Warwickshire Health and Wellbeing Board

Agenda

20th November 2013

A meeting of the Warwickshire Health and Wellbeing Board will take place in **Committee Room 2, Shire Hall, Warwick** on **Wednesday 20th November 2013 at 13.30.**

The agenda will be:-

1. (13.30 – 13.35) General

(1) Apologies for Absence

(2) Members' Disclosures of Pecuniary and Non-Pecuniary Interests.

Members are required to register their disclosable pecuniary interests within 28 days of their election of appointment to the Council. A member attending a meeting where a matter arises in which s/he has a disclosable pecuniary interest must (unless s/he has a dispensation):

- Declare the interest if s/he has not already registered it;
- Not participate in any discussion or vote;
- Must leave the meeting room until the matter has been dealt with (Standing Order 42); and
- Give written notice of any unregistered interest to the Monitoring Officer within 28 days of the meeting

Non-pecuniary interests must still be declared in accordance with the new Code of Conduct. These should be declared at the commencement of the meeting.

(3) Minutes of the Meeting of the Warwickshire Health and Wellbeing Board on 25th September 2013 and Matters Arising

Draft minutes are attached for approval.

2. (13.35 – 13:50) George Elliot Hospital – Improvement Plan Position Update

Kevin McGee – George Eliot Hospital NHS Trust

Mobilising Communities to Develop and Maintain Independence

3. (13.50 – 14.05) Priority Families – Partner Engagement and Progress Update

Nick Gower-Johnson - Localities Manager, Communities Group

4. (14.05 – 14.20) Smoking in Pregnancy – 'Upping Our Game'

Paul Hooper - Group Manager Community Safety & Substance Misuse

5. (14.20 –14.35) Winter Pressures & Feel Well in Winter Campaign – Agencies Working Together and Building Resilience

John Linnane – Director of Public Health - WCC /
Chris Lewington - Head of Strategic Commissioning

Access to Services

6. (14.35 –14.50) Autism Strategy and Self-Assessment Framework

Chris Lewington - Head of Strategic Commissioning

7. (14.50 – 15.10) CCG Commissioning Intentions – Feedback from the Workshop on 30th October 2013 and the Board's Approval

John Linnane – Director of Public Health - WCC

8. (15.10 – 15.30) Integration and the Transformation Fund
(a) The Way Forward in Warwickshire

County Councillor Angela Warner

(b) Integration Transformation Fund – Budget Transfer Update

Chris Norton - Strategic Finance Manager

Working Together

9. (15.30 – 15.45) Children's Safeguarding Board Report

Cornelia Heaney - Safeguarding Children's Board Development Manager / Dara Lloyd - Panel Manager, Child Death Review

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

Health and Wellbeing Board Newsletter Newsletter

Forthcoming Workshop:

26th November at 2.00pm in the Conference Room, Northgate House at Warwick – Joint MoU and Francis Report Workshop (putting into practice the joint MoU and discussing the implications of the Francis Report)

Future Agenda Items:

Health and Wellbeing Strategy – Progress on Outcomes

Improving Outcomes for Vulnerable Children and Young People

Mental Health Strategy

Veterans Health and Wellbeing Issues

Review and Update of the Joint Strategic Needs Assessment (March)

Drugs and Alcohol (March)

Health and Wellbeing Board Membership

Chair: Councillor Izzi Seccombe (Warwickshire County Council)

Warwickshire County Councillors: Councillor Maggie O'Rourke, Councillor Bob Stevens, Councillor Heather Timms

Clinical Commissioning Groups: Heather Gorringe (Warwickshire North), David Spraggett (South Warwickshire), Adrian Canale-Parola (Coventry and Rugby)

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

NHS England: Martin Lee – Medical Director

Healthwatch Warwickshire: 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 Warwickshire Health and Wellbeing Board held on 25 September 2013.

Present:-

Chair

Councillor Izzi Seccombe

Warwickshire County Councillors (In addition to the Chair)

Councillor Maggie O'Rourke
Councillor Bob Stevens

GP Consortia

Gillian Entwhistle – South Warwickshire CCG
Heather Gorringe – Warwickshire North CCG
Jill O'Hagan – Coventry and Rugby CCG

Warwickshire County Council Officers

Wendy Fabbro – Strategic Director, People Group
John Linnane – Director of Public Health

Borough/District Councillors

Councillor Michael Coker (Warwick District Council)
Councillor Derek Pickard (North Warwickshire Borough Council)
Councillor Gillian Roache (Stratford District Council)
Councillor Roma Taylor (Nuneaton and Bedworth Borough Council)
Councillor Claire Watson (Rugby Borough Council)

Healthwatch Warwickshire

Deb Saunders – Chief Executive Officer

NHS England

Martin Lee – Medical Director

The Chair welcomed Wendy Fabbro, Director of the People Group back to the Board after her absence on sick leave and trusted her recovery would continue to progress well.

1. (1) Apologies for Absence

County Councillor Heather Timms
David Spraggett (South Warwickshire CCG)
Adrian Canale-Parola (Coventry and Rugby CCG)

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

Councillor O'Rourke – Employee of South Warwickshire NHS Foundation Trust
Councillors Pickard and Watson – Co-opted Members of the Warwickshire County Council Adult Health and Social Care Scrutiny Committee

(3) Minutes of the meeting held on 17 July 2013 and matters arising

With a minor change regarding the date of a workshop on the Winterbourne Concordat, which will take place in December 2013, the minutes were agreed as a true record of the meeting.

Arising from minute number 2, the Chair and Bryan Stoten reported on the national recognition and positive feedback about the Warwickshire tobacco control declaration. The Chair also reported on the Warwickshire Dementia Conference held on 17th September, attended by over 170 people. There had been positive feedback, with the County being identified as a dementia friendly community. It was planned to hold another conference in 2014, with the focus being on acute and residential care.
An action plan from the conference would be submitted to the November Health and Wellbeing Board. (Chris Lewington to action)

2. The Work of NHS England Drugs and Alcohol Team

Hayden Duncan, Regional Manager of the Drugs and Alcohol Team gave a presentation to the Board and supporting documents had been circulated. A context was provided on the similarities and differences related to alcohol and drug misuse. Both problems were widespread, but drug addiction was more concentrated, which was demonstrated by the statistics included in the document. It showed the health damage caused by alcohol and drug misuse, statistics on death rates and the harm caused to families and communities. The annual costs of alcohol-related harm, through crime and lost productivity and the overall costs of drug addiction to society were reported. Mr Duncan also spoke about outcomes from drug use, strategies for tackling both drug and alcohol issues and targeting expenditure on preventative measures.

The Chair thanked Mr Duncan for the presentation and spoke about the need for agencies to work together to tackle drug and alcohol related misuse.

Resolved

That the presentation on the work of NHS England Drugs and Alcohol Team is noted.

3. George Eliot Hospital - Update

A verbal update was provided by Kevin McGee, Chief Executive of the George Eliot Hospital NHS Trust. He reminded that in August 2011, it was determined that the Hospital was not sustainable, either in financial or clinical terms. An extensive process had followed, in liaison with the Department of Health and the Treasury, for approval to invite bids for a partner. The objective was to secure the best solution for the local area. The Trust had been heavily monitored and scrutinised. It was hoped the revised arrangements would become a model of good practice and, in time a pilot for other areas.

By July 2014, the Trust hoped to announce a preferred partner. Between then and March/April 2015, the Trust would work closely with the preferred partner to move to the revised structure. Mr McGee also spoke about the relatively small size of the George Eliot Hospital NHS Trust. However, it was still required to meet the same requirements as all other NHS trusts.

The Chair invited questions and Wendy Fabbro, Director of the People Group asked how stakeholders would be involved in the process. A project board would include representatives of clinical commissioning groups and patient representatives. This would be supplemented by wider stakeholder engagement and further details would be issued during the week commencing 30th September. Community forums would also be arranged.

The determination of the criteria for selecting a partner was a key aspect raised by the Chair. Mr McGee confirmed the stakeholder group would be involved in the setting and weighting of such criteria. **The Chair also asked about the scope of the contract for the partner and asked Kevin McGee to ensure that she was informed about this. (**Chair to action)

Councillor Maggie O'Rourke asked about the retention of current services, which would be the starting point, but changing demands for the NHS would have an influence.

In response to a question from Bryan Stoten, it was confirmed that the various local government bodies would be involved. Related to this, Councillor Derek Pickard questioned responsiveness to issues raised by local authorities. Mr McGee agreed that an open dialogue was needed and an offer was made to engage in local forums and the democratic process.

Mr McGee then spoke about ensuring the delivery of safe hospital services and the next stage of the Keogh Review. He confirmed that a 2-day inspection process was currently being undertaken and stated that the Hospital's safety indicators were mostly good. A key challenge was attracting and retaining staff. He touched on the increases in activity and

notably emergency activity, together with the move to 7-day effective working. Capacity issues had been identified over the previous winter period and additional bed spaces and staffing were planned for this year.

John Linnane reminded about the Public Health England publication on mortality levels, health inequalities and the statistical variances across the County, asking that those issues be kept in mind. Clarification was provided on the mortality statistics, in response to a further question from Councillor Michael Coker. It was noted that mortality rates at the Hospital were falling, broadly in line with average levels and each case was investigated. Councillor Bob Stevens also sought further information about the Hospital's forward plans. The Chair thanked Mr McGee for the update.

Resolved

That the update on the George Eliot Hospital is noted.

4. Healthwatch Warwickshire – Update and Joint Work Memorandum of Understanding

The Chair proposed a minor variation to the Agenda to include as part of this item the consideration of the related joint work Memorandum of Understanding.

Deb Saunders, Chief Executive of Healthwatch Warwickshire spoke to a circulated report, which provided background on Healthwatch and a data report for the first quarter of 2013/14. She advised that the mechanisms for data collection were being fine-tuned. The officer emphasised the role of Healthwatch as the voice of the public, also explaining the consortium's organisational structure and bodies involved. Reference was made to survey work undertaken and to the Health and Social Care Forum. Deb Saunders publicised the Healthwatch Charter, which would be launched the following day, spoke about the organisation's staffing structure and some of the projects being undertaken.

Questions about signposting to services delivered by Healthwatch and promotion of the organisation were responded to. The evaluation of performance data was discussed and the Chair confirmed the role of the County Council's Scrutiny Committee. The voluntary transport service was raised, with discussion about the possible removal of funding. It was questioned whether an equality impact assessment had been completed. There had been a call for evidence by Healthwatch and feedback was encouraged.

John Linnane offered to provide a further update on the voluntary transport scheme to the next Overview and Scrutiny Committee. (John Linnane to action) He also spoke about the grant system and operation of this service. He felt the future was uncertain, whilst referring

to the transition funding provided this financial year and on-going work with the schemes to assist them to become self-sufficient.

Wendy Fabbro spoke about the engagement with Youth Members of Parliament on health issues.

The Chair noted the points raised and questioned when the data from Healthwatch's call for evidence would be available, which Deb Saunders advised would be in approximately two months.

The Chair referred to the joint work Memorandum of Understanding (MoU), which was a result of a discussion between the Chair of the Health and Wellbeing Board, Chair of Healthwatch Warwickshire and Chairs of the Adult Social Care and Health and Children and Young People Overview & Scrutiny Committees. The aim of this work was to agree and clarify working relationships between the four bodies. There was a need to avoid duplication and ensure effective scrutiny of the Board's Strategic decisions. Ann Mawdsley, from Democratic Services at the County Council provided further information on the MoU, which was driven by the Francis report and issues at George Eliot Hospital. The document would be submitted for final approval to the next Adult Social Care & Health Overview and Scrutiny Committee. It would also be presented to the next Healthwatch Board.

The Chair commented that Warwickshire was one of the first areas to produce a MoU and the Local Government Association Board for Health was taking this approach as an example of good practice.

Resolved

That the Warwickshire Health and Wellbeing Board:

1. Approves the Memorandum of Understanding.

2. Agrees to a half-day joint workshop to apply the MoU and consider the implications and joint actions in response to the Francis Report and recommendations.

5. Director of Public Health's Annual Report

John Linnane, Director of Public Health spoke to the Annual report for 2013, which had been circulated, together with a summary document. Public Health was returning to local government after 39 years with the NHS. He commented on demographic changes and the aging population, the variation in mortality indicators between affluent areas and those with deprivation. The mortality gap hadn't narrowed. He also reminded of the drug and alcohol issues raised earlier in the meeting and spoke about hospital admissions associated with alcohol misuse. He confirmed the problems were not limited to those from young people

binge drinking. Another key issue was smoking, particularly involving pregnant women. **Mr Linnane proposed to bring a paper to the next Board on this topic.** (John Linnane to action)

Councillor Maggie O'Rourke sought clarification about the high numbers of road accident deaths, which was proportionate to the significant lengths of major roads through the County. Obesity statistics were also discussed. The links to the Health and Wellbeing Strategy were questioned by Councillor Claire Watson and it was confirmed this document did link, but focused on the health strategy aspects, rather than healthcare. The comparative statistics on smoking amongst pregnant women and breast feeding were also raised by Councillor Gillian Roache. The Chair felt it would be useful to have this data disaggregated by local area. In response to a question from Councillor Derek Pickard, it was confirmed that all councils would receive a copy of the Annual Report. Mr Linnane hoped to attend meetings with all councils and would be writing to them shortly.

Resolved

That the Warwickshire Health and Wellbeing Board notes the Director of Public Health's Annual Report for 2013 and approves the recommendations contained within it.

6. (i) Refresh of the Health and Wellbeing Strategy

John Linnane gave a verbal report on the interim Health and Wellbeing Strategy that had been approved in March 2013. He advised that a refresh was due in 2014 of the Joint Strategic Needs Assessment. At the last Board Meeting, a report was submitted on the "Living in Warwickshire" survey.

Councillor Gillian Roache spoke about the good partnership working in the County. Bryan Stoten referred to the increasing numbers of non-health people on the public health registers, with local government environmental health and planning disciplines being mentioned particularly. Nicola Wright from Public Health Warwickshire commented on the input of planning and licensing experts into health issues.

Resolved

That the report is noted.

(ii) Board Performance Framework

John Linnane provided a verbal update. The draft Board Performance Framework had been shared with key stakeholders and from the feedback received, was being revised. Dr Linnane commented on the Board's performance monitoring role and there was a need to look at key

issues and the performance of the health service and health outcomes across the County. The target was to finalise the Board Performance Framework over the next two meetings.

Resolved

That the Warwickshire Health and Wellbeing Board notes the report.

7. Home Improvement/Housing - Presentation

A presentation was made by Steve Shanahan, Head of Housing at Rugby Borough Council. This concerned the redesign of the service to provide adaptations to properties, to improve the quality of life for residents. A multi-agency approach had been used to join up and streamline the process for home improvement applications, resulting in a reduction in the waiting time, typically from 395 days to 150 days for completion of the works.

Dr Heather Gorringe asked about the comparative time taken for the completion of works and it was confirmed that the service was now one of the fastest in the Country, but endeavours were being made to improve still further.

Resolved

That the Warwickshire Health and Wellbeing Board notes the report.

8. Pioneer Bid

Gillian Entwhistle of the South Warwickshire Clinical Commissioning Group gave a verbal update, following the report to the Board Meeting on 17th July. It was explained that over 100 bids had been submitted under this initiative. However the bids submitted from Warwickshire and Coventry had proved unsuccessful. The Board was advised that the funding allocated under the scheme had been reduced significantly. Councillor Bob Stevens spoke to this item about pursuing integration issues.

Resolved

That the report is noted.

9 Warwickshire North Clinical Commissioning Group (CCG) – Strategy

Dr Heather Gorringe addressed the Board on the production of the 3-year clinical strategy, which would be considered by the Warwickshire North CCG Board the following day. Input had been received from a range of stakeholders, to shape the Strategy. The key principles were to

ensure the delivery of safe, local services, seven days per week, to deliver the best outcomes for patients. The need to travel in some cases was acknowledged. Other areas touched on were urgent/emergency care, end of life, dementia and mental health care. The document would be available via the CCG website.

A request was made by Councillor Claire Watson that in future, reports to the Board were all provided in writing. This was agreed.

Bryan Stoten referred to health inequalities and the need to focus on young people as a priority group. Dr Gorringe responded that children's services at the George Eliot Hospital had recently been redesigned.

Wendy Fabbro referred to the publication "Great Expectations" on children's health. **It was suggested that the Observatory be asked to extract relevant information from this data relevant to Warwickshire.**

The Chair welcomed the move to 7-day care at the Hospital.

Resolved

That the Warwickshire Health and Wellbeing Board notes the report.

10. Any Other Business

John Linnane displayed a poster for the 2013 flu inoculation campaign. He confirmed that one third of Warwickshire residents were entitled to a free inoculation and wide publicity was planned to encourage residents to take up the offer.

The meeting rose at 15.45

……..Chair

Item 3

Warwickshire Health and Wellbeing Board

20th November 2013

Priority Families in Warwickshire – Half Way through the Programme - Where have we got to?

A. Recommendations

1) That the Board notes and comments on the progress made by the Programme
2) That the Board considers the approach that should be taken to promote the sustainability of the Programme beyond 2015
3) That the Board extends its thanks to all partners so far involved in the management, coordination and delivery of the Programme
4) That the Board considers ways in which the Programme can better engage with schools, health commissioners and providers

B. Key Issues

1) Securing improved linkages with schools and health commissioners / providers
2) Planning for the second Phase of the Programme (beyond April 2015) once further information available from Government as to the terms on which the Programme is to be run
3) Ensuring that the Programme continues to meet its targets and remains in sound financial health
4) Ensuring that, in addition to meeting targets, the lessons learned from the Programme fully inform the ways in which relevant services are planned, commissioned and delivered in the future

C. General Report

1 Background

During the course of discussion with all of those who have an interest in the 'Troubled Families agenda' a universal view has been expressed that we in Warwickshire should find a better and less judgmental brand for the Programme. This is a view that it shared by the majority of local authorities in the country. As a result, we have named our Programme 'Priority Families'. Professionals seem to like this term and those families that we have been in contact with seem content with it too. Government has made it clear that there is no problem in branding the scheme locally and even the Team leading the work there calls itself the 'Families Team' rather than the 'Troubled Families Team'.

1.1 **What the work on Priority Families is all about:**

- ✓ Ensuring that our priority families get the support they need at the right time in a way that enables helps them to achieve greater independence and stability
- ✓ A focus on the earliest possible intervention, preventing vulnerable families and individuals within them from developing complex needs
- ✓ A focus at the community level to help improve communities who are most in need
- ✓ Ensuring that the activities delivered through the work are based on a co-ordinated, assertive and challenging but nonetheless supportive approach
- ✓ Ensuring that various initiatives that are aimed at Families in need are joined up and complementing each other.

1.2 **Our aim and commitment is to**

- ✓ Have a much better understanding of all the priority families in the county
- ✓ Have a new joined up way of identifying and meeting the needs of all these families
- ✓ Remove the inefficiency lack of coherence and bureaucracy in the current system to save us all time and money
- ✓ Have a simplified system for sharing and recording information about our families in a way that help them get the support they need, without them having to complete separate forms and assessments
- ✓ Have a single budget from which the services that are required can be controlled and checked
- ✓ Make sure our resources are focused on those that need them most
- ✓ Build a sustainable model for work with priority families beyond the duration of this Programme

1.3 **Building on Good Practice Guidance (DCLG publication: *Working with Troubled Families*- December 2013) and the Five Family Intervention Factors**

- ✓ Dedicated Workers dedicated to families
- ✓ Practical 'hands on' support
- ✓ A persistent, assertive and challenging approach
- ✓ Considering the family as a whole
- ✓ A common purpose and agreed action

2 The Programmes

In 2011 the Government, through the Department for Communities and Local Government (DCLG) and the Department for Work and Pensions (DWP), informed all local authorities of the need to 'turn around' the lives of 120,000 families in the UK over three years – i.e. up to 31st March 2015. This paper focuses on two Programmes:

- The DCLG Troubled Families Programme, originally scheduled to run from 1 4 12 to 31 3 2015. However, as a result of the Spending Review announcement in June 2013, the current Government has made clear its intention to EXTEND the programme to 31st March 2018. In effect this means that a further 12 months to 31st March 2016 is *guaranteed* with any further extension to 2018 or beyond conditional on the outcome of the General Election in May 2015.

- The DWP / ESF Programme relating to Families with Multiple Problems which started on 1 4 12 is scheduled to continue until December 2014. This Programme was independently commissioned by DWP and, in Warwickshire, the independent provider charged with the responsibility for delivery is EOS of Birmingham

It is most unlikely that any extension will be granted to the DWP/ ESF Programme.

3 The Numbers

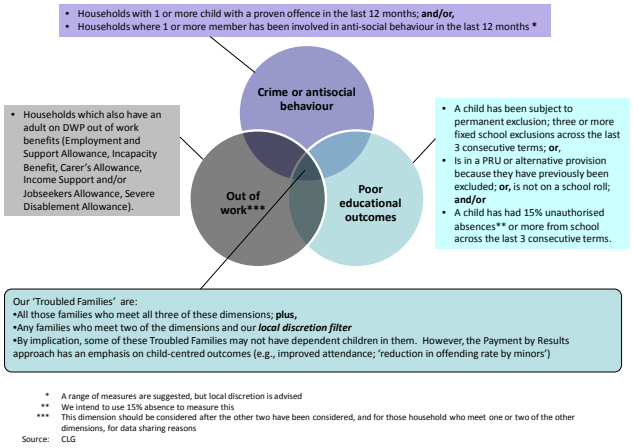
3.1 Based on the Government's calculation from 120,000 nationally, the Government indicated a target figure of 805 'troubled' families in Warwickshire.

3.2 Of these 805 the Government informed us that 671 families will be addressed through the DCLG programme. The remaining 134 families will be routed through either the DWP-European Social Fund (ESF) programme or via other programmes/initiatives

4. DCLG Troubled Families Programme

4.1 Criteria

Figure 2: Government criteria for identifying 'Troubled Families'



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

4.2 The 'Poor Educational Outcomes' criterion shown above has been now been revised (March 2013) to introduce some elements of discretion in favour of head teachers who consider that patterns of attendance cause ' equivalent' concern to the 15% unauthorised absence target (see Appendix)

4.3 Where all three of the National Criteria are present, a family will automatically qualify for the programme.

4.4 Where 2 of the 3 National Criteria are present it is open to the Council and its partners to include a family within the programme through the application of a third Local Criterion.

4.5 A list of local criteria has been developed in conjunction with service managers and partners. These have been grouped into 4 categories as follows:

- Child Protection / Safe Guarding
- Health/ Mental Health and Well Being
- Financial Inclusion & Housing
- Reducing Crime/ Anti Social Behaviour and Promoting Rehabilitation

4.6 This categorisation together with more information about the National Criteria is shown at Appendix One.

5 The Numbers: Requirements, Identification & Profiling

5.1 Identification & Profiling

In terms of the number of families (starting from the figure of 671 – see above):

5.2.1 Application of **national** criteria

- In the first year of the Programme, 196 families were identified as fulfilling both the crime and education criteria. Of these, **52** families also met the worklessness criteria and therefore automatically qualify for the DCLG programme.

5.2.2 **Application of local criteria:**

A refresh for Year 2 kicked off in May 2013 to help identify further families that meet the criteria using national criteria data for the period April 2012 to March 2013. In brief the headline figures to note is that a total (across years 1 & 2) of **991** families have now been identified, a total of **93** of which meet all 3 of the national criteria and the remaining **896** through meeting 2 of the national criteria and any 1 of the following local criteria:

- NEET or At Risk of NEET (RONI)
- On Integrated Offender Management
- Geographical filter (living in a Police Partnership Priority Area and/or living in 10% most deprived nationally)
- Over the last three years have been on a Child Protection Plan or are Looked After Children

5.2.3 **Prioritising**

The fact that we have now successfully at the half way stage (18 months in) identified **186 more** than the required number of families for the entire three year Programme means that we need to agree an approach to prioritising those families that should attach to the Programme.

We are developing an approach based on the following suggestions*:

- First Priority to be given to those families that satisfy all 3 National Criteria
- Second Priority to be given to those families that satisfy the Education criterion and one local criterion of which top priority should be given to those families that satisfy the 'edge of care' local criterion.
- Full consideration to be given to all family circumstances, with priority afforded to those families in respect of which it is known that difficulties and challenges have existed over generations or affect an extended family
- Local Coordinating Groups to decide in their own area a ranking of local criteria that reflect local needs and issues

* This approach will be considered by the Priority Families Programme Board at its next meeting.

5.2.4 **Overview as at 4th November 2013**

The current total of **991** families can be disaggregated as follows:

North Warwickshire -	57 (6%)
Nuneaton & Bedworth -	478 (48%)
Rugby -	184 (19%)
Stratford -	84 (8%)
Warwick -	154(16%)
Unknown -	1 (0.1%)
Out of County –	32 (3%)

5.2.5 The total is clearly presently skewed towards Nuneaton & Bedworth Borough. This is partly a consequence of the local filter 'living in 10% most deprived nationally as all of the communities meeting that filter are in Nuneaton & Bedworth, coupled with the high incidence of unemployment in the Borough.

5.2.6 We have developed a ward by ward breakdown of the families that have been identified which is available on request. This is attached as Appendix 2.

5.3 **'Start Work'**

5.3.1 Warwickshire committed to ***'start work'*** with **250** families in 2012/13 and received 'up-front' attachment fees from Government totalling £800k.

5.3.2 The programme then requires us to work with a further 335 families in 2013/14 and the remaining 86 families by the end of March 2015 –so the profile is:

Yr 1	250 families
Yr 2	335 families
Yr 3	86 families

5.3.3 As at **the end of October 2013,** we calculated that we had 'started work' with **420** families (i.e. our Year One cohort of 250 plus 170 towards our Year Two cohort of 335).

5.3.4 **In summary, latest available data shows that we have as at 30TH October 2013 (19 months through the first 36 months of the Programme):**

- ✓ Identified **and** started / finished work with all of our Year One Cohort of families as well as 50% of our Year 2 Cohort
- ✓ Identified 20% more than our overall target of 805 families
- ✓ Started / finished work with 52% of our overall target of 805 families
- ✓ Submitted successful Payment by Results claims for 130 families (see 6.1) – 16% of our target number of families

5.5 Local Coordinating Groups (LCG's)

5.5.1 5 district based LCG's have been established to identify families and oversee delivery arrangements in each of the 5 district: borough council areas of the county.

5.5.2 The Groups have been meeting on a monthly basis since early 2013 (arrangements in Rugby started a month or so previously). The initial roles of the LCG's include the following:

- Using local knowledge and discretion to confirm the local Priority Families cohort
- To identify existing interventions, assessments and case management arrangements (e.g. FIP, MARAC, MAPPA, Integrated Offended Management, Social Care) in respect of each of the families, the level of intervention that is likely to be required and to begin the process of developing / consolidating individual family plans
- To identify the worker / agency best placed to contact / liaise with each family and obtain their agreement to joining the Programme

5.5.3 The following additional roles proposed are:

- Identifying the types of intervention that will be successful at a local level
- Developing and taking ownership and management of family plans for each of the families included within the cohort – family plans to be outcomes driven with clear links to the Payment by Results (PBR) criteria
- Overseeing the delivery of targeted interventions at a local level
- Taking responsibility for the delivery of a more co-ordinated cross-agency approach to family intervention at a local level including effective links with existing local strategic groups

5.5.4 Membership of the LCG's is as follows:

- Borough / District Council (to cover Housing, Anti-Social Behaviour and Environmental Health)
- Common Assessment Framework (CAF) and Early Intervention Service (EIS)
- Targeted Youth Support
- Family and Parenting Support
- Youth Justice Service and Family Intervention
- Warwickshire Police
- Safeguarding / Children in Need
- Warwickshire Probation
- Schools via networking and Area Behaviour Partnerships
- Health (current focus on Health Visitors and School Nurses)
- Citizen's Advice Bureau
- Housing Associations
- Local Voluntary Organisations

5.5.5 Following a meeting in October 2013, it has been agreed that a sixth and separate coordinating Arrangement should be established for the approximately 100 families living in Camp Hill, Nuneaton. This work will be carried out via an existing partnership (the Camp Hill Partnership) which is chaired and facilitated by Bromford Housing. There were two reasons for this decision:

a) To partially relieve the Nuneaton & Bedworth LCG of some of its work pressures and

b) To ensure that the particular community initiatives that apply in Camp Hill could be linked with the Programme and vice versa

5.6 Segmentation

5.6.1 By 'Segmentation' we mean the process through which families are categorised by reference to their needs and issues. Work needs to be done on the criteria that should be applied to undertake this task but, in line with national thinking and on the basis that we need to 'get on with it' we are assuming that there will be three categories of intervention:

- ✓ **Intensive Intervention** – to be undertaken via the Family Intervention Project / others. This involves a key worker working intensively with a small case load of families (no more than 5 at a time). It is assumed that 30% of the families included within the programme (202) will fit within this category
- ✓ **Moderate Intervention** – to be undertaken by an agency (probably known to the family). This involves a key worker approach but there are fewer issues to be faced / addressed and the overall intervention / set of interventions is less intensive. It is assumed that 40% of the families included within the programme will fit within this category (269) and that a key worker would be able to manage a case load of up to 15 families at any one time
- ✓ **Light Intervention** - to be undertaken by an agency well placed with the family concerned or perhaps third sector providers via a dedicated worker. It is assumed that 30% of our priority families will meet this category (201). It is also assumed that a case load of 30 families per worker would be reasonable. The attached diagram from DCLG helps to summarise this approach (please note that in Warwickshire we are calling 'Family Intervention Light' , 'Moderate Intervention;' and 'Super Light' is being called 'Light**.** Over the three years of the programme the following target figures apply in relation to the number of families to be worked with:

Intervention Type	Year One Families	Year 2 Families	Year 3 Families	Total Families
Intensive Intervention	75	101	26	202
Moderate Intervention	100	134	34	268
Light Intervention	75	100	26	201
Total	250	335	86	671

5.6.2 Within this context the capacity requirements for 'front-line' key worker staff is:

Intervention Type	Year One Staffing fte	Year 2 Staffing fte	Year 3 Staffing fte
Intensive Intervention	15	20	5
Moderate Intervention	6	9	2
Light Intervention	2.5	3.5	1
Total	23.5	32.5	8

6 Resources & Recruitment

6.1 Budget and Payment by Results Claims

6.1.1 The maximum additional funding available from DCLG to support the Priority Families Programme in Warwickshire is just over £2.6m. This is made up of a combination of Attachment Fees (up-front payments to support work for each family) and a reward or Payment by Results payment payable once positive outcomes have been achieved with a family.

The delivery and funding profile over the duration of the Programme (up to April 2015) is as follows:

Year	No of Families to start work with	Up front funding (Attachment Fees) £	Payment by Results (Maximum) £	Total £
2012/13	250	800,000	200,000	1,000,000
2013/14	335	804,000	536,000	1,340,000
2014/15	86	137,600	206,400	344,000
Total	**671**	**1,741,600**	**942,400**	**2,684,000**

6.1.2 It is assumed for the purpose of the programme budget that in addition to the 'up front' funding of £1,741,000 the programme will yield a minimum of 30% of the amount available under Payment by Results. This would amount to £282,700 making a total budget of £2,024,300.

6.1.3 During the July (PBR) window our claim was limited to 45 families and a claim for this number of families was successfully submitted to Government on 26th July 2013. The comparatively small nature of the claim resulted from the following:

- In order to make a successful claim we need to evidence success for both education and crime /asb criteria over the same time period.
- Education data is collected by the LA from schools two terms in arrears through the thrice yearly schools census.
- As a result of the time lag that has resulted, we have not been able to line up the education data with the crime / asb data.

6.1.4 Thanks to the efforts of a wide range of partners (within and outside the County Council) we were, during October 2013, able to at least partially address some of these constraints. As a result we successfully submitted a PBR claim for a total of a further 85 families (81 relating to Crime /ASB/Education and 4 'Return to Work')

6.1.5 Taking all of this into account, we have so far made successful claims for 130 families and have received /will receive approximately £85,000 or 30% of the minimum amount of PBR that we require over the three year Programme.

6.1.6 In respect of the 130 successful family claims, the area figures are:

Area	Successful Claims as at 30 10 13	% of families identified in the Area as at 30 10 13
North Warwickshire	9	15%
Nuneaton & Bedworth	67	14%
Rugby	28	15%
Warwick	16	9%
Stratford	10	12%

6.2 Recruitment of Staff

6.2.1 In discussion with partners and key staff, the following issues were identified:

- Ensuring that there is sufficient capacity 'within the system' in relation to the three intervention types
- Ensuring that there are suitable support and supervision arrangements in place for front-line staff (this is highly demanding and taxing work – especially at the 'hard-end'). We are currently identifying the need for clinical supervision based on reflective practice as well as managerial supervision.
- Identifying the range of interventions likely to be required over and above those that are currently readily available to families. We are assessing the need and investigating the most appropriate commissioning and spot purchasing arrangements

6.2.2 In line with these discussions, recruitment processes have been completed for key workers as follows:

- **Intensive Intervention**: 9 additional key workers enhancing the existing Family Intervention Teams (North & South) resulting in an overall team of 19 intensive key workers. These Key Workers will be managed through Warwickshire Youth Justice and Family Intervention Service
- **Moderate Intervention**: 8 additional Family Support Workers to work closely with nominated Children Centres where there is most need, the CAF process and specific groups where there is a high level of need, e.g. children at risk of exclusion. These Key Workers will be managed through Warwickshire County Council's Family and Parenting Support Service

6.3 Other Uses of Resources

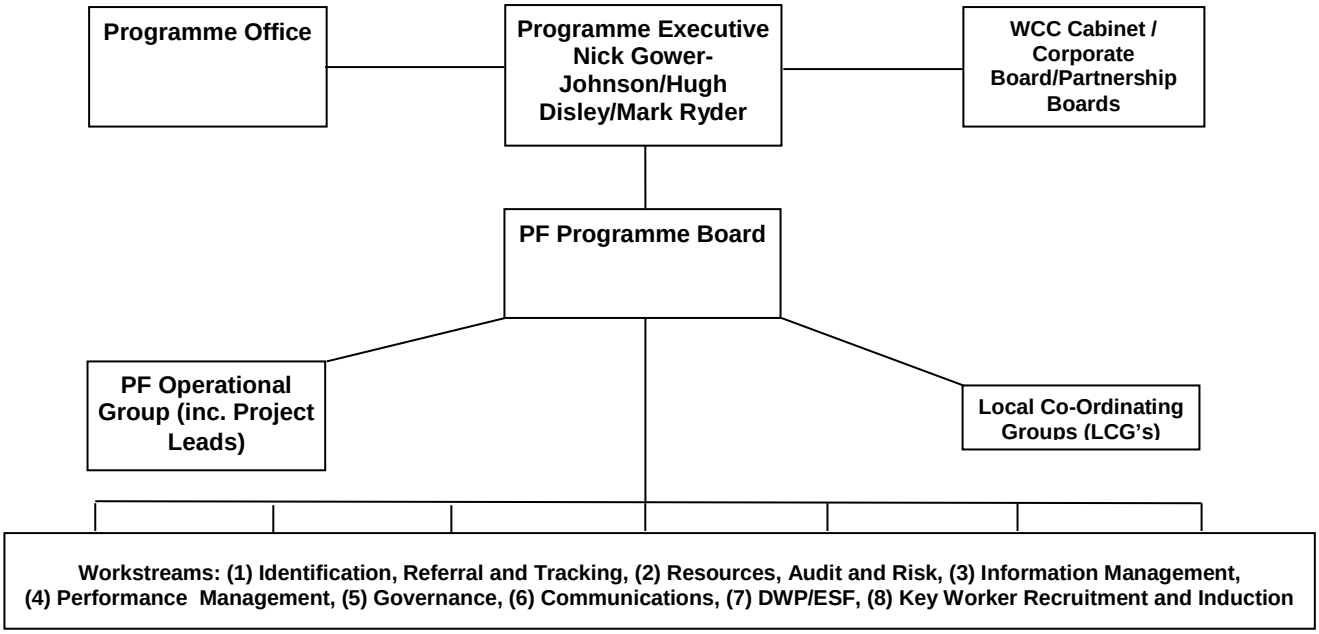
6.3.1 This includes allocations in respect of:

- Supporting Programme Management and Delivery
- Enhancing management / supervisory capacity in respect of Family Intervention, and the CAF Process and the focus on work with identified Priority Families
- Supporting the establishment of the County Council's Attendance, Compliance and Enforcement (ACE) Team and their focus on identified Priority Families (This Team is made up of professionals with in-depth knowledge and experience in addressing school attendance and disaffection issues)
- Support for addressing debt, and benefit issues faced by families in the North of the County via BRANCAB
- Support for Family Expenses (small grants made available to organisations working with families to help them overcome urgent issues)
- A prudent level of contingency

7 Governance and Performance Management

7.1 Governance of the Project can be summarised as:

Priority Families (PF): Governance
DCLG/DWP



7.2 Further information on the individual roles of these groups can be obtained on request.

7.3 We are currently working on finalising a suite of Performance Indicators for final approval by the Programme Board

8. DWP-ESF Programme: July 2012-December 2014

Key criteria for the project involve:

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

This project is delivered through an independent provider (EOS of Birmingham) which has been commissioned by DWP. The provision is based on a key worker being allocated to families to work with them and identify and remove barriers to employment and provide support to those who obtain employment. Referral to the project can be made as follows:

Primary referral route:
Via Warwickshire County Council (key contact is Jo Prosser) 01926 742643

joprosser@warwickshire.gov.uk

EOS has placed information on the Support for Families programme to view on the web. See the link below and cascade to staff who may find this useful in making decisions about referring a family.

http://eosworks.co.uk/customers/families/

9. Visit from DCLG on 30 April 2013

9.1 A visit was arranged with with Sue Strickland and RobertMcCulloch-Graham from DCLG's Families Team. This was not an inspection visit but nevertheless our visitors are very experienced professionals and posed some challenging questions when they were with us! Overall, they said that they were 'very impressed' with what they saw and heard and commented particularly positively on:

- The solid partnerships / strong levels of buy-in that we have formed internally within the County Council and both operationally (particularly with District and Borough Councils) and strategically with external partners
- The sound use of the additional resources that the Programme has brought to Warwickshire.
- Our commitment to building on existing working models and approaches as opposed to setting up new services
- The models that we are operating in respect of intensive and moderate levels of intervention
- The practical interface between Social Care and Family Intervention

9.2 They suggested that the following areas of our work need further development:

- Along with the majority of local authorities, the need to 'up the pace' in Year 2 of the Programme.
- The need to develop our approach to those families that only require comparatively modest levels of intervention (FIP light) where this is best achieved through the actions of a single lead agency
- Developing a partnership approach to sustaining the work beyond the duration of the Programme - i.e. after 201

10. Key Priorities over the next few months

These include:

a) **On-going Meetings of Local Co-ordinating Groups:** To identify, allocate and put in place steps to monitor the progress families that are on the programme and to include successfully launching our work via the Camp Hill Partnership.

b) **Finalise definition and application of Local Filters:** As outlined in Appendix Two.

c) **On-going Training /Support of Key Workers:** to deliver effective interventions to the families via staff supported through the Programme (to include Family Support Workers employed by schools directly)

d) **Continue our partnership work with Department for Work and Pensions / Job Centre Plus** regarding the arrangements applying to the secondment of their full time member of their staff to our Priority Families Team

e) **Finalise our discussions regarding Case Management Systems:** That are audit compliant, ICT secure and ensure that we are able to performance manage effectively and meet Payment by Results requirements.

f) **Expand and Update our Dedicated Web Presence** for practitioners and partners to access relevant and up to date information in relation to the Priority Families Programme via the webpage www.warwickshire.gov.uk/priorityfamilies

g) **Robust Programme Management Arrangements** that deal with all aspects of project management and governance and have regard to the emphasis placed by Central Government on resources, audit and performance management**.**

h) Payment by Results: Our financial planning has been predicated on the basis that we will successfully claim at least 30% of the maximum amount due. We have completed claims in July and October 2013 and are now planning for the next claim round in January 2014.

i) Making sense of the range of data bases and information sources relating to school attendance and exclusions – This issue lay at the heart of the reduction in our PBR claim in July and reflects some complex organisational arrangements. We seem to be making some headway in 'unpicking' them but the situation is far from ideal and requires a longer term and more coordinated/coherent approach than currently exists

j) Light Intervention & Sustaining Progress: We need to further develop our approach to those families requiring Light Intervention (probably via a single agency). At the same time, we need to be mindful of the need to ensure that those families who have progressed and addressed many of their concerns have access to any necessary community based on-going support and contact.

k) **Updating the Warwickshire Information Sharing Charter** in order to address some issues that have arisen in the early days of the Programme. A specific Information Sharing Agreement has been developed for the Programme and is currently in the process of being adopted both by the Programme Board and individual agencies.

l) **On-going Data Refresh** via Warwickshire Observatory and key partners to identify families that meet the criteria for the Programme.

m) **Continue our work with both Schools and Health providers, commissioners and their representatives** to ensure their full engagement in the development and delivery of the Programme including the referral of families to the Programme.

n) **Continue our work with the DWP / ESF Provider** in order to maximise the effectiveness and reach of the Programme.

o) **Ensuring that we participate fully in the National Evaluation Programme** being undertaken by DCLG and take what steps are necessary to complement this through local evaluation arrangements. Progress on this nationally has been limited.

p) **Progress the work of our Evaluation Group** which is currently looking at a range of issues including:

- Linking with the National Evaluation Programme
- Finalising our suite of Performance Indicators for the Programme
- Developing ways of localising the management, coordination and delivery of the Programme
- Developing approaches to volunteering aimed at supporting families with low level needs or those that have successfully completed the Programme (to be focused in Rugby to start with)
- Identifying the impact of the Programme on educational attainment / achievement
- Assessing the Cost : Benefits of the Programme

q) **Taking forward collaborative work with our sub regional partners –** Coventry & Solihull. We are already involved in joint training, and regularly exchange thinking and approaches. All 3 authorities are determined to build on this positive work.

Nick Gower Johnson
Priority Families Coordinator
06.11.13

Appendix 1

Identifying families for the Priority Families Programme Revised March 2013

DCLG Programme

To qualify for the programme, 3 national or 2 national and 1 local criteria must be met.

Three National Criteria

1. **Crime/anti-social behaviour**

Identify young people involved in **crime** and families involved in **anti-social behaviour**, defined as:

Households with 1 or more under 18-year-old with a proven offence in the last 12 months
AND/ OR
Households where 1 or more member has an anti-social behaviour order, anti-social behaviour injunction, anti-social behaviour contract, or where the family has been subject to a housing-related anti-social behaviour intervention in the last 12 months (such as a notice of seeking possession on anti-social behaviour grounds, a housing-related injunction, a demotion order, eviction from social housing on anti-social behaviour grounds).

It should be noted from recent guidance that DCLG regard this as 'an indicative rather than an exhaustive list'. This means that comparable measures or interventions can be used that draw on information from a range of local partners including police, landlords and council colleagues to make sure that we find 'families of concern''.

It is important to select measures for which we will be able to evidence progress within our own internal audit arrangements.

2. Education

In March 2013, DCLG clarified that children with exclusion/attendance problems **equivalent to** those specified in the original criteria above may be included within the definition. Head Teachers and Troubled Families Coordinators should apply their professional discretion to identify children whose patterns of attendance are **of equivalent concern** to those set out in the original criterion.

As a result, we would like to clarify the criterion as follows (changes to the original criteria are shown in bold italics):

- *Households affected by truancy or exclusion from school, where a child:*

- *Has been subject to permanent exclusion;*
- *Has had 3+ fixed school exclusions across the last 3 consecutive terms;*
- *Is in a Pupil Referral Unit or alternative provision because they have previously been excluded* ***or for the purposes of improving their behaviour;***
- ***Has been placed in specialist provision within a mainstream school for the purposes of improving behaviour which is comparable to the use of alternative provision;***
- *Is not on a school roll; or*
- *Has had 15%+ unauthorised absences from school across the last 3 consecutive terms* ***or evidence of a pattern of poor attendance that gives the Head Teacher an equivalent level of concern. Authorised absence may be taken into account where there is a comparable attendance problem masked by recording practices.***

3. Work

Once you have identified everyone who meets one or both of criteria 1 and 2, you may identify households which **also** have an adult on Department for Work and Pensions out of work benefits (Employment and Support Allowance, Incapacity Benefit, Carer's Allowance, Income Support and/or Jobseekers Allowance, Severe Disablement Allowance).

All families who meet all of criteria 1-3 in your area should automatically be included in the programme. The balance should be identified using your local discretion.

Local Criteria

Use this local **discretion filter to add** other families who meet any 2 of the 3 criteria above. The local criteria are set out in the Appendix

DWP-ESF Programme

Key criteria for the project involve:

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

This project is delivered through an independent provider (EOS of Birmingham) which has been commissioned by DWP.

The provision is based on a key worker being allocated to families to work with them and identify and remove barriers to employment and provide support to those who obtain employment.

Referral to the project can be made as follows:

Primary referral route:

Via Warwickshire County Council (key contact is Jo Prosser) 01926 742643 joprosser@warwickshire.gov.uk

EOS has placed information on the Support for Families programme to view on the web. See the link below and cascade to staff who may find this useful in making decisions about referring a family.

http://eosworks.co.uk/customers/families/

Priority Families Local Criteria

Group	Filter	Measure	Data Source	Outcome
Child Protection / Safe Guarding	Families with a child (ren) on a Child Protection Plan / or which have had a CPP in the previous 3 years /families who have had a child (ren) looked after in the last 3 years			
Health / Emotional / Physical Wellbeing	Families with a child / parent / Carer with mental health / emotional wellbeing needs Families affected by Drug / Alcohol Misuse Families affected by Domestic Abuse Families with Young Carers	A child or yp whose life is affected by their caring role or at risk of taking on caring responsibilities that would normally be expected of an adult		
Financial Inclusion / Housing	Where family is homeless / living in inadequate accommodation or where security of accommodation is at risk Families affected by Poverty / Low Income / Debt Where 16-18 year old in family who is NEET and a member of one of the defined vulnerable groups / or a child under 16 at risk of NEET (RONI)		Learning & Achievement (People Group)	Additional 7 families identified meeting this filter and the Education and Crime filters

Group	Filter	Measure	Data Source	Outcome
Reduce Crime / ASB / Promote Rehabilitation	Families with a child (ren) that include a member who is subject to the Integrated Offender Management Programme	As described	Probation	No additional families identified
	Geographical filter – based on Index of Multiple Deprivation and / or the Partnership Priority Areas of Warwickshire Police	Living Lower Super Output Areas in the 10% most deprived nationally and/or living in Police Priority Area	Observatory	Additional 215 families meeting this filter and the Education and Worklessness criteria. Additional 6 families meeting this filter and the Crime/ASB and Worklessness filter
	Frequent Police Call Outs / District Council call outs to 'nuisance families			
	District Council frequent call outs to nuisance families / Housing ASB / Environmental Health ASB			
	Fire related Anti-Social behaviour			
	Where a family member is currently serving a prison sentence or otherwise in custody			

Warwickshire Priority Families – By Ward as at 5 11 2013

North Warwickshire Borough – 62 Families (by address)

(6% of county total)

Ward Name	No. of Families	Proportion of Borough Total (%)
Arley and Whitacre	15	24%
Hartshill	11	18%
Polesworth East	6	10%
Atherstone Central	4	6%
Atherstone North	4	6%
Atherstone South and Mancetter	4	6%
Baddesley and Grendon	4	6%
Coleshill South	4	6%
Hurley and Wood End	3	5%
Dordon	2	3%
Newton Regis and Warton	2	3%
Water Orton	2	3%
Fillongley	1	2%

Nuneaton and Bedworth Borough – 476 Families (by address)

(48% of county total)

Ward Name	No. of Families	Proportion of Borough Total (%)
Wem Brook	86	18%
Camp Hill	85	18%
Bar Pool	69	14%
Abbey	53	11%
Kingswood	44	9%
Bede	20	4%
Poplar	20	4%
Slough	18	4%
Arbury	16	3%
Galley Common	15	3%
Heath	14	3%
Attleborough	13	3%
Exhall	9	2%
Weddington	6	1%
Bulkington	3	1%
St. Nicholas	3	1%
Whitestone	2	0.5%

Rugby Borough – 180 Families (by address)
(19% of county total)

Ward Name	No. of Families	Proportion of Borough Total (%)
Benn	40	22%
Newbold and Brownsover	38	21%
New Bilton	27	15%
Rokeby and Overslade	18	10%
Admirals and Cawston	15	8%
Eastlands	10	6%
Wolstons and the Lawfords	7	4%
Revel and Binley Woods	5	3%
Hillmorton	4	2%
Leam Valley	4	2%
Coton and Boughton	3	2%
Paddox	3	2%
Bilton	2	1%
Dunsmore	2	1%
Wolvey and Shilton	2	1%

Stratford District – 86 Families (by address)
(8% of county total)

Ward Name	No. of Families	Proportion of District Total (%)
Stratford Avenue and New Town	9	10%
Bidford and Salford	7	8%
Studley	7	8%
Alcester	6	7%
Southam	6	7%
Stratford Alveston	6	7%
Stratford Mount Pleasant	6	7%
Wellesbourne	5	6%
Harbury	4	5%
Sambourne	4	5%
Shipston	4	5%
Kineton	3	3%
Henley	2	2%
Kinwarton	2	2%
Quinton	2	2%
Snitterfield	2	2%
Stratford Guild and Hathaway	2	2%
Aston Cantlow	1	1%
Bardon	1	1%

Ward Name	No. of Families	Proportion of District Total (%)
Brailes	1	1%
Burton Dassett	1	1%
Ettington	1	1%
Long Itchington	1	1%
Stockton and Napton	1	1%
Tredington	1	1%
Vale of the Red Horse	1	1%

Warwick District – 151 Families (by address)
(16% of county total)

Ward Name	No. of Families	Proportion of District Total (%)
Brunswick	41	27%
Warwick West	16	11%
Crown	15	10%
Whitnash	14	9%
Willes	13	9%
Warwick North	11	7%
Warwick South	8	5%
Milverton	6	4%
Park Hill	6	4%
Clarendon	5	3%
St. John's	5	3%
Abbey	2	1%
Bishop's Tachbrook	2	1%
Cubbington	2	1%
Manor	2	1%
Radford Semele	2	1%
Leek Wootton	1	1%

Note: Numbers have been provided where postcodes have been mappable on the geographical information system

	Name	Contact Information
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Item 4

Warwickshire Health and Wellbeing Board

20th November 2013

Smoking in Pregnancy - Upping our game

Recommendations

That the Warwickshire Health and Wellbeing Board:

1) Makes the reduction in smoking in pregnancy one of its key priorities.

2) Endorses the proposed actions to reduce the harm from women smoking during pregnancy.

3) Requests partner agencies to participate in the delivery of a detailed action plan.

1.0 Introduction

1.1 Tackling tobacco has been recognised by the Board as one of the most important things we can do to improve the health of people in Warwickshire as it is the number one preventable cause of premature death and disease within the County.

1.2 The Tobacco Control Plan for England (2011) sets out a national ambition to reduce smoking as recorded at the time of delivery to 11% or less by the end of 2015. If rates continue to fall at levels seen over the last six years, this ambition will not be achieved. This is especially true for Warwickshire where around 1 in 6 pregnant women are still smoking at the time of delivery.

1.3 On 17th July 2013 the Health and Wellbeing Board signed up to the Local Government Tobacco Control Declaration which set out the Council's commitments in relation to reducing smoking among the local population and tobacco control. This declaration has been well received and praised by national bodies such as Public health England.

1.4 When making the declaration the board agreed to act at a local level to reduce smoking prevalence and health inequalities; to raise the profile of the harm caused by smoking to our communities; develop plans with our partners and local communities to address the causes and impacts of tobacco use. Emphasis was given to the importance of reducing smoking in pregnancy.

2.0 Smoking in Pregnancy in Warwickshire

2.1 Smoking in pregnancy is known to have a number of adverse effects on the outcomes of pregnancy, including an overall increase in the risk of infant mortality by an estimated 40%. Specific risks include an increased risk of miscarriage, premature birth, stillbirth, placental abnormalities, low birth-weight and sudden unexpected death in infancy.

2.2 Action needed to reduce smoking in pregnancy has been known for some time but taking it is not always easy, as there are obstacles that face both women and the professionals who support them.

2.3 Many women will quit as soon as they discover they are pregnant. For others, their understanding of the risk posed to their unborn baby may not be sufficient to motivate them to quit; or they may face significant barriers that prevent them from stopping. Midwives and other professionals working with pregnant women can also face significant obstacles: not all receive appropriate time, training and tools; and IT systems, referral pathways and communication mechanisms can be insufficient.

2.4 In Warwickshire the specialist stop smoking in pregnancy service (now commissioned through Public Health) helps women who are pregnant and smoke to make quit attempts and support is extended to partners and families. Whilst the service is relatively successful for those who engage with the service there are some pregnant smokers who are not identified and others for whom the support is not appropriate.

2.5 These and other barriers can be overcome. The attached draft strategy report provides recommendations on how significant progress can be achieved. It highlights that by working together we can make changes that will give babies born in Warwickshire a much better start in life.

2.6 Virtually all partner agencies have a role to play to ensure that the prevalence of smoking in pregnancy is driven down and that future generations of Warwickshire citizens begin their lives smokefree.

3.0 Next steps

3.1 The proposed action plan has been developed to improve and enhance the current provision and to ensure that at every stage pregnant women are given the opportunity to receive support to quit smoking. Partner agencies are encouraged to endorse the action plan and commit to help reduce smoking prevalence among pregnant women.

Background Papers

1. An Action Plan to Reduce Smoking in Pregnancy in Warwickshire (Revised Draft V7)

	Name	**Contact Information**
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Strategic Director	Monica Fogarty	
Portfolio Holder	Cllr Stevens	

An Action Plan to Reduce Smoking in Pregnancy in Warwickshire (Revised Draft V7)

Introduction

Tackling tobacco is one of the most important things we can do to improve the health of people in Warwickshire as it is the number one preventable cause of premature death and disease within the County. This is even more important for women who smoke during pregnancy.

Currently at least 1 in six pregnant women are still smoking at the time of the birth of their child.

The Tobacco Control Plan for England (2011) sets out a national ambition to reduce smoking as recorded at the time of delivery to 11% or less by the end of 2015. If rates continue to fall at levels seen over the last six years, this ambition will not be achieved.

This 3-year action plan outlines the key actions required to tackle this issue and improve the health of future generations.

Background

Smoking in pregnancy

Smoking in pregnancy is known to have a number of adverse effects on the outcomes of pregnancy, including an overall increase in the risk of infant mortality by an estimated 40%. Specific risks include an increased risk of miscarriage, premature birth, stillbirth, placental abnormalities, low birth-weight and sudden unexpected death in infancy.

Smoking affects fertility in both men and women affecting every system involved in the reproductive process.

Smoking remains a major cause of new-born deaths, early births and babies born with low birth weight. Smoking is associated with approximately:

- 5-8% of premature births
- 13-19% of cases of low birth weight in babies carried to full term
- 5-7% of preterm-related deaths
- 23-34% of deaths caused by sudden infant death syndrome (cot death)[1]

[1] Dietz PM et al. Infant morbidity and mortality attributable to prenatal smoking in the U.S. Am J Prev Med. 2010 Jul;39(1):45-52. doi: 10.1016/j.amepre.2010.03.009

In the UK, smoking in pregnancy causes up to 5,000 miscarriages, 300 peri-natal deaths and around 2,200 premature births each year.[2]

Women who smoke take longer to conceive than women who do not smoke.[3]

Maternal smoking may have a negative impact on the fertility of both female and male off-spring and even affect a smoker's grandchildren.[4]

Maternal smoking is a major risk factor for low birth weight and babies who are small for their gestational age.[5]

In 2010, mothers under the age of 20 were nearly four times as likely to smoke before or during pregnancy, compared to mothers aged 35 or over (57% compared with 15%) and younger mothers, women in disadvantaged circumstances and those who have never worked tend to be more likely to smoke throughout their pregnancy[6]

More women quit smoking when they are pregnant than at any other time during their lives. Pregnant smokers are twice as likely to attempt to quit smoking as non-pregnant women, but only about half of pregnant women actually stop smoking during pregnancy.[7]

It is recognised as being difficult for some women to quit smoking, especially if not supported by their partner, and they may need pharmacotherapy support. Since nicotine is metabolised up to 60% faster by pregnant women, higher doses of NRT may be needed[8]. Many clinicians are unaware of this.

Further detailed information on the effects of smoking on reproduction can be found here http://ash.org.uk/files/documents/ASH_112.pdf

What we know about prevalence in Warwickshire

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[2] Royal College of Physicians, Tobacco Advisory Group. Ch 3. Effects of smoking on fetal and reproductive health. In: Passive smoking and children: A report by the Tobacco Advisory Group of the Royal College of Physicians. 2010 Mar

[3] Shiverick KT. Chapter 24 – Cigarette smoking and reproductive and developmental toxicity. In: Gupta RC, editor. Reproductive and Developmental Toxicology Burlington, MA: Elsevier; 2011. ISBN: 978-0-12-382032-7.

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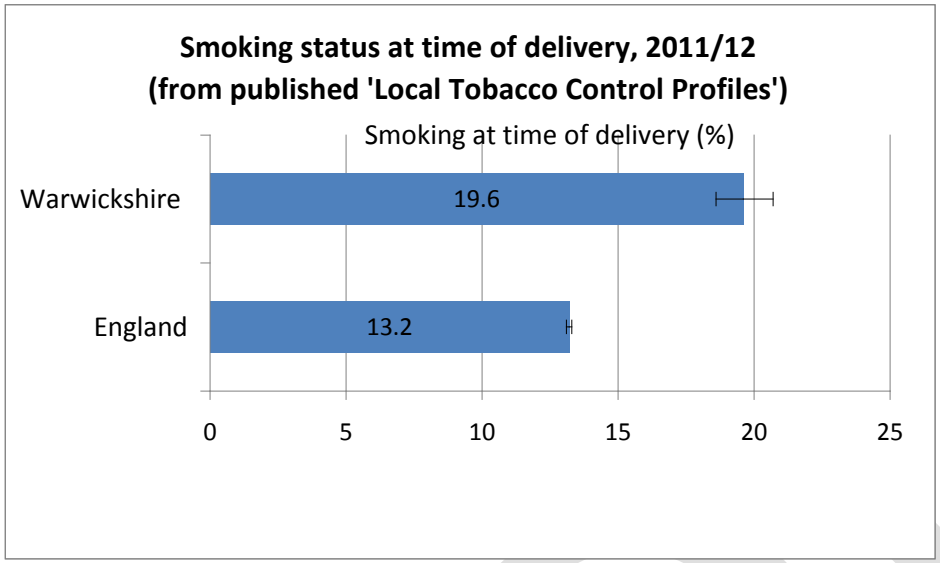
[6] Health and Social Care Information Centre. Chapter 11. Dietary supplements, smoking and drinking during pregnancy. In: Infant Feeding Survey – UK, 2010 (NS). 2012 Nov 20.

[7] Murin S, Rafii R, Bilello K. Smoking and smoking cessation in pregnancy. Clin Chest Med. 2011Mar;32(1):75-91, viii. doi: 10.1016/j.ccm.2010.11.004

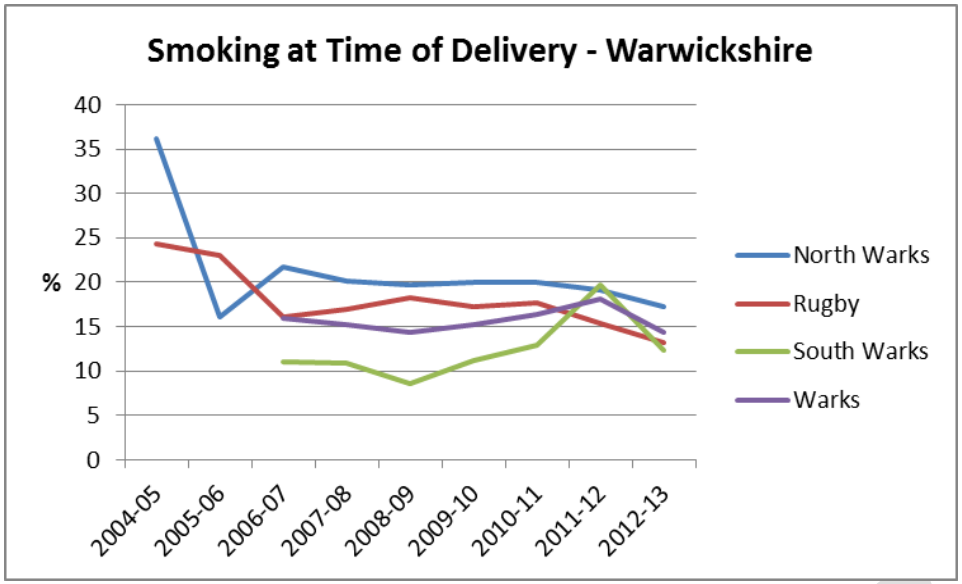
[8] Coleman T et al. Pharmacological interventions for promoting smoking cessation during pregnancy. Cochrane Database Syst Rev. 2012 Sep 12;9:CD010078. doi: 10.1002/14651858.CD010078.

Information about smoking is routinely collected from pregnant women, although there are concerns about the validity and accuracy of the data that is collected because it is a difficult time to ask questions, sometimes people feel embarrassed about the fact that they smoke and do not tell the truth and sometimes records are not updated. These variables make it very difficult to obtain the true picture. Robust audit is needed to validate the data. Nevertheless, as data is collected and published, we need to take account of this. Information from the 'Local Tobacco Control Profiles' about smoking at time of delivery for Warwickshire is shown below. This suggests a considerably higher prevalence of smoking at time of delivery in Warwickshire than nationally.



Source of data: Public Health England. Local Tobacco Control Profiles for England. [Online] Available from: http://www.tobaccoprofiles.info/tobacco-control#gid/1000110/par/E12000005/ati/102/page/3 [Accessed 14 June 2013] .

Locally collated information over a longer period of time gives a different picture, and the considerable year-to-year variation seen may reflect differences in data collection rather than real difference in prevalence.



Source of data: Public Health Manager, Warwickshire Stop Smoking Service

The following table shows how variable the reported data can be even between quarters.

2012/13	NW	Rugby	SW	Warks overall
Q1	15.85	14.5	26.21	20.27
Q2	19.26	12.12	29.37	22.1
Q3	16.88	13.79	8.68	12.59
Q4	17.07	12.37	15.33	14.64
*Year**	*17.26*	*13.19*	*19.89*	*17.4*

(*Not statistically accurate but a good indication)

Smoking during pregnancy is strongly associated with age and socioeconomic position, and contributes to inequalities in health. People in deprived circumstances are more likely to take up smoking, to start younger, to smoke more heavily and to be less likely to quit smoking, each of which increases the risk of smoking-related disease.

Smoking is the single most modifiable risk factor for adverse outcomes in pregnancy. It is therefore a shocking statistic that at least one in six babies born in Warwickshire is born to a mother who smokes.

Women who smoke should be strongly encouraged by all health professionals, and given a high level of support, to give up smoking before planning a pregnancy, or as early in the pregnancy as possible. Support should also be offered to close family members/members of the household. Given that there are also adverse effects for babies and children exposed to secondhand smoke, attention also needs to be given to ensuring that women who have succeeded in given up smoking during pregnancy are supported not to take it up again after delivery.

There are many immediate benefits of women giving up smoking in pregnancy and in the longer term we are looking towards a smokefree generation.

Warwickshire (Specialist) Stop Smoking in Pregnancy Service

Specialist Advisors to support women (and close family members) to stop smoking in pregnancy are located throughout the county.

Midwives refer pregnant smokers to this service when booking their pregnancy appointment.

They are then phoned by a Stop Smoking in Pregnancy (SSIP) Advisor to discuss the options for stopping smoking.

They can choose from stop smoking services at doctors' surgeries, pharmacies or other venues. Alternatively the Stop Smoking Pregnancy Advisor can visit them at home.

All stop smoking services provide regular support appointments over the first few months of stopping (up to and including post natal visit) and free nicotine replacement products such as patches or gum.

Smokers are up to four times more likely to stop smoking with Warwickshire NHS Stop Smoking Service than by making unsupported attempts.

Information can be obtained from and referrals can be made to the Warwickshire NHS Stop Smoking Service by phoning 0800 085 2917. Pregnant smokers can also phone the national NHS Pregnancy Helpline free on 0800 169 9 169. Lines are open from 12.00-9.00 every day offering confidential counselling for pregnant smokers who want to stop. A flexible call back service is also available.

Performance

Carbon Monoxide (CO) Testing

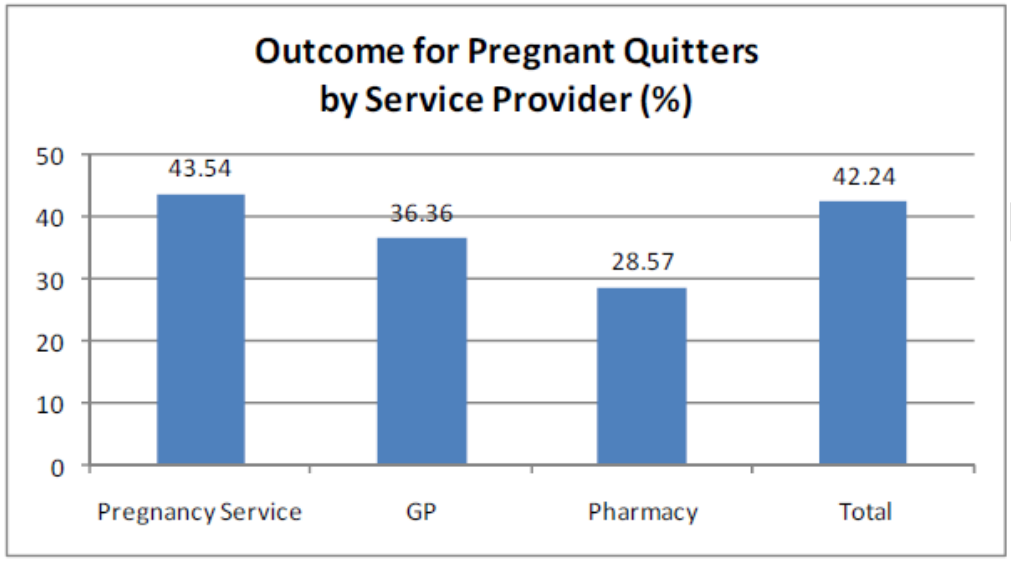
From April 2012 to March 2013 only 47% of all women who were referred to the stop smoking in pregnancy service were CO tested at booking by their midwife. Whilst this has increased from 31% last year there will be a concerted effort to get to as near to 100% as possible.

An audit carried out by public health staff earlier in the year, which used cotinine testing to determine smoking status at delivery, revealed some interesting data but numbers of tests undertaken were not sufficient to provide statistically reliable prevalence. Consideration is being given to a repeat audit. Information from other audits show that under-reporting of up to 20% is likely.

Performance Data
A breakdown of 2012/13 service performance is shown below. Out of 966 pregnant women referred to the service 322 received treatment leading to 136 successfully quit at 4 weeks.

	Total	Pregnancy Service	GP	Pharmacy
4-week quit	136	118	16	2
Not quit	117	104	11	2
Lost to follow-up	69	50	16	3
TOTAL	322	271	44	7

The majority (84%) of smoking pregnant women who entered treatment were seen by the specialist service. The specialist service also had the best quit rate (compared to other providers) In addition, helping partners and other family members to quit at the same time as the pregnant woman increases the chances of her success.



In last 18 months efforts to increase CO testing at booking have been made. This has seen a rise in the numbers of pregnant smokers being referred who have been CO tested but the level is still far short of the 100% aspirational target. Initiatives have included

- Delivery of training to Community Midwives by the SSIP service
- Provision of resources, (e.g. new A4 Tear off CO sheet)
- Regular communication between local SSIP advisors & community midwives
- Meetings with Midwifery leads to highlight CO testing
- Sharing information regularly with Midwifery leads

Midwifery bookings and CO testing for Warwick Community Midwives from April 2013 are shown below.

Month	Booking Numbers	CO Testing	Declined testing	No. of Refs	% Refs CO Tested
April	303	155 - 51%	17 - 5.6%	21 - 6.9%	8 - 38%
May	213	135 – 63%	17 - 8%	8 - 3.75%	5 – 62%
June	199	138 – 69%	24 - 12%	20 - 10%	12 - 60%
July	191	115 – 60%	25 – 13%	15 - 7.8%	12 – 80%
August	217	124 – 57%	28 - 13%	10 - 4.6%	6 – 60%
September	198	130 - 66%	17 - 8.6%	15 - 7.6%	12 – 80%
Totals	1321	797 – 60.3%	128 – 9.68%	89 – 6.7%	55 – 61.8%

Based on CO testing smoking prevalence would be just 6.7%. 524 women were not tested. 396 not known and 128 asked but declined. The assumption must be that smoking women might decline a test. Further investigations are underway but this underlines the importance of aspiring to achieve 100% CO monitoring and having a protocol for dealing with those who choose not to take the test.

Guidance

NICE's published formal guidance on how to stop smoking in pregnancy and following childbirth in June 2010 and it is in the process of producing guidance on smoking cessation in maternity care settings. When writing the recommendations, the Public Health Interventions Advisory Committee (PHIAC)

considered the evidence of effectiveness (including cost effectiveness), commissioned reports, expert testimony, fieldwork data and comments from stakeholders and experts. Full details are available from http://guidance.nice.org.uk/PH26

The evidence statements underpinning the recommendations are listed in appendix C.

The evidence reviews, supporting evidence statements and economic modelling report are also available online.

The guidance is for NHS and other commissioners, managers and practitioners who have a direct or indirect role in, and responsibility for, helping women to stop smoking when pregnant and following childbirth. This includes those working in: local authorities, education and the wider public, private, voluntary and community sectors.

NICE says all pregnant women who smoke – and all those who are planning a pregnancy or who have an infant aged under 12 months – should be referred for help to quit smoking.

This action plan below has also been influenced by the 'Smoking Cessation in Pregnancy -A Call to Action' report published in June 2013. http://www.ash.org.uk/files/documents/ASH_893.pdf which reviewed NICE's existing recommendations and considered how these could be implemented more effectively.

Recognising the difficulties and importance of tackling this issue the implementation plan has taken into account the need to provide a supportive environment and clear mandate to professionals who work in this field and to the organisations they represent. The aim is to ensure that every opportunity is taken for influencing/affecting change in terms of reducing smoking in pregnancy and the roles that each appropriate service/organisation has to do this.

It is recognised that, although pivotal to success, the Stop Smoking in Pregnancy Service is only a part of the picture and that midwifery services really form the hub of the work that is in place and/or needs to develop. It is also acknowledged that there are many other programmes that could influence the success of the drive to reduce smoking in pregnancy and in turn this action plan could have positive impacts on other programmes. Therefore, the accountability for delivery does not sit solely with the Stop Smoking Service nor with any other group or agency but is a collective responsibility of those working to improve the health and wellbeing of Warwickshire residents.

In order to ensure the following draft action plan is implemented a high-level multi-agency steering group should be convened.

In addition to carrying out the recommendations listed attention should be paid to possible joint working at a sub-regional/regional basis.

Other Context

Health Minister Dr Dan Poulter has also stated (August 2013) that consideration is being given to a national CO monitoring scheme http://bit.ly/14MEaPy. This would lead to CO monitoring being a mandatory requirement instead of 'guidance'. Warwickshire would support this.

There is some evidence[9] that general measures such as smoke free law will have some impact on preterm births. But this is not sufficient to achieve the step change in improvement desired.

In Warwickshire Births have increased by 8% over the six year period 2007-2012 (5.3% from 2008-12).

Royal College of Obstetricians and Gynaecologists state that interventions to promote smoking cessation may prevent SGA (small for gestational age) – the health benefits of smoking cessation indicate that these interventions should be offered to all pregnant women who smoke.[10]

What we want to achieve.

The Warwickshire Joint Health and Wellbeing Strategy 2012-15[11] commits to ensuring that every pregnant woman is assessed for smoking ….and helped to adopt a healthy lifestyle.

In addition to this we want to see substantial reductions in the numbers of women who smoke during pregnancy in Warwickshire leading to reduced negative health effects and an increase in the provision of smokefree homes for Warwickshire children.

By the end of March 2014 the action plan below to be ratified by the Health and Wellbeing Board and detailed responses and agreements received from those charged with specific actions. There will be a substantial increase in the awareness of smoking in pregnancy as a priority in all sectors of Warwickshire.

During the early stages of this strategy we aim to improve the process for the identification of pregnant women who smoke and in particular to offer every pregnant woman carbon monoxide monitoring at booking (with addition checks throughout pregnancy);

100% of identified smokers will be referred to the specialist stop smoking in pregnancy service and the most appropriate follow up action taken.

In addition, a consistent and appropriate training programme for professionals who have contact with pregnant women will be developed and introduced where most impact can be made.

By 2014/5, a solid data collection system would be in place providing accurate information to clinicians and population data to Public Health Warwickshire so that further progress may be monitored more accurately.

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9 Impact of a stepwise introduction of smoke-free legislation on the rate of preterm births: analysis of routinely collected birth data. Cox et al *BMJ* 2013;346:f441 doi: 10.1136/bmj.f441(14/2/13)

10 The Investigation and Management of the Small–for–Gestational–Age Fetus, Green–top Guideline No. 31 2nd Edition February 2013. Royal College of Obstetricians and Gynaecologists

11 http://www.warwickshire.gov.uk/Web/corporate/wccweb.nsf/Links/CC4F93D949591610802257A1600590B25/$file/WarwickshireJointHealthAndWellbeingStrategy-PublicConsultation.pdf (p21)

Regular monitoring of the action plan will be undertaken and reported to the Health and Wellbeing Board to ensure momentum is not lost. A detailed refresh of the plan will be undertaken after no more than two years.

Proposed Warwickshire Smoking in Pregnancy Action Plan 2013

NOTE: 'Recommendations' are those made in 'Smoking Cessation in Pregnancy - A Call to Action'

Theme	Recommendations (abridged) and where appropriate amended *in italics*	Local Action in Warwickshire	Who	Action by (timescales)	Outcomes
Data Collection	1 Data on smoking status, collected at booking visit and throughout pregnancy, is recorded accurately *for 100% of pregnant women* and *95%* validated using CO screening.	Clinical commissioning groups (CCGs) will include this requirement in service specifications and sanctions imposed if not achieved (Looking for all to be CO tested first, then the result checked verbally)	CCGs working with Public Health/WSSS	April 2014	More accurate monitoring of smoking in pregnancy.
	2 NHS England should consider whether continuing to collect Smoking at time of delivery (SATOD) data is the best way of measuring smoking in pregnancy. (Alternatives suggested)	CCGs through commissioning intentions and the contract process should aim for the collection of as near to 100% accurate a measure of smoking prevalence at delivery and all practicable stages of pregnancy as possible (Recognising the limitations of SATOD)	CCGs working with Midwifery	TBC	More accurate monitoring of smoking in pregnancy. Increase in women referred for smoking cessation,

Theme	Recommendations (abridged) and where appropriate amended *in italics*	Local Action in Warwickshire	Who	Action by (timescales)	Outcomes
Data Collection (Continued)		and to use alternative measures (such as audit overseen by Public Health Warwickshire - PHW) as a means of validating prevalence. Consideration be given to the 'Blackpool' method of data collection at 36 weeks.	Smoking in Pregnancy Steering Group/WSSS	March 2014	Alternative method of determining levels of smoking in pregnancy.
	3 NHS England should work with Public Health England and the Health and Social Care Information Centre to produce a briefing document, outlining best practice for collecting the new maternity and children's data set.	Warwickshire Health Economy to adopt best practice and to inform the consultation on the CHIMAT data.	All relevant organisations	TBC	Consistent measuring and benchmarking possible
	4 Once data collection is of a consistent and high standard trusts with high or unchanging rates of smoking in pregnancy to be targeted for additional support.	Quarterly data to be shared with the Heads of Midwifery and actions to be agreed to address smoking in pregnancy. Other actions will depend on results of	PHW	March 2015	Targeted action and resources to achieve improvement

Theme	Recommendations (abridged) and where appropriate amended *in italics*	Local Action in Warwickshire	Who	Action by (timescales)	Outcomes
		data collection.			
	5 Clinical/medical directors/*Heads of Midwifery* should ensure that systems are in place to facilitate the collection and recording of CO readings during antenatal appointments.	Review of processes to be undertaken and amendments to systems where necessary to make recording easier to do and harder to avoid. Quarterly monitoring to take place including feedback to Heads of Midwifery. Consideration be given to sanctions where non-compliance known and not addressed by organisations or individuals.	Trusts supported by CCGs/PHW/WSSS	March 2014	Accurate assessment of smoking status
	The Health and Social Care Information Centre should provide aggregated SATOD data at NHS trust level, to enable trusts to benchmark themselves against one another.	Benchmarking to be carried out when data comparable. Consider using 'Blackpool' method of data collection	PHW	TBC	Benchmarking using accurate data
Implementing NICE Guidance **a) Audit and implementation of**	1. NHS England, in partnership with NICE, should commission an audit to investigate the extent to which the NICE	Local audit of implementation of NICE Guidance to inform further commissioning of smoking in pregnancy	PHW/WSSS	March 2015	Compliance with NICE guidance and better outcomes for

Theme	Recommendations (abridged) and where appropriate amended *in italics*	Local Action in Warwickshire	Who	Action by (timescales)	Outcomes
guidelines	guidance has been implemented locally and support areas found not to have acted on the recommendations.	and maternity services in conjunction with CCGs			pregnant women
	2. Government organisations (including the department of health, NHS England and Public Health England), relevant royal colleges and baby and parenting charities should coordinate a programme of work to promote and endorse the NICE guidance.	Local promotion of the content and purpose of NICE guidance through clinical groups and Specialist Smoking in Pregnancy Service outreach	CCGs/Midwifery Trusts/ PHW/WSSS	March 2015	Compliance with NICE guidance and better outcomes for pregnant women
	3 There should be commitment from senior staff at a local level to ensure that the NICE guidance is fully implemented	Clear plan in place for review and the adoption and roll out of NICE guidance with all relevant partners (midwives, relevant doctors, nurses, administration staff, pharmacists and those working in the voluntary/community sector) to be encouraged to be engaged with the	Director of Public Health, heads of midwifery, clinical/medical directors and Trust Chief Executives	September 2014	Compliance with NICE guidance and better outcomes for pregnant women

Theme	Recommendations (abridged) and where appropriate amended *in italics*	Local Action in Warwickshire	Who	Action by (timescales)	Outcomes
		guidance. Appropriate clauses should be included in relevant Warwickshire Contracts and appropriate sanctions taken where non-compliance noted.			
b) Identifying and Referring Smokers	4. CCGs and local authorities should work in partnership to ensure that there is an effective and robust referral pathway for pregnant smokers.	Review existing pathways and amend where necessary. Appropriate clauses should be included in relevant Warwickshire Contracts (including Health Visitors ; Family Nurse Partnership etc)	PHW/CCGs/WSSS/Trusts/NHS C LAT	March 2015	Strengthening of contracts to ensure Smoking in pregnancy is treated as priority.
	5 Providers should ensure that CO monitors are provided for all midwives and that clear procedures are in place for training of staff and for the regular calibration of the CO	Monitors are already provided but use to be reviewed and mandated. Appropriate clauses should be included in relevant Warwickshire Contracts. through	WSSS/ Trust clinical/medical directors and heads of midwifery)/CCGs	March 2015	Strengthening of contracts to ensure Smoking in pregnancy is treated as priority.

Theme	Recommendations (abridged) and where appropriate amended *in italics*	Local Action in Warwickshire	Who	Action by (timescales)	Outcomes
	monitors.	working with CCGs			
	6 Requirement in service specifications that midwives discuss smoking status at booking with all women and that all women are *offered* screening for CO. Midwives should give very brief advice on cessation to identified smokers and promptly refer a minimum of 90% of those with a CO score of, say, 4 or higher (depending on make of CO machine) to local stop smoking services. CO screening should be done in the first booking visit and throughout a woman's pregnancy. Providers should ensure that midwives are given the time, training and tools to do this; and should develop procedures to performance manage the process.	Requirements are already in service specifications but need supporting. There is an aspiration for 100% CO monitoring and recording of smoking status but targets would need to be set appropriately to avoid 'gaming' or unintended consequences. A protocol need to be developed for how to deal with clients who decline the test and those who have high CO readings but claim to not smoke. MECC Training to extend to Smoking in Pregnancy	PHW/CCGs WSSS/PHW PHW (MECC lead) Maternity Service Managers	March 2014 March 2014 September 2014 March 2014	Improved monitoring of CO at all stages of pregnancy. Protocol developed and agreed Smoking in Pregnancy included in MECC where appropriate. Improved referral rates

Theme	Recommendations (abridged) and where appropriate amended *in italics*	Local Action in Warwickshire	Who	Action by (timescales)	Outcomes
		Warwickshire has an 'opt out' service but this needs higher % of referrals following higher percentage of CO testing. All women who say they smoke and all those identified as smoking by the CO reading should be referred. Provision for training (including myth-busting sessions) and development of mandatory training programme Review clauses included in Warwickshire Contracts to consider possible action where smoking status of pregnant women not being determined by clinical staff.	WSSS/ Trust clinical/medical directors and heads of midwifery) PHW	September 2014 March 2015	Training programme developed and being implemented for key staff Robust monitoring of actions

Theme	Recommendations (abridged) and where appropriate amended *in italics*	Local Action in Warwickshire	Who	Action by (timescales)	Outcomes
		(See also 'training' – below)			
	7. Health and Wellbeing Boards should ensure that all those responsible for providing health and support services *(including commissioned services)* for pregnant women and young families are sufficiently equipped to enable them to identify smokers, raise awareness of the benefits of stopping, and offer referrals to local stop smoking services. They should also be supported to raise awareness of the dangers of secondhand smoke, identify partners and household members who smoke and advise that they receive support to quit from a local stop smoking service.	Warwickshire H&WBB to endorse Action Plan and encourage action from wider community including but not exclusively • Pharmacists • Baby food/clothing retailers • Children's Centres • WCC/Districts and Boroughs through Priority Families; Housing and benefits work • Relevant charities (e.g. 'Tommy's'*) • Schools and	PHW plus action from commercial and third sector organisations	November 2013	High level commitment to achieving aims of strategy

Theme	Recommendations (abridged) and where appropriate amended *in italics*	Local Action in Warwickshire	Who	Action by (timescales)	Outcomes
		PSHE • Social Care and other public health practitioners e.g. HVs/ FNP • GPs *Note: In November 2012 a session was held for Tommy's staff across Warwickshire covering brief interventions on smoking issues, including general smoking cessation interventions, smoking in pregnancy interventions and Smokefree homes.			
c) Local Stop Smoking Services	8. Local authority commissioners and stop smoking services should ensure that there is sufficient expertise available to meet the needs of all pregnant smokers and ensure that there is a requirement of the commissioned service	The WSSS has specialist advisors but if additional demand is generated the capacity of the service should be kept under review. This can be partly controlled by referral into general adult services where	PHW	December 2013	Identification of ways to improve capacity with limited resources

Theme	Recommendations (abridged) and where appropriate amended *in italics*	Local Action in Warwickshire	Who	Action by (timescales)	Outcomes
	to involve customers. The local authority commissioners should demonstrate the involvement of women in the development and review of services, and review whether their needs have been met to inform the JSNA and further commissioning of the service	appropriate. The service will be reviewed as part of the strategic commissioning review process across public health Customer involvement surveys to be undertaken. (Possible development of reference panels) Oversight should be via H&WBB/JSNA	WSSS/PHW PHW/WSSS	March 2015 September 2014	Service fit for purpose and best value. Learning from customer experiences
	9. Local authority commissioners should include a requirement in service specifications that all women are phoned by the local stop smoking service within one working day (24 hours) of receiving a referral and seen within one week.	Referral pathway to be reviewed and implemented to comply with recommendation. (NOTE: Due to current working practices; team locations and limitations of technology Warwickshire is not able to comply with 24hr rule at this point but text	PHW/WSSS	September 2014	Improved response times to referrals

Theme	Recommendations (abridged) and where appropriate amended *in italics*	Local Action in Warwickshire	Who	Action by (timescales)	Outcomes
		options being tested in Rugby and are working well (Nov 13). Training for midwives has more emphasis on midwives phoning through referrals to the 0800 number so these can be picked up quickly.			
	10. Local stop smoking services should offer intensive support programmes for pregnant smokers up to the point of delivery and up to two months post-partum (or longer if appropriate to prevent relapse).	Specialist provision is resourced for quitting smoking but not post-partum. A response to this recommendation within limited resources to be developed including the consideration of health visiting/ FNP continuing smoking cessation support after delivery. (NOTE: FNP already engaged and positive)	PHW/WSSS	September 2014	Improved health outcomes post-delivery (including smoke free homes)
c) Local stop smoking services (Cont)	11. Local authorities and the NHS should follow the NICE smoking in pregnancy guidance on NRT provision.	Service specification encourages use of NRT in quitting but the evidence for this treatment needs to be publicised with relevant	WSSS/CCGs	March 2014 (and ongoing)	Evidence based (and safe) practice

Theme	Recommendations (abridged) and where appropriate amended *in italics*	Local Action in Warwickshire	Who	Action by (timescales)	Outcomes
		health professionals especially GPs/ midwives through training.			
Training	1. There should be implementation of the NICE guidance: all midwives, and other health professionals working with women who smoke while pregnant, should have training on smoking cessation that is appropriate to their role.	Training is offered by WSSS but others have role in ensuring release of staff to attend and mandating of training as part of core offer. Appropriate clauses should be included in Warwickshire Contracts where appropriate.	Maternity Service Managers, PHW and relevant professional bodies and organisations; CCGs.	March 2015	Robust system for training key staff.
Training (continued)	2. The Nursing and Midwifery Council should specify that mandatory education on smoking in pregnancy and brief intervention training for all midwives be provided as part of their pre-registration training and continued professional development.	Support for this recommendation to be encouraged from all Warwickshire partners. Note: There is the on-line 'Very Brief Advice (VBA) & VBA on Secondhand Smoke and NCSCT Briefing for midwives/other health professionals. Warwickshire could work towards minimum	PHW; WSSS; Maternity Service Managers and relevant professional bodies and organisations. ?H&WBB WSSS	TBC	Professional recognition of importance of smoking in pregnancy

Theme	Recommendations (abridged) and where appropriate amended *in italics*	Local Action in Warwickshire	Who	Action by (timescales)	Outcomes
		mandatory VBA training on-line plus face to face training for midwives and other key staff.			
	3. To ensure that midwives are competent in discussing smoking with women and delivering CO screening.	As part of MECC and specialist smoking cessation training all midwives and maternity support workers undertake regular training and are adequately resourced to equip themselves to raise the issue of smoking with women.	PHW; WSSS; Maternity Service Managers and relevant professional bodies and organisations.	March 2015	Training packages available for all staff to improve practice and knowledge
	4. Health Education England should ensure that all practitioners who assist pregnant women to stop smoking are provided with appropriate evidence-based training resources that allow them to address the core competencies required in providing effective smoking cessation advice.	Training supported through commissioning routes with additional support from Warwickshire Public Health working with Health Education England	PHW; WSSS; Maternity Service Managers and relevant professional bodies and organisations. PHE	March 2015	Training packages available for all staff to improve practice and knowledge
	5. Local commissioners should ensure that all	CCG/PHW to develop targets for local training.	CCGs/PHW/WSSS	March 2015	Validated training

Theme	Recommendations (abridged) and where appropriate amended *in italics*	Local Action in Warwickshire	Who	Action by (timescales)	Outcomes
	practitioners who assist pregnant women to stop smoking are sufficiently trained, achieving full NCSCT certification and completing the NCSCT specialty pregnancy online module, or training to an equivalent standard. There should also be mandatory targets for the numbers of staff trained to this level.	Appropriate clauses should be included in Warwickshire Contracts. Discussions will need to be initiated regarding the validation of training under the new system (i.e. post-consortia).	PHW/PH Coventry		packages available for all staff to improve practice and knowledge
	6. Brief intervention training should be undertaken by doctors, nurses, health visitors, administration staff, sonographers and other medical practitioners who work with pregnant women. medical royal colleges, Health Education England, the National Centre for Smoking Cessation and Training*, service managers and voluntary organisations – among others – have a role to play in promoting the uptake of this training.	Once training regime agreed, multi-agency/professional promotion of provision to take place. Particular regard to be taken wrt NRT use in pregnancy Discussions will need to be initiated regarding the validation of training under the new system (i.e. post-consortia).	CCGs/PHW/ WSSS PHW/PH Coventry	March 2015	Importance of smoking in pregnancy training promoted to all relevant staff

Theme	Recommendations (abridged) and where appropriate amended *in italics*	Local Action in Warwickshire	Who	Action by (timescales)	Outcomes
	7. Service managers should ensure that there are good role models available to support colleagues through support and supervision. Less experienced staff can learn through mentoring, gaining experience in how to talk to women and interpreting different CO readings	Identification of Smoking in Pregnancy Champions.	WSSS	September 2015	Identified 'champions' in all key agencies promoting smoking in pregnancy as a priority
Communication between health professionals	1. Public Health England should identify a senior officer to champion efforts to reduce smoking in pregnancy, working across sectors to ensure that every opportunity to tackle smoking in pregnancy is taken.	Warwickshire response TBC but in general this would be supported.		TBC	
	2. Health and Wellbeing Boards should prioritise reducing the prevalence of smoking during pregnancy, ensuring that *(through the commissioning process)* there are clear and	Smoking in Pregnancy to be acknowledged as priority. Report scheduled for November 2013	PHW	November 2013	Smoking in Pregnancy acknowledged as a priority by all agencies.

Theme	Recommendations (abridged) and where appropriate amended *in italics*	Local Action in Warwickshire	Who	Action by (timescales)	Outcomes
	streamlined pathways in place to identify and support pregnant smokers, and that services meet the needs of the local population.				
	3. Public Health England should work with Royal Colleges and other professional organisations to ensure that there are national mechanisms in place to enable professionals to offer one another support and share good practice in reducing smoking in pregnancy	Warwickshire response TBC		TBC	
	4. Stop smoking services should develop close working links and cross referral pathways with third sector organisations at community level who provide on-going support and advice to young families and young women.	Increase involvement of Children's Centres and other relevant organisations including (but not exclusively) Pharmacists; charities and others who work with pregnant women and/or women of child bearing age.	WSSS + Relevant third sector organisations.	September 2013	Third sector agencies engaged in delivery of smoking in pregnancy plan
	5. The Smokefree Action Coalition (SFAC) should	Warwickshire response TBC. Note:	PHW	March 2014	Smoking in Pregnancy

Theme	Recommendations (abridged) and where appropriate amended *in italics*	Local Action in Warwickshire	Who	Action by (timescales)	Outcomes
	consider how it can encourage action to reduce smoking in pregnancy	Warwickshire is a member of the SFAC			incorporated in wider tobacco control plans
	6. The CLeaR partnership should review items in the CLeaR model to ensure that smoking in pregnancy is considered comprehensively across local government services and policy.	Warwickshire is a member of the CLeaR partnership and Smoking in Pregnancy will be a key p[art of the impending CLeaR Assessment (As part of the re-launch of the local smoke free alliance)	PHW	March 2014	Smoking in Pregnancy incorporated in wider tobacco control plans
	7. Offices of Tobacco Control (OTC), where they exist, should continue to support their region to reduce smoking in pregnancy levels by developing protocols, encouraging partnership working and sharing good practice.	Warwickshire response TBC. There is no Office of Tobacco Control in the West Midlands but this can be mitigated for by utilising connections with OTC in other regions and the Tobacco Control Collaborating Centre.	PHW	TBC	Shared resources with other areas.

Theme	Recommendations (abridged) and where appropriate amended *in italics*	Local Action in Warwickshire	Who	Action by (timescales)	Outcomes
	8. The National Screening Committee should consider CO screening as part of its antenatal screening programme.	Warwickshire response TBC but as a minimum to advocate for screening to be adopted as part of programme.	PHW	TBC	Screening part of antenatal programme
		Additional 'communication with health professionals' strategy to be developed to ensure that consistent messages are being given to relevant staff such as – NRT use in pregnancy; importance of accurate recording of smoking status (current position not acceptable) it is to be expected that midwives will identify teratogenic and harmful substance abuse, as part of assessment and prenatal reviews. A 'zero tolerance' attitude is being adopted about this issue, from raising and asking the question, to CO monitor use, to data	PHW/Commissioners/WSSS in conjunction with WCC and other Communications Leads	March 2014	Communications plan for professionals developed.

Theme	Recommendations (abridged) and where appropriate amended *in italics*	Local Action in Warwickshire	Who	Action by (timescales)	Outcomes
		collection and collation.			
Communication with the Public	1. Member organisations of the Challenge Group, in partnership with the Department of Health and Public Health England, should agree a consistent set of messages to inform professional bodies, parents, training providers, and other members of the voluntary sector on the key issues in smoking in pregnancy. Baby and parenting charities should take a lead on producing and disseminating these messages	Messages disseminated by Warwickshire Organisations should match those generated nationally. Links to be made with locally relevant Baby and Parent Charities. Specific use of WCC and other partner resources (such as links with Community Organisations to be explored).	ALL PHW/WSSS WCC Localities	Ongoing September 2014 September 2014	Consistent messages delivered Involvement of third sector in development of plans Improved use of community resources
	2. The importance of CO screening should be communicated both to pregnant women and	Utilise national resources to enhance those already in use.	WSSS	Ongoing	Consistent and cost-effective use of national

Theme	Recommendations (abridged) and where appropriate amended *in italics*	Local Action in Warwickshire	Who	Action by (timescales)	Outcomes
	professionals, particularly midwives, through the development of two new resources outlining the dangers of CO.				campaigns
	3. Public Health England should build and expand upon the Start4Life brand, ensuring that all pregnant women are aware of the risks of smoking in pregnancy, the benefits of quitting, the support available to help them quit, and the importance of CO screening.	Local Promotion of Start4Life	PHW/WSSS	Ongoing	Consistent and cost-effective use of national campaigns
	4. Comprehensive, multi-agency, communications strategy to highlight the importance.	Warwickshire will support national campaigns. In addition specific local campaign will be commissioned (e.g. Pharmacy campaign planned for February 2014 with Healthy Living Pharmacies)	ALL esp. WCC comms. PHW, WSSS, WCC comms	Ongoing	Consistent and cost-effective use of national campaigns

Theme	Recommendations (abridged) and where appropriate amended *in italics*	Local Action in Warwickshire	Who	Action by (timescales)	Outcomes
	5. Digital interventions should be part of the development of future communication strategies for women who smoke during pregnancy to ensure the most effective (and cost-effective) interventions are in place across England.	Warwickshire will support national campaigns and utilise digital networks within county. All partners will be encouraged to carry messages and signpost from their respective websites/intranets.	ALL esp. WCC comms.	Ongoing	Consistent and cost-effective use of national campaigns and use of local resources (especially digital media) to enhance message delivery
	6. Where there is strong evidence to support an effective intervention, this should be commissioned and implemented. This is the responsibility of Clinical Commissioning groups, Local Authorities and local stop smoking services.	Integrated evidence-based commissioning will take place.	CCGs/PHW	March 2015	Evidence based practice commissioned
	7. Where it is known that a woman is trying to conceive, health professionals and others who have contact with her should identify the woman's smoking status, offer very brief advice if	Referral pathways and MECC campaign to be specifically used to promote early quit attempts in women (and their partners) trying to conceive. Should also be considered in workplace	WSSS/PHW/ LPC/ Health Living pharmacies	March 2014	Referral pathways developed and used leading to increased numbers of referrals.

Theme	Recommendations (abridged) and where appropriate amended *in italics*	Local Action in Warwickshire	Who	Action by (timescales)	Outcomes
	she smokes, and refer her to stop smoking services.	(maternity care)			
Additional Actions		Smoking in Pregnancy to be a priority theme for the revitalised Smoke Free Warwickshire (SFW) Alliance	SFW	March 2014	SFW alliance members committed to SIP as a priority and monitoring of strategic actions undertaken
		Increase provision of smokefree homes through campaigns and personal advice to pregnant women; their partners and families.	SFW/Midwives/Others who visit client homes	Action plan June 2014	Clarity over methodology for promoting smoke free homes and increased promotions
		Influence the PHSE agenda to include information on the effects of smoking on pregnant women and foetuses.	SFW/School Nurses/ Head of Learning and Education	September 2014	Agreed plan of action
		Consideration be given to ways in which workplace health promotion can include smoking in pregnancy	PHW	June 2014	Plan of action developed.

Theme	Recommendations (abridged) and where appropriate amended *in italics*	Local Action in Warwickshire	Who	Action by (timescales)	Outcomes
		messages			

NOTE: For Public Health Warwickshire (PHW) also read Stop Smoking Commissioner (Group Manager: Community Safety and Substance Misuse).

WSSS – Warwickshire Specialist Stop Smoking Service.

SFW – Smokefree Warwickshire

* The NCSCT specialty module Pregnancy and the Post-Partum Period is available via their website to all practitioners who have already passed the Stage 2 Assessment and have Full NCSCT Certification. This module is intended for anyone who helps pregnant smokers stop smoking.

It provides:

- information on the health effects of smoking in pregnancy and the post-partum;
- evidence showing the benefits of cessation and effective methods to help pregnant women to stop smoking;
- guidance on best practice in assisting pregnant women to stop smoking;
- links to useful resources
- 'test yourself' questions

The module also includes an assessment. This consists of 20 multiple choice questions and the pass mark is 70%.

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Warwickshire Health and Wellbeing Board

20 November 2013

Winter Pressures & Feel Well Campaign – Agencies Working Together and Building Resilience

Authors:

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Purpose: To update and request support from the Warwickshire Health and Wellbeing Board with regard to current multi-agency resilience arrangements for winter, including public winter campaigns.

Winter Resilience in Health and Social Care:

An exercise was held on 6th November 2013 (Exercise Paladin) in Leicester, with the aim of testing primarily NHS, but also multi-agency emergency arrangements (local authority public health representative participated). The exercise related to a mass casualty and chemical release event (related to a train crash) at a time when the health and social care economy was experiencing winter pressures due to persistent cold weather. A common theme identified by agencies attending the exercise was the need to work on a mechanism for

agreeing PHE and NHS communications to the public and to health providers in the context on a major incident (full report to be published on 18th December). A second event is planned for the 21st November, relating to winter pressures and the operational impact of Norovirus outbreaks. The Local Health Resilience Partnership and NHS England Local Area Team are assuring NHS provider plans and Local authority planning for winter pressures. Local authority public health teams are convening a cold weather multi-agency communications group (including colleagues from NHS England, CCGs, Public Health England and Local Government), with a remit for ensuring consistency of both professional and public messaging/alerting during the winter, and ensuring compliance with the National Cold Weather Plan and the Warwickshire Cold Weather Plan. Business continuity plans are in place for all social care services including commissioned services.

Upstream Resilience: Feel Well, Norovirus and Warm and Well campaigns

The "Feel Well' campaign is being launched through the partnership efforts of the Clinical Commissioning Groups, the Arden Commissioning Support Unit, secondary care Provider Trusts and the Public Health Departments in Coventry and Warwickshire.

The campaign will be delivered through a variety of media and engagement events. Messages include ensuring that all those who are eligible receive their flu vaccination, and the importance of good hand hygiene in the wintertime due to circulating viruses such as Norovirus and colds/flu. Advice is given about staying warm and active, avoiding falls and ensuring individuals have sufficient supplies of food, drink and regular medications in the home. The campaign also aims to support people to access health advice appropriately, giving details of the range of sources of advice available, with a view to reducing pressure on A&E.

Complementary campaigns related to Norovirus prevention, led by South Warwickshire Foundation Trust (SWFT), are also being launched. Hand hygiene posters (adapted from SWFT materials) are to be

cascaded out to nursing and residential homes, as well as nurseries and schools through the efforts of Public Health Warwickshire. Warm and Well activities (led by the Warwickshire Warm & Well Partnership Board) are being taken forward on a multi-agency basis. Warm and Well thermocard leaflets are being distributed to GP surgeries to be given to vulnerable patients, as well as vulnerable patients identified by social care colleagues. It is envisaged that these leaflets will also be distributed through the county wellbeing hubs, through housing officers, hospital discharge teams and the ambulance service (pending agreement). Further distribution will be advised upon by the Affordable Warmth Steering Group. Warm and Well messages include simple advice and guidance of steps to take in keeping homes warm in the winter, and signposting to an advice line (run by Act on Energy Freephone 0800 988 2881) who can advise on how to reduce fuel bills and make homes more energy efficient. Advice regarding how to claim winter fuel and cold weather payments, as well as details of other relevant financial support is given.

Seasonal Flu Vaccination Campaign

As part of the assurance role for flu vaccination, Warwickshire County Council are working closely with NHS partners to maximise uptake of flu vaccination across all groups, particularly focusing on groups with lower uptake historically (clinically at risk adults and children, pregnant women, carers and health and social care staff).

Flu vaccination has been promoted via a range of media (including radio and television), with a particular focus on opportunities provided by local authority links. Promotional materials have been sent out to GPs, pharmacies, libraries and sports centres. Support for the campaign has also been sought from school (including special school) head teachers. The importance of ensuring informal carers are vaccinated has been raised with carers' groups and an antenatal promotional campaign is due to be launched.

Pharmacy vaccination vouchers have been distributed to all local authority directly employed social care staff who provide personal care. Letters have been written to care home and home care service managers regarding the responsibility to ensure their staff are adequately vaccinated, facilitated by the Strategic Commissioning Unit of the People Group. CCG colleagues have been asked by NHS England colleagues to request assurance from their providers that their front-line staff are being offered vaccination, and that this is being treated as a priority.

It is planned to rigorously evaluate the campaign in Warwickshire (and Coventry) this year, with a view to identifying personal and professional barriers to vaccination uptake, and understanding how those partners involved in the campaign would like to be supported in future campaigns.

Recommendations to Health and Wellbeing Board

1) To note that adequate major incident, winter pressures response and business continuity plans are in place and tested for the winter.
2) To promote uptake of seasonal flu vaccination among any staff who are in clinical risk groups, and employed health and social care staff who provide direct personal care.
3) To consider how we can further the reach of the Warwickshire Warm and Well Messages within the most vulnerable groups, e.g. scope for working with hospital discharge teams, housing officers etc. Support with providing contacts would be appreciated.
4) To consider the response the Health and Wellbeing Board might like to make with regard to the recent disproportionate increases in the price of fuel initiated by fuel companies recently.

Item 6

Warwickshire Health and Wellbeing Board

20 November 2013

Autism Self-Assessment Framework (SAF) 2013

Recommendations

For the content of the Autism SAF 2013 to be discussed at the Health & Wellbeing Board.

1.0 Background

1.1 During August 2013, the Department of Health requested that each local authority complete a second self-assessment to mark progress on the implementation of the 2010 Adult Autism Strategy. It was recommended that the content of the SAF be discussed at the local Health and Well Being board prior to end of January 2014. This local self-evaluation will be used as evidence for local planning and health needs assessment strategy development as well as supporting local implementation work.

1.2 This exercise builds on the first self-assessment exercise which looked at what progress had been made since February 2012. This was based around the self-assessment framework which the Department of Health launched in April 2011 to support localities with the delivery of the Adult Autism Strategy and the statutory guidance for health and social care which was issued in December 2010. The individual returns received and related reports from February 2012 can be found at www.improvinghealthandlives.org.uk/projects/autsaf2011.

1.3 The purpose of this year's self-assessment was to:

- assist local authorities and their partners in assessing progress in implementing the 2010 Adult Autism Strategy;

- see how much progress has been made since the baseline survey, as at February 2012;

- provide evidence of examples of good progress made that can be shared and of remaining challenges.

2.0 Process

2.1 Written notification was received from Norman Lamb on 2 August, an online template was made available and hosted by the IHAL (Improving Health & Lives) Observatory. The deadline for the final submission was **30 September 2013.**

2.2 The self-assessment template consisted of 37 questions divided into 9 sub sections:

- Local authority area
- Planning
- Training
- Diagnosis led by the local NHS Commissioner
- Care & Support
- Housing & Accommodation
- Employment
- Criminal Justice System
- Self Advocate stories – (optional) up to five stories.

2.3 For some questions there was a RAG rating system (Red, Amber, Green) including a scoring criteria. This enabled respondents to highlight areas where progress was limited as well as an opportunity to report actions which have enabled progress. Good practice examples & self advocate stories were also encouraged where actions had made a positive impact on individuals' lives.

3.0 Warwickshire's response.

3.1 Responsibility for consolidation of data and completion of the Autism SAF sat with each local authority, with the 3 Warwickshire CCGs and Arden Cluster Commissioning Support Unit invited to contribute.

3.2 For those questions where RAG ratings were required, no Red ratings were identified and the majority of ratings were either Amber or Green.

3.3 Some examples of green ratings include:

- Engaging people with autism and their carers in planning
- Autism awareness training made available to all staff working in health & social care settings.
- Advocacy services – advocates receiving specific training to work with people with autism. People with autism having access to advocacy services.
- Transition processes to adult services having an employment focus.

3.4 Some areas which highlighted where further actions or improvement is needed include:

- Improving data collection methods for capturing information on numbers of adults with autism in Warwickshire. Possibility of developing an autism register following diagnosis.
- Establishing closer links & engaging more effectively with the Criminal Justice System (CJS) in regard to autism awareness and supporting people with autism through the CJS.

3.5 Areas of work where marked progress is being made include:

- Development of diagnostic pathway for adults with autism – working jointly with Coventry City Council & CCGs. Including exploring E-learning opportunities for GPs and development of an online Autism portal.
- All Age Autism Strategy (2014-2017) – in second phase consultation stage, scheduled for sign off by cabinet in March 2014, followed by the development of an Autism Partnership Board.
- Autism Needs Assessment - recently completed and to be included in Warwickshire's JSNA.
- Autism Trainer programme – working with 15 adults with autism and family carers to become co-facilitators of autism awareness training to frontline health and social care staff. 6 month pilot running from Sept 2013- March 2014.

- Practitioner training (Working with people with autism – Skills for Multi-disciplinary Practitioners) working jointly with Coventry City Council.
- Safe Places Scheme – phased rollout across Warwickshire. Over 60 Safe Places already established in Warwick/Leamington, Stratford and Rugby with the next 3 month pilot in Nuneaton and Bedworth launched on 4 Nov and North Warwickshire scheduled for March 2014.

3.6 The implementation of the All Age Autism strategy from March 2014, will address the majority of the amber ratings through future commissioning intentions which would improve overall ratings in preparation for next year's self-assessment process.

3.7 Prior to submission on 30 September 2013, the contents of the SAF was presented to a group of people with autism and family carers who ratified the ratings.

4.0 Background Papers

1. Warwickshire's completed Self Assessment 2013 (PDF) document.
2. Update on development of Warwickshire's All Age Autism Strategy.

	Name	**Contact Information**
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Portfolio Holder	Cllr Josie Compton	

Warwickshire's All Age Autism Strategy (2014-2017)

Warwickshire's All Age Autism Strategy provides a real opportunity for the needs of people with autism and their carers to be recognised and ensure that they have the same opportunities as everyone else.

The strategy aims to provide a clear and consistent joined up approach to support throughout a person's life. It also highlights the importance of personalised services and support offering individual's more choice and control, with a particular emphasis on a clear plan and support when moving from children's to adult's services.

A comprehensive public consultation was conducted during March - May 2013 which provided an ideal opportunity for the citizens of Warwickshire to inform and shape the strategy.

A range of innovative methods of engagement were used to obtain views from a broad and diverse range of people including children and adults with autism, their families, social care and health professionals, service providers, as well as the general public on a number of key themes.

These methods included:

- **Twitter** – on line social media which not only promoted and publicised the consultation but also provided an opportunity for people to put forward their views. **We had 42 tweets and 120 followers.**

- **Questionnaires** – two questionnaires were co-produced with adults with Asperger Syndrome. An under 16 year's version which was pictorially supported to appeal to children and younger adults and a generic version which anyone could complete. Both versions were available in paper format and on line on the council consultation website. In total we received **343** questionnaires **– 75 Under 16 year's surveys & 268 generic surveys.**
- **Visits to four local support networks** – provided an excellent opportunity to have more in depth 1:1 dialogue with people with autism and their families.
- **Creative Consultation** – an artist was commissioned to work with **147 children and young adults within 11 Warwickshire and Coventry non mainstream schools and colleges,** using art as a way of obtaining views and opinions and posing a key question, 'What's important to me?'.

As part of the consultation, the on-line & paper versions of the surveys asked respondents if they would be interested in getting involved with opportunities to implement and monitor the strategy. We received a really positive response with over **120 people expressing an interest**.

Following phase one of the 3 month public consultation (March-May 2013), responses received from the various methods of consultation and engagement were collated and analysed.

These responses highlighted a number of key emerging themes which have set the direction for **seven** strategic objectives including:

- Develop a clear & consistent pathway including offer of support following diagnosis.
- Increasing Awareness & Understanding of autism.
- Education, Learning & Development.
- Transition into adulthood.
- Access to services & support.
- Community Life (Social Inclusion, Housing Support & Keeping Safe)
- Support for carers & families of people with autism.

Each objective outlines views collected during the consultation and future commissioning intentions which will be implemented, monitored and reviewed during the lifetime of the strategy.

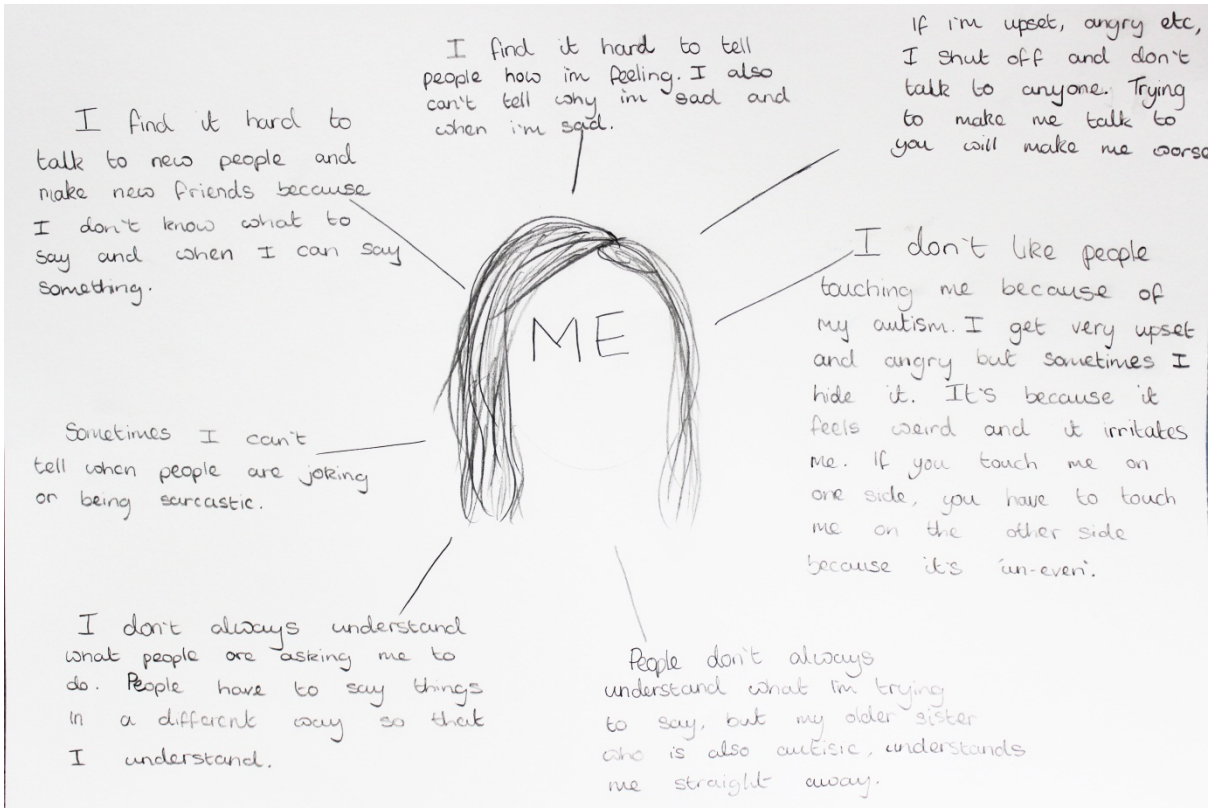
Phase two consultation process is currently underway; it started on Monday 21st October and will run until Friday 29 November 2013. The aim of this consultation is to check with respondents whether we have interpreted their views correctly and also share with people how we propose to respond to their views highlighting proposed commissioning intentions within the strategy using 'You said…we will' methodology.

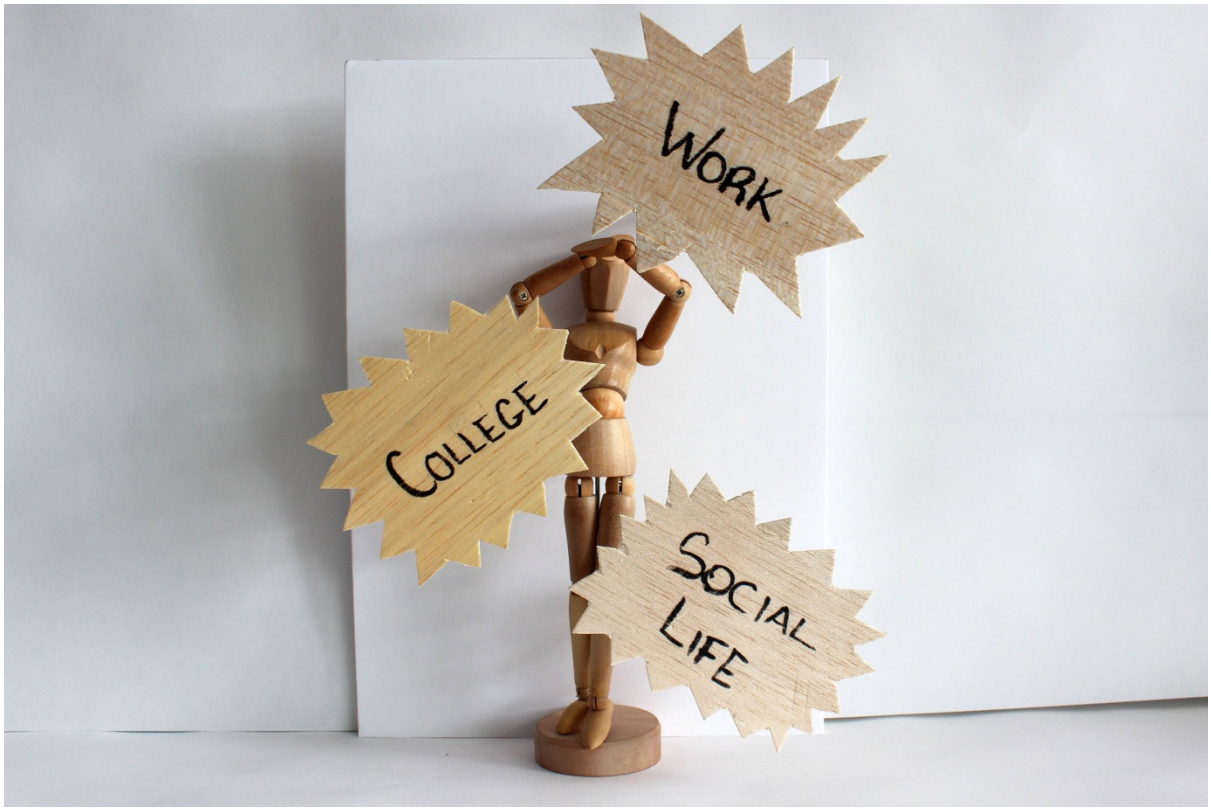
Following phase two consultation, the draft strategy will be updated taking into consideration all comments received. The strategy will then be signed off by cabinet in March 2014 and an Autism Partnership Board will be developed, a multiagency group including people with autism and family/parent carers who will be responsible for tracking and monitoring progress of the strategy.

An autism needs assessment has also been completed providing an analysis of the predominantly quantitative data, available from Warwickshire County Council and partners' systems along with the publically available information on ASD at a national and local level. This supplements the qualitative information and insight gained from the consultation and together provides the most informed and accurate picture of ASD in Warwickshire to date.

See below a selection of images from the creative consultation.


EVERYONE DESERVES EQUAL CHANCES
AUTHORS
WE ARE WHO WE ARE!
DEAL WI IT!
ACTING
SINGERS
SCRIPT
SCRIPT WRITING
SONG WRITING/ GUITAR PLAYING
WE ALL HAVE OUR OWN STRENGTHS!
WE ALL HAVE THE RIGHT TO FIND OUR OWN STRENGTHS!


I find it hard to talk to new people and make new friends because I don't know what to say and when I can say something.
I find it hard to tell people how im feeling. I also can't tell why im sad and when i'm sad.
If i'm upset, angry etc, I shut off and don't talk to anyone. Trying to make me talk to you will make me worse
ME
I don't like people touching me because of my autism. I get very upset and angry but sometimes I hide it. It's because it feels weird and it irritates me. If you touch me on one side, you have to touch me on the other side because it's 'un-even'.
Sometimes I can't tell when people are joking or being sarcastic.
I don't always understand what people are asking me to do. People have to say things in a different way so that I understand.
People don't always understand what I'm trying to say, but my older sister who is also autistic, understands me straight away.


WORK
COLLEGE
SOCIAL LIFE

Autism Self Evaluation

Local authority area

1. How many Clinical Commissioning Groups do you need to work with to implement the Adult Autism Strategy in your local authority area?

3

Comment

There are currently three CCGs covering Warwickshire - Coventry and Rugby CCG, South Warwickshire CCG & Warwickshire North CCG.

2. Are you working with other local authorities to implement part or all of the priorities of the strategy?

- ⊗ *Yes*
- ○ *No*

If yes, how are you doing this?

Working collaboratively with Coventry City Council to develop a diagnostic pathway for adults. This work also includes joint learning and development opportunities eg: Practitioner training focussing on theory and application to support people with autism and training for GPs and General Practice staff. Other areas of partnership working have included creative consultation sessions within 11 specialist schools and colleges across Warwickshire and Coventry to obtain views from children and young adults on future services and support. Further projects are being scoped in regard to working sub-regionally with Coventry & Solihull exploring flexible higher learning opportunities utilising local schools and colleges to avoid costly out of county college placements and supporting young adults to maintain and sustain local community connnections.

Planning

3. Do you have a named joint commissioner/senior manager of responsible for services for adults with autism?

- ⊗ *Yes*
- ○ *No*

If yes, what are their responsibilities and who do they report to? Please provide their name and contact details.

Becky Hale (All Age Disabilities - Service Manager) (beckyhale@warwickshire.gov.uk - tel: 01926 742003) reporting to Head of Strategic Commissioning. Holds overall joint strategic commissioning responsibility for all age disability services including physical disabilities, learning disabilities and mental health services. Operational service manager for disability including adults with autism and young people in transition is currently Doris Sheridan (interim).

4. Is Autism included in the local JSNA?

- ○ *Red*
- ⊗ *Amber*
- ○ *Green*

Comment

Warwickshire's autism needs assessment and outcomes of the three month public consultation process have been completed as a key requirement of our local strategy development and these will be incorporated into our local JSNA when it is reviewed and updated next year (2014) by the Health and Wellbeing board.

5. Have you started to collect data on people with a diagnosis of autism?

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Comment

As an outcome of the needs assessment exercise, we have recently reviewed and improved our internal data collection processes and have now included a classification for autism on our client management system (Carefirst). This will enable us to collect accurate data on adults with autism who have accessed social care services. Currently, data is not recorded annually but collected as and when a person with a diagnosis of autism has a social care assessment undertaken. There is currently adhoc data sharing with health and this will be improved through the diagnostic pathway project whereby health practitioners will be required to collect and share local data on adults with a diagnosis as part of the pathway model.

6. Do you collect data on the number of people with a diagnosis of autism meeting eligibility criteria for social care (irrespective of whether they receive any)?

- ⊗ *Yes*
- ◯ *No*

If yes, what is

the total number of people?

350

the number who are also identified as having a learning disability?

237

the number who are identified as also having mental health problems?

4

Comment

As a result of conducting a local needs assessment for people with autism in Warwickshire and as part of the internal data collection processes review, a new classification for Autism has been included onto our client management system (Carefirst) which will enable us to collect more up to date accurate data on people with autism in Warwickshire.

7. Does your commissioning plan reflect local data and needs of people with autism?

- ⊗ *Yes*
- ◯ *No*

If yes, how is this demonstrated?

Warwickshire's All Age Autism Strategy is currently being developed and will incorporate a local needs assessment which sits alongside the public consultation undertaken concurrently. The strategy brings together data across partners to improve our understanding of the needs of people with ASD in Warwickshire and will supplement the qualitative insight offered by the consultation. It addresses the demographic picture of Warwickshire including prevalence, needs and both the supply and utilisation of relevant services in the county.

8. What data collection sources do you use?

- ◯ *Red*
- ◯ *Red/Amber*
- ◯ *Amber*
- ⊗ *Amber/Green*
- ◯ *Green*

Comment

As part of the needs assessment exercise which will form part of the All Age Autism Strategy, we have reviewed & improved our internal data collection systems and now include a classification for autism on our Client Management System (CareFirst). It has proved more difficult to collect data from health practitioners as GPs do not currently collect data and there is no local register available, although this will be addressed through the development and implementation of local diagnostic pathway. Our current data sources include both local and national research, statistics and data sources: Adults - National Autistic Society, Office of National Statistics, Department of Health's (PANSI) Projecting Adult Needs and Services Information system, adult social care CareFirst (Client management system) and for children - School Census, Assessment, Statementing and Reviewing Service (ASRS), Integrated Disability Service (IIDS) - deliver local internal services and support to children and young people with disabilities.

9. Is your local Clinical Commissioning Group or Clinical Commissioning Groups (including the Support Service) engaged in the planning and implementation of the strategy in your local area?

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Comment

Warwickshire's All Age Autism Strategy is still under development. The needs assessment and public consultation to inform the strategy were completed by end of July 2013. Our local CCGs are fully aware of the development of the strategy and have been regularly consulted during the planning stages. First draft of the strategy will be ready by the end of September, whereby a further short consultation process is planned during Oct & Nov with an aim to confirm strategic objectives and commissioning intentions with all key stakeholders including engagement with CCGs. Once the strategy has been signed off by WCC cabinet in Feb 2014, a local Autism Partnership Board will be formed to implement & monitor the progress of the strategy and will include representation from CCG groups or CCG business support unit. The local Clinical Commissioning groups have been involved in agreeing and endorsing & monitoring the progress of the diagnostic pathway model and implementation through the clinical reference group.

10. How have you and your partners engaged people with autism and their carers in planning?

- ◯ *Red*
- ◯ *Amber*
- ⊗ *Green*

Please give an example to demonstrate your score.

Warwickshire recently conducted a three month consultation process to inform Warwickshire's All Age Autism strategy using a range of engagement methods to engage with a cross section of people on the autistic spectrum. These methods included: Creative consultation sessions - We recognised that for some people with autism, especially children and young people, completing questionnaires or taking part in groups would be a barrier to participation in the consultation process, so we explored a less language based approach. We commissioned an artist, after a rigorous application and selection process, to deliver 11 workshops in the County's non mainstream schools and colleges. Again, working under the overarching theme of 'What's important to me' and focussing on the questionnaire headings, using a mannequin and a variety of arts materials, the artist worked with participants to create a visual story or image that was photographed and then used as a tool to explore experiences and aspirations.
147 children and young people participated over the 11 sites, with a gender split of 114 male and 33 female. Following on from this process, a best practice article has been recently published in the Social Care Guardian and Arts Professional publications and a public exhibition is currently being held at a Warwickshire Art Gallery to display a selection of the images.
Twitter account created: a specific Twitter account was set up to spread the word about the consultation process and allow people to interact with us and give their views. This was particularly important as we are aware of the high usage of social media amongst young people. At the time of this submission we have sent 42 tweets and have 120 followers. This was a useful medium as people tweeted and shared the consultation links, thus helping us reach more people.

Autism Partnership Board - once the strategy has been developed, a multi-agency strategic group including people with autism and family/parent carers will be responsible for monitoring and tracking progress of the implementation of the strategy.

Questionnaires: To ensure we had as wide as reach as possible we developed two separate questionnaires (Children and young people under16 years and a generic version which anyone could respond to. Both versions were co-produced by people with autism and family carers under the overarching theme of 'What's important to me' and were available on line and in paper format. The website which hosted both on line surveys was designed by an adult with Aspergers syndrome. 343 surveys were completed - 268 generic surveys & 75 under 16 surveys. Focus groups - Ensuring that family/parent carers were able to input into the consultation process was an important aspect, four parent /carer groups were attended across the County . This also provided an opportunity for 1:1 dialogue on the key themes for the consultation. Another positive outcome from the consultation was that 120 people have expressed an interest in getting involved in implementing, monitoring and reviewing the strategy.
Other areas where people with autism and family/parent carers have been involved include:
- Recruitment and selection panel for autism specialist social worker for Adult Autism Team.
- Tender Evaluation Panel for commissioning creative artist - 4 young adults with autism from the Wacky Forum were involved in participating in a tender evaluation panel. This comprised of each shortlisted artist conducting a 30 minute workshop with the panel members and the panel then using a scoring matrix to rate each of the artists. Their contribution to the tender process equated to 38% of the overall score.
- Positive about Autism 'Train the Trainer' programme - Fifteen adults with Autism and family/parent carers of people with autism from Warwickshire have completed training to provide them with the skills to become co-facilitators delivering training to a wide range of front line health and social care staff. As someone who has autism or supports someone with autism they have a unique perspective and are seen as 'Experts by Experience'.
Following the training in June 2013, participants will be involved in co-delivering a rolling programme of Autism Awareness training sessions with an experienced trainer during September 2013 to March 2014, sharing their lived experiences of autism.
The National Autistic Society are providing the support function to the participants who will, over time further develop this work by supporting participants to lead training sessions and look at developing a future social enterprise model. This would mean that collectively as a group they will have the opportunity to become an independent training body.

11. Have reasonable adjustments been made to everyday services to improve access and support for people with autism?

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Please give an example.

Warwickshire have recently updated and reviewed customer access to the community care assessment process. Social care workers within the autism team work co-productively with customers to include specific details within a customer's support plan. Each customer's support plan will provide clear information and details in regard to any areas where reasonable adjustments are required and then the team will work with providers to implement any reasonable adjustments and support them to have a level of understanding of the customer's needs and support, including any suggested coping strategies and mechanisms. The team also engage with customers using mobile phones (text messages) and emails providing a range of communication methods.

Warwickshire's contracting and procurement processes ensure that within each service specification there are clear expectations of the service as well as guidance outlining the required level of skills and knowledge to work with a particular client group. This is closely monitored through our contract monitoring processes and peer review programme (which involves people who use services and family carers who conduct quality assessment audits for all social care services)and through our customer review processes.

EXAMPLE from social worker(Adult Autism & Asperger Team):
I was allocated to AH to conduct a social care needs assessment as a follow up of the referral made to the Adult Autism and Asperger Team. AH is in his early 20's, has a diagnosis of Autism and epilepsy, he lives with his mother and sister in a council ground floor flat. AH at the point of referral was sleeping on the lounge sofa , unemployed and not in education. He was depressed, anxious and not managing to engage with the Job Centre appointments as he found the environment uncomfortable to be in due to his sensory needs. I was able to establish a good relationship with AH and we met at times that were convenient to him and his mother who was his main carer. During the assessment AH informed me that he wanted to get a job, live independently and have friends with similar interests in the local community as he felt socially isolated.

AH relied on his mother for support to manage his finances and to attend any medical or job appointments which was putting a strain on her as she was now working full time. It was apparent that AH needed support to apply for housing and to look for a job starting with voluntary work placements as he had disclosed that he was not keen to get back to education. AH had limited living skills and would benefit from learning to cook easy meals as he was relying on his mother to provide snacks for him before she went to work. AH was also not able to manage his finances. A referral was made to the Supporting Independence service for support with cooking and budgeting and he was able to gain support weekly by having two sessions for 12 weeks.

AH was asked for his thoughts after the 12 weeks support had ended and he said "It was good, I learnt to cook a lot of new things. I had help with budgeting too as this is not one of my strong points".

AH was referred to WEST (Warwickshire Employment Support Team) for support with looking for a job and he was able to start attend a job club every Wednesday.This enabled him to receive support to look for specific roles like cleaning and ware house work which he had previous experience in.

He was able to practise for interviews and receive support from his peers who were in the same situation of looking for employment. AH said "West have got me three interviews this week, that's loads more than Remploy .They support me to interviews as well, as sometimes I get stuck when I'm talking".

In order to ensure that AH had ongoing support that would help him achieve his goal of of living independently in the community a referral was made to KEY RING.The service offers a network of support to customers living in the area to meet up for social opportunities and also have an allocated key worker who supports the individual to manage their daily life. AH needed support with registering on the Council Housing list and support to manage his daily routine with regards to appointments and maintaining the skills he was supported to learn initially by the Supporting Independence service which included cooking and budgeting.

AH spoke about his experience with KEY RING and said "It's better than what I thought it would be. I thought it would only last for a couple of weeks.I can speak to people better, though I still get nervous. I have been going to the Hub (Bromford's Hub at Leamington Town Hall where Key Ring Members meet every Friday) and met my new best friend D. I speak to most people there and we sometimes play football in the park.

I have just enrolled on a beginners computer course with my key worker's support. I am happy as he will also support me with my medical appointments. I am happy with the way life's going at the moment."

12. Do you have a Transition process in place from Children's social services to Adult social services?

- ⊗ *Yes*
- ○ *No*

If yes, please give brief details of whether this is automatic or requires a parental request, the mechanism and any restrictions on who it applies to.

Childrens social work teams will identify young people who will require ongoing support into adulthood. Two six monthly multi-agency meetings are held to discuss each case and then agree on timescales for transition and identify who will take responsibility for working with the young person. Restrictions which apply which relate to FACS eligibility criteria which determines an individual's level of need. In Warwickshire our current practice states that we have a duty to provide services to individuals who have been assessed as having critical or substancial needs. People who do not meet this level of need are signposted by social care teams to universal services and support within their local communities.

Warwickshire has been reviewing its transitions process and have developed a short term improvement action plan which will be implemented and a planned consultation is being scoped to obtain people's views on the planned improvements.

Further work is needed to understand and co-ordinate a process so that we are fully aware of the numbers & support needs of younger adults with autism (often these people have not had a diagnosis) and who attend mainstream schools and out of county placements, leaving care team & careers service.

13. Does your planning consider the particular needs of older people with Autism?

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Comment

The local needs assessment has been developed to inform an all age autism strategy (which includes older people), data and information has been collected and addresses the demographic picture of Warwickshire including prevalence, needs and both the supply and utilisation of relevant services in the county. The autism classification on our internal Client management system will assist us to capture data on customers with autism including older people. Autism Awareness training is made available to a wide range of staff inluding those who work with in older people's services as well as the Positive About Autism 'Train the Trainer' programme which involves people with autism co-delivering autism awareness training sessions to staff from all social care client groups (including staff who deliver services and support to older people). As the strategy is being implemented, the action plan will further identify areas where more work is required eg: reasonable adjustments, in particular to meet the needs of older people with autism.

The social work teams also work with older carers looking at future plans for the cared for person, identifying support and services and the carers wishes which may become relevant in the future for the individual. Providing peace of mind and security for the carer and other family members.

The council is looking at a customer's presenting needs to identify an individual's primary needs and then determine through the assessment process the appropriate services and support. This will be pertinent for older people whereby the council will have a clear policy and guidance for teams.

Training

14. Have you got a multi-agency autism training plan?

- ⊗ *Yes*
- ◯ *No*

15. Is autism awareness training being/been made available to all staff working in health and social care?

- ◯ *Red*
- ◯ *Amber*
- ⊗ *Green*

Comment: Specify whether Self-Advocates with autism are included in the design of training and/or whether they have a role as trainers. If the latter specify whether face-to-face or on video/other recorded media.

During the period, (1st April 2012-31st March 2013), Warwickshire have delivered 39 Autism Awareness sessions, 359 people attended the training from a range of children and adults social care & health teams, service providers & library service.
Positive About Autism 'Train the Trainer' programme - Fifteen adults with Autism and family/parent carers of people with autism from Warwickshire have completed training to provide them with the skills to become co-facilitators delivering training to a wide range of front line health and social care staff. As someone who has autism or supports someone with autism they have a unique perspective and are seen as 'Experts by Experience'.
Following the training in June 2013, participants will be involved in co-delivering a rolling programme of Autism Awareness training sessions with an experienced trainer during September 2013 to March 2014, sharing their lived experiences of autism.
The National Autistic Society are providing the support function to the participants who will, over time further develop this work by supporting participants to lead training sessions and look at developing a future social enterprise model. This would mean that collectively as a group they will have the opportunity to become an independent training body. To date: 104 places have been booked on the 8 planned sessions - (Sept 2013-March 2014) attendees range from children and adults health and social care staff, voluntary sector organisations, local providers & Criminal Justice System.

Warwickshire are also exploring e-learning opportunities as part of the intention to develop a suite of training tools.

Practitioner training - Working with People with Autism: Skills for Multidisciplinary Practitioners in Coventry & Warwickshire has been developed jointly with Coventry City Council and sessions have been delivered over 8 sessions (July-Nov 2013). To date: Warwickshire have been allocated 40 places - 15 places booked so far.

Once the All Age Autism Strategy has been implemented in early 2014, one of the key strategic objectives includes - 'Increasing Awareness and Understanding' - this will incorporate a set of future commissioning intentions including the development of a local autism training plan.

16. Is specific training being/been provided to staff that carry out statutory assessments on how to make adjustments in their approach and communication?

- ○ *Red*
- ⊗ *Amber*
- ○ *Green*

Comments

From April 1st 2012 - 31st March 2013, Autism Awareness sessions were attended by: 359 health and social care staff, service providers and library staff - over 39 sessions.

As mentioned in the reponse to Q15 - Warwickshire is working in partnership with Coventry City Council to offer Practitioner training to all adult social care practitioners. This training is available to all staff who carry out statutory assessments and the programme includes:
Learning outcomes of programme: Enabling practitioners to be confident in co-producing an assessment with a person with Autism.

Understand the impact of the Autism Act 2009 and how it relates to their role

Be aware of the work and priorities of the Local Implementation Board for Autism in Coventry and equivalent for Warwickshire

Recognise that a person has Autism and understand the characteristics of Autism

Explain how the FACs criteria can be applied to the person with Autism

Practice the skills to enable the successful co-production of the person centred assessment

Start to develop a learning resource of tools, techniques and strategies to use in their role

Reflect on their learning and identify how this will impact on their practice

Sessions being held: 8 sessions (July-Nov 2013)
Warwickshire have been allocated 40 places - 15 places booked so far.

Further learning & development sessions will be developed as part of the local strategy implementation whereby a detailed training plan will identify future key areas for learning and development.

Warwickshire have recently applied for further funding through the Winter Pressures programme to look at providing the Learning Disability Occupational Therapists with training enabling them to complete sensory assessments of customers with autistic spectrum disorders.

The goal of this training would be to support people to live more independently & increase participation. This would enable the identification of needs which are not social care and when appropriate liaise with health and other agencies to meet needs. This will provide a rationale for interventions and provide potentially cost effective solutions for individuals.
The training would also provide increased knowledge and skills for OTs and the wider social care team, recognising that the numbers of this customer group are increasing as more people are being diagnosed. By increasing knowledge and skills within the adult team we will be able to support transition from children's to adult services making this a positive experience for young people.

17. Have Clinical Commissioning Group(s) been involved in the development of workforce planning and are general practitioners and primary care practitioners engaged included in the training agenda?

- ⊗ *Yes*
- ○ *No*

Please comment further on any developments and challenges.

Warwickshire & Coventry are jointly working with the local CCGs to support the training of G.Ps and General Practice staff to understand Autism with information on their information portal and support in undertaking the screening and applying the pathway. This work will be prioritised as part of the development & implementation of the local diagnostic pathway over the next 12 months.

18. Have local Criminal Justice services engaged in the training agenda?

- ○ *Yes*
- ⊗ *No*

Please comment further on any developments and challenges.

Information on multi-agency autism learning and development programmes are promoted and publised widely and our mailing lists include criminal justice services however to date, there has been low take-up to these programmes. We recognise that further work is needed to engage more effectively with the CJS and our autism training plan highlights this as an area where the 'Train the Trainer' programme could prove really beneficial to those staff who work within CJS.
To date: there are 3 staff from CJS who are attending the planned sessions with further targetted promotion and publicity being undertaken to increase take up.

Nigel Archer - CJS Development Coordinator.
All of the police forces who have taken the training and S&W Probation have placed links to the download advice documents which he has created on their intranet sites for use by staff.

All the training delivered is contextualised to the specific roles who receive it based on my prior experience in the CJS and is not just awareness but provides advice and guidance pertinent to their role.

Warwickshire Police have a number of trainers trained by Nigel Archer in a training package which they have been or are still delivering to operational staff.
During May 2013, staff from Warwickshire Probation Trust and Warwickshire Multi Agency Public Protection Arrangement (MAPPA) Staff received training.

Staffordshire & West Midlands Probation Trust -arranged 3 Autism Awareness seminars (July 2011-October 2012) for staff across SWM PT approximately 137 colleagues attended.
A number of these seminars have also been arranged on a more local level and in total over 200 members of our staff have received this training.

On 10th October 2013, Nigel will be delivering training to all operational Probation Officers in the Warwickshire Probation Trust. A small number have already had a shortened input in a workshop as part of a larger conference. They only number around 120 staff and not all of these are operational, so there wil be approximately 70 -100 staff attending this training.

Information received from Warwickshire Police:
Officer Safety Training (Version 15.2) which included information on autism was delivered was training in 2011/12, 830 officers received this training.

Diagnosis led by the local NHS Commissioner

19. Have you got an established local diagnostic pathway?

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Please provide further comment.

Warwickshire are working in partnership with Coventry City Council to develop and implement a local diagnostic pathway for adults with autism. The proposed model is inclusive of G.P engagement and includes a triage process and access to a support pathway and community care assessment. We are currently waiting for the CCG to include this as part of their commissioning intentions and contract of the local health provider for the diagnostic function itself. This model is reflective of good practice and is in the process of being evaluated by Sheffield Hallam University who have already shown support of the model and the sustainable approach to a local pathway. It is envisaged that the pathway model will be piloted for a six month period starting from Autumn 2013, with a number of adults with autism and will also provide an opportunity to familiarise & skill the workforce. Following the pilot, a full evaluation process will be undertaken to review and gain feedback from service users/carers, review impact, capacity and ensuring it is fit for purpose, before the model is embedded into everyday work practices.

20. If you have got an established local diagnostic pathway, when was the pathway put in place?

Month (Numerical, e.g. January 01)

Year (Four figures, e.g. 2013)

Comment

As mentioned in response to Question 19 - a test model pathway will be piloted for six months commencing Autumn 2013.

21. How long is the average wait for referral to diagnostic services?

Please report the total number of weeks

Comment

Warwickshire do not currently have a formal diagnostic pathway, as mentioned in response to Q19, a model is being developed and piloted.

22. How many people have completed the pathway in the last year?

Comment

As the model pathway has only recently been developed and not yet tested, I am unable to respond to this question until the post pilot evaluation process has been undertaken.

23. Has the local Clinical Commissioning Group(s)/support services taken the lead in developing the pathway?

- ⊗ *Yes*
- ○ *No*

Comment

The Arden Cluster CCG business support unit have been jointly involved with Warwickshire & Coventry local authority Autism Leads in developing the pathway model which was recently approved by the local clinical reference group as well as the proposed six month pilot period to test the model. The local health provider has also been heavily involved in designing the model and undertaking capacity modelling.

24. How would you describe the local diagnostic pathway, ie Integrated with mainstream statutory services with a specialist awareness of autism for diagnosis or a specialist autism specific service?

- ○ *a. Integrated with mainstream statutory services with a specialist awareness of autism for diagnosis*
- ⊗ *b. Specialist autism specific service*

Please comment further

The response for this question relates to the proposed new pathway model detailed in question 19. We have developed a specialist diagnostic pathway however the principle following diagnosis will be to direct individuals back into mainstream services for ongoing support eg: LD, MH. Autism specialist will continue to provide advice and guidance to mainstream teams but will not hold caseloads.

25. In your local diagnostic path does a diagnosis of autism automatically trigger an offer of a Community Care Assessment?

⊗ *Yes*
○ *No*

Please comment, i.e. if not who receives notification from diagnosticians when someone has received a diagnosis?

The proposed new model pathway includes an offer of a community care assessment.

26. What post-diagnostic support (in a wider personalisation perspective, not just assuming statutory services), is available to people diagnosed?

Post diagnostic support currently includes access to all mainstream services and reasonable adjustments are made when necessary to ensure that the services are personalised to the individual.

For social care support, if an individual meets Warwickshire's FACS (Fair Access to Care Services criteria) they will be offered a Personal Budget. The individual can choose how to spend their personal budget to meet their needs. One way this budget can be taken is via a Direct Payment. This allows the individual to have more choice and control on arranging their own care and support to meet their needs. Warwickshire's Directory is an online provision providing details of all services and support available across Warwickshire whereby people can exercise choice and control in sourcing their own care and support.

The council through managed budgets can also support an individual to arrange services and support.

Supporting People (housing related support) is offered to individuals to support them to maintain their own tenancies, budgeting and bill management and environmental issues.

WEST (Warwickshire Employment Support Team) provide support to access voluntary or paid employment.

Supporting Independence Service - (SIS) provide short term (up to 12 weeks) service to individuals focussing on promoting and sustaining independence.

Community Hubs provide a range of information and advice on local services and support including community facilities.

Advocacy services are available for individuals who require an independent person to act on their behalf or support the person with decision making.

IDS (Integrated Disability Service) offer parents Autism Awareness sessions post diagnosis, to offer support and advice on how to support a child with autism and live with autism.

Warwickshire are also currently researching service models which would support vulnerable adults who do not meet the FACS eligibility to access time limited intervention support services. This model would include adults with autism.

Warwickshire' s All Age Autism Strategy will provide further detail on commissioning intentions for future services and support including post diagnostic support.

Care and support

27. Of those adults who were assessed as being eligible for adult social care services and are in receipt of a personal care budget, how many people have a diagnosis of Autism both with a co-occurring learning disability and without?

a. Number of adults assessed as being eligible for adult social care services and in receipt of a personal budget

5647

b. Number of those reported in 27a. who have a diagnosis of Autism but not learning disability

63

c. Number of those reported in 27a. who have both a diagnosis of Autism AND Learning Disability

135

Comment

No further comments.

28. Do you have a single identifiable contact point where people with autism whether or not in receipt of statutory services can get information signposting autism-friendly entry points for a wide range of local services?

- ⊗ *Yes*
- ○ *No*

If yes, please give details

Initially individuals with autism can make contact with the council's Customer Service Centre, the person will be initially screened and then signposted to either the Access (duty) team or the South Learning Disability team. Depending on the enquiry, individuals are either signposted by social work teams to voluntary and community sectors organisations who offer a range of information and advice or a community care assessment is arranged.

It is envisaged that the Community Hubs will be asked to provide this service as part of the All Age Autism Strategy. There are currently six community hubs located across Warwickshire, providing information and advice to adults with LD and their families/carers on a range of local services and support. Due to the broadness of the Autism spectrum, the community hubs are already supporting people with LD who also have autism. Future plans for developing this service will include a local contact point for people with autism and their families and provide signposting to local services and support.

29. Do you have a recognised pathway for people with autism but without a learning disability to access a community care assessment and other support?

- ⊗ *Yes*
- ○ *No*

If yes, please give details

Warwickshire have a dedicated adult Autism & Asperger team which includes one social worker and two social care workers for adults who support people to complete assessments and support plans to meet their needs. There is a recognised pathway for people with autism to follow in order to obtain a community care assessment and other support. The pathway includes a screening process to determine level of priority which then defines which social work team can best address the presenting need of the individual. The social care team will work co-productively with the individual to enable them to source the right services and support to meet their needs.

30. Do you have a programme in place to ensure that all advocates working with people with autism have training in their specific requirements?

◯ *Red*
◯ *Amber*
⊗ *Green*

Comment

The council offers autism awareness training which is available to a wide range of agencies and organisations including advocacy services. The council contracts with an advocacy organisation who offer support to people with autism who as part of their contract requirements with the council ensure that all their staff have completed Autism awareness training.

The council's contracting and procurement processes outline in the service specification the training requirements and levels of skills required to provide this particular service. This is then monitored as part of the council's contract monitoring processes and checked through peer review quality audits.

31. Do adults with autism who could not otherwise meaningfully participate in needs assessments, care and support planning, appeals, reviews, or safeguarding processes have access to an advocate?

◯ *Red*
◯ *Amber*
⊗ *Green*

Comment

Warwickshire refer people with autism to advocacy services if following initial assessment the individual requires the support to engage in the assessment and support planning process, appeals, reviews or safeguarding processes. All advocacy organisations are invited to attend Autism Awareness training and Positive About Autism 'Train the Trainer' sessions.

The advocacy organisation who currently have a contract with the council do ensure that all their staff undertaken autism awareness training (49 in total). Staff training requirements are also detailed in the service specifications and are monitored through the council's contract monitoring processes.

As part of the council's contractual arrangements with advocacy providers we stipulate if specific training is required. Where appropriate we involve an IMCA and support best interest decisions where adults with autims lack capacity and where appropriate, family members may act as advocates.

32. Can people with autism access support if they are non Fair Access Criteria eligible or not eligible for statutory services?

◯ *Yes*
⊗ *No*

Provide an example of the type of support that is available in your area.

Currently we do not offer social care services to people with autism who do not meet our FACS eligibility criteria. These individuals are signposted to voluntary and community sector organisations who are able to provide support services, information and advice. This is currently being reviewed as part of the Transitions review project with a focus on early intervention and preventative services to reduce the numbers and costs of long term care.

The council are required through the Care and Support Bill 2013, to signpost those people who are not eligible for services and support to external voluntary and community sector organisations and then review the outcome for the individual.

As outlined in response to Q26, Warwickshire are currently researching service models which would support vulnerable adults who do not meet the FACS eligibility to access time limited intervention support services. This model would include adults with autism.

33. How would you assess the level of information about local support in your area being accessible to people with autism?

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Comment

Warwickshire Service Directory:

The rating for this question is based on the fact that the service directory is web based and is reliant on the individual to have access to a computer. Although there is provision within the local community eg: community hubs and libraries whereby an individual can access the internet. Warwickshire Directory provides on line detailed information on range of universal services and support available across Warwickshire.

The directory includes a range of services from
home care and residential care provider, day opportunities, local support networks, supported living providers. The general public can also access information on local events or activities within their locality. There is the facility for customers to inform the directory team if they cannot find what they are searching for. The team will investigate within the directory whether this service is available and if needed would highlight any service gaps to relevant commissioners or market facilitation team.

Also information is widely available in other formats eg paper through a range of voluntary and community sector organisations across Warwickshire.

Customer & carer engagement within services, community networks and customer reviews identify areas where information needs to made more accessible. These views are fed into the customer engagment team who disseminate to relevant teams and then ensure that changes are made and fed back to the customer.

Community Hubs also hold a wide range of information on services and support and can signpost people to community services. As well as having access to the on line service directory.

The six community hubs across Warwickshire already provide information and advice to people with LD who also have autism. But future plans for this service will also include people with ASD and their families.

As part of the recent consultation on the All Age Autism strategy, people with autism and their families told us that the council needs to be more transparent about information sharing and making information about services and support more readily available in a range of formats. This will be addressed as part of the strategy implementation.

Housing & Accommodation

34. Does your local housing strategy specifically identify Autism?

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Comment

Warwickshire are currently developing an Accommodation Strategy which will include commissioning intentions for housing and accommodation options for customers including specialist housing for people with disabilities and autism.

There is currently a 9 site tender process being undertaken with sites identified across the county with opportunities for developments of specialist housing including autism.

Further work is being scoped in regard to collecting local housing needs data for people with autism as part of a wider needs analysis to understand the current and future housing needs of our local population.

We are also currently in discussions with Solihull regarding potential joint housing development opportunities for people with high support needs including people with autism.

Employment

35. How have you promoted in your area the employment of people on the Autistic Spectrum?

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Comment

Autism Awareness training is made available to a wide range of agencies and organisations including local employers. To date take up is low and we recognise this is an area which we need to focus on within the All Age Autism strategy. The strategy will highlight the need for more promotion and awareness with local employers to recognise the benefits of employing people with autism.

Social care workers have provided support to specific customers to work with employers and the Job centre to provide strategies for individuals to gain and maintain employment.

WEST (Warwickshire Employment Support Team) also work with local employers to raise awareness of people on the autistic spectrum in particular around making reasonable adjustments and promoting the benefits of employing people with autism. WEST promote employment of people with autism using a variety of methods including: social networking sites, Twitter and Facebook, Job Fairs, working with careers service, working in schools and at transition events including colleges and through supported internships. There are close working relationships between social work teams and WEST including local servcie providers and work programme providers like local job centres, CDA & JHP.

WEST have supported 31 people with autism over the past 12 months: 16 are in employment into a variety of job roles including: adminstrative, gardening, warehouse operatives, kitchen porter, domestic and college student support roles.

36. Do transition processes to adult services have an employment focus?

- ◯ *Red*
- ◯ *Amber*
- ⊗ *Green*

Comment

The Self Directed Support process includes access to work and learning opportunities which are explored within the assessment and support planning processes with the individual.

Employment is a key priority indicator idenitified by the Adult Social Care Outcomes Framework which each local authority has to demonstrate progress and outcomes for individuals on an annual basis called the Local Account.

WEST offer work based training which includes, work place conduct, preparation for work skills, interview techniques. This training is accredited by: Edexcel and sessions are arranged across the county at various locations. WEST have also made links with a local provider and the Job Centre to identify possible routes to employment and preparation for work skills.

WEST have been working in partnership with Hereward College in Coventry to support young people with autism into work placements and paid employment.

It is acknowledged that further work is required to look at working with younger adults working through transition in order to offer work placements/internships and opportunities for developing social enterprises.

Criminal Justice System (CJS)

37. Are the CJS engaging with you as a key partner in your planning for adults with autism?

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Comment

Autism Awareness 'Train the Trainer' programme is available to all local organisations and agencies including CJS. Attendees for these sessions running from March-Sept 2014, include staff who work within CJS - to date 3 people from the CJS have booked onto the training. Further targetted promotion and publicity is planned to increase take up on the training.

Warwickshire's All Age Autism Strategy will include a section on Awareness and Understanding & Keeping Safe. A local training plan will be developed which will include different levels of learning and development for ASD, a range of organisations and agencies, including CJS will be targetted to attend.

Autism Partnership Board - a multi-agency group will be developed to implement and monitor progress of the Warwickshire's Autism strategy. Group membership will involve senior staff from CJS. Smaller working groups will be developed to focus on key priorities within the strategy including Keeping Safe - membership of these subgroups will include officers/staff from across the CJS.

West Midland Autism Alert Card - approximately 145 cards have been issued to Warwickshire citizens. Information regarding application instructions have been included on WCC website and in our local Learning Disability Partnership Board Newsletter. Further promotion and publication is planned as part of implementing the strategy.

Safe Places Scheme - Warwickshire is working in partnership with Warwickshire Police to implement the scheme across Warwickshire. Safe Places are local places where local people can go for help and support if they feel unsafe within their local communities. PCSOs work with people with LD to review each of the Safe Places which include libraries, supermarkets, cinemas, leisure centres, local shops and cafes etc. The scheme is being rolled out across Warwickshire with 3 month pilots in each district and borough. To date there are over 60 Safe Places in Leamington, Warwick, Stratford and Rugby. Wtih pilots planned for Nuneaton and Bedworth in November and North Warwickshire from Jan 2014. The scheme will be fully operational across Warwickshire by June 2014.

Awareness raising programme is being planned for Autumn 2013, within all Warwickshire schools to raise awareness of the scheme to all children.

Optional Self-advocate stories

Self-advocate stories.

Up to 5 stories may be added. These need to be less than 2000 characters. In the first box, indicate the Question Number(s) of the points they illustrate (may be more than one. In the comment box provide the story.

Self-advocate story one

Question number

37

Comment

Safe Places Champion (adult with autism)

A Safe Place is where you can go, to report a hate crime and ask for help it can be a place like a shop, supermarket or a caf You know when they are a Safe Place as they have a sticker in their window.

When you go into a Safe Place you show them your hate crime card, which has your contact details on, and also includes any health or communications needs.

I became a Safe Place Champion for Safe Places because I want to speak up for people with learning disabilities. I also live in the area where the safe places scheme is being piloted so I know the area well.

I want to help change people's views and attitudes about people with learning disabilities.

Everybody should feel safe when out and about. I feel that I have made a difference already as I raise awareness about learning disabilities. Being involved helps to make my community safer, I feel that my views about hate crime are listened too, as I have experience of being in these types of situations.

My role involves me working with the PCSO, also known as a Police Community Support Officer. We look at finding places to become safe places. We visit these places and we tell them all about the safe places scheme and ask them if they would like to come on board.

After 3 months we then go out again to review to check how the safe place is getting on and to make sure they have all the information and help they need.

As part of my role as a Safe Places Champion I also carry out Mystery Shopping Visits to the registered Safe Places to check that they are supporting people in the right way. This involved me using acting and going into the Safe Place and telling staff that I need help or support because of being harassed or verbally abused. Following the visits the Safe Place is given feedback and we will then work together to make sure that vulnerable people get the right help and support.

Being a Safe Place Champion has given me more confidence and more self - esteem as I have the chance to speak to Staff at the Safe Places and also work alongside the Police Community Support Officer to carry out reviews and monitor the Safe Places.

I think the Safe Place is a wonderful scheme because it is going to reduce crime for people with learning disabilities. Everybody should feel safe when out and about.

Self-advocate story two

Question number

10

Comment

Young person with autism

Interviewing Artists for Warwickshire County Council's
Creative Consultation on the All Age Autism Strategy

My job role was to interview the artists and see how they coped with people that have autism (and might have just got diagnosed) and give them the support they need. The artist who was picked by the young person's panel would be working with children and young people in schools and colleges to ask them what they thought about the council's autism strategy.The interviewees showed good techniques and initiative because they gave each of us tasks to complete and we could ask for help if needed. After each interviewee completed their workshop with us, we all went into a different room and filled out a questionnaire and spoke about what we liked and didn't like.

I liked that there is going be a new person that would work directly with children and young people with autism and that I could benefit from some of the questions that they asked. When I was asked to do the interviews I was nervous because I had never done this before but throughout the day my nerves went. The bit I felt uncomfortable with was when the questions came at the start, asking about what autism means because I had no idea of what it meant until recently. I felt doing this by myself would have put more pressure on me doing the tasks and answering the questions but having it in a group I didn't feel as much pressure because everyone was taking part.

I really enjoyed it and I would like to do it again but I didn't like putting pressure on interviewees and talking about them. I think it was good that the Council asked our support person to find people with autism to see if they could work with the interviewees before they got the job.

Self-advocate story three

Question number

35

Comment

Ups and downs of being in Employment with Asperger's Syndrome. (Adult with Asperger's Syndrome)

I have been in employment for almost 11 years, I started in a food preparation factory for 18 months. Then moved to a Supermarket for almost 10 and some of my employers (Line managers) have made it very stressful for me. The work they give me has been very easy so much so I don't need to think much about how to do them. My tasks while there include fetching in shopping trolleys, loading shelves, cleaning up any mess that has happened by the cash machine Trolley area.

From August 2008 - November 2010 I had a supervisor that I feel took an immediate disliking to me. She tried to make my job as difficult as possible for me. By early summer 2010 I decided that I couldn't cope anymore so I spoke up about how she was treating me to my key worker in the support to work program work step .I felt like no matter what I did just wasn't going to be good enough for her. She got very personal with me about my life and interests in front of my colleagues in the staff room.

When my parents found out they suggested kept a log of every incident that happened when she was on shift so I did. November 2010 was the final straw and I decided that the best thing would be to go off with stress. I went in with my Dad a week later to discuss with the grocery manager and he moved me over to provisions. I felt relief on the first few months but when I got to April and was still just filling milk and collecting trolleys I felt like this was going to be it forever.

From November 2012 I have been working for an advocacy project which is all about giving people with learning disabilities help to speak up for themselves . I have done something different every week and I have learned a lot from doing that kind of work I am treated as an equal whilst there by my colleagues.

When I was told that I had been successful with the post I was just so relieved that I was going to be working in a different environment. It meant I was able to reduce the time I was at the supermarket. Almost a year has passed and I am still feeling really happy in my advocacy job and I still get on brilliantly with the staff there and have done a lot of great things.

The team I work with support me really well, they understand about autism and although sometimes they forget they are good at asking me what it is I need.

Self-advocate story four

Question number

15

Comment

Parent Carer of child with autism - Co-facilitator for Autism Train the Trainer programme.

My main aim in being part of the co-facilitator group is to help raise awareness of Autism on an ongoing basis. I want to get the message out there of what it is like to live with Autism. There are so many misconceptions; everyone is unique.

The initial training in June gave everyone the chance to agree the learning needs of trainees and what was expected of us as trainers. It gave me the chance to stand up in front of an audience (a taste of things to come) and talk about how my family are affected by Autism.

The follow-up meetings have been sporadic as it has been difficult to get the whole group together however; NAS has been supportive and accommodated everyone's needs, offering one to one meetings if agreed dates were inconvenient. During the meetings I had the chance to 'tell my story', whilst gaining valuable feedback from everyone. All stories were powerful and will prove valuable in the training sessions. Everyone benefited; learning from each other's experiences by discussing problems which have arisen through lack of awareness by various professionals. Although none of us were experts in Autistic Spectrum Disorders/Autism, we were experts in living with the condition.
Training people within Social Care will increase their knowledge and understanding of Autism and those with the condition will stand a better chance of accessing the services they need.

As a trainer I hope to give first hand news of the problems which can be encountered in the 'real world.' I want to raise awareness of Aspergers Syndrome and especially PDA (Pathological Demand Avoidance) as it is a relatively new condition with more people now being diagnosed. The training will hopefully give them the information they need to help them to understand and communicate effectively with those persons whilst dispelling any misconceptions.

The support given to us as a group from Warwickshire County Council and the National Autistic Society will help us as 'experts with experience' to become an independent body eventually reaching a wider audience e.g. Doctors, Dentists, Fire Service to name a few. Raising awareness can only help our children/young adults in the future, especially with gaining employment. I hope training will become mandatory in all workplaces.

Self-advocate story five

Question number

Comment

This marks the end of principal data collection.

Can you confirm that the two requirements for the process to be complete have been met?

a. Have you inspected the pdf output to ensure that the answers recorded on the system match what you intended to enter?

☒ *Yes*

b. Has the response for your Local Authority area been agreed by the Autism Partnership Board or equivalent group, and the ratings validated by people who have autism, as requested in the ministerial letter of 5th August 2013?

☒ *Yes*

The data set used for report-writing purposes will be taken from the system on 30th September 2013.

The data fill will remain open after that for two reasons:

1. to allow entry of the dates on which Health and Well Being Boards discuss the submission and
2. to allow modifications arising from this discussion to be made to RAG rated or yes/no questions.

Please note modifications to comment text or additional stories entered after this point will not be used in the final report.

What was the date of the meeting of the Health and Well Being Board that this was discussed?

Please enter in the following format: 01/01/2014 for the 1st January 2014.

Day

20

Month

11

Year

2013

Item 7

Warwickshire Health and Wellbeing Board

20 November 2013

Clinical Commissioning Groups' (CCGs) and Social Care Commissioning Intentions

Recommendations

That the Warwickshire Health and Wellbeing Board (HWB):

1. **Consider and approve the commissioning intentions of:**
   - **Warwickshire North Clinical Commissioning Group**
   - **Coventry and Rugby Clinical Commissioning Group**
   - **South Warwickshire Clinical Commissioning Group**
   - **WCC Social Care and Public Health**

In addition, the Board is requested to:

2. Once approved, support Commissioners' new approach of commissioning by outcomes, monitor the progress on the implementation of the commissioning plans and hold Commissioners to account;
3. Strengthen collaboration and request partners, including local councils to identify their commissioning intentions.

1.0 Background

1.1 The Health and Social Care Act 2012 gives health and wellbeing boards specific functions and duties in relation to commissioning plans:

- A duty to be involved in the preparation and/ or revisions of the CCG commissioning plans;
- A duty to provide an opinion on whether the commissioning plans have taken proper account of the joint health and wellbeing strategy;
- A duty to include a statement of the final opinion of the health and wellbeing board in the published commissioning plans. (This is legally a duty of the CCG to include the health and wellbeing board's statement in their commissioning plan);
- A duty to review how far each CCG has contributed to the delivery of the joint health and wellbeing strategy.

1.2 Also, health and wellbeing boards have the power to:

- Request information for the purposes of enabling its functions from:
  a. Local authorities in the area
  b. Members or those they represent.
- Issue a statement of views on how commissioning of health and social care services, and wider health-related services, could be integrated.

2.0 Progress to date

2.1 The Chair of the Warwickshire Health and Wellbeing Board and the Warwickshire County Council's Portfolio Holder for Public Health have called a meeting with the Warwickshire County Council's and CCGs' leadership teams to discuss and review the draft commissioning intentions of the CCGs and Social Care. The meeting took place on 30 October 2013 and consisted of:

- Presentation of commissioning intentions by relevant parties
- Discussion around common themes and key issues
- Discussion around links to the Warwickshire Interim Health and Wellbeing Strategy
- Conclusion and recommendations.

2.2 A number of findings led to the reinforcement of the unity of the CCGs and Warwickshire County Council in their messages to service providers and recommendations to the Warwickshire Health and Wellbeing Board to approve the Health and Social Care commissioning intentions.

3.0 Key findings

3.1 This section provides a summary of key findings identified through a comparative analysis of the Warwickshire's Health and Social Care Commissioning Intentions 2014-15. The analysis focusses on the commonalities and differences between the intentions based around:

- Commissioning principles
- Key commissioning priorities.

3.2 A number of common themes and underpinning principles has been identified across all CCGs' and Social Care commissioning plans:

- Partnership work with Local Authorities
    - Joint Commissioning with Social Care
    - Focus on prevention and lifestyle (Public Health)/ Implementation of the Making Every Contact Count (MECC) programme

- Integration
    - Teams, services, pathways etc.
    - Electronic Records Systems

- Quality of care and patient safety
- Stakeholder engagement, incl. patients
- Access to services, incl. 24/7 care
- Value for money (review of service specifications and contracts)
- Focus on self-management
- Working with the community and voluntary sector.

3.3 Public Health commissioning intentions, particularly in relation to health care providers have been incorporated into the CCGs' commissioning plans.

3.4 The CCGs are intending to review the way in which many services have been historically contracted, particularly from the acute sector, in order to ensure better outcomes for patients, good quality care and an appropriate access to it. This will have an impact on the way in which these services are commissioned with a much greater focus on outcomes, value for money and innovative solutions, which inevitably in turn will lead to greater competition. The Board is requested to support this approach.

3.5 The table below depicts key commissioning priorities identified within the Commissioning Intentions 2014-15 across all CCGs, Social Care and Public Health in Warwickshire. It also identifies links between the commissioning priorities and the priorities and outcomes described in the Warwickshire Health and Wellbeing Strategy.

Table 1. Key commissioning priorities per type of service, including integrated services and teams

- linked to/ reflective of the Warwickshire Health & Wellbeing Strategy

AGENCY / PRIORITY	WARWICKSHIRE NORTH CCG	COVENTRY & RUGBY CCG	SOUTH WARWICKSHIRE CCG	WCC SOCIAL CARE	PUBLIC HEALTH WARWICKSHIRE
Mortality	Y	Y	Y		Y
Urgent and Emergency Care	Y	Y	Y	Y	Y
Stroke	Y	Y	Y	Y	Y
Frailty	Y	Y	Y	Y	Y
Cardiovascular Disease (CVD)	Y				Y
End of Life	Y	Y	Y	Y	
Mental Health	Y	Y	Y	Y	Y
Dementia	Y	Y	Y	Y	Y
Long term conditions	Y	Y	Y	Y	Y
Learning Disability	Y		Y	Y	
Children and Maternity	Y	Y	Y	Y	Y
Cancer	Y				Y
Diabetes	Y	Y	Y		Y
Lifestyle Management	Y	Y	Y	Y	Y

3.6 CCGs and Social Care have jointly agreed that they will:

- Develop mechanisms that enable people to manage their own care through self- assessment, information and advice, and online resources.
- Create opportunities and initiatives to develop community based and preventative support services that deliver the health and social care outcomes that prevent, postpone and delay the need for formal support.
- Together identify, develop and implement opportunities to achieve financial savings and wider benefits through cooperation and working together around the key points of the health and social care interface, particularly, but not exclusively, in relation to older people and pathways out of hospital.
- Given the outcomes of Winterbourne and the Francis Report, strive to deliver a vibrant competent workforce with quality at its core across all services including those that are commissioned across the health and social care economy.

4.0 Key issues

4.1 It has been recognised that the delivery of the commissioning ambitions and plans will pose a significant issue considering the financial pressures on organisations, hence the need to:
- Support new approach to commissioning by outcomes;
- Cooperate and promote Integration.

4.2 It has been identified through the discussions that all Commissioners will need to be specific about their plans and work closely together to address the challenge of reducing the health and wellbeing inequalities across the county. It was felt that this will require further clarification and inclusion in all commissioning plans.

4.3 It has been recognised that the challenge of making Integration happen will require clear success measures to be jointly developed.

5.0 Conclusions

5.1 The Board will monitor progress on the development and implementation of the CCGs' and Social Care commissioning plans through regular reports and updates at the Board's meetings and/ or via the relevant sub-groups' activity.

5.2 With this in mind, the Board is recommended to approve the Warwickshire's Health and Social Care commissioning intentions and promote the Commissioners' key decisions to providers of the health and social care economy in Warwickshire.

6.0 Background Papers

6.1 Warwickshire North CCG Commissioning Intentions 2014-15

6.2 Coventry & Rugby CCG Commissioning Intentions 2014-15

6.3 South Warwickshire CCG Commissioning Intentions 2014-15

6.4 Social Care Commissioning Intentions 2014-15

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NHS
Warwickshire North
Clinical Commissioning Group

Commissioning Intentions – 2014/15

Quality & Equality First

1 ABOUT THIS DOCUMENT

This document sets out the Commissioning Intentions of NHS Warwickshire North Clinical Commissioning Group (WNCCG) that will underpin our contracting requirements for 2014/15, and to take a forward look at the financial years 2015/16 and 2016/17.

It contains the following sections

- **Introduction** – a brief outline of how our commissioning intentions have been developed and how they fit within our development as an organisation
- **NHS Warwickshire North Clinical Commissioning Group (WNCCG)** – an overview of our values, population and the health and wellbeing challenges that we will need to address in Warwickshire North
- **NHS Warwickshire North CCG Integrated Plan** – priorities that we have agreed to work on in 2012/13 and for the years 2013 -2017
- **NHS Warwickshire North CCG Vision for Quality** – outlines our clinical strategy for the next 3 years, and what change we expect across the system
- **Commissioning Principles** – outlines the principles that underpin how financial resources will be deployed to support improvement in the health of the Warwickshire North population. Outlines the basis of high level commissioning intentions that will apply to all providers
- **Commissioning Intentions**
  - Outlines our service vision
  - Provides details on the changes we want to be reflected in all 2014/15 acute contracts but we have provided more detail for George Eliot Hospital NHS Trust (GEH) as our main acute provider
  - Details the changes to community services for Warwickshire North that we would like South Warwickshire CCG to secure in the South Warwickshire Foundation Trust 2014/15 contract on our behalf
  - Outlines the changes to services that we would like the Coventry and Rugby CCG to secure for Mental Health and Learning Disability services in the Coventry and Warwickshire Partnership Trust 2014/15 contract on our behalf
  - There are a number of other contracts where we are part of a larger consortium of CCGs notably Pathology services, West Midland Ambulance Service and the new 111 service. Our specific requirements are also detailed in this section.
- **Contract Timetable** – a high level indication of the deadlines we are going to work to in order to achieve a signed contract by 31 March 2014.

2 INTRODUCTION

Our commissioning intentions for 2014/15 build on the programme of work outlined in the NHS Warwickshire North CCG's Integrated Plan and reflect our clinical strategy as a CCG.

These commissioning intentions are intended to provide our providers and partners with a transparent declaration of the CCG direction of travel and priorities that we will be focusing on in 2014/15.

Whilst the broad strategic direction that underpins the commissioning intentions is reflective of the strategy outlined within the NHS Warwickshire North Integrated Plan 2013, specific commissioning intentions both build on existing Quality Innovation Productivity and Prevention (QIPP) schemes that were established during 2012/13 and reflect new, emergent thinking from clinicians with respect to how services can best be shaped and re-modelled to deliver improved health outcomes whilst securing quality and cost improvements. In line with financial allocations for 14/15, further work will be undertaken to continuously identify and work up in-year QIPP schemes with providers. Whilst the financial challenges are at the forefront of our minds we are also keen that the requirement to reduce cost does not hamper our ability to innovate, improve quality and deliver services differently.

We are expecting more detail to emerge following the publication of the Operating Framework in December 2013. We will need to review these intentions once the requirements become available.

We want to collaborate with our providers, local authorities and other partners to deliver improved services and better health outcomes for the people of Warwickshire North. This means firstly, making the most of the services that we and local authorities commission. A key requirement of providers this year will be for all providers to evidence the right quality of service and the right quality of transfer of patients from one provider to another. We want patients and carers to experience seamless care and the information accompanying patients to be appropriate, timely, accurate and complete to support the best outcomes and experience.

We believe that QIPP schemes need to be worked on together in order to get the best commitment to implement the change from all parties.

The commissioning intention process has been led by the clinical leaders of Warwickshire North CCG and they have been approved by the CCG Executive. They are based on the priorities identified in the Warwickshire Joint Strategic Needs Assessment and Health and Wellbeing Strategy, national and regional priorities, QIPP work streams and views of local General Practices (GP), stakeholders, patients and carers.

CCGs will collaborate with one another through the commissioning cycle process to ensure all parties to any contract are appropriately engaged. The CCG will also collaborate with public health at Warwickshire County Council and NHS England to ensure that everyone is engaged with the collaborative.

3 OUR POPULATION

3.1 Our Values

- Quality and Equality first
- Dignity, respect and compassion in the services we commission
- Working together, improving health and securing sustainable services
- Benefiting the whole community, as wasted resources are wasted opportunities for others.

3.2 Our Population

NHS Warwickshire North CCG has worked with Warwickshire Public Health to identify the Joint Strategic Needs Assessment (JSNA) priorities for Warwickshire North.

Our priorities take into account the health needs identified in Warwickshire's JSNA, which include the needs of:

- Children and Young People (especially Looked After Children)
- Lifestyle factors affecting health (Obesity, Physical activity, Smoking, Alcohol and substance misuse, Sexual health)
- Vulnerable communities (reducing health inequalities, improving care for people with disabilities, and safeguarding)
- Ill health (covering long term conditions, and mental health and wellbeing)
- Old Age (dementia and frail elderly).

The CCG has a statutory duty to reduce health inequalities and by doing so will ensure that the CCG:

- Plans and commissions services in an integrated way across health and social care so that health and social care services better meet everyone's needs within the local community, including people in vulnerable circumstances and those with the worst health outcomes
- Ensuring a focus on vulnerable groups at every stage of the commissioning cycle – from JSNA to contract negotiation rounds – to include people unregistered with general practice, children, people with learning disabilities, severe mental illness, or co-morbidity, and minority ethnic groups, for all service commissioning, and in particular with any potential service reconfiguration
- Making use of provider incentives such as Clinical Quality and Innovation (CQUIN) to target lifestyle factors in health such as breastfeeding promotion, smoking cessation, increasing physical activity etc., and promoting good practice for providers as employers through the contractual framework (such as provision of stop smoking interventions for staff)
- Developing Key Performance Indicators (KPIs) with health inequality-based outcomes relating to specific provider contracts (such as smoking cessation in mental health services)
- Addressing inequalities in primary care by driving up primary care quality and tackling variations in practice performance, and prioritising service provision in deprived areas with poorer health outcomes.

Our Health and Wellbeing Challenges are as follows:

- **The population of WNCCG is growing -** The rate of population growth is below the County rate with the lowest growth in North Warwickshire. Nuneaton and Bedworth's population grew at 5.1% since 2001. Projections show a predicted overall increase of 7.9% (North Warwickshire Borough Council (NWBC)) and 12.6% (Nuneaton and Bedworth Borough Council (NBBC)) by 2033
- **The population of WNCCG is ageing -** In North Warwickshire the over 65 population is expected to grow by 60% by 2030 (48% Warwickshire). In Nuneaton and Bedworth the growth is projected at 43%
- **Health Inequalities Persist -** Life expectancy in the north of Warwickshire is lower than the Warwickshire average, in Nuneaton and Bedworth the rates are significantly lower than the England average. There is considerable variation across the area
- **Educational attainment in the North is significantly below the national Average -** In North Warwickshire the percentage of pupils achieving 5 A*-C grades was 49% and 52% in Nuneaton and Bedworth, with significant variation across the area. Attainment is lower in those who are entitled to Free School Meals
- **Looked After Children and Safeguarding – T**he rate of Looked After Children per 10,000 population is higher in Nuneaton and Bedworth than other areas of Warwickshire at 89 children per 10,000 population. Attainment figures for Looked After Children are significantly lower than achieved by non-Looked After Children. The rate of Child Protection per 10,000 population is highest in Nuneaton and Bedworth compared to the rest of Warwickshire
- **Economy: Unemployment in Nuneaton and Bedworth is the highest in the County -** In July 2012 the claimant count stood at 2,861 a rate of 3.7% of the resident working age population
- **Improved Access to Services -** The rural nature of North Warwickshire means that some people face problems accessing everyday services such as jobs, education, GP surgeries, shops etc. This can be a significant problem for people who do not have their own transport
- **Sexual Health –** Nuneaton and Bedworth has the highest rate of chlamydia (although declining) cases across Warwickshire
- **Mental Well Being** –the positivity measure for Warwickshire North has 8 of the 11 worst measures for the County, although Nuneaton and Bedworth have some of the best measures too
- **Long Term Condition disease prevalence/ incidence/ mortality**
- **Cancer** - Whilst WNCCG has lower cancer incidence, mortality is amongst the highest in Warwickshire particularly in the under 65s. This suggests late detection of cancers. Screening uptake also varies across the area
- **Diabetes** - There appears to be higher identification rates and higher numbers of people on diabetes registers in the North, although there is considerable variation across practices
- **Chronic Obstructive Pulmonary Disease (COPD)** - Evidence suggests that diagnosis in Warwickshire North is higher than the Warwickshire and national rate however; data would suggest more than 30% of patients are still not recorded on the COPD registers. There is significant variation in observed to expected rates across practices. Mortality from respiratory disease is significantly higher in North Warwickshire and Nuneaton and Bedworth in persons aged 65-84 years

- **Coronary Heart Disease (CHD)** - Data suggests a under diagnosis or under recording of CHD in primary care. In addition, mortality from CHD is significantly higher than in England (44.98 rate) for both North Warwickshire and Nuneaton and Bedworth
- **Stroke** - The ratio of expected to actual numbers recorded on the stroke register is lower than the England and Warwickshire average, suggesting an under diagnosis/recording. There are higher mortality rates for all persons in the North of the County compared to England as a whole
- **End of Life Care** - In addition to the disease specific issues mentioned above, there are significantly higher levels of patients across Warwickshire North who are dying in their own homes (22.8%) compared to 20.3% nationally and higher rates in Nuneaton and Bedworth dying in hospital (60.3% compared to 54.5% nationally). For hospital deaths this relates particularly to CHD across the area all causes of death in Nuneaton.

Priorities for upstream interventions and rationale

The 2 partnership priorities for Nuneaton and Bedworth and North Warwickshire that have been agreed in consultation with stakeholders across the area are:

- **Rising levels of obesity -** There is a significantly high prevalence of obesity across Warwickshire North when compared to the national average. 27.3% of adults in North Warwickshire and 29% in Nuneaton classified as obese compared to a Warwickshire average of 25% and a national average of 24.2%. In children, measurements of obesity are also above the Warwickshire rate at 8.5% in North Warwickshire and 9.9% in Nuneaton and Bedworth compared to 7.8% in the County. At Year 6 this rises to 19.5% in North Warwickshire and 17.7% in Nuneaton and Bedworth compare to 16.2% in Warwickshire as a whole
- **Increasing levels of alcohol related harm -** The rate of alcohol related hospital admissions in North Warwickshire and Nuneaton and Bedworth has seen an overall increase in the last 5 years in both males and females. The rate for males in Nuneaton and Bedworth is significantly above the England average.

In addition, smoking remains priority for the NHS in Warwickshire North:

- **Smoking remains the single biggest preventable killer in the UK -** Across Warwickshire North, more than 22% of adults smoke and in Warwickshire 19.6% of women smoked during pregnancy, with numbers increasing.

We are working very closely with public health, North Warwickshire and Nuneaton and Bedworth Borough councils; and Warwickshire County Council to understand the impact of the projected population growth on the Warwickshire North care system.

3.3 Making every contact and interaction count

WNCCG intends to continue to work closely with public health in Warwickshire to ensure that services which influence public health behavioural change are integrated with those services which WNCCG commission. It is essential that all partners work together to make the most of our available resources and continuously reinforce the healthier lifestyles message. It is envisaged that these services will have clear links with health checks and with all services through 'Making Every Contact Count'.

NHS Warwickshire North CCG is committed to listening to our population – our patients, carers and the public. In order to ensure that this is systematically embedded in everything we have developed and implemented a strategy for public engagement to ensure that the decisions we make are in the best interests of patients.

The CCG recognises the importance that everyone has to play in the redesign and delivery of services and therefore we are committed to working jointly with partners to reduce inequalities and develop joint strategic planning and joint commissioning where this leads to enhanced benefits to our population.

3 OUR STRATEGIC DIRECTION

We have made a significant amount of progress in determining our direction of travel over the next three years and have worked to articulate this into a language that is meaningful for our practices, population and partners.

2014/15 will be the second year of delivery of our Integrated Plan, and we will be implementing our Vision for Quality which specifically targets improvement in urgent and emergency care, mental health and dementia, frailty and those at the end of life over the three years 2014/15 to 2016/17.

3.1 NHS Warwickshire North CCG Integrated Plan and Vision for Quality

The NHS Warwickshire North CCG Integrated Plan set out the direction of travel from 2013 to 2017, the Vision for Quality was an action to be completed within the plan, to determine in more detail the quality we expect in four key priority areas. Our commissioning intentions have been based on this. This is particularly important in terms of the financial forecast and the requirement for provider reform.

NHS Warwickshire North CCG has three strategic objectives:

- Making better use of the money we already spend
- Building a sustainable system by investing in prevention, early identification and best care for patients
- Building an excellent CCG that improves outcomes for patients is a great partner to work with and a great place to work

The Integrated Plan outlines our aims for QIPP delivery from 2013 – 2017.

3.2 Vision for Quality

3.2.1 Our approach

The following outlines how we have worked to develop our clinical strategy, our "Vision for Quality":

Patient and Public Feedback

We undertook two patient surveys. One on stroke rehabilitation and one on Urgent and Emergency Care which were both publicised online and sent to GP practices. In addition, for stroke we distributed the surveys via the Stroke Association and local support groups. For urgent and emergency care carried out the survey in public places in Nuneaton and Bedworth and North Warwickshire.

On 29th April the CCG held a patient workshop event at Bedworth Civic Hall for members of the Warwickshire North Patient Group Forum and core members from the voluntary sector such as Healthwatch and Warwickshire Race Equality Partnership.

The event was attended by 30 people and provided a valuable opportunity to listen to people's views and experiences on End of Life; Urgent and Emergency Care; Dementia and Stroke. Each workshop was led by a clinician and a facilitator who gave an overview on each subject before inviting attendees to give their views on each area.

Copies of patient packs from the workshop were sent to all 28 GP practice Patient Participation Groups and additional feedback was gathered and fed in to the clinical strategy.

More than 250 individual comments were collated in response to the questions: what's working well, what's not working well and what's important for the future? Output of this feedback has been fed into the commissioning intentions for the Vision for Quality Services.

Voluntary Sector Feedback

We held a voluntary sector workshop on 19th June 2013 and the day was attended by more than 60 individuals representing 44 organisations. At this event our GPs, staff and partners from the county council also supported round table discussions on the topics of mental health, dementia, stroke/TIA and frailty.

Specialist support groups

CCG engagement staff also attended a number of local community based specialist support groups throughout the spring and summer, to inform them of the work and gather their views and opinions.

Overall, more than 450 individual comments were collated in response to the questions: what's working well, what's not working well and what's important for the future?

GP Feedback

The CCG held 12 fortnightly clinical sessions with representatives from its 28 practices and information packs were sent out prior to the sessions. Each of the 8 service areas were considered at the sessions. Some areas, including urgent and emergency care were discussed on more than one occasion and other sessions were used as consolidation sessions to ensure all representatives were in agreement with the key messages.

At the sessions, where it added value to the debate, we had visiting speakers to give expert input such as Professor Matthew Cooke (Professor of Clinical Systems Design at the University of Warwick), Mr Martin Lee (Medical Director at Arden Area Team), Dr Sharon Binyon (Medical Director at Coventry and Warwickshire Partnership Trust (CWPT)), Dr Rob Holmes (Associate Medical Director at Coventry and Warwickshire Partnership Trust and Dr A Atta (Associate

Medical Director at Coventry and Warwickshire Partnership Trust), Mr Andrew Arnold, (Medical Director, George Eliot Hospital (GEH)), Mr Reddy (Associate Medical Director Surgery) and Dr James Egbuji (Consultant Physician), Dr Meghana Pandit (Medical Director, University Hospital Coventry and Warwickshire (UHCW) and a number of other lead staff from Warwickshire County Council and South Warwickshire Foundation Trust (SWFT) to provide the GPs with information on local services e.g. Commissioner for Dementia from the County Council and Team Leads for Intermediate Care from South Warwickshire Foundation Trust.

Provider Trusts

The CCG Chief Officer and Chair have met with Chief Executives and Medical Directors from our respective providers to brief them on the work. This includes GEH, UHCW, SWFT and Coventry and Warwickshire Partnership Trust.

In addition, lead managers and medical staff from the providers attended an urgent and emergency care workshop in June 2013 to discuss the proposed model for urgent and emergency care. The Medical Directors from the providers have been invited to meet with our GPs on a number of occasions to consider the strategic outputs.

What are the next steps?

Findings from The Vision for Quality and a high level implementation plan was agreed at the Governing Body meeting on 26 September2013.

Further public, patient and voluntary sector engagement is scheduled for October 2013 and findings have already been shared with some of the key providers i.e. George Eliot Hospital, South Warwickshire Foundation Trust, University Hospitals of Coventry and Warwickshire and Coventry and Warwickshire Partnership Trust. A copy of the final draft report has been sent to all member practices; provider organisations; social care and County and local borough councils, West Leicestershire CCG, and shared with the Warwickshire Health and Well Being Board on the 25 September 2013.

Dates to share with and the Warwickshire Health Overview and Scrutiny Committee are being arranged.

3.2.2 Developing the Strategy

The NHS faces some significant challenges:

- More people living longer with more complex conditions
- Increasing evidence that for some conditions better outcomes are achieved by having a smaller number of more specialised services

- Increasing costs whilst funding remains flat or the rising expectations of quality of care. an increasing expectation of patients in terms of choice and living independently for as long as possible
- The support for self-management of long term conditions, rather than the paternalistic medical model.

Here in Warwickshire North, additional to these, we have a population that in neighbourhoods suffers significant inequalities, a difference of 10 years life expectancy for men and 7 years life expectancy for women between the best and worst areas, a population that is served by too few GPs and a small local hospital that is in special measures following the Keogh review which identified urgent priority actions as:

- leadership of quality
- pace of change
- patient locations and moves
- low levels of clinical cover, particularly out of hours
- medical handovers
- sepsis care bundle performance and management
- culture at the trust
- understanding of mortality issues
- incident reporting
- pressure ulcers

Having held discussions with representatives of patients and the public, local GPs and providers, the following principles have been agreed to shape services for patients across the boroughs of Nuneaton and Bedworth, and North Warwickshire:

- Our services should be provided as locally as possible, as long as they are safe, high quality, meet the standards in the NHS Constitution and can achieve the best health and care outcomes for our population. However, this will not affect our patients' rights to choose to receive services elsewhere.
- Our services should be available seven days a week and we need a plan to achieve this.
- It is acceptable for our patients to travel to specialist services if the right standard of care cannot be achieved locally.

The CCG considered, as part of its clinical strategy 8 service areas (4 groupings):

- Urgent and emergency care and Emergency General Surgery; Cardio Vascular Disease (CVD); Stroke, Transient Ischaemic Attack (TIA) and Heart Failure
- Frailty and End of Life
- Dementia
- Mental Health

6 COMMISSIONING PRINCIPLES

The following principles underpin how financial resources will be deployed to support improvement in the health of the Coventry and Warwickshire populations as defined by the Coventry and Warwickshire CCGs in 2012.

All of our providers are expected to:

- Work collaboratively with relevant partner organisation to develop integrated service provision where this is beneficial
- Ensure clear accountability for handover and direction between individuals, teams and organisations
- Ensure that the care delivered is safe, of high quality meeting national and local standards
- Support improvements in health outcomes
- Be clinically effective
- Be cost effective
- Be aiming to move more provision of care into the community or ambulatory care models to replace traditional inpatient care;
- Promote equitable access
- Be responsive to individual and population needs
- Support patient choice – in respect of provider, location and treatment (as appropriate)
- Be affordable within a finite budget
- Contribute to the Warwickshire Health and Wellbeing Strategy and consider their part in addressing the issues and challenges raised within it

Our providers need to assure us that the interventions on patients when care is transferred from the GP to the provider, are adding value. Most specifically, we expect our providers to adhere to clinical pathways and thresholds. Through clinical discussions we expect to expand the number of pathways and gain agreement on an increased number of clinical thresholds. Where guidelines exist nationally (NICE) or locally these must be adhered to.

Commissioners expect their providers to undertake robust capacity planning across services to ensure capacity reflected final contracted activity levels.

In carrying out their commissioning functions, clinical commissioning groups will:

- Work with their local populations to effectively identify local health needs and commission services from the providers best placed to meet the needs of their patients and population
- Commission services from providers who offer a safe and effective service
- Commission services from providers who can offer best value for money
- Commission services from providers who offer timely access to appropriate services
- Work in partnership with providers to identify further areas for QIPP delivery that promote health outcomes whilst reducing costs for both the commissioner and the provider
- Support providers to work collaboratively with each other and with the commissioners (across Health and Social Care) to improve patient experience and assist in seamless Health and Social Care provision, contributing to QIPP savings

- Work towards ensuring there are agreed service specification, contracts and outcome measures for all commissioned services
- Our providers not only have a role in treating illness but preventing it. We therefore expect that providers will deliver services that ensure that 'Every Contact Counts'. Every contact should be seen as an opportunity for a public health intervention.

Our providers should ensure that the ethos of 'No Decision About Me, Without Me' is demonstrable in all services, and we expect that patients and their families/carers be involved in developing care plans and development of services. The CCG will use live feedback from the public, patients and carers to inform our views of the quality of care that is commissioned and provided. Additionally where there is cause for concern, we will undertake more detailed investigation to gain assurance of the quality of service being provided.

7 COMMISSIONING INTENTIONS

7.1 Service vision

We want to systematically tackle the pressures within the health and social care system to deliver better outcomes for our population. To do this we will seek to commission in a way that reshapes the patients experience of care pathways from end to end.

Mortality

Mortality rates are unacceptably high and this must be tackled. The Trust has worked to improve mortality rates, which is evidenced by the last two standardised hospital mortality indicator rates. However, this needs to be further improved upon and sustained longer term. George Eliot Hospital must implement the mortality action plan, the key areas for improvement are:

- Significant improvements in the mortality and crude mortality rates to bring the hospital in line with other peer hospitals
- Focus on leadership – through Medical Director/Deputy Medical Director mortality case note review
- Focus on clinical leadership to address actions from the Keogh review, learning from Mid Staffs/Francis and learning from audits e.g.: record keeping, accuracy of death certificates.
- Evidence of improved and timely medical handover of patients.
- A review of all deaths in the Trust as they occur to identify lessons to learn
- A reduction in the length of stay of patients
- A reduction in the number of patients staying in hospital as part of their palliative care when they could be cared for either at home or in the community
- Significant improvement in management of fluid balance
- Monitoring of the Early warning signs and systems and appropriate action
- Evidence of significant improvement in the actions resulting from the notes audit work identifying poor record keeping
- Reduction in the number of wards patients move through during their stay

NHS Warwickshire North CCG will continue to implement the Arden System Plan.

Urgent and Emergency Care and Emergency General Surgery

Single Site Urgent Care Centre co- located with A&E and based at the GEH site

No change is proposed for patients who are transferred by ambulance "blue light" and who need an Accident and Emergency (A&E) or urgent paediatric assessment service. All other patients who arrive at the Urgent Care Centre (UCC) will be streamed (through the single point of access) to the best team of professionals to meet their needs.

- A&E
  - Providing for patients arriving in 999 ambulances who require emergency treatment, trauma, resuscitation, first presentation of severe illness i.e. those not suitable for other urgent care pathways.
- Specialist medical assessment (frailty)
  - A specialist medical assessment (multidisciplinary team) consisting of emergency physicians and also geriatricians who also have a community portfolio and can provide expert support to GPs and others to allow patients to remain at home where possible, thereby enhancing links out of hospital
- Mental health urgent assessment
  - An urgent mental health assessment to ensure patients with mental health problems are treated and supported for their mental health illness as well as their physical ailment.
- Primary care assessment
  - A 24 hour on site GP/primary medical service to provide in-hours and out of hours assessment and treatment for the local population.
- Social care and community urgent assessment
  - A specialist community health and social care team to provide specialist assessment, access to services to allow patients to stay ambulatory, get quick assessment and return to their home, or to an appropriate other environment to receive care within the community.
- Ambulatory care clinics
  - An expansion of the number of conditions treated in ambulatory and specialist clinics, for advice to GPs and urgent specialist assessment same day/next day, offering more appropriate care and reducing the need for hospital admission.
- Fast diagnostics
  - An expansion of urgent access to diagnostics tests for GPs to appropriately prevent an A&E attendance or emergency admission.
- Accessing an urgent specialist opinion
  - Ability of GPs to access a specialist for an opinion rather than sending the patient into hospital.

Cardiovascular Disease, Stroke and TIA

Stroke/TIA

- Improved management of medical risk factors for stroke/TIA such as high blood pressure and diabetes by peer review of GP practices.
- Ensure we have a robust integrated stroke rehabilitation service with two distinct phases: (1) early supported discharge (ESD) service (for up to six weeks post-discharge from hospital) and (2) community rehabilitation service which takes patients following their discharge from the ESD service.
- Centralise admissions of all patients with an acute presentation of cerebrovascular disease in a specialist centre to maximise their care and then repatriate them to GEH when it is clinically safe to do so. Hyper-acute stroke patients already go direct to UHCW.
- An annual report produced by the stroke and TIA service that reports activity, patient outcomes, patient experience and safety across the patient pathway as well as organisation-specific. This would allow the CCG and patients to be confident that the stroke and TIA services were helping patients achieve good outcomes.

CVD and Heart Failure

- Work with partner agencies to collaborate on optimising the impact of all our actions to reduce cardiovascular risks.
- Agree and implement a heart failure pathway between primary and secondary care with clear stages and responsibilities, including appropriate diagnostic waits.
- Access to urgent specialist opinion for GPs to prevent patients being admitted unnecessarily
- Production of an annual report by the cardiologists at GEH describing audits and key performance indicators. In addition, describing improvements to meet the challenges following the West Midlands Quality Review Service (WMQRS) review.
- Maintain the provision of NHS Health checks in all GP practices in Warwickshire North, ensuring vulnerable groups are targeted. Agree a plan to address any variation at practice level.
- Working with partners to create greater access and uptake of lifestyle management services where this is necessary.
- Procure a cardiac rehabilitation service which builds on utilising local lifestyle management services and exercise on referral schemes and offers more specialist services where it is appropriate.
- Standardise referral pathways and referral forms to improve the quality of referral through the DXS system for CVD.
- Improve QoF performance against relevant indicators, especially blood pressure.

Frailty

- Development of a Specialist Medical Assessment Unit (Frailty) at GEH site with geriatric input into the community to prevent admissions and better treat patients outside of hospital.
- Access to urgent specialist opinion for GPs to prevent patients being admitted unnecessarily
- Closely aligned mental health, social care and community teams working with GEH to ensure a seamless admission into hospital and discharge from inpatient stay. Some admissions and length of stays will be avoidable with more appropriate non-hospital services and workable pathways.
- Ensuring that all opportunities for joint commissioning of integrated services are exploited.
- Exploring ways to appropriately address the rising admissions from residential homes where care is best provided in the home.
- Annual plan from GEH outlining achievement against standards outlined in the Silver Book 2012 (The Geriatrics Society), as well as participating fully in all relevant national audits (e.g. Stroke, hip fracture, dementia, falls and bone health, continence).
- Risk stratification of patients in GP surgeries to proactively manage their conditions outside of hospital.
- Work with Warwickshire County Council to implement the Carers Strategy 2012-2015.

End of Life

- Primary, community, secondary care, voluntary organisations and hospices working in a more integrated way to ensure the number of patients who die in their place of choice increases.
- Enhance community end of life care to enable people to be cared for in their usual place of residence.
- Ensure our acute hospitals have a systematic approach to supporting the identification of people approaching the end of life and coordinating their care across organisational and professional boundaries.
- Increased number of patients on GP palliative care registers who are enabled to die at home. This will be facilitated by practices using a risk stratification tool to identify them.
- Implement an assessment and advance care planning for people identified in the last year of life, particularly those with dementia where capacity may become an issue; and with the patient's consent enter details on Electronic Palliative Care Coordination system.
- Work with Warwickshire County Council to implement the Carers Strategy 2012-2015.
- Increase the availability of carer respite to support those caring for the person who is approaching the end of life.
- Build end of life care competence and capacity in the primary care workforce.
- Promote the use of national best practice tools in end of life care, including prognostication tools to support primary care teams in identifying when patient needs are changing and a different approach to their care is required.
- An increased focus on identifying people at the end of their lives in nursing homes and with advanced dementia and proactively making advanced plans for their care.
- Improved training and literature on end of life discussions and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions.

Mental Health

- Continue to review the care of those patients placed out of the area and where appropriate care for near to Warwickshire for those with a mental health illness, personality disorder or degree of autism
- Review the role of the Crisis Resolution team and their impact on preventing admissions.
- Further understanding and use of Care Clusters, which is how mental health care will be commissioned from 2014/2015.
- Improve communication between secondary and primary care using CQUIN; the CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of providers' income to the achievement of local quality improvement goals.
- Improvement of the Eating Disorder Service (via NHS England).
- Integration of all Single Point of Entries into one referral point to make access to all services simpler (as planned by CWPT).
- Further development of the psychiatric liaison team and linking directly with the Single Point of Contact at the front end of GEH A&E.
- Improved waiting times for IAPT.
- Maintenance of the Child and Adolescent Mental Health Service (CAMHS) waiting times.
- Improved coordination and management of patients with a dual diagnosis of a mental illness and drug or alcohol dependence between Coventry and Warwickshire Partnership Trust and the Recovery Partnership.
- Ability to access a specialist opinion from a consultant psychiatrist for urgent advice through the single referral route.

Dementia

- Ensuring that opportunities for integrated care are secured by working with Warwickshire County Council and others through joint commissioning.
- Requirement for brain imaging (Computerised Tomography (CT) scan) to be undertaken prior to patients being seen in the memory clinic, so that there is one appointment when all results are available to the expert.
- Improve diagnosis rates of dementia through primary care (GP direct enhanced service) and secondary care CQUIN.
- Work with Warwickshire County Council to implement the Carers Strategy 2012-2015.
- An agreed and documented patient pathway across health, social care and the voluntary sector in line with NICE guidance. Specifically, in health, this would pick up:
    - Improvement in the post diagnosis support for patients and families.
    - Improved information for patients and carers at time of diagnosis.
    - Increase in support for patients through Admiral nursing (Admiral Nurses are mental health nurses specialising in dementia) or Dementia Advisor

Increase in community teams and assessment to increase the amount of care received closer to home.

- A Crisis Resolution Home Team to increase the responsiveness of services into people's homes.

- Further development of The Arden Mental Health Acute Team (AMHAT) which will be linked with the Urgent Care Centre and also provide support for patients with mental health problems and dementia to UHCW

Elective Care

NHS Warwickshire North CCG intends to commission services and pathways which improve patient experience, remove unwarranted attendances at hospital and reduce resource burden to both commissioners and providers. The CCG intends to work with providers to commission efficient pathways of care to deliver on the 18 week promise, make services as person centred and streamlined as possible - removing any inefficiencies and ensuring effective patient centred handovers between individuals, teams and organisations.

The CCG wishes to see clinical networks in place for stroke, subspecialty medicine, emergency general surgery and paediatrics, so that services can safely be delivered locally with robust clinical governance, clinical audit, workforce rotas, learning and development can be achieved to deliver the best outcomes irrespective of location. This will also ensure that the right elective and emergency conditions are seen by the right person, with the right competency, experience and skills in the correct clinical environment.

Rehabilitation and connecting with other services

Rehabilitation should get patients back to levels of quality of life as close as to previous to illness. WNCCG intends to ensure that patients/clients have a positive outcome in relation to their care as outlined in the NHS Outcomes Framework:

- Preventing people from dying prematurely
- Enhancing quality of life for people with long term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm
- The CCG will ensure that all providers adopt the NHS Outcomes Framework along with corresponding outcomes indicators.

WNCCG intends to Improve the quality of care that people receive in residential and nursing homes. Part of this will be having specialist services that can work with homes to care for patients proactively as to avoid instability and management of infection but also to respond rapidly to assess and advise patients with deteriorating health. The CCG also intends to ensure residential staff have sufficient training and support to enable residents to die in the home rather than in hospital.

NHS Warwickshire North CCG wishes to work jointly with providers to develop a range of rehabilitation services to meet the needs of the population. Rehabilitation is a key component of all pathways for long term conditions. It has an established role in pathways for people with cardiac disease and heart failure, chronic lung disease and chronic neurological conditions. Rehabilitation services can support safe, supported and timely discharge from hospital - especially

for people with complex needs - reducing hospital length of stay. Other benefits of rehabilitation services include reduced dependency on health and social care support and associated costs and it also delivers significant cost savings through alternative pathways of care and reduced longer term support costs.

In the case of specialised services, commissioned by NHS England, WNCCG wishes to work with these commissioners to ensure that our population receives seamless care.

Early identification, prevention and best management

An essential component of care for patients with long term conditions is the focus on early identification of long term conditions, self-management where appropriate and comprehensive care planning. WNCCG would like to work together with partners to review the long term conditions pathways across the area to ensure that the provision of coordinated, integrated care across hospital, community, primary care and social services as identified in the WMQRS 2012. The aim being to avoid unnecessary admissions, achieve reduced lengths of stay (LOS) whilst maintaining or improving the quality of care that patients receive. CVD is a particular priority identified in the Vision for Quality.

Though the ambulatory care team, the CCG would like to see the development of phone advice and hot clinics in order to prevent admissions and treat those patients suffering with exacerbations of chronic illnesses, for instance; COPD, CVD etc. as stated earlier.

The CCG will work with other commissioners to review the learning disability services and services for those with autism in line with the Joint Strategic Needs Assessments carried out in these areas.

Learning Disability Services

- Adjustments are in place to accommodate the health needs of people with learning disabilities accessing acute care. Building on the evidence from the national review and direction about the particular health risks and issues impacting on people's experience and outcomes of health services.
- The CCG has reviewed with local authority colleagues all patients placed out of the area who are placed in a hospital setting (reference Winterbourne) to ensure they are receiving the right care in the right place and where appropriate, provide care closer to Warwickshire. This coming year we will widen our review to additionally include patients with both a learning disability and an additional mental health disorder.
- The CCG would like to ensure the review of care packages and decision making for those with Learning Disabilities admitted for treatment and assessment to ensure a more timely discharge and prevent readmission.

Children and maternity

The CCG believes that Children and Young People need holistic care that meets their needs and will work jointly with partners and providers to ensure that children, young people, their advocates and carers are involved in their care planning to ensure that care is centred around the child/young person.

The CCG will work with partners across health, social care and education to develop and implement a Children and Young People's Plan.

We will commission services that ensure that when children have complex care needs that their care is provided in a seamless way to ensure that children are able to live as full and independent life as possible.

WNCCG will develop and maintain links to the West Midland's Maternity and Children's Strategic Clinical Network in order share evidence and best practice for paediatric and maternity services. We will be active members of the Arden Maternity Network that was established September 2013; the remit of the Network is to reduce risk and variation across the local maternity services delivering positive outcomes for mothers and babies.

For Paediatrics the CCG wishes to explore how the additional doctors and nurses can help us to better support the most complex children (looked after children; high numbers of troubled families; and child abuse).

The CCG will work with other agencies to ensure joint working with education, social care and other strategic partners. When a child is absent from school due to illness or health reasons that partners work together to ensure that the child and family are supported.

The CCG will work with partners to see improved integrated sharing of information between police, health and social care, working with the Warwickshire Safeguarding Children's Board to understand the issues in Warwickshire North and the reasons we have so many children on child protection plans so that we can work in partnership on earlier intervention.

The CCG is committed to ensuring that the transition from Children's to Adult services is integrated across Providers to support young people in the Transition to adult services.

The CCG wishes to see the implementation of the recommendations from the West Midlands Quality Review (November 2012) and that all the quality standards to achieve the paediatric diabetes best practice tariff are met. The priority areas include:

- Appropriate staffing levels to support 140 children and young people a year
- Number of children managed on insulin pumps increase from 9% to 15% in line with NICE guidance
- Point of care HBA1c testing (or robust alternative) available in paediatric diabetes clinics, resulting in fewer venous samples. Immediate results are particularly beneficial for poorly compliant teenagers.
- Programme of regular audit and data collection
- Transition to adult services

In terms of maternity, the CCG would like to ensure the following:

- The midwife to birth ratio is maintained at 1:32.
- A reduction in C-Section rates and a greater improvement in inter uterine growth restriction (IUGR) screening detection to reduce the number of still birth in line with the national average.
- Improved recording of data and the measurement of care.
- Implementation of the pathway review on the care of mothers who are identified as "high risk" to ensure that mothers who are high risk are seen at specialist centres
- Working with public health colleagues to achieve a reduction of smoking in pregnancy

Lifestyle Interventions

Smoking (maternity and mental health)

Smoking has a significant impact on the health of people with mental health problems, with higher levels of smoking responsible for a large proportion of the excess mortality of people with mental illness.

Smoking can cause complications in pregnancy, including increased risk of miscarriage, premature birth and low birth weight. Passive smoking can cause wheeze and asthma, middle ear infection and sudden infant death among children whose mothers smoke.

- Trusts should provide intensive stop smoking support for people using mental health services
- Trusts should provide intensive stop smoking support for people using maternity services
- Trusts should monitor and audit the level of patient referrals and uptake of stop smoking interventions to include both the number of referrals and the number of referrals that result in people stopping smoking
- Performance management of stop smoking services in trusts should include: smoking status at discharge from care, smoking status of mothers at time of delivery, and long-term stop smoking (quit) rates

In particular the following specific key performance indicators will be commissioned:

- 100% of pregnant women offered CO monitoring at booking; 95% are monitored
- 100% of pregnant women have smoking status recorded at booking
- 100% smokers in pregnancy are offered specialist smoking cessation support; 75% are seen by the service
- 100% of women have smoking status recorded at time of delivery

Making Every Contact Count (MECC)

Making every contact count ensures that all opportunities, through face to face contact, to support people to make informed lifestyle changes are taken. It also ensures that there is consistency in messages regarding healthy lifestyle across all providers of services.

- Ensure MECC is embedded in all Service Specifications
- Ensure that there is a trained 'MECC Champion' in each clinical area or nursing team
- Each trust to have a clear action plan to achieve rolling out of MECC to all front-line clinical staff by March 2018

In particular the following specific key performance indicators will be commissioned:

- All provider trusts will have a named MECC champion in each clinical area/ nursing team
- Each provider has a clear action plan to roll out MECC
- 100% of frontline staff are MECC trained by March 2018

Immunisation (Influenza and Measles Mumps and Rubella (MMR))

- Trusts will pro-actively and robustly offer flu vaccinations to front line clinical staff, as per DH guidance, with the aim to ensure a minimum of 90% uptake
- Trusts will undertake flu vaccinations with long stay in-patients in clinical risk groups during the flu vaccination campaign. They will also ensure that the GP is informed of the vaccination by fax or email within 7 working days of the immunisation being given
- Trusts will ensure that staff working in outpatient clinics will robustly and proactively encourage patients in eligible clinical risk groups (as per Department of Health (DH) guidance) to attend their own registered GP practice for flu vaccination
- Trusts will ensure that staff working in community and hospital antenatal clinics will robustly and proactively encourage all pregnant women to attend their own registered GP practice for flu vaccination
- Trusts will proactively and robustly ensure that all frontline and clinical staff have evidence of immunity to measles either by antibody titre levels or evidence of two doses of MMR vaccine

In particular the following specific key performance indicators will be commissioned:

- Achievement of 10% increase year on year in frontline staff flu immunisations

Breast feeding

Increase in initiation of breast feeding has been a requirement for a number of years. Warwickshire has prioritised the achievement of the UNICEF Baby friendly initiative (BFI) across all maternity and community providers.

- BFI stage 3 achieved by December 2015 by all maternity providers
- 75% breast feeding initiation achieved by March 2014

Maternal obesity

Maternal obesity is a key risk factor in terms of pregnancy outcomes. All maternity providers are to develop and implement a maternal obesity pathway by March 2014.

Community-based Services

All services provided in the community should continue to be provided from those locations to ensure that the local area receives services local to them. Therefore all contracts will require a schedule of where each service is provided from.

7.2 CQUIN

It is anticipated that as in 2013-14, the majority of CQUIN schemes will support the implementation of agreed patient safety and QIPP initiatives.

7.3 Any Qualified Provider

There is an expectation that Commissioners will continue to increase patient choice in local services via the Any Qualified Provider (AQP) route during 2014-15. Providers will be expected to work with Commissioners to identify services where AQP could be beneficial to patients and engage with the Commissioner s during any consultation phases prior to the qualification process.

WNCCG will endeavour to share information with Providers who maybe affected by AQP in a timely manner as possible. Appropriate notice for a variation in service will be given by the commissioners for any services moving to AQP.

7.5 Specific Commissioning Intentions: George Eliot Hospital NHS Trust

Mortality

Mortality rates are unacceptably high and improvements in the quality and care and treatment must be tackled. The Trust has worked to improve mortality rates, which is evidenced by the last two standardised hospital mortality indicator rates. However this needs to be further improved upon and sustained longer term. George Eliot Hospital must implement the mortality action plan, the key areas for improvement are:

- Significant improvements in the mortality and crude mortality rates to bring the hospital in line with other peer hospitals
- Focus on leadership – through Medical Director/Deputy Medical Director mortality case note review
- Focus on clinical leadership to address actions from the Keogh review, learning from Mid Staffs/Francis and learning from audits e.g. record keeping, accuracy of death certificates.
- Evidence of improved and timely medical handover of patients.
- A review of all deaths in the Trust as they occur to identify lessons to learn
- A reduction in the length of stay of patients
- A reduction in the number of patients staying in hospital as part of their palliative care when they could be cared for either at home or in the community
- Significant improvement in management of fluid balance
- Monitoring of the Early warning signs and systems and appropriate action
- Evidence of significant improvement in the actions resulting from the notes audit work identifying poor record keeping
- Reduction in the number of wards patients move through during their stay

Patient experience and quality of care

- **No decision about me, without me** - Providers are expected to embrace the national policy and to ensure that all their clinical processes support informed patient choice and decision making.
- **Making every contact count** - Key public health messages to be conveyed at each contact with patients
- **Avoidable harm** - To avoid the number of pressure ulcers, Health Care Acquired Infections, falls and medication errors
- **CQUINs from 2013-14** - providers are expected to ensure that all the CQUIN's from 2013-14 are mainstreamed into core delivery and that CQUINS form previous years continue to be part of the core offer
    - Friends and Family Test
    - NHS Safety Thermometer – Improvement
    - Dementia
    - VTE (Venous Thromboembolism)
    - Mortality
    - Response to Francis
    - Outpatient and Elective Care
    - Specialist Palliative Care
- **Patient experience -** Providers are expected to develop an agreed work plan to improving patient experience through learning and listening to patients and their carers
- **NHS Constitution -** Providers are expected to provide services in line with the NHS Constitution
- **Outcomes framework –** WNCCG intends on ensuring that patients/clients have a positive outcome in relation to their care as outlined in the NHS Outcomes Framework:
- Preventing people from dying prematurely
- Enhancing quality of life for people with long term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm
- The CCG will ensure that all providers adopt the NHS Outcomes Framework along with corresponding outcomes indicators.

Urgent and Emergency Care and Emergency General Surgery

Single Site Urgent Care Centre co- located with A&E and based at the GEH site

No change is proposed for patients who are transferred by ambulance "blue light" and who need an A&E or the paediatric assessment service. All other patients who arrive at the Urgent Care Centre (UCC) will be streamed (through the single point of access) to the best team of professionals to meet their needs.

- A&E
  - Providing for patients arriving in 999 ambulances who require emergency treatment, trauma, resuscitation, first presentation of severe illness i.e. those not suitable for other urgent care pathways.
- Specialist medical assessment (frailty)
  - A specialist medical assessment (multidisciplinary team) consisting of emergency physicians and also geriatricians who also have a community portfolio and can provide expert support to GPs and others to allow patients to remain at home where possible, thereby enhancing links out of hospital
- Ambulatory care clinics
  - An expansion of the number of conditions treated in ambulatory and specialist clinics, for advice to GPs and urgent specialist assessment same day/next day, offering more appropriate care and reducing the need for hospital admission.
- Fast diagnostics
  - An expansion of urgent access to diagnostics tests for GPs to appropriately prevent an A&E attendance or emergency admission.
- Accessing an urgent specialist opinion
  - Ability of GPs to access a specialist for an opinion rather than sending the patient into hospital.

Cardiovascular Disease, Stroke and TIA

Stroke/TIA

- Centralise admissions of all patients with an acute presentation of cerebrovascular disease in a specialist centre to maximise their care and then repatriate them to GEH when it is clinically safe to do so.
- An annual report produced by the stroke and TIA service that reports activity, patient outcomes, patient experience and safety across the patient pathway as well as organisation-specific. This would allow the CCG and patients to be confident that the stroke and TIA services were helping patients achieve good outcomes

CVD and Heart Failure

- Agree and implement a heart failure pathway between primary and secondary care.
- The ability for GPs to access immediate advice from a senior specialist. This is also a part of the proposed Urgent and Emergency Model of Care.

- Production of an annual report by the Cardiologists at GEH describing audits and key performance indicators. In addition, describing developments to meet the challenges following the WMQRS review.

Frailty

- Development of a Specialist Medical Assessment Unit (Frailty) at GEH site with geriatric input into the community to prevent admissions and better treat patients outside of hospital. This is part of the Model for Urgent and Emergency Care.
- The ability for GPs to access immediate advice from a senior specialist. This is also a part of the proposed Urgent and Emergency Model of Care.
- Closely aligned health and social care community teams working with GEH to ensure a seamless admission into hospital and discharge from in patient stay. Some admissions and LOS will be avoidable with more appropriate non-hospital services and workable pathways.
- Annual plan from GEH outlining achievement against standards outlined in the Silver Book (The Geriatrics Society) as well as participating fully in all relevant national audits (e.g. Stroke, hip fracture, dementia, falls and bone health, continence).

End of Life

- Primary, community, secondary care, voluntary organisations and hospices working in a more integrated way to ensure the number of patients who die in place of choice increases.
- Ensure our acute hospitals have a systematic approach to supporting the identification of people approaching the end of life and coordinating their care across organisational and professional boundaries

Mental Health

- Further development of the psychiatric liaison team and linked directly with the Single Point of Contact at the front end of GEH A&E

Dementia

- Acute hospitals have increased staff training in managing dementia, to increase the identification and referral of patients for Memory Assessment (CQUIN incentivised in 12/13) however GPs report inconsistency of information getting back to them about patients assessment and referral to a memory clinic. Providers to ensure that the result of any dementia screening and any action taken by the Trust is included in the discharge letter and is communicated to any relevant clinicians and carers.

Care Homes

- Developing support services that can work with homes (involving GP and specialist input) to care for patients proactively as to avoid instability but also to respond rapidly to assess and advise patients with deteriorating health
- Ensure residential home staff have sufficient training and support to enable residents to avoid unnecessary hospital admission and where necessary to die in the home rather than in hospital
- Standardisation of care across nursing homes to improve level of care across WNCCG and reduce unnecessary attendances to hospital

Cancer

- We wish to see providers working in a networked model across CCGs and Specialised Commissioning to provide cancer services. This will include the commissioning of site specific cancer groups and a review of current multi-disciplinary teams for cancer.
- Providers are expected to raise local awareness and early diagnosis for agreed cancer initiatives
- Providers need to adjust assumptions for the change in Chemotherapy tariff; impact of chemotherapy drugs and specialised commissioning; impact of sub-cut chemotherapy and provision of care
- Providers should work with other agencies to signpost to Citizens Advice Bureau/financial support
- Providers should implement the findings for improvement from cancer peer reviews in a timely way
- Providers need to adjust capacity assumptions for endoscopic capacity/introduction of flexi-sig within the bowel screening programme
- Providers need to increase the percentage of Image Guided Radio Therapy (IGRT)/ Specialised commissioning
- Providers may need to develop plans to test Human Papilloma Virus (HPV) for head and neck cancer
- Providers need to adjust assumptions for the impact of reduced availability of Bacillus Calmette-Guerin **(**BCG) to treat bladder cancer, leading to higher numbers of surgery and impact on critical care
- Providers to ensure positron emission tomography (PET) scanning to assess response to cancer treatment is in line with evidence based practice
- GEH needs to increase magnetic resonance imaging (MRI) capacity
- Providers need to conform with the Cancer Outcomes and Services Dataset
- Providers need to ensure complete cancer staging information is sent to West Midlands Cancer Intelligence Unit (WMCIU) for at least 70% of all cancers
- The CCG expect no patient to wait over 100 days for cancer treatment.

Mental Health, Learning Disabilities, Substance Misuse and Dementia

- **Learning Disabilities** - Reasonable adjustments are in place to accommodate the health needs of people with learning disabilities accessing acute care. Building on the evidence from national review and direction about the particular health risks and issues impacting on people's experience and outcomes of health services.

Childrens' and Maternity Services

- **Transition from Children's to Adult services** - Commissioners wish to explore means of enhancing integrated working across Providers to support young people in the transition to adult services
- **Paediatrics** – Continue to commission paediatric inpatient services at UHCW, with all other services remaining at GEH alongside the 16-hour short stay paediatric assessment unit (SSPAU).
- **Paediatric Diabetes –** The CCG wishes to see the full implementation of the recommendations from the West Midlands Quality Review (November 2012) and that all the quality standards to achieve the paediatric diabetes best practice tariff are met. The priority areas include:
    - Appropriate staffing levels to support 140 children and young people
    - Number of children managed on insulin pumps increase from 9% to 15% in line with NICE guidance
    - Point of care HBA1c (Glycated Haemoglobin) testing (or robust alternative) available in paediatric diabetes clinics, resulting in fewer venous samples. Immediate results are particularly beneficial for poorly compliant teenagers.
    - Programme of regular audit and data collection
    - Transition to adult services
- **Maternity** – see a reduction in C-Section rates and an improvement IUGR (inter Uterine growth restriction) screening detection to reduce the number of still birth babies in line with the national average

Emergency care

- **Urgent care redesign** - The CCG intends to work with stakeholders to commission a redesigned urgent care system. The aim being to ensure that patient's needs are being met in an emergency through integrated service provision for urgent primary care, minor illnesses/injuries and 999 emergencies.

Outpatients and Elective Care

- **Outpatient pathway redesign** - Commissioners wish to streamline outpatient pathways to improve patient experience, remove unwarranted attendances at hospital and reduce resource burden to both commissioners and providers
- **Consultant to Consultant referrals** – in line with policy, commissioners wish to minimise consultant to consultant referrals and will not pay for consultant to consultant referrals outside of the policy
- **Physiotherapy** - Commissioners will explore means of increasing the cost effectiveness and access of physiotherapy services improving integration across the primary and secondary care interface and by agreeing criteria to ensure that patients both access the service appropriately and are discharged in a timely manner when treatment is not having the desired clinical impact
- **Access** – all services commissioned should be in line with national targets for patient access in line with the NHS Constitution
- **Pathways** – commissioners wish to agree a programme of pathway reviews to ensure that they are efficient, person centred and effective.

Capacity and demand plan

- **Bed base** – commissioners wish to agree a plan with the Trust that will adjust its bed base to reflect the impact of service change and reductions in length of stay, for example; the shift from inpatient management to day case and Outpatient Procedures; the impact of schemes to prevent inappropriate admission and to expedite discharge from hospital.

Prescribing and Secondary Care Drugs

- **High Cost Secondary Care Drugs –** No payment for Payment by Results (PBR) excluded drugs unless Provider can demonstrate compliance with NICE guidance or agreed local prescribing protocol
- **Home care medicines** - Providers are expected to continue to implement the 3 year strategy for home care medicines and services and their supply, as per the DH Homecare review, and to be implementing year 2 of this from 1 April 2014.
- **Blueteq** – Agree a rollout plan to implement Blueteq proformas across the Trust to ensure high cost drugs are being used in line with NICE/local criteria.
- **Preferred products** – to review the use of less expensive products, (e.g. biosimilars, Certolizumab) with clinical engagement to generate cost efficiencies for both provider and commissioner.
- **Repatriation** – to explore the opportunities for repatriation of drugs which can be purchased cheaper by the hospital than by community services or homecare companies.

Tuberculosis (TB) Service

WNCCG along with the other Coventry and Warwickshire CCG's intends to review the current TB service to ensure that the best outcomes are achieved for patients within the current resource

Patient Transport Services

Commissioners intend to retender the service; this will impact on the 2014/15 contract

Community-based Services

All services provided in the community should continue to be provided from those locations to ensure that the local area receives services local to them. Therefore all contracts will require a schedule of where each service is provided from.

General

- Commissioners expect that all providers will comply with all guidance issued by the Department of Health in relation to new or revised targets, counting and charging, changes to PBR and other national priorities
- Commissioners expect that all providers will have plans in place and be able to demonstrate compliance with/progress towards (as applicable) the national innovation targets as set out in Innovation, Health and Wealth (November 2011)
- The Trust is expected to achieve national requirements in respect of the national Maternity Pathway tariff

- Non-PBR prices – the national tariff inflator/deflator figure per the 2014/15 Operating Framework will be applied to all non-PBR prices
- Local prices will be agreed and offer flexibility to support innovation in care pathway redesign

Terms and Conditions

- All providers will be expected to provide CCG specific contract monitoring reports
- Commissioners will not pay for any self-referrals to outpatients unless as part of an agreed pathway
- Commissioners will not pay for any cancelled operation on the day of the operation for non-clinical reasons
- No payment for consultant to consultant referrals outside policy
- No payment for LPP/Aesthetic procedures outside of policy
- No payment for PBR excluded drugs unless Provider can demonstrate compliance with NICE guidance or agreed local prescribing protocol
- Where an incomplete data set is submitted, 5% of the funding will be withheld until the full data set is submitted on which Commissioners will then raise queries, as appropriate
- Target response times to be agreed for Advice and Guidance requests made via Choose and Book
- All providers are expected to share via the Clinical Quality Review (CQR) meetings, the quality impact assessments that they undertake for their internal cost improvement programmes
- All providers are expected to share via the CQR meetings, any reports they prepare for their own Boards in relation to Energising for Excellence
- Electronic transfer of letters needs to be universal
- Discharge letters to include clear description of future management plan and discharge care arrangements
- Any proposed changes to PBR prices must be notified to the CCG by 1 January 2014. Changes to non-PBR prices will only be agreed if it is shown that existing prices are clearly out of line with national benchmarked figures
- Provider to notify commissioners of proposed pricing structure changes associated with those areas that will attract a local tariff e.g. Excluded Devices. Commissioners intend to review non-PBR pricing structure to ensure this is in line with West Midlands providers
- Provider to notify commissioners of its intentions to charge for new activity or make changes to existing pathways that will impact on costs e.g. QIPP
- All locations of services will be listed in the contract
- The CCG wishes to explore new contracting mechanisms including prime provider contracts

7.6 Specific Commissioning Intentions: South Warwickshire Foundation Trust Community Health Services

We, along with other CCGs in the area, would like to work with South Warwickshire CCG to secure the following community commissioning intentions for 2014/15 in the SWFT contract on our behalf:

- A comprehensive review and re-commissioning of community services
- Integrated health and social care teams with shared records where in the best interest of the patients
- Better regular information on the quality and volume of service delivered evidencing adequacy of resource for population need
- Better integration and linked services between GP and primary care teams, and community services and teams to improve continuity of care.
- Ensure care is based on need
- Prevent inappropriate secondary care admission
- Facilitate early secondary care discharge
- Prevent inappropriate admissions to nursing and residential care so that patients do not become unnecessarily institutionalised and are given every opportunity to regain their independence and return to their original place of residence
- Reduce impairments attributable to long term conditions
- Rehabilitate to the optimum so that patients return to the level of independence they had before becoming unwell
- Promote social inclusion where appropriate
- Allow the development of patient capability in self directing their care and self-managing their conditions
- Support integrated health and social care for children and young people so that the transition between care provided for a child as he or she grows up is managed
- Allow patients to end their lives in the place of their choice
- Adopt the principle of “referrer decides” so that patients who are referred to community health services are accepted, trusting the judgement of the referring professional

Specifically for NHS Warwickshire North CCG we would like to ensure the following is commissioned:

Urgent and Emergency Care

Single Site Urgent Care Centre co- located with A&E and based at the GEH site

No change is proposed for patients who are transferred by ambulance “blue light” and who need an A&E service. All other patients who arrive at the Urgent Care Centre (UCC) will be streamed (through the single point of access) to the best team of professionals to meet their needs.

- Specialist medical assessment (frailty)

  - A specialist medical assessment (multidisciplinary team) consisting of emergency physicians and also geriatricians who also have a community portfolio and can provide expert support to GPs and others to allow patients to remain at home where possible, thereby enhancing links out of hospital

- Social care and community urgent assessment
  - A specialist community health and social care team to provide specialist assessment, access to services to allow patients to stay ambulatory, get quick assessment and return to their home, or to an appropriate other environment to receive care within the community.

Frailty

- Closely aligned health and social care community teams working with GEH to ensure a seamless admission into hospital and discharge from in patient stay. Some admissions and LOS will be avoidable with more appropriate non-hospital services and workable pathways.

End of Life

- Primary, community, secondary care, voluntary organisations and hospices working in a more integrated way to ensure the number of patients who die in place of choice increases.
- Enhance community end of life care to enable people to be cared for in their usual place of residence
- Ensure our acute hospitals have a systematic approach to supporting the identification of people approaching the end of life and coordinating their care across organisational and professional boundaries

Care Homes

WNCCG is cognisant of issues with regard to the capability and resilience of the care home sector. The CCG would wish to work with the community teams to ensure that community services as they develop continue to enhance the wider system capability, preventing crisis intervention and working to reduce unnecessary admissions to hospital.

Tissue Viability

WNCCG is aware of the pilot work on reshaping leg ulcer management to include specialist tissue viability input to clinics and the successful impact that this had on healing rates and therefore outcomes for patients. The CCG supports proposals to roll out this model within the current resource and the savings both in prescribing and District Nursing time that this will deliver.

Community services

Community services should be linked closely with GP Practices to co-ordinate care, risk stratify and target support for patients to allow them to stay at home and prevent unnecessary admissions to other services.

7.7 Specific Commissioning Intentions – CWPT

Urgent and Emergency Care and Emergency General Surgery

Single Site Urgent Care Centre co- located with A&E and based at the GEH site

No change is proposed for patients who are transferred by ambulance "blue light" and who need an A&E service. All other patients who arrive at the Urgent Care Centre (UCC) will be streamed (through the single point of access) to the best team of professionals to meet their needs.

- Mental health urgent assessment
    - An urgent mental health assessment to ensure patients with mental health problems are treated and supported for their mental health illness as well as their physical ailment.

Mental Health

- Further understanding and use of Care Clusters which is how mental health care will be commissioned from 2014/2015.
- Maximise use of communication CQUIN to improve communication between secondary and primary care
- Integration of all Single Point of Entries into one referral point to make access to all services simpler (as planned by CWPT). Audit trail to be available to referrers
- Further development of the psychiatric liaison team and linked directly with the Single Point of Contact at the front end of GEH A&E
- Improved waiting times for IAPT
- Maintenance of the CAMHS waiting times
- Improved coordination and management of patients with a dual diagnosis of a mental illness and drug or alcohol dependence between Coventry and Warwickshire Partnership Trust and the Recovery Partnership
- Ability to access a specialist opinion from a consultant psychiatrist for urgent advice through the single referral route and one telephone number
- Improvement of the Eating Disorder Service

Dementia

- An agreed and documented patient pathway across health, social care and the voluntary sector in line with NICE guidance. Specifically, in health, this would pick up:
    - Improvement in the post diagnosis support for patients and families
    - Improved information for patients and carers at time of diagnosis
    - Increase in support for patients through Admiral nursing or Dementia Advisors
- Requirement for brain imaging (CT scan) to be undertaken prior to patient being seen in the memory clinic. This already takes place but not prior to referral in a one stop shop model.
- Coventry and Warwickshire Partnership Trust are undergoing the following developments which are supported by the CCG in addressing issues which have been raised in the review:
    - Post diagnosis support is being developed

  - Investment is being made in community teams and assessment to increase the amount of care received closer to home. These should link into general community teams to ensure that all needs are met in one coordinated plan.
  - A Crisis Resolution Home Team is also being developed to increase the responsiveness of services into people's homes.
  - The Arden Mental Health Acute Team (AMHAT) has been established to increase links between acute hospital care and mental health services, speeding up the process for patients accessing appropriate support
  - Acute hospitals have increased staff training in managing dementia, to increase the identification and referral of patients for Memory Assessment (CQUIN incentivised in 12/13)
- The CCG will clarify the policy for dementia specific medication
- Improve diagnosis rates of dementia through primary care (GP direct enhanced service) and secondary care (CQUIN) which is monitored as part of the quality and contracting process.
- An increase in the options available for carer respite

7.8 Pathology Contract

The Commissioners are keen to work with the Pathology Network in order to achieve the following for the Contract 2014/15:

- To continue the implementation of Order Comms to a successful completion.
- To work with the CCG to continue the review of Phlebotomy services to improve both Domiciliary and clinical and community based locations phlebotomy services to the advantage of patients and to improve equity of access for patients.
- To review and continue ongoing CQUIN projects where necessary
- To work towards "Transforming Pathology Services" goals to ensure the effective continued Pathology Services for patients in the Coventry and Warwick areas.
- To deliver a financial reduction across the CCG for 14/15.
- Participate in collaborative procurement of new pathology provider across Coventry and Warwickshire

7.9 Ambulance Service

The Commissioners are keen to work with the West Midlands Ambulance Service in order to achieve the following for the Contract 2014/15:

- To continue to improve call triage and clinical treatment advice to ensure the correct response for patients. To improve "hear and treat".
- To work with trusts to resolve where possible delays in turnaround times, to follow up and seek advice from other Trusts on their reduction and resolution in delays.

- Reduce conveyance to Emergency Departments unless clinically necessary. To seek other services input that would be more appropriate for the patient.
- To promote the 111 service where appropriate.

7.10 Locally Enhanced Services

WNCCG is currently reviewing all locally enhanced services (LES) and will commission services in line with this review for 2014/15.

7.11 Information Management & Technology

Appendix 1 details the IM&T commissioning intentions for 2014-15.

8 Timetable

The following details the timetable for an agreed contract by no later than 31 March 2014 (or earlier if instructed to do so):

Date	Action
30 September 13	Commissioning Intentions sent to providers Counting and charging letter received from providers
7 October 13	Second draft of new QIPP Plans for 2014/15 (including proposed CQUIN schemes) and revised plans for continuation of existing QIPP schemes (90% complete) to be submitted to Director of Commissioning for discussion at Integrated Delivery Board on 16 October 13
14 October 13	1st draft of WNCCG medium term financial plan to confirm the likely QIPP gap Governance arrangements to oversee planning process in place (e.g. QIPP & CQUIN Technical Groups)
16 October 13	Second draft of new QIPP Plans for 2014/15 (including proposed CQUIN schemes) and revised plans for continuation of existing QIPP schemes (90% complete) discussed at Integrated Delivery Board
24 October 13	Practice Managers Forum discussion and engagement on commissioning intentions/plans
November 13	Practice Forum Group discussion and engagement on commissioning intentions/plans
11 November 13	Final new QIPP Plans for 2014/15 (including proposed CQUIN schemes) and revised plans for continuation of existing QIPP schemes to be submitted to Director of Commissioning for sign off at Integrated Delivery Board on 20 October 13 – to enable discussion with providers
20 November 13	Final new QIPP Plans for 2014/15 (including proposed CQUIN schemes) and revised plans for continuation of existing QIPP schemes signed off at Integrated Delivery Board – to enable discussion with providers
October - December 13	Contract Negotiation Principles Workshop – CCG and Provider Develop financial and activity modelling outputs to support individual CCG baselines per contract Develop QIPP proposals including financial and activity modelling Develop CQUIN schemes Contract negotiation meetings
Mid December 13	Publication of National Operational Framework (tbc) plus publication of national tariff and refresh of headline and supporting indicators
End December 13	Confirm individual CCG baselines
End December 13	QIPP plans signed off with leads identified Confirm individual CCG baselines CQUIN agreed Activity and financial modelling
10 January 14	Formal Contract offer issued to Provider
January – March 14	QIPP implementation phase
31 January 14	Activity & Finance and Terms and Conditions to be agreed and confirmed
February 14	Executive to Executive escalation meetings (if required)
28 February 14	All contracts to be signed (in line with contract agreement in January)

Key Leads and Contact Details

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Appendix 1: COMMISSIONING INTENTIONS for 2014-15 – Information Management and Technology

This section sets out key broad areas where the CCG expects providers to progress information technology developments to improve the efficiency and quality of care. These include collaborative developments across the health economy and provider-specific developments.

The CCG expects to work with providers over the next period to develop more specific plans which can be formalised as contractual commitments where appropriate.

Providers are expected to work collaboratively with commissioners to:

1. Ensure that key national and local systems currently being implemented are fully exploited to deliver efficiency and quality benefits. These include:
   - Electronic Palliative Care Co-ordination System
   - Summary Care Record
   - Electronic communications between Trusts and GP Practices
   - the IT products of the Warwickshire Common Assessment Framework programme
2. Develop and implement new national IT solutions , and comply with national IT targets and guidelines including:
   - NHS e-referrals service (Choose and Book replacement), to make e-referrals available to patients and health professionals for all secondary care by 2015
   - safe digital record keeping as a precursor to achieving integrated digital care records across the health and care system – using the approaches and standards set out in 'Safer Hospitals, Safer Wards: Achieving an Integrated Digital Care Record'. This should include implementation of electronic prescribing capabilities consistent with Section 5.2 of 'Safer Hospitals, Safer Wards' which will also enable the sharing of patient medication records across care transitions
   - where Providers proceed to implement Lorenzo, maximise opportunities for Lorenzo to support integrated care
   - wherever possible digital access to services, in particular the 10 high impact digital initiatives set out in 'Digital first: The delivery choice for England's population'
   - appropriate use of digital technologies to improve efficiency including those set out in the 'Digital Technology Essentials Guide'
3. Continue to work with LHE partners to identify and implement solutions to :
   - wider sharing of patient records across care settings to support integrated care, working towards national target of ensuring that integrated digital care records (IDCRs) become universally available at the point of care for all clinical and care professionals by 2018
   - patient / carer tools to support self-care, collaborative care and healthy lifestyle, including access to records
   - shared business intelligence / analytics across commissioners and providers where practical
   - Consistent approach to messaging and infrastructure.

NHS COVENTRY & RUGBY

CLINICAL COMMISSIONING GROUP

COMMISSIONING INTENTIONS

2014/16

Date: 30th September 2013

Status: Draft – For further review by Members subject to submission to Governing Body in November for approval.

INTRODUCTION

This year (2013/14) is the CCG's first year of operation as a statutory commissioning body and in line with the ethos of CCGs as membership organisations, local priorities for action have been developed in partnership with member practices and their localities and patients and public from across the CCG area. The process through which these priorities were developed included consideration of the Health and Wellbeing Strategies for Coventry and Warwickshire, the plans and proposals in respect of People services in Coventry City Council and Warwickshire County Council and the emerging priorities for NHS England.

Through an on-going process of engagement, over 1000 patients and members of the public have identified their priorities for action in respect of the five strategic priorities of the CCG:

- Best practice in acute hospital care
- Wellbeing of people with mental health needs
- Health of (frail) older people
- Healthy living and lifestyle choices
- High quality, safe GP practices

During August 2013, the process was repeated at three separate workshops involving representatives from member practices in each of the CCGs three localities along with CCG staff and key staff from the two local authorities.

From these engagement activities, six work programmes have been selected as those likely to make the most significant contribution to improving health outcomes for our population. Over the coming months, the CCG will engage with a wide range of stakeholders to develop ideas as to what changes should be made to existing services within each of these seven work programmes in order to improve the health outcome secured. These ideas will then be reviewed for do-ability and likely impact and the resultant prioritized set of actions will be detailed within the CCG's Operational Plan 2014-16.

Whilst this document details our priority workstreams, we will of course continue to make progress across our entire service portfolio as we seek to secure the best possible mix of services to meet the needs of the population we serve. Further we will work closely with Public Health and Local Authority colleagues to make every effort to reduce acknowledged health inequalities.

Given the continued constraint on public sector spending, the financial context for 2014/15 and future years will be extremely challenging. Meeting increasing demand with a static resource will require the CCG to work with its members its public and service providers (new and existing) to innovate and to deliver services differently. At the same time we are adamant that reducing costs will not be at the expense of maintaining acceptable levels of safety, quality and patient experience. Locally and nationally, the NHS is managing the impact of constrained public spending and a funding settlement that is more challenging than many can remember. It is likely that all organisations will need to make bold and difficult decisions. CRCCG will ensure that any such decisions are taken only after an explicit consideration of the impact on quality, safety and patient experience and an open discussion with our public and our other local stakeholders.

All of the above combine to create a significant challenge for a relatively new organisation but one that we are committed to facing with boldness, integrity and endeavour.

Our six selected priority work programmes are as follows:

	HEALTHY LIVING & LIFESTYLE CHOICES	PRIMARY CARE QUALITY	FRAIL OLDER PEOPLE	MENTAL HEALTH	ACUTE HOSPITAL CARE
Diabetes	√	√			√
End of Life		√	√	√	√
Dementia		√	√	√	√
24/7 Urgent Care	√	√	√	√	√
Stroke Care	√	√	√	√	√
Children 0-5 years	√	√		√	

CRCCG COMMISSIONING PRIORITIES FOR 2014/16

1. **CRCCG Work Programme: Diabetes Management**

In 2002, the Department of Health estimated that 5% of total NHS expenditure is used for care of people with diabetes. This figure is now believed to be closer to 10% of total NHS expenditure which equates to £9 billion per year. People with type 2 diabetes have a risk of death from cardiovascular causes that is two to six times that among people without diabetes.

Structured, systematic care for people with type 2 diabetes aims to minimise the risks from disease – related vascular complications such as cardiovascular, eye, foot and kidney disease. The National Institute for Health and Care Excellence (NICE) has produced quality standards for the clinical management of diabetes in adults which map onto the five key areas of care i.e. structured education, lifestyle and self care, blood glucose control and insulin therapy, management of complications, hospital and emergencies.

Desired changes:

- Enhanced patient awareness and greater support for Self-Care
- 9 annual checks – improved primary care attainment
- Community consultant led diabetes service – providing support to improve the quality of diabetes care in primary care and reducing variation
- Reduction in out-patient activity that will be delivered via a different model in the community
- Use of technology (Diabetes Manager) to risk stratify diabetes patients and provide virtual clinics

2. **CRCCG Work Programme: Dementia Care**

Dementia is increasingly one of the most important causes of disability in older people. There are around 800,000 people with dementia in the UK, and the condition costs the economy £23 billion a year. By 2040, the number of people affected is expected to double - and the costs are likely to treble. A quarter of hospital beds are occupied by people with dementia. Early identification can

dramatically improve quality of life for people with dementia but at the moment, the diagnosis rate is less than 50%.

The Prime Minister's Dementia Challenge launched in March 2012. It sets out plans to go further and faster in improving dementia care, focusing on raising diagnosis rates and improving the skills and awareness needed to support people with dementia - and their carers.

Both Coventry and Warwickshire have 'Living well with Dementia' strategies and the CCG will work with its two Local Authority partners and other stakeholders to develop implementation plans to secure the desired outcomes detailed in those strategies.

Our focus will be on:

- Increased early diagnosis and intervention
- Automatic contact from post-diagnostic support services
- Greater use of assisted technology
- Enhanced support for Carers
- Improved end of life planning and care
- A consistent specification and quality framework for dementia care providers

3. CRCCG Work Programme: 24/7 Urgent Care

NHS urgent and emergency care services provide life-saving and life-changing care for patients who need medical help quickly and unexpectedly. We know our accident and emergency departments are under increasing pressure and we want to improve the urgent and emergency care system so patients get safe and effective care whenever they need it.

Initial reports from the national review of urgent and emergency care have identified a number of issues which we believe are also pertinent to modernising and improving our local urgent care system. For example, the national review identifies that in some cases, such as heart attack and stroke patients get better outcomes by going straight to specialist centres and not to A&E.

The review also highlights that some people who present at A&E, and who we treat there, would have more appropriate care and a better patient experience if they were seen in a primary or community care setting. These may be people with long term conditions that need careful management, or people who are having problems getting an appointment at their local GP surgery.

The review further acknowledges that patients find it hard to navigate between primary care, our hospitals and social care services. In many cases some of our most vulnerable patients e.g. frail elderly, need careful management and input from a number of different agencies and sometimes they, or their carers, are just not able to understand and work with this range of services, and find themselves in A&E as a last resort.

All of these issues featured large in the engagement events with member practices, patients and the public.

Our focus is likely to be on:

- Increased emphasis on prevention and self-care
- Further development of our integrated practice teams with their focus on keeping people out of hospital
- Assurance that clinical safety within our hospitals is maintained throughout the 24 hour period, seven days a week
- Sharing of clinical information to support better decision making by emergency teams
- Working with our CCG members to ensure maximum benefit is secured from available primary care resource
- Increased access to community and social care services in the evening and at weekends
- Increased support to care homes to avoid unnecessary hospital attendance
- Re-specification of Out of Hours services
- Work with Primary Care commissioners to review the role of the Coventry Walk in Centre.
- Review of the Rugby Urgent Care Centre

4. CRCCG Work Programme: End of Life

The CCG is committed to supporting every individual and their family to retain their personal dignity, autonomy and choice throughout the care pathway towards the end of their life.

Nationally, there is a disparity between preferences expressed by the majority to die at home or in a hospice and the numbers actually dying in hospital (58% of all deaths); this is replicated locally (59.1% Coventry and 55% Warwickshire). In the case of people with dementia, the vast majority die in a care home whilst the vast majority of deaths from heart disease or pulmonary disease occur in hospital and the majority of these will have been admitted from their own home (including a residential care home) in the final week of life.

Care at the end of life has been recognised as making up a significant proportion of all health care expenditure in the NHS; research indicates that inpatient hospital care increases sharply at the end of life, particularly in the final two months.

Our focus is likely to be on:

- Extended use of advance care planning
- Implementation of shared care plans accessible by all service providers to ensure good co-ordination of care
- Extension of Hospice at Home to provide support to community (and patients in care homes)
- Strengthening of integration across health, social care and voluntary sector

5. CRCCG Work Programme: Stroke Care

Stroke is the third biggest cause of death in the UK and the largest single cause of severe disability. Each year more than 110,000 people in England will have a stroke, which costs the NHS over £2.8 billion.

The most important care for people with any form of stroke is prompt admission to a specialist stroke unit. Everyone who could benefit from urgent care should be transferred to an acute stroke service that provides 24-hour access to scans and specialist stroke care, including thrombolysis.

Successful stroke services are built around a stroke-skilled multi-disciplinary team that is able to meet the needs of the individuals. Intensive rehabilitation immediately after stroke, operating seven days per week, can limit disability and improve recovery. Specialised rehabilitation needs to continue across the transition to home or care home, ensuring that health, social care and voluntary services together provide the long-term support people need, as well as access to advocacy, care navigation, practical and peer support.

Improvements we are looking to secure:

- Improved primary prevention
- Improved outcomes of stroke patients, by reducing the levels of death and disability following a stroke
- Reduced length of stay of stroke patients in bed based services
- Social care staff better supported to care for stroke survivors

6. CCG Work Programme: Children 0-5 years

Our Coventry population is a relatively young one (compared to the national average) and there has been a rapid increase in the birth-rate both within the most deprived communities of Coventry and within Rugby.

Focussing on the first few years of life is crucial to preventing many of the problems that will affect children as they grow up and in their later life. Working with other commissioners of children's services, most notably Public Health, we want to support families to help their children to have the best chances for a long and healthy life. We need to provide this support early as we know that the earlier it is provided, the bigger the impact.

Subject to further dialogue with commissioning partners, our focus as a CCG is likely to be on:

- Further reductions in smoking in pregnancy
- Reducing other antenatal risk factors (including alcohol, mental health and domestic violence)
- Strengthen safe guarding arrangements including the sharing of information across agencies
- Looked After Children
- Reduction in avoidable short stay emergency admissions

OUR CORE COMMISSIONING PRINCIPLES

All of our commissioning activities will be undertaken with the intention of assuring Quality & Safety, promoting Integration and securing Best Value.

I) Quality & Safety

The quality and safety of clinical services is an essential element of all service reviews and developments. The learning from recent independent inquiry's such as Francis have highlighted the importance of Q & S being central to the development and monitoring of care delivery. To drive up quality we propose that each commissioning priority has an identified clinical lead and GP commissioning lead, this will also support the drive for greater integration. It is also essential that all developments meet NICE quality standards and follow NICE clinical guidelines. It is the intention to establish clinical networks to support the development and implementation of commissioning priorities.

CRCCG believes the highest quality care is often the most cost effective. Focussing on quality and safety – for example minimising health acquired infections, drug errors and delayed discharges – can improve cost effectiveness. Further, there is still much unexplained variation in clinical practice and clinical outcomes and we will be working with our provider organisations to reduce this variation and to implement acknowledged best practice within available resource. Where appropriate we will use CQUIN and other contractual levers to incentivize quality improvements / desired changes in clinical practice.

II) Integration

National Voices, a coalition of health and social care charities, has identified the lack of joined-up care as a source of huge frustration for patients and carers and has said that "achieving integrated care would be the biggest contribution that health and social care services could make to improving quality and safety". National Voices has reported that "people want to experience seamless care, where it comes from is secondary". Linked to this, a key recurring theme from our local discussions with our members and our public has been the need to share patient records and care plans to improve the co-ordination of care.

The June 2013 Spending Round was extremely challenging for local government, handing councils reduced budgets at a time of significant demand

driven pressures on services. Any reduction on local social services is likely to result in an increased pressure on health services. To make a real improvement to the care people receive, and to secure maximum benefit from the combined health and social care spend, we have to change the way we do things in the future, and ensure care is provided at the right time, in the right place.

As a CCG we will intend to support integrated care by:

- bringing together providers and commissioners to look at how we can spend our money to the best effect
- promoting the appropriate sharing of clinical records
- Further development of our integrated practice teams
- increasingly contracting for integrated pathways of care

The Integration Transformation Fund announced in the Spending Round should provide an additional focus to making integrated working a reality. The ITF is intended to 'provide an opportunity to transform care so that people are provided with better integrated care and support'. In their joint statement on the ITF, NHS England and the Local Government Association state that "Unless we seize this opportunity to do something radically different, then services will get worse, costs to taxpayers will rise, and those who suffer the most will be people who could otherwise lead more independent lives." The £3.8bn of NHS resources that will transfer into the ITF nationally is not new money; it is money that is already being spent on a range of services. Our joint challenge over the next 12 to 18 months is to agree the system/pathway changes that will enable spending to be redirected from treatment services to preventative care and hence reduce the overall cost of provision. To achieve this, statutory partners need to work together to make finance an enabler rather than a barrier to change. As above, as a CCG we are committed to providing resources to pump-prime agreed service changes but we will only be able to do this if our service providers work with us and accept a joint responsibility for overall cost containment.

III) Best Value

The CCG is aiming to achieve a position where it is assured that its level of investment in each service type is appropriate to the quantity and quality of service being delivered. At the same time, we recognise the need to reduce the reliance on urgent care systems and to better manage activity flows into and out of secondary care. Accordingly, we want to move to a position where there

is a common understanding of the relative cost and productivity of each service and a joint commitment to using that knowledge to shape a more sustainable system for the future. This will of course require a high degree of trust and transparency and may require investment in some services and disinvestment in others. Within this context, we appreciate the need for each organisation to deliver its own financial duties and risk rating. It is not in our interest to create instability within a key partner organisation. Our belief is that long term financial sustainability is best achieved through all health and social care organisations working in a more collaborative and transparent manner, recognising a mutual dependency. This approach is consistent with the emerging Integration agenda.

The CCG will expect Providers to absorb all internal cost pressures within existing funding levels (less the national tariff adjustment).

We would discourage Providers from pursuing counting and charging changes which would result in a net effect that commissioners pay more for the same. Whilst we understand the attraction of this approach, our joint emphasis must be on reducing not maintaining or increasing overall costs. The CCG would wish to use any available investment funds to support pathway redesign and associated non-recurrent restructuring costs.

CRCCG PROPOSED QIPP SCHEMES FOR 2014/15

We will be maintaining and where possible, up-scaling the QIPP schemes we have been pursuing in 2013/14. However, the scale of financial challenge facing the CCG for the foreseeable future requires additional schemes to be identified. Proposed schemes for 2014/15 (in addition to our six priority work programmes) are shown below; these will be revised as detailed project plans are developed and tested.

We would also invite Providers (new and potential) and other Stakeholders to put forward proposals as to how services could be delivered more cost effectively. Funding for new investments is limited but all Invest to Save proposals that have the potential to deliver savings to commissioners will be given due consideration.

Existing Schemes	Proposed Schemes
• GP Referral Management • GP Prescribing • Specialist Prescribing • MH Out of Area Placements • Continuing Healthcare • Procedures of Low Clinical Value • Orthopaedic Procedures • Effective Discharge (XBDs) • Avoidable Admissions ➢ Integrated Practice Teams ➢ COPD ➢ Heart Failure	• Falls Prevention • Surgical Thresholds • Dermatology • Pathology • Outpatient Pathways • CCG Running Costs • Avoidable Admissions ➢ End of Life ➢ Care Homes ➢ Vaccine Preventable

CRCCG POTENTIAL PROCUREMENT ACTIVITIES FOR 2014/15

Planned Procurements:

- Termination of Pregnancy Services
- Primary Care Enhanced Services
- Individual Patient Packages (Residential and Home Based nursing care)
- Pathology
- NHS 111 (regionally led)

The CCG is currently reviewing the following services. The outcome of those reviews will inform in-year procurement decisions and timelines:

- Improving Access to Psychological Therapies
- iMSK
- Out of Hours
- Walk In Centre (potentially via NHS England)

The CCG reserves the right to initiate additional procurements at any time.

The three CCGs within Coventry & Warwickshire have articulated a joint intention to explore and implement new approaches to contracting and procurement in order to encourage innovation and collaboration within and

across the Provider landscape. We will be looking to develop service specifications based on outcomes (see below) and to using, where appropriate, approaches such as competitive dialogue and lead contractor models to secure effective supply chains capable of delivering these outcomes in a patient centred and cost effective manner.

COMMISSIONING FOR QUALITY & IMPROVED HEALTH OUTCOMES

CCG commissioners are held to account for improving health through the NHS outcome frameworks. We believe that our six priority workstreams will deliver significantly improved outcomes across each the five domains:

NHS Outcomes Framework					
	Preventing people from dying prematurely	**Enhancing quality of life for people with long term conditions**	**Ensuring that people have a positive experience of care**	**Helping people to recover from episodes of ill health or following injury**	**Treating and caring for people in a safe environment and protecting them from avoidable harm.**
Diabetes Care	√	√	√		
Dementia Care		√	√		√
End of Life Care		√	√		
24/7 Urgent Care		√	√		
Children 0-5	√		√		√
Stroke Care	√			√	√

It is understood that the role of CQUIN payments is being reviewed nationally and that they may not necessarily operate in the same way as previous years. Assuming that locally determined quality payments continue in some form, our intention is to focus on a small number of high impact schemes for each Provider contract.

It is anticipated that as in 2013-14, the majority of CQUIN schemes will support the implementation of agreed QIPP initiatives and key areas of clinical need identified in year as requiring major improvement.

Subject to any emerging national guidance, Coventry & Rugby CCG would wish to see at least one collaborative CQUIN where achievement is dependent upon collaboration across the Acute and Community interface and delivery of an economy-wide quality improvement.

INFORMATION & COMMUNICATIONS TECHNOLOGY (ICT)

Providers are expected to work collaboratively with commissioners to progress information technology developments that improve the efficiency and quality of care. These include collaborative developments across the health economy and provider-specific developments.

Providers are expected to work collaboratively with commissioners to:

Ensure that key national and local systems currently being implemented are fully exploited to deliver efficiency and quality benefits. These include:

- Electronic Palliative Care Co-ordination System Summary Care Record
- Electronic communications between Trusts and GP Practices
- the IT products of the Warwickshire Common Assessment Framework programme

Develop and implement new national IT solutions, and comply with national IT targets and guidelines including:

- NHS e-referrals service (Choose and Book replacement), to make e-referrals available to patients and health professionals for all secondary care by 2015
- safe digital record keeping as a precursor to achieving integrated digital care records across the health and care system – using the approaches and standards set out in 'Safer Hospitals, Safer Wards: Achieving an Integrated Digital Care Record'. This should include implementation of electronic prescribing capabilities consistent with Section 5.2 of 'Safer Hospitals, Safer Wards' which will also enable the sharing of patient medication records across care transitions
- where Providers proceed to implement Lorenzo, maximise opportunities for Lorenzo to support integrated care

- wherever possible digital access to services, in particular the 10 high impact digital initiatives set out in 'Digital first: The delivery choice for England's population'
- appropriate use of digital technologies to improve efficiency including those set out in the 'Digital Technology Essentials Guide'

Continue to work with LHE partners to identify and implement solutions to:

- wider sharing of patient records across care settings to support integrated care, working towards national target of ensuring that integrated digital care records (IDCRs) become universally available at the point of care for all clinical and care professionals by 2018
- patient / carer tools to support self care, collaborative care and healthy lifestyle, including access to records
- shared business intelligence / analytics across commissioners and providers where practical
- consistent approach to messaging and infrastructure.

NHS
South Warwickshire
Clinical Commissioning Group

Commissioning Intentions

2014-15

better healthcare for everyone

1 About This Document

Our commissioning intentions for 2014/15 are a more detailed focus on year two of the NHS South Warwickshire Clinical Commissioning Group (CCG) Integrated Plan 2013-16 (the 'Integrated Plan').

We have continued with our commitment to engage with our partners. We have held a series of engagement events with public and patient groups, the South Warwickshire CCG Members' Council, the voluntary sector and providers to develop this document.

Since the approval of the Integrated Plan there have been some changes to our financial planning assumptions which we have outlined in section two.

The Integrated Plan has transformation of the urgent care system at its heart. During 2013/14 we recognised that we needed to describe our vision for the urgent care system more clearly. Section three outlines our approach, highlights our early successes and the key changes that we want to make in 2014/15 and beyond.

In response to the changing environment we have established a new style of working to deliver the changes outlined in the Integrated Plan at greater pace, scale and with an increased level of grip. In section 4 we outline the three priorities which will enable us to deliver the changes at the pace required.

Finally in section 5, we provide detailed information on the specific changes that will need to be reflected in provider contracts for 2014/15. Where possible, changes will take effect from the 1st April. However, some schemes will require in year changes to contracts following procurement processes.

2 What to expect in 2014/15

The financial context for 2014/15 and future years will be extremely challenging. National changes to what is classified as a specialised service mean that we no longer commission services for some patients and instead NHS England does that for us on a larger footprint. As a result of these changes we have experienced a greater reduction in our budget than we had planned for when the Integrated Plan was developed. This means that we have several millions of pounds less than we had originally planned for 2014/15.

A requirement for greater integration between health and social care will lead to an expansion in pooled funding arrangements. The social care budget is likely to be significantly reduced in the forthcoming years so we need to work together to commission services that meet both health and social care need.

The Transformation Integration Fund provides us with new opportunities to commission integrated care for our population; however, there is no new money to fund this transfer. We will therefore need to reduce health spend in other areas to release the money that will be required to deliver pooled funding arrangements.

To meet these challenges the CCG will commission models of care that enable a growing demand for health services to be met at the same, or lower cost, than current models of care. Any new additional investment will therefore be limited to mandatory service developments only e.g. NHS 111.

There will be an increased focus on the value for money (quality, cost, performance) of each and every service offering. This will result in the expansion of those services offering good value for money and disinvestment from those that do not. Market testing and procurement will feature more heavily than in the past as a tool for realising innovation and value for money.

The value for money agenda will extend to the CCG itself and there will be a focus on reducing CCG running costs to release resources to pay for health care.

All this indicates that in order to achieve financial balance, NHS South Warwickshire CCG will need to adopt innovative ways of working to ensure clinical and cost effective, quality care for patients.

Our provider organisations should expect:

- ✓ Contract values in 2014/15 to at best be no greater than those of 2013/14;
- ✓ To be challenged on value for money of their service offerings;
- ✓ To work with the CCG to deliver innovative solutions that address demand pressures at the same or lower cost;
- ✓ To respond positively to an increased requirement to compete for future contracts

3 Creating a sustainable urgent care system

During 2013/14 there has been an increased focus on urgent care at both a national and local level. In response to this we have established a South Warwickshire Urgent Care Board (UCB) which brings together partners from the health and social care economies in south Warwickshire. The UCB will oversee the delivery of all urgent care initiatives across the south Warwickshire system.

In order to provide clarity on how our Integrated Plan will deliver a sustainable urgent care system we divided it into four key components and mapped our Quality Innovation Productivity and Prevention (QIPP) schemes onto the four areas.

The following points explain the four components; describe the changes we have made and want to make in the future and the actions that we will take during 2014/15.

Prevention and Self-Management

Individuals, families, carers and communities need to play their part in ensuring that the urgent care system in south Warwickshire is sustainable. Alongside Local Authority partners we are committed to supporting communities build support networks and create a sense of collective responsibility for health and wellbeing.

During 2013/14 we set ourselves the target of recruiting 1% of our population as **health champions**. We are making good progress towards this and the number of 16-18 years olds who have joined is extremely encouraging. For 2014/15 we will aim to recruit 3% of our population.

We set ourselves the target of reducing paediatric admissions by 3%. We will be buying **self-help books for all new parents and a web package** which will help them look after their children at home for 2014/15.

In collaboration with Warwickshire Public Health, 9,600 people aged 40-74 will be offered a health check each year, with the remainder of the eligible population being offered a **health check** within the next five years.

In 2014/15 we will continue to progress our work on **Building Social Capital** working with Local Authority colleagues to develop improved relationships with the voluntary and community sector and develop new approaches to working with the local population.

Loneliness is one of the major underlying causes of ill health. Work has already commenced in 2013/14 and **Combating Loneliness** will be a significant project within our work programme next year.

We invite patient group chairs from all 36 practices to monthly meetings to discuss key issues. Discussions about the urgent care system highlighted the challenge norovirus gives the system. Motivated to make a difference the patient group is planning a **hand washing campaign**. Supported by Public Health, environmental health and the Warwickshire County Council Education Team they are going to work with schools and employers to improve how people wash their hands.

Improving the management of long term conditions/high need patients

We have made significant progress in the last 12 months on improving the co-ordination and quality of care for our most vulnerable and complex patients.

With Warwickshire County Council we have been working with all 26 nursing homes in south Warwickshire to improve the quality of care and 'up skill' staff in nursing homes. We have recruited a team of specialist nurses who are giving additional training and support to nursing home staff. It is anticipated that from November 2013 all 26 nursing homes will have enhanced GP cover which will mean that nursing patients all have advanced care plans and have more frequent input from a doctor than they have had previously.

In collaboration with social care we will start a process in October 2013, to procure support tailored to residential homes. We aim to have a new service in place by 1st April 2014.

We want to improve the quality of End of Life (EoL) services for our population. On the basis that each year 1% of our population dies, we want our end of life registers to reflect this. By March 2016 we want 0.8% of our population on an End of Life Register.

Significant work is being undertaken by our member practices and by the end of 2013/14 we will be implementing the following initiatives to improve EOL services:

- Gold Standards Framework Primary Care Training Programme;
- Electronic Palliative Care Co-ordination System (EPaCCs);
- The Route to Success in End of Life Care in our 26 nursing homes;
- End of Life best practice tools in primary care and nursing homes and;
- We will have awarded and mobilised a contract for a practice development team.

Work has also been undertaken by South Warwickshire Foundation Trust on workforce integration and implementation of telehealth.

Whilst these have been positive steps, partners across the system recognise that the current contractual structures do not always facilitate professionals to work in the best interests of the patient.

Our member practices believe that there are more innovative and effective ways of delivering services in the community that will deliver person centred care. They want improved relationships with community staff, in particular the district nurses. In the short term this will be delivered through an existing workforce integration and hub redesign project. In the longer term, we will collaborate with Warwickshire County Council to **commission a new service for long-term conditions and those patients with complex needs.** This will include mental health and dementia but not children's' services in the first instance. This will not have any contractual impact on providers during 2014/15 but is likely to impact in 2015/16.

Whilst work is underway to commission new services we want to continue to make progress towards delivering more integrated, person centred care. Therefore during 2014/15 we, and social care, will be aiming for all individuals aged over 75, and/or those with multiple long term conditions, to have **person centred goal setting and a care plan** put in place that is accessible to all professionals within the system. We are currently undertaking initial scoping and expect to be able to share our approach with providers and other partners in October.

From 2014/15 we will be making Personal Health Budgets available from within our Resource Allocation Policy to patients who are eligible for Continuing Health Care.

We also believe that there are opportunities to transfer outpatient activity for long term conditions back to primary care and deliver improved outcomes. Starting with Diabetes we are exploring how primary care could manage more diabetics with support from Diabetes Consultants. We would however wish to continue to refer patients into secondary care for the '**Super 6**':

i. Antenatal Diabetes;
ii. Diabetic foot care;
iii. Renal (estimated glomerular filtration rate <30);
iv. Insulin pumps,
v. Type 1/adolescent diabetes (unstable control)
vi. Inpatient Diabetes care

Discussions are at an early stage but we have made good progress and would hope that we are in a position to make these changes during 2014/15.

We will be expanding this to other long term conditions and Mental Health Clusters 1 (Common Mental Health Problems, low severity), 2 (Common Mental Health Problems) and 3 (Non-psychotic, moderate severity).

Admission Avoidance

Over recent years we have made inroads into admission avoidance. The **Community Emergency Response Team** (CERT) has been operational for several years, improved psychiatric liaison is now in place and there has been improved use of **ambulatory pathways**.

However, discussions with our member practices have revealed that many of the options available to them are not designed to support them in the community when patients first start to show deterioration. This primarily relates to those with long term conditions and complex needs but analysis of A&E attendances and emergency admissions, undertaken for the South Warwickshire Urgent Care Board, has demonstrated that we need an improved community urgent response service for all of our population.

By November 2013 we will have commissioned an **Admission Avoidance Programme** (Phase 1) to keep people at home. This will provide patients with access to specialist opinion and/or diagnostics within 24-48 hours for patients.

In November 2013 we will start the more comprehensive **Admission Avoidance Programme** (Phase 2). This will impact on services outside of the hospital and is anticipated to significantly change the number and type of contracts we have with providers from April 2015.

NHS 111 is an important part of the urgent care system and we continue to work collaboratively with CCGs in the West Midlands to secure a sustainable service for our local population.

Supporting Discharge

Our major focus in 2013/14 has been the progression of the Discharge to Assess service. The service is still being piloted but the early results are extremely encouraging. The data generated from the pilot will inform a business case that will set out the capacity required within care homes and support resources. The Governing Body will consider the full business case in January 2014.

The actions for 2014/15 have all been mapped against the Integrated Plans aims and objectives which can be found in section 5.

4 Making the Integrated Plan Real

Our approach to delivering the Integrated Plan during year one was on an individual projects basis. These projects were designed to change elements of services within the framework of our existing contracts. Whilst this approach has delivered changes to the care delivered to our local population it is not delivering change with the pace, scale and grip that we want.

To create a step change we have identified three priorities which will enable us to deliver change at pace but also reflect a level of pragmatism about what is achievable. We will start working in line with these priorities from September 2013.

Within these priorities we have provided examples of the projects that would be delivered within each of the three approaches. Many of these have been described in the previous section but we will of course deliver improvements in all parts of the system; not just urgent care.

Priority One: Commissioning for Health and Social Care Outcomes

The Transformation Integration Fund provides us and social care with significant opportunities to deliver integrated health and social care. We have had a number of very positive discussions and will be sharing a first draft of our plans with the Health and Wellbeing Board in November.

We will develop new types of contracts (Outcome based) for NHS and non-NHS providers so that providers are incentivised to work together to provide person centred care. Central to this approach will be the shift to commissioning by outcomes. In partnership with Warwickshire County Council we want to ensure that payments to providers are based on supporting people to attain their personal goals rather than what professionals and organisations believe to be what the individual needs.

Public and Patient involvement is essential in developing our priority areas and ensuring this approach to commissioning is effective. We will be seeking to maximise the already well-established engagement routes to tap into the energy and enthusiasm so many of our local residents have, in order to support us as organisations make things better for the local population.

In order to identify areas where we can make the largest impact, we will be developing a two year work programme for Older People, Mental Health/Learning Disabilities and Children. We will be jointly engaging with providers and the local population on the areas that would benefit most from joint commissioning during Autumn 2013.

Increased integration will require professionals to work in a different way – both between members of their own profession and with those from other professions. We will foster a proactive, positive approach to these situations and encourage those who find these changes difficult to focus on the improved outcomes for their clients or patients rather than becoming entrenched in their views. There will be large implications in terms of workforce planning, education and training that we will need to address to ensure that this new approach to work is safe and sustainable.

In commissioning for health and social care outcomes we will be seeking to undertake competitive processes. The joint engagement work and development of our first draft of the Transformation Integration Fund will indicate the areas where we are seeking to implement this approach. However, from existing work we have identified the following areas for 2014/15:

- Admission Avoidance Programme (Phase 2) (Includes Out of Hours (OoH));
- Discharge to Assess;
- Support to Residential Homes;
- Child and Adolescent Mental Health Services (CAMHS);
- Falls Service.

Priority Two: Drive Innovation and Productivity by Going to the Market

This priority again requires a more significant use of competitive approaches and use of the market. The key difference is that within this priority we will seeking to use competitive processes not to provide more integrated care within the same cost envelope but to release money from the system to close the financial gap that we face.

This may be done in conjunction with social care, but will be more typically undertaken in discrete services commissioned by NHS South Warwickshire CCG, and will be characterised through greater use of Any Qualified Provider (AQP).

The details of the proposed procurements can be found in Section 5 where all of our Quality, Innovation, Productivity and Prevention (QIPP) schemes are mapped against the aims and objectives of our Integrated Plan. However, the most significant of these include

- Re-tender Improving Access to Psychological Therapies (IAPT) Services;
- Any Qualified Provider (AQP) for Procedures of Limited Value;
- Rationalisation/retendering of voluntary service contracts in partnership with Warwickshire County Council, Stratford-upon-Avon District Council and Warwick District Council;
- Super 6 for Diabetes;
- Doppler Scanning;
- Locally Enhanced Schemes currently under review.

Priority Three: Systematic Approach to Quality and Prevention

For those services unaffected by large-scale change we still expect continuous improvement and contribution to our strategic plan. This takes the form of quality improvements and actions to support our population to take action to prevent chronic disease. In the main, these improvements will be delivered through contract terms and conditions but some will be QIPP schemes that we will deliver.

As with the previous section we have mapped the details of contractual Terms and Conditions and QIPP schemes onto the aims and objectives of our Integrated Plan.

Quality and safety permeate throughout every aspect of commissioning. We will ensure all providers deliver the expected rights and pledges from the NHS Constitution, comply with national quality standards, such as NICE, and operate to the high standards expected within the NHS.

Safety of patients is our number one priority and we expect our providers to comply with national standards relating to safeguarding vulnerable adults and children, reducing hospital acquired infections and community infections, as well as the Duty of Candour.

We monitor quality by measuring performance against specific quality and performance indicators, serious incidents, clinical audits, patient experience information, morbidity and mortality data and GP feedback. Drawing on the Francis Report and Keogh, we will be increasing the breadth and depth of the sources of quality information and implementing a pro-active visiting programme to our providers. We expect all of our providers to play a full and active role in the prevention of ill health. Stopping and delaying the onset of chronic disease is the basis of a sustainable health and care system.

Making Every Contact Count (MECC) ensures that providers take every opportunity to support people to make informed lifestyle changes are taken. MECC will be embedded in all of our service specifications and providers will contractually be required to have a trained 'MECC Champion' in each clinical area or nursing team. Each provider needs to have a clear action plan to achieve rolling out of MECC to all front-line clinical staff by March 2018.

Smoking has a significant impact on the health of people with mental health problems, with higher levels of smoking responsible for a large proportion of the excess mortality of people with mental illness. We have therefore developed a set of terms and conditions that we want reflected in contracts with providers that will deliver reduced levels of smoking in patients with mental illness and for women who are pregnant. In addition to a focus on smoking, all maternity providers are to develop and implement a maternal obesity pathway by March 2014.

Providers need to ensure that they encourage all staff to have their flu vaccinations; provide vaccinations to long-stay in-patients and encourage all patients, but especially pregnant women, to attend their own GP practice for their flu vaccination.

Providers should be able to assure themselves and us that they proactively and robustly ensure that all frontline and clinical staff have evidence of immunity to measles.

Increasing initiation of breast feeding has been a requirement for a number of years. All maternity providers need to have achieved Baby Friendly Initiative stage 3 achieved by December 2015 and 75% breast feeding initiation needs to be achieved by March 2014.

As a group of practices we take the ongoing review of our own and peer performance very seriously. Our strength as a CCG is a result of the collective efforts of all 36 practices and we therefore have implemented robust processes to hold each other to account through a GP performance framework. We expect the same commitment to continuous improvement from all clinicians within the system.

We have closely monitored our access rates for elective and non-elective activity for several years, during 2013/14 we expanded this to diagnostics and imaging and in 2014/15 we will include mental health. Outlier practices will be actively reviewed and managed throughout 2014/15.

Information Management and Technology

This section sets out key broad areas where the CCG expects providers to progress information technology developments to improve the efficiency and quality of care. These include collaborative developments across the health economy and provider-specific developments.

The CCG expects to work with providers to develop more specific plans which can be formalised as contractual commitments where appropriate.

Providers are expected to work collaboratively with commissioners to:

Ensure that key national and local systems currently being implemented are fully exploited to deliver efficiency and quality benefits. These include:

- Electronic Palliative Care Co-ordination System;
- Summary Care Record;
- Electronic communications between Trusts and GP Practices;
- The IT products of the Warwickshire Common Assessment Framework programme.

Develop and implement new national IT solutions , and comply with national IT targets and guidelines including:

- NHS e-referrals service (Choose and Book replacement), to make e-referrals available to patients and health professionals for all secondary care by 2015;
- Safe digital record keeping as a precursor to achieving integrated digital care records across the health and care system – using the approaches and standards set out in 'Safer Hospitals, Safer Wards: Achieving an Integrated Digital Care Record'. This should include implementation of electronic prescribing capabilities consistent with Section 5.2 of 'Safer Hospitals, Safer Wards' which will also enable the sharing of patient medication records across care transitions;
- Where Providers proceed to implement Lorenzo, maximise opportunities for Lorenzo to support integrated care;
- Wherever possible digital access to services, in particular the 10 high impact digital initiatives set out in 'Digital first: The delivery choice for England's population';
- Appropriate use of digital technologies to improve efficiency including those set out in the 'Digital Technology Essentials Guide'.

Continue to work with LHE partners to identify and implement solutions to develop :

- Wider sharing of patient records across care settings to support integrated care, working towards national target of ensuring that integrated digital care records (IDCRs) become universally available at the point of care for all clinical and care professionals by 2018;
- Patient / carer tools to support self care, collaborative care and healthy lifestyle, including access to records;
- Shared business intelligence / analytics across commissioners and providers where practical;
- A consistent approach to messaging and infrastructure.

5 QIPP Schemes and potential contract impacts

This section provides a summary of the QIPP schemes which we anticipate continuing into 2014/15 together with the potential new schemes which we envisage emerging from the themes and priorities identified in the earlier sections of this document. These (*) are in various stages of development and reflect our entire QIPP pipeline. Not all will convert into QIPPs for 2014/15. We have also indicated the potential impact which these schemes could have on contracts. In addition, there is the expectation that all relevant KPIs will roll forward into the 2014/15 contract.

Objectives	2013/14 QIPP SCHEMES THAT WILL CONTINUE INTO 2014-15	POTENTIAL* NEW QIPP SCHEMES FOR 2014/15	CONTRACT IMPACT
AIM 1: To build relationships with patients and communities			
Improve Communication between organisations and professionals	• Improved Utilisation of Choose and Book; • Development of standards to improve the transfer of information on discharge;	• A&E to notify GP surgery if patient attends A&E during opening hours with minor ailments; • Diversion of patients back to GP from A&E;	• This could potentially impact on SWFT A&E attendances and/or follow-ups; • Providers are expected to work collaboratively with commissioners to ensure that key national and local IT systems are fully exploited to deliver efficiency and quality benefits; • A&E discharge summaries to be received by practices within 24 hours of discharge;
Co-ordinated services for dementia patients and their carers		• Work with practices and third sector to establish self-help meetings for carers of dementia sufferers; • Review and re-commission services for patients requiring an assessment for cognitive dysfunction;	• Impact on CWPT contract could be potential re-procurement of services for patients requiring an assessment for cognitive dysfunction.

Objectives	2013/14 QIPP SCHEMES THAT WILL CONTINUE INTO 2014-15	POTENTIAL* NEW QIPP SCHEMES FOR 2014/15	CONTRACT IMPACT
Prevention of admission for the frail elderly through integrated health and social care services	• Discharge to assess (D2A) • Psychiatric Liaison; • Admission Avoidance Programme Phase 1.	• Admission Avoidance Programme Phase 2; • Jointly commission service for long term conditions and complex patients.	• Potential reduction in SWFT emergency admissions; • Potential reduction in SWFT LOS and excess bed days.
Support individuals to die in their place of choice	End of Life Project that includes: • Gold Standards Framework Primary Care Training Programme; • Electronic Palliative Care Co-ordination System (EPaCCs); • The Route to Success in End of Life Care nursing homes; End of life best practice tools in primary care and nursing homes and; • Practice development team.		• All organisations use a common DNAR form that transfers between organisations.
Develop a thriving engagement network	• Health Champions (increased from 1% to 3% of our population); • Self-help tools for parents.	• Reduce vaccine preventable admission; • Rationalise voluntary/third sector contracts; • Hand washing campaign; • Building social capital; • Combatting loneliness; • Reduced obesity related admissions;	• Reduction in Admissions; • Potential reduction in elective activity.

Objectives	2013/14 QIPP SCHEMES THAT WILL CONTINUE INTO 2014-15	POTENTIAL* NEW QIPP SCHEMES FOR 2014/15	CONTRACT IMPACT
AIM 2: To improve health and reduce health inequalities			
Improve the management of Long Term Conditions	• Ambulatory Pathways; • Health Checks.	• Super 6 for Diabetes; • Personal Health Budgets; • Commission new stroke pathway; • MDT review of patient with long term conditions that have two or more admissions in a twelve month period.	• We want to commission a new model of Diabetes services around the 'Super 6'. We will review the contract impact; • We want to commission a new stroke pathway and we will review the contract impact.
Improve the Choices made by pregnant women	An objective for 2015/16 and 2016/17	• Reduce the caesarean section rate from its level of 27% (21% of first time mums undergoing unplanned sections).	• 100% of women have smoking status recorded at time of delivery; • BFI stage 3 achieved by December 2015 by all maternity providers; • Ensure that staff working in community and hospital antenatal clinics will robustly and proactively encourage all pregnant women to attend their own registered GP practice for flu vaccination.
Stop the trend of increased alcohol related admissions	• Alcohol team in A&E and primary care support;		
Reduce the unplanned variation in Primary Care quality and prescribing	• Primary Care Prescribing; • Reducing variations in referral rates for pathology, diagnostics, electives, A&E attendance and emergency admissions	• Access to Mental Health services.	• Could potentially reduce referrals to mental health services.

Objectives	2013/14 QIPP SCHEMES THAT WILL CONTINUE INTO 2014-15	POTENTIAL* NEW QIPP SCHEMES FOR 2014/15	CONTRACT IMPACT
AIM 3: To improve the quality of care and transform services			
Improve the access to Mental Health Services through improved communication between professionals	An objective for 2015/16 and 2016/17	• Retender of IAPT service • Retender CAMHS service • Review maternal mental health services • Reduce self-harm admissions • Review of all patients receiving joint packages of care to ensure services reflect patient needs/goals (includes s117) • Review Learning Disability inpatient pro vision in light of Winterbourne Review)	• Potential impact for CWPT • Potential impact for CWPT • Potential reduction in service levels (CWPT) • Potential reduction in service levels (CWPT)
Reduce avoidable harm	• Contract Terms and Conditions +CQUIN + Quality Metrics	• Commission a falls prevention service jointly with social care.	• Inform SWFT for information
Improved patient experience	• Implementation of patient feedback process/ encouraging feedback • NHS 111 • Domiciliary phlebotomy	• Person centred goal setting/care planning • GP feedback system	
Improve the quality of care of nursing home residents	• Nursing home admission avoidance • Additional medical care to nursing homes	• Commission support to residential homes	• Potential impact on admissions levels

Objectives	2013/14 QIPP SCHEMES THAT WILL CONTINUE INTO 2014-15	POTENTIAL* NEW QIPP SCHEMES FOR 2014/15	CONTRACT IMPACT
AIM 4: To make the best use of our resources			
Providers will have reduced unnecessary steps in their processes	An objective for 2015/16 and 2016/17	• Directly bookable doppler for GPs to reduce/review demand on Deep Vein Thrombosis clinic • Reduce duplication of diagnostics • Improve18 week Referral to Treatment flow and reduce unnecessary steps	• This should reduce non-elective admissions and potentially increase Doppler activity
Adherence to NICE and other evidence based guidance	• High Cost Drugs • Low Priority Procedures (LPP)	• Introduce wound care formulary • Develop a Continence Aid Policy • Develop commissioning policies to reduce procedures of low clinical value activity	• Potential reduction in the number of low clinical value activities
Optimise Continuing Health Care spending	• Mental Health Out of Area Repatriation • Continuing Health Care Reviews		
Commission services within our resource envelope	• Enteral Feeding	• Value for money review of all block and/or non- NHS community and third sector contracts • Price Equalisation in non-NHS contracts • Evaluation of the cost-effectiveness of make, share, buy arrangements (Commissioning Support Services) • Identification of services amenable to AQP	

Strategic Commissioning
People Group

Commissioning Intentions

Christine Lewington
Head of Strategic Commissioning

October 2013

PEOPLE GROUP COMMISSIONING INTENTIONS 2014-2015

PEOPLE GROUP COMMISSIONING INTENTIONS 2014-2015

PREFACE

The purpose of these commissioning intentions is to provide an indication to our current and potential new providers of social care how, as a commissioning led authority, we intend to shape, with our health colleagues, the health and social care system within Warwickshire.

It is not intended to set out all of the activities that the People Group will be undertaking in any year but will;

- provide a context for commissioning changes
- list agreed commissioning intentions including changes that will improve the quality of services and/or achieve improved value for money
- signal to providers the areas where resources will be reducing or where new models of care will be required.

The commissioning intentions respond to the needs of communities within Warwickshire and is built on a set of outcomes that underpin the People Group Vision. These outcomes are set out in Appendix 1 and demonstrate our aspirations which are that people are; safe, independent, cared for, enjoy life, healthy, able to learn and contribute.

Key messages for providers – we will be seeking:

1. **Evidence of person centred care**
2. **More efficient and innovative service delivery year on year**
3. **Improved evidence of delivery of outcomes including Quality of service provision**
4. **All commissioned services will need to register on the Warwickshire Directory.**

PEOPLE GROUP COMMISSIONING INTENTIONS 2014-2015

INTRODUCTION

Like all councils Warwickshire is facing tough financial times. With a savings programme in excess of £92 million for the council and savings across the Clinical Commissioning Groups means that overall there is less money within the health and social care economy. This document describes the People Groups commissioning intentions for the next few years.

As the largest part of the council the People Group will inevitably need to make some significant decisions about the future shape and scope of services to meet the needs of children, young people and vulnerable adults including their carers, within a reduced financial envelope.

The demographic profile of Warwickshire identifies older people as a key priority for the health and social care economy and as is already demonstrated the impact of this is being felt significantly across the three acute services. We have agreed to work together with health colleagues to look across the health and social care economy to identify ways of helping people to manage their own care, through better access to information and advice, to deliver care closer to home and to build on the assets and community resources that are often untapped.

At a national level the number of reforms; SEND, the New Ofsted and CQC inspection Frameworks, Dilnot, The Care Bill, the Integration Agenda with Health, to name just a few, will all, over the next few years have a significant impact on the demand and shape of services. Implementation of these reforms will be challenging, with high risks of confusion, complexity and complaints; it will involve substantial extra work for us as a council during a period of severe financial challenges.

Without doubt Integration is recognised as a key vehicle to steer through these economically challenging times for both health and social care. Already we are working positively with our health colleagues across each of the three clinical commissioning groups.

Our key focus in these coming years will be to continue to build a strong integrated health and social care economy. We will also, through stronger dialogue with providers, identify efficiencies, opportunities and innovative solutions that allow commissioners to base buying decisions on stronger evidence of what works for customers.

We will co-produce commissioning solutions that empower people to make informed decisions for themselves and stop drawing people into services, instead recognising people's strengths and attributions and build on these to ensure that they live full and independent lives.

With a growing number of children, young people, older people and people with disabilities including those with multiple and often complex needs and diminishing resources there is even more imperative to enable and support a shift of resources from expensive specialist provision towards evidence based early interventions. This will be our priority during the coming year.

KEY MESSAGES FROM THE JOINT STRATEGIC NEEDS ASSESSMENT

WARWICKSHIRE PEOPLE & PLACE: KEY MESSAGES FOR ALL

Population Change and Increasing Dependency - During the last ten years, Warwickshire's population grew in line with national figures by 7.8% to 545,47. The largest growth has occurred in the very young and the old with the greatest growth in those aged over 85 and not necessarily in good health. This has occurred without a corresponding growth in the working population and the result is an increasing dependency ratio.

Households and Communities - The number of households in the county has grown by 9.5%, more than the national average and more than population growth. There has been growth, likely to continue, in single occupancy households, older people living independently at home for longer and people living with their parents for longer. The way that people relate to and identify with their neighbours, localities, communities and social networks is also changing: In the future, it is likely that these will be less obviously defined by spatial boundaries.

Economic and Labour Market Change – Although overall unemployment rates are falling, a**s a proportion of all unemployed residents, long term unemployment now makes up 21% of all unemployment in June 2012 in Warwickshire, compared to 11% a year prior**. The unemployment rate amongst the 18 – 24 age group, although also now falling, is more than twice the rate of those aged over 24 and a third of these have been claiming JSA for more than six months.

The Changing Nature of Social Care- Local Authorities budgets have reduced and will continue to do so. The drive towards maintaining independence, the move to more preventative approaches, the duty to promote the integration of health and 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.

Persisting Inequalities - Our more prosperous neighbourhoods have been best placed to deal with the impacts of the recession and associated trends. Inequalities in educational attainment, life expectancy and the numbers of Looked After Children are some of those that still persist and the gap between the North and the South continues to increase.

The Impact of Technology on Future Need - New technologies can also facilitate change in the way health and wellbeing needs are addressed. In 2010, around 20% of us owned smartphones. At the end of 2012, this figure rose above 50% for the first time. 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.

THE 5 THEME & 10 TOPIC KEY MESSAGES

1. CHILDREN & YOUNG PEOPLE

Educational Attainment - T**he 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. However, one in three of the county's pupils are not attaining what is generally regarded as a minimum level of educational attainment. In the localities and groups such as LAC or those on Free School Meals with the very lowest levels of**

attainment, numbers can be as low as only half of pupils are achieving what is commonly regarded as the minimum educational standard.

Looked After Children (LAC) - The number of LAC in Warwickshire has increased from 636 at 31st March 2011 to 681 at 31st March 2012. 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. Although the growth is slowing, this year's growth still represents an increase of 7%.

2. LIFESTYLE FACTORS EFFECTING HEALTH AND WELLBEING

Several lifestyle factors are increasingly a concern at both a national and local level. However, locally there is particular concern around obesity, a lack of physical activity and smoking, particularly during pregnancy.

One in four adults in Warwickshire or about 110,000 people are obese and this number is rising. 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.

It is estimated 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.

Smoking remains the primary cause of preventable mortality with over 900 deaths a year in Warwickshire. It is estimated that 19.1% of people aged over 18 in Warwickshire are smokers; nearly 83,000 adults. Of even more concern is that the amount of smoking in women at the time of delivery is significantly higher in Warwickshire at 23% of mothers compared to England's 13%.

3. ILL HEALTH

Long-Term Conditions (LTCs) - Around 1 in 3 adults live with at least one LTC and with a growing and ageing population; Warwickshire is predicted to see significant increases in these numbers. The numbers of patients recorded on general practice disease registers show that there are potentially large numbers of undiagnosed or unrecorded cases.

Mental Wellbeing - For people aged between 16 and 74 living in Warwickshire, the rate of common mental health conditions is 121.4 per 1,000 people. This means that an estimated 46,000 people aged between 16 and 74 in Warwickshire have a common mental health problem.

4. VULNERABLE COMMUNITIES

Reducing Health & Wellbeing Inequalities – Has been covered throughout.

Disability -.There are estimated to be 34,664 people aged 18-64 with a moderate or serious physical disability in Warwickshire and this is predicted to rise to 37,397 by 2030, contributed to by the ageing population. 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. 54.5% of social care customers with a learning disability were identified as living in their own home or with their family against the national average of 70%.

Safeguarding - Over the past three years, referrals to children's social care in Warwickshire have risen steadily by 18% from 2009 to 2012. Figures also show a 33% rise in the number of children made the subject of Section 47 enquiries and a significant increase in the number of children who were made subject to a CP Plan.

PEOPLE GROUP COMMISSIONING INTENTIONS 2014-2015

5. OLD AGE

Dementia - In 2012, there were 3,169 patients on Warwickshire GP's disease register for dementia. However, 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. Between 2012 and 2028, the number of people with dementia is projected to increase by 57%.

Ageing & Frailty - 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' figure of £553 for Warwickshire against an England average of £1,096.

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OUR STRATEGIC APPROACH

As a council our strategic approach will be focussed on early intervention and prevention and will work on the premise that all individuals, be they children, young people or vulnerable and/or frail and elderly adults want to become or remain independent of the state.

For children and young people our emphasis will be on early intervention to give young people a good start in life and enable them to reach their full potential.

For vulnerable adults and the frail elderly our emphasis will be on helping them, where appropriate, to stay out of registered care and to build on capacity within local communities and in the voluntary sector.

And for informal carers we need to make sure that they have access to help and support and that we work with schools, neighbourhoods and community organisations to grow the pool of carers to ensure that caring is a characteristic of a resilient community rather than being an increasing burden on isolated individuals.

A different approach is now required if, as a People Group, we are to continue to meet eligible needs. This needs to be an approach that looks for and builds on the assets that individuals and communities have and an approach that values the capacity, skills, knowledge, connections and potential in individuals and the communities within which they live.[i] The more familiar 'deficit' approach focuses on the problems, needs and deficiencies in a community. It designs services to fill the gaps and fix the problems. As a result, a community can feel disempowered and dependent, People can become passive recipients of expensive services rather than active agents in their own and their families lives.[ii] We now need a different approach, one which accords with the re-ablement model. This means a move towards a different dialogue and way of working with citizens, communities and the wider public. Our strategic approach, therefore will focus on interventions that assist people to resolve the crisis that they face based on recovery and restoration.

But we recognise there will be times, when despite all efforts, some people will need additional support. When they do we need ensure that services are delivered at the right time and in the right place. Care closer to home will be a priority over the next year with an emphasis on avoiding unnecessary admissions and supporting discharge back into the community. We need to build extra case and support people to remain in their own home with support. And when residential care is the only option we want to ensure that people receive person centred care.

Aligned to this is the need to assure people who use care services of the high standards and quality of local services. This is particularly pertinent for those who purchase their own care and are given confidence, through a robust quality assurance framework that the services offered are of a high standard. During the next few years there has to be a vigour and rigour in securing cost benefits and good outcomes for individuals.

As commissioners we need to ensure that services are available and so we're working with the market to promote innovation whilst at the same time ensuring that services continue to deliver a high standard of care, with dignity and respect and the lifestyle choices of individuals remains central to decisions and services delivered.

PEOPLE GROUP COMMISSIONING INTENTIONS 2014-2015

WORKING TOWARDS INTEGRATION

Many of these changes cannot be made by the People Group acting alone. Commissioning can only be effective if all parties who have an interest work together. We have already agreed with each of the respective clinical commissioning groups that we will aim to be more strategic in how we deploy resources, which will require better collaboration and coordination across the council and the Clinical Commissioning Groups as well as with Districts and Boroughs.

Jointly we have agreed that we will:

- Develop mechanisms that enable people to manage their own care through self assessment, information and advice and online resources.
- Create opportunities and initiatives to develop community based and preventative support services that deliver the health and social care outcomes that prevent, postpone and delay the need for formal support.
- Together identify, develop and implement opportunities to achieve financial savings and wider benefits through cooperation and working together around the key points of the health and social care interface, particularly, but not exclusively, in relation to older people and pathways out of hospital.
- Given the outcomes of Winterbourne and the Francis Report we will, and together, strive to deliver a vibrant competent workforce with quality at its core across all services including those that are commissioned and across the health and social care economy.

It is already well evidenced that there are many benefits for working together and aligning services and pathways. Together the council and the clinical commissioning groups have identified key areas of focus for integration that includes:

South Warwickshire Clinical Commissioning Group

Redesigning the voluntary sector offer
Discharge to Assess
Falls Services
Mental Health including CAMHS
Long Term Conditions eg; Dementia
Admission Avoidance
Care Home/End of Life Care.

Warwickshire North Clinical Commissioning Group

Redesigning the voluntary sector offer
Discharge to Assess (community based model)
Integration Community Services
Long Term Conditions eg; CVD, Dementia
Care Homes/End of Life Care
Admission Avoidance (Redesign of A & E)
Redesigning children health services

Coventry & Rugby Clinical Commissioning Group

Redesigning the voluntary sector offer
Discharge to Assess (Community Based Model)
Long Term Conditions eg; Dementia
Mental Health including CAMHS
Integrated Community Services
Care Homes/End of Life Care
Vulnerable Children 0 -5 yrs eg; looked after childrens health

PEOPLE GROUP COMMISSIONING INTENTIONS 2014-2015

PEOPLE GROUP MISSION STATEMENT

The People Group mission is to support people, especially the most vulnerable and disadvantaged, to access throughout their lives, every opportunity to enjoy achieve and live independently.

"We believe in **personalising services** and evidenced based **early intervention** which is delivered by working with **strong cohesive communities** and **diverse markets** and **integrating services** wherever it makes sense to do so using an **evidenced base** approach in all that we do"

And we aspire to a whole systems approach as defined by The Association of Directors of Adult Social Services (ADASS) at a time of budget pressures[iii] which are:

Prevention – Living an active life as a citizen for as long as possible

Recovery – Achieving as full a recovery as possible and receiving help in times of crisis.

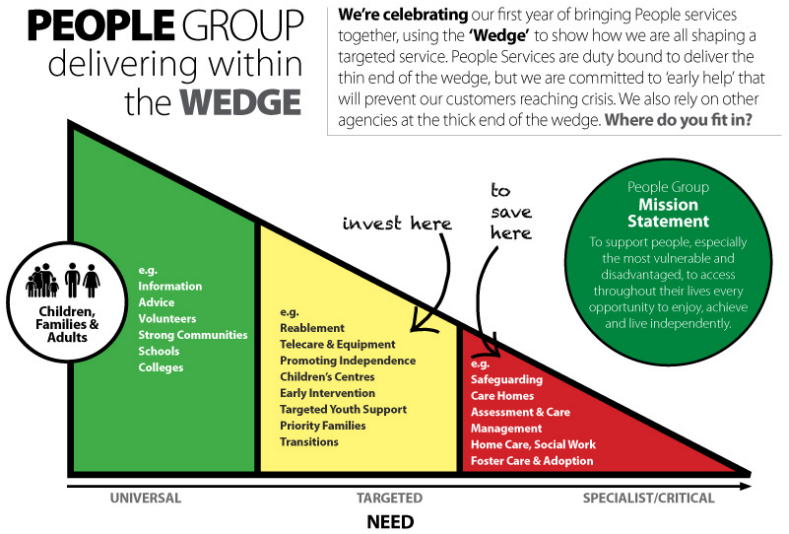
Contribution – Making a fair contribution to this support; financially, through informal care and support; or from carers or the person concerned playing their part in achieving the desired outcomes.

Continued Support – Getting a personal budget and choosing how to spend this from a range of services that offer value for money

Efficient Processes – Designing processes to minimise waste, and eliminating anything that does not add value to what people need.

Partnership – Working together to achieve these outcomes across health and social care, councils or government, and the independent sector.

It is clear that innovative solutions need to be found to ensure that financial efficiencies can be achieved. This means being clear with our providers about future ways of working and opportunities for market innovation, changes and development. It will also mean managing the expectations of our clients as we prioritise and reorganise services to meet austerity budget challenges. We already have a strengthening partnership with the health economy and other strategic partners. We need to continue to develop these even further so that joint commissioning becomes the norm.



PEOPLE GROUP COMMISSIONING INTENTIONS 2014-2015

OUR COMMISSIONING PRINCIPLES

- Puts **Co-production** at the heart of commissioning
- A real focus on **Personalisation**. Driving through change about how services commissioned with personal budgets are controlled by customers from a market that is developed and responds to customer choice and control.
- Works within an **Evidenced Based** framework and have a focus on Early Intervention and Prevention so that children, young people and vulnerable adults can live independent lives without recourse to more formal forms of support.
- Fully embrace re-ablement, rehabilitation and recovery, acknowledging that many people can recover and regain all or much of their **Independence**.
- Fully utilises intelligence to ensure an **Efficient** use of resources are properly targeted demonstrating quality and effective use of resources aligning commissioning intentions with financial outturn and customer outcomes delivered.

OUR COMMISSIONING PRIORITIES

1. **To empower customers and families** by providing accessible sources of information and advice, involving customers in their individual plans, and by increasing the use of self assessment and timely intervention
2. **To enable customers and families to learn, work and live safely in their own homes and communities** by accessing locally based services and opportunities, reducing unnecessary admissions to institutional settings such as residential care and out of authority schools and colleges. We will continue to commission, jointly where possible, high quality specialist provision for those with acute/severe needs.
3. **To prevent, postpone and minimise people's need for formal forms of support** by commissioning evidenced based targeted support that ensures early identification, assessment and timely intervention.

WORKING WITH THE MARKET

In order to maximize the effectiveness of commissioning the People Group will work with others; people who use services, their families and carers, partners, providers and the rest of the Council to develop the following:

• Market/Gap Analysis. This is currently fragmented and further analysis will be undertaken to enable commissioners and providers to better understand where there are gaps in provision. These will be produced and published through our Market Position Statements some of which have already been published (LINK HERE)

• Financial. The People Group will continue to develop its approach to value for money and will focus in particular on areas of service where spend is above that of comparator Authorities. We want to work with providers to find better cost effective solutions. We will continue to use the care fund calculator so that as a council we are transparent. We want to introduce other elements such as; open book accounting and individual service funds.

• Market Development. The People Group will continue to use "Framework Agreements" which enable individuals to purchase services directly via their personal budgets, where this is appropriate. We will also look at other forms of contracting and align this to our financial efficiencies. We will provide opportunities for partnerships and sub-contracting between providers to encourage the market to become more flexible and responsive. We are keen to encourage new types of organisations into Warwickshire that will provide real choice and are responsive to how people want to live their lives.

• Market Management and Quality. The market management functions will focus on fee rates, viability of the market and ensure that the council has good intelligence to understand the shape and the sustainability of the market. Included within this will be a review and reshape of our contract monitoring function to improve the robustness and voice of consumers of our commissioned services, making sure there is contract compliance. Within this framework we will introduce more robust outcome based contracts and establish a stronger mechanism for measuring the impact of interventions.

With providers we will endeavour to secure high quality provision and ensure that all providers, including personal assistants appropriately safeguard vulnerable people. The delivery of quality services and safeguarding will continue to be a priority.

• Partnership Approach. The People Group continues to be committed to working with communities, neighbourhoods, individuals and the voluntary sector to achieve its outcomes and the approach to commissioning services will complement the assets communities already have in place. Importantly we will establish mechanisms through the use of IT to gather feedback from users of services about the services we commission on their behalf.

PEOPLE GROUP COMMISSIONING INTENTIONS 2014-2015

COMMISSIONING INTENTIONS

DRIVING DOWN DEMAND

1. With health and Public Health review all voluntary and independent sector contracts to re-align and focus the outcomes on the commissioning priorities and reduce the need for more formal forms of support.

2. With health continue to reduce the number of people entering residential and nursing care directly from hospital. To do this a range of models will be used; intermediate care, improved end of life care within a residential/nursing care setting to reduce admissions.

3. With partners develop community based services to reduce hospital admissions.

4. Continue to populate the Warwickshire Directory and the development of an online self assessment and emarket place so that young people, parents and carers and people who need social care services can; get information about the range of services and purchase their own care, all in one place. We will explore the concept of an IT system that allows people to arrange and pay for services on-line should they wish too and will continue to work with health to continue the evolution and implementation of a joint online assessment process that is accessible by all key agencies.

5. Review our support services for people taking their personal budget as a direct payment to make sure that everyone is getting access to the right information and advice to maximise the benefits of Direct Payments. Enable user led and third sector organisations to offer advice and support to people to manage their personal budget as an alternative to direct support from the local authority. This includes advice and support to employ personal assistants.

6. Ensure all new or reviewed provider contracts are part of the 'care with confidence' scheme within the Warwickshire Directory.

7. Tender the Sub-regional Advocacy and user empowerment contracts and ensure that advocacy is a strong feature as services transform across health and social care. We will continue to work with the region to review mediation services for parents in dispute with WCC and complete commissioning and embedding of advocacy services for parents / carers.

8. Through the New Sparks investment stimulate individuals ,local communities and small enterprises to provide a range of services for children, young people or vulnerable adults to; increase social stimulation, reduce isolation, prevent escalation in need and promote health and increase wellbeing within local communities. This will include the development of localised support for carers.

9. With health partners, including public health, we will review all commissioned services from the third sector to make sure that services are responding to health and social care priorities and providing value for money. We will also work closely with our District and Borough partners to meet local priorities and particularly to respond to any gaps.

10. Working alongside colleagues across the council to produce a robust voluntary strategy that will support new approaches to build community capacity, for example progressing “time banks” and “time credits” and other volunteering initiatives.

11. Deliver a joint policy and protocol on Integrated Community Equipment (ICES) and Assistive Technology (AT) as the first offer and develop the market capacity to respond to increasing demand over time with approaches which are creative and innovative, yielding efficiency savings. Included in this will be a requirement that AT is used within Extra Care Housing schemes.

12. With health partners and develop strategies that maximises self-management of conditions within the community with appropriate support from primary care.

13. Provide information and advice on where people can access independent support and appropriate guidance to help them make informed choices about financial planning for care. It is our intention to work with providers to address issues and implications associated with the future funding of care and support and reduce risk as we await the final guidance in relation to Dilnot.

PEOPLE GROUP COMMISSIONING INTENTIONS 2014-2015

COMMISSIONING INTENTIONS

CHILDRENS SERVICES

1. Review the outcomes of the Dartington project to date to better understand the impact to date and to commission Family Therapy Services to reduce numbers of looked after children if appropriate.

2. Explore options for creating local and residential capacity within Warwickshire, including the potential for a block contract for a children home in Warwickshire to accommodate up to 4 young people for long term placements or short term assessment placements. Sub-regional contract options would be explored within this activity.

3. Review current residential placements and identify up to 3 Children and Young People in the first instance who are appropriate for a step down model service from residential care to fostering. We will engage with the market to pilot with up to 3 people.

4. Review the current West Midlands Residential Childrens Care Framework. Options to continue the contract should be appraised alongside the possibility of exit with future placements using the care fund calculator.

5. Review and re-commission the short term emergency foster placements to achieve efficiencies and improved outcomes.

6. Ensure the 2014 sufficiency Duty has a clear commissioning dimension.

7. Review and re-model internal fostering for 1 to 1 placements to reduce high cost external placements and explore options to commission foster care support from IFAs to sustain these placements (initially 10 places).

8. Re-let the sub-regional fostering framework with a view to increase capacity whilst sustaining high quality provision and reduce the range of prices paid for a standard service. We currently have 12 providers and are seeking to increase this to 30 – 40 and thereby increase the proportion of placements on the framework up to 85% (from 50%).

9. Work with the market to explore innovative solutions for family and parenting assessments in more appropriate settings.

10. Commission a one front door for homelessness support and a hub model for the county.

11. Commission a voluntary or independent provider to develop a supported lodging scheme for young people 16 plus who are at risk of entering the looked after system.

12. Re-commission the young carers contract in partnership with Public Health with a focus on the impact of their caring responsibilities to reduce their needs in later life for ongoing public services.

13. With public health, raise awareness and build capacity within communities to enable self reliance and help to reduce the need for more formals forms of support.

14. Jointly review and commission a streamline and efficient speech and language services.

15. Review and re-commission education arrangements for young people with disabilities 16+ to produce a local offer that reduces the number of young people being placed out of county by 100 in the next four years. (Stats: currently 150 children 16+ placed out of County).

16. Repatriate all young people with SEND from out of County Independent schools unless there is good reason otherwise and discuss with providers the development of a framework of a range of support they could offer in county schools to continue to provide on going and relevant support to keep young people in County. (230 children in independent schools at a cost of £10m – 2013)

17. Redesign and reduce spend on transport costs

18. Tender the redesigned Childrens Centre model and transition to new providers.

19. Review CSW contract to redesign and streamline and reduce duplication.

PEOPLE GROUP COMMISSIONING INTENTIONS 2014-2015

ALL AGE DISABILITIES

1. Commission a range of residential and community short breaks services for disabled people of all ages that promote choice and flexibility, encourage the use of direct payments and facilitate a shift from residential to community provision. To include commissioning a minimum of 21 residential short stay beds for disabled adults and young people in transition (16 - 17 years), 4 residential short stay beds for children and young people up to 18 years and a range of overnight and daytime community short breaks in each district operated by a minimum of 10 different service providers countywide. For disabled children and young people it is anticipated that approximately 1,500 residential short stay nights will be required.

2. In partnership with Health, review CAMHS services with the intention of realigning financial resources to increase access to Tier 1 and 2 support and reduce the need for Tier 3 and 4 interventions. Learning from sub-regional partners, explore and secure investment to pilot a Tier 3.5 CAMHS service to reduce hospital admissions for young people.

3. De-commission financial support services to parents of children with disabilities. (We pay Macintyre to pay parents annually at a cost to us of £12k).

4. Commission specialist housing and support for between 54 and 70 people with disabilities, Autism and/or mental health issues in Warwickshire with specific focus on enabling people to move out of residential care and to repatriate home to Warwickshire.

5. In partnership with CCG's implement commissioning intentions agreed in Warwickshire's joint plan to deliver the requirements of the Winterbourne concordat with particular focus on exploring the development of lead commissioning and pooled budget arrangements; facilitating the repatriation of 4 people out of county in inpatient facilities; supporting individuals placed in Brooklands to return to their local community and to reduce the need for future hospital admissions in and out of county through service re-design and commissioning activity.

6. Agree a sub-regional ordinary residence protocol to support the commissioning of new specialist services to meet the high support needs of people with a learning disability, physical disability and/or autism with a particular focus on young people in transition.

7. Pilot Individual Service Funds with up to 8 learning disability, Autism and/or mental health providers to deliver greater flexibility, improved outcomes for customers and to achieve at least a 2% efficiency saving on support packages commissioned via this arrangement.

8. Ensure assistive technology is the first offer of support to disabled people and their families; encourage the market to use innovative technologies to promote independence and reduce reliance on paid support and de commission at least a quarter of all supported living

waking nights and sleep ins through the use of Assistive Technology.

9. Commission 5 Changing Places and 5 sensory rooms in each local area to promote community access and to reduce reliance on paid support.

10. Jointly agree the health and social care offer for people with complex needs who require building based day provision and re-commission services as appropriate; including Warwickshire County Councils Complex Needs Service within the existing budget. Explore the opportunity to pool budgets across health & social care to commission jointly.

11. Commission a range of community support solutions, including accommodation with support where appropriate, for approximately 56 16-17 year olds who are likely to meet adults FACS criteria over the next 2 years.

12. Review and re-design or de-commission all employment contracts for disabled people, including people with Autism and people with mental health issues. Ensure through development and revision of service specifications that all commissioned support providers actively work to support disabled people into employment, learning or volunteering.

13. In partnership with Public Health, review and re-design or de-commission mental health well-being hubs and learning disability community hubs to ensure effective use of resources.

14. Align with Coventry and commission a minimum of 10 Shared Lives carers in Warwickshire over the next four years to provide a minimum of 15 placements for people with disabilities, Autism, mental health problems and/or complex needs.

15. Ensure that all commissioned services are working to a service specification that reflects the nature and cost of what they are delivering. In particular, remove 104 supported living schemes for 282 people with a learning disability and autism from the homecare framework and achieve a 5% efficiency on commissioned hourly rates.

16. Develop a new on-line tendering process for commissioning accommodation with support packages that encourages a minimum of 5 new providers in to the local market and ensures that customers receive support that meets their desired outcomes within their available personal budget.

17. In partnership with Public Health, review all mental health service contracts and agree future commissioning intentions.

18. Clarify through all services specifications the requirement for customers, parents and carers to transport individuals to and from service provision, unless otherwise in individual circumstances. Strategically review transport options available to disabled people and consider outsourcing current services to make efficiencies.

19. Commission a user led organisation to provide peer to peer early intervention support to people with autism that enables them to learn, live and work locally with a clear focus on preventing escalation of need.

20. Review services provided internally by the Services for Deaf Team and commissioned externally from Warwickshire Association for the Blind to design a new sensory impairment service that meets statutory requirements, promotes positive outcomes and value for money.

21. Invest in a service to support vulnerable adults who are bordering on FACS eligibility focussed on enabling them to remain independent and to prevent escalation of need in to statutory services.

PEOPLE GROUP COMMISSIONING INTENTIONS 2014-2015

FRAIL ELDERLY THEMES

TRANSFORMING CARE AT HOME

1. With health and for those over the age of 75 years, establish a care planning process that is person centred and includes advance care planning and make this available to professionals across the health and social care economy.

2. Review the domiciliary care framework and jointly commission a model of integrated community based services incorporating; reablement, assistive technology, community based services in a bid to provide care closer to home and develop a quality market place that offers affordable and sustainable support.

ACCOMODATION WITH SUPPORT

3. Review the Housing Improvement Agency service with housing partners to ensure it achieves measurable outcomes for the frail elderly population of Warwickshire.

4. Implement the outcomes of the Home Truths project to reduce the utilisation of residential care by 5 %

5. Increase the specialist residential and nursing care provision within Warwickshire by 10% with at least 5% of these in Intermediate Care and 5% in Dementia Care. Review all contracts relating to elderly care across the residential and nursing care market to continually drive up quality including End of Life care to avoid unnecessary admissions to acute care.

6. Over the next four years commission in excess of 1500 Extra Care Housing with support. Ensuring provision for people who are frail as a suitable alternative to residential care.

7. Improve the overall standards and performance in residential and nursing care homes to avoid people having to go into hospital unnecessarily.

8. Review and re-commission Warwickshire Care Services residential care services.

9. For people who choose to enter a residential care home, work with providers to:

- Develop personalised support arrangements
- Reduce unplanned hospital admissions and ensure that staff can support people to remain in the care home until their death in accordance with their advanced care plan (if this is their choice).

10. Expand the person centred care training for residential and nursing care staff to improve the quality of care across the County. Link this to quality premium payments where appropriate.

11. Work with relevant stakeholders to improve the availability of appropriate accommodation for vulnerable people across the County.

12. With partners develop a relevant statement of intention for accommodation with support, so to ensure aims and outcomes are shared across Warwickshire.

HEALTH & WELLBEING

13. Jointly commission a falls prevention strategy that supports people in the community and those in residential and nursing care homes and reduce admission to acute care for falls by a minimum of 20%.

14. Develop an End of Life Care Strategy with health and one which responds to the recommendations of the Social Care Framework for End of life Care which supports people to die well in an environment of their choice.

15. Jointly review and commission a joint model for stroke care and those with acquired brain injuries that includes a specialist social rehabilitation service for people with neurological and other disabilities so that people can retain their independence as quickly as possible.

16. With health provide dementia advisors to enable people with dementia to live well.

17. Working with partners, incorporate the use of advance care planning and support planning tools to enable people to plan for support at their end of life and reduce the number of people admitted to an acute setting to die by 10%.

18. With health partners, including primary care, work to achieve more timely diagnosis rates for people with dementia in line with the national target of 67% diagnosis rates (currently 42% in Warwickshire)

19. Commission dementia training to ensure that the health and social care workforce is skilled and competent in delivering person centred care There is an expectation that savings will be achieved by improved models of person centred care.

PEOPLE GROUP COMMISSIONING INTENTIONS 2014-2015

CARERS

20. Review and re-commission young carers services ensuring that the primary causes and solutions are captured within the 'Think Family' framework.
21. With health review and re-commission a range of community based services including short breaks for carers to reduce carer break-down to reduce unnecessary admissions to Acute and residential care by 5%.

22. Review, redesign and commission a local carers support resource that incorporates a range of support services for carers. Establish an infrastructure of peer led support groups that combined across the county form a carer consortium with the expectation that they will empower carers to shape their own means of representation, support, and services and opportunities. This should acknowledge carers as experts by experience and recognise and value the role they undertake in families and communities

INTEGRATED WORKING WITH HEALTH

23. Develop an integrated health and social care approach which enables quick and safe access to a full range of crisis support, rehabilitation and recovery services, including interim support to enable time to plan for the longer term.

24. Work with health partners to enable people with dementia to live in their own home, avoiding unnecessary hospital admissions and premature admission to residential care.

25. Work with health partners to maximise ongoing funding provided to create and develop services and support that reflect all the principles of personalisation, re-ablement and recovery.

26. Work with health partners to develop an effective model for the distribution of Continuing Health Care funding that ensures timely assessment and quality support.

27. With health partners develop dementia navigators to support customers with dementia to live well

MEASURING SUCCESS

This document has set out to briefly describe our commissioning intentions, but detailed delivery plans either have been or will be developed for each intention. To measure our success an Outcomes Framework for the People Group is attached as Appendix 1. This will underpin the performance of all commissioned services from the People Group

[i] A Glass half full. I&DEA. March 2010.
[ii] Ditto
[iii] Joining up health and social care…pg 9

17 October 2013

To: CCG Clinical Leads
Health and Wellbeing Board Chairs
Chief Executives of upper tier Local Authorities
Directors of Adult Social Services

cc: CCG Accountable Officers
NHS England Regional and Area Directors

Dear Colleagues

Next Steps on implementing the Integration Transformation Fund

We wrote to you on 8 August 2013 setting out the opportunities presented by the integration transformation fund (ITF) announced in the spending review at the end of June. While a number of policy decisions are still being finalised with ministers, we know that you want early advice on the next steps. This letter therefore gives the best information available at this stage as you plan for the next two years.

Why the fund really matters

Residents and patients need Councils and Clinical Commissioning Groups (CCGs) to deliver on the aims and requirements of the ITF. It is a genuine catalyst to improve services and value for money .The alternative would be indefensible reductions in service volume and quality.

There is a real opportunity to create a shared plan for the totality of health and social care activity and expenditure that will have benefits way beyond the effective use of the mandated pooled fund. We encourage Health and Wellbeing Boards to extend the scope of the plan and pooled budgets.

Changing services and spending patterns will take time. The plan for 2015/16 needs to start in 2014 and form part of a five year strategy for health and care. Accordingly the NHS planning framework will invite CCGs to agree five year strategies, including a two year operational plan that covers the ITF through their Health and Wellbeing Board.

A fully integrated service calls for a step change in our current arrangements to share information, share staff, share money and share risk. There is excellent practice in some areas that needs to be replicated everywhere. The ingredients are the same across England; the recipe for success differs locality by locality.

Integrated Care Pioneers, to be announced shortly, will be valuable in accelerating development of successful approaches. We are collaborating with all the national partners to support accelerated adoption of integrated approaches, and will be launching support programmes and tools later in 2013.

Where does the money come from?

The fund does not in itself address the financial pressures faced by local authorities and CCGs in 2015/16, which remain very challenging. The £3.8bn pool brings together NHS and Local Government resources that are already committed to existing core activity. (The requirements of the fund are likely to significantly exceed existing pooled budget arrangements). Councils and CCGs will, therefore, have to redirect funds from these activities to shared programmes that deliver better outcomes for individuals. This calls for a new shared approach to delivering services and setting priorities, and presents Councils and CCGs, working together through their Health and Wellbeing Board, with an unprecedented opportunity to shape sustainable health and care for the foreseeable future.

Working with providers

It will be essential for CCGs and Local Authorities to engage from the outset with all providers, both NHS and social care, likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity requirements across the system. CCGs and Local Authorities should also work with providers to help manage the transition to new patterns of provision including, for example, the use of non-recurrent funding to support disinvestment from services. It is also essential that the implications for local providers are set out clearly for Health and Wellbeing Boards and that their agreement for the deployment of the fund includes agreement to the service change consequences.

Supporting localities to deliver

We are acutely aware that time is pressing, and that Councils and CCGs need as much certainty as possible about how the detail of the fund will be implemented. Some elements of the ITF are matters of Government policy on which Ministers will make decisions. These will be communicated by Government in the normal way. The Local Government Association and NHS England are working closely together, and collaborating with government officials, to arrive at arrangements that support all localities to make the best possible use of the fund, for the benefit of their residents and patients. In that spirit we have set out in the attached annex our best advice on how the Fund will work and how Councils and CCGs should prepare for it.

The Government has made clear that part of the fund will be linked to performance. We know that there is a lot of interest amongst CCGs and Local Authorities in how this “pay-for-performance” element will work. Ministers have yet to make decisions on this. The types of performance metrics we can use (at least initially) are likely to be largely determined by data that is already available. However, it is important that local discussions are not constrained by what we can measure. The emphasis should be on using the fund as a catalyst for agreeing a joint vision of how integrated

care will improve outcomes for local people and using it to build commitment among local partners for accelerated change.

Joint local decision making and planning will be crucial to the delivery of integrated care for people and a more joined up use of resources locally. The ITF is intended to support and encourage delivery of integrated care at scale and pace whilst respecting the autonomy of locally accountable organisations.

This annex to this letter sets out further information on:

- How the pooled fund will be distributed;
- How councils and CCGs will set goals and be rewarded for achieving them;
- Possible changes in the statutory framework to underpin the fund;
- The format of the plans for integrated care and a template to assist localities with drawing up plans that meet the criteria agreed for the fund;
- Definitions of the national conditions that have to be met in order to draw on the polled fund in any locality; and
- Further information on how local authorities, CCGs, NHS England and government departments will be assured on the effective delivery of integrated care using the pooled fund.

Leads from the NHS and Local Government will be identified to assist us to work with Councils and CCGs to support implementation. More details on this can be found in the annex. We will issue a monthly bulletin to Councils and CCGs with updates on the Integration Transformation Fund.

Yours faithfully

Carolyn Downs
Chief Executive
Local Government Association

Bill McCarthy
National Director: Policy
NHS England

NHS England Publications Gateway Ref. No.00535

Annex

Advice on the Integration Transformation Fund

What is included in the ITF and what does it cover?

Details of the ITF Fund

The June 2013 SR set out the following:	
2014/15	2015/16
An additional £200m transfer from the NHS to social care, in addition to the £900m transfer already planned	£3.8bn pooled budget to be deployed locally on health and social care through pooled budget arrangements

In 2015/16 the ITF will be created from the following:
£1.9bn NHS funding
£1.9bn based on existing funding in 2014/15 that is allocated across the health and wider care system. Composed of:
• £130m Carers' Breaks funding
• £300m CCG reablement funding
• £354m capital funding (including c.£220m of Disabled Facilities Grant)
• £1.1bn existing transfer from health to social care

1. The Integration Transformation Fund will be £3.8 billion worth of funding in 2015/16 to be spent locally on health and care to drive closer integration and improve outcomes for patients and service users. In 2014/15 an additional £200m transfer from the NHS to social care in addition to the £900m transfer already planned will enable localities to prepare for the full ITF in 2015/16.

2. In 2014/15 use of pooled budgets remains consistent with the guidance[1] from the Department of Health to NHS England on 19 December 2012 on the funding transfer from NHS to social care in 2013/14. In line with this:

3. *"The funding must be used to support adult social care services in each local authority, which also has a health benefit. However, beyond this broad condition we want to provide flexibility for local areas to determine how this investment in social care services is best used.*

4. *A condition of the transfer is that the local authority agrees with its local health partners how the funding is best used within social care, and the outcomes expected from this investment. Health and wellbeing boards will be the natural place for*

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

discussions between the Board, clinical commissioning groups and local authorities on how the funding should be spent, as part of their wider discussions on the use of their total health and care resources.

5. *In line with our responsibilities under the Health and Social Care Act, NHS England is also making it a condition of the transfer that local authorities and clinical commissioning groups have regard to the Joint Strategic Needs Assessment for their local population, and existing commissioning plans for both health and social care, in how the funding is used.*

6. *NHS England is also making it a condition of the transfer that local authorities demonstrate how the funding transfer will make a positive difference to social care services, and outcomes for service users, compared to service plans in the absence of the funding transfer"*

7. In 2015/16 The fund will be allocated to local areas, where it will be put into pooled budgets under joint governance between CCGs and local authorities. A condition on accessing the money in the fund is that CCGs and local authorities must jointly agree plans for how the money will be spent, and these plans must meet certain requirements.

How will the ITF be distributed?

8. Councils will receive their detailed funding allocation following the Autumn Statement in the normal way. When allocations are made and announced later this year, they will be two-year allocations for 2014/15 and 2015/16 to enable planning.

9. In 2014/15 the existing £900m s.256 transfer to Local Authorities for social care to benefit health, and the additional £200m will be distributed using the same formula as at present.

10. The formula for distribution of the full £3.8bn fund in 2015/16 will be subject to ministerial decisions in the coming weeks.

11. In total each Health and Wellbeing Board area will receive a notification of its share of the pooled fund for 2014/15 and 2015/6 based on the aggregate of these allocation mechanisms to be determined by ministers. The allocation letter will also specify the amount that is included in the pay-for-performance element, and is therefore contingent in part on planning and performance in 2014/5 and in part on achieving specified goals in 2015/6.

How will Councils and CCGs be rewarded for meeting goals?

12. The Spending Review agreed that £1bn of the £3.8bn would be linked to achieving outcomes.

13. In summary 50% of the pay-for-performance element will be paid at the beginning of 2015/16, contingent on the Health and Wellbeing Board adopting a plan that

meets the national conditions by April 2014, and on the basis of 2014/15 performance. The remaining 50% will be paid in the second half of the year and could be based on in-year performance. We are still agreeing the detail of how this will work, including for any locally agreed measures.

14. In practice there is a very limited choice of national measures that can be used in 2015/6 because it must be possible to baseline them in 2014/5 and therefore they need to be collected now with sufficient regularity and rigour. For simplicity we want to keep the number of measures small and, while the exact measures are still to be determined, the areas under consideration include:

    - Delayed transfers of care;
    - Emergency admissions;
    - Effectiveness of re-ablement;
    - Admissions to residential and nursing care;
    - Patient and service user experience.

15. In future we would hope to have better indicators that focus on outcomes for individuals and we are working with Government to develop such measures. These can be introduced after 2016/7 as the approach develops and subject to the usual consultation and testing.

16. When levels of ambition are set it will be clear how much money localities will receive for different levels of performance. In the event that the agreed levels of performance are not achieved, there will be a process of peer review, facilitated by NHS England and the LGA, to avoid large financial penalties which could impact on the quality of service provided to local people. The funding will remain allocated for the benefit of local patients and residents and the arrangements for commissioning services will be reconsidered.

Does the fund require a change in statutory framework?

17. The Department of Health is considering what legislation may be necessary to establish the Integrated Transformation Fund, including arrangements to create the pooled budgets and the payment for performance framework. Government officials are exploring options for laying any required legislation in the Care Bill. Further details will be made available in due course. The wider powers to use Health Act flexibilities to pool funds, share information and staff are unaffected and will be helpful in taking this work forward.

How should councils and CCGs develop and agree a joint plan for the fund?

18. Each upper tier Health and Wellbeing Board will sign off the plan for its constituent local authorities and CCGs. The specific priorities and performance goals are clearly a matter for each locality but it will be valuable to be able to:

    - Aggregate the ambitions set for the fund across all Health and Wellbeing Boards;

- Assure that the national conditions have been achieved; and

- Understand the performance goals and payment regimes have been agreed in each area.

19. To assist Health and Wellbeing Boards we have developed a draft template which we expect everyone to use in developing, agreeing and publishing their integration plan. This is attached as a separate Excel spread sheet.

20. The template sets out the key information and metrics that all Health and Wellbeing Boards will need to assure themselves that the plan addresses the conditions of the ITF. We strongly encourage Councils and CCGs to make immediate use of this template while awaiting further guidance on NHS planning and financial allocations.

21. Local areas will be asked to provide an agreed shared risk register, with agreed risk sharing and mitigation covering, as a minimum, steps that will be taken if activity volumes do not change as planned. For example if emergency admissions increase or nursing home admissions increase.

What are the National Conditions?

22. The Spending Review established six national conditions:

National Condition	Definition
Plans to be jointly agreed	The Integration Plan covering a minimum of the pooled fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Well Being Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and Local Authorities should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.
Protection for social care services (not spending)	Local areas must include an explanation of how local social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with the 2012 Department of Health guidance referred to in paragraphs 2 to 6,

National Condition	Definition
	above.
As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends	Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The forthcoming national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England will provide guidance on establishing effective 7-day services within existing resources.
Better data sharing between health and social care, based on the NHS number	The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care. Local areas will be asked to: • confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to; • confirm that they are pursuing open APIs (ie. systems that speak to each other); and • ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place. NHS England has already produced guidance that relates to both of these areas, and will make this available alongside the planning template. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by the Department of Health).

National Condition	Definition
Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Local areas will be asked to identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning.
Agreement on the consequential impact of changes in the acute sector	Local areas will be asked to identify, provider-by-provider, what the impact will be in their local area. Assurance will also be sought on public and patient engagement in this planning, as well as plans for political buy-in.

How will preparation and plans be assured?

23. Ministers will wish to be assured that the ITF is being used for the intended purpose, and that the local plans credibly set out how improved outcomes and wellbeing for people will be achieved, with effective protection of social care and integrated activity to reduce emergency and urgent health demand.

24. To maximise our collective capacity to achieve these outcomes and deliver sustainable services we will have a shared approach to supporting local areas and assuring plans. This process will be aligned as closely as possible to the existing NHS planning rounds, and CCGs can work with their Area Teams to develop their ITF plans alongside their other planning requirements.

25. We will establish in each region a lead local authority Chief Executive who will work with the Area and Regional Teams, Councils, ADASS branches, DPHs and other interested parties to identify how Health and Wellbeing Boards can support one another and work collaboratively to develop good local plans and delivery arrangements.

26. Where issues are identified, these will be shared locally for resolution and also nationally through the Health Transformation Task Group hosted by LGA, so that the national partners can broker advice, guidance and support to local Health and Well Being Boards, and link the ITF planning to other national programmes including the Health and Care Integration Pioneers and the Health and Well Being Board Peer Challenge programme. We will have a first review of readiness in early November 2013.

27. We will ask Health and Well Being Boards to return the completed planning template (draft attached) by 15 February 2014, so that we can aggregate them to provide a composite report, and identify any areas where it has proved challenging to agree plans for the ITF.

Item 8(b)

Health and Wellbeing Board
November 2013

Funding Transfer from NHS England to Warwickshire County Council 2013/14

Recommendations -

That the Health and Wellbeing Board approves the proposed use of this money and approves the Section 256 Agreement set out in Appendix 1.

1 Introduction

1.1 In 2011/12 the Department of Health began to transfer significant sums of money into social care services in order to benefit health. This money was passed through Primary Care Trusts until 2012/13. In 2013/14 the transfer is being made directly from NHS England and administrated by the NHS England Area Team.

1.2 The total amount to transfer nationally in 2013/14 is £859m, of which the figure for Warwickshire is £8m. The adult social care relative needs formula was used to distribute the funding across local authorities.

1.3 Payments have to be made via a "Section 256" agreement between NHS England and Warwickshire County Council (Section 256 refers to the part of the 2006 NHS Act which gives health authorities the power to transfer money to local authorities).

1.4 NHS England has set out that it requires local Health and Wellbeing Board approval for spending proposals, outcomes, and monitoring arrangements in order to transfer the money.

1.5 This report sets out the proposed use of the transfer for 2013/14 and explains how the proposed use meets the criteria set out.

1.6 This report does not consider or make recommendations on any other funds and is not to be confused with the £300m fund relating to reablement, or the £130m fund relating to carers breaks.

1.7 This report and the associated Section 256 agreement only relate to 2013/14. Any decisions about future funding in 2014/15 or beyond will be the subject of separate reports and decisions.

2 The Purpose of The Transfer

2.1 The following criteria are specified by the Department of Health:

- The funding must be spent on adult social care services that benefit health.
- The local authority must secure agreement with local health partners as to how the funding is best used and the outcomes expected from the investment.
- The proposals must have regard to the local Joint Strategic Needs Assessment and to the existing commissioning plans for local social care and health services.
- The local authority must demonstrate how the funding will make a positive difference to services and outcomes compared to what would have happened in the absence of the transfer.
- The funding can be used to support existing spending, to prevent reductions in spending that would otherwise occur due to budget pressures, or to support new spending.
- It is expected that this transfer will also cover any costs to local authorities arising in 2013/14 as a result of the Caring for Our Future White Paper (with the exception of Guaranteed Income Payments disregard which is funded separately).

3 Spending Proposals

3.1 The table below sets out the spending proposals and associated outputs.

Service	£'000	Outputs
Reablement	4,348	Number of episodes of reablement provided (approximately 2,300)
Respite Care	1,600	Number of bed days provided (approximately 5,300)
Telecare	150	Number of service users supported (approximately 500)
Integrated Community Equipment Services	1,400	Number of items of equipment issued (approximately 17,000)
Dementia Care	500	Hours of homecare provided (approximately 34,000)
Total	7,998	

3.2 The funding is provided as a single figure for Warwickshire, which is a legacy of the previous Primary Care Trust health structure. Other local

health funding is now split between Clinical Commissioning Group (CCG) areas. The table below sets out how the funding would notionally be split by CCG.

Clinical Commissioning Group	% of County	£ Notional Apportionment of Transfer £'000
North	33%	2,639
Coventry and Rugby (Rugby element only)	18%	1,440
South	49%	3,919
Total	100%	7,998

3.3 Spending on social care services is guided by the application of FACS criteria which ensures consistency of support across the county. This means that spending on social care across the county may not be in direct proportion to how the health funding formula would apportion it. It is therefore not proposed to make the spending in each area match these figures but it is proposed that how the spending does happen across the county is monitored and that this pattern is then reported and understood to help to inform future commissioning activity.

4 Outcomes

4.1 The high level outcomes for customers of social care and health services are summarised in the table below:

Outcomes	
People are independent	People, including those who are vulnerable, are able to live independently and in their own homes. When people develop are needs are able to recover their health and independence quickly.
People enjoy life	Carers of vulnerable people can balance their caring roles and maintain their desired quality of life.
People are cared for	People with care needs have security, stability and are cared for in a positive and safe environment which is appropriate to their individual needs. People with care needs are treated with dignity, respect and sensitivity to their individual circumstances.

People can access the right services:	People have choice and control in the services they access.
…at the right time	Services respond in a timely manner to assess and support people to regain, retain and maintain independence as soon as possible. People have the support they are entitled to, when they need it.

4.2 The transfer specifically relates to services around the boundaries of health and social care. To this end the following more specific areas are relevant.

- Minimising delayed discharges from hospital.
- Minimising inappropriate admissions to hospital, residential care, and nursing care.
- Minimising inappropriate discharges from and readmissions to hospital.

4.3 The following specific outcome indicators are proposed to reflect this:

- Proportion of older people (65+) who are still at home 91 days following discharge from hospital.
- Delayed discharges from hospital.

5 Monitoring Arrangements

5.1 It is proposed to monitor the activity outputs and outcomes listed in Section 3.1 and 4.3 above on a quarterly basis via the Joint Adults Commissioning Board.

5.2 Local authority and health services will monitor and manage a greater number of measures and indicators than these and review them more frequently and in more detail. However, the intention of this agreement is to set out the high level measures of activity that relate to the transfer, rather than to detail all of the measures that may be used.

6 Links to JSNA and Current Commissioning Plans

6.1 The priorities set out within the current joint strategic needs assessment include reference to long-term conditions, mental well-being, dementia, and ageing and frailty. The commissioning intentions of the local authority and health services are guided by the joint strategic needs assessment.

6.2 Long term conditions: around one in three adults live with at least one long-term condition, driven in part by an ageing population, and in part by unhealthy lifestyle choices.

6.3 Mental well-being: over 10% of adults living in Warwickshire live with common mental health problems.

6.4 Dementia: there are over 3000 patients on Warwickshire GPs disease register for dementia. However, data suggests that only 43% of people in Warwickshire with dementia have been formally diagnosed.

6.5 Ageing and frailty: the largest underlying causes of death for the three years from 2008 to 2010 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.

6.6 The customers being supported by this expenditure will in large part be living with long-term conditions, mental health conditions, dementia, and ageing and frailty related conditions.

7 Recommendations

7.1 That the Health and Wellbeing Board approves the proposed use of this money and approves the Section 256 Agreement set out in Appendix 1.

November 2013

Author: Chris Norton, Strategic Finance Manager, People Group, Warwickshire County Council

Wendy Fabbro, Strategic Director, Warwickshire County Council

Gillian Entwhistle, Chief Officer, South Warwickshire Clinical Commissioning Group

Steve Allen, Accountable Officer, Coventry and Rugby Clinical Commissioning Group

Andrea Green, Chief Officer, North Warwickshire Clinical Commissioning Group

Appendix 1

Section 256 2013/14 Social Care Transfer Version 1

DATED **November 2013**

NHS England **(1)**

and

Warwickshire County Council **(2)**

Agreement

Section 256 Revenue Grant

(In duplicate)

THIS AGREEMENT is made on November 2013
BETWEEN:

(1) **NHS England** of Quarry House, Leeds, LS2 7UE, or any successor body, or other NHS Organisation;

(2) **THE WARWICKSHIRE COUNTY COUNCIL** of Shire Hall, Warwick CV34 4RR ("**the Council**").

RECITALS

(A) The Council is the local Social Services Authority within the meaning of the Local Authority Social Services Act 1970

(B) NHS England is empowered by Section 256 of the 2006 Act to make payments to the Council as local Social Services Authority towards expenditure incurred or to be incurred by it in connection with any social services functions (within the meaning of the Local Authority Social Services Act 1970), other than functions under section 3 of the Disabled Persons (Employment) Act 1958

(C) NHS England has agreed to make payments to the Council towards expenditure incurred by it in commissioning and/or providing social care services.

(D) The Council has agreed to accept such payments and will use them to commission and/or provide social care services.

1. Definitions

1.1 The following expressions shall where the context so admits have the following meanings:

"**Agreement**" means this Agreement;

"**Annual Voucher**" means a document to be prepared by the Council and submitted to the PCT to show the correct use of the Revenue Grant in any Financial Year, in the form as set out in Schedule 3;

"**Council**" means Warwickshire County Council;

"**Financial Year**" means the 12 month period from 1 April of any year to the following 31 March of the next year;

"**Revenue Grant**" means the following sum to be paid to the Council. pursuant to this Agreement. Payment profiles are set out in Schedule 2:

Financial Year	2013/14
Amount	£7,997,949

"Social Care Services" means services provided under the enactments listed in the Local Authority Social Services Act 1970), other than functions under section 3 of the Disabled Persons (Employment) Act 1958

2 Interpretation

2.1 Obligations undertaken or to be undertaken pursuant to this agreement by more than a single person shall be made and undertaken jointly and severally.

2.2 References to any statute or statutory provision in this agreement shall be deemed to refer to any modification or re-enactment thereof for the time being in force whether by statute or directives and regulations (intended to have direct application within the United Kingdom) adopted by the Council or the European Communities.

2.3 The headings are inserted for convenience only and shall be ignored in construing the terms and provisions of this Agreement.

2.4 References in this Agreement to any clause or sub-clause or schedule without further designation shall be construed as a reference to the clause or sub-clause of or schedule to this Agreement so numbered.

3 Purpose of Transfer

3.1 It has been agreed between the parties how the Revenue Grant will be spent, and this is set out in Schedule 1.

3.2 The key joint strategic aims underpinning the agreement are focussed around (1) principles of rehabilitation, recovery & reablement; (2) the development of joint pathways to ensure care support networks can respond to a customers needs, regardless of their capacity or complexity; and (3) providing a seamless journey for the customer through the assessment and support process.

3.3 The following statements set out these aims more specifically…

3.3.1 To rehabilitate to the optimum so that patients return to the level of independence they had before becoming unwell.

3.3.2 To prevent inappropriate secondary care admission and to facilitate timely secondary care discharge

3.3.3 To prevent inappropriate admissions to nursing and residential care so that patients do not become unnecessarily institutionalised and are given every opportunity to regain their independence and return to their original place of residence.

3.3.4 To reduce impairments attributable to long term conditions

3.3.5 To be inclusive in nature and reflect equality requirements by allowing all people who would benefit from access to receive services including people with a learning difficulty, mental health need, and physical impairment

3.3.6 To promote social inclusion where appropriate

3.3.7 To allow the development of patient capability in self directing their care and self-managing their conditions

3.3.8 To allow patients to end their lives in the place of their choice

4 Revenue Grant

4.1 NHS England will pay the Revenue Grant to the Council in accordance with payment schedule set out at Schedule 2.

4.2 The Revenue Grant is to be expended on or reserved for planned expenditure on Adult Social Care Services and for no other purpose.

4.3 Any Revenue Grant not committed or spent by the 31st March 2014 will after that date be under the sole control of the Council to determine its use within the spirit of the original purpose of the transfer.

4.4 The Council shall submit to the PCT an Annual Voucher in the form set out in Schedule 3.

5 Commencement

5.1 This Agreement shall come into force on the 1st April 2013 and will continue until the 31st March 2014.

6 Warranty

6.1 The Council and NHS England both warrant that they have the power to enter into this Agreement.

7 Law

7.1 The construction validity and performance of this Agreement shall be governed by the laws of England and Wales.

8 Dispute Resolution

8.1 If any dispute or difference ("the Dispute") arises out of or in connection with this Agreement the parties shall use their best endeavours to reach agreement promptly and amicably.

8.2 Any dispute or disagreement which arises out of or in connection with this Agreement shall be referred to an appropriate manager by each of the parties who shall within 28 days of the dispute or difference arising attempt to resolve the same.

8.3 To the extent that the dispute or difference is not resolved by the managers referred to in clause 8.2 it shall be referred within 28 days after their consideration to the Strategic Director (People Group) of the Council and the Chief Executive of the Local Area Team who shall seek to resolve the same.

8.4 If agreement cannot be reached within 28 days of a referral to the officers referred to in clause 8.3 the Parties may seek mediation from a panel comprising members of the NHS England (or an equivalent authority), the Government Offices for the Region, and ADASS.

Schedule 1

The financial breakdown of the Revenue Grant is as follows:

Service	£'000	NHS England Subjective Description	NHS England Subjective Code
Reablement	4,348	Re-ablement services	52131019
Residential Respite Care	1,600	Bed-based intermediate care services	52131020
Telecare	150	Telecare	52131016
Integrated Community Equipment Services	1,400	Community equipment and adaptations	52131015
Dementia Care	500	Other social care (please specify)	52131024
Total	7,998		

Schedule 2

Schedule of Payments

The Revenue Grant will be paid in one instalment of £7,997,949 paid by the end of December 2013.

Schedule 3

Annual Voucher

THE WARWICKSHIRE COUNTY COUNCIL .....…….....

PART 1 STATEMENT OF GRANT EXPENDITURE FOR THE YEAR 1 April 2012 to 31 MARCH 2013

(if the conditions of the payment have been varied, please explain what the changes are and why they have been made)

Scheme Ref No. Revenue

Total and Title of Expenditure Expenditure

Project £

PART 2 STATEMENT OF COMPLIANCE WITH CONDITIONS OF TRANSFER

I certify that the above expenditure has been incurred in accordance with the conditions including any cost variations for each scheme approved by NHS England in accordance with the Directions made by the Secretary of State under Section 256 of the NHS Act 2006 as substituted by Section 1 of the Health and Social Services Adjudication Act 1983 and amended by Section29 of the Health Act 1999

Signed ..... Date .....

Review by NHS England

I/We have examined the entries in this form and the related accounts and records of the WARWICKSHIRE COUNTY COUNCIL and have carried out such tests as I/we consider necessary and I/we have obtained such explanations as I/we consider necessary.

I am/We are of the opinion that:

- the entries are fairly stated
- the expenditure has been properly incurred in accordance with the Memorandum of Agreement signed by the Trust

Auditor …….. Date ……..

The Common Seal of **WARWICKSHIRE PRIMARY CARE TRUST**
was affixed in the presence of:

Name ……

Signature ……

The Common Seal of **WARWICKSHIRE COUNTY COUNCIL**
Was affixed in the presence of:

Name ……

Signature ……

ANNUAL REPORT

2013

"Keeping Children Safe and Healthy"

Warwickshire County Council

Working for Warwickshire

Contents

1. Forward by Chris Hallett - Independent Chair.

In previous annual reports I have commented how the important business of safeguarding children is taking place in a very difficult economic and organisational climate. This has continued to be the case this year. The Board has received regular reports from agencies at each of its meetings describing how they are managing these challenges. In many ways this is being done effectively although there are now worrying signals in respect of early help reductions for families which in the longer term could well lead to more children being placed in vulnerable situations. The Board intends to monitor the impact of changes in early help settings over the next year.

This year has also seen significant changes to key personnel within agencies with experienced professionals leaving Warwickshire. It is well known that staffing changes or gaps can be crucial to maintaining effective services so whilst we welcome new members to the Board we hope they can now settle into their roles and contribute to the continuing challenge of keeping children safe in Warwickshire.

Dealing with change whilst maintaining effective services remains a crucial aspect of 2013-2014. New national guidance on Working Together 2013 is being embedded in our practice. The challenge of dealing effectively with child sexual exploitation has led the Board to instigate new strategies and procedures as well as a tool kit for practitioners. National media has exposed several high level incidents of children being exposed to sexual exploitation and Warwickshire needs to continue to be vigilant and well prepared to tackle this area of abuse.

No one should be in any doubt as we contemplate the year ahead of the ongoing task of keeping children safe in Warwickshire. Board members, Associate members and members of the various subcommittees and working groups have worked hard and without their dedication and diligence the progress made as highlighted in this Annual Report would not have been achieved. I thank them all for their continued contributions.

Chris Hallett

Independent Chair WSCB

2. Local background and Context.

Warwickshire is a two tier County Council in the West Midlands composed of five district/borough Councils. The demography of the county varies markedly from district to district, with the south of the county in general being more affluent than the north, which features significant deprivation in parts.

Deprivation covers a broad range of issues and refers to unmet need caused by a lack of resources of all kinds, not just financial. The English Indices of Deprivation use various indicators across seven distinct domains of deprivation, which can be combined to calculate an overall relative measure of deprivation – The Index of Multiple Deprivation 2010 (IMD 2010). Although it should be noted that much of the data used to construct the indices relate to the year 2008. The Indices of Deprivation 2010 show that Nuneaton & Bedworth Borough has the highest levels of deprivation in Warwickshire with a ranking of 108 out of 326 Local Authority Districts in England, according to the rank of average score measure of deprivation (where a rank of 1 indicates the most deprived authority). This means Nuneaton & Bedworth are within the top third most deprived Local Authority Districts in England. There are nine Lower Super Output Areas (LSOAs) in Warwickshire ranked within the top 10% most deprived SOAs nationally on the overall Index of Multiple Deprivation 2010. These are all located within Nuneaton & Bedworth Borough. Stratford on Avon District is the least deprived District in the County, ranked 278th out of 326 Local Authority Districts. In between, North Warwickshire is ranked 182nd, Rugby 219th and Warwick District 257th.

The table (see next page) contains additional socio economic contextual indicators highlighting the disparity between the North and the South of the County in terms of unemployment, worklessness and economic hardship, impacting on family cohesion, educational outcomes, health and general wellbeing. Like any District level measure, local variations and concentrations of deprivation will be masked across all five Districts and Boroughs. For example, two areas in Nuneaton and Bedworth recorded over 50% of children living in “poverty” according to the HMRC measure, and further areas in Warwick, Rugby and North Warwickshire with over a third of children.

It is also worth noting that as part of Troubled Families programme which aims to tackle the root cause of problems that cause truancy, youth crime, anti-social behaviour and worklessness, almost 800 families have been identified that meet three of the identified criteria (national and local criteria) within Warwickshire. Almost half of these families reside in Nuneaton and Bedworth Borough (47%). Child protection was one of the areas used to identify these families.

Socio-Economic Indicators

District	Jobseekers Allowance (June 13) % working age population	All DWP working age benefit claimants (Nov 12) % working age population	% of Children in "Poverty"* (August 2010)	Free School Meal Eligibility (Jan13) % pupils attending maintained school in Warwickshire eligible for FSM
North Warks	2.1%	11.2%	14.2%	11.3%
Nun. & Bed.	3.5%	14.9%	19.6%	15.1%
Rugby	2.3%	9.6%	13.7%	10.1%
Stratford on Avon	1.0%	7.8%	10.0%	7.1%
Warwick	1.6%	8.3%	11.6%	9.2%
Warwickshire	**2.1%**	**10.3%**	**13.9%**	**10.6%**
England	4.1%	13.8%	20.6%	18.3%

*Source: NOMIS, School Census, HMRC *Number of children living in families in receipt of CTC whose reported income is less than 60 per cent of the median income or in receipt of IS or (Income-Based) JSA, divided by the total number of children in the area (determined by Child Benefit data)*

Warwickshire continues to have Children's Trust arrangements and these too operate at two tiers. The Countywide Children and Young People's Plan has three priority outcomes, Achievement, Health and Safeguarding these are supported by four areas of priority work: the positive contribution of young people, early intervention through integrated working, effective commissioning, and resources and infrastructure. These priorities fit well alongside those of the Safeguarding Children Board, and particularly welcome is the emphasis on early intervention and integrated working.

3. Statutory and Legislative context for LSCBs.

Local Safeguarding Children Boards (LSCBs) were established by the Children Act 2004 which places the responsibility on Local Authorities to co-ordinate an LSCB in their area.

The role of the Board is to co-ordinate local multi-agency safeguarding arrangements and evaluate the effectiveness of these arrangements. To do this the Board has several functions it must perform, including producing local inter-agency safeguarding procedures, reviewing the deaths of all children in its area to identify learning which may prevent future child deaths, conducting Serious Case Reviews into the deaths of any children where child abuse or neglect are known or suspected, or cases where children are seriously harmed by abuse or neglect and poor multi-agency working may have been a factor, and publishing an annual report on the effectiveness of child safeguarding arrangements in the area.

Safeguarding Boards must include senior members of staff from Local Authority children's and adult's services, District/Borough Councils, Police, Health Service, Education, Youth Justice, Probation and the Careers Service, and they should be chaired by someone suitably experienced in safeguarding children who is independent of the partner agencies.

4. Governance and Accountability arrangements.

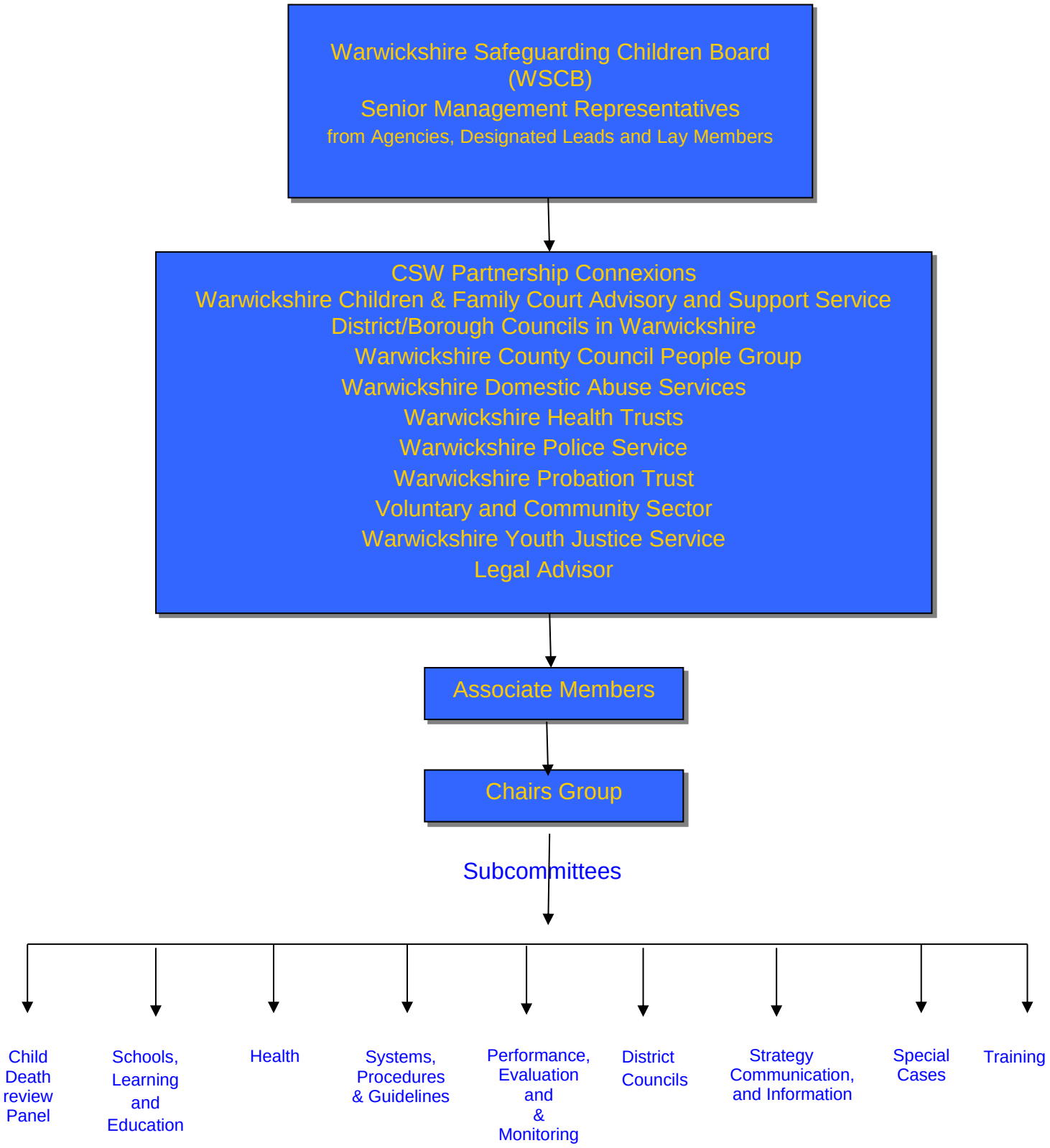
Warwickshire Safeguarding Children's Board has an independent chair, Chris Hallett. In addition to the Chair, the Board directly employs three members of staff, the Development Manager, Inter-agency Training officer, and an Administrator, these posts are hosted by the County Council and funded by the contributions made by member organisations as set out below.

The Child Death Overview functions are managed and supported by a team of two staff, the CDOP Manager and an assistant. This arrangement is made in co-operation with Solihull and Coventry, with the CDOP team working on behalf of all three CDOP panels. The posts are funded jointly by Warwickshire County Council, Coventry City Council and Solihull MBC, in addition to the funding provided by the local authorities directly to the respective Safeguarding Children Boards.

Board Meetings.

In 2013-2013 WSCB met quarterly on 23rd May 2012, 26th September 2012, 5th December 2012 and 6th February 2013.

Structure of Warwickshire Safeguarding Children's Board.



Board members as of 31/3/2013:

Chris Hallett (WSCB Independent Chair)

Jacqueline Barnes

Associate Director of Nursing NHS Warwick and NHS Coventry

Maria Barnes

Service Manager North Safeguarding – People Group, Warwickshire County Council

Detective Superintendent Amanda Blakeman

Warwickshire Police

Jenny Butlin-Moran

Service Manager Child Protection - People Group, Warwickshire County Council

Jackie Channell

Designated Nurse Child Protection – NHS Coventry and NHS Warwickshire

Mel Coombes

Associate Director of Nursing–Coventry and Warwickshire NHS Partnership Trust

Martin Cowan

Housing Advice Manager, Stratford District Council

Craig Dicken

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

Hugh Disley

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

Keith Drinkwater

Lay Member and Vice Chair

Liz Elgar

Service Manager - Coventry and Warwickshire CAFCASS

Wendy Fabbro

Strategic Director – People Group, Warwickshire County Council

Victoria Gould

Young People's Legal Services Manager, Warwickshire County Council

Jodie Green

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

Cornelia Heaney

Development Manager - Warwickshire Safeguarding Children Board

Helen Hipkiss

Assistant Director Patient Experience, NHS West Midlands

Sue Ingram

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

Detective Inspector Nigel Jones

Warwickshire Police

Detective Chief Inspector Richard Long

Warwickshire Police

Jameel Malik

Head of Housing/Property Warwick District Council

Angela O'Boyle

Lay Member

Adrian Over

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

Simon Powell

Assistant Director (Community Development) - North Warwickshire Borough Council

Phil Sawbridge

Head of Service Safeguarding - People Group, Warwickshire County Council

Steven Shanahan

Head of Housing Services - Rugby Borough Council

Dr Peter Sidebotham

Designated Doctor Child Protection – NHS Warwickshire

Mark Simmonds

Inter-agency Training Officer - Warwickshire Safeguarding Children Board

Calvin Smith

Service Manager Safeguarding, People Group, Warwickshire County Council

Steve Stewart

Executive Director - Coventry and Warwickshire Partnership: Connexions

Cllr Mrs Heather Timms

Warwickshire County Council Lead Portfolio Holder for Children - People Group, Warwickshire County Council

Lesley Tregear

Service Manager - Warwickshire Youth Justice Service

Andy Wade

Assistant Chief Probation Officer – Warwickshire Probation Trust

Alison Walshe

Director of Commissioning Development, Arden Cluster NHS Coventry and NHS Warwickshire

Jenny Wood

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

WSCB Budget 2012 -2013

Income	Children's Services	51,497	
	Health	32,952	
	Police	17,508	
	Probation	8,295	
	CAFCASS	550	
	District Councils	10,260	
	CSWP	1,025	
	WCC Learning and Development	41,050	
	Sales	320	
	Fees	950	
		183,500	
Expenditure			
Staffing including travel,			127,819
Services and supplies (desks, PC, phone, stationery, photocopying, subscriptions, postage)			6,585
Training: Room Hire			2,864
Catering			1,173
Monies not spent on SCR and re-print of 'Blue Book' which will be spent on Learning and Improvement Activities in 2013-2014			45,059
			183,500

WSCB did not commission any Serious Case Reviews in 2012-13, nor was the anticipated re-print made of the inter-agency procedures, consequently an additional sum of £45 059 is carried forward into the budget for 2013-2014. The revised statutory guidance, 'Working Together', and the proposed framework for Ofsted inspections of LSCBs set out an expectation that the range and depth of quality assurance activities carried out by LSCBs will need to be more extensive than has been the case to date. It is therefore planned to use the money carried forward from previous years to commission external reviews in support of the new Learning and Improvement programme WSCB is developing. This will delay the need to look to partners for increased financial support to the Board for a period of time, and allow WSCB some time to formulate a view about a long term approach to undertaking this kind of activity.

5. Progress against Strategic Objectives.

The annual report for WSCB published last year set out the strategic plan for 2012-2015 under four strategic objectives derived from the Munro Review of Child Protection in England:

Create and Maintain a Learning System

Strengthen Accountabilities

Promote Effective Practice

Promotion of Early Help for Children, Young People and Families.

The work undertaken by WSCB and its sub-committees is clustered under these overarching objectives, and progress against them is set out below.

5.1 Create and Maintain a Learning System.

The approach to 'Learning' taken by WSCB is a holistic one combining the delivery of training and conferences with reflective learning derived from reviews and inspections of work done by partner agencies in Warwickshire and other LSCBs.

Provision of Safeguarding Training.

The Board has continued to run its own inter-agency training programme. This combines core training for a wide range of professionals whose work may bring them into contact with children, and also more specialist training for those who are directly involved in the delivery of early help and child protection plans. The programme is devised, co-ordinated and evaluated by the Inter-agency Training Officer, Mark Simmonds who also delivers much of it. Mark undertook a consultation exercise with some young people who have experienced the child protection 'system' in Warwickshire to ensure that their perspectives were reflected in the training materials. This year, the inter-agency training officer has also been providing child protection training to staff working in Adult social care teams, in keeping with the WSCB 'Think Family' strategy.

From September 2012 to July 2013 there have been 853 attendees at WSCB training. Attendance from within the different professional groups has been quite varied with most coming from social services, but others such as the Police sending 24 people, the voluntary sector 58 and health with 134. There were a total of 434 people attending the raising awareness safeguarding training, 120 of this figure were people who work in the adult sector which was offered to them over eight sessions specific to this group of professionals.

It was noticed that from September through to December 2012 the number of applications for training being offered had reduced to the point where six planned training sessions had to be cancelled. There are a number of possibilities why this

may be so, and Mark has been undertaking some enquiry to better understand these. It is evident from feedback that for at least some agencies this includes the risk of hard pressed services facing cancellation charges if at the last minute staff cannot be released from service delivery.

We are not proposing that this changes WSCB's stance with regards charges, however, it is felt to be helpful if we add in the Training Directory that it is appreciated that there can be unavoidable circumstances where cancellations have to be made and in those cases either the candidate or their manger contacts the training officer to discuss this. In effect this already occurs when managers contact the training officer to discuss the reason why a staff member had not been able to attend. The effectiveness of the charging policy is shown with the number of non-attendances over the past twelve months being just 5.

At the conclusion of the consultation /enquiry into falling numbers at training, the training offer will be revised to ensure it is meeting the learning needs identified, and other practical changes that may help will be considered.

Training evaluation

Training is always very well evaluated, to ensure this remains so two extra questions have recently been incorporated into the feedback questionnaire which ask delegates to feedback on the quality of the training, specifically "clarity of communication" and "method of delivery". It was felt that these would help us to capture feedback on the trainer/s and so enable feedback to them and pick-up on any issues should they arise.

The WSCB Training Pool has continued to be a valued and very effective way of delivering WSCB's awareness raising training needs around safeguarding. It will continue to be monitored to ensure it is able to operate effectively and to ensure its delivery of training is sustained. Recruitment to the pool will be kept under review and appropriate steps taken should the need arise.

A noteworthy achievement this year has been the rolling out of Child Protection training to GPs throughout Warwickshire, which was delivered by the Designated Nurse for Child Protection. Discussions are continuing between the Coventry and Rugby Clinical Commissioning Group and the Local Area Team about the practicalities of providing safeguarding training for other independent health professionals carrying out NHS work, such as dentists.

The Inter-agency Training Officer produces a report of training activity in the year which is available on the WSCB website.

9th WSCB Annual Conference

In October 2013 the 9th Annual Conference was held, which was entitled 'Evidence-Based Programmes in Safeguarding Children – Implementing in Warwickshire what

works.' This was an opportunity to learn about the work Warwickshire County Council have been doing with the Dartington Social Research Unit to better understand the pathways followed by children and young people who come into Local Authority care and how the looked after "system" and other interventions can be best utilised to meet their needs. By identifying groups with similar characteristics, appropriate evidence based interventions can be provided with the aim of diverting some of the children from care altogether, or returning others home more quickly and with an increased likelihood of return being successful. The conference also heard speakers from Dartington explain what is meant by 'evidence based', and considerations for evaluating the merits of various interventions that could be offered in a particular situation.

It would be expected that the extent of the effectiveness of the programme could take some time to be evident, but the early signs are encouraging. WSCB is now involved in a second phase of the project to look at evidence based approaches which could reduce the number of children needing a child protection plan and support more effective use of the child protection system. Work on this aspect began in April 2013.

Munro Development Demonstrator Activities.

Warwickshire County Council was successful in applying to be a 'Munro Development Demonstrator Site' and WSCB participated in several relevant Learning Events:

- **Learning about work to prevent Child Sexual Exploitation.**

Several members of the Board and partner agencies made a visit to the Blackpool 'Awaken' team which is a multi-agency co-located child sexual exploitation (CSE) team. Learning from this included the value of being able to offer consistent workers to young people over long periods of time to enable them to build up trust and feel supported, the need to provide good support to the staff doing this work as it can be emotionally draining, the value of co-location to enable the sharing of 'soft' intelligence, and build up a local picture of CSE activity, and some approaches to supporting young people to be good witnesses in criminal proceedings. This information is being considered by partners in the consideration of how to shape Warwickshire's response to CSE.

Further to this visit, WSCB signed up to the National Working Group for CSE, in order to be able to continue learning from the experiences of other areas, and relevant staff are attending the Forums.

- **Stoke on Trent and Staffordshire MASH.**

WSCB partner agency staff attended a conference sharing learning from the first year in operation of the Staffordshire and Stoke on Trent Multi agency Safeguarding

Hub (MASH). Learning from this will be shared at a workshop for WSCB and WSAB members in the autumn of 2013 as partner agencies in Warwickshire consider whether this is an approach to multi-agency working that would add value in Warwickshire.

- **Evaluating Systems Review methodologies.**

Two case reviews using aspects of systems review methodologies were undertaken and evaluated in preparation for the anticipated changes to statutory guidance on the conduct of Serious Case Reviews. (SCRs) The first was a case review commissioned by the Special Cases sub-committee for a case which did not meet the mandatory SCR threshold. This review was undertaken by the Development Manager (Vic Tuck) and included the use of the 'conversations' with front line staff that are key to the SCIE 'Learning Together' review methodology. The second was a single agency review commissioned by Children's Social Care using 'SILP' (Significant Incident learning Process), another systems review approach, developed by Paul Tudor. The SILP methodology was evaluated as a Munro Development Demonstrator Site activity by the Development Manager (Cornelia Heaney) with a view to considering the value of its possible application for local case reviews and SCRs commissioned by WSCB.

Both these reviews illustrated the value of hearing from staff directly involved to understand the 'local rationality', i.e. why the actions that were taken seemed sensible or even obvious at the time, and that this can provide a way of getting beyond adjusting parts of the process, and increase the ability to examine the functioning of interacting parts of the system. The learning will be put into practice in reviews being conducted in the current year.

Child Death Overview Panel. (CDOP)

WSCB CDOP has continued to meet throughout the year to review the deaths of children in Warwickshire. This statutory duty is intended to ensure that factors contributing to the death which may have been modifiable are identified and fed back to the relevant agencies to try and reduce such factors being a feature of child deaths in the future. Warwickshire works in partnership with Solihull and Coventry to share a CDOP team, composed of the CDOP Manager and an assistant. As well as being a practical and cost effective solution, this enables learning in the sub-region to be shared. Anonimised data is reported by all areas to the Department of Education, but the reviews held by our colleagues in the sub-region are particularly relevant to learn from because of the overlap in health and third sector resources, and the mobility of families across county borders which means that identified modifiable factors have more shared applicability.

As a result of learning from reviews in recent years, a 'Safe Sleeping' Campaign was held to promote information to parents and carers that is known to be relevant to preventing Sudden Infant Death.(SIDS). In the following year, the number of SIDS

deaths reduced, but those that were reviewed still featured some modifiable factors, and worryingly, in the cases where parents were asked, they had heard the safe sleeping information but had chosen to apply it selectively. This year, The CDOP Manager held a conference to share information with partners in the sub-region about the Derby 'safe sleeping' assessment, which is a tool used by midwifes and health visitors in Derby to work pro-actively with parents to maximise the safety of infant sleeping arrangements. Midwifery leads in Warwickshire and another authority in the sub-region are developing local use of the tool to try and further reduce infant deaths with modifiable factors.

Other changes in Warwickshire brought about as a result of learning from CDOP reviews included the provision of new equipment, and training in its use, in Delivery suites, clarified practice guidance given to staff in a range of health settings, and improving signage on challenging stretches of road. In 2013-14 The CDOP Manager is seeking to work with the County Council Business Intelligence team to undertake and analysis of the data collected in the sub-region over the 5 years the panels have been in operation to see what be learned by looking at the data in the round.

The CDOP Manager produces a full report of CDOP activity in the sub-region, and this is available from the WSCB website.

Serious Case Review.

No serious case reviews were initiated during the year.

Local Case Reviews.

Two case reviews were commissioned by WSCB to learn from cases which did not meet the mandatory SCR threshold. The learning from these cases resulted in work including:

- Ensuring that only qualified social workers undertake statutory assessments of children in need.
- Social Care and Housing are working together to ensure that the commissioning arrangements address the housing needs of vulnerable young people.
- A review of the joint protocol for homeless 16 and 17 year olds between housing and social care is being undertaken.
- Introduction of "Edge of Care" meetings for this group of young people.
- Further Work to explore the interface between CAF and Social care which has informed the revision of the protocol, and
- Introduction of the practice of undertaking a core assessment when a number of initial assessments have previously been undertaken.

5.2 Strengthen Accountabilities.

Quality and Effectiveness of Practice.

In May 2012 WSCB agreed an update to the Performance Management Framework**,** which draws together the various review and audit activities of the Board into one framework. This includes the implementation of the Board's strategic objectives, monitoring of actions plans drawn up in response to inspections, monitoring of agency audits of the effectiveness of their safeguarding activity, and monitoring actions agreed in response to case reviews together with the use of the Case Escalation Process.

External Inspection.

There has been a substantial amount of activity during the year responding to the findings of external inspection, this is summarised below.

- **Ofsted and CQC joint inspection of Safeguarding and Looked After Children.**

It was reported last year that this inspection conducted in October and November 2011 found the overall effectiveness of safeguarding in Warwickshire to be 'good'. However there were recommendations for improvement, and action in response to these continued into this year, with progress of this monitored by WCSB. This has included:

Revising the written statement of Thresholds for Intervention and promoting this eg by including it in inter-agency training, publishing on the WSCB website, and circulating to partners through an email circulation list.

Children's Social Care Operations Managers took part in an exercise to review how thresholds were interpreted locally throughout the County. Work to improve the consistency of threshold application is continuing, and is a theme of the new phase of the Dartington Social Research Unit work referred to in 5.1 above.

Training has been provided to all the GP practices in Warwickshire. Responsibility for oversight of training sufficiency and quality in NHS provider organisations sits with the Coventry and Rugby Clinical Commissioning group from April 2013, and they have created the post of a Training Lead to assist with this.

Work has begun, and is continuing, to ensure child protection plans are 'SMART' and have well defined intended outcomes.

- **Ofsted Thematic Inspection: Parents with Mental Health and Substance mis-use Problems, 'What about the Children?'**

This inspection was carried out in several areas across England, including Warwickshire. Local learning from this inspection resulted in a number of actions being taken in Warwickshire:

The development of a 'Think Family' protocol which has been adopted by both the Children's and Adult's Safeguarding Boards,

The development of a Think Family Board which will act as a vehicle for taking forward a number of the issues identified by the thematic inspection and resultant report.

- **Joint inspection by HMIC et al looking at Appropriate Adult arrangements and detention after charge, 'Who's Looking out for the children?'**

This report was published in November 2011, and in response Warwickshire Youth Justice Service drew up an action plan which aims to:

- Agree a new protocol with Police to set timescales and standards for managing young people detained in police cells,
- Improve timeliness and quality of appropriate adult service to young people,
- Implement a range of measure to address the vulnerability of young detainees, such as provision of health assessment and privacy when booking in,
- Increase the number of transfers to Local Authority accommodation. ('PACE beds').
- Develop arrangements for getting relevant service user views.

WSCB will seek information about the implementation of these arrangements in 2013-14.

- **HM Inspectorate of Probation led Joint Inspection of Offender Management in Warwickshire.**

This inspection was conducted in May 2012, and was positive overall with high scores (and 'minimum' improvement required) for many areas assessed. However some recommendations were made to improve safeguarding of children, namely improving the management oversight of cases where child protection risks were identified, and ensuring that objectives to deal with child protection issues are included in all sentence plans.

A report on progress to address these recommendations will be made to WSCB in 2013-14.

- **Ofsted Thematic Inspection: Protecting disabled children.**

This inspection report was published in August 2012, and Warwickshire Integrated Disability Service conducted a review of their children's safeguarding practice in the light of its findings. The multi-agency team was found to offer many strengths, and the arrangements for co-working with child protection social work teams when required was considered to be sound. However it was also noted that the number of child protection plans in respect of children with profound disabilities was low (averaging 4 at any time), and although this could be explained by the amount of support available to the families of these children it is also possible the figure is explained by poor recognition of child protection needs among severely disabled children, and so it is proposed that this will be the subject of future audit activity.

WSCB also noted that the services to Deaf children were given as part of an all ages specialist service, and in 2013-14 intends to commission an audit of children's safeguarding within this service to ensure the particular safeguarding needs of Deaf children are being met within it.

- **HMI Probation led Joint Inspection of Youth Offending Work in Warwickshire.**

Warwickshire Youth Justice Service was inspected in October 2012. The inspection found that youth offending work in Warwickshire was good, with staff committed to producing good outcomes and to safeguarding young people, and with good governance of the Youth Justice Service. However there were two findings which posed a challenge in relation to inter-agency safeguarding practice in Warwickshire. The inspectors found that the WSCB procedures relating to child sexual exploitation (CSE) were not sufficient to support good practice, and that there was ineffective escalation of safeguarding referrals to Children's Social care resulting in an inadequate response to some identified cases of sexual exploitation.

WSCB has made the development of a CSE strategy and an inter-agency procedure reflecting current best practice a priority work area, and both of these were ready to be signed off at the WSCB meeting May 2013. The escalation process continues to be promoted at WSCB training events, and further work will be done in 2013-2014 to identify how to embed it fully in inter-agency safeguarding practice.

Audit activity: Audit of compliance with statutory safeguarding requirements ('s.11')

Preparation began for the completion of a new audit of the compliance of partner agencies with the statutory requirements on them to engage in safeguarding and promoting the well-being of children. The decision was made to undertake a full audit because there has been significant change in the makeup and status of organisations since the last similar audit was undertaken by WSCB in 2011, for example the winding up of PCTs and establishment of Clinical Commissioning

Groups, schools obtaining Academy status and becoming independent of the Local Authority and the winding up 'Connexions' and establishment of CSWP. Following consultation with colleagues in the Health and Education sub-committees, a tool has been developed which is aligned with others used in the sub-region to streamline work for agencies operating in more than one LSCB area, and this will be sent out in the early autumn of 2013.

Changes to the previous S.11 audit include more enquiry about the sufficiency and reach of safeguarding training and the request for more illustrative evidence.

Monitoring of actions from Serious Case Reviews.

The Health, and Schools and Learning sub-committees of the Board continued to monitor the action plans drawn up following the SCR conducted in the previous year. Continued audit in the Arden cluster has demonstrated compliance with the requirement to record the names of children's fathers, and to record the identity of adults accompanying children at a contact, and also shown satisfactory notification to health visitors and GP of children's presentation at unscheduled care centres in the Arden Cluster.

The Education action plan was completed with the signing off and circulation of guidance to early years settings and schools on the recording of parents and others with parental responsibility in a child's records.

Warwickshire Safeguarding Children Board Escalation Processes

Warwickshire Safeguarding Children Board (WSCB) recognises that in most circumstances, the application of the provisions of the Children Act 1989 and the four categories of harm to children set out in the *Warwickshire Safeguarding Children Board Interagency Child Protection Procedures,* make it possible for professionals to refer cases appropriately and for there to be agreement between the Children's Team and the referrer on the status and disposal of the referral.

However, the Board also recognises that there are situations where disputes over thresholds for referral to social care, and initiation of child protection procedures may occur.

Similarly, the Board acknowledges that in most cases professional practice involving the safeguarding of children in Warwickshire is of a high standard. However, on occasions, concerns about professional practice may be raised.

Government reports and Serious Case Reviews conducted in Warwickshire show us that when children are subject to chronic child abuse and repeated or prolonged involvement in child protection processes, there is a danger of these complex cases "drifting". In these cases, the risks to children may become particularly acute and there is an increased likelihood of a serious incident arising. The emotional and psychological damage to these children is also likely to accumulate if there is no

demonstrable improvement in their care. The escalation process has been reviewed to include measures to address the possibility of 'drift' for such cases, and it is now a four part practice framework document which covers the following areas:

- Referrals where the threshold for intervention is contested.
- Situations where there are concerns about professional practice.
- Children subject of a child protection plan exceeding 15 months and 33 months
- Children subject to more than 1 child protection plan

Taken together the four parts are seen as forming an integrated approach to escalation processes in Warwickshire.

Review of cases under the third and fourth criteria in 2012 -2013

In respect to children subject to a child protection plan for longer than 15 months an enhanced risk analysis is completed at the review conference to ensure all agencies remained focused on the change required to ensure the child's safety.

Where a child has been subject to a previous child protection plan focused attention is given to the request for a further conference. Discussions take place between the Independent Reviewing Service and Operational teams to ensure that any further plans are developed in full cognizance of the history on the case.

The case of any child subject to a third child protection plan will be the subject of scrutiny by the Performance Monitoring and Evaluation sub- committee of the board The task of the committee is for members to satisfy themselves that the child protection plan is progressing satisfactorily or to make a decision that a more Independent Review is required.

During the period 2012 -2013 12 families (23 Children) were subject to a third child protection plan in Warwickshire. In some cases only one of the children within a sibling group may have been subject to a third plan but all of the children are included in these figures.

After scrutiny 7 cases were considered to be progressing satisfactorily. In 5 of the cases a member of the committee conducted a more in depth review of the case and made recommendations where necessary to ensure the plan was not blocked in any way.

Legal oversight was maintained on all cases as an additional measure to ensure appropriate actions within planning.

In all cases the sub -committee was able to satisfy itself that plans were appropriately on track.

The figures for children subject to a second child protection plan in Warwickshire have improved over the last year.

	2012	2013
% of children subject to a second or third child protection plan.	16.5%	13.3%

The evidence would suggest that the use of escalation processes can contribute to more robust child protection planning and increased confidence in multi-agency decision making processes.

Other Quality Assurance activity.

- **DCS 'Test of Assurance'.**

At the completion of the first year in operation of the County Council 'People Group', WSCB sought information from the Leader and the Chief Executive of the County Council that the Director of the People Group, which holds the combined statutory responsibilities of Director of Adult Services and Director of Children's Services (DCS) was able to satisfactorily carry out the duties in respect of children.

The chair of WSCB had a meeting with the Leader of the Council and the Chief Executive to discuss the effectiveness of the DCS arrangements, and a formal report of this information was scheduled to be presented to the Board at the February 2013 meeting. Although the paper had to be put back until May, the information provided in this process set out the approach taken by the County Council to ensuring there is effective strategic leadership to children's safeguarding, including the importance of the support provided to the DCS in this respect by the Safeguarding Head of Service.

- **Seeking information about the consideration given to safeguarding by the Health and Wellbeing Board.**

The WSCB Chair wrote to the chair of the Health and Wellbeing Board to seek reassurance about the priority being given to safeguarding in their work plans. A report was made to the Board in February which affirmed their intention that Safeguarding would be one of their priority areas. WSCB will seek further information about how this develops as the Health and Wellbeing Board establishes itself.

- **Safeguarding procedures and the safeguarding components of SLAs for the Clinical Commissioning Groups**

The Health sub-committee scrutinised the safeguarding elements of the arrangements being put in place by the establishing Clinical Commissioning Groups, including the contracts for designated nurse and doctor, Safeguarding procedures, and SLAs for service providers.

- **Ofsted 'Good Practice by Local Safeguarding Boards' Health check**

The Strategy and Communications sub-committee has initiated a self-assessment 'health check' of the functioning of the Board using questions suggested in the Ofsted 'Good Practice; report. This will be completed during 2013-14, and will provide a basis for developing the approach that WSCB takes to increasing its own effectiveness.

5.3 Promote Effective Practice.

Provision of Policies, Procedures and Guidance.

Throughout the year a range of procedures and policies have been developed, and others reviewed. Significant among these is a major revision of the inter-agency child protection procedures, which has been the main work strand for the Systems and Procedures sub-committee. Unfortunately, the expected publication of 'Working Together', the statutory guidance for inter-agency safeguarding did not materialise in 2012, appearing finally towards the end of March 2013. The final review of the procedures therefore was held up for this, and the procedures were not published during the year as hoped. However, the decision was taken that this edition of the WSCB procedures will be published on-line only enabling continued revision of the procedures to take place more readily in the future as it will be much easier to review the document one section at a time.

Child Sexual Exploitation Procedures

New Child Sexual Exploitation Procedures were however completed, as a stand-alone document. This procedure sets out responses to CSE at all stages of the safeguarding continuum, from prevention to immediate safeguarding in high risk situations, and is accompanied by a set of tools to support practitioners in recognising signs of CSE, judging the level of risk and developing a plan to respond. A training strategy to support the new procedure is being developed by the Training sub-committee. The material is informed by research done by the University of Bedfordshire and Barnados, and by the experience of colleagues in other LSCBs.

This is a new approach in Warwickshire, and will be reviewed after the procedure has been in operation for a year.

Child Sexual Exploitation Strategy and Improvement Plan.

WSCB has drawn up a CSE strategy and associated improvement plan which addresses the four themes of raising awareness of CSE, improving the statutory response and service provision, improving the evidence base, and increasing prosecution and disruption of offenders. A new sub-committee of the Board is being established to drive this work.

CDOP Protocol for the Involvement of Parents, Families and Carers.

A Protocol has been agreed for the involvement of significant people in the life of the child whose death is being reviewed. Further work has been done, led by the CDOP Manager, to implement this in the sub-region. This has included developing a leaflet for parents and carers and agreeing the processes for who will give this to them, and how they will be supported. The protocol will be implemented during 2013-2014

Private Fostering.

The County Council recruited a Practice Leader for Private Fostering, Jenny Packeer, in December 2012, and this appointment has enabled work to be done updating Private Fostering paperwork and procedures and awareness raising activities amongst both the public and professionals about what Private Fostering is and the duties parents and private foster carers have to report this to the Local Authority for assessment.

The numbers of assessed Private Foster care arrangements in Warwickshire remain low (4 on the 31/3/2013), but the Practice Leader for Private Fostering is receiving a growing number of enquiries from people asking if situations need to be assessed, including from the Family Group Conference service of the County Council, school teachers, CAF officers and Independent Reviewing Officers as well as children's social workers. Not all are Private Fostering arrangements at the time of enquiry, but the enquiries indicate a growing awareness of this issue. Many have followed on from training/ briefing events, which would appear to suggest this is an effective way or increasing awareness amongst professionals. A full report of Private Fostering Activity in 2012-2013 will be compiled separately for consideration by WSCB.

WSCB - MAPPA Joint protocol.

A WSCB- MAPPA (Multi-agency public protection arrangements) protocol was agreed, and signed by the chair of each body in December 2012, in order to formalise the co-operation between the two bodies. MAPPA co-ordinates the management in the community of offenders posing a risk of harm, including those who pose a risk of harm to children and registered sex offenders.

In the main, prior to the establishment of the Protocol, the co-operation between agencies in Warwickshire had been good. However since formalising the links between the two bodies, attendance by a WSCB representative at all MAPPA meetings has been consistent, which has helped to put in place better risk management plans to manage the risk sex and dangerous offenders pose to the public of Warwickshire, in particular, children. MAPPA also now makes a formal contribution to the work of WSCB through the participation of the MAPPA chair in the Strategy and Communication sub-committee.

5.4 Promotion of Early Help.

The inclusion of 'Early Help' in the agenda of Safeguarding Children' Boards is a new development, and much of the work in Warwickshire this year has been in relation to better understanding the range and scope of the Early Help provision in the County. The Strategy and Communications sub-committee is tasked with establishing the processes by which the effectiveness of Early Help plans will be evaluated, which requires knowing not just how well each project is functioning, but also understanding whether, taken together, Early Help services reach all reasonable need. The Early Intervention Business Unit of the County Council People Group is drawing up an Early Help and Support Policy, which will provide the basis of this process.

Information reports were requested and considered from early intervention services, including an overview report from Hugh Disley, Head of Service, Early Intervention Business Unit who reported the following services currently being provided in Warwickshire:

- Family and Parent work including Family Group Conferences, Triple P training, etc.
- The Common Assessment Framework (CAF) which engages and works with families who have identified issues, supported by a team of CAF officers employed by the County Council and working closely with colleagues in Social Care,
- Children Centres work with parents and early years (pre-birth to 5 year olds)
- Targeted Youth Support. Support for 1:1 with teenagers in crisis and support for teenagers in care as well as ensuring the voice of our looked after community gets heard through the Children in Care Council (CICC).

and

- Children's Health Teams especially the work with School Nurses and Health Visitors.

WSCB also received information about the delivery of the PREVENT work strand and the 'Priority Families' project, which is Warwickshire's work under the Troubled Families initiative. The funding provided under this initiative is being used in Warwickshire to fund additional posts in existing services including the Family Intervention Service and family centre workers.

It is understood that extremist groups identify and recruit vulnerable children and young people who have emotional and behavioural issues including those who, for instance, are on the autistic spectrum. Consequently WSCB appointed Hugh Disley as the Board representative to the Prevent Working Group to ensure that safeguarding issues are addressed, and appointed the Safer Schools Partnership to oversee the Preventing Violent Extremism in Education part of the Prevent Working Plan.

The work the County Council has being doing with the Dartington Social Research Unit, outlined in 8.1 above, involves the use of evidenced based intervention

methods to prevent children and young people coming into care. ‘Triple P’, a parenting programme, was selected as the most suitable for the needs identified, and is now being offered widely in the County in a range of services.

WSCB notes however that as a result of budget pressures throughout the system, some of these services and resources are being reduced, and the Board will be seeking further information in 2013-2014 to establish whether the reach of early help services if sufficient to be effective in reducing the need for tier 3 and 4 services.

6. Effectiveness of Safeguarding Children arrangements in Warwickshire.

This report summarises and comments on safeguarding activity in Warwickshire between 1 April 2012 and 31 March 2013.

Warwickshire's Safeguarding Children Board has agreed the dataset on which this report is based. It includes this year data about initiation of CAFs (early help assessments conducted using the Common Assessment Framework) in order to make some preliminary findings about the effectiveness of Early Help in Warwickshire.

Links between Safeguarding and Poverty.

As can be seen from the data reported in this section, there is significant variation in the quantity of safeguarding activity taking place in each District of the County. There will be a range of factors influencing this, but a particularly influential consideration is the variation in levels of child poverty, which was shown by the Millennium Cohort study (Centre for Longitudinal Studies), among others, to be highly correlated with multiple risk factors associated with poorer outcomes for children. The information set out above in section 3 of this report provides some illustration of the variation in indicative measures of family poverty and deprivation between Districts in Warwickshire.

Warwickshire Safeguarding Statistics 2012/13
Summary of Key Issues

- There were 676 children subject to an Initial Child Protection Conference held during 2012/13. This represents a 11.6% increase on last year when 606 children were conferenced.

- There has been a significant increase in the number of children who were made subject to a Child Protection Plan with 609 plans initiated during 2012/13 in comparison to the 520 initiated in 2011/12. Following the pattern seen last year, more plans were again initiated than closed this year which is why the number at year end again saw an increase.

- As at 31 March 2013, 550 children were subject to a Child Protection Plan in Warwickshire. This is an 3% increase on the 534 children subject to a plan as at 31st March 2012.

- The highest number of child protection cases continues to be in the north of the county, with 42.5% of CP cases as at 31 March 2013 being in Nuneaton & Bedworth.

- As at 31 March 2013, the largest group of children who were subject to a Child Protection Plan were those aged 5-9 years. This is a change to previous years when the largest group of children subject to a CP Plan at year end were aged 1-4 years.

- Out of the five Child Protection Plan categories, children subject to a plan under “Multiple” categories has seen the greatest increase this year, up 5.4% to 45.3% this year.

- 8.9% of children who are subject to a CP Plan in Warwickshire at 31 March 2013 were BME. This is slightly lower than the overall proportion of the general 0-17 population in Warwickshire that are BME (10%).

- The number of child protection plans closed during the year which had been open for two years or more (Previously National Indicator 64) saw a reduction this year, down from 10.8% to 8.0%. This was an improvement in performance.

- The percentage of children becoming subject to a child protection plan for a second or subsequent time (Previously NI65) during 2012/13 saw an improvement in performance this year, down from 16.5% to 13.3%.

- 98.6% of children who had been subject to a plan continuously for at least three months had been reviewed within timescales during 2012/13. This is a slight decrease on last year when 100% was achieved.

3. CAFS during 2012/13

During 2012/13 a total of 653 CAFS were initiated within Warwickshire. The largest number of CAFS were initiated within the most deprived district within Warwickshire, Nuneaton & Bedworth. Whilst the highest number per 10,000 of the local child population were initiated in the second most deprived ward within Warwickshire, North Warwickshire.

District	Number of CAFS initiated during 2012/13	Number of CAFS initiated per 10,000 of the 0-17 child population
North Warks	99	79 per 10,000
Nun. & Bed.	192	70 per 10,000
Rugby	165	75 per 10,000
Stratford on Avon	88	38 per 10,000
Warwick	109	41 per 10,000
Warwickshire	**653**	**58 per 10,000**

The largest number of CAFS initiated during 2012/13 were as a result of contact by Education, accounting for over half of all CAFS initiated during the year.

Agency	**As a % of all CAFS received during 2012/13**
Education - Primary/Secondary/School Health	58.8%
Social Care	13.8%
Children's Centre	6.9%
Health Visitor/Midwife/Health Other	4.0%
EIS (Early Intervention Service)	3.5%
Youth Justice Service	2.3%
PSA	1.8%
Other Organisations (10 or less CAFS initiated)	8.9%
Total	**100%**

In Warwickshire, professionals in universal and early intervention services are supported to undertake CAFs and act as the lead professional for a family support plan by a team of CAF officers based around the county. Evaluation conducted

by this team shows that families who have family support plans overwhelmingly value the help and find it useful. However, compared with the numbers of families receiving services at the child protection end of the safeguarding continuum, the numbers are very low. These numbers do not by any means provide a complete picture of early help, many families are receiving early help by way of, for example, evidence based parenting programmes or drop in services at a Children's Centre without this being initiated via a CAF. However comparison of the numbers of CAF with the numbers of referrals to social care, and the numbers of CP plans asks the question whether all the families that would benefit from a written assessment of their needs and strengths are receiving this.

Also of relevance is the initiating agency for CAFs. The largest age group of children with a CP plan is 5-9 years, and the second largest is 1-4 years. By contrast, more than half of CAFs are initiated by schools or school health, and very small numbers are initiated by health visitors, midwives and Children's Centres. This raises the possibility that opportunities to use CAF and family support plans are being missed that might have the potential to divert young children away from suffering, or being at risk of suffering, significant harm. This question will receive attention as part of the work Warwickshire is doing with Dartington SRU.

4. Referrals and Assessments during 2012/13

During 2012/13, there were 6524 referrals to children's social care teams. This is a slight decrease on the number of referrals seen in the previous year. Of these referrals, 54% resulted in an initial assessment and 30.4% resulted in a child in need service (both s.17 'child in need' and child protection) lasting 2 months or more.

	2010/11	**2011/12**	**2012/13**
Number of referrals received during the year	6101	6998	6524
Number of referrals moved on to initial Assessments started during the year	3902/6101=64.0%	4216/6998=60.2%	3525/6524=54%
Number of Core Assessments started during the year	859	918	847
Number of new child in need cases opened during the year that stayed open for 2 months or more	1756	2068	1982

The high level of referrals to social care which do not result in a significant 'child in need' service is a cause for concern. This is in respect of the 'cost' to social care of processing these, meaning there is less resource for service delivery in relation to cases which are assessed to meet the social care threshold, and also the risk that families receive a reduced service from early help agencies while the referral is being considered. It is startling that in Warwickshire 653 CAFs were undertaken last year, while 4,542 cases caused a referrer to feel sufficiently concerned to refer to social care but did not get a service from social care that lasted more than 2 months, and 2,999 of these cases were ruled out before a statutory assessment.

In a focus group conducted by the Dartington researcher working with Warwickshire, participants felt that the rising number of referrals reflected successful training and awareness raising over a period of years resulting in professionals in universal and early intervention services recognising more need and risk, and also that relationships between agencies are evolving and becoming closer. It seems likely that continued work is needed to embed understanding of thresholds, and also to make coherent and effective early help responses to more of the cases which sit below the 'child in need' threshold. These issues are also going to be looked at further in the work with Dartington SRU.

As might be expected, the largest number of referrals were received by teams in Nuneaton & Bedworth, accounting for 27.2% of all referrals received. However, Stratford saw the highest rate of referrals per 10,000 although they had the lowest number of referrals moving on to an initial assessment. Nuneaton & Bedworth had the second highest rate of referrals per 10,000 and the highest proportion of referrals moving on to initial assessment.

District	Number of referrals received during 2012/13	Number of referrals per 10,000 of the 0-17 child population	% of referrals going on to initial assessment
North Warks	619	494 per 10,000	47.3%
Nun. & Bed.	1775	650 per 10,000	66.1%
Rugby	1136	514 per 10,000	62.4%
Stratford on Avon	1710	731 per 10,000	44.6%
Warwick	1035	389 per 10,000	60.5%
Warwickshire*	**6524**	**583 per 10,000**	**54%**

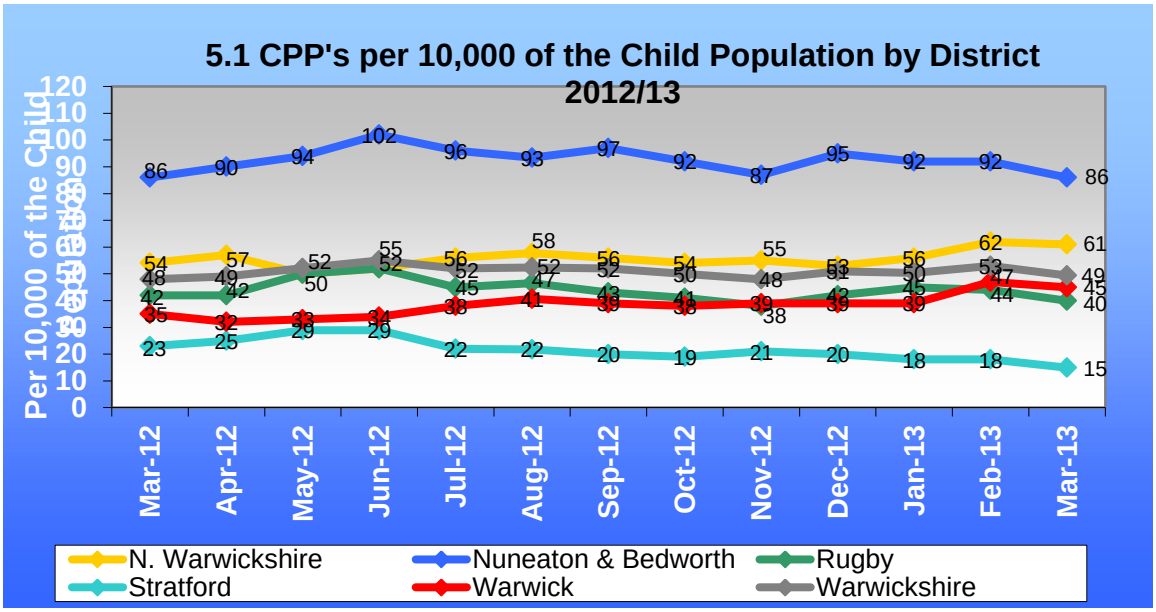
*The total includes referrals received by countywide teams and IDS.

29.6% of all referrals were made by the police. Many of these are Domestic Abuse related referrals. The second largest number of referrals were received from schools accounting for 16.5% of all referrals.

Agency	**As a % of all referrals received during 2012/13**
Police	29.6%
Schools/Colleges	16.5%
Other Professional Worker	16.3%
Health	7.2%
Relative	6.7%
Emergency Duty Team	5.4%
Anonymous	4.9%
NSPCC	2.5%
Other Local Authority	2.4%
Housing	2.0%
Probation	1.8%
Self	1.3%
Psychiatric Services	0.8%
Neighbour	0.7%
All other (agencies who made less than 20 referrals)	1.9%
Total	**100%**

5 Number of children subject to a child protection plan per 10,000 of 0-17 population.

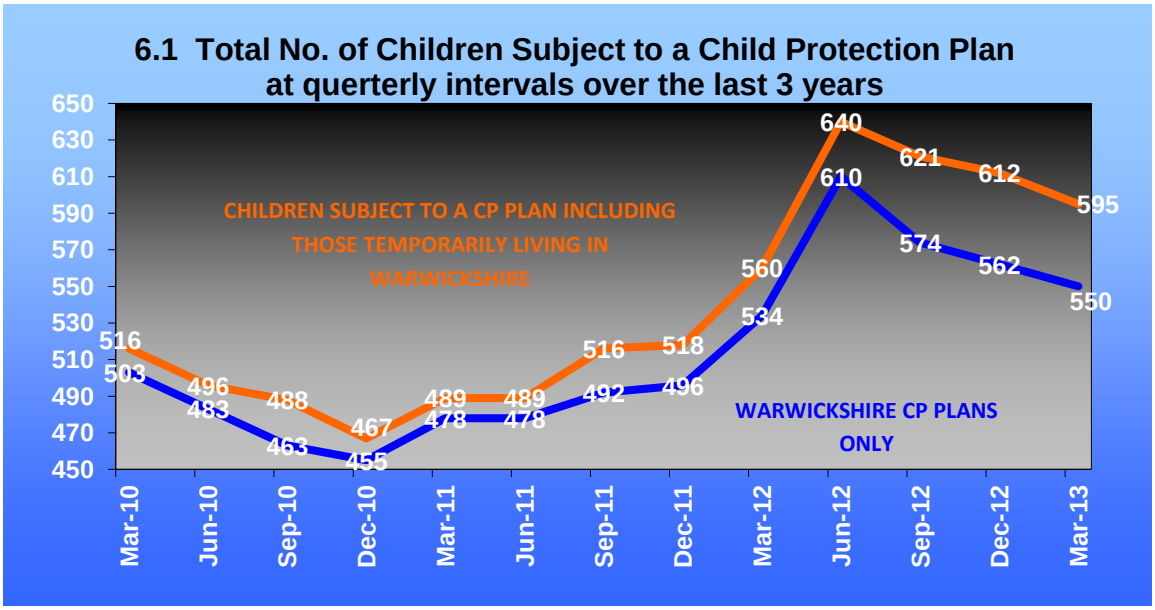
The county rate per 10,000 has increased from 48 at 31 March 2012 to 49 at 31 March 2013. This is a small increase over the year, compared with increases in previous years, and when viewed in conjunction with the following graph(6.1) showing the figures for the whole County over three years, it represents a stabilisation of numbers that were continuing the marked rise begun at the start of 2011. The highest rates per 10,000 continue to be within the north of the county, probably linked to the higher rates of deprivation in these districts.



The most significant rise this year has been seen in Warwick District (up from 35 per 10,000 at 31 March 2012 to 45 per 10,000 at 31 March 2013) whilst Stratford District saw the largest decrease (down from 23 per 10,000 to 15 per 10,000). The Stratford District also saw an increase in the initiation of legal proceedings, so it may be that there has not been a fall in child protection activity overall, as once in care a child would no longer have a CP plan.

6. Children subject to a child protection plan at 31st March

As at 31 March 2013, 550 children were subject to a Child Protection Plan in Warwickshire. This is a 3% increase on the 534 children subject to a plan as at 31st March 2012. There has also been an increase in the number of children subject to a CP Plan who were temporarily living in the area, up from 26 as at 31 March 2012 to 45 as at 31 March 2013. Chart 6.1 shows how this number has progressed over the past three years.



6.2 Child Protection Plan Demographics

	31-Mar-11	31-Mar-12	31-Mar-13
Gender			
Male	242	276	260
Female	224	249	276
Unborn	12	9	14
Age			
Unborn	12	9	14
Under 1	44	64	54
1 to 4	173	167	152
5 to 9	123	150	175
10 to 15	115	128	132
16 - 17	11	16	23
Ethnicity			
White British/Irish/Other	430	456	479
BME	35	66	49
Not Recorded	1	3	8
Unborn	12	9	14

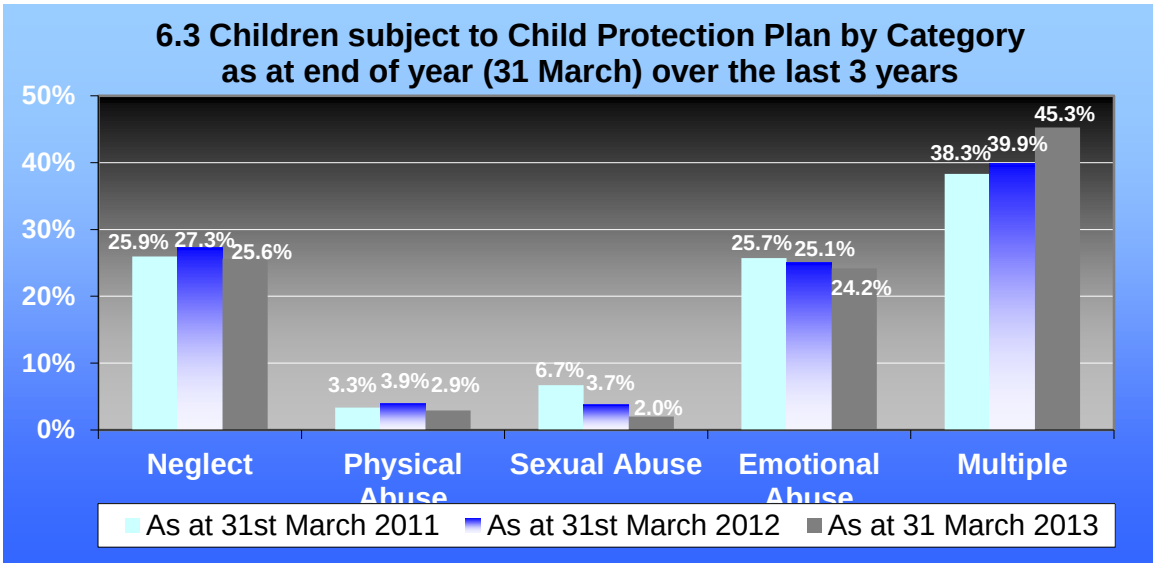
As at 31 March 2013, the was a higher ratio of females than males subject to a CP Plan in comparison to the national published child protection data which showed a slightly higher ratio of males to females. It is worth noting that previous years have shown a higher ratio of males in Warwickshire being subject to CP Plans. We also had a slightly higher proportion of unborn children subject to a plan than was seen in the published national child protection data for 31 March 2012.

As at 31 March 2013, the largest proportion of children subject to a Child Protection Plan in Warwickshire were those aged 5 to 9. This is a slight change on previous years when the largest proportion of children subject to plan were in the 1 to 4 age bracket. In comparison the largest age group subject to a CP plan nationally were those aged 1 to 4 which is the second largest group in Warwickshire as at 31 March 2013. It is also interesting that the largest proportion of the local Warwickshire 0-17 population are aged 10 to 15 whilst this is only the third largest age group of children subject to a CP Plan. These highlights the relative vulnerability of younger children and the importance of making timely responses to emerging need and risk for these children.

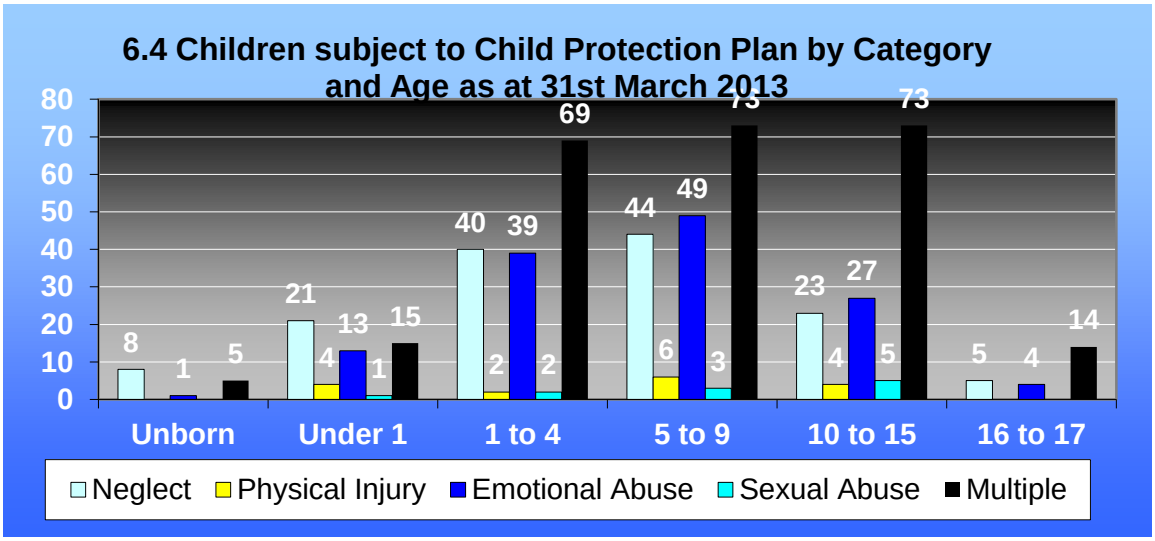
8.9% of children who are subject to a CP Plan in Warwickshire at 31 March 2013 were BME. This is slightly lower than the overall proportion of the general 0-17 population in Warwickshire that are BME (10%) but is significantly lower than the national proportion of BME children that are subject to a CP Plan (19.4%). At present there is not a comparison data set of the ethnicity of children receiving CAF and other early help services which makes it hard to explain this difference.

A commonly suggested reason for the relative over-representation of Black and Asian children in the CP population nationally is that the reach of early help services to their families is less good than for white European families, another that their families are more likely to be social dis-advantaged. The lower figure locally may reflect the particular demography of BME families in Warwickshire. The more systematic collection of ethnicity data by the CAF team which has now begun may help to answer this question.

6.3 Chart 6.3 shows the categories under which children were subject to a Child Protection Plan as at 31st March 2013 with the previous year's figure shown for comparison. Increases were seen this year in children under 'Multiple' categories, up 5.4% to 45.3%. However, slight decreases were seen in children subject to Child Protection plans under all of the individual categories.

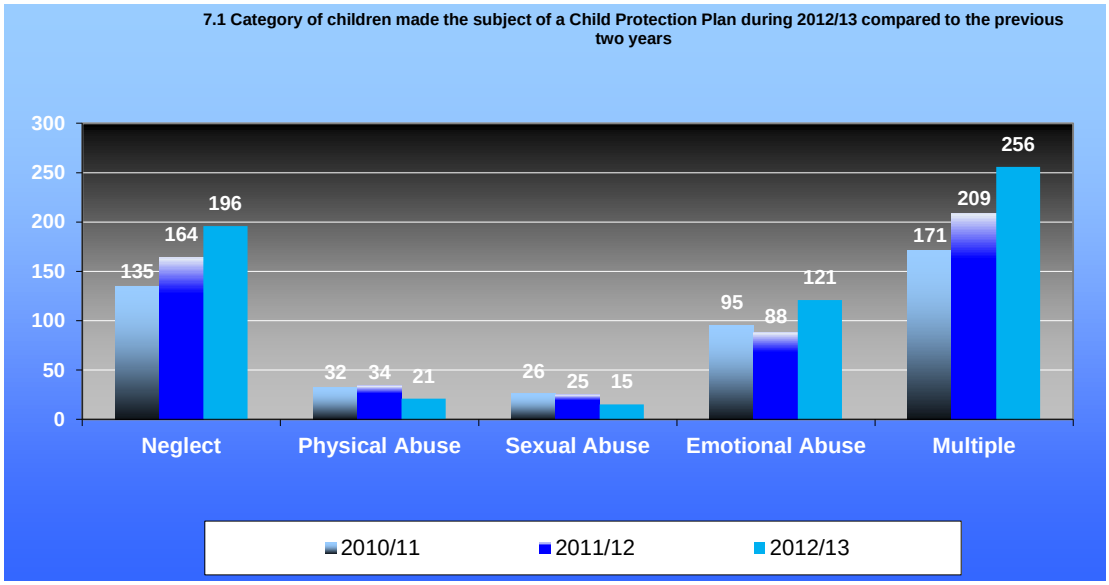


6.4 Chart 6.4 shows children by category and age range. As at 31 March 2013, the largest number of children subject to a Child Protection Plan were those aged 5 to 9 and those aged 10 to 15 who had 'multiple' categories. The largest number of children under a single category though were those aged 5 to 9 for 'emotional abuse'.



7. Child Protection Plans Initiated during the year.

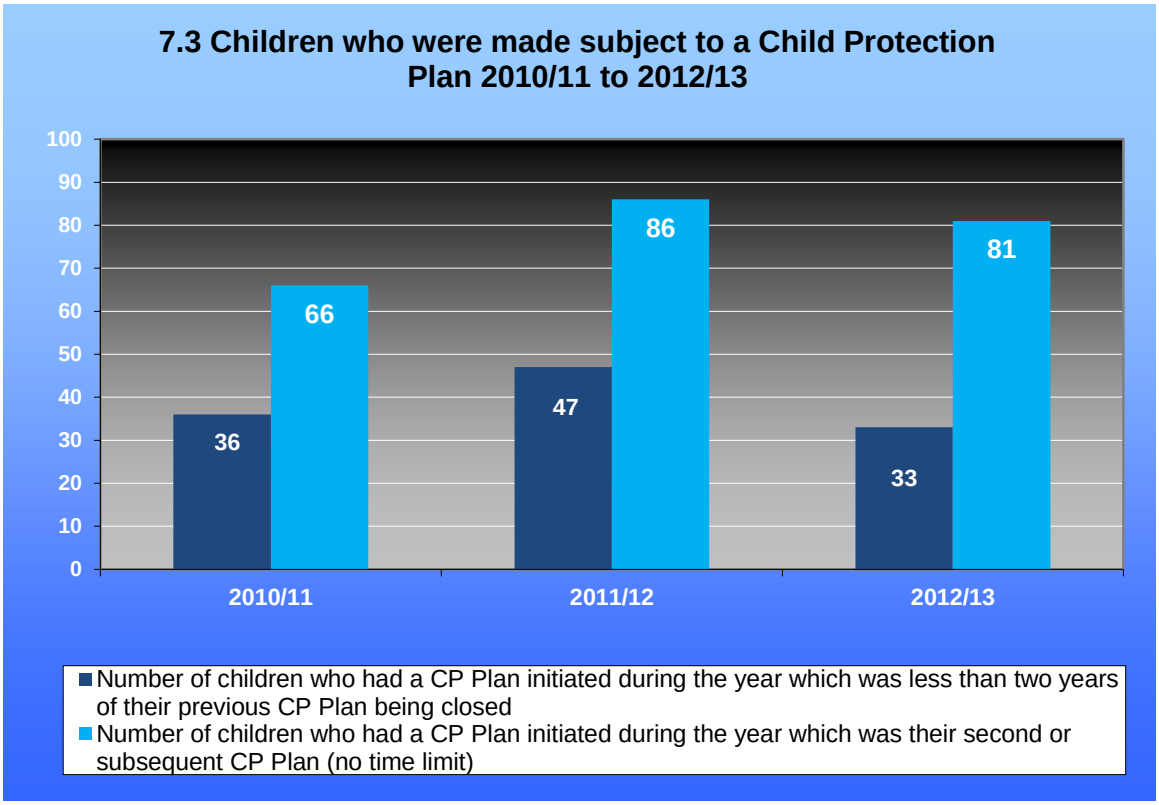
7.1 The majority of the 609 children made subject to a Child Protection Plan during 2012/13 were given the category of 'Multiple'. This was followed by the categories of Neglect and Emotional Abuse. The category that has seen the biggest increase compared to last year was for those with 'multiple' categories whilst the biggest decrease was seen in those who had a plan initiated under the category of 'physical abuse'. (See Chart 7.1 below).



7.2 Of the 609 children who became subject to a Child Protection Plan during the year ending 31st March 2013, 528 (86.7%) of these became subject of a Child Protection Plan for the first time compared to 434 (83.5%) last year. A further 81 (13.3%) children became subject to a Child Protection Plan for a second or subsequent time. This is a positive decrease on last year when 86 (16.5%) of the total number (520) of children became subject to a Child Protection Plan for a second or subsequent time.

7.3 Chart 7.3 shows the number of children who became the subject of a child protection plan for a second or subsequent time over the last three years. This chart also identifies those who became subject to a child protection plan for a second or subsequent time within less than two years of their previous plan. A longer gap between repeat plans means it is more likely to be unrelated to the original reasons for a plan, for example it could reflect a change in the composition of the household. It is positive that repeat plans over any times interval have fallen this year, and the larger fall in repeat plans shortly after the end of the previous one is an encouraging

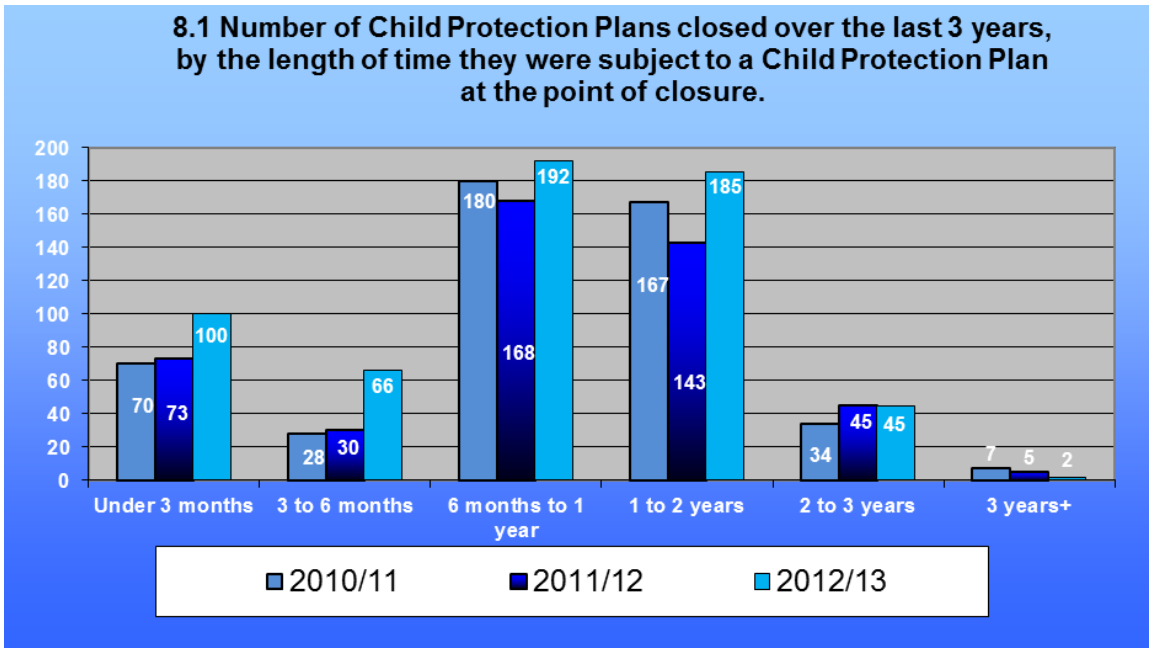
sign that work done to increase the focus of child protections plans may be having some effect.



The number of children who became subject to a plan for a second or subsequent time has decreased from 86 last year to 81 this year. The number for whom a second or subsequent plan was initiated within 2 years or less of their previous plan having been closed also saw a decrease, down from 47 to 33.

8. Duration of Child Protection Plans.

8.1 590 children had their plans closed during the year ending 31st March 2013. This is an increase of 126 (27.2%) when compared with the 464 discontinued during the previous year. Chart 8.1 shows the number of children who had their Child Protection Plans closed during 2012/13, by the length of time they were subject to a Child Protection Plan at the point of closure compared to the previous 2 years.



8.2 Table 8.2 shows this year's discontinued plans by the length of time the child was subject to a Plan as a percentage of all plans closed in the year and compares this with the previous two year's figures.

8.2 Duration of Child Protection Plans Prior to Discontinuation			
	2010/11	**2011/12**	**2012/13**
Under 3 months	14.4%	15.7%	16.9%
3 months but under 6 months	5.8%	6.5%	11.2%
6 months but under 1 year	37.0%	36.2%	32.5%
1 year but under 2 years	34.4%	30.8%	31.4%
2 years but under 3 years	**7.0%**	**9.7%**	**7.6%**
3 years and over	**1.4%**	**1.1%**	**0.4%**

8.3 Performance for Child Protection Plans lasting 2 years or more (previously national indicator NI64) was 8.0%, which is a positive decrease on last year's figure of 10.8%. It is also pleasing that there is a fall in very long plans of more than 3 years. Plans lasting more than 2 years are reviewed under the escalation process to provide some external scrutiny of the plans for the child. This process will be developed to use the cases to learn about blockages in the system and consider ways of addressing these.

The small increase in the number of plans lasting less than 3 months is cause for concern. It is unlikely that three months is long enough for meaningful work to be accomplished, and the cost to the family of being subjected to a CP conference and all that that entails is probably greater than any benefit from such a short plan in most cases. This is likely to be another focus of work done with the Dartington SRU as there may be other ways to manage these cases more effectively.

9. Initial Child Protection Conferences held during the year.

9.1 During the year ending 31st March 2013 there were 676 children subject of an Initial Child Protection Conference. This represents an 11.6% increase on last year when 606 Children were subject to an Initial Child Protection Conference. Of the 676 Children subject to a conference held during 2012/13:

- 627 children (92.8%) were subject to an Initial Conference that took place within 15 working days of initiation of the S.47 Enquiry
- 609 (90.1%) resulted in the initiation of Child Protection Plans.

	2010/11	2011/12	2012/13
Number of Children subject to an Initial CP Conference during the year	536	606	676
Number of children whose initial child protection conferences were held within 15 working days of the initiation of the s.47 enquiries which led to the conference	517/536 = 96.4%	574/606 = 94.7%	627/676=92.8%
Total number of CP Plans initiated during the year following an Initial Child Protection Conference	459/536=85.6%	520/606=85.8%	609/676=90.1%

The fall in the number of initial conferences held within 15 days of the s.47 enquiry beginning demonstrates the strain that is experienced by the whole system, and in particular the review unit, by the continuing rise in child protection activity.

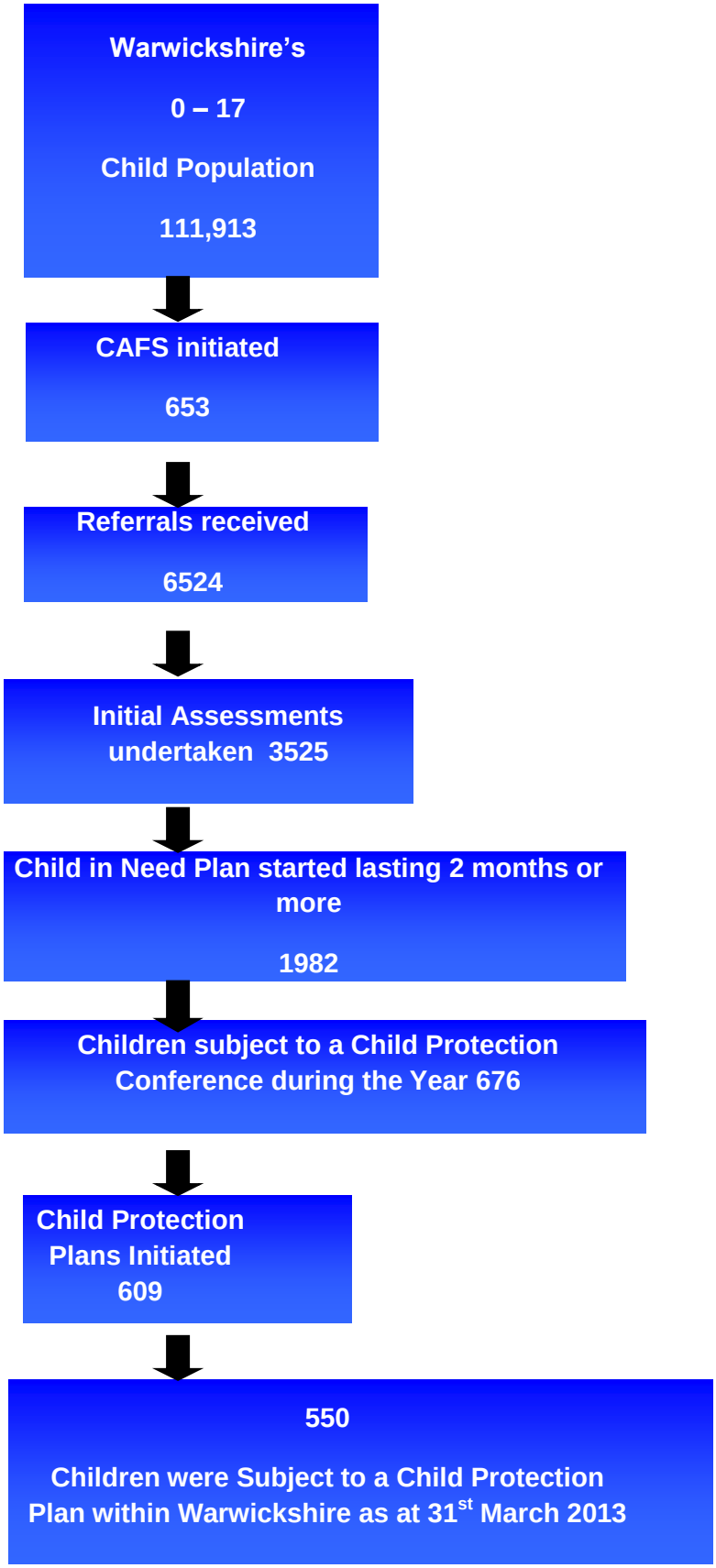
10. Reviews of Child Protection

10.1 During the year ending 31st March 2013, 421 children had been subject to a plan continuously for at least three months. Of that 421, 415 (98.6%) had been reviewed within timescales. This is a slight decrease on last year when 100% was achieved. Again, this is a statistical demonstration of the difficulty for the system in absorbing the increase in demand.

	31-Mar-11	31-Mar-12	31-Mar-13
Children subject to a plan continuously for at least three months who were reviewed within timescales	354/357=99.2%	409/409=100%	415/421=98.6%

11. Summary of Child Protection Activity.

11.1 The chart below summarises some of the activity detailed in Sections 3-9.



12. Number of Private Fostering arrangements.

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

	2010/11	2011/12	2012/13
The number of notifications of new private fostering arrangements received during the year	12	9	12
Number of new arrangements that began during the year	12	8	11
Number of private fostering arrangements that ended during the year	18	11	11
Number of children under private fostering arrangements as at year end (31 March)	**7**	**4**	**4**

7. Business Plan for 2013-2014

Action Required	By Whom	Complete by	Reason for Action and Outcomes Required
A. Create and Maintain a Learning System *Actions continuing from workplan 2012-2013*:			
Hold 10th Annual Conference – theme to be Child Sexual Exploitation.	Strategy and Communications subcommittee .	December 2013	Share work being done, promote understanding of concepts underpinning our strategy, learn from others who are more advanced in their development of these services.
Participate in 2nd cycle of Munro Development Demonstrator sites	Performance, Monitoring and Evaluation sub-committee	March 2014	Share our learning with others, and learn from other LSCBs.
Undertake analysis of accumulated CDOP data	CDOP Manager	September 2013	Maximise opportunity to prevent child deaths by addressing modifiable factors.
Develop links with Warwickshire Children in Care Council	Performance, Monitoring and Evaluation sub-committee .	December 2013	To build the experience of children and young people into our assessment of the effectiveness of safeguarding services, to promote the development of services which children and young people experience positively.
Monitor application in Warwickshire of the	Chairs group	November 2013	To understand whether social workers

Action Required	By Whom	Complete by	Reason for Action and Outcomes Required
Professional Capabilities Framework for social workers			are being equipped to provide leadership to inter-agency safeguarding work.
Agree processes for ensuring integration of learning from SCRs held in other areas into WSCB work plan	Special Cases	December 2013	To inform service development in Warwickshire
Nominate individuals who sit on both Health and Wellbeing Board and WSCB to act as a link between the two Boards, and to provide regular bi-lateral feedback	Chair of WSCB and Chair of H and WB Board	December 2013	To promote mutual understanding of the roles of the two Boards and to facilitate bi-lateral communication, to promote the alignment of priorities between the two Boards.
Actions arising out of Learning and Review Activities:			
Complete training needs analysis, and enquiry into the reasons for reducing attendance, and develop new training programme accordingly	Inter-agency Training Officer;	November 2013	To ensure training offered by WSCB is useful, accessed by the right staff, and results in better safeguarding practice on the front line.
B. Strengthen Accountabilities *Actions continuing from work plan 2012-2013*:			
Implement scrutiny of agencies' own audits as set out in Performance	Performance, Monitoring and Evaluation sub-committee-	March 2014	Inform judgements about the effectiveness of safeguarding practice

Action Required	By Whom	Complete by	Reason for Action and Outcomes Required
Monitoring Framework			
Implement use of reviews of cases with extended CP plans under the escalation process to learn about functioning of the CP system, as set out in the Performance Monitoring Framework	Performance, Monitoring and Evaluation sub-committee	Ongoing, to March 2014	To identify blockages or complications in the system which may be hampering practitioners from performing well.
Complete s.11 Audit and provide feedback to agencies on proposed action plans; monitor implementation of these	Performance, Monitoring and Evaluation sub-committee	March 2014	Understand where improvements are needed to ensure children are being safeguarded, to provide oversight of improvement plans
Monitor the roll out of services in the new SARC and seek information from the SARC about the arrangements for safeguarding children and young people	Designated doctor and nurse and Development Manager	September 2013	On behalf of WSCB; ensure that the arrangements for children in the service meet their safeguarding needs holistically
Complete 'Health Check' of WSCB's own Functioning	Strategy and Communications sub committee	September2013	Understand where WSCB needs to improve its own performance
Develop new data set for use in annual report	Development Manager with Performance, Monitoring and Evaluation sub-committee	March 2014	Better understand the effectiveness of safeguarding activity
Develop WSCB approach to assessing	Strategy and Communication sub-	February 2014	Provide a framework for understanding

Action Required	By Whom	Complete by	Reason for Action and Outcomes Required
'Early help'. *Actions arising out of learning and review activities*:	committee		the effectiveness of services
Request update information about agency action plans following inspection recommendations: Probation, Youth Justice.	WSCB	April 1013	Ensure learning is put into practice and outcomes for children and young people improved
Undertake audit of Deaf children's services	Performance, Monitoring and Evaluation sub-committee	February 2014	WSCB understand whether the particular safeguarding needs of deaf children are recognised and addressed
Feed into the action plan for the 'Think Family' Board, and request regular feedback on the progress of this work	WSCB members who sit on Think Family Board	Ongoing until March 2014	Promote and support effective safeguarding of children whose parents have mental health, drug and substance misuse difficulties
Commission multi-agency audit to investigate repeat child protection plans	Performance, Monitoring and Evaluation sub-committee	December 2013	Better understand causes of repeat plans, identify changes that could be made to CP plans to increase their effectiveness
Seek feedback on investigation being conducted as part of the work with Dartington SRU on the effectiveness of 'step down' arrangements at the end of a	Performance, Monitoring and Evaluation sub-committee	Ongoing until conclusion of the project in March 2014	Better understand functioning of safeguarding system, identify areas of weakness that need to be addressed

Action Required	By Whom	Complete by	Reason for Action and Outcomes Required
CP plan Develop a framework to support partners undertake audit in respect of the DfE Children's Safeguarding Performance Framework question L10, and request this audit be undertaken. ('How do you know whether children and parents/carers feel that referrals were made at the right time, for the right reasons, by the right agencies?'	Performance, Monitoring and Evaluation sub-committee	March 2014	To inform the development of service delivery which is appropriately offered to parents and carers and to children and young people in a way which maximises the likely effectiveness.
Develop a new training course supporting staff to make and receive referrals for child in need and child protection services, incorporating an understanding of Warwickshire's Thresholds statement and Escalation procedure. *Actions arising out of the revised statutory guidance 'Working Together':*	Inter-agency Training Officer	March 2014	Promote understanding of the Thresholds document and Escalation Procedure, improve timely response to families in need.
Draw up 'Learning and Improvement' Framework	Special cases sub-committee	December 2013	Required by WT 2013-08-01, ensure that learning and audit activities result in improvement
Make a formal link with the JSNA steering	Strategy and Communications sub-	December 2013	Required by WT 2013, ensure that

Action Required	By Whom	Complete by	Reason for Action and Outcomes Required
group by giving a member of this group who sits on WSCB the responsibility represent WSCB's concerns to the JSNA, and feedback JSNA learning to the Board; review the effectiveness of this arrangement.	committee		WSCB bases its work on needs assessment done by the JNSA, and that need identified by WSCB is fed back to the JSNA for consideration by the Health and Wellbeing Board and Children's trust
Make formal links with the Health and Well Being Board by giving a member of this Board who sits on WSCB the responsibility provide feedback to each Board about the work of the other; review the effectiveness of this arrangement	Strategy and Communications sub-committee	December 2013	Ensure work strands of each Board reflect the knowledge and work of the other
Develop a WSCB Training strategy setting out the training staff working with children should receive, and whether this should be single agency or multi-agency.	Training sub-committee	February 2014	Required by WT 2013, ensure that partners are clear what is expected of them with regard to the provision of training for staff, ensure practitioners have the knowledge and confidence needed for good safeguarding practice.
Request information from Coventry and Rugby CCG about their enquiries into how Health provider trusts are satisfying themselves that designated staff for child protection have sufficient time, funding, supervision and support to carry out their safeguarding duties	Health sub-committee on behalf of WSCB	February 2104	For WSCB to be satisfied that this statutory requirement is being met

Action Required	By Whom	Complete by	Reason for Action and Outcomes Required
Review arrangements for appointing, and reviewing the appointment of the independent chair	Chair's sub-committee with WCC Chief Exec	December 2014	To put in place arrangements in Warwickshire which comply with statutory requirements, to ensure that WSCB enjoys strong leadership and is able to carry out its responsibilities to a high standard
C Promote Effective Practice *Actions continuing from 2012-2013*			
Complete the update of Inter-agency safeguarding procedures.	Systems and Procedures sub-committee.	December 2013	Provide staff in Warwickshire with clear and helpful procedures and guidance which support effective safeguarding practice
Monitor the contribution and function of the Principle Social Worker in WCC	Chairs group	November 2013	Promote and support effective children's social work practice
Form a CSE sub-committee	Development Manager	September 2013	Ensure CSE strategy is implemented, and kept under review in recruitment
Convene Safer recruitment task and finish group when new LADO in post (expected to be September)	LADO and representatives of partner agencies	November 2013	To support compliance with statutory guidance, to ensure recruitment practices keep children safe

Action Required	By Whom	Complete by	Reason for Action and Outcomes Required
Actions arising out of learning and review			
Provide joint training for adult's and children's practitioners to ensure that needs arising for children as a result of parents' mental health and drug problems are understood, assessed and met	Inter-agency Training Officer and Training subcommittee	March 2014	Support "Think Family" protocol and promote effective partnership working
Contribute to, and support the implementation of the Warwickshire 'Violence against women and girls' strategy	Strategy and Communications sub-committee other individuals as appropriate	March 2014	To contribute to the development of an effective and useful strategy, to reduce violence against women and girls in Warwickshire, to reduce the number of children living in households where domestic abuse is a feature.
Develop a 'Neglect' strategy	Strategy and Communications sub-committee	December 2014	To provide a coherent response to the issues uncovered in case reviews, to increase the effectiveness of responses in Warwickshire to chronic deficits in parenting capacity across the safeguarding continuum, to reduce the harm done to children caused by drift in the management of their services
Re-develop the WSCB website, including material for parents and children as well as	WSCB team with Strategy and Communications sub-committee	January 2014	Provide one easy point of access to procedures, strategies, policies and

Action Required	By Whom	Complete by	Reason for Action and Outcomes Required
professionals			forms used in inter-agency children's safeguarding in Warwickshire, to provide information about the Board to staff and the public, to provide information about children's safeguarding services, and sources of information and support to children, young people and their parents and carers
Actions arising out the revised statutory guidance 'Working Together'			
Develop procedures for single social work assessment of children in need	Social Care	March 2014	Required by WT 2013, remove the distinction between initial and core assessments
Develop protocols for assessment	Social Care and Systems and Procedures sub-committee	July 2013	Required by WT2013,Provide clarity for referrers about what to expect when a referral is accepted by Social Care
Review 'Threshold for Intervention' Document to address requirements of new guidance	Social Care and Systems and Procedures sub-committee	September 2013	WT 2013 includes requirement to define threshold for s.20 accommodation and s.31 application for a care order, to support inter-agency dialogue about the appropriate level of intervention for a family at a particular point in time.
Publish Information sharing protocol	Systems and Procedures sub-	December 2013	Support agencies in balancing the

Action Required	By Whom	Complete by	Reason for Action and Outcomes Required
	committee in co-operation with the Safer Communities partnership		requirements of data protection/ confidentiality and co-operation to promote good safeguarding practice.
D Promotion of Early Help *Actions continuing from 2012-2013*			
Request information about the WCC Early Help and support strategy	WCC and partners as requested	July 2013	To assist WSCB with making an assessment about the effectiveness of Early Help services
Participate in the second phase of the work WCC is undertaking with Dartington SRU to use evidence based approaches to prevent children from needing CP plans.	WCC and partners as requested	March 2014	To safely reduce the number of children in Warwickshire with child protection plans, reduce the number of children experiencing significant harm.
Actions arising out the revised statutory guidance 'Working Together'			
Develop WSCB processes for assessing the effectiveness early help.	Strategy and Communication sub-committee;	February 2014	Required by WT 2013, reduce the number of children requiring services at tiers 3 and 4, reduce the number of children experiencing significant harm.