, alcohol and drug misusers and there is also an on-going issue of TB among hard to reach groups (alcoholics, drug addicts and homeless people) mainly in the Leamington Spa area.

Figure 9: TB rates in Arden



What should be done about this?

- Increased awareness: Maintain high awareness of TB, particularly among health professionals, high risk groups and people who work with them, teachers, and the public.
- Strong commitment and leadership: Create a strongly led, well coordinated and adequately resourced TB programme (standardised treatment with supervision and patient support).
- High quality surveillance: Provide the information required to: identify outbreaks; monitor trends; inform policy; inform development of services, and monitor the success of the TB programme.
- Excellence in clinical care: Commission and provide uniformly high quality, evidence based treatment and care for patients with suspected and diagnosed TB.
- Well organised and coordinated patient services: Commission and provide high quality coordinated services for TB diagnosis, treatment and continuing care, which also meet the needs of individual patients.
- First class laboratory services: Provide laboratory services of consistent high quality which support clinical and public health needs.
- Highly effective disease control at population level: Increase the evidence base for, and the consistency of the application of public health interventions for TB.
- An expert workforce: Ensure TB control has an appropriately skilled workforce and that physicians and nurses with expertise in TB continue to be recruited, trained and retained.
- Leading edge research: Increase understanding of TB and its control; improve the evidence base for its control; and develop better tools for its diagnosis, treatment and prevention.

What is the local plan?

- The strategic group should work towards establishing regular TB cohort review meetings to monitor whether patients have access to expert clinical services including advice from a physician with expertise in TB, treatment that adheres to national guidance and high standards of diagnostic microbiology facilities.
- The strategic group should work with TB commissioners to strengthen new entrant screening initiatives amongst high risk communities through innovative primary care and hospital-based schemes.
- TB commissioners should ensure effective directly observed therapies commissioned from appropriate agencies including community pharmacists and community organisations.
- PHE-employed immunisation staff working in the NHS Commissioning Board Area Team should work with partners to establish a robust BCG vaccination programme including monitoring of coverage.
- Local authority TB commissioners should ensure effective community awareness is continued and strengthened further through a range of targeted means and channels.
- The strategic group should develop a programme of education and training for primary care professionals working in communities at increased risk of TB.

Healthcare-acquired Infection

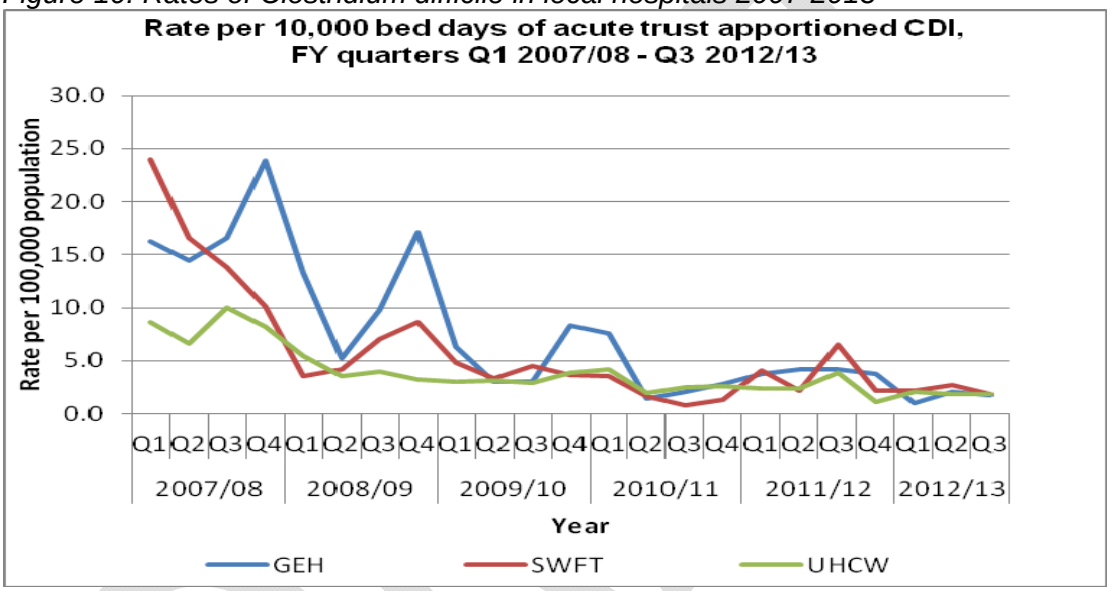
Why is this important?

Healthcare associated infections (HCAIs) are infections transmitted to and from patients (and healthcare workers) as a result of healthcare procedures, in hospitals and other healthcare settings. These infections can cause a significant amount of illness, increase the length of hospital stay and sometimes even lead to death. Many are preventable by effective infection prevention and control arrangements. Surveillance of certain infection such as *C.difficile* and MRSA is compulsory

What does the data tell us?

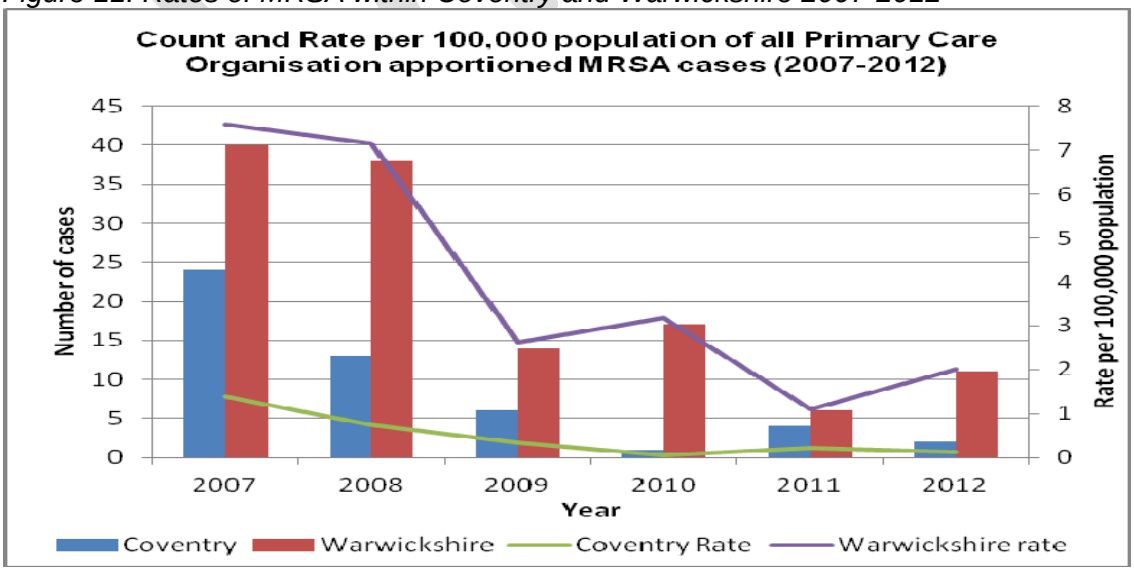
There has been a steady decline in Clostridium difficile infection (CDI) reported from local hospitals.

Figure 10: Rates of Clostridium difficile in local hospitals 2007-2013



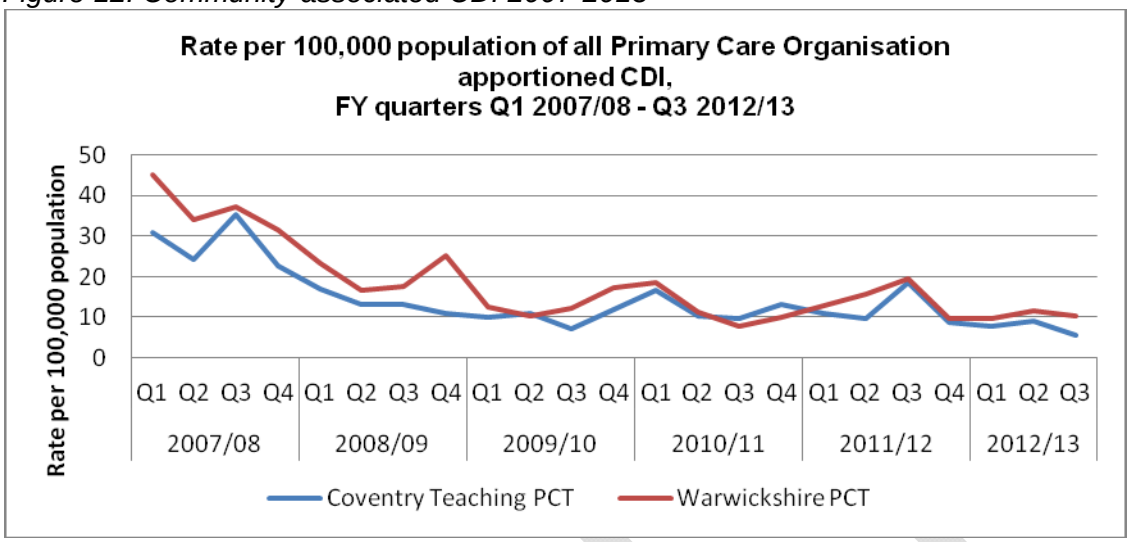
Similarly the reported cases of MRSA have reduced in the recent years.

Figure 11: Rates of MRSA within Coventry and Warwickshire 2007-2012



The decline in these infections could be attributed to a heightened awareness, an increased and impoved surveillance and infection prevention and control procedures. However, Community-associated infections are still an issue.

Figure 12: Community-associated CDI 2007-2013



What should be done about this?

In the new system CCGs and the Local Authorities (LAs) will work closely with the new Public Health England (PHE) to reduce HCAI within the community. It is not clear as yet how these roles will be organised, however some prior understanding of the issues within the community need to be addressed:

- Developing LA, CCG and Provider Trusts understanding of HCAI and their role in preventing and monitoring rates of HCAI within their boundaries.
- CCGs, as commissioners, must obtain assurance of effective arrangements for infection prevention and control from the providers.
- The DPH using existing frameworks, and guidance to develop a strategy for the LA to set their own targets for the reduction of HCAI.
- Working together LA, CCGs and PHE identify and set priorities for the reduction of HCAI in the community with emphasis on the following areas:
    - Outbreak control management in educational establishments and residential and care homes.
    - Provision of infection control training, advice and audit for health care and educational establishments.
    - The management of community HCAI cases e.g. PVL *Staphylococcus.*

What is the local plan?

- The CCG's and LA to develop a mutually agreed Infection Prevention strategy to inform the assessment and development of an assurance framework for Infection Prevention & Control ensuring providers deliver HCAI reductions.
- PHE, CCG's and LA to develop clear guidance on the roles and responsibilities of each organisation in the management of outbreaks of Norovirus, Clostridium difficile etc.
- Develop the local provision of infection prevention and control, training and audit to support educational establishments and Local Authority licensed premises.

Community Infection Prevention and Control

Why is this important?

Community Infection Prevention and Control (CIPC) is concerned with preventing the spread of infection in primary and community care settings. A wide variety of healthcare is delivered in these settings thus it is becoming increasingly important that CIPC services are available and imbedded in the local delivery of healthcare. Healthcare-associated infections arise across a wide range of clinical conditions and can affect patients of all ages. Healthcare workers, family members and carers are also at risk of acquiring infections when caring for patients. All providers of healthcare services are expected to have provision for infection prevention and control.

There is also a significant need for effective infection prevention outside the healthcare sector for example in residential care, within schools or within cosmetics industry. Provision of CIPC is a joint effort between Community Infection Prevention & Control Nurses, Health Protection Units and Environmental Health Departments.

What is the local plan?

As CIPC services are delivered and commissioned by several partners, it has been agreed that a Memorandum of Understanding should be developed locally to define the accountability for these services.

It is expected that the Directors of Public Health will received assurance of effective service provision through the Health Protection Committee.

Population Screening Programmes

Why is this important?
Screening is offered to healthy people who show no signs of illness, but may be at increased risk of a disease or condition. The current UK population screening programmes include antenatal and newborn, as well as young person and adult screening programmes (i.e., cancer and vascular screening). They have a significant effect on population health by identifying cases of illness at an early stage when treatment is more likely to be successful, thus preventing complications and death.

Robust quality assurance and initiatives to ensure good coverage are essential to ensure effectiveness and safe operation of local screening programmes.

All national programmes are currently undergoing transition as commissioning responsibilities are transferring from local PCTs to the NHS Commissioning Board and quality assurance responsibilities are taken up by Public Health England.

Screening has been identified as a high risk area during the transition on a local, regional and national level; it is therefore vital that Directors of Public Health in Coventry and Warwickshire maintain an oversight of the delivery of the programmes through the Health Protection Committee.

Sexually Transmitted Infections

Why is this important?

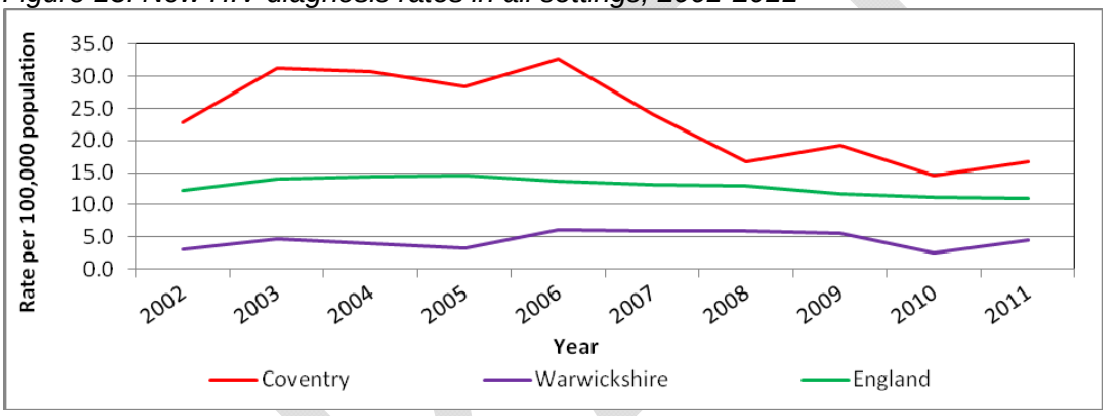
HIV and sexually transmitted infections (STIs) have a significant public health impact due to the burden of disease, long-term complications and deaths, and cost to the health service. In addition to causing physical illness, there are often adverse psychosocial implications for affected individuals.

HIV is now a treatable medical condition, but is still frequently regarded as stigmatising, is a risk factor for chronic medical conditions and consequently potential years of life lost from HIV are significant. An estimated quarter of infected individuals in the UK are unaware of their diagnosis. Late diagnosis is the most important factor associated with HIV-related morbidity and mortality and increased treatment costs.

What does the data tell us?

HIV

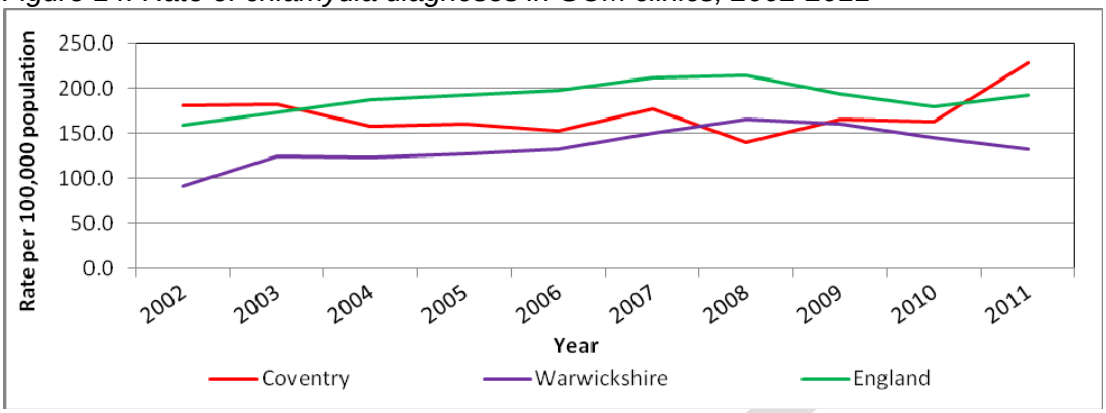
Figure 13: New HIV diagnosis rates in all settings, 2002-2011



- In Coventry, rates of new HIV diagnoses have been well above the England average for the last ten years, despite having fallen from their 2006 peak. Rates remain high at 15-20 new diagnoses per 100,000 population. Almost two-thirds (61.5%) of new HIV diagnoses in Coventry from 2009 to 2011 were diagnosed late.
- The prevalence of diagnosed HIV infection in Coventry in 2011 was 2.8 per 1000 population, above the high prevalence threshold at which expanded testing for HIV is recommended (2 per 1000 population).
- In Warwickshire, rates of new HIV diagnoses have been relatively low for the last ten years compared to national rates. Half of new HIV diagnoses in Warwickshire from 2009 to 2011 were diagnosed late.

Other STIs

Figure 14: Rate of chlamydia diagnoses in GUM clinics, 2002-2011



Coventry

- Over the last ten years, there have been considerable overall increases in diagnoses of the five main STIs genitourinary medicine (GUM) clinics, generally reflecting national trends (see graphs for individual trends). In particular, gonorrhoea diagnoses have more than doubled in the last five years and are approaching the peak levels observed in 2003.
- The Public Health Outcomes Framework includes a target diagnosis rate for chlamydia screening of 15-24 year olds in all settings (in GUM and the community) of 2,400 diagnoses per 100,000 population aged 15-24. In 2011/12, the diagnosis rate for Coventry was 1664 diagnoses per 100,000 population, well below the regional and national rates (both ~2000 per 100,000 population).

Warwickshire

- Although diagnosis rates of the five main STIs in Warwickshire are mostly lower than the national average, they have still seen overall increases in the last ten years. Diagnoses of anogenital herpes have trebled since 2007.
- In 2011/12, the chlamydia diagnosis rate in 15-24 year olds in all settings in Warwickshire was 1481 diagnoses per 100,000 population aged 15-24, well below the target and regional and national rates (see above).

What should be done about this?

The national strategy for sexual health was published in 2001, supported by development of recommended standards for services. Important national guidelines have also been published, such as that from the National Institute for Health and Clinical Excellence (NICE).

What is the local plan?

Further innovative solutions should be sought to help deal with this health issue which has escalated in recent years.

- PHE to facilitate the strengthening of surveillance, particularly for infections diagnosed in primary care.
- Sexual Health Commissioners should strengthen routine HIV testing to improve detection of infection among individuals at risk – early diagnosis will be of enormous benefit to the individuals themselves, and will help reduce spread of infection to others.
- Partner organisations of the Arden Health Protection Committee to develop a multi-faceted approach to improve the uptake of testing among partners of individuals infected with any STI.
- Sexual Health Commissioners to ensure robust evaluation of health promotion services to identify what works locally; this will help inform future provision of effective services aimed at those most at risk to influence their knowledge, attitude and behaviour, and consequently interrupt the chain of transmission.

Immunisation and Vaccination

Why is this important?

Worldwide vaccination and immunisation programmes are the second most effective public health intervention after clean water and have saved many lives. It is important to emphasise the need to achieve high uptake of vaccines in order to prevent the re-emergence of vaccine preventable diseases in our local communities. National evidence shows that inequalities in immunisation uptake are persistent. Evidence shows that children with incomplete immunisations are more likely to live in disadvantaged areas and are less likely to use primary care services. They also tend to have younger mothers or lone parents, come from larger families, and as babies had a least one hospital admission.

Immunisation programmes will be commissioned by the NHS Commissioning Board from April 2013.

What does the data tell us?

Figure 18: Primary childhood immunisation coverage at 12 months in Arden 2006-2012 with regional and national comparison

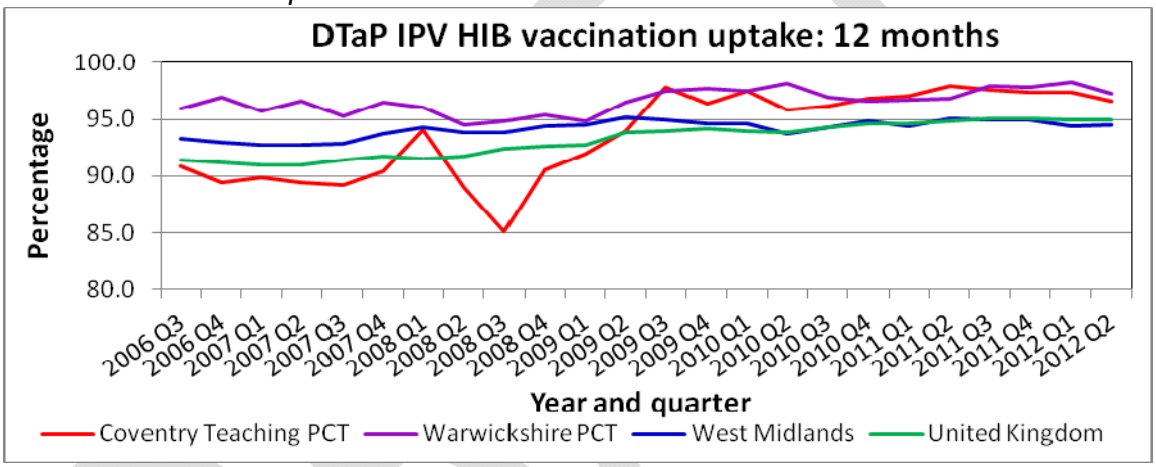
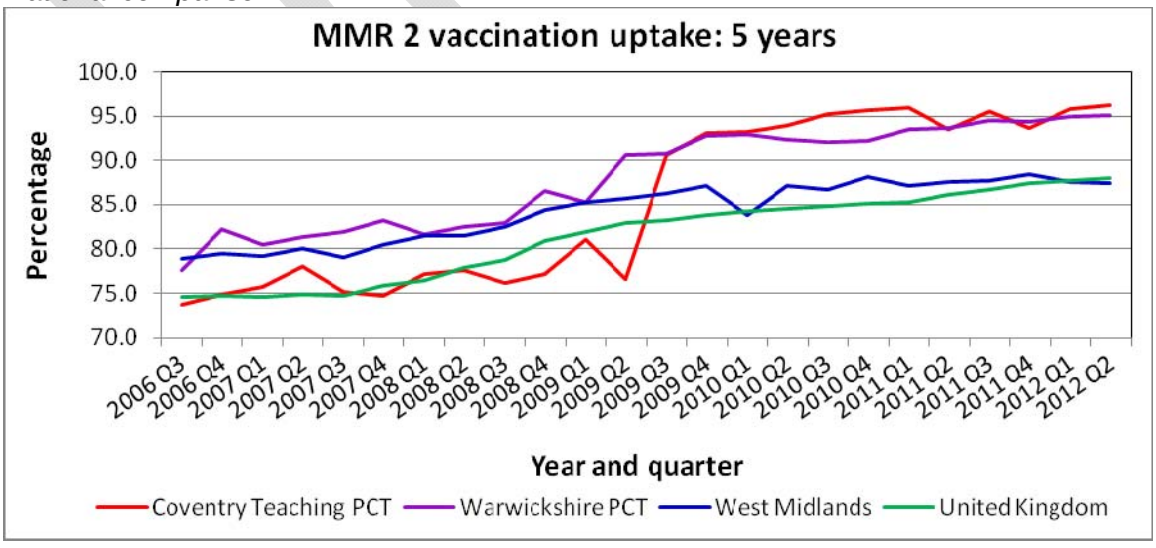


Figure 19: MMR vaccination coverage trends at five years in Arden 2006-2012 with regional and national comparison



- Coventry has come far with its performance on immunisation over the last 2 years from being one of the bottom performers in the UK to one of the top, so it is vitally important that

this good work continues and Coventry leads the way in protecting its children from vaccine preventable diseases.

- Warwickshire has poor data for the school leaver booster. Child Health data suggests that 60% of 14-15 year olds have been vaccinated by the school immunisation team, but many more are likely to have been vaccinated at the GP surgery and the data not supplied to Child Health. In Coventry, one fifth of diphtheria, tetanus and polio is given in schools between 13 and 18 years of age. Teenage immunisations are higher than the national average with school leaver booster for children in school year 10 (2011/12) at 88.5% uptake.
- Human Papillomavirus Vaccination (HPV) is a vaccine to protect girls from cervical cancer and it is administered routinely to Year 8 girls (12-13 year olds) via a school based programme. In 2011/12, Warwickshire achieved an uptake of 95.7% of girls having received one dose of HPV vaccine (85.4% were fully vaccinated with three doses of vaccine). Coventry achieved 92% receiving the first dose (91.3% all three doses).
- Travellers and other hard-to-reach groups have lower levels of vaccination coverage which can exacerbate existing inequalities. However it is difficult to assess genuine levels of uptake as there is no available data on immunisation in unregistered practice populations.
- A recent audit in Coventry showed that data flows between GP Practices and CHIS are still not robust and many children who are immunised are not reported. Some children are missing out on immunisation because demographic data is not routinely updated to CHIS.

What should be done about this?

The aims of those responsible for immunisation programmes are to:

- Reduce the risk of vaccine preventable disease by maximising the uptake of vaccinations achieving national targets.
- Reduce health inequalities in relation to accessibility to vaccine services.
- Ensure that the uptake of new immunisation programmes is maximised.
- Improve rates of influenza vaccination among health and social care workers
- Effective immunisation programmes rely upon the accurate identification of eligible populations, efficient call and recall systems and well informed immunisers.
- For influenza, to identify and vaccinate the eligible population as recommended by the Department of Health

What is the local plan?

- The work of the Arden Immunisation Committee needs to continue beyond the transition to ensure that there is a cohesive plan across the immunisation programmes. Very few immunisation programmes are delivered by one single provider.
- Coventry and Warwickshire have a strong and effective training programme. This work needs to be preserved and protected beyond the transition.
- Improve data collection on all immunisation programmes to ensure accurate local data.

Environmental Health

Environmental health aims to protect against environmental factors that may adversely impact human health or the ecological balances essential to long-term human health and environmental quality. Such factors include, but are not limited to: air, food and water contaminants; radiation; toxic chemicals; disease vectors; safety hazards; and habitat alterations.

The Arden Health Protection Committee has agreed air quality as an environmental health priority for this strategy.

Air Quality

Why is this important?

Air quality is a key issue with major implications for the health of the population across both Coventry and Warwickshire. Poor air quality can lead to significant adverse health effects, particularly in those sections of the population that are more susceptible such as the young, the elderly, or those suffering from heart or lung related disease (WHO, 2004).

What does the data tell us?

Figure 20: Nitrogen Dioxide Concentration monitored at Coventry and Warwickshire's Automatic Monitoring Stations (2005-2009)

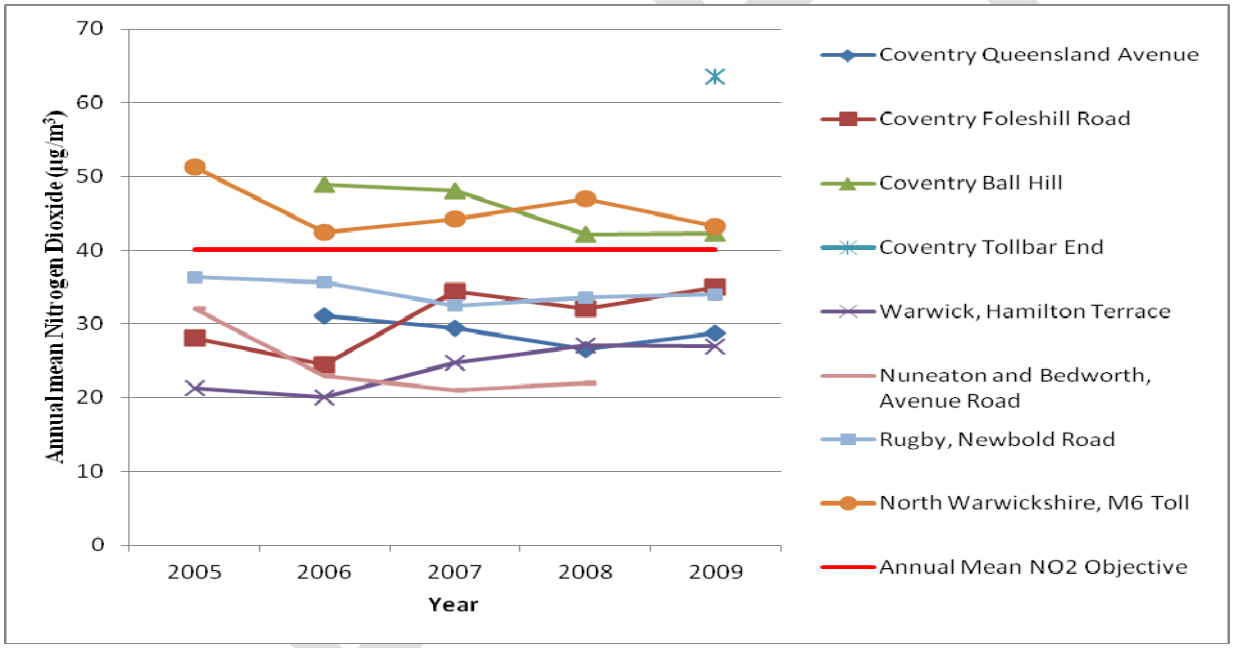
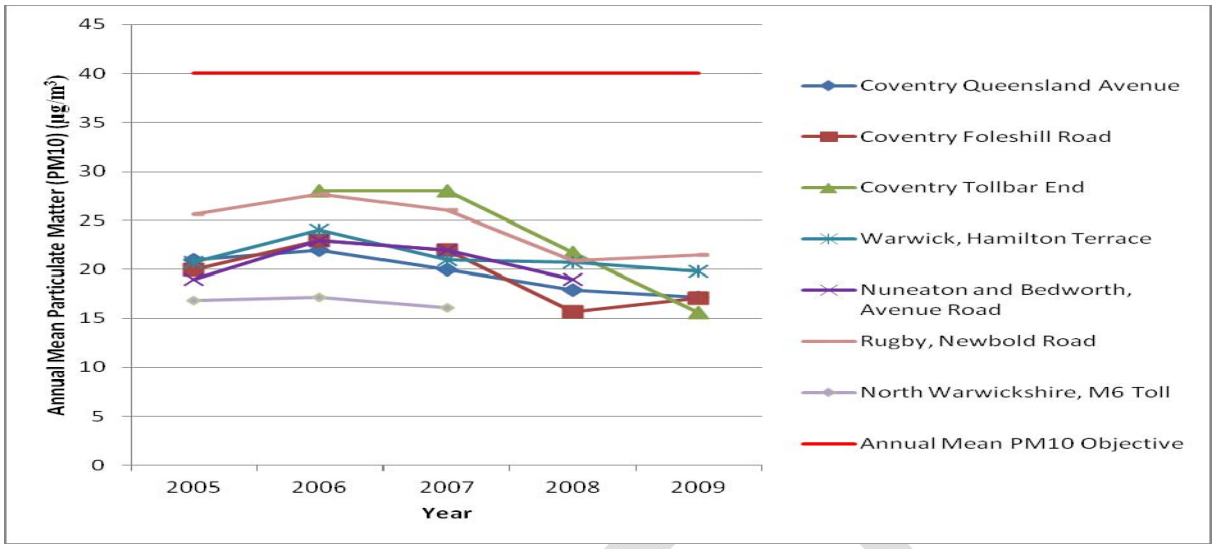


Figure 21: Particulate Matter (PM_{10}) Concentrations monitored at Coventry and Warwickshire's Automatic Monitoring Stations (2005-2009)



Note: Data presented for illustration of trends only. Monitoring stations are located for specific purposes e.g. background locations, high pollution areas and consequently are not directly comparable. It should be noted that there have been some issues in relation to the performance of Coventry's automatic monitoring equipment, data capture at some stations in certain years is low and consequently not all data can be considered robust.

In common with most other areas in the country hourly peak air quality standards are not generally exceeded

- In each of the local authority areas annual mean NO_2 levels are exceeded in some areas. The main cause of this is traffic pollution.
- Air Quality Management Areas (AQMAs) have been declared in each area related to NO_2 exceedance. Action Plans are in place for these and a few AQMAs have subsequently been revoked.
- There is a direct link between health impacts and particulate levels, with $PM_{2.5}$ levels being particularly relevant. Further data in relation to $PM_{2.5}$ levels in the Coventry and Warwickshire area is needed.

What should be done about this?

- Improvement in air quality is heavily dependent upon traffic management. Increased collaboration between stakeholders is required to ensure improvement.
- Raising the importance of air quality in the decision making process of transport planning.
- Increased understanding and health impacts of $PM_{2.5}$ levels in each local authority area.

What is being done locally?

- Air Quality Management Areas declared where pollutants exceed national air quality objectives.
- Air Quality Action Plans produced by all authorities in conjunction with Warwickshire County Council (as highway authority) and Highways Agency (major roads).
- Innovative solutions being investigated, e.g. Low Emission Zone pilot (Warwick), use of real time monitoring during trials with altering traffic lights (Coventry).

List of Abbreviations

AQMA	Air Quality Management Area
AT	Area Team (of the NHS Commissioning Board)
CCG	Clinical Commissioning Group
CDI	Clostridium difficile infection
CIPC	Community Infection Prevention & Control
DAAT	Drug and Alcohol Action Team
DPH	Director of Public Health
GEH	George Eliot Hospital
GP	General Practitioner
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HPA	Health Protection Agency
IDU	Injecting drug user
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
NHS	National Health Service
NHS CB	NHS Commissioning Board
NICE	National Institute for Health and Clinical Excellence
NO_2	Nitrogen dioxide
PCT	Primary Care Trust
PHE	Public Health England
$PM_{2.5}$	Particulate matter of aerodynamic diameter less than or equal to 2.5µm
STI	Sexually transmitted infection
SWFT	South Warwickshire Foundation Trust
TB	Tuberculosis
UHCW	University Hospitals Coventry and Warwickshire
WHO	World Health Organisation