Warwickshire Health and Wellbeing Board

Agenda

20th January 2014

A meeting of the Warwickshire Health and Wellbeing Board will take place in **Committee Room 2, Shire Hall, Warwick** on **Monday 20th January 2014 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 20th November 2013 and Matters Arising

Draft minutes are attached for approval.

Mobilising Communities to Develop and Maintain Independence

2. (13.35 – 13:55) Veterans Health and Wellbeing Issues

Bill Basra / Emily Fernandez

3. (13.55 – 14.10) Living in Warwickshire Survey – Presentation

Dr. John Linnane

Access to Services

4. (14.10 – 14.30) Reports from NHS Trusts:

(a) Response to the Keogh Report on Accident and Emergency Services

Kevin McGee, David Eltringham and Glen Burley

(b) Coventry and Warwickshire Partnership Trust – Preparations for the Inspection and Foundation Trust Status

Rachel Newson

5. (14.30 –14.45) Impact of the 2014 Operating Framework – CCGs

Gillian Entwistle

Working Together

6. (14.45 – 15.00) "Better Care" (formerly Integration Transformation) Fund

Wendy Fabbro and Representatives of Clinical Commissioning Groups (verbal report)

7. (15.00 – 15.15) Mental Wellbeing Draft Strategy

Charlotte Gath

8. (15.15 – 15.30) Health & Wellbeing Strategy – Progress on outcomes

Nicola Wright

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

Health and Wellbeing Board Newsletter

Date of Future Meetings:

Extraordinary Meeting on the Integration Transformation Fund –
Monday 11th February 2014, Committee Room 2, Shire Hall, Warwick

Wednesday 26th March 2014, Committee Room 2, Shire Hall, Warwick

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 20 November 2013.

Present:-

Chair

Councillor Izzi Seccombe

Warwickshire County Councillors (In addition to the Chair)

Councillor Bob Stevens
Councillor Heather Timms

Clinical Commission Groups

Heather Gorringe – Warwickshire North CCG
David Spraggett – South Warwickshire CCG

Warwickshire County Council Officers

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

Healthwatch Warwickshire

Deb Saunders – Chief Executive Officer

NHS England

Brian Hanford – Associate Medical Director

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)

1. (1) Apologies for Absence

Councillor Maggie O'Rourke (Warwickshire County Council)
Councillor Claire Watson (Rugby Borough Council)
Kevin McGee (Chief Executive, George Eliot Hospital)

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

Councillor Derek Pickard declared a non-pecuniary interest as a member of the County Council's Adult Social Care and Health Overview and Scrutiny Committee and The George Eliot Hospital Stakeholder Group.

(3) Minutes of the meeting held on 25 September 2013 and matters arising

The minutes were agreed as a true record of the meeting.

With regard to the second paragraph of Minute number 4, Deb Saunders (Healthwatch) clarified that this matter related to the Healthwatch Engagement Charter. It was also requested that the date of the next meeting be included on the summons.

2. George Eliot Hospital - Improvement Plan Position Update

Dr Gordon Wood (Associate Medical Director, George Eliot Hospital) updated the Board on the Hospital's work to secure a strategic partner. An outline business case has been produced and the Trust started the procurement phase in September. From the responses received, the Trust was compiling a list of suitable applicants for the next stage.

The Board was updated on the outcome of the Keogh review. This included the George Eliot hospital being joined with University Hospitals Birmingham NHS Trust as part of a 'buddying' process and an outline of the recommendations made for improvement. Other news included the appointment of a new Director of Finance, the positive feedback regarding the new paediatric service and the Trust's ambulatory care unit being shortlisted for an award at the 2013 Health Service Journal awards.

Councillor Bob Stevens sought further information about the statistics on bed days, the objective to improve patient turnover and better ward checks, to secure reductions in hospital inpatient periods. In response to a question from Dr John Linnane, Gordon Wood replied that following the Keogh review, there had been an increase in the numbers of ward rounds by senior doctors and consultants. The mortality statistics had reduced, to a level not considered high. There is an objective to improve further and every death at the Hospital is reviewed, in consultation with the partnered Birmingham NHS Trust.

Councillor Gill Roache asked whether the George Eliot's status was a barrier to attracting staff, which was acknowledged. Achieving 7-day cover was a further issue discussed.

Councillor Heather Timms noted that there was nothing in the update about pressure ulcers. It was heard that an update would be provided to

Board members prior to the next meeting. Ann Mawdsley (Democratic Services, Warwickshire County Council) added that the County Council's Adult Social Care and Health Overview and Scrutiny Committee (ASCHOSC) was due to receive an update from Dawn Wardell on this topic at its next meeting.

Dr Gordon Wood responded to a question from Councillor Michael Coker about the funding required for additional staffing to secure improvements to services and how this would be sustained. The move to 7-day services was a national issue and there was a clear mandate to improve.

Dr John Linnane referred to the numerous challenges being faced by the Hospital. He asked how the Board could be both assured that the Hospital was sustainable and how the Board could help. The role of the Clinical Commissioning Groups was also discussed. Councillor Gillian Roache spoke of the additional burden caused through the requirement to record staff levels on each ward.

Resolved

That the update on the George Eliot Hospital is noted.

3. Priority Families – Partner Engagement and Progress Update

Nick Gower-Johnson (Localities Manager, Warwickshire County Council)explained that the programme was now half way through, but would be extended until at least April 2015.

His report set out the key issues of securing improved linkages between schools and health commissioners / providers, planning for the second phase of the programme and ensuring the programme continued to meet its targets. Background was provided, together with detail on the work on priority families, its aims and commitments. The report set out the proposals to build on good practice from a DCLG publication 'Working with Troubled Families'.

Information was provided about the programmes, the calculation of troubled family numbers in Warwickshire and the assessment criteria. An overview was provided, as at November 2013, of the location of the 991 families involved, disaggregated by area. The work undertaken to date was reported. Five district-based Local Coordinating Groups have been established to identify families and oversee delivery arrangements. Further sections of the report covered segmentation, in terms of the level of intervention required, the resources required to deliver the work and an update on the recruitment of staff. The governance and performance management arrangements were reported, together with key priorities over the coming months.

Reference was made to some of the arrangements in place, an example being those for Camp Hill. Multi agency and partnership working was having a positive impact on the lives of the families supported. To date, funding has been attracted for over 130 families and the benefits for both the families and the local communities were reported. Statistically, the scheme is in the top quartile nationally and details were given of planned way forward.

Wendy Fabbro referred to the scheme's outcomes and requested that details of achievements be circulated. The Chair added that statistics on the numbers of children needing support would be helpful. Wendy Fabbro asked whether there were any residual costs from the scheme and the impact on other existing services and queried if there had been some duplication in service provision. Mr Gower-Johnson provided reassurance on how those involved sought to avoid duplication.

Councillor Bob Stevens commented on the need for prevention rather than remedies and he sought assurance about information sharing. It was confirmed that the appropriate systems were in place and information was only shared when necessary. Early intervention was also discussed.

Dr Heather Gorringe questioned whether extra resources had been allocated to the Camp Hill initiative and made a comparison to Wembrook, which was worse statistically.

Deb Saunders pursued the point about partnership work with the three CCGs, suggesting attendance at Healthwatch, where all three CCGs were represented.

Resolved

That the Board:

1) notes the progress made on Priority Families and requests extra information on the impact on other services, costs and achievements.

2) extends its thanks to all partners so far involved in the management, coordination and delivery of the Programme.

4. Smoking in Pregnancy – “Upping Our Game”

Dr. Linnane reported that smoking in pregnancy levels in Warwickshire were unacceptably high. An initiative to address this was the tobacco Control Declaration, signed by the Board on 17th July 2013. It is intended to produce a simple fact sheet and engage partner organisations. The need for a clear assessment of the problem and training were other issues reported.

It was noted smoking by expectant mothers affected 1 in 6 unborn babies. The Department of Health had acknowledged its own targets wouldn't be achieved. All agencies acknowledged the issues faced, but were struggling to make an impact. An action plan had been developed, which was appended to the report and partners were thanked for their input to it. The need for more accurate data and more effective carbon monoxide testing were also raised. It was planned to form a steering group and periodic updates would be provided to the Board.

Gillian Roache referred to the work of District and Borough Councils on smoking generally.

Resolved

That the Warwickshire Health and Wellbeing Board:

1) Agrees that the reduction of smoking in pregnancy is 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.

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

Dr John Linnane introduced this item, to explain the arrangements in place for the coming winter months. The report included sections on winter resilience in health and social care, upstream resilience and the seasonal flu vaccination campaign.

Dr Linnane spoke about the campaign, for which a launch was planned and about flu vaccinations, including the plans to build upon the previous year's good practice. Flu vaccinations would be available from local pharmacists. Exercises and scenarios were planned to prepare for the issues that occurred over winter. A specific example was the hand wash campaign to address known issues like the novo virus.

Councillor Bob Stevens stressed the need to look after elderly neighbours in bad weather, issues associated with slips and falls and the need to engage communities. This point was echoed by the Chair, who recognised the positive outcomes from previous efforts to engage communities. It was confirmed that accident and emergency services were prepared with increased consultant and nursing staff levels. Councillor Gillian Roache referred to rising fuel costs. In Stratford there was a reliance on heating oil which didn't get the same media coverage in terms of cost rises, as gas and electricity costs. Reference was made

to an initiative through the Warwickshire Rural Community Council, for oil purchase at lower costs and it was requested that this information be circulated.

Resolved

That the Warwickshire Health and Wellbeing Board:

1) Notes that adequate major incident, winter pressures response and business continuity plans are in place and tested for the winter.

2) Will 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.

6. Autism Strategy and Self-Assessment Framework (SAF)

Chris Lewington (Head of Strategic Commissioning, Warwickshire County Council) presented this report. 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 Wellbeing board prior to end of January 2014. The report set out the purpose of the self-assessment completed, the process undertaken and Warwickshire's response.

Chris Lewington explained the purpose of the assessment, noting that significant progress had been made to date. She outlined the areas where more work was needed, particularly around data collection and engaging with housing colleagues and those working in criminal justice. The Health and Wellbeing Board was well placed to retain an overview of the Autism Strategy. The Chair advised that she had received a lot of correspondence on this important issue. She was pleased with the direction of travel. Deb Saunders also endorsed the positive feedback.

Resolved

That the update on the Autism Strategy and Self-Assessment Framework is noted.
That the Board extends its thanks to Chris for leading a multi agency initiative to such positive outcome

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

Dr. John Linnane addressed the Board, referring to the circulated report and particularly a chart which compared priorities against the actions of partner agencies. There was a commitment to a range of priorities designed to improve the health and wellbeing of Warwickshire residents. He felt it important that there was a clear, unanimous message from the Board on this commitment.

With reference to the report recommendation on strengthening collaboration, the chief executives of district and borough councils wanted to be involved where they are commissioning services relevant to Health and wellbeing. Brian Hanford reminded of the commissioning role of NHS England, which would also like to be involved in the process. The Chair felt that the good progress made should be publicised. Councillor Bob Stevens added that the key was monitoring implementation. WF reported on the People Group outcomes framework that will facilitate monitoring the delivery of health and wellbeing improvements and commended its use to the board. Councillor Gillian Roache complemented the report and acknowledged the different weight each CCG would give to localised priorities, which was appropriate to meet needs in their respective areas. She also stated the need to share good practice throughout the County.

Resolved

That the Warwickshire Health and Wellbeing Board:

1) approves the commissioning intentions of:
   - Warwickshire North CCG
   - Coventry and Rugby CCG
   - South Warwickshire CCG
   - WCC Social Care and Public Health

2) supports Commissioners' new approach of commissioning by outcomes, monitors the progress on the implementation of the commissioning plans and holds Commissioners to account

3) strengthens collaboration and requests partners, including local councils to identify their commissioning intentions.

8. Integration and the Transformation Fund

(a) The Way Forward in Warwickshire

A report was circulated, which Councillor Angela Warner and Chris Norton spoke to. A core function of Health and Wellbeing Boards was to

promote integration. Linked to this, an Integration Transformation Fund (ITF) will be made available from 2015/16. The distribution of funding was reported. In part this will be influenced by progress made by CCGs and councils in working together. Details of the national conditions that would need to be addressed in local ITF plans were provided, together with the proposed way forward in Warwickshire.

Integration was being progressed through the Joint Commissioning board – a WCC and CCGs officer steering group to inform a draft ITF plan that would be produced by January. There were plans for a joint workshop in December, and an event to be facilitated by Public Health and NHS England area team in January and an extraordinary Board Meeting on 11th February, to sign off the final plan. CCGs governing bodies and WCC Cabinet will agree the final plan in January.

A question about possible conflicts of interest was submitted. Further points concerned commissioning guidance, future funding arrangements and the potential need to rethink how the partners worked together. Wendy Fabbro provided reassurance that joint work around governance arrangements was already taking place. This was a complex process, but there was an absolute commitment to serve the whole of health and social care. David Spraggett explained that the £35m of resources involved wasn't additional money, but a redistribution of money that was currently spent elsewhere. Other speakers considered it a virtual fund to further health and wellbeing aims and touched on funding needed for disabled facility grants to help people live independently, for longer.

Resolved

That the Warwickshire Health and Wellbeing Board notes the report.

(b) RE-ablement s256 Fund – Budget Transfer Update

A report was presented by Chris Norton on the funding transfer to Warwickshire County Council. By way of introduction, it reminded of the significant funding transfers to social care, in order to benefit health, via a Section 256 agreement, under the 2006 NHS Act. The report included sections on the purpose of the transfer, the spending proposals and outcomes. The monitoring arrangements, links to JSNA and current commissioning plans were also reported.

Chris Norton provided a verbal update on the feedback received to the draft agreement and sought the Board's approval to a number of minor changes.

Resolved

That the Health and Wellbeing Board approves the proposed uses of this money and approves the Section 256 Agreement set out in Appendix 1, subject to the reported changes.

9. Children’s Safeguarding Board Report

Cornelia Heaney (Safeguarding Children's Board Development) presented the Warwickshire Safeguarding Children’s Board Annual Report for 2013. She gave an outline of the document’s content, which included a local background, the statutory and legislative context and a section on governance arrangements. It reported progress against strategic objectives and the effectiveness of the safeguarding children arrangements, together with the Business Plan for 2013-14. Cornelia Heaney touched on the areas of work relevant to the Health and Wellbeing Board. There had been a small reduction in the numbers of children being referred for protection related issues. Reference was made to the percentage of referrals that resulted in Common Assessment Framework intervention(CAFs). The Child sexual Exploitation Strategy was another area raised.

Questions were submitted and responses provided about the work being undertaken, the need to avoid duplication in provision and troubled families intervention. Discussion took place about the low numbers of health referrals on child protection and CAFs, which must be an area for further work. A suggestion was made that the health sub groups provide a report to a future Board meeting on this. Also, it would be interesting to see comparative data for neighbouring areas. The Chair spoke about a recent conference, where a presentation had been received about child sex exploitation issues in Oxford. With regard to the circulated document, Councillor Gillian Roache suggested the addition of a column showing actions that had been completed.

Dara Lloyd Manager (Panel Manager, Child Death Review) then spoke about the work of the Child Death Review Panel. This was a sub-panel of the Safeguarding Board, which shared knowledge and reviewed every case of child death. The Panel’s Annual Report had been submitted to the Safeguarding Board in September and circulated for the Board’s information. An overview was given of the document, with particular reference to a key element on sudden infant death syndrome. Dara Lloyd explained the contributory factors to this syndrome and a planned campaign to raise awareness on procedures for safe sleeping. Funding was being sought for this aspect of the Panel’s work.

Resolved

That the Warwickshire Health and Wellbeing Board notes the report.

10. Any Other Business

The Chair referred to the first issue of the Health and Wellbeing Board newsletter.

She explained that correspondence had been received from the Leaders of Stratford, Redditch and Bromsgrove councils, seeking the Board’s support to the campaign to save the Alexandra Hospital. Whilst the Hospital is located in Worcestershire, it served several communities in Warwickshire. Officers will be asked to circulate this information for the Board’s feedback. This situation was being monitored closely and there were potentially positive and negative issues that would arise if the Alexandra Hospital was closed. Wendy Fabbro spoke about the level of referrals each month and the need for a considered view, because people diverted to Warwick would get access to the ‘discharge to assess’ scheme not available from the Alex. Dr Linnane noted that the Overview and Scrutiny Committee had been looking at this issue for some time. He gave statistics on the numbers of outpatient and emergency admissions. There were potentially significant implications for some Warwickshire residents, especially in Stratford. Ann Mawdsley confirmed that the Worcestershire Health Overview and Scrutiny Committee would consider the recommendations at its December meeting and the Warwickshire ASCHOSC would be closely involved. Brian Hanford confirmed that NHS England would be consulted as part of any formal process and Martin Lee could report back to the Board.

Reference was also made to the joint Memorandum of Understanding (MoU) and the session to be held on 26th November, to apply the MoU to the Francis recommendations.

The meeting rose at 15.45

………………………..Chair

Item 2

Health and Well-Being Board

20th January 2014

Veteran's Health and Wellbeing

Recommendation(s)

1. That the report be noted.
2. That the needs of veterans be incorporated in future Joint Strategic Needs Assessments.
3. That Clinical Commissioning Groups be invited to forge closer links with Veterans Organisations and those involved in Veteran's Health via a programme of engagement sessions in 2014; and
4. That the Health and Well-Being Board request a process for encouraging those engaged in frontline delivery (including GP's) to identify the numbers and needs of veterans within their population.

1.0 Context

1.1 On 30th June 2012, the County Council in conjunction with other partners within the Coventry, Solihull and Warwickshire area signed the Armed Forces Community Covenant. The principal aim of the Community Covenant is to encourage all parties within a community to offer support to the local armed forces community and make it easier for service personnel, families and veterans to access the help and support available from the MOD, statutory providers and from the charitable, community and voluntary sector. In addition other underpinning principles are to promote integration and raise awareness.

1.2 Since the signing of the Covenant, the Armed Forces Community Covenant Partnership has been established which meets on a six monthly basis. During its meetings the issue of establishing closer links with the Health and Well Being Board has been discussed with a view to raising the profile of veterans health issues and working together to remove any barriers that ex-servicemen and their families may be facing. This report and accompanying presentation, therefore should be seen as the first step towards better collaborative working

1.3 Within this report the term veteran/ex-service personnel and dependants is used. The Royal British Legion has identified this as being:

Veterans - Anyone who has previously served in any of the following ways is a veteran: the UK Armed Forces, both Regular Forces (including National Service or the Home Guard), or Reserve/Auxiliary Forces; the Mercantile Marines in hostile waters; the Allied Civil Police Forces; full-time, in uniform for a Voluntary Aid Society in direct support of the Armed Forces; or as a British subject serving under British command in the forces of an allied nation.

Dependants - Dependent spouses/partners, dependent divorced/separated spouses, dependent widow(er)s and dependent children, make up veterans' dependants.

2.0 Issues for Consideration

2.1 Through discussions with partners within Public Health, Veterans Organisations and Service Providers (Combat Stress, Coventry and Warwickshire Partnership NHS Trust etc.) the emphasis on health has focussed on mental health/emotional well being with issues facing ex-servicemen falling into the following 4 categories:

a) Understanding Need: Through working with partners to progress the aspirations of the Covenant it is evident that information on the numbers of ex-servicemen within the County and where they are based needs to be improved in order to then get a better understanding of need which in turn can then inform commissioning of services.

b) **Culture:** It is evident that the transition from military to civilian life is rarely straightforward and that many ex-service personnel struggle to understand how to access appropriate health services. These will be compounded where individuals are suffering from mental health/emotional well being issues. Lord Ashcroft is leading the Veterans' Transition Review set up by the government in September 2012 to address this issue.

c) Improving Access: It was in recognition of the difficulties in accessing services that Public Health were successful in their bid for MOD monies in relation to a project that seeks to raise awareness and understanding around services available to Veterans and their families which includes LA and NHS Services. Whilst the Armed Forces Community Covenant Partnership have welcomed the project its success will be maximised if it acts as a catalyst for addressing the issues that will be highlighted to the Board.

d) Raising Awareness: Through discussions with partners it has become evident that in other parts of the country awareness raising campaigns have been held (e.g. Lincolnshire) to enhance the profile of veterans needs amongst health professionals and to remove barriers that veterans may be facing by encouraging early disclosure which improves diagnosis and accessing the appropriate support.

2.2 In terms of issues affecting mental health/emotional well being, professionals working within the field have generally observed the following:

a) Individuals who need to access services in "Civvy Street" find the process confusing and often don't know where and to whom to turn to for assistance. Having mental health or emotional well being problems place an additional barrier to their ability to seek support.

b) Service personnel are often reluctant to disclose that they have health issues as this would have been seen as letting their comrades down when in service. They therefore often prefer to address issues themselves rather than accessing services

c) There is also a degree of pride involved or a feeling that they are not really a “Veteran” and therefore either don’t want to ask for support or don’t feel they are entitled to it.
d) Mental Health problems are often triggered by other issues such as unemployment; relationship breakdown; debt etc. which are an increasing problem in the current economic climate.
e) Early service leavers (ESL) – those who leave before their expected term - are three times as likely to take their own lives compared to members of the general population, as well as be in debt, engage in anti-social behaviour, have relationship difficulties. Half of ESL have a psychiatric diagnosis, the most common being depression and anxiety (20%) together with alcohol problems (13%). PTSD rates commensurate with general population (5%) but can be severe.
f) Mental health rates more common in reservists than regular troops.
g) 10% of the homeless population are thought to be veterans (KCMHR, 2009) and 4% of the prison population has served in HM Armed Forces.
h) Veterans have particular difficulties accessing appropriate NHS services, and rarely obtain the best psychological treatments as only a minority of ex-service personnel with mental health problems seek help – mostly due to the perceived stigma attached to doing so
i) Veterans find engaging with civilian mental health services problematic and there is high drop out
j) Carers and families of veterans have particular needs that would be better met if standard services were adapted in a culturally sensitive way
k) Veterans want to get involved in shaping services and helping other veterans.
l) There is a tendency for NHS services to refer veterans directly to Combat Stress regardless of the severity of their difficulties. Combat Stress are seeing an increasing numbers of veterans who would be ideal candidates for anxiety/depression work via the IAPT service and who have been referred inappropriately. This in turn requires greater understanding from NHS professionals. Combat Stress have also indicated that there is difficulty in getting veterans referrals into NHS secondary mental health services for trauma work.

3.0 Current Provision

3.1 In terms of current provision the Royal British Legion support beneficiaries through person centred services. Individuals are assigned a Caseworker or Case Officer who will agree an action plan and identify the internal or external services a veteran or their dependents can access. Legion services can be accessed via the website www.britishlegion.org.uk / Freephone 0808 802 8080 7 days a week 8am – 8pm or through area teams at locations across the county. Specific health related services include:

a) Independent Living Advice - If a beneficiary suffers from an illness or injury or they care for someone with an illness or injury assistance is given to claim disability related benefits and, if needed, to appeal decisions and represent at tribunals.
b) Poppy Calls – Handy Van service Assistance with small household repairs and minor adaptations around the home. This could include putting up curtain rails, fitting grab rails, building ramps and providing care phones and fitting Key Safes.
c) War Pensions & Compensation Service - If a beneficiary has a claim with an injury arising from their service the Legion can give advice on how to claim and also support appeals and represent at tribunals.
d) Poppy Break Centres - The Legion offers breaks to individuals, couples and families. If someone is recovering from an illness, bereavement, or other life affecting event the Legion can provide a comfortable and enjoyable break.
e) Care Homes - There are 6 Legion Care Homes in the UK each providing long term nursing and personal care including Galanos House at Southam.
f) Admiral Nurse Service - The Legion has partnered with Dementia UK to provide a nursing service to support sufferers and carers. The focus of the service is to give dementia patients a better quality of life, and for carers and families to get the practical support and advice they need. This service is operating in the Black Country, Coventry area and parts of Birmingham.
g) Shoulder to Shoulder – Mentoring project in partnership with Combat Stress aimed at Veterans with Mental Health problems.

3.2 It should also be noted that a veterans contact point also exists to provide a 'gateway' to other agencies and sources of support. This is a Sub-Regional Service that is based in Nuneaton and can be accessed via www.veteranscontactpoint.org.uk or 02476 343793.

3.3 Within Coventry & Warwickshire Partnership NHS Trust there are a comprehensive range of mental health multi-disciplinary services that can serve the needs of veterans well. At present there is no specific pathway for veterans or routine identification of veteran service users comprehensively across services. IAPT services now identify veteran status and in secondary care this is likely to be implemented in 2014. There is potential to join up existing knowledge and skills in a more culturally sensitive (to veterans) manner and this is being proposed at present to GPs.

4.0 Next Steps

4.1 The principal reason for this report is to raise awareness of the issues affecting veterans and their families in relation to health needs. As mentioned there is a need to determine more specifically issues around need and distribution and these (along with the need for collaboration) provide the rationale for the recommendations set out in the front of this report.

Background papers

1. Public Health Bid to MOD
2. Cabinet report on HORSA Building (Veterans Contact Point)
3. Securing excellence in commission for the Armed Forces and their families

	Name	**Contact Information**
Report Author	Jane Britton (RBL)	jbritton@royalbritishlegion.org.uk
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Item 3

Warwickshire Health and Wellbeing Board

20 January 2014

'Living in Warwickshire' Survey – Headline Analysis

Recommendations

That the Warwickshire Health & Wellbeing Board:

1. Note the headline findings from the 'Living in Warwickshire' survey, as a key part of the emerging evidence base for the review of Warwickshire's Joint Strategic Needs Assessment (JSNA) during the early part of 2014.

2. Consider the policy implications arising from the analysis to date.

3. Identify any further analyses which the Board would like to see undertaken as part of our overall analysis of the survey results.

1.0 Key Issues

Background

As part of our work on Warwickshire's Joint Strategic Needs Assessment (JSNA), it was acknowledged that a lack of robust intelligence existed on the lifestyle characteristics of the local population and the perception of residents with regard to local public services. To address this gap in our knowledge, in July 2013, the Board agreed to sponsor a large scale survey of local people which focussed on issues around 'Living in Warwickshire'.

It was proposed that the survey would aim to capture perceptions type data about life in Warwickshire, use and satisfaction with public services, and also health and lifestyle data and intelligence.

The Board agreed to act as the strategic project sponsor, and the Board's name was used as a means of promoting the survey to Warwickshire's residents, and to help encourage the maximising of survey response rates.

The project was managed by colleagues in Public Health Intelligence and the Warwickshire Observatory.

Response rate

During September and October 2013, 25,000 surveys were sent out to a random stratified sample of households across Warwickshire. By the time of the closing date,

7,617 completed surveys were returned, resulting in a response rate of 30%. This was over 50% higher than our target response of 5,000 surveys.

Around 1,500 surveys were received from each of the five District and Borough Council areas in Warwickshire, which will enable us to carry out sufficiently robust analysis at a sub-County level.

Although paper surveys went sent out in the post, recipients were also given the option to complete the survey online if they wished. Just under 300 people, or 4% of all respondents, chose to complete the survey this way.

To help improve the representativeness of the responses, the returned questionnaires have been weighted in accordance with the profile of Warwickshire's population in terms of age, sex, ethnicity and district/borough area.

Analysis: Key Headlines

The following key points are County level headlines from our analysis so far. More detailed geographic, population group and theme-based analysis will follow over the coming months as we further examine these.

About the local area

- 89% of respondents are very or fairly satisfied with their local area as place to live. This compares with 85% when the same question was asked in the 2009/10 Warwickshire Partnership Place Survey.

- Only one in three of those surveyed agree that they can influence decisions affecting their local area, a similar proportion to the result in the 2009/10 Partnership Place Survey.

- 71% of respondents are very or fairly satisfied with the quality of services they receive from Warwickshire County Council.

- The most important factors in making somewhere a good place to live are the level of crime, health services, and clean streets. These were selected by 61%, 53% and 44% of residents respectively.

- In terms of what most needs improving in their local area, road and pavement repairs (46%), activities for teenagers (35%) and the level of traffic congestion (34%) were selected by the largest proportions of residents.

- 29% of households identified parking where they live as either a very or fairly big problem.

- 48% of respondents are either fairly or very worried about having their home broken into and having something stolen, slightly lower than the corresponding figure from the 2009/10 Partnership Place Survey (51%).

- Nearly one in three residents do not feel very safe or not safe at all walking alone after dark in their local area.

About the immediate neighbourhood

- 39% of respondents feel that they do not belong very strongly or not at all strongly to their immediate neighbourhood. However, in terms of practical actions, over two thirds have collected a parcel from the postman, taken in or put out bins, or kept an eye on property for their current neighbours.

- 29% of residents indicate they have been actively involved with at least one local community or voluntary organisation in the last twelve months. However, this proportion falls to 12% for those who have engaged in formal volunteering for an average of at least two hours per week over the past year.

Using technology

- In the past three months, 61% of respondents had used the internet to access information on local public services, 26% to use local online services, and 12% to report a fault or local issue online. Some 28% had used the internet to look for a job.

- One in ten respondents had not used the internet at all over the past three months.

- In relation to mobile devices, there is almost a 50/50 split between respondents indicating they are likely to access information about, or use, public services in their area via a smartphone, and those that are not.

About your lifestyle

- 6% of respondents self-reported that their general health was either poor or very poor. This is in line with figures from the 2011 Census. However, only 28% of stated that their health was very good, in contrast to the equivalent figure of 47% from the Census results.

- 40% of respondents felt they were a little overweight with 6% thinking they were very overweight.

- 18% stated that they had been feeling relaxed over the previous two weeks either rarely, or none of the time.

- More than one in ten stated that they had been feeling close to other people over the previous two weeks either rarely, or none of the time.

- Nearly half of all respondents were either fairly or very worried about day-to-day budgeting and the cost of living, with just over half fairly or very worried about longer-term financial planning.

- Just over one in four people reported that they were consuming the recommended five-a-day portions of fruit and vegetables in their diet, the same proportion as the 2009/10 Partnership Place Survey.

- Half of those surveyed stated that they had a takeaway meal once a week and one in five reported that they consumed fast food once during a typical week.

- On average, people undertook 215 minutes of moderate physical activity during a typical week. This compares favourably with the recommended guideline of 150 minutes of moderate exercise per week.

- Nearly half of people have an alcoholic drink once a week or more, whilst just over 15% are abstainers.

- Just over one in ten respondents would like to cut down on their current level of drinking.

- 12% of people reported that they were regular cigarette smokers. Of those who were smoking, 34% were planning to stop, 20% were concerned smokers, and 16% were in the process of stopping. However, just under a third stated that they were contented smokers.

- For ex-smokers, nearly half gave up smoking at the first attempt. However, 29% took three or more times to give up.

- For current smokers, 87% had previously tried to give up smoking at least once, with 31% having tried on three or more occasions.

What do residents like and dislike most about living in Warwickshire?

- In terms of what people most like about living in Warwickshire, the survey results reveal that the County's easily accessible central location, and the attractive surrounding countryside are the main positives, although there are lots of others too.

- In terms of what people most dislike, residents voiced concerns around traffic congestion, and also public transport provision. A final major dislike includes Warwickshire being a long way from the seaside surely demonstrating that our residents possess a good sense of humour!

2.0 Further Analysis

The better than expected response rate and subsequent survey sample size will provide statistically robust results at both County and District/Borough level. It is also hoped that the numbers of responses will enable us to carry out some sub-district level analysis to provide greater insight on the results. This is likely to be at Middle Super-Output Area (MSOA), Locality or grouped Locality level or on an Urban/Rural basis. We also plan to provide analysis on a range of other demographic characteristics (age, sex) where possible.

Significance testing will be carried out on the results to ensure that findings are statistically significant and not merely due to random variation within the data.

A small number of follow-up focus groups are also now being planned to explore some of the underlying issues raised from the survey in more detail, or related to specific communities or local areas in the county. These will help to further unpick, understand and gather richer qualitative intelligence on the key issues emerging from the survey findings.

3.0 Next steps

The detailed analysis of the survey results will be taking place over the coming months. This will include an in-depth look a range of the topics included in the survey. These include:

- Satisfaction with the local area/local services
- Fear of crime
- Community cohesion/neighbourliness/volunteering
- Use of technology
- Health status & mental wellbeing
- Concerns over employment/finances/the economic situation
- Healthy eating habits & physical activity
- Alcohol consumption & smoking
- What people most like and dislike about living in Warwickshire

The results from the survey will be widely disseminated amongst the County Council, partners and the public, with key messages and analysis disseminated as these are completed over the next six months, as part of the Board's communications and engagement plan, as well as informing analysis for the JSNA and for any future refresh of the Health & Wellbeing Strategy.

More detailed analysis and interpretation of the survey results will be presented at the March 2014 Health and Wellbeing Board meeting.

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Agenda Item 4(a)

GEH REPORT FOR THE HEALTH & WELLBEING BOARD MEETING ON THE 20 JANUARY 2014

Board update on the response to the Keogh Report on Accident and Emergency Services

Keogh Review

The Trust was subject to a review of its services by Professor Bruce Keogh, Medical Director at the Department of Health. This review, along with a review of 13 other Trusts with historically high mortality rates, was ordered by Prime Minister David Cameron following the Francis Report into standards of care at Mid Staffordshire Hospital.

Following the publication of the Professor Keogh's review, the Trust was given the additional support to help it improve mortality rates. This includes being joined with University Hospitals Birmingham NHS Trust (UHB) as part of a 'buddying' process, which is ongoing.

The recommendations included in the review included making improvements to out of hours consultant cover and reducing the number of times patients were moved.
Since the publication of the review, many improvements have been made, including:

- Work has completed on a 41 bed Acute Medical Unit that will act as a short stay ward for patients who require treatment, tests or observations that will last no more than a couple of days. It also acts as an area where all admissions through our A&E department are assessed by a consultant before being directed to the appropriate ward for specialist treatment. It is operated as a consultant led service, 7 days a week. GP's are able to refer direct into the unit from primary care via a GP/ community interface.

- 25 +new nurses have been employed to date for core areas, some of which staff our newly configured Acute Medical Unit. A continuous rolling programme of nurse recruitment is in place. Currently the Trust is out for recruitment for 5 Acute Medical Unit consultant physicians.

- The Trust is making good progress towards the delivery of 90% Trust target for the use of Sepsis Care bundles. All out of hours patient moves are sanctioned by the consultant on call, which has resulted in patient moves being significantly reduced.

- Enhanced junior medical cover has been in place since June. A Medical staffing officer is in post who ensures integrity of the rota which is monitored daily. The Trust has implemented a system whereby every shift is reviewed for planned versus actual attendance and there is a clear escalation policy for any failure to fill any clinical staffing post to ensure safe staffing levels.

- The Trust has appointed to a new post of 'Head of Patient Safety and Mortality' to help understand all the underlying data and issues driving mortality. SHMI and HSMR figures continue to reduce. An analysis of deaths for the period April 2013 to June 2013 showed a preventable death rate of 4% and an external evaluation of preventable deaths at the Trust by Clinicians at University Hospital of Birmingham found 5%, both within the expected range of 4 – 6%.

A&E Services

GEH introduced a Trust wide transformation programme in October last year with the primary focus and outcome being 'safe standards in emergency care'. This was in direct response to the recommendation from Keogh and led to the implementation of a series of change programmes. This included the review of the discharge process and flow across the

hospital to support the safe transfer of patients form A&E directly to the right bed to be cared for by a team of specialist doctors and nurses. A number of efficiency schemes were implemented which included the early review of all patients as part of the 'golden hour' ward round; effectively this means an early review of every ward by the senior clinical team to review those patients requiring urgent intervention and those patients requiring decision for discharge. The ward teams were then responsible for implementing a comprehensive discharge plan to ensure patients' left the hospital safely with comprehensive discharge plans.

A second programme of work focussed on securing a 7 day service across key areas such as diagnostics, pharmacy, mental health and also by Consultants and Physician Associates deliberately rostered across the 7 days to secure continuity of patient care with early implementation of treatment or discharge plans. The ward reconfiguration allowed an expansion of the Acute medical Unit (AMU) and also Ambulatory care pathways. These exciting initiatives, based on best practice acute care, enabled patients to access ambulatory pathways for condition such as cellulitis, respiratory and cardiac conditions that would have ordinarily required an in-patient stay. The AMU, provides the hub for entry of all acutely ill patients that is staffed and geared up for early intervention, decision making and treatment plans across 7 days.

All these initiatives have provided the platform of change going into winter this year and early indications suggest their impact has ensured timely access to beds and treatment plans, admission avoidance and early discharge, thus freeing up the necessary speciality beds to respond to the surge in activity and acuity of patients anticipated during winter. Quarter 3 of this year has witnessed a stable environment for the emergency patients based on these new ways of working which has manifested itself in high performance across the 4 hour standard, length of stay reductions and an increase in the number of patients managed by alternative pathways rather than acute beds.

Kevin McGee
Chief Executive

January 2014

Item 4(b)

Warwickshire Health and Wellbeing Board

20th January 2014

University Hospital Coventry and Warwickshire- Response to the Keogh Report on Accident and Emergency

1. Recommendation(s)

1.1 The Warwickshire Health and Wellbeing Board note the response from University Hospital Coventry and Warwickshire (UHCW) in relation to the plans outlined within the Keogh plan for Accident and Emergency Services in England. Furthermore, the Board are asked to note the measures taken by the Trust to continue to provide timely and high quality care to our patients in line with the principles of Getting Emergency Care Right.

2. Background

2.1 Sir Bruce Keogh published plans for 'Transforming Urgent and Emergency Care Services in England' in November 2013. The plans propose changes to Accident and Emergency Services to make them more responsive and personal for patients, deliver better clinical outcomes and enhance patient safety. Sir Bruce Keogh says that his plans will take five to six years to implement.

2.2 In essence, the plans would establish two types of accident and emergency service, with specialist expertise in areas such as stroke and trauma concentrated in fewer hospitals.

2.3 The proposed plans aim to ease pressures on Accident and Emergency services by proposing five key areas of change:

- **Providing better support for people to self-care:** The NHS will provide better and more easily accessible information about self-treatment options so that people who prefer to can avoid the need to see a healthcare professional.

- **Helping people with urgent care needs to get the right advice in the right place, first time:** The NHS will enhance the NHS 111 service so that it becomes the smart call to make, creating a 24 hour, personalised priority contact service. This enhanced service will have knowledge about people's medical problems, and allow them to speak directly to a nurse, doctor or other healthcare professional if that is the most appropriate way to provide the help and advice they need. It will also be able to directly book a call back from or an appointment with, a GP or at whichever urgent or emergency care facility can best deal with the problem.

- **Providing highly responsive urgent care services outside of hospital so people no longer choose to queue in Accident and Emergency:** This will mean: putting in place faster and consistent same day, every-day access to general practitioners, primary care and community services such as local mental health teams and community nurses to address urgent care needs; harnessing the skills, experience and accessibility of community pharmacists; developing our 999 ambulance service into a mobile urgent treatment service capable of treating more patients at scene so they do not need to be conveyed to hospital to initiate care.

- **Ensuring that those people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery:** Once it has enhanced urgent care services outside hospital, the NHS will introduce two types of hospital emergency department with the current working titles of Emergency Centres and Major Emergency Centres. Emergency Centres will be capable of assessing and initiating treatment for all patients and safely transferring them when necessary. Major Emergency Centres will be much larger units, capable of not just assessing and initiating treatment for all patients but providing a range of highly specialist services. The NHS envisages around 40-70 Major Emergency Centres across the country. It expects the overall number of Emergency Centres – including Major Emergency Centres – carrying the red and white sign to be broadly equal to the current number of Accident and Emergency departments. 70 to 100 remaining Accident and Emergency departments would become ordinary emergency centres, which will cope with problems requiring less specialised care.

- **Connecting urgent and emergency care services so the overall system becomes more than just the sum of its parts:** Building on the success of major trauma networks, the NHS will develop broader emergency care networks. These will dissolve traditional boundaries between hospital and community-based services and support the free flow of information and specialist expertise. They will ensure that no contact between a clinician and a patient takes place in isolation – other specialist expertise will always be at hand.

3. Key Issues

3.1 The five key areas for change provide a template for the wider health economy to enhance the delivery of Accident and Emergency Services for our local communities, alongside community based services.

3.2 As a major tertiary centre and university teaching hospital, the key area that UHCW have the most ownership over is area four – “ensuring that those people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery”. However in order to deliver against this element of the Keogh plan, the remaining four areas of the Keogh plan will also need to be successfully moved forward within the wider health economy.

3.3 Getting the emergency care pathway right has been a major priority for UHCW, because it is a key part of ensuring the delivery of safe and effective care for our patients. Our recent strong performance (see Appendix 1) is a testimony to the hard work of clinicians and managers and a number of actions have been critical to that success:

- **Getting Emergency Care Right:** a change management programme of work ‘Getting Emergency Care Right’ is currently underway with the organisation aimed at improving the patient flow in its Accident and Emergency Department.

- **Seven day working:** UHCW is exploring seven day working, ensuring key teams (e.g. in diagnostics and patient discharge) are working seven days per week to maintain patient flow at the weekends.

- **Establishing clinics as an alternative to admission:** 14 alternative pathways went live on 11 November 2013 and offer clinic based best practice care as an alternative to admission to hospital.

- **GP responder trial:** working with West Midlands Ambulance Service NHS Trust and Coventry and Warwickshire NHS Partnership Trust to support GP’s attending to 999 calls in an attempt to appropriately avoid bringing patients to the Accident and Emergency Department.

- **Establishing a Frail Elderly Assessment service:** this service is designed to support frail older people and avoid them being admitted to hospital.

4. Conclusions

4.1 The Warwickshire Health and Well Being Board are asked to note the paper.

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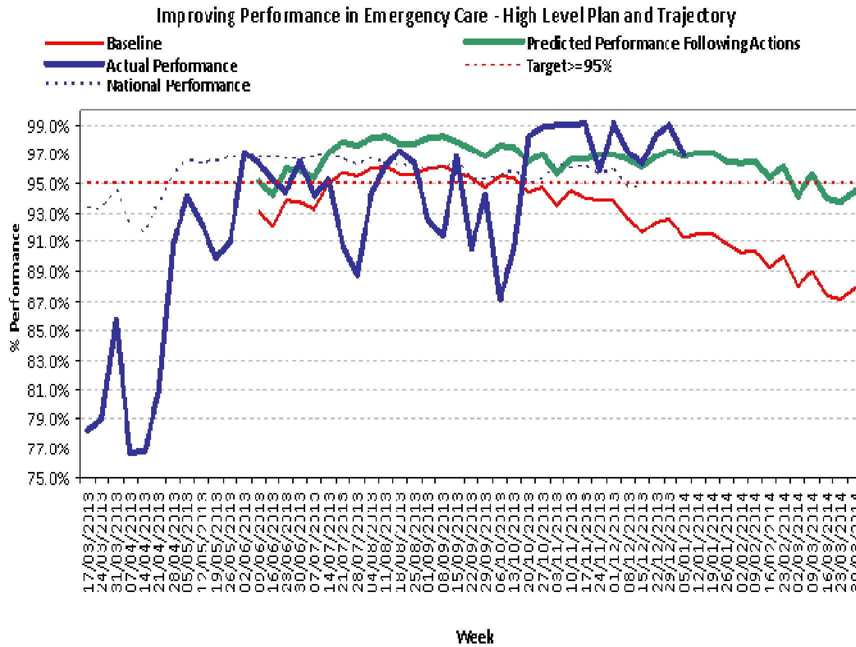
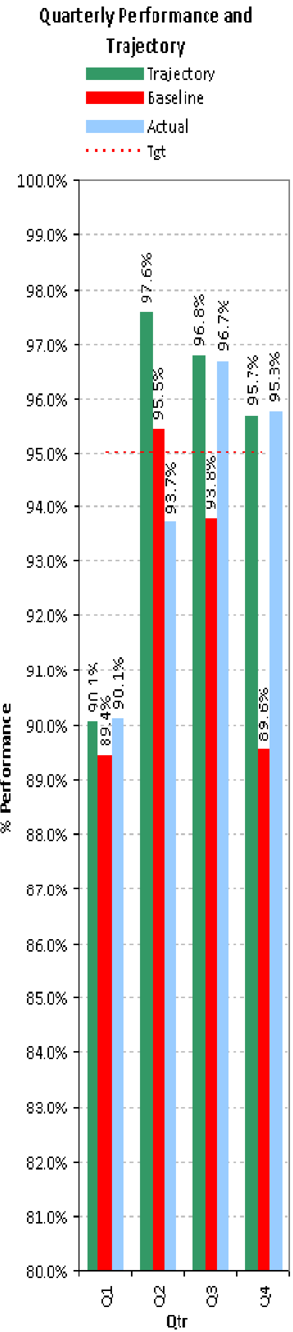
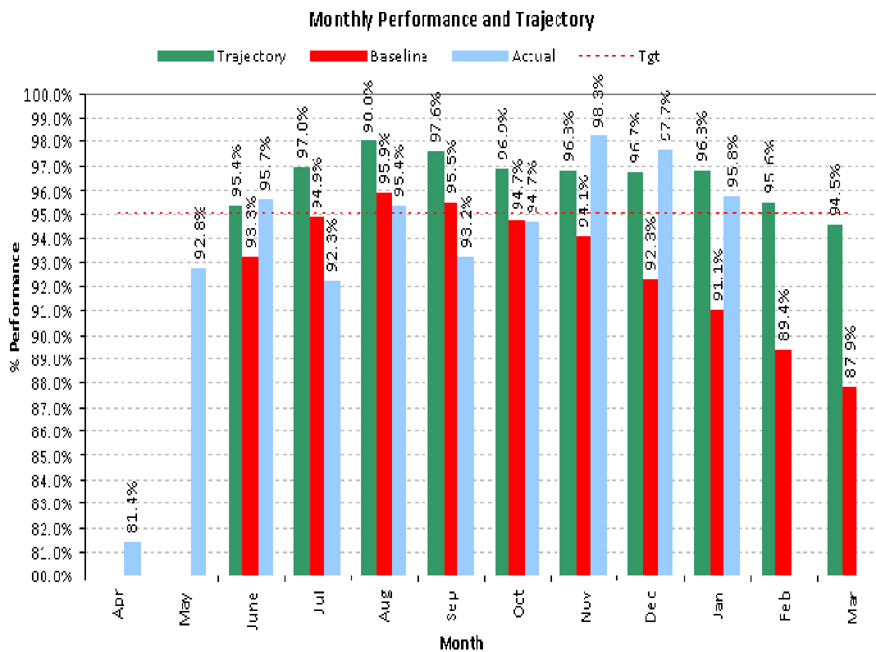
Head of Service		
Strategic Director		
Portfolio Holder	David Eltringham	

Appendix 1: Improved Performance in Emergency Care







Agenda Item 4(c)

South Warwickshire NHS
NHS Foundation Trust

Warwickshire Health and Wellbeing Board

20 January 2014

Response to the Keogh Report on Accident and Emergency

1. Recommendations

1.1 The Warwickshire Health and Wellbeing Board is asked to note the response from South Warwickshire NHS Foundation Trust in relation to the vision set out in the Keogh plan for 'Transforming Urgent and Emergency Care Services in England'. The Health and Wellbeing Board are also asked to note the Trust's improved performance in this area and the consequential closure of the recent Monitor investigation.

2. Key Issues

2.1 National Policy

2.1.1 The proposals suggest a fundamental shift in how urgent care is to be provided, with more extensive services outside hospital and patients who have more serious or life threatening conditions being treated in centres that have the appropriate clinical teams, expertise and equipment.

2.1.2 The blueprint is the first stage of a review led by Prof. Sir Bruce Keogh, Medical Director of NHS England. Sir Bruce explains in his three to five year 'blueprint' that he feels that changes are necessary and are "the only way to create a sustainable solution and ensure future generations can have peace of mind that, when the unexpected happens, the NHS will still provide a rapid, high quality and responsive service free at the point of need".

2.1.3 The plans will keep patients who do not need emergency treatment out of hospitals. Under the plans Accident & Emergency Departments will be divided into a **two distinct types**. This will take the form of 70 'major emergency centres' which will treat patients who have the most serious conditions; and 100 other centres that will manage patients thought to have less serious injuries. In addition more patients will be treated over the phone, at pharmacies or by paramedics.

2.1.4 Commentators have pointed out that the reforms could see patients who suffer heart attacks and strokes travelling further from home by ambulance in order to access specialist care, which Keogh said cannot be safely provided alongside every casualty unit.

2.1.5 The report puts forward the following proposals in five key areas:

- Providing better support for people to self-care.
- Helping people with urgent care needs to get the right advice in the right place, first by enhancing the NHS 111 service and by creating a 24 hour, personalised priority contact service. Allowing them to speak directly to a

nurse, doctor or other healthcare professional if that is the most appropriate way to provide the help and advice they need.

- Being able to directly book a call back from, or an appointment with, a GP or at whichever urgent or emergency care facility can best deal with the problem.
- Providing highly responsive urgent care services outside of hospital to avoid unnecessary A&E attendance including faster and consistent same-day, every-day access to general practitioners, primary care and community services. Also harnessing the skills, experience and accessibility of community pharmacists; developing the 999 ambulance service into a mobile urgent treatment service capable of treating more patients at scene so they don't need to be conveyed to hospital to initiate care.
- Ensuring that those people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery. The NHS will introduce two types of hospital emergency department with the current working titles of Emergency Centres and Major Emergency Centres (around 40-70 nationally). Emergency Centres will be capable of assessing and initiating treatment for all patients and safely transferring them when necessary. Major Emergency Centres will be much larger units, capable of not just assessing and initiating treatment for all patients but providing a range of highly specialist services. The overall number of Emergency Centres – including Major Emergency Centres – carrying the red and white sign will be broadly equal to the current number of A&E departments.
- Building on the success of major trauma networks, the NHS will develop broader emergency care networks. These will dissolve traditional boundaries between hospital and community-based services and support the free flow of information and specialist expertise. They will ensure that no contact between a clinician and a patient takes place in isolation.

2.2 Local Implications – South Warwickshire NHS Foundation Trust

2.2.1 In other parts of the country many of the recommendations made regarding secondary care will change the configuration of local hospital services but in the case of Coventry and Warwickshire, these arrangements are **broadly already in place**. In particular, we have already implemented centralised models (centred around University Hospitals Coventry and Warwickshire NHS Trust) for hyper-acute stroke care, major trauma and for the treatment of heart attacks.

2.2.2 The Trust has been involved in some national development work looking at creating better emergency care across hospital and community settings. A major report was published by the Health Foundation in April of last year entitled **'Improving patient flow'** which was the result of a three year study of a change problem at Warwick Hospital and Sheffield hospitals. The premise of the work was to ensure that we did "today's work today", reducing delays and speeding up clinical processes. We demonstrated that by focussing on immediate tasks, we improved quality and reduced length of stay. In our case we extended some of this thinking into community services and developed services such as the Community Emergency Response Team (CERT) who offer a 2 hour response to speed up discharge and to offer alternatives to admission. Our work is now being replicated in Wales, Scotland and Northern Ireland and was used as evidence to support the original Keogh review.

2.2.3 The hospital based solutions included the development of **7 day working** which has now been adopted as one of Sir Bruce's key "ambitions". As a consequence we now have a consultant Physician supported by consultant Radiology back-up on site over the entire week and closely monitor process flow. At ward level we have moved to single consultants working "hot" weeks, so that they are available to manage patient throughout the entire week, improving on the timeliness and continuity of decision making. We have also improved the frail elderly pathway ensuring that patients get the right specialist assessment during the early part of their stay.

2.2.4 The result of these programmes has been that the Trust has seen a reduction in mortality and length of stay and has now achieved the 4 hour A&E standard in each of the last 7 months, with the latter resulting in **Monitor closing its investigation** into previous breaches of the target. The focus on productivity has also ensured that these results have been achieved whilst being the only acute provider in the local area to be able to operate at below national tariff cost.

3. Conclusions

3.1 The Warwickshire Health and Wellbeing Board is asked to receive and note this report.

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Strategic Director		
Portfolio Holder		

Coventry and Warwickshire Partnership NHS
NHS Trust

Briefing to Warwickshire Health & Wellbeing Board – 20 January 2014

Care Quality Commission Inspection and Foundation Trust Application – current position

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The Trust is further preparing for reactivating its assessment by the Regulator, Monitor in Spring/Summer 2014. The Trust was assessed by Monitor during 2013 when it deferred its decision to authorise the Trust for a six month period with recommendations to:

- Decentralise Risk Register
- Improve Board oversight of Directorate performance
- Strengthen monitoring of changes relating to the Trust's cost improvement programme, once these are implemented.

All recommended actions are now complete and the Trust is currently arranging for a review of the changes to provide third party assurance to Monitor. The election to the Shadow Council of Governors is complete and Governors are participating in a development programme to ensure they are ready to take up their statutory duties once the Trust is an authorised Foundation Trust.

The Trust has been selected as a pilot site for the Care Quality Commission's national programme of inspection of care and this commences on 20 January 2014. The inspection team will be present within the organisation from 20 – 25 January 2014. We anticipate a report will be with the Trust in around six weeks' time, although this has not been confirmed. Once this inspection concludes satisfactorily, the Trust will be in a position to reactivate a further assessment by Monitor. It is anticipated that the Trust will be authorised as a Foundation Trust and Licensed to operate around autumn 2014.

Josie Spencer
Director of Operations and Deputy Chief Executive

Warwickshire Health and Wellbeing Board
20th January 2014

Warwickshire Public Mental Health Strategy 2014-16

Recommendations

That the Warwickshire Health and Wellbeing Board:

- Considers, and approves for consultation among partners, the Public Mental Health Strategy 2014-16

.

1.0 Introduction

1.1 This strategy document sets out a work programme for Public Health Warwickshire to improve the mental health and wellbeing of people living in Warwickshire, working in partnership with key strategic groups and organisations across Warwickshire.

2.0 What the strategy covers

2.1 The strategy outlines the reasons for having a public mental health strategy, and the potential economic benefits of investment in public mental health.

2.2 It reviews the evidence base for public mental health interventions and considers those which have been shown to be cost-effective.

2.3 The strategy outlines the national approach to public mental health and the three tier approach which characterises public health – universal interventions, targeted prevention, and health improvement for vulnerable population groups (Levels 1,2 and 3 respectively).

2.4 The strategy outlines key aims for a Warwickshire Public Mental Health Strategy and proposed priorities, together with an outline for an implementation Action Plan.

3.0 Key aims for the strategy

3.1 The identified key aims for the strategy are:

Level 1

- To champion mental health for all, and to promote and improve public mental health and wellbeing across the life course, from childhood to old age, working in partnership with key stakeholders

Level 2

- To promote and improve the mental health and wellbeing of looked after and vulnerable children and young people in Warwickshire
- To commission evidence-based public health interventions to prevent mental ill health, suicide and dementia
- To increase access to, and availability of, low level support and early intervention services for people at risk of mental health problems

Level 3

- To narrow the gap in health inequalities for people living with severe mental illness
- To increase timely diagnosis rates for dementia, and improve availability of post-diagnosis support

4.0 Next steps

4.1 With the agreement of the Health and Wellbeing Board this Public Mental Health strategy will be disseminated for consultation among partners (principally those represented at the Health and Wellbeing Board and those listed on p4 of the strategy document, particularly noting the importance of collecting views from service users, carers and the public).

4.2 The aim is to consult on the identified priorities and proposed action plan.

4.3 The Action Plan will be developed, following consultation, to include more detailed outcomes and timescales, and those areas where business plans are needed for potential future investment. It is intended to finalise the strategy and bring it back to the Health and Wellbeing Board for sign-off at the March meeting.

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Portfolio Holder for Public Health	Cllr Bob Stevens	

Appendix

Warwickshire Public Mental Health Strategy 2014-16

DRAFT

Date for review: January 2015

Charlotte Gath, Paula Mawson, Claire Taylor

Mental Health and Wellbeing Team, Public Health Warwickshire

January 2014

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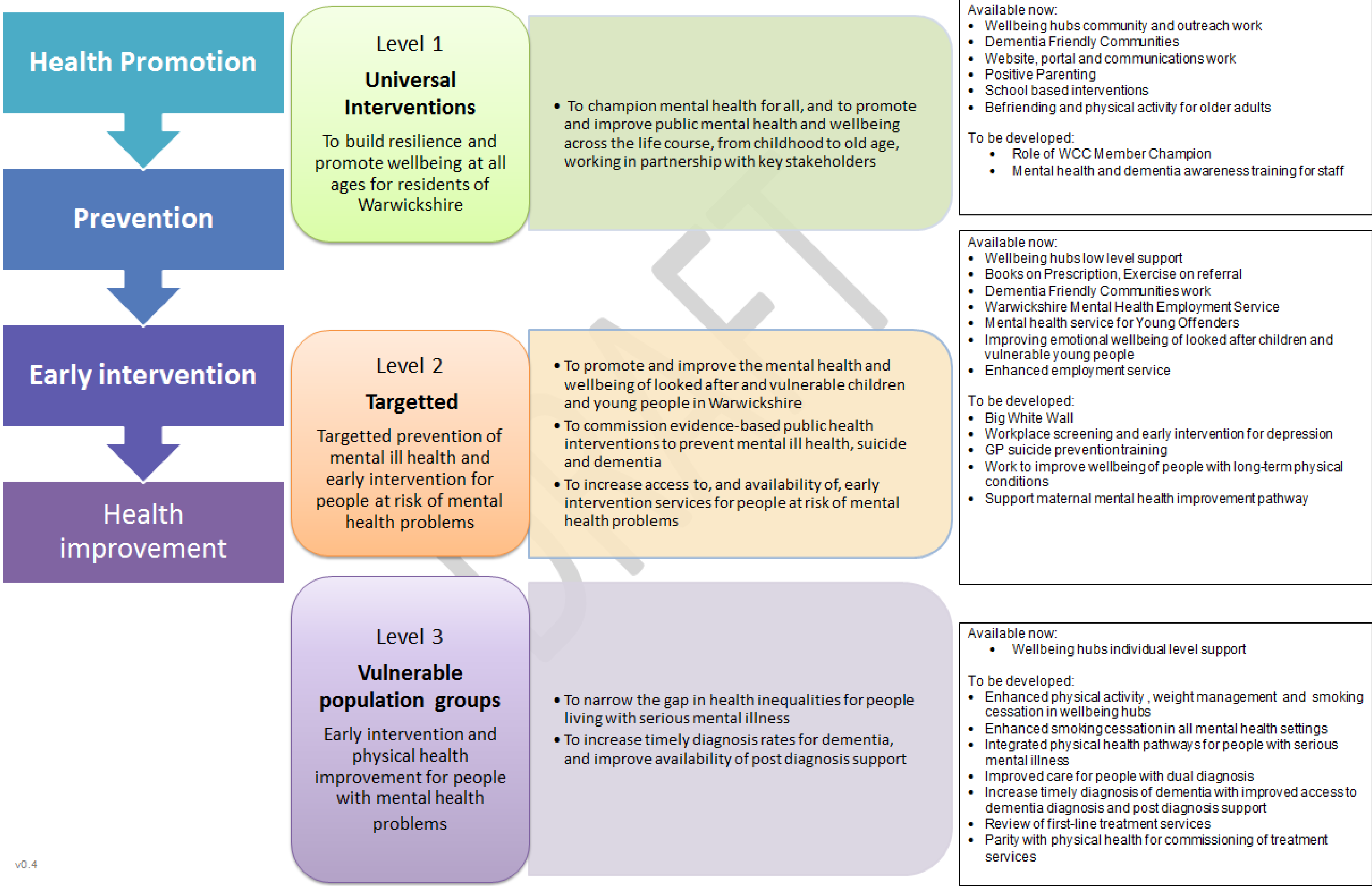
Warwickshire's Three Tier Mental Health and Wellbeing Strategy Summary



Overall aim and vision

Public Health Warwickshire aims to provide and commission good information, evidence, support and resources to improve the mental health and wellbeing of people living in Warwickshire, working in partnership with key strategic groups and organisations across Warwickshire.

This strategy outlines our work programme towards this aim for 2014-16.

Our partners

It will form the basis for work undertaken through and alongside Warwickshire's Health and Wellbeing Board, and in partnership with the following:

Warwickshire County Council's People Group and Localities Programme

Warwickshire's District and Borough Councils (North Warwickshire, Nuneaton and Bedworth, Rugby, Stratford and Warwick)

Clinical Commissioning Groups (Warwickshire North, Coventry & Rugby, South Warwickshire)

Arden Commissioning Support Unit (CSU)

Coventry and Warwickshire Partnership Trust (CWPT)

Warwickshire's Youth Justice Team

Voluntary Sector and independent organisations (Rethink, Coventry & Warwickshire Mind, Friendship, Care & Housing, Age UK, Alzheimers Society among others)

And most importantly, mental health service users, carers and the public (including consultation through user involvement services)

Definitions:

The terms ‘mental wellbeing’ ‘mental disorder’ and ‘mental illness’ are used in this strategy with the following definitions:

- **Mental health and wellbeing** refers to a combination of feeling good and functioning effectively. The concept of feeling good incorporates not only the positive emotions of happiness and contentment, but also such emotions as interest, engagement, confidence and affection, and having a sense of purpose such as working towards valued goals, and experiencing positive relationships. It also includes strengthened resilience in coping with physical or mental illness, or social disadvantage.
- **Mental disorder** includes mental illnesses as well as personality disorder and alcohol and drug dependency
- **Mental illness** refers to depression and anxiety (‘common mental disorder’) as well as schizophrenia and bipolar disorder (‘severe mental illness’)

Please note that learning disability is not covered directly in this strategy but improving wellbeing and physical health for people with learning disability is a priority which will be considered in a separate strategy document. In addition there is already a Warwickshire Dementia Strategy, which is currently being refreshed, and this should be considered in parallel with this Mental Health Strategy as there is considerable overlap.

Why have a Public Mental Health Strategy?

The title of the Government's national mental health strategy states that there is "no health without mental health"[7]. Improving mental health and wellbeing is an integral part of improving the public's health[8] and good mental health provides the bedrock for good physical health and for a range of other important life skills, capacities and capabilities[3].

The following are selected key messages for commissioners of public mental health services developed by the Joint Commissioning Panel for Mental Health (www.jcpmh.info) – a national group of organisations which includes the Royal Colleges of GPs, Psychiatrists and Nursing, Mind, Rethink, and the Mental Health Network, who aim to inform high-quality mental health commissioning in England[3]. This strategy quotes extensively from the JCPMH Guidance for Commissioning Public Mental Health Services.

1. Mental wellbeing is associated with a wide range of improved outcomes in health, education and employment, as well as reduced crime and antisocial behaviour.
2. Mental disorder starts at an early age and can have lifetime consequences. Opportunities to promote and protect good mental health begin at conception and continue through the life-course, from childhood to old age.
3. Improved mental wellbeing and reduced mental disorder are associated with: better physical health, longer life expectancy, reduced inequalities, healthier lifestyles, improved social functioning, better quality of life
4. Public mental health involves: a) an assessment of the risk factors for mental disorder, the protective factors for wellbeing, and the levels of mental disorder and wellbeing in the local population
b) the delivery of appropriate interventions to promote wellbeing, prevent mental disorder, and treat mental disorder early
c) ensuring that people at 'higher risk' of mental disorder and poor

wellbeing are proportionately prioritised in assessment and intervention delivery

5. Good evidence exists for a range of public mental health interventions. These can reduce the burden of mental disorder, enhance mental wellbeing, and support the delivery of a broad range of outcomes relating to health, education and employment.
6. Public mental health is a central part of the work of Health and Wellbeing Boards, which are responsible for developing strategic plans to address the public health of the local population.
7. Despite evidence based interventions with a broad range of impacts, only a minority of people with a mental disorder currently receive any treatment. Furthermore, spending on the prevention of mental disorder and promotion of mental health represents less than 0.1% of the annual NHS mental health budget.
8. Investment in the promotion of mental wellbeing, prevention of mental disorder and early treatment of mental disorder results in significant economic savings even in the short term. Due to the broad impact of mental disorder and wellbeing, these savings occur in health, social care, criminal justice and other public sectors.

Background facts and figures

The following also highlight the importance of prioritising public mental health given the scale and impact of mental health problems nationally:

- *At any one time, at least one person in six is experiencing a mental health condition* (McManus et al, 2009). Depression and anxiety affect about half of the adult population at some point in their lives.

- *Mental health conditions account for 23% of the burden of disease in England (compared to 16% for cancer and 16% for heart disease) but comprises just 13% of NHS spending.* Three quarters of people affected never receive any treatment for their mental health condition (LSE 2012).

- *Mental ill health costs some £105 billion each year in England alone.* This includes £21bn in health and social care costs and £29bn in losses to business (Centre for Mental Health 2010).

- *Half of all lifetime mental health problems emerge before the age of 14* (Kim-Cohen et al, 2003; Kessler et al, 2005)

- *People with a severe mental illness die up to 20 years younger than their peers in the UK* (Chang et al, 2011; Brown et al 2010). The mortality rate among people with a severe mental illness aged 18-74 is three times higher than that of the general population (HSCIC 2012).

- *People with mental health conditions consume 42% of all tobacco in England* (McManus et al, 2010). The single largest cause of increased levels of physical illness and reduced life expectancy is, among people with severe mental illness, higher levels of smoking (Brown et al 2010)

Local facts and figures for Warwickshire

Figures from Warwickshire's Joint Strategic Needs Assessment (JSNA)[1] the Community Mental Health Profile 2013 for Warwickshire[2] show the following:

- 4.5% of 16-18 year olds were not in employment, education or training in 2011 (England average 6.2%)
- There were 101 hospital admissions caused by unintentional and deliberate injuries in under 18s in 2009/10 (England average 123)
- 10.6% of adults over 18 in the county had depression in 2010/11 (England average 11.68%)
- The rate of hospital admissions for alcohol attributable conditions, per 1000 population, 2011/12 was 21.1 (England average 23.0)
- By 2014 more than 9,500 people aged 65 and over are projected to have depression in Warwickshire
- The allocated average spend for mental health per head for Warwickshire in 2011/12 was £167 (England average £183)
- The number of total contacts with mental health services, as a rate per 1000 population in Warwickshire, 2010/11 was 308 (England average 313)
- In 2009 there were 39 suicides in Warwickshire. The suicide rate is comparable to both the England rate and the West Midlands regional rate
- The excess under 75 mortality rate for adults with serious mental illness in Warwickshire 2010/11 was 1048 (England average 921)
- The percentage of adults (18+) with dementia 2011/12 was 0.57% (England average 0.53%)
- This equates to an estimated 7000 people in the county living with dementia, ranging from over 1,800 people in Stratford-on-Avon to around 700 in North Warwickshire
- Of these around 40% have been formally diagnosed, as the ratio of recorded to expected prevalence of dementia, across Warwickshire, in 2010/11 was 0.39 (England average 0.42)

The early analysis for the recent ‘Living in Warwickshire’ survey (September 2013) shows that for the shortened WEMWBS questions (Warwickshire Edinburgh Mental Wellbeing Scale – a recommended and validated measure of wellbeing) a majority of people responded that in the last two weeks they had been feeling useful, had been dealing with problems well, had been thinking clearly, feeling close to other people, and been able to make up their mind about things either often or all of the time. However for the two questions on optimism and feeling relaxed in the last two weeks, 36.9% of people responded that they had felt optimistic about their future for only some of the time, and 15% had felt optimistic either rarely or not at all. Of the 4.3% who reported not having felt optimistic about their future at all in the last two weeks, this represents 1 in 23 of the 7500 Warwickshire residents who responded ie 323 people. In addition, 41.9% of people reported feeling relaxed for some of the time, and 17.5% had felt relaxed either rarely or not at all.

Health inequalities

Wider health inequalities are affected by levels of mental wellbeing - people with mental health problems are more likely to have a poor diet, take less exercise, smoke more and misuse drugs and alcohol. For those with serious mental illness, increased health inequalities are very marked in that people with a diagnosis of serious mental illness die on average 20 years younger than the general population, mainly because of poorer physical health linked to heart disease and stroke.

Public mental health interventions can reduce and prevent health and social inequalities which impact on individuals, communities and higher risk groups. Such inequality underlies many of the risk factors for mental disorder, and mental disorder itself causes further inequalities in poor health and social functioning which can be prevented by: early identification and treatment, early interventions for

health risk behaviours and early treatment of physical illness in those with mental disorder, and targeted wellbeing promotion to facilitate recovery of those with mental disorder. Conversely improving mental wellbeing overall leads to improvements in the factors associated health inequalities – reducing risky lifestyle behaviours, and increasing educational attainment and employment.

A number of recent reports have highlighted the negative mental health impact of the economic downturn with employment problems, falling incomes, welfare reforms and increasing poverty and homelessness all contributing to poorer mental health, with resulting higher rates of anxiety, depression and suicide[6]. This adds some sense of urgency to redressing these effects where possible.

Economic reasons for investment in public mental health

There are good economic reasons for investing in public mental health and there is good evidence that public mental health interventions deliver large economic savings and benefits[4]. Improved mental health leads to both direct and indirect savings in NHS costs – for example reduced use of GP and mental health services, improved physical health and reduced use of alcohol and smoking consumption. Improved mental health also leads to savings in other areas: reduced sickness absence due to mental ill health, reduced costs to individuals and families, and to reduced spending in education, welfare and criminal justice, as well as increasing the overall economic benefits of wellbeing for individuals and families.

In 2011 the Department of Health published a report by Knapp et al "Mental Health Promotion and Mental Illness Prevention; the Economic Case"[5] which outlined significant savings which can be made from public mental health interventions. Some examples were summarised in a table showing that for every £1 invested in public mental health interventions, the net savings were:

- £84 saved – school-based social and emotional learning programmes
- £44 saved – suicide prevention through GP training
- £18 saved – early intervention for psychosis
- £14 saved – school-based interventions to reduce bullying
- £12 saved – screening and brief interventions in primary care for alcohol misuse
- £10 saved – work-based mental health promotion (after one year)
- £10 saved – early intervention for pre-psychosis
- £8 saved – early intervention for parents of children with conduct disorder
- £5 saved – early diagnosis and treatment of depression at work
- £4 saved – debt advice services

[= Total returns on investment (all years): economic pay-offs per £1 expenditure quoted by Knapp et al]

The evidence base for interventions

A review of current evidence on public mental health interventions has shown that the following are effective in improving mental health with a clear underlying evidence base[4,5,8,9]

- Promoting parental mental health and positive parenting
- Commissioning mental health training – awareness, support, signposting, first aid – for all frontline staff
- Improving physical health for people with mental health problems
- GP suicide prevention training
- Reducing isolation and loneliness among older people, and encouraging exercise

In addition the following were evaluated using economic analysis to establish cost-benefits, and were shown to generate significant economic benefits, including savings in public expenditure, as well as achieving gains in health and quality of life by improving mental health:

- Parenting programmes to prevent conduct disorder
- School-based programmes to prevent conduct disorder
- School-based anti-bullying programmes
- Workplace mental wellbeing programmes and screening/early intervention for depression
- Debt advice
- Employment

The government's national strategy "No Health Without Mental Health"[7] outlines priority work areas and what local public health services can do

We have based this strategy on these national recommendations.

- **Develop a clear plan for public mental health** – (incorporating the three-tier approach to improving public mental health)
- **Champion 'mental health for all'** – articulating the many benefits, including financial benefits, of prevention, promotion and early intervention in mental health for everyone in their communities, and ensuring mental health is integrated across policy areas
- **Support positive parenting** – this can play a vital role in supporting attachment and linking parents with evidence-based interventions to support their child's wellbeing
- **Commission or provide evidence-based mental health training for non-mental health professionals** – training builds awareness of mental health issues, addresses myths and stigma, and enables professionals to support and signpost to the right services
- **Ensure health improvement efforts consider the specific physical health needs of people with mental health problems** – targetted interventions for people with mental health problems, including severe mental illness, can help deliver improved public health outcomes
- **Strengthen services and access for people with complex needs including severe and enduring mental illness** – especially for those with dual diagnosis of mental health problems and substance misuse
- **Set ambitious expectations and monitor outcomes** – including data on health inequalities

The three tier approach

The three tier approach to a public mental health strategy includes:

1. Universal interventions to build resilience and promote wellbeing at all ages
2. Targetted prevention of mental ill health and early intervention for people at risk of mental health problems
3. Early intervention and physical health improvement for people with mental health problems

Level 1 mental health promotion interventions focus on increasing mental health and wellbeing including: starting well, developing well, living well, working well and ageing well.

Level 2 prevention interventions prevent mental illness and a range of associated issues including: mental disorder and dementia, health risk behaviour, inequality, discrimination and stigma, suicide, violence and abuse.

Level 3 early intervention occurs in the following areas: treatment of mental disorder and sub-threshold mental disorder, promotion of physical health and prevention of health risk behaviour in those developing mental disorder, promotion of recovery through early provision of a range of interventions, and recognition of mental disorder.

Key aims for a Warwickshire Public Mental Health Strategy

Using needs assessment data available in Warwickshire's JSNA, and national priorities outlined above, the following have been identified as key aims for the Warwickshire Public Mental Health Strategy at each of the levels of the three tier approach.

Level 1

- To champion mental health for all, and to promote and improve public mental health and wellbeing across the life course, from childhood to old age, working in partnership with key stakeholders

Level 2

- To promote and improve the mental health and wellbeing of looked after and vulnerable children and young people in Warwickshire
- To commission evidence-based public health interventions to prevent mental ill health, suicide and dementia
- To increase access to, and availability of, low level support and early intervention services for people at risk of mental health problems

Level 3

- To narrow the gap in health inequalities for people living with severe mental illness
- To increase timely diagnosis rates for dementia, and improve availability of post diagnosis support

Proposed priorities and developing an action plan

Linking the three tier approach and key aims, the following sections outline what we already have in Warwickshire, what we can do more of with existing resources, and proposed investment for commissioning public mental health interventions in selected priority areas.

We have prioritised interventions which are evidence based, particularly those which have been shown to be cost-effective, but have also selected other priorities and proposed actions on the basis of needs assessment and consultation with users and carers. The actions listed below are suggested as current priorities for the coming year, and include proposed investment areas. We will continue to develop the action plan towards 2015-16.

What we already have in place and work underway

Current Public Mental Health support services we commission in Warwickshire:

Warwickshire Wellbeing Hubs - services in Nuneaton, North Warwickshire, Rugby, Stratford and Leamington which provide information, a listening ear, practical support, and sign-posting on a 1 to 1 basis for people with issues affecting their mental health and wellbeing. The hubs also offer drop-in support and outreach services across Warwickshire.

Rugby Dementia Day Service – the Bungalow is a day service in Rugby for people with dementia. The service adopts a person-centred approach, providing a variety of activities which help maintain the independence and wellbeing of the person with dementia while giving carers a break.

Warwickshire Mental Health Employment service (countywide) – this provides employment and training services for people with mental health

problems. The services help people access employment, retain their jobs and regain self-confidence and independence.

Warwickshire User Involvement Service – this is for individuals over the age of 18 who have accessed mental health or dementia services. The service is available to ensure individuals are actively involved and engaged in the planning, commissioning and delivery of mental health services in Warwickshire.

Mental Health Service for Young Offenders (countywide) – this service aims to improve emotional and mental wellbeing of young people who are in contact with the Youth Justice System and to reduce their offending and re-offending, improve their physical health and the emotional functioning and wellbeing of their families.

Work is also currently ongoing to progress tenders for Advocacy Services (which includes Independent Mental Health Advocacy) and the Big White Wall (early intervention on line support service for people experiencing mental health issues).

Partnership services have been developed for the Books on Prescription Scheme (self-help books available in libraries) and Exercise on Referral Schemes, including for people with dementia.

Communications and website development includes the recent production of mental health pages on the Warwickshire Direct website containing details of mental health services in Warwickshire (mainly those commissioned by health and social care) at www.warwickshire.gov.uk/mentalhealth and the dementia portal containing advice and information for people with dementia and their carers www.livingwellwithdementia.org

Public health is also leading the Awareness and Understanding workstream of the Warwickshire Dementia Strategy, in particular promoting Dementia Friendly Communities, with a focus on pharmacies, libraries and the Fire Service, and working with CCGs to increase the timely diagnosis of dementia.

Level 1: Universal interventions to build resilience and promote wellbeing at all ages

Key aim:

- **to champion mental health for all, and to promote and improve public mental health and wellbeing across the life course, from childhood to old age, working in partnership with key stakeholders**

1.1 WCC has recently appointed a councillor Member Champion for Mental Health, Cllr Dave Shilton, whose role will be to promote mental health, and reduce stigma and discrimination for people with mental health problems, across the council in all its work areas.

We will work closely with Cllr Shilton to develop and support this role, and also the work of the Health and Wellbeing Board in improving mental health and wellbeing in Warwickshire. We will use evidence-based national programmes including 'Five Ways to Wellbeing', the campaign against discrimination 'Time to Change' and through the Making Every Contact Count (MECC) campaign.

We will promote and improve mental wellbeing by ensuring that the above programmes are supported through

- **Developing services (both commissioned and partnership)**
- **Developing a suite of resources**
- **Engaging service users**
- **Promoting community wellbeing (eg by engaging with locality teams and community resources)**

1.2 There is good evidence that commissioning of mental health training – awareness, support, signposting and first aid – for frontline staff is an effective public health intervention.

From feedback received in Warwickshire we are aware that a range of practitioners have requested additional support in this area, including developing awareness and their ability to signpost to other services.

We will commission mental health and dementia awareness training for selected frontline staff in Warwickshire County Council and in the five borough and district councils (North Warwickshire, Nuneaton & Bedworth, Rugby, Stratford and Warwick), and in health, social care and voluntary sector settings.

1.3 We will aim to promote and improve the mental health and wellbeing of children and young people in Warwickshire. There is good evidence that positive parenting programmes are cost-effective as public health interventions. They should follow an evidence-based model (such as the Triple P model), be easily accessible to families at highest risk, and be linked with health visitors, general practice and maternity services.

We will provide evidence to help underpin and target positive parenting, working with CCGs, NHS community services and Warwickshire County Council's People Group to support the development of cost-effective positive parenting programmes in Warwickshire.

1.4 The recently revised CAMHS needs assessment for Warwickshire[1] highlights the importance of early intervention and mental health awareness training for schools, pre-school workers and health professionals. There is good evidence that school-based programmes to prevent both bullying and conduct disorder are cost-effective as public mental health interventions.

We will work with colleagues in Education, CAMHS commissioning, children's' services and the voluntary sector, and will provide the evidence to support development of cost-effective programmes with these aims.

1.5 For older people, reducing isolation and loneliness, and encouraging physical exercise, have both been shown to improve mental wellbeing and reduce the risk of depression. Improving the quality of older people's lives through psycho-social interventions and enhanced physical activity

has been shown to improve mental and physical health, reduce use of health and social care services, and reduce A&E attendances and hospital admissions.

We will work with CCGs, WCC People Group and WCC Localities Programme, as well as the voluntary sector, to support the development of befriending schemes for older adults and enhanced opportunities for older people to be physically active, and will support the development of a broader multi-agency piece of work aimed at tackling rural isolation and loneliness.

Level 2: Targetted prevention of mental ill health and early intervention for people at risk of mental health problems

Key aims:

- **To promote and improve the mental health and wellbeing of looked after and vulnerable children and young people in Warwickshire**
- **To commission evidence-based public health interventions to prevent mental ill health, suicide and dementia**
- **To increase access to, and availability of, low level support and early intervention services for people at risk of mental health problems**

2.1 Public Health Warwickshire has begun commissioning the Big White Wall – a clinician-led online support system for people with mental health problems which GPs can refer patients to directly.

We will monitor the Big White Wall implementation and outcomes and commission increased access for Warwickshire residents if it is shown to work well in practice locally.

2.2 Public Health Warwickshire and WCC's People Group currently commission Wellbeing Hubs in several venues across the county which offer low level support, one-to-one counselling, signposting to other services, and outreach for people at risk of common mental health problems.

We will work with CCG GP leads to increase referrals to the Wellbeing hubs, and to increase access and take-up of the one-to-one sessions available. We will commission increased community outreach work of the wellbeing hubs ensuring their mental wellbeing messages have a higher profile among communities in Warwickshire, and helping with early intervention for common mental health issues.

2.3 Public Health Warwickshire currently commissions the mental health component of the Youth Justice team, from Coventry & Warwickshire Partnership Trust. Young people in the youth justice system are at least three times more likely to have mental health problems than the non-offending population and problems may be exacerbated by contact with the youth justice system[1].

We will continue to support the Youth Justice mental health service and will provide evidence to support the commissioning of Speech and Language services to young offenders with communication difficulties, currently a gap in service provision.

2.4 Children in the care of the local authority often experience a greater degree of health risks and problems than their peers[1]. Their wellbeing is impacted by poverty, abuse and neglect which can lead to debilitating mental health problems. Warwickshire's JSNA includes the aim to narrow the gap in outcomes for looked after children and young people as compared with that of the general population.
In addition the children of parents with mental health or substance use problems, who often act as their carers, are vulnerable to developing mental health problems themselves.

We will work with CAMHS commissioning colleagues and CCGs and will provide evidence to underpin programmes aimed at improving emotional wellbeing of looked after children and other vulnerable groups of children and young people.

2.5 There is also good evidence for cost-effectiveness of programmes aimed at improving working lives – support for the unemployed, creating healthy working environments, early recognition of and intervention for depression in employees, and supported work for those recovering from mental illness. The Royal College of Psychiatrists is currently running a campaign aimed at improving working lives, recognising the impact employment has on mental health. Public Health Warwickshire currently commissions an employment service for people with mental health problems in Coventry and Warwickshire.

We will seek to consider enhanced Coventry and Warwickshire employment services to support more people with mental health problems to retain existing employment and in obtaining work, as well as tackling employment issues and discrimination for people with mental health problems at work.

2.6 In line with the evidence around improving working lives, workplace screening for depression followed by intervention such as cognitive behavioural therapy has been shown to be effective.

We will explore the potential to commission targetted workplace screening and early intervention for depression and anxiety disorders.

2.7 Suicide prevention is one of our identified priorities and a review of the evidence has shown that investment in GP suicide prevention training is highly cost-effective with economic savings in the wider public sector as well as health, and reductions in the more intangible costs of pain and suffering to individuals and families.

We will work with CCGs and Coventry and Warwickshire Partnership trust, and the voluntary sector, to develop and commission suicide prevention education programmes specifically for GPs.

2.8 People with long term physical conditions (LTCs) are vulnerable to developing mental health problems.

We will link with practice nurses and other frontline staff to ensure effective signposting for people with long-term conditions to wellbeing hubs and other wellbeing support sessions.

2.9 We recognise the impact of poor maternal health on women, babies and families and will support work which is already underway in Warwickshire on this.

We will work with key partners and provide evidence to underpin a Warwickshire maternal mental health strategy, and help to develop a pathway that includes heightened awareness by practitioners of women at risk of postnatal mental health problems.

Level 3: early intervention and physical health improvement for people with mental health problems

Key aims:

- **To narrow the gap in health inequalities for people living with severe mental illness**
- **To increase timely diagnosis rates for dementia, and improve availability of post-diagnosis support**

3.1 Tackling the Excess Under 75 Mortality Rate for adults with serious mental illness has been identified as a clear priority in Warwickshire, and this is reflected in national public health priorities. In 2010/11 1048 adults with serious mental illness died prematurely, and the average life expectancy of people with serious mental illness is 20 years less than that of their peers.

The mental health charity Rethink has recently produced a stark report on the health inequalities experienced by people with serious mental illness (Lethal Discrimination report 2013[10]). This highlights the fact that the excess mortality is not due to suicide but is mainly due to cardiovascular disease, with increased likelihood of a poor diet, obesity, lack of exercise and smoking as contributory risk factors. There is much that can be done to tackle this and the report emphasises improved physical healthcare and smoking cessation as the priority areas.

Targeted smoking cessation in mental health settings should be a priority for commissioning, as outlined in the recent NICE guidance[11,12]

We will work with CCGs, smoking cessation co-ordinators and Coventry & Warwickshire Partnership Trust to support commissioning of enhanced supported smoking cessation to people using mental health services in all settings, and we will encourage the use of MECC (Making Every Contact Count) in all such settings.

3.2 Improving physical health for people with mental health problems has good evidence as a public mental health intervention. There is already work underway in developing exercise on referral programmes for people with dementia or mental health problems in Warwickshire.

We will consider an enhanced role for the Wellbeing hubs, with a greater emphasis on physical health and activity, weight management and smoking cessation for service users.

3.3 There needs to be clearer shared care across primary and secondary care for the physical health of people with serious mental

illness, ensuring an integrated approach to physical health. This includes improving access and take-up of GP health checks for people with serious mental illness and targeted reduction of risk factors for cardiovascular disease.

We will work with the Clinical Reference Group (clinicians from CWPT and GP leads) to support the development of more effective integrated physical health pathways for people with serious mental illness ensuring that there is a sustained and targeted reduction in cardiovascular risk factors for all.

3.4 Less than 50% of those living with dementia in Warwickshire are thought to have been formally diagnosed. A timely diagnosis enables maximum support for individuals and their families to live well with dementia, optimise health and slow disease progression.

There is already a considerable amount of work going on in Warwickshire through the multi-agency Dementia Strategy Board to increase awareness of dementia and to improve the lives of people living with dementia.

We will work with CCGs to increase timely diagnosis rates across the county and so ensure people can access dementia support services when it is appropriate for them to do so.

3.5 Increasing timely diagnosis of dementia requires improved access to specialist diagnosis through memory clinics

We will work with CCGs and CWPT to provide evidence for development of clear pathways and improved access to memory clinic assessment and diagnosis, with effective tailored post diagnosis support for those identified as having dementia and their carers. This will include development of dementia community support provision to include 'dementia navigators' (to provide information, advice and low level support).

3.6 There have been several recent reports highlighting the importance of achieving parity between mental health care and physical health[13,14]

We will work closely with the Health and Wellbeing Board and with CCGs to assist in developing their commissioning intentions and to ensure an ongoing focus on improving mental health commissioning and services, so that treatment of mental illness is managed with the same urgency and importance as physical illness.

3.7 Dual diagnosis and co-morbidity between mental illness and alcohol or substance misuse often creates barriers to services and makes people less likely to receive help they need, increasing their disadvantage in both mental and physical health terms.

We will work with CCGs, Arden CSU and CWPT, as well as colleagues in Warwickshire's drug and alcohol team to support improved service access and care for people with dual diagnosis.

3.8 IAPT (Individual access to psychological therapies) services which are firstline treatment services for people with mental health problems are currently being reviewed in Warwickshire.

We will work with Arden CSU, CCGs and CWPT to provide the evidence to support the development first line mental health services which are responsive, link effectively with community mental health teams, and meet patients' needs.

Developing an Action Plan

Of the proposed interventions at Levels 1,2 and 3 above, the majority of these require strengthened partnership working and could be developed within existing resources.

PRIORITY AREA	TIMELINE
1.1 Champion mental health for all	Develop plan for Health and Wellbeing Board by March 2014
1.3 Positive Parenting	Review of what is currently available in Warwickshire and development plan established with partners by May 2014 – with WCC People Group
1.4 Schools based mental health awareness, bullying and conduct disorder prevention programmes	Review of what is available and develop plan with multi-agency colleagues by June 2014
1.5 Loneliness campaign, befriending schemes and increased physical activity for older people	Multi-agency working group established by January 2014 with work plan identified by June 2014
2.3 Investigate commissioning of speech and language services to support Youth Justice mental health service and consider option appraisal	By March 2014
2.4 Wellbeing of looked after children and vulnerable children/young people	Support engagement with People Group, CAMHS commissioners and CCG colleagues - ongoing
2.8 Support for people with long term	Work with CCGs and Social Care, Healthwatch and others - ongoing

physical conditions	
2.9 Maternal mental health	As above
3.1 Smoking cessation in mental health settings	Work with CCGs to commission enhanced smoking cessation services in mental health settings by April 2015
3.3 Integrated physical health care for people with serious mental illness	Develop and implement integrated physical health plan by October 2014 – CCG clinical leads and CWPT Clinical Reference Group (CRG)
3.4 and 3.5 Timely diagnosis of dementia	Ongoing work on Dementia Awareness and Understanding. Support commissioning of memory clinic pathway by March 2014 (Dementia Strategy Board and CRG)
3.6 Parity with physical health	Ongoing – CCGs
3.7 Dual diagnosis and co-morbidity	Ongoing – CCGs and Clinical Reference Group
3.8 Firstline treatment services (IAPT review)	Ongoing as above

Proposed investment areas

The following are proposed as potential priority investment areas for commissioned services.

Intervention	Timing
1.2 Mental health and dementia awareness training for frontline staff	Tender for and commission appropriate training by March 2014
2.1 Extend access to online mental health support	Commission as appropriate following Big White Wall evaluation
2.2 Enhanced role of wellbeing hubs	Consider increased community outreach work of hubs, increase access and take-up of low level support
2.5 Enhanced employment services	Review enhanced employment services for people with mental health problems in Warwickshire 2014-15
2.6 Workplace screening and early intervention for depression programme	Review options to commission workplace screening and intervention beginning with local authority and health staff- if appropriate develop business case. By December 2014
2.7 Suicide prevention training for GPs	Develop plan, tender and commission by October 2014
3.3 Enhanced role for wellbeing hubs for improving physical health and wellbeing	Commission enhanced physical wellbeing support by March 2014
3.5 Dementia post-diagnosis Community Support	Develop plan for dementia navigators, tender and commission by December 2014

Outcomes and timescales

The overarching outcomes indicators for this work are from the national Public Health, Adult Social Care and NHS Outcomes Frameworks as below: We will monitor progress towards these overarching outcome indicators and in addition set interim targets to measure progress based on the six key aims and priority areas.

Public Health Outcomes Framework 2013-16

Improving the wider determinants of health

1.8 Employment for those with long-term conditions….. including adults who are in contact with secondary mental health services (also in NHSOF, ASCOF)

Health improvement

2.7 Hospital admissions caused by unintentional and deliberate injuries in under 18s

2.8 Emotional well-being of looked after children

2.23 Self-reported wellbeing

Healthcare public health and preventing premature mortality

4.9 Excess Under 75 mortality rate in adults with serious mental illness (also NHOF 1.5)

4.16 Estimated diagnosis rate for people with dementia (also NHSOF 2.6i)

NHS Outcomes Framework 2013-14

Enhancing quality of life for people with mental illness

2.5 Employment of people with mental illness (also PHOF as above)

Enhancing quality of life for people with dementia

2.6ii A measure of the effectiveness of post diagnosis care in sustaining independence and improving quality of life

Improving experience of health care for people with mental illness

4.7 Patient experience of community mental health services

If the strategy priorities are agreed we will develop a more detailed Action Plan building on the above to include detailed costings, specific progress measures and outcomes, as well as reporting timescales to the Health and Wellbeing Board.

KEY SUPPORTING DOCUMENTS AND REFERENCES

1. Warwickshire Joint Strategic Needs Assessment http://jsna.warwickshire.gov.uk - this includes the Adult Mental Health Needs Assessment 2012, and updated Children and Mental Health Services Needs Assessment for Warwickshire, 2013
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3. Guidance for Commissioning Public Mental Health Services: Joint Commissioning Panel for Mental Health, July 2013 www.jcpmh.info
4. Promoting Mental Health and Preventing Mental Illness: the Economic Case for Investment in Wales. Friedli and Parsonage, October 2009
5. Mental Health Promotion and Mental Illness Prevention: the Economic Case (Knapp et al, Department of Health, April 2011)
6. UCL Institute for Health Equity: The Impact of the Economic Downturn and Policy Changes on Health Inequalities in London
7. No Health without Mental Health National Strategy and Implementation Framework: Department of Health 2012
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9. Commissioning Mental Wellbeing for All – a Toolkit for Commissioners (National Mental Health Development Unit, NMHDU November 2010)
10. Rethink Mental Illness - Lethal Discrimination Report, September 2013
11. NICE Guidance 2013 – Smoking Cessation in Secondary Care Settings
12. Smoking and Mental Health. Joint Report by the Royal Colleges of Physicians and Psychiatrists, 2013

13. Whole-person Care: from Rhetoric to Reality – Achieving Parity between Mental and Physical Health, Royal College of Psychiatrists, March 2013
14. Parity of Esteem, Centre for Mental Health Briefing Note, October 2013

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Warwickshire Health and Wellbeing Board

20 January 2014

Warwickshire Health & Wellbeing Strategy – progress on outcomes and future activity

Recommendations

That the Warwickshire Health and Wellbeing Board (HWBB):

1. **Consider the progress made to date in relation to the Board's priorities**
2. **Approve the approach to the review of the Health and Wellbeing Strategy and future activity for the Board and its partners**

1.0 Background

1.1 The Warwickshire Interim Health and Wellbeing Strategy was approved by the shadow Health and Wellbeing Board in March 2013 following a public consultation and engagement with key stakeholders. The Strategy identified three priorities for health and wellbeing in Warwickshire:

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

Priority 2 Improving access to services

Priority 3 All agencies working together

Each priority is underpinned by detailed areas of focus, which have been reflected in the Board's annual work programme (Appendix I) and a draft performance framework (Appendix II).

1.2 Following approval of the Strategy and the Work Programme 2013-14, sub-groups have been tasked to undertake work in relation to the Board's priorities. Since then partners have been working to promote, deliver and report back on projects and actions which have emerged from the Board's Strategy and activity.

2.0 Progress to date

2.1 Since April 2013 the Warwickshire Health and Wellbeing Board has taken a lead on a number of initiatives and activities, ensuring that the priorities and outcomes outlined in the Health and Wellbeing Strategy are considered within commissioning and action plans.

2.2 Progress against the following specific areas of work should be noted:

- Strategic role. The JSNA and Board's Interim Strategy identifying key health and wellbeing strategic priorities are in place and being delivered. The Board's

Outcomes Framework has been developed, and the priorities are reflected in all Clinical Commissioning Groups' and Social Care commissioning intentions and plans.

- Adding value – The Board uses existing partnership structures to deliver the Strategy; roles and accountabilities have been defined (Joint HWBB, HWW and O&S MoU, Outcomes Framework, Board's Work Programme).

- Integration. Integration is a key activity and progress is being made through joint CCG and Social Care commissioning initiatives. As part of the Government's "Better Care" programme, strategic plans are being developed which will describe integration initiatives and projects under way or to be implemented across Warwickshire. The Board's extraordinary meeting on 11 February 2014 will be dedicated to discussing and approving the outline plan.

- Activity –Some of the key achievements include the review and approval of the CCGs' and Social Care commissioning intentions and clarifying roles and establishing links with other committees and organisations, e.g. Joint Memorandum of Understanding between the Health and Wellbeing Board, Healthwatch Warwickshire and WCC's Scrutiny functions. The Board is keen to provide evidence that it is 'making a difference'. The HWBB has identified the key outcomes and indicators that partners can agree, deliver towards and monitor improvements (Appendix II).

- Partnership work. The Board's partnership has been formed and extended to include all 5 District and Borough Councils as voting members as well as the Police & Crime Commissioner, a representative of the community and voluntary sector and NHS Trusts' leads as regular contributors. A number of joint events were organised, including the Dementia Conference and the Regulatory Services workshop.

- Public engagement – The Board's Communication and Engagement Strategy is in place and being delivered; patient and public engagement is delivered through the partnership and active involvement of Healthwatch Warwickshire. A number of engagement mechanisms are being used to enable effective communication with stakeholders and the public (HWBB Newsletter, webpages and the blog are being reviewed and updated, Twitter).

2.3 More detail regarding the Board's activity can be found in the Board's Work Programme (Appendix I). It should be noted that the actions listed in Appendix I do not reflect all the work partners are involved in which contributes to the delivery of the Health and Wellbeing Strategy.

3.0 Key issues and areas of future focus

3.1 Making Integration happen. 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 cooperate and promote Integration. The challenge of making Integration happen will require clear success measures to be jointly developed.

3.2 Addressing health and wellbeing inequalities. It has been identified that all partners 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.

3.3 Developing relationships. It has been recognised that there is a need to establish better links and clarify reporting mechanisms between the Health and Wellbeing Board and the Children's Trust, WCC Safeguarding Boards and the Community Safety partnerships.

3.4 Warwickshire Health and Wellbeing Strategy. It is proposed that the interim Strategy be reviewed in line with the JSNA update, starting from March 2014 for the new Strategy to be in place in autumn 2014. A draft project plan is being developed which will enable a thorough engagement with and input from all key stakeholders, followed by a public consultation activity facilitated by Healthwatch Warwickshire, and which will incorporate lessons learnt from the previous process.

4.0 Conclusions

4.1 The Board will continue making progress on its outcomes through the activity of its relevant sub-groups and partnerships.

4.2 With this in mind, the Board is recommended to consider the key issues and approve the draft Outcomes Framework and the plans to review the Health and Wellbeing Strategy.

5.0 Background Papers

5.1 Appendix I – WHWBB Work Programme 2013-14. Updated January 2014
5.2 Appendix II – WHWBB Performance Framework. Revised January 2014

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Governance					
Priority/ Item	**Lead officer(s)**	**Timescales**	**Committee date**	**Outcomes/ Outputs**	**Completed**
Agree chairmanship and membership post elections	Paul Williams	May 2013	11.06.13	Chair and portfolio holder members confirmed	Y
Agree relationship with the Cabinet	Monica Fogarty/ John Linnane	tbc	tbc	Approval system agreed	
Report on the Board's activity and performance	Nicola Wright/ Monika Rozanski	Jan - Mar 2014	20.01.14	Report submitted, published and considered by the Board	In progress
Draft HWBB work programme for 2014-15	Monika Rozanski/ Nicola Wright	Mar 2014	26.03.14	Draft submitted for consideration by the Board	
Priority 1: Mobilising communities to develop and sustain their independence					
Priority/ Item	**Lead officer(s)**	**Timescales**	**Committee date**	**Outcomes**	**Completed**
Discuss and agree action plans around dementia	Chris Lewington	Sep 2013	17.09.13 (workshop)	Improved diagnosis of dementia; people with dementia are appropriately supported to live independent lives for as long as possible	Y
Approve action plans and monitor progress on alcohol consumption and related health & wellbeing issues	Paul Hooper	Ongoing	20.11 13	Plans agreed and being delivered; Reduced number of alcohol related hospital admissions	Y
Consider/ discuss veterans' health and wellbeing issues	Bill Basra/ Emily Fernandez	Jan 2014	20.01.14		Y
Monitor progress of the Priority Families programme	Nick Gower Johnson	Ongoing	20.11.13	Reduced proportion of children in poverty, reduced number of 16-	Y

				18 year olds not in education, employment or training, reduced number of long-term unemployed	
Approve action plans and monitor progress on smoking in pregnancy	Paul Hooper/ Jacquie Ashdown	Ongoing	20.11.13	Plans approved and being delivered; increase in number of non-smoking population; reduction in smoking in pregnancy	Y
Monitor progress of the “discharge to assess” project	Wendy Fabbro/ CCGs	Ongoing	Reports for information & consideration / updates from the WCC & CCG Leads Group	Project being implemented	In progress
Consider impact of the Winterbourne View and approve learning disability strategies	Chris Lewington	Jan 2014	Workshop – 13 Jan 2014	Issues and impact discussed/ considered.	In progress
Consider issues relating to winter pressures and approve relevant plans	John Linnane/ Chris Lewington	Nov 2013	20.11.13	Issues and plans considered and approved	Y
Priority 2: Access to Services					
Priority/ Item	**Lead officer(s)**	**Timescales**	**Committee date**	**Outcomes**	**Completed**
Monitor progress and outcomes of the George Eliot Hospital Inquiry, approve strategies for improvement and monitor their implementation	Kevin McGee	Ongoing	20.06.13 17.07.13 25.09.13 20.11.13 20.01.14	Strategies for improvement approved and being delivered/ reduction in mortality rates	Y
Discuss, approve and monitor progress of CCG plans and	CCG Leads	Ongoing	20.11.13 (workshop –	CCG plans linked to the Health & Wellbeing Strategy and JSNA;	Y

commissioning intentions			30.10.13)	CCG plans approved and being delivered	
Discuss, approve and monitor progress of social care plans and commissioning intentions	Chris Lewington	Ongoing	20.11.13 (workshop – 30.10.13)	Social care plans linked to the Health & Wellbeing Strategy and JSNA; commissioning intentions approved and being delivered	Y
Monitor progress towards Foundation status of local trusts	Trust Leads	Ongoing	TBC	Progress reports considered and approved	
Discuss and approve strategies and monitor progress on managing pressures and patient safety in A&E departments	Hospital & CCG Leads	Ongoing	20.01.14	Strategies approved and being delivered; reduction in inappropriate A&E visits	
Discuss and approve strategies and monitor progress of out of hours services	CCG Leads	Ongoing	TBC (WCC & CCG Leads mtg)	Strategies approved and being delivered; out of hours services in place	
Discuss and agree strategies to improve mental wellbeing of the local population	Charlotte Gath	Jan 2014	20.01.14	Strategies agreed and being delivered	
Discuss and consider reports from Healthwatch Warwickshire	Deb Saunders	Sep 2013 Mar 2014	25.09.13 26.03.14	Reports and issues considered	In progress
Priority 3: Public Services – Working Together					
Priority/ Item	**Lead officer**	**Timescales**	**Committee date**	**Outcomes**	**Completed**
Agree engagement with the Police & Crime Commissioner/ Police and consider the PCC priorities	PCC/ Nicola Wright	Jun 2013	11.06.13	Principles of working together agreed; PCC priorities considered and reflected in relevant health and wellbeing plans	Y
Discuss/ approve the Health Protection Strategy	Nicola Wright	Jun 2013	11.06.13	Strategy approved and being delivered	Y
Review and approve JSNA	John Linnane/ Wendy Fabbro	Jun 2013	11.06.13	JSNA updated and in place	Y

Discuss and approve WHWBB Communications & Engagement Strategy/ Approach	Monika Rozanski/ Comms officer	Jul 2013	17.07.13	Strategy in place and being delivered	Y
Consider the "Living in Warwickshire" survey proposal	Gareth Wrench	July 2013	17.07.13	Proposal agreed and survey completed	Y
Approve and monitor progress of the Pioneer Project (integrated services)	Anna Burns	Ongoing	17.07.13 25.09.13	Proposal approved by the Board and project being implemented	Y
Agree and approve Warwickshire's "Better Care" integration plans	Chris Lewington/ CCGs	Oct 2013 – Mar 2014	11.02.14 (reports from the Joint Commissioning Board's and working groups)	Outline plan agreed and submitted	In progress
Agree the Board's expectations of key commissioners	Nicola Wright/ John Linnane	Jul 2013	20.08.13	Principles of working together agreed/ Activity reports from the WCC & CCG Leads group and the Joint Commissioning Group	Y
Discuss and approve partners' offers to deliver Warwickshire Health & Wellbeing Strategy	Nicola Wright/ Monika Rozanski	Ongoing	Ongoing engagement with partners	Partners' offers/ action plans approved and being delivered	Y
Discuss and agree plans for monitoring progress on the implementation of the recommendations in the Francis Report	Monika Rozanski/ Ann Mawdsley	Nov 2013	20.01.14 (joint HWBB, HWW and O&S workshop – 26.11.13)	Involvement and roles of the Health & Wellbeing Board, Healthwatch Warwickshire and Overview & Scrutiny discussed and agreed	Y
Discuss and agree a relationship with Overview & Scrutiny (MoU)	Cllr Izzi Seccombe/ Monika Rozanski	Sep 2013	20.01.14 (joint HWBB, HWW and O&S workshop –	Basic principles of working together agreed	Y

			26.11.13)		
Discuss and agree a relationship with Healthwatch Warwickshire (MoU)	Monika Rozanski	Nov 2013	20.01.14 (joint HWBB, HWW and O&S workshop – 26.11.13)	Basic principles of working together agreed	Y
Discuss and agree strategies around social housing to improve health and wellbeing of local population	Nicola Wright/ DCs + BCs	Ongoing	25.09.13 (ongoing engagement with partners)	Strategies agreed and being implemented	In progress
Agree the approach to developing & review Warwickshire Health & Wellbeing Strategy	Nicola Wright/ Monika Rozanski	Mar – Sep 2014	20.01.14 – agree approach 22.09.14 – approve strategy	Strategy reviewed and approved	
Consider Director of Public Health Annual Report	John Linnane	Sep 2013	25.09.13	Report submitted and considered	Y
Engagement with Providers	Nicola Wright/ Monika Rozanski	October 2013	(Workshop – tbc)	Standing invitation to HWBB's active observers group; Principles of working together agreed	In progress
Engagement with the Coventry & Warwickshire Partnership Trust	John Linnane	tbc	Board to Board meeting tbc	Standing invitation to HWBB's active observers group; basic principles of working together agreed	In progress
Consider children safeguarding issues	Sue Ross / Cornelia Heaney	Nov 2013	Report for information & consideration	Report discussed and considered	Y
Engagement with NHS England (Area Team)	Nicola Wright/ John Linnane	September 2013	Ongoing	Membership on the Board; Basic principles of working together agreed	In progress

Introduction

A Health and Wellbeing Strategy for Warwickshire was formally approved by the Health and Wellbeing Board on 19 March 2013. In order to assess the impact of the strategy and achievement of our outcomes and priorities, a performance and outcomes framework for the strategy has been developed.

An overview of the framework

The performance framework now comprises of four elements:

I. Dashboard of outcomes and indicators (page 3)

The dashboard contains key priorities and outcomes to be reported on to the Health and Wellbeing Board by partners, who have the responsibility to develop and deliver specific plans, including:

- Commissioning intentions and plans
- Integration plans
- Other specific strategies and projects.

The dashboard will be used to measure the impact of the Health and Wellbeing Strategy and will include specific performance indicators from the following national outcomes frameworks: Public Health, Social Care and NHS. Other appropriate quality measures will be identified in cooperation with Healthwatch Warwickshire and Commissioners and will be included in the dashboard at a later stage.

II. Reporting

The Board will receive 6 monthly summary reports on progress consolidating data from partners against each of the outcomes. Only significant issues and risks will be escalated to the Board at any time by exception.

III. Themed discussions

Priority-themed agendas for the Board's meetings will encourage partners to focus on the key priorities. Any member of the Board, or an invitee, will be able to challenge the Board to take action on a key issue.

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IV. Peer Review

To evaluate its progress and achievements as well as exchange ideas and learning, the Board may choose to take up a Peer Review challenge, either as part of the LGA offer to Health and Wellbeing Boards, or provided by partners.

V. Board's Work Programme

The Board will work to its annual work programmes developed to reflect the Board's key priorities as specified within the Strategy.

The outcomes framework

The outcomes that the Board is aiming to achieve are set out overleaf, along with an initial list of national and local indicators it will use to measure progress. The indicators have been split into three priority categories.

National indicators have been drawn largely from the national NHS Outcome Framework (NHSOF), Public Health Outcomes Framework (PHOF) and Adult Social Care Outcome Framework (ASCOF), and reflect what has been identified within the Warwickshire Health and Wellbeing Strategy as key factors in achieving the Board's three priorities.

Local indicators have been drawn from the Joint Strategic Needs Assessment (JSNA), and like the national indicators, reflect what has been identified within the Warwickshire Health & Wellbeing Strategy as key factors in achieving the Board's three priorities.

Reviews

The outcomes and indicators contained within this framework will be reviewed in line with reviews of the Health and Wellbeing Strategy on an annual basis, or as indicated by the Board.

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Warwickshire Health and Wellbeing Board's Performance Framework

DASHBOARD OF OUTCOMES

Our Principles: Independent living | Prevention and early intervention | Integration | Partnership work | Quality | Value for money | Engagement

Key Statutory Frameworks: Adult Social Care Outcomes Framework (ASCOF) | NHS Outcomes Framework (NHSOF) | Public Health Outcomes Framework (PHOF)

	OUTCOMES	INDICATORS
PRIORITY 1: Mobilising communities to develop and sustain their independence, health and wellbeing	People have healthy lifestyles	1.1. Smoking rates in over 18s reduced (PHOF 2.14) 1.2. Smoking rates at time of delivery reduced (PHOF 2.03) 1.3. Rates of alcohol related hospital admissions reduced (JSNA) 1.4. Weight in schoolchildren reduced engaging local communities in creating opportunities for physical activity (PHOF 2.06i, 2.06ii) 1.5. Utilisation of outdoor spaces for exercise increased (PHOF 1.16)
	People are independent	1.6. Rates of diagnosis for people with dementia improved (NHSOF 2.6i – Being Developed) 1.7. Number of people with dementia being supported in sustaining independence post diagnosis increased (NHSOF 2.6.ii – Being Developed) 1.8. Number of adults with learning disability who live in their own home or with their family increased (PHOF 1.06i) 1.9. Number of people using social care who have control over their daily life increased (ASCOF 1B) 1.10. Number of admissions to residential and nursing homes reduced (ASCOF 2A)
PRIORITY 2: Improving access to services	People have better access to services	2.1. Hospital admissions reduced and discharges improved (PHOF 4.11) 2.2. Patients' access to primary care services improved (NHSOF 4.4i) 2.3. Proportion of people feeling supported to manage their condition increased (NHSOF 2.1)
PRIORITY 3: Public services working together	Integrated/ better coordinated care	3.1. People's experience of integrated care improved (NHSOF – Being Developed) 3.2. Better Care Plans developed and delivered
	People are poverty free	3.3. Proportion of children in poverty reduced (PHOF 1.01) 3.4. Number of young people not in education, employment or training reduced (PHOF 1.05) 3.5. Number of winter deaths reduced (Excess Winter Deaths, WMPHO) 3.6. Proportion of affordable housing increased (JSNA)

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